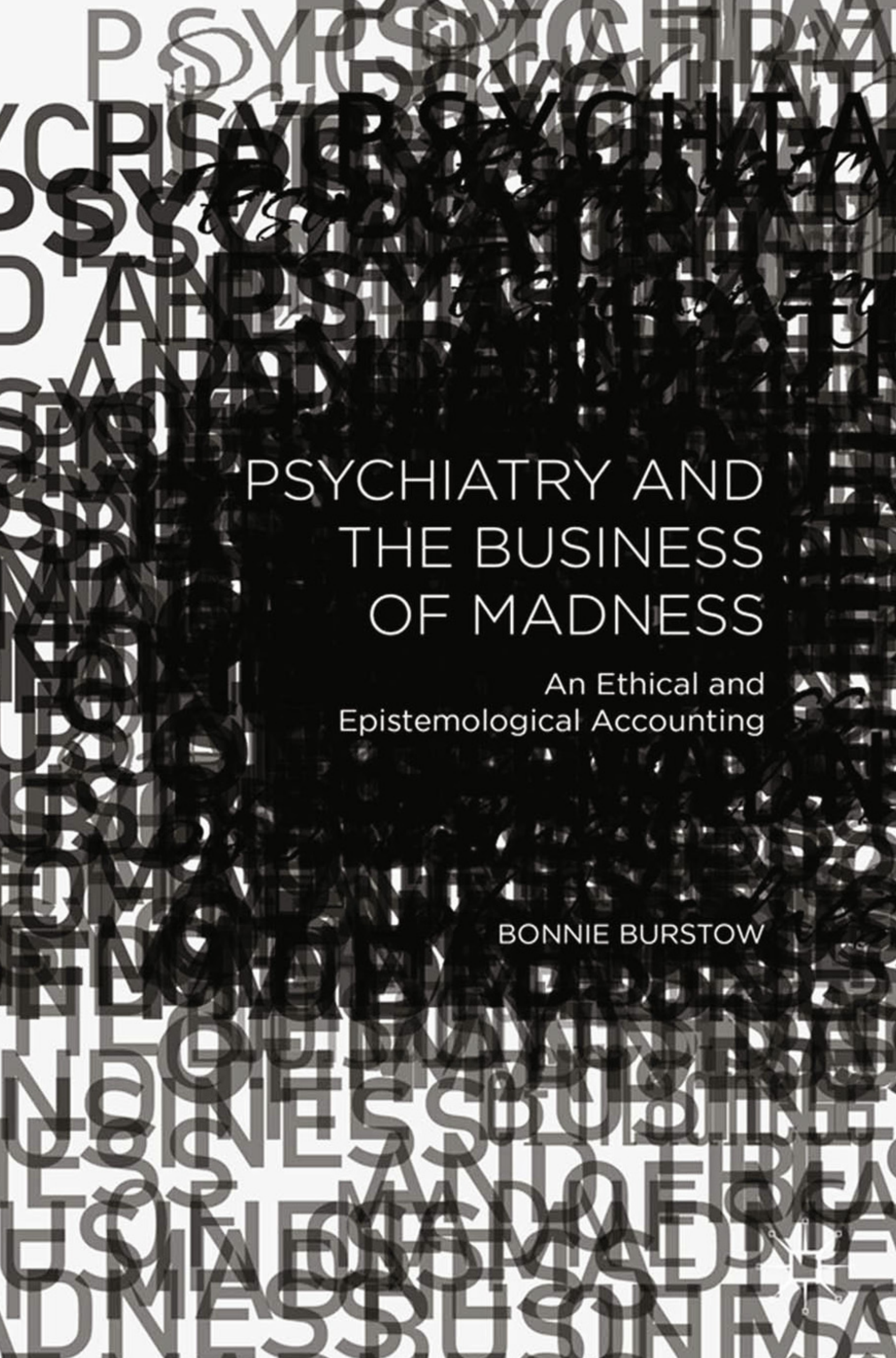

PSYCHIATRY AND THE BUSINESS OF MADNESS

An Ethical and Epistemological Accounting

BONNIE BURSTOW

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This book is dedicated to psychiatric survivors and their loved ones everywhere

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CHAPTER 1

Introduction to the Study: Unveiling the Problematic

This is a study of psychiatry. It is a study of an area officially a branch of medicine and overwhelmingly seen as legitimate, benign, progressive, and effective. That psychiatry is typically so viewed is readily apparent and may seem a "no-brainer." Doctors specialize in it. It is covered by our health insurance, overseen by ministries of health. A high percentage of the population uses its treatments. People encourage their loved ones to consult a psychiatrist when encountering "personal problems." And the media routinely report its "discoveries" and "improvements," much as they report "breakthroughs" in the treatment of cancer. But what if society had it wrong? What if this were not legitimate medicine? What if psychiatry's fundamental tenets and conceptualizations were inherently faulty? Indeed, what if—despite some helpful practitioners—it does far more harm than good? Such is the position of this book. While, on the face of it, this position may sound bizarre, it is important to note that for decades now scholars have indeed demonstrated fundamental and overwhelming problems both with the treatments and with the underlying conceptualizations (see, e.g., Szasz, 2007/2010; Breggin, 1991a; and Woolfolk, 2001). Correspondingly, unlike with any other branch of medicine, there is a long-standing international movement (largely comprised of folk that it has allegedly served) protesting most everything about it.[1]

While I in no way dispute the very real abyss of agony and confusion into which human beings sink, nor the enormous importance of support, what makes this book a challenge is that it invites the reader to take an about-turn or, minimally, to hold in abeyance the seemingly indisputable truths about psychiatry that they may have taken for granted all their lives—that whatever its shortcomings, for instance, it is benign and scientifically valid. I ask you more fundamentally to be open to questioning the very concept of mental illness on which psychiatry rests, a counterintuitive thing to do given that mental illness appears to be all around us—in the rambling of the street person, on billboards, in hospitals—and, as such, seems as real as the air we breathe. What is involved here, to be clear, is revisiting what seems to be cut-and-dry, stepping outside the circle of certainty that has bit by bit been built up around this institution and daring to rethink.

This is a foundational study, a critical archeology, as it were.[2] The ultimate purpose of the study is to awaken and to disturb. Not an easy task for in part psychiatry has the power that it does precisely because it is reassuring, in other words, precisely because we do not wish to be "disturbed." We want to know that the people whose being-in-the-world particularly trouble us are elsewhere or are someone else's problem. At the same time, we want to know that there are creditable people with answers—and on the surface minimally, who could be more credible than the people entrusted with the health of society? We want to know that our ways of life are reasonable. We want to know that both those who strike us insane and those who just need a "tune-up" can be helped, that there are concrete and discrete diseases at the root of the misery that people face, that we as a civilization have progressed tremendously, that there are now expert, enlightened, and indeed humane solutions to human unhappiness, misery, and confusion.

Fear, of course, underlies much of this need for comforting answers. While we may have trouble accessing this level, on a deep level, to varying degrees, it is ourselves that we fear; and it is reassuring that there are experts at hand that can keep us from losing our grip. We may also be authentically frightened and wanting to protect people dear to us who are in obvious distress. The medical paradigm in this regard acts like a metaphoric tranquilizer in its own right. Behind the medical language and commitment lies a deep-seated angst. We fear the subterranean parts of ourselves—the part that thinks or acts in ways that appear out of step; we fear for those close to us, all the more so if they strike us as vulnerable. In the process, we essentially "other" what does not strike us as rational, as "okay," as "normal." Correspondingly, we fear the "other," the person who is not like us, or who we fervently pray is not like us. If the person is uttering words that we cannot wrap our minds around, if they are muttering to themselves, if their appearance is decisively outside our comfort zone, we are especially likely to surmise that they present a danger to the community and "need" to be under control. Except when they are our loved ones—and often not even here, for note, it is kin who most commonly turn to psychiatry—the compassion that we often feel in the process generally does not alter this judgment, for we are convinced, indeed are continually primed to be convinced, that such measures are for their own good.

This depiction, of course, overgeneralizes for the purpose of making a point. Without question, there are many people—kin, fellow survivors, even relative strangers—who struggle authentically to help distressed or distressing others irrespective of their own position on psychiatry. More to the point, there are some—myself included—who view psychiatry differently. Throughout the world, nonetheless, though most especially in the West, there has been a huge acceptance of psychiatry. Country after country has mental health laws, has places of detention called "mental hospitals." Correspondingly, the general populace speaks readily of "mental illness," of "schizophrenia." The buy-in progressively, in other words, is enormous. From the vantage point of this book, that is the bad news.

The good news is, however profound the buy-in, there are fissures in most people's acceptance of psychiatry, and these can be seen in the everyday world. Take those moments that come upon us unaware. Occasionally when watching a television program, we witness a fictional judge responding to the testimony of a fictional "mental health expert" with a degree of ridicule, maybe a touch of irony, and without necessarily intending to do so, we begin to nod in acknowledgment. We may be concerned by how cloudy our next door neighbor's thoughts have become since starting Prozac and find ourselves expressing the thought that some people are "overmedicated." Even some medical model psychiatrists (psychiatrists who believe that biological abnormities underlie what they call "mental disorders") exhibit such doubt. That is, while regarding old standbys like "bipolar" as unquestionable—for it seems impossible to question the legitimacy of this category—there are medical model psychiatrists themselves who are uncomfortable with several of the "disorders," moreover who express dismay over how readily "distress" is conflated with "disorder" (e.g., Horwitz, 2002). Herein lies the beginning of critique. That we all have such glimpses, or to put it another way, that we all experience such moments of disjuncture, I would add, is important for they are a base from which to proceed. Moreover, it is urgent that they be attended to, for as researchers such as Whitaker (2010) have amply demonstrated, we are facing a virtual epidemic of iatrogenic diseases (diseases caused by medicine, in this case, by psychiatry); the alleged progress in which society takes comfort is dubious; indeed, we have allowed something which is arguably highly problematic even on a small scale to mushroom out of control; and as members of society, we have reason to be concerned.

The Focus of This Book

The business/institution of psychiatry is the focus of this book. By this I mean not only psychiatry as a discipline and profession per se, albeit that is most focal. I mean all that surrounds it, make it possible. Insofar as they facilitate the work of psychiatry, I include here the various apparatuses of the state—courts, mental health laws, ministries which provide funding, mechanisms of enforcement, mechanisms of oversight. I include industries that feed it and which are in turn fed by it, such as the pharmaceutical industry and the medical research industry. I include the army of professionals that contribute to the work of psychiatry—nurses, doctors, social workers, psychologists, caseworkers, academic researchers, occupational therapists, policemen. While it most assuredly is not focal, for the work involved is typically contractual and largely of a different order, naturally I include as well the branch of psychiatry known as psychoanalysis, but only peripherally—that is, only to the extent that it is part of, buys into, depends on, or contributes to the work of the larger institution. The question is, how are we to understand this institution? How does it work? What is it genus? Its nature?

Starting the Work: Beginning to Bring the Institution into View

A few facts become obvious once we step back far enough to get to a good look at this institution. To begin with, psychiatry is prestigious. It is, of course, largely because medicine per se is prestigious—hence the significance of its being a branch of medicine or being seen as medical. Insofar as psychiatry is prestigious, it exercises power. The point is that people believe what medical doctors state and what medicinal doctors recommend. At least as significant as its power to persuade and hardly separable from this is its power to act and to enforce. The bottom line is that psychiatry is sanctioned by the state, is funded by the state, is authorized to act by the state. Moreover, it is given authority to intrude in highly personal ways in the private lives of others (generally when at their most vulnerable)—even authority to strip people of what normally is thought of as basic human rights—freedom of movement, freedom of association, freedom of thought itself. In this regard, as everyone who has been picked up and dragged to an institution against their will knows only too well, psychiatry is essentially a coercive, an almost "above the law" institution, backed by the power of the state and facilitated by other agents of the state. Even on a seemingly tame level, it is enabled to do what it would be blatantly illegal for anyone else to do. For example, its members are authorized to prescribe psychedelic drugs that are listed as addictive, whereas others who dispense similar substances face criminal charges. On a more obviously problematic level, it is not only mandated to incarcerate involuntarily, it is the only profession that can as a matter of course utterly take away the freedom of people who have committed no crime. Correspondingly, both directly and indirectly, it may force people to imbibe substances which they vehemently do not want—substances which dramatically alter their very being-in-the-world—all this in the name of help. As such, it is not only a regime of ruling, to employ the language of institutional ethnographer Dorothy Smith (2006, 2005, and 1987), it is a particularly formidable one.

As is the case with most institutions, to a large extent, psychiatry operates through discourse, through language, through speech. There is something very special about its language, however, something critical to understanding it. Significantly, a high percentage of its speech is what philosopher J. L. Austin (1979) calls "performative." That is, its words have the force of law and are "true" because someone in the profession utters them. In this regard, it is in many ways akin to the speech of kings in earlier eras. Just as a nobleman or peasant in a bygone era would have been exiled by the sheer fact of the reigning king stating they are in exile, someone is officially "mentally ill" or "of danger to self or others" by virtue of the fact that they have been pronounced so by psychiatry. To use a more obvious example, someone is in effect committed involuntarily to an institution by virtue of two psychiatrists having signed a document so declaring it.[3] Once such a document is signed, significantly, it would make no more sense asking if the person were "really committed" than it would asking if a person is "really exiled" after the ruling monarch has pronounced them so. The very fact that two psychiatrists have signed to this effect makes it so. On a different level, what likewise adds to psychiatry's power, its core concepts and words—words like "schizophrenia," "mentally ill"—are hegemonic, that is, are dominant, are accepted far and wide as valid, indeed, have become so much a part of everyday life that the fact that they are intrinsically ideological escapes detection. By the same token, they are accepted as authoritative in courts of law. So are the pronouncements based on them. By this I do not mean that they cannot be challenged, but the challenge must be part of the same discourse, must obey the same rules. To be clear, while a psychiatric pronouncement such as "Jill is schizophrenic" may be called into question, only on the basis of the words of other psychiatrists—people, significantly, who have undergone comparable training, overwhelmingly believe in the same concepts, apply the same texts, are granted the same credibility.[4] As such, this powerful system is additionally a closed system, a circular system, with every part reinforcing every other, and with little or no room afforded to other “expertise,” certainly not the expertise of the “patient” or friend or parent who may understand things differently.

Gaining a Concrete Feel for the Regime

As institutional ethnographers such as Smith (2005 and 2006) have pointed out, we understand regimes of ruling best not so much by looking at examples as by finding entry points in the everyday world, points of disjuncture in real people’s lives, then using that disjuncture as a way to open up the regime. Roughly speaking, a “point of disjuncture” is a rupture in the fabric of our daily existence—one which we have no easy way of comprehending or addressing, for it largely originates from “elsewhere and elsewhen.” A simple example would be taking our children for their weekly walk to the park only to discover a bulldozed site where the local park used to be.

An entry point that I would pursue now for the purposes of initial understanding is the situation of an unfortunate young man, a horrified mother, a “suicide,” and an official complaint. Something horrific has happened. Devastated, a young man has killed himself. A profound disjuncture for the young man and for his mother. The mother has filed a complaint with the College of Physicians and Surgeons of Ontario. It is this complaint (my first knowledge of the situation) which is our entry into the regime. As we follow the leads provided, fundamental truths about the institution surface, with those truths shedding light on the case just as the case sheds light on the institution as a whole.

While I will be anonymizing them for reasons of confidentiality, a number of documents related to the complaint are sitting on the desk in front of me. One which is particularly instructive is called “Reasons Supporting Review of CPSO Inquiries, Complaints and Reports Committee Decisions: #_________” (identifying number of complaint deleted). Start reading it and it becomes clear the claimant Julia James (an interviewee for my research) filed a complaint charging psychiatrist Dr. R. W. Hunt with incompetence following the suicide of her son Kevin James (all pseudonyms). It is also clear that while the College had concerns about some of Dr. Hunt’s actions and so ordered some minor remedial measures, it did not find Dr. Hunt guilty of incompetence. It is clear, correspondingly, that Julia is appealing that decision.

I also have on my desk the formal decision of the Inquiries Complaints and Reports Committee (named “Inquiries, Complaints and Reports Committee Decisions and Reasons”). Examples of related documents likewise on my desk are: (a) two summary statements of the chronology of events that culminated in the complaint; (b) a psychiatric admission order file dated September 17, 2004, from the Department of Psychiatry in a general hospital, hereafter referred to as “General Hospital”; (c) a “Consultation Report” from the General Hospital; (d) a document entitled “Clinical Conference Summaries” from that same hospital, dated September 20, 2004; (e) a clinical summaries report from the General Hospital, dated September 23, 2004; (f) a patient registration record for Kevin James from the General Hospital, dated March 22, 2005; (g) a patient discharge sheet from the General Hospital, dated March 23, 2005; and (h) what is called

"Psychiatric Note"—the report of a consultation from a Dr. J., dated November 7, 2005.

Trace where these documents lead and listen to the expert knowledge of the claimant who navigated this system, and a huge bureaucracy involving complaints comes into view, one that would appear to place the claimant at a distinct disadvantage. Salient facts here include: Regulations restricting what can be used as evidence prevented Julia from using statements unearthed in a related complaint against a second psychiatrist; claimants are provided with little information about the process; neither claimants nor their lawyers may cross-examine the physician being charged. Correspondingly, the deliberating panel was largely stacked with psychiatrists—a seeming conflict of interest, yet a standard one for it is policy that the doctors on these panels come from the same discipline as the physician being charged. Nor was the claimant apprised of what would appear to be important information—former complaints against this psychiatrist and a previous finding of misconduct.

The issue of what is interpreted as evidence or good evidence presents further problems. What is not surprising given the constitution of the panel, good evidence appears to be conflated with what psychiatrists say and associated with very little else. Indeed the very fact the psychiatrists have written something on an official document tends to give their opinions or their beliefs the status of fact, even when there is good reason to believe that psychiatrists have gotten the story wrong. By way of example, in their report, the Inquiries, Complaints and Reports Committee state that Mr. James "had a strong family history of bipolar disorder, possibly schizophrenia and relatives who had committed suicide." A few pages later, they depict the family background as "a strong family history of psychotic illness." Such statements constitute a point of disjuncture for Julia for according to her, only one relative had committed suicide previously—one, additionally, who was highly accomplished; and while relatives have had their problems, from her vantage point, her family could not legitimately be described as having a substantial history of "mental illness."

Objecting to this depiction, Julia writes in her appeal, "We do *not* have 'a strong family history of psychotic illness.'" The question arises: If there was no such history, how do these facts arise, which the panel confidently quotes? Julia hints at one answer when she speaks of how psychiatry interprets everyday feelings. A further answer—and one, note, equally pivotal—links in with the bureaucratic, document-laden nature of this process. Such "facts" are sprinkled throughout the psychiatric files named earlier, albeit they are files created on the basis of examining one patient only—Kevin James. A number of the General Hospital records, for example, make reference to such a history. Additionally, Dr. J. (the psychiatrist doing the consult) himself refers to such a history. Statements in this regard include, "A maternal uncle committed suicide after coming out as homosexual," and "a maternal great-aunt also committed suicide" (p. 2)—the first claim, according to Julia, a mixture of fact and fiction and the last totally fictitious. Now to be clear, Julia acknowledges that one family member had serious problems and rightly or wrongly was diagnosed as "schizophrenic." One member, however, does not constitute "a strong family history." What Julia is essentially alleging is that psychiatrists have used this member to impugn the stability of the rest, in the process manufacturing facts. Of course the reader may doubt the veracity or accuracy of Julia's statements. And for sure, there is always the possibility that her statements too misrepresent. That, however, is not the point. The point is that her words bear no weight, whereas the words of psychiatrists are taken as fact, this despite there being no *independent* evidence—that is evidence outside the tangle of psychiatric claims—backing them up.

To be clear, I am in no way suggesting that *this* psychiatrist, *any of* the psychiatrists, or *the panel itself* purposely misrepresented the family background. What I am suggesting is that people have a tendency to find what they are looking for and when it comes to "mental illness," medical professionals look for a telling history.

By virtue of appearing in the medical record, also by virtue of the deliberators too being part of the system, these contentious pieces of history become facts. These facts in turn become the basis for a decision by the college. While it is not explicitly stated, the insinuation is that Kevin's suicide is attributable to a horrendous family history of mental illness and suicide and hence *not due to psychiatric incompetence*. In this construction, the presence of a family member testifying to inaccuracies in Kevin James's file is irrelevant. Irrelevant also is the fact that Kevin just might have been alive today had the "cure" not been worse than "the disease." Herein lies a clear disjuncture. Unfortunately, it is hardly the only disjuncture in Kevin and Julia's story.[5]

What is the situation to which this compilation of files bear witness? The short story is: A talented functioning high school student, Kevin more or less entered the psychiatric system at age 15. Years of cycling through a frightening number of psychiatric drugs followed, some of the most noteworthy of which include: Dexedrine (an amphetamine or stimulant); Adderall (a dextroamphetamine and stimulant); Effexor, an SSRI (selective serotonin reuptake inhibitor) antidepressant; Risperidone (an antipsychotic); Ativan (a minor tranquilizer); Imovane (a minor tranquilizer or anti-anxiety drug); Celexa (an SSRI antidepressant). Some of the medication in question was prescribed by the General Hospital staff. Most was prescribed and initiated by two independent psychiatrists—Dr. Hunt, who is the subject of this complaint; and Dr. Elder (also a pseudonym), who is the subject of a separate complaint. Kevin was on some of these drugs for a very long time, in the case of Dexedrine almost nonstop. He was often on a number simultaneously. Then bit by bit, it happens—a profound disjuncture for Kevin, for his family. A little over a decade after entering the system, this young man's life is in shambles; he tells his parents that his life has been ruined and that he will never get back the functioning brain that he once had. Soon thereafter, he proceeds to a subway station and jumps to his death.

A terrible tragedy no matter how we understand it, and no doubt one that it is tempting for many to call "nobody's fault." This story nonetheless raises the question of the drugging of children. Correspondingly, it raises the question of polypharmacy.[6] That said, let me tell the story again, this time, slowing it down considerably.

At the age of 15 in 1997 a young high school student Kevin James decisively entered the psychiatric system, although at the time neither he nor his parents suspected, nor had reason to suspect just how decisively. He did not see himself, and was not someone who could be seen as, in serious trouble. He was a student who received reasonable grades; and he was coping. However, his teachers felt that he could do better. Correspondingly, while he was a bright and highly creative young man, he had been sad, according to his mother, as a result of deaths in the family.

He is prescribed a mild dose of Effexor by a psychiatrist. Shortly thereafter, he is tested for ADHD by a learning disability specialist at the request of his school (a common entry point into psychiatry). No evidence of ADHD is detected/reported. He subsequently becomes a patient of Dr. Hunt, who, significantly, is *not* an expert on ADHD. Dr. Hunt "determines" that Kevin has ADHD. He prescribes the stimulant Dexedrine—a highly addictive stimulant. While Dr. Hunt's account and the claimant's account differ here, according to the claimant, additionally, Kevin is given this stimulant without consultation with the parents and without anyone being informed of any of the risks.

As is often the case with psychiatric drugs, Kevin fares well for some time, finishing high school, starting university, becoming progressively involved in professional theater. In early 2004, however, after years of use, Dexedrine starts presenting problems for Kevin. He becomes extremely agitated, for example—and he attributes this to the Dexedrine. Apparently not understanding the possible consequences, he cold turkeys the Dexedrine. He also stops seeing Dr. Hunt.

What follows imminently is what everyone describes as a "psychotic break" as well as a suicide attempt culminating in Kevin being involuntarily admitted to the General Hospital. From here the story worsens. According to Julia, Dr. Hunt lies when consulted, stating he has not seen Kevin for months; whereas Dr. Hunt maintains that there was no consultation; and the psychiatrist in charge of Kevin's case at the hospital states that he does not remember. Whatever the reality here, not realizing that Dexedrine withdrawal is involved, the psychiatrist at the General Hospital interprets the "psychotic break" as evidence of an underlying "psychotic disorder," possibly schizophrenia. The psychiatrist places him on the antipsychotic Risperidone, which Kevin stops taking soon after being discharged. Correspondingly, the psychiatrist discharges him into the care of Dr. Hunt.

Once again, Dr. Hunt prescribes Dexedrine, which Kevin takes, albeit not convinced that this is the right drug. Enter Dr. Elder, the other psychiatrist who ends up being the subject of a complaint.

At this point, on the advice of a friend, Kevin sees Dr. Elder. In light of General Hospital's account of the "psychotic break" (an account, you will recall, which contained no reference to cold turkeying Dexedrine), Dr. Elder assumes that Kevin is schizophrenic. Correspondingly, he convinces Kevin's parents that Kevin is indeed psychotic and needs to take an antipsychotic (Risperidone). Unaware of the basis of this prognostics, at this point, the parents do what they are primed to do. They believe the doctor; they accept "the fact" that their son is seriously psychotic and "needs to take his meds." Correspondingly, they strongly urge their son to take his "medication," which he does. And at this point, Kevin descends deeper and deeper into the world of drugs.

Despite the fact that Kevin appears to be reacting badly to the drugs, between November 2004 and January 2005, to the parents' growing consternation, Dr. Elder increases the dose of the antipsychotic. He also adds other drugs, including Celexa (SSRI antidepressant). In the process, Kevin's cognition and general condition deteriorate dramatically. By late January, he is in what his mother describes as a stupor and can barely talk. She speaks to Dr. Elder, and at her encouragement, Celexa is discontinued. However, on February 15, Dr. Elder puts Kevin on 37.5 milligrams of Effexor (SSRI antidepressant) daily. Unbeknownst to the family, he increases this dosage to 75 milligrams. According to the complainant, drastic deterioration follows. Kevin has blurred speech and is unable to process even the most simple information.

What follows after this is a complicated story with many twists and turns, with Kevin becoming violently ill and vomiting uncontrollably, with Kevin becoming so needy that he cannot be left alone, with Julia discovering for the first time the comparatively high dosage of Effexor that her son was on, with Kevin detoxing from the Effexor with the agreement of Dr. Elder yet feeling that he direly needs it, indeed as with the Dexedrine, often begging for it. Other key developments include: Kevin being intermittently suicidal; Kevin intermittently drinking vast quantities of alcohol and intermittently taking himself to or being taken to hospital—either the General Hospital or CAMH; and a psychiatrist at the emergency at CAMH advising the parents that Dexedrine is not a drug for depression and not intended for long use, also surmising that Kevin may be one of those people missing an enzyme that allows them to break down drugs like Effexor. During this time also an independent psychiatrist with specialized training in pharmacology advises the family that Dexedrine is the worst thing that Kevin could have taken.

In March of 2005 on his own initiative Kevin sees Dr. Hunt again. Again Dr. Hunt prescribes Dexedrine. According to Julia, when she intervenes, objecting to the Dexedrine, Dr. Hunt labels her hostile and offers to refer her to a counselor for help.

This is a moment of profound awakening for Julia. Her son is in dire trouble, and the psychiatric profession seems to be deeply implicated. Moreover, her son is demonstrably addicted to some of the psychiatric drugs administered. No longer content to go along, she threatens to expose Dr. Hunt to the College of Physicians and Surgeons of Ontario if he does not get a second opinion. Dr. Hunt proceeds to arrange for a consultation with Dr. J. Dr. J's report is one of the files on my desk.

Of all the reports, this one seems most careful and measured. While Dr. J. writes that the Dexedrine "is not causing any apparent harm at the current time," he concurs with Kevin's decision to discontinue the Dexedrine at the end of the school year, noting that "it is a tricky drug to use, especially as one gets older." He suggests that amphetamine withdrawal could have caused the psychotic break. Correspondingly, he states point blank, "There is no evidence of schizophrenia." He also raises the question of bipolar and the possibility of other antidepressants.

In fall of 2006 Kevin indeed goes off the Dexedrine. While hardly his old self, he appears to be getting his life together, gets an apartment in Orillia, picks up some work. However, in November 2007 he becomes despondent and returns home. In June of 2008 he again sees Dr. Elder, and although his parents are unaware of it at the time, Dr. Elder prescribes Adderall (an amphetamine similar to Dexedrine).

From here the situation deteriorates rapidly, with Kevin again being in and out of hospital and drinking heavily. A brief calm sets in with Kevin eating well and making plans for his future. Not long thereafter, he tells his mother that he is schizophrenic and that he has destroyed the family. A suicide watch is set up at his behest and a couple of trips to the hospital follow. At one juncture Kevin leaves the house, stating that he is going to visit his grandfather. Instead he proceeds to a subway station and jumps in front of a train.

The child with a promising future, the young man who once read philosophy and directed Shakespeare plays is now dead. A couple of weeks later, his parents find a stash of Dexedrine in his drawer.

Going Where the Documents Point

What do the documents uncover or begin to uncover? Various levels of problems, I would suggest. Correspondingly, the further back one steps so as to get a good look at the institution, the more fundamental the problems that appear.

On a simple level, they say something about how the complaints process works, how it disadvantages the claimants, how indeed, it is complicit in manufacturing the "facts" on which its judgment depends. By privileging the voices of the "experts," it either obliterates the other voices, or turns them into secondary texts which are only understood via the texts or testimony of the experts. Note, in this regard, Kevin and indeed the claimant herself has a substantive family history of mental illness by virtue of the doctors saying so. At the same time, it reveals breakdowns in the system—communication breakdowns in particular—how slippage occurs between psychiatrists, between psychiatrist and hospital, thereby placing the "patient" in jeopardy. On a deep level, moreover, it provides a glimpse into how psychiatry manufactures "medical facts" and how it both sidelines and co-opts family.

Read through these documents additionally and take in the state to which this once promising 15-year-old was eventually reduced, and one begins to suspect something more basic—a fundamental problem with the pathologizing and the concomitant drugging of children. Indeed, if we pick up this thread and read through the psychiatric literature with it in mind, a curious fact comes to light—the enormous escalation in the psychiatrization of children since 1987. Indeed, it is as if the industry had suddenly discovered a comparatively untapped market and decided to aggressively pursue it. Robert Whitaker's (2010) American figures are instructive in this regard. As Whitaker reveals, the number of children on disability in the United States in 1987 for "mental disabilities" were 16,200 and they comprised only 5 percent of the children on disability (see p. 216 ff.). By the end of 2007, 561,569 were on disability, comprising half the children on disability. The "children's mental disability numbers," to put it another way, rose 35-fold. Correspondingly, almost all of these were placed on psychiatric drugs, just as Kevin was. While the claim of the medical establishment is that the far lower figures in the past can be attributed to children walking around with undiagnosed mental illness, at least as creditable an answer is that psychiatry is creating mental illness. As Whitaker demonstrates, this is true even literally, for the psychiatric medication on which children are routinely placed and indeed on which Kevin was placed have been proven to create disabilities (e.g., side effects of the stimulants are "psychosis" and "bipolar" symptoms). Something profoundly circular is at work here. Children are put on drugs that cause psychotic symptoms. They are then seen as psychotic and placed on additional drugs.

If the threads followed to date suggest that the approach to children is problematic, a careful examination of the psychiatric literature reveals that the problem is hardly limited to children. As Whitaker (2010) and Colbert (2001) demonstrate, there is no evidence that the adults labeled mentally ill have a chemical imbalance; as with children, adults are placed on drugs on the basis of a presumed chemical imbalance for which there is no indicator, despite decades of looking for one. Correspondingly, research shows that even those seen as psychotic before being on the drugs would have fared better had they never taken them.

I am aware that it is here that even the most open-minded would tend to draw the line. Minimally, they would hold out when it comes to "schizophrenics," for it is "common knowledge" that schizophrenia at very least is a bona fide medical illness, necessitating drugs. Harrow's (2007) study is instructive in this regard. Harrow conducted a longitudinal 15-year study on long-term outcomes for people diagnosed with schizophrenia. The study proves conclusively that in the long run people diagnosed with schizophrenia who do *not* take the antipsychotic medication have considerably better global functioning than people diagnosed with schizophrenia who *do* take the medication. The point is, even were the schizophrenia diagnosis given to Kevin "correct," putting him on such drugs would not only have done him no service in the long run, it would in all likelihood have placed him on a downhill trajectory, albeit one initially undetectable.

I have been avoiding the question of incompetence. I would like to come back to it at this time, for it is this that the case is about. At the risk of disappointing some readers, I will not be rendering an opinion on the question of incompetence as the industry defines it, though for sure, costly mistakes were made. Examples are "misdiagnosis," polypharmacy, and the use of drugs for longer than they are intended. Note in this regard that Kevin was treated for ADHD despite the fact that a specialist in ADHD had found no sign of it. Kevin was thought to be psychotic and perhaps "schizophrenic" on the basis of "symptoms" produced by cold turkeying Dexedrine. Investigate Dexedrine, moreover, and some telling facts come to light. Significantly, the FDA black box warning for such amphetamines (see PDR Network, 2013, p. 2273) states that their use may lead to drug dependence (hence Kevin's addiction to it), and what is every bit as significant, it warns that it can lead to psychotic symptoms. By the same token, Breggin (2000a) reveals and studies such as Cherland and Fitzpatrick (1999) establish that stimulants such as Dexedrine and Adderall can cause manic- and schizophrenic-like disorders.

Viewing the documents in this light may lead some readers to conclude that the two psychiatrists at the center of this case were incompetent. That is one level of understanding and one possible conclusion. Significantly, however, it is one that does not materially challenge the status quo. The larger question is—and some may feel nudged to ask it—what does "competence" even mean in a system such as this? How can we speak of competence when the entire industry is in the business of creating diseases and imbalance? Indeed, would anyone even be better off with a technically competent psychiatrist over a technically incompetent one? A preposterous question on the face of it, but I ask you to indulge me for a moment.

Let us look once again at the three doctors featured most strongly in this case. One, Dr. J. (the psychiatrist who provided the official consultation), is without question competent by industry standards. Indeed, one possible construction that one could put on what has unfolded—and it is not mine—is that this is a story about two bad psychiatrists and one good one. However, what if Dr. J. had been Kevin's psychiatrist? Would Kevin have fared better? At the risk of sounding perverse, let me introduce some doubt in this regard. More particularly, let us look more closely at Dr. J.

On the basis presumably of his conjecturing that Kevin might be "bipolar," Dr. J. ended his report by recommending that another antidepressant be looked into. While he carefully suggests that there is no conclusive evidence of bipolar, in raising bipolar, he seems to be ignoring the fact that "bipolar symptoms" are caused by the stimulants themselves. This far we can see from the documents themselves insofar as we view them in light of the literature on the stimulants. Go beyond these documents, additionally, and you will discover that Dr. J. is a major proponent of electroshock (ECT). Additionally, he is someone who had coauthored an article in which he described using electroshock as a form of restraint, moreover, recommended using it as a form of restraint, this despite the fact that such use at least appears incompatible with Ontario's Mental Health Act (see in this regard Newman, 1984; and Jeffries and Rakoff, 1983). How do we feel about a doctor who casts aside the mental health act when it is inconvenient, who sidesteps the very slim protection that patients have? Given that he comments on Kevin's "depression" and given that electroshock is specifically recommended for depression, still other questions arise. Had Kevin been his patient, would Dr. J. have used ECT—a treatment, significantly, that has been conclusively proven to create cognitive impairment, moreover, that commonly leaves people unable to navigate their lives (in this regard, see Sackeim et al., 2007; Breggin, 1991b; and Burstow, 2006)? And if so, would Kevin truly have been any better off?

To be clear, I did not introduce the alleged sidestepping of the law to demonize or even single out Dr. J., nor would it make sense to do so. Unfortunately, despite the esteem in which society holds doctors, as now retired mental health lawyer Carla McKague once put it, "psychiatrists routinely break the law."[7] The point is that Dr. J. essentially uses the same harmful substances, draws on the same resources, plays by the same rules. Competence as the industry understands it—and for sure Dr. J. is highly competent—may be reassuring in other words. However, it is a deceptive reassurance for it leaves the client in no less jeopardy—just a slightly different kind of jeopardy.

Just as the validity of the concept of "competent psychiatric practice" starts to be called into question by these texts, so does the validity of the related concepts of "diagnosis" and "misdiagnosis." If harm would have pertained to Kevin irrespective of whether or not the diagnosis of "schizophrenia" were correct, the question arises whether the diagnoses themselves have validity. As I will be demonstrating later in this book, a careful look at their construction (see in this regard Kirk and Kutchins, 1997; Mirowski, 1994; and Woolfolk, 2001) reveals fundamental philosophic flaws in the diagnostic conceptualizations, the fact that they hopelessly overlap, for example.[8]

This brings us to the kingpin—"mental illness" itself. Conjecturing that the College's construction of Kevin as having a long history of extreme mental illness may have contributed significantly to her losing the case, in her appeal, Julia responds:

> If Kevin was mentally ill, then so am I, since we were temperamentally identical. And if I am mentally ill, it has never interfered with my ability to function at a high level, just as it has never interfered with Kevin's ability to function until he was given psychotropic drugs. I am an anxious person, and so is most of my family, but I think that . . . society should rethink the trend to labeling all the people who are sad and worried and encouraging them to dull their feelings with drugs.

There is heroism in this statement. Illusions about professionals at an end, this is a mother standing up for her child, moreover, standing up for her whole family. Imagine what it must have taken to pen this knowing full well that the officials in question will inevitably see you as part of a family which is a hotbed of "psychosis." She is also a woman indicting the system as a whole. While you get the sense that she is flirting with the idea, Julia, of course, falls short of stating that there is no validity in the concept of "mental illness," perhaps because this is further than she would personally venture, perhaps because advancing such a claim would be imprudent under the circumstances. The reader is under no such constraints. Begin looking through the critical literature, indeed, and one quickly discovers that many have convincingly argued just that.

The point is, as Szasz and others have repeatedly pointed out (e.g., Szasz, 1961, 1970, 1987, 2007/2010; Woolfolk, 2001; and Schaler, 2004), the very concept of "mental" illness is untenable, for illness by definition pertains to *the body*. The *mind* is simply an activity of the body. As such, it can no more be said to have an illness than "running" does, also an activity of the body. To put it another way, "mental illness" is, as Szasz (1961) asserts, a metaphor. Indeed the fact that it is metaphoric only is even acknowledged by the early psychiatric pioneers. Note, in this regard, Kraepelin (1901/1968, p. 1), who stated in his lectures, "It is true in the strictest sense we cannot speak of the mind as being diseased," or Von Feuchtersleben (1847/1955, p. 412), who clearly identified the use of medical language as a form of analogy, writing, "The maladies of the spirit . . . can be called diseases of the mind only per *analogiam*." Now, to be clear, there is nothing wrong with using metaphors or analogies. We use them all the time. We refer to sick jokes, to the economy as sick. However, we do not bring in a doctor to cure the sick joke or attend to the ailing economy.

Of course, the brain is an organ of the body; brains do have illnesses; accordingly, for centuries now biological psychiatrists have argued that "mental illnesses" are brain diseases whose physical-chemical markers are simply yet to be discovered. This notwithstanding, what is generally considered the psychiatric bible—*The Diagnostic and Statistical Manual of Mental Disorders* or DSM (see American Psychiatric Association, 2013) does not claim that the diagnoses in question are brain diseases, only that it hopes that the biological basis of the various "mental illnesses" will be found. The framers put it in this somewhat duplicitous way because after over a century of looking, and indeed after dedicating vast sums of money to such research, moreover with bald-faced assertions ever circulating, including from official sources, that schizophrenia, for example, has been "discovered" to be a brain disease, there is no proof whatsoever that a brain disease or any other disease underlies any of the current "mental illnesses."[9] The fact that this is an institution that operates on conjecture and declaration rather than on proof, an institution that not just occasionally but routinely calls things diseases in the absence of observable physical markers, I would add, raises the question whether we are truly dealing with medicine here, at least in the modern sense of the term. Indeed, it raises the question of whether we are dealing with science at all.

To be clear, no one here is denying that people may be highly distraught, that people become confused, that people sometimes are in dire need of help. Nor is anyone denying that some people may have been helped by a psychiatrist just as some people may have been helped by counselors, priests, homeopaths, or teachers. What is at issue is "the medical model" and the institution constructed in its name.

This Entry Point/Other Entry Points

It was to a large extent an accident that our initial entry point into this institution was Kevin/Julia's story. While it may look as if I chose it because it was extreme, significantly, what is so upsetting about this story is that aside from the sobering ending, it is *not* extreme, indeed is something that *routinely happens*, happens more and more with every passing day—a child being put on a substance like stimulants, a young person being plied with ever more psychiatric drugs, in the fullness of time that person becoming progressively less able to cope. What is also apropos, I did not exactly choose it. Confident that any disjuncture could serve as a pathway into this system—and that is the strength of institutional ethnography as methodology—I attended a meeting of people critical of psychiatry, explained the focus of my research, and invited anyone who so wished to become a research participant and share their psychiatric files with me. Then I held my breath. While naturally, a careful consent process followed, my decision going in was to use as my entry point into the regime the documents of the very first person that proffered their files. Julia was the first to raise her hand—and I thank her as well as others who did so. Other situations which I known over the years and other files could have easily served as an entry point and would have shed a similar light.

That is not to say that there would have been no differences. Some—Connie's story, for example—would have shed more light on electroshock and on the punitive dimension of psychiatry (see Chapter Eight). By the same token, stories that take up daily life in the hospital would have shed more light on the hospital per se—its coercive nature, the privileges system, what is euphemistically known as the "revolving door syndrome." While there are warnings of this in Julia/Kevin's story, some stories would additionally have made more visible the way in which psychiatry catches whole families up in its net, often generations of abused women. Consider, in this regard, Sandy's testimony, "My mother has a psychiatric history as well . . . oh yah, grandmother, mother, sister . . . and it's the same thing; she had been abused" (in Burstow, 1994). These differences notwithstanding, most all points of entry would have led us to examine carefully the question of drugs, additionally, the issues of rights and grievances. All would have shown a regime of ruling in which the psychiatrist's voice displaces all other voices and creates the facts to which the system, indeed, the world as a whole gives credence. All would have shown the centrality and power of the psychiatric file. If pursued with rigor, moreover, eventually all would have pointed to the importance of going extra-local, to texts like the DSM, to vast industries like the multinational pharmaceuticals, to structures, documents, activity beyond the view of the people caught up in the system. Correspondingly, all would have begun to bring into view an institution whose fundamental conceptualizations and treatments are problematic. Moreover, they would have provided a reason and a standpoint for further inquiry.

Locating Myself as Researcher

I have come to what understanding I have precisely by beginning with such voices, heeding such voices. I come to it, correspondingly, out of a very particular location. I am a child of a psychiatric survivor, Sam Grower—a man who in his thirties came to be labeled and treated as "manic-depressive." This beginning in itself has provided me with a very special entry point.

My father, indeed, at times seemed to have what would commonly be called "delusions." Also, his moods could change on a dime. Now he led a relatively good life; this, I would add, despite being a psychiatric survivor. Despite frequent hospitalizations and repeatedly being subjected to electroshock, in the last years of his life he ended up holding down an important government post. That notwithstanding, much of his adult life, especially his thirties and forties, was tumultuous. Moreover, I could not help but notice that there were consequences to the "treatments"—ones quite different than those the profession spoke of—memories, for example, that never came back, regrets that he did not know how to name. Also despite what everyone referred to as his "mood swings" on one hand and his "depression" on the other, I could not help but notice that he did not just "end up in trouble," that there were economic crises that understandably propelled him into a downward spiral (e.g., being sufficiently poverty-stricken that he had not the money to put food on the table). Correspondingly, as I lay in bed at night taking in the sounds about me, it was painfully obvious that a very particular dynamic between my parents generally preceded what were then called "breakdowns"—shouting matches, for example, which my mom invariably won, which, I suspect, she felt she had to win for the sake of the family, and which my father almost invariably emerged from feeling deflated.

Albeit she was a highly astute woman, for a long time I thought that my mother was unaware of her role in what was transpiring. Then one day I returned home from school to find her in the hall, shaking her head. When asked what was wrong, she answered, "Your dad's in hospital again." Then she added, "And *I* did it" (an overstatement with its own truth). As I looked in her eye, I realized that she knew, to a degree, had always known—she just did not know how to shift this dynamic in which they were both caught. It was around this time also that I began to suspect the role of drugs (in this case, blood pressure medication) in my father's depression—something later verified.

My father died very young from a heart attack. I did not forget the lessons that I learned from him. What I learned, to spell it out, is that while for sure people have their own vulnerabilities, the social and the interpersonal are deeply implicated in "individual problems," correspondingly, that psychiatry itself just might be a house of cards.

Later because of my work and because of my politics, I was to come into contact with many psychiatric survivors, initially, indeed, a large number of electroshock survivors. I quickly came to understand that most shock survivors were women, and what was alarmingly clear, while most received far less shock treatment than my father, they were significantly more impaired by it. That gender was an important issue here was all too evident. So was the chilling fact of professional misrepresentation, for the women to a person had been told that ECT was "safe and effective." As I took in the very real plight of the women around me—women who could no longer do meaningful work, women who took notes all day long because they could not remember even the simplest details—how hollow psychiatry's litany of reassurances began to seem! Again, a moment of disjuncture and an invitation to inquire further.

For over 35 years, I have made common cause with psychiatric survivors. I have done so as an ally centrally involved in such activities as demonstrations, hearings, and journal editing. I do so as a scholar who teaches courses, mounts conferences, pursues research, supervises theses in this area, all of them to varying degrees, taking up the psychiatric survivor standpoint.[10] Albeit from a place of privilege that necessarily gives me pause, I do so as a feminist psychotherapist who supports clients injured by the system. More fundamentally, I do so as a fellow creature who knows that, ultimately, we all *bear responsibility for*, moreover, we all *have a stake in*, what kind of world we create. These activities, these voices, and this type of standpoint underpin this book.

The Research/The Grounding/The Process

This book is the culmination of decades of research. It is also the product of two very specific research projects—conducted primarily between January 2008 and November 2103. Both of them investigate psychiatry as an institution, and they are called, respectively, "The Psychiatry Project" and "The Madness Project." The first included 89 interviews, analysis of hundreds of documents, and dedicated periods of observation. The second included 6 interviews and 1 focus group.

The primary data underpinning this book, of which these projects are part, includes interviews, institutional texts, research texts, observation notes, and statistical information. Examples of texts drawn on are: case files, psychiatric manuals, personal notes, historical books, professional texts, critiques of psychiatry, advertisements, research articles, reports on drug trials, submissions to the FDA (Food and Drug Administration), websites, videotapes, and survivor testimony. This latter category, I would clarify, includes both formal and informal testimony, with the lion's share of the formal delivered at hearings held at city hall in Toronto—a three-day hearing into electroshock in 1984 and two two-day hearings in 2005, one into electroshock and the other into psychiatric drugs.[11] Interview data includes interviews which I have conducted over the years, though most of it arises from the more focused research projects.

Two different types of interviewees figured in the Psychiatry and the Madness projects per se—people who self-identified as participants (n = 93), and officials who were granting an interview as part of what they saw as their job (n = 8) and so might best be thought of as "informants." Some of the officials interviewed were participants in the full sense, while others were not. Given my intent to come to as full an understanding as possible of the workings of the institution, interviews were not restricted to a few populations only. Rather I interviewed several people from each primary constituency whose involvement with the institution suggested that they had knowledge pertinent to opening up key aspects of the regime. Participants, accordingly, included not only psychiatric survivors and psychiatrists, which it centrally did, but more extensively, survivor advocates; family and friends of survivors; administrators of "services"; peer workers; mental health lawyers; psychiatric residents; psychiatric supervisors; current and former officials of related governmental bodies such as Health Canada; employees attached to the legal apparatus (e.g., chairs and registrar of Ontario's Consent and Capacity Board); practitioners of cognate disciplines (e.g., psychology, social work, nursing); and students.

In total, counting those interviewed in the two years before these particular projects officially commenced, I interviewed 119 people. I examined and analyzed hundreds of texts. As a part of the Psychiatry Project, I also conducted 15 professional observations—all of them hearings of Ontario's Consent and Capacity Board. Such focused observation, I would add, not only led to further elaboration and not only constituted a form of verification in their own right, they unearthed poignant contradictions and more generally allowed me to see beyond the stories that the participants or that I myself knew to tell.

As with all qualitative research but institutional ethnography especially, sampling was purposeful and strategic. Common sampling strategies employed include maximum variation, critical case, stratified purposeful, and opportunistic.[12]

Overall, as the reader will discover as she continues this journey, there is an organic and reflexive nature to how this research and this book progressed. On one hand, the study was informed by observations which I have made over the years, as a professional, as an advocate, as a community member, as an activist. On the other, incidents that called out for attention kept occurring in the community of survivors and allies—someone unexpectedly killed himself, two pivotal members of the community ended up in serious conflict with one another. As an active member of the community, I inevitably struggled to figure out how these played out as they did and at times tried to assist. The analysis that arose from that pondering and those actions in turn themselves guided the investigation.

Different types of research were conducted—for example, content analysis, historical research, medical research, statistical research—with a variety of methodologies coming together. The intent was to shine as much light as possible and in whatever way possible. Given that a formidable regime of ruling was the focus and given that institutions largely rule through texts, not surprisingly, among the methodologies most fruitful were institutional ethnography and critical discourse analysis—and in that order.

The reader already has a taste of institutional ethnography as well as the ways in which it is employed in this inquiry. The brain child of Dorothy Smith (2006, 2005, and 1987), institutional ethnography (commonly referred to as "IE") is concerned with unpacking regimes of ruling. Particularly focal is the analysis of institutional texts and the work sequences in which they are embedded. The assumption of IE is that ruling happens through texts, more specifically through the activation of texts. IE concepts and strategies most pivotal to this inquiry include: standpoint in the everyday world, the disjuncture, arriving at the problematic, tracing local problems to extralocal origins, and the identifying and prioritizing of what has come to be called "boss texts"—texts higher up in the hierarchy that influence both the creation and the deployment of other texts.

To unpack a few of these terms, a standpoint is not the same as a perspective. A person's standpoint is a privileged view made possible (albeit far from automatically given) by their location. What an institutional ethnographer does is assume the standpoint of the person(s) experiencing the disjuncture and methodically trace how it comes about, in the process "researching up" through the institution. A disjuncture in turn, as already discussed and shown in the interrogation of Kevin's death, is at once a contradiction and a profound rift in people's lives—one that they have no easy way of comprehending—for it originates from elsewhere and elsewhen. An example of a simple and less dire disjuncture is taking your children out to the local park to play just as you have every Saturday for the past six years, only to find a bulldozed lot where the park used to be (for this example, see Turner, 2014). An institutional ethnographer would follow every thread that presents itself in an attempt to trace what has happened. Of particular importance in such tracing are boss texts—texts high up in the textual hierarchy. As one traces the use of these texts to generate subsidiary texts and investigates how all the texts come together at once to enact and to rationalize, one begins to glimpse the profound ideological circle which characterizes the ruling regime and the intricate ways in which people are trapped.

A mode of discourse analysis which is explicitly counterhegemonic, critical discourse analysis—the second of the major methodologies taken up—is likewise focused on texts, on the exercise of power, and on the functioning of institutions. Critical discourse analysts on whose approaches I draw include Foucault (1969/1989 and 1980), Bloomaert (2005), and Gee (2005). Albeit I tend to avoid his terminology in the interest of clarity, the pioneering concepts of the postmodernist philosopher Michel Foucault (1980) have particularly served as touchstones. Significant Foucauldian concepts drawn on are "the archive" (roughly speaking, the set of terms and concepts which function in a discourse, more particularly, the rules by which some things can be said and others are disallowed) and "subjugated knowledge" (the knowledge or discourse that a specific discourse suppresses or "disqualifies as inadequate") (p. 82).

While drawing on both institutional ethnography and critical discourse analysis, significantly, I depart from each in key ways. Institutional ethnography focuses overwhelmingly on routinized and intentional text-act sequences—that is, the intentional activation of texts which people do as they perform the work of the institution. While for sure, such a focus is extremely helpful in understanding how certain kinds of problems arise—how they are continually created and recreated, as it were—I would suggest that texts profoundly influence practice *even when they are* *not purposefully activated*. Concepts like *family psychosis*, for example, lodge in our heads, dictate what we see. Correspondingly, ideology has a life beyond any particular text. Indeed, texts come and go (at times with such rapidity that IE's detailed mapping can be counterproductive), while both the ideology and the underlying material interests remain intact.[13] Accordingly, while the activation of texts is pivotal to this inquiry, I nonetheless also examine texts without reference to their activation, moreover, for reasons very different than clarifying their role in text-act interfaces.

My differences with Foucault—the discourse theorist on whom I most heavily draw— are equally significant. Foucault (1969/1989 and 1980) articulates an approach to history in which ruptures are key, progress is an illusion, truth is a product of power, and where no discourse is superior to another. While Foucault is clearly correct that history cannot be treated as linear, and while the notion of progress is indubitably intrinsically problematic, unlike Foucault, I do not see all discourse as equal. This being the case, throughout this book I very clearly and very deliberately treat some statements and some discourse as having more validity than others. Indeed, fundamentally, this is an inquiry that is in the business of evaluating—hence the subtitle of this book—"An Ethical and Epistemological Accounting." In this regard, I am at odds with the relativism into which postmodernism inevitably slides. So, in a manner of speaking, are the postmodernist theorists themselves—Foucault included.

The point that I am making here is a philosophic one—not an empirical one. What I am suggesting is that a stance toward truth/knowledge that does not dissolve into relativism necessarily underpins both inquiry and ethics. To use Foucault as an example, insofar as Foucault conducts research and insofar as he makes pronouncements with respect to ethics, which he very clearly does, he implicitly assumes a less relativistic stance toward truth than his theory propounds.[14]

To be clear, without question, power is implicated in all knowledge, indeed, creates knowledge, with the disciplines largely dictating reality. Correspondingly, we all think and know via discourse. What is also demonstrably the case, our situation shapes and to a significant degree dictates what we see, what we know. The question, nonetheless, arises: If truth were *only* a by-product of power and positionality—that and nothing more—if we cannot at least conclude that some statements are erroneous whereas others, say, are more congruent with "facticity," ultimately, what would be the point of conducting any kind of research—the anti-oppression research of critical postmodernism included?[15] And what would be the *point of* or the *basis for* ethical argument?

What I do overtly, I am suggesting, all researchers do, whether explicitly or implicitly, whether they are aware of it or not. In this regard, I am not so much defying the current scholarly trend as narrowing the gap between what is said and what is done.

Perspectives

Just as data comes from varied sources, multiple perspectives inform this study. The primary perspectives drawn on include: critical theory, constructivism, feminism, critical disability discourse, antipsychiatry, and labeling theory.

Standing in a Tradition

I stand in a tradition of critical scholars committed to revealing what might be called *the hidden face* of psychiatry. Arguably, the single most important figure in this tradition is psychiatrist Thomas Szasz. Since first uncovering the metaphoric nature of "mental illness" (see Szasz, 1961)—and it is for such discourse-related work that he is known—Szasz became a trailblazer. Other groundbreaking theorists who have appreciably contributed to this area and whose work likewise informs this book include philosopher Michel Foucault (1961/1988), who explores early psychiatry as a discourse and calls attention to its structure and its function in society; existential analyst R. D. Laing (1959/1965), who replaces medical concepts with existential ones and argues that "symptoms" might be best seen as solutions to social and interpersonal dilemmas; psychiatrist Peter Breggin (1983 and 1979), who puts forth the hypothesis that there is a one-to-one correlation between the "effectiveness" of psychiatric treatments and the brain damage produced; Howard Becker (1963) and Erving Goffman (1961), members of a groundbreaking group of sociologists known as "labeling theorists," who demonstrated convincingly that labels and professionals play a central role in creating "deviance"[16]; journalist Robert Whitaker (2010 and 2002), whose extensive research into the relationship between psychiatry and the multinational pharmaceutical industry has revealed conflicts of interest of staggering proportions; feminists Phyllis Chesler (1972), Elaine Showalter (1987), and Paula Caplan (1995) for tracing the construction of woman as mad; Frantz Fanon (1952/1967), who interrogated the racism and laid bare the colonial enterprise; Kirk and Kutchins (1992) for shedding light on DSM processes; Erik Fabris (2011), a sociologist/psychiatric survivor who highlights the survivor narrative; and psychiatrist David Healy (2009), who has revealed harrowing truths about the psychopharmaceutical industry (note, given their privileged access to confidential material because of their status as expert witnesses in liability suits, Breggin and Healy are especially referenced—albeit Healy, significantly, with respect to drugs only).

By paving the way, such scholars make this book possible. Some additionally have contributed to this work more concretely by serving as consultants or informants—Peter Breggin, for example.

Differences/The Specific Contributions of This Book

A central feature which clearly distinguishes this book is that unlike the vast majority of scholarship in this area, which tends to have a single focus or orientation, it combines many different dimensions, being at once a sociological, ethical, historical, medical, and meta-scientific investigation. What relates to this, rather than examining a part of the institution or one element of practice (e.g., use of drugs), it elucidates and "maps" the institution as a whole. The intent is to provide readers with a multifaceted understanding, such that they can walk away with a holistic grasp of how psychiatry "works," what psychiatry "does." In this regard the strategic and systematic use of institutional ethnography is critical. Correspondingly, its presence is palpable. You see it in the intricate tracing that pervades the book; you see it in the multiple diagrams and maps—all serving to explicate the disjuncture. Even where IE as a methodology does not to appear to be involved, as, say, in the history chapters, it is there in the background now guiding, now deepening the inquiry. As such, *IE serves not only as a primary methodology but as the overriding epistemology of this book*. IE, that is, is the lens through which we view all aspects of the institution, whether it be the relationship with government, hospital texts, the nature of "prescribing," the very act of "diagnosing," or the history which has led to the current state of affairs—and the point is, ultimately, it is only by holding all such aspects together that we can arrive at a grounded and comprehensive evaluation. That IE grounding in itself, I would add, separates this book from all other works on psychiatry, while opening up whole new ways of knowing.

While I do not wish to overstate this, for everyone's positionality holds its own limitation (and promise), my positionality is also different, with the fact of that difference entering into what this inquiry could accomplish. The enormity of their contribution notwithstanding, the vast majority of the foundational researchers in this area are white males, more to the point, scholars who approach the subject from a *somewhat* privileged and in many cases *very* privileged vantage point. A simple case that illustrates the distorting effect of this privilege is the ease with which most unqualifiedly repeat the agreed-on date when Pinel unchained "*the* mental patients" (emphasis added) without noticing that initially only male inmates were released from their fetters.[17] The privilege that arises from my being white and being a professional acknowledged, positionalities which have contributed in especially cogent ways to this inquiry as it unfolded are: being a woman, being a professional who has long specialized in work with people who inhabit "alternate realities," being a social activist who is part of a community and who makes common cause with psychiatric survivors.

That said, arguably what most distinguishes and recommends this book is precisely the thesis or "argument."

The Argument

At the same time as unearthing institutional processes, in what might be thought of as a parallel process, much like a lawyer in a courtroom, this book in essence "makes a case." Facet by facet, chapter by chapter, it purports to do nothing less than demonstrate extensively, conclusively, and in a variety of different ways that psychiatry is untenable and unacceptable. Beyond that, it demonstrates that the problems with this institution run so deep that what might be construed as "improvement" is not and cannot be sufficient. This "case," as it were, forms the core, the very heart of the book. Toward the end, I argue that not only must psychiatry be dismantled but that the problems individualized by psychiatry run deeper than what can be solved by eliminating the institution, necessary though that is. The book culminates in a preliminary but meaty discussion of the more sweeping societal changes called for. What emerges is at once a rough blueprint of a better world and the opening words of what I hope will develop into an ongoing social dialogue—geared at the "everyman" and "everywoman" in all of us.

Herein lies what might in the long run prove to be the book's major contribution, what might lead you, say, to periodically take it down from the shelf and begin thumbing through it. It illuminates psychiatry in an uncompromising way, identifying at once problems specific to it and the more fundamental problems underlying these. In the process, it articulates much needed principles, touchstones, and guidelines. It provides insight into how life's conundrums might be approached—decently and humanely. Correspondingly, it begins laying the foundation for a better future—one in which we all have a voice, moreover, one that serves the most vulnerable among us and, indeed, everyone.

The Questions

Questions explored in depth in the coming chapters include: Where *are* we as a society, and just how did we arrive here? How do we keep creating/recreating this institution? How are psychiatric diseases constructed? What bearing do "diagnoses" have on "treatments"? How does the concrete work of psychiatry happen? How did psychiatry come to acquire the privileged relationship which it enjoys with the state? What underlies psychiatry's ongoing "discoveries"? And what are the mechanisms by which they are produced? How does the education of psychiatrists construct the profession and its discourse? What happens to psychiatrists-in-training when they have a crisis of conscience and refuse to go along? What is psychiatry's relationship to neighboring disciplines and professions (psychology, social work, nursing)? To the multinational pharmaceuticals? Are the psychopharmaceuticals or is psychiatry "calling the shots"? What conflicts of interest pertain? What is the relationship to women? To people of color? To non-Western cultures? To corporate capitalism? What is the role of evidence-based research? What concretely is known medically? What are the short- and long-term effects of the major treatments? And what is the real price to us as a society?

In the process of addressing these questions, bit by bit, we will arrive at a more grounded sense of why the Julia/Kevin story played out as it did. More generally, we will acquire an overview of how the everyday problems of "mental patients" come to be.

Parameters and Conventions

With psychiatry overwhelmingly a Western invention, my focus is almost exclusively on the West. There is a special emphasis on the United States, given the obvious dominance of American institutions. Correspondingly, Canada generally and Ontario in particular are front and center, for the research problematic surfaced here. An IE exploration into psychiatry, I would point out, could just as easily have materialized from problems originating in, say, India or Nigeria, and hopefully, this investigation will pave the way for IE inquiries differently situated.

Throughout, I avoid employing words that are part of psychiatric rule—words such as "psychiatric medication," "hallucinations," "mental illness" itself. Where a psychiatric term appears without scare quotes, additionally, I ask you to view it as if it were enclosed within scare quotes. I am aware of course that this arms-length treatment of psychiatric discourse may be disconcerting at times. As noted, psychiatric terminology has become so hegemonic that we *expect* these words, feel that *something is not quite right* if they are not being employed—itself an integral part of the problem at hand.

Getting Our Bearings: A Chapter by Chapter Breakdown

The current chapter has established the standpoint, has introduced the problematic, and indeed, begun the inquiry. Chapters Two and Three are history chapters. They identify beginnings, show trajectories, excavate what lay beneath various claims to progress. Chapter Four interrogates the psychiatric bible—the DSM—laying bare fundamental conceptual problems and at once illuminating the politics involved and using the discoveries made to shed light on the profession as a whole. Building on the findings, Chapter Five provides an expansive and detailed overview of the working of various parts of the system, from hospital, to mental health legislation, to pharmaceutical complex, bringing in the state and the media in the process. Correspondingly, step by step, it follows the "patient" not so much as she "progresses," to be clear, but as she is "processed"—now by one subsystem, now by another. By tapping into such data as educational texts and the beliefs and experiences of participants, Chapter Six explores the making of psychiatrists and related practitioners and probes the workings of the "mental health team." Chapters Seven and Eight, respectively, investigate drugs and electroshock as treatment—what the trends are, what happens to the recipient, what we know, what the research does and does not establish. By contrast, Chapter Nine is the visionary chapter. The way having been paved for it, it takes up the pressing and inevitable question: In light of the enormity of the harm done, as society, where do we go from here?

We cannot understand where we might go or even where we are, of course, if we do not understand where we have been; for the past leaves traces. It also expands the boundaries of the imaginable. Moreover, it writes large what current discourse obscures. Tracing the "history of madness" in its many twists, turns, and surprises, correspondingly, is the business of the next two chapters.

CHAPTER 2

The Evolution of "Madness": A Journey "through Time," Part One

Read through most histories of psychiatry, and a very simple story emerges—one that psychiatry promulgates as truth and which predisposes us to see the "modern" psychiatrist as the inevitable heir to an honorable tradition. The story begins with a brief nod to what existed "pre-psychiatry." Overwhelmingly, what is viewed as medical is seen as progressive, as scientific, as humane. Correspondingly, what is identified with earlier players is seen at best as a prelude to psychiatry and, more typically, as brutal, as a veritable darkness which the medical doctor was called upon to dispel with the light of "his" truth. From doctors quite rightfully objecting to the burning of witches, the tale constructed is one of cumulative progress, all made by great white men whose actions are essentially liberatory and whose "discoveries" are formative. It is essentially linear, with one "discovery" leading to the next, the culmination being the medical model as we know it (e.g., Bynum, 1983).

Indeed, University of Toronto historian Shorter (1997), whose history of psychiatry is generally accepted as definitive (see Porter, 2002), tells a version of this story, albeit while identifying psychoanalysis as a major misstep. In this regard, he states:

> The story that I want to tell is straight forward. It begins in the new therapeutic asylums of the late eighteenth century . . . It is . . . interrupted by half of century . . . with the dominance of Freud's theories; and it concludes in our time with the renewed triumph of the views stressing the primacy of the brain. (Shorter, vii)

Correspondingly, under the heading, "a world without psychiatry" (pp. 1–4), he paints a dismal picture of what predated psychiatry—nothing but hovels to dwell in and brutality to bear. "In a world without psychiatry," he concludes (p. 4), "rather than being tolerated and indulged the mentally ill were treated with a savage lack of feeling . . . To maintain otherwise is fantasy."

Unapologetically hegemonic, such discourse positions the psychiatrist as hero—and the hero for the most part "does good." That is, while one or more mistakes were made along the way (in Shorter's rendition, the "mistake" is psychoanalysis), with the exception of the medical, what predates psychiatry is seen as woefully lacking in humanity. Correspondingly, psychiatry's evolution is presented as linear, as organic, as of a piece.

To use legal historian Nicholas Kittrie's (1971) apt image for it, the story constructed is essentially "history told backward," this with an idealized view of the present. What the historians do essentially is construct current practice as intrinsically good and natural, then write psychiatric history as if the totality of it, save for a few missteps along the way, led to the current state of affairs. At the same time, much like a travel book presents a postcard-like view of a country by focusing on and glamorizing specific sites, they emphasize, individualize, and heroize specific psychiatric "accomplishments," also called "advances." What is obscured in the process is how certain views and players came to efface all others. What are obscured more particularly are the vested interests, the discontinuities, the reality of institutional creation, the jockeying for position, the play of power, the social realm, the centrality of the state, the very real and arguably brutal intrusions into the lives of those hypothetically "served."

I proceed instead with a hermeneutic of suspicion and an eye to diversity. The attempt is to be as fair as possible to the different players, while focusing keenly on the play of power, the recycling of themes, the discontinuities, the piecing together of different aspects of the current institution. What emerges are tales about conflict, about difference, about a battle for supremacy. Key elements highlighted in the process are: the significance of the women healers and the astrologers, the professionalization of medicine, the medical profession's supremacy over other healers, the formidable changes in medicine in the nineteenth century, psychiatry's progressive imitation of medicine, the rise and fall of "moral management," the ascendancy of the pharmaceutical industry, the crafting of psychiatry's master narrative. Throughout, the state is necessarily kept front and center. The point is that psychiatry is a function of the state, and as such, understanding the current institution is contingent on seeing how the relevant state powers developed and became encapsulated in psychiatry.

This is the first of two history chapters. The history chapters are essential to this investigation because they make visible what is pervasive and yet hidden in the current structures and paradigm. Dynamics which I invite the reader to take special note of when navigating this particular chapter include: the play of power, the conflation of the two state powers, "treatment as assault," the role of competition and profit, the significance of gender, what was lost in the triumph of the doctors, the strategic importance of as well as the lack of foundations for the medical model, the exponential growth of the madness industry in the hands of medicine.

Given that this chapter contains a plurality of stories, given that various discourses appear, disappear, and reappear, and given that there are nonlinear principles here which are critical to grasp, what follows is not always linear. The linear story per se begins with the classical period—humours theory in particular. It ends in the late nineteenth century with the appearance of "classificatory psychiatry." As the state powers which were to eventually form the core of psychiatry are writ large in the early Anglo-Saxon tradition, *our* account begins here. Then we will revert at various points to earlier times.

The Structural Reality: The Powers of the State

As Kittrie (1971) has demonstrated, in Anglo-Saxon tradition, two primary state powers underpinned the management of the "mad." One is the police power to pick up and confine anyone posing a threat to the peace. This is one of the two powers which underpin current commitment laws. It is the same power that allows the state to detain people and place them in regular prisons. The second is *parens patriae*, which, states Kittrie, is "derived from the English concept of the King's role as father of the country" (p. 2). A concept clearly patriarchal in origin, it can be traced back to ancient Roman tradition in which the father as head of the family has jurisdiction over his children. The state's right to intervene *so as to treat* is part and parcel of *parens patriae*. The early English beginnings of the *parens partriae* tradition are evident in the eleventh-century decree of Aethelred II that the king is the protector of the stranger who has no kin to protect him. Later and more targeted statutes enacted by Edward II (*De Praerogative Regis*, 2, 17 Edw. C. 9 and 10, 1384) spell out the sovereign's responsibility "initially to the property and ultimately to the person of the insane" (Kittrie, p. 9). Given the money to be made from controlling people's property, significantly, for a very long time the wealthy and not the poor were the primary "beneficiary" of such *parens patriae* provisions. With the commodification of poverty, eventually, however, the face of *parens patriae* was to alter dramatically.[1]

Early Years: Different Approaches to Madness

What is madness? And how should we respond to it? These are questions that have been asked from time immemorial. Throughout most of the history of madness, different sorts of players and very different types of theories abounded. On a simple level—and it was never this simple—there was a supernatural and a natural explanation, with some holding the two as incompatible while others combined them. In the supernatural paradigm, madness was most commonly seen as divine punishment for a transgression (note in this regard, the position of the ancient Hebrews as manifest in Deuteronomy 6:5, "God will smite thee with madness"). By the same token, the Babylonians attributed mental problems to spiritual invasion (for both, see Porter, 2002, p. 12 ff.). "Treatment" consisted alternately in driving out evil spirits, appeasing the gods, leading a better life. It should be added that in this paradigm, certain kinds of madness were also seen as benign—indeed as a wondrous and wonderful thing (e.g., artistic inspiration). By contrast, the natural paradigm (now dominant) almost invariably theorized madness as problematic, and it invariably attributed both obviously physical and psychic problems to natural causes. Correspondingly, problems, for the most part, were seen as an issue of organic balance. Of the various practitioners who addressed madness—and most civilizations had a variety of such operatives—spiritual figures and practitioners in the art of magic are most identified with the supernatural; astrologers comfortably straddled both realms; and a medley of workers including folk healers and doctors inhabited the natural.

Despite real differences between different types of practitioners, for a long time, most moved comfortably between paradigms, indeed even borrowed from other types of practitioners. This attitude of openness is evident in many of the doctors themselves. Indeed, as late at the seventeenth century, doctors attributed melancholia not only to natural causes but also to the Tempter (e.g., Burton, 1621/2001), and their counsel included both repentance and prayer. Medical absolutism was long in coming. Nonetheless, most psychiatric historians date its prominence earlier, something made possible by Hippocrates—the most influential of the early Western doctors.

Totally ruling out otherworldly explanations, Hippocrates himself uncategorically dismissed such notions as divine madness. Correspondingly, medicalizing the area, he viewed psychic problems, indeed all purportedly "medical" problems, as indicative of an imbalance of bodily fluids called "humours."

While this perspective was only one of many vying for medical acceptance, humoural discourse progressively came to dominate Western medicine, as did the practices that it bootstrapped into existence; and it is largely out of this tradition that modern biological psychiatry emerged. Disorders were largely attributed to humoural imbalance. An excess of yellow bile, for instance, was seen as producing a choleric temperament, whereas an excess of black bile brought on melancholia. Names which Hippocrates gave for the various conditions are recognizable even today—to wit, epilepsy, mania, melancholia, and paranoia. And the treatments which he advocated were still in wide use in the nineteenth century. They include: bloodletting, purges, emetics, the application of hot and cold water (for details, see Porter, 2002; Conrad and Schneider, 1980; and Foucault, 1969/1989, 1961/1988). To a degree, herein lies the prototype for biological psychiatry.[2]

A wrinkle that it is important to note, while this was still nascent, from early on, special types of madness were associated with women, with aspects of women's sexual or reproductive anatomy explicitly implicated. Historically, the most important of these was "hysteria," named after the Greek word for uterus (*hystera*). In hysteria, the uterus is seen as rising up from its normal position in the body, wandering about, hitting up against other organs, thereby giving rise to tumultuous passion—an early appearance in medical discourse of women's purported biological propensity for madness.[3]

With the classical largely equated with Hippocrates, it is common for psychiatric theorists to portray the classical era as a period of reason and contrast it with the "dark days" that befell Europe with the rise of Christianity. However, as Porter (2002) notes, in the classical era too, the mad were frequently compared to beasts and subjected to ridicule. Moreover, despite the standard focus on Hippocrates, classical otherworldly accounts were also prominent. That aside, the question arises: What makes explanations predicated on undetectable physical imbalances inherently superior to explanations predicated on unseen spiritual forces?

Europe: Madness in the Middle Ages and Renaissance

Cruelty can easily be detected in the treatment of people deemed mad both in the Middle Ages and the Renaissance. The "mad" were routinely driven out of cities by whips. They wandered the streets, having to beg to eke out a living. As in Greek and Roman times, they were seen as children, compared to animals, subjected to ongoing ridicule. Additionally, as documented by Foucault (1961/1988), they were sent off in ships called the Ship of Fools, with people coming to gawk at them when the ship arrived at port. As such, Shorter (1997) is correct that the approach to the "mad" was hardly ideal. To label it appalling compared to today is a different matter altogether.

What this view ignores is that comparatively few were considered or treated as mad, as contrasted with the billions so treated today. In fact, even as late as the seventeenth century, the famous Bethlehem (Bedlam) Hospital—the sole hospital for "lunatics" in all of England—held fewer than 30 patients. What is likewise apropos, as noted by Southworth (1998), there was a curious paradox at the heart of the medieval/Renaissance perception of madness. On one hand, the mad were looked down upon and seen as a walking-talking morality lesson—a visible warning of the sad state to which unwise living or folly can reduce a person. On the other, in a world where folly or Unreason was the norm, people saw wisdom in the fool, especially certain types—hence such appellations as "wise fool." At moments, moreover, they saw the fool as the one wise figure in a world gone mad. That Feste in Shakespeare's *Twelfth Night*, even more significantly, the Fool in *King Lear* transparently spoke sooth and were to be heeded is testament to the depth of this paradox.

Indeed, despite the cruelty, there were times when a kind of awe overtook the onlookers as they beheld the "madman" for in the fellow creature known as "unaccommodated man" they saw the real thing, the essential human creature, stripped of pretension. And they could be readily moved to compassion. Note in this regard the befriending of Poor Tom in Shakespeare's *King Lear*. Indeed, so powerful is Lear's identification with this almost naked figure that he is impelled to strip off his own clothes (see Act III Scene IV, lines 105–112). Note also the king's obvious fondness for the Fool. "How dost, my boy?" he asks, as the storm gathers strength. "Art cold? I am cold myself…Come" (Act III Scene II, lines 68–78). Hardly an attitude that could be depended on. Nonetheless, when the Elizabethan looked into the face of "madness" (significantly, *male* madness primarily), they saw kinship, a reflection of themselves.

What connects with this and what indeed most distinguishes the medieval/Renaissance engagement with madness is the highly visible place afforded it in most every nook and cranny of the community. The point is that while a small number were deemed dangerous and kept at home, the overwhelming majority were an integral part of society. To quote Southworth in this regard:

> Before what Michel Foucault has termed "the great confinement" of the seventeenth century when the insane were locked away…the most startling feature of their existence was their visibility at every level of society, including the highest. Whether they were treated with kindness or cruelty (and there were plentiful instances of both), they were accepted as a normal thread in the social fabric. (p. 50)

An essential part of any good estate, they appeared at court in the person of the court jester, in some cases enjoying illustrious careers.[4] They were on the streets, in the parlors, at church. What was transpiring, to be clear, was at once a revulsion, a fascination, and, to a degree, a love affair with madness.

Medieval/Renaissance *Parens Patriae*

Throughout these periods and throughout Europe, with England taking a lead, various types of *parens patriae* measures were enacted. Such measures allowed for oversight of the property of the "mad"—a practice characteristically both corrupt and lucrative. Even in these early days, note, there was money to be made in the lunatic trade.

If these particular *parens patriae* provisions applied mainly to the rich, others were directed at "lunatic paupers." In England parishes were required to provide sustenance to "lunatic paupers." Correspondingly, the "impoverished mad" were to varying degrees covered under the poor laws, which progressively swept Europe—Europe's solution to increased population and pauperization. In most countries the impoverished mad fared better under such legislation than other groups, for unlike the "undeserving poor," they were seen as "deserving" and so largely escaped such punitive measures as bridewell incarceration.[5]

The designation "deserving," I would add, was a tricky appellation, which arguably backfired in the long run. The point is that it set the stage for any treatment no matter how intrusive to be seen as something society "owes" its "unfortunates." As such, paradoxically, it paved the way for the massive incarcerations and the brain-damaging treatments to come.

The Oppression of Women: The Hammer against Witches

The persecution of the witches plays a unique role in the history of madness. It began in 1484 when Pope Innocent VIII issued a bull empowering the inquisitors Krämer and Sprengler to eradicate witchcraft from Christendom (see introduction to Krämer and Sprengler's *Malleus Mallificarum*, 1486/2006). It ended toward the close of the seventeenth century when the witchcraft discourse fell apart (see Conrad and Schneider, 1980). In the interim, thousands of luckless souls were tortured and put to death. Look at who its victims were and look at their purported crimes, moreover, and the hatred of women and the intent to curtail female power become evident. Significantly, the vast majority were women, and the highest level boss text, the bull itself, explicitly names such offenses as killing infants in the mother's womb—and killing of infants in the womb (abortion), note, was largely the work of women healers or midwives (see p. 3 ff.).

A number of dynamics were to make the witchcraft craze pivotal to the evolution and development of psychiatry. For one thing, Krämer and Sprenger articulated in minute detail how to detect a witch and how to distinguish witchcraft from insanity, and in so doing, in essence, provided a blueprint for how to construct and operationalize diagnoses, also, as Szasz (1970) suggests, to a degree pioneered differential diagnosis. The precision of their schema, I would add, serves as a reminder that complex classification is no guarantee of validity. What is far more significant, doctors weighed in on the phenomena and in the process gave birth to a new discourse.

Beginning with Weyer and continuing through the centuries, a handful of doctors argued that most of the women in question were guilty of nothing, were simply mentally deranged and self-deluded mortals, and, as such, were being mistakenly prosecuted (for details, see Szasz, 1970). That these doctors saw through what was happening *to a point* and as caring individuals fought to end the senseless torture and murder of women is at once true and laudable. Significantly, though, as Porter (1997) shows, there were doctors that took the opposite stance—who testified against "witches" at trial. More significant still, most doctors who mounted a defense demonstrably used the occasion to advance their own particular psychiatric theory—for example, that these women were afflicted with hysteria (see Porter, p. 25 ff.). That said, whatever the intention—and when it comes to institutions nothing is ever straightforward—in the long run, what happened is that the crusading doctors substituted one stigmatizing label—"mad" (a label which fell squarely within their jurisdiction)—for another—"witch" (significantly, a label under someone else's jurisdiction). It was not simply *any* women, moreover, being portrayed as mad for it was not simply any women who were accused of witchcraft. It was disproportionately women who allegedly poisoned (ergo, the women healers who gave herbs); it was women who performed abortions (again, the women healers). Correspondingly, it was women who gave counsel (once again, the women healers). Examine this structurally, and a rather disturbing story involving power surfaces.

Two of the medical doctors' major competitors in the "healing business" were the Church and women healers. While this dynamic played out over a long stretch of time, in one fell swoop, so to speak, the doctors who "came to the defense of the women" effaced the power of both—the Church by positioning it as grievously mistaken, and the women healers by positioning them as mad.[6] In the process they positioned mad-doctoring itself as inherently humane and libratory. Herein lay the beginning of a discourse which was to prove eminently useful.

The Seventeenth and Eighteenth Centuries: Doctors, the Mad, and the State

While Foucault (1961/1988) paints a picture of a "great confinement" that engulfed Europe in the seventeenth century, at this juncture incarceration on a mass scale occurred in one European country only—France. In 1656 Louis XIII decreed the opening of Hôpital Général in Paris (not a medical establishment, but a prison). By the 1660s, 6,000 "undesirables" were confined there; and in 1667, it was decreed that comparable institutions would be opened up in every French city (for details, see Foucault 1961/1988). It is this incarceration that set the stage for Pinel's alleged "freeing of the mad"—an act later constructed to symbolize the liberatory nature of psychiatry.

In other European countries, meanwhile, people deemed mad were seldom incarcerated, though a smattering of small madhouses began popping up, the clientele being largely the propertied mad. Such madhouses were commonly run by women, known for their gentle touch. More generally, at the start of the century, there were many different types of practitioners "treating the mad," including clergy, apothecaries, necromancers, and astrologers, with the doctors not especially favored by common folk. That the doctors were not popular was not surprising. Despite talk of advances, the truth is that they were relying on the same treatments that they had been using for centuries (bleeding, purging, vomits, use of opium, use of fear). Indeed, as Szasz (1970) documents, the only real additions to their repertoire at this juncture were torturous ones—ones, significantly adapted from the Inquisition and which left commoners scurrying to the astrologers instead. Over time such torture became their trademark, in a manner of speaking, their "contribution" to the field.

An example of one such treatment (invented in the late seventeenth century by Charles Darwin's grandfather, Erasmus Darwin) was "Darwin's chair." "In this chair," explains historian Erwin Ackerknecht (1968, p. 38), "the insane were rotated until blood oozed from their mouths, ears, and noses, and for years, the most successful cures were reported as a result of its use"—an early example of psychiatry's tendency to establish effectiveness by "proclaiming" it. Moreover, hardly an optimal choice—that is, insofar as one had a choice.

Significantly, throughout the seventeenth and the early part of the eighteenth century, a few changes took place that were to dramatically and permanently alter the landscape. On the societal level, the population continued to grow, as did poverty—all of which culminated in an ever increasing emphasis on social control. On the professional level, correspondingly, the medical profession as a whole began to substantially professionalize. At the same time, as articulated by Foucault (1963/1973), medical advances of a scientific nature were made. And progressively, the state enlisted doctors in efforts to safeguard public health (an extension of *parens patriae*), leading to a mammoth reduction in incidences of the plague, smallpox, malaria, and leprosy. More hospitals and clinics sprang up. An optimism gradually set in that medicine could solve all social problems—an optimism that was extended to the mad doctors despite the fact that mad doctoring was in no way connected with the scientific advances. Acting, indeed, capitalizing on their improved reputation, medically trained mad doctors progressively distanced themselves from other madness practitioners and pressured for and began winning monopolistic control. Additionally, bit by bit, the bureaucratic mechanism which we identify with psychiatry began being put into place.

To use England as an example, some key landmarks include: In London, in the 1600s the College of Physicians was granted permission to fine unlicensed practitioners, and it used this allowance to harass practicing astrologers, thereby eroding the presence and importance of these competitors. Around this same time, the involvement of doctors was made mandatory at public madhouses. In the eighteenth century, correspondingly, processes very similar to what exists now came into being with the passage of the first "Madhouses Act" (the Act provides for licensing and inspection of madhouses and stipulates that institutionalization requires certification by two doctors). By the beginning of the eighteenth century, additionally, the workhouse movement was under way (see MacDonald, 1981; Conrad and Schneider, 1980; Whitaker, 2002; Porter, 2002; and Hunter and MacAlpine, 1963).

What we have by the last half of the eighteenth century is a dramatic increase in *parens patriae*, one, moreover, which involved a new and privileged position for medicine—and that included the "alienists" (new term for mad doctors). Operating within an expanding territory, they were now agents of the state with extensive powers, some of them monopolistic. However we regard the jurisdictional and hegemonic control won by medicine as a whole—and monopolies are problematic at the best of times—one thing which these changes amounted to was a new dispensation for the mad. With *parens patriae* closely aligned with police power, the new dispensation essentially entailed increased state control, more incarceration, forced labor, bureaucratization, and *specialization*—to wit, the ascendancy of an as-yet unscientific branch of medicine. Herein, I would suggest, lies the birth of psychiatry.

Moral Treatment/Moral Management

Toward the end of the eighteenth century and extending to the mid-nineteenth, a new approach to the treatment of the "insane" was pioneered. While increasingly claimed by psychiatry, for some time it was practiced by doctor and layman alike, with lay practitioners such as the Quakers playing a particularly formative role. It is alternately known as "moral treatment" and "moral management."

Accompanied by a discourse which positions it as "humane" (see Pinel, 1801/1962), what distinguishes moral treatment is a pronounced psychological orientation, a view of madness as correctable moral error, and, most especially, an emphasis on the relationship between patient and practitioner. In hindsight it is not surprising that a religious community like the Quakers took a lead in developing it for it owes much to the original spiritual explanation of madness—that madness connects with wrongdoing, with going astray. Bearing a resemblance to psychotherapy, correspondingly, the relationship is seen as primary. The point is, not through physic (whether this be opium or confinement) but through the force of his personality, through his demeanor, through the relationship, the "keeper" is to help the patient regain his reason (translation: behave acceptably).

Written histories of moral management typically begin with Pinel, who wrote at length on the subject, contrasting his treatment of patients with the brutality preceding him (hence the "unchaining story" with which psychiatry's narrative typically begins).[7] William Tuke, a nonmedical Quaker who established "The Retreat," is generally mentioned next. Unquestionably, it is important to highlight both Pinel and the Tukes, for they are huge figures in the development of moral management. Beginning here, however, reinforces current hegemony.[8] The point is, elements of the discourse and key practices appear prior to official "moral management," and in these, we can most easily detect several of its central features.

A critical figure and the first to use the term "management" was Dr. Francis Willis—a late-eighteenth-century English physician and clergyman whose treatment of the King George III of England brought both madness and his treatment of it to the attention of the world. The use of the eye as a tool of intimidation, the use of threats, a brutal domesticating approach are all evident in his widely publicized treatment of the king.

Arriving on the scene with his entourage, together with a straight waistcoat, Willis proceeded to take charge. He immediately isolated the king. He went on to restrict the king in the straight waistcoat for the slightest "infraction." He also "sheeted" him (straddled him in linens). Correspondingly, by the force of his personality and well-timed threats, which he invariably made good on, over an extended period of time he intimidated King George into "behaving."[9]

A careful examination of Willis's language reveals the conceptualizations underpinning his work. Upon arriving, he informed the king that "his ideas were now deranged and he required *attention* and *management*" (my italics; quoted from

Hunter and Macapline, 1963, p. 53). Observation and control were clearly being implied. Explaining his method, correspondingly, he informed the king's regular physician that he "broke in" patients like "horses" (p. 53). His words underscore the truth of "management." It is "a system of... intimidation, coercion, and restraint" (p. 92) commonly associated with animal domestication. The return to morality is to be effected precisely by approaching the "deranged" patient as if he were an animal and proceeding to tame the wild beast.

What relates to this and what particularly distinguishes Willis's style is the commanding use of the eye. Just as the equestrian intent on breaking a horse looks him squarely in the eye, Willis cultivated the use of the eye for mastery. Indeed it is via the language of the countenance more than anything else that the necessary message was to be conveyed and control secured. Note, in this regard, the following account of Willis:

> He is said to be adept at controlling patients with his gaze. It is reported that on his first meeting a new patient, his usual friendly and smiley countenance changed its expression. He suddenly became a different figure completely, commanding respect even of the maniac by his piercing eye... Even the fiery Edmund Burke is reported to have flinched and turned away when Willis "fixed" on him. (Hunter and MacAlpine, pp. 270–272)

This command countenance, this piercing eye, this highly deliberate and relentless taming was to play a major role in the subsequent development of moral management.

The "Willis effect" was not lost on Dr. Benjamin Rush (1812), Quaker, head of the Philadelphia hospital, and long hailed as the father of American psychiatry. With Rush, we find a similar use of terror, of animal imagery. Correspondingly, he emphasizes assuming total control and advocates a modus operandi that is transparently Willis's trademark. Note, in this regard, the following counsel:

> The first object of a physician, when he enters a cell or chamber, of his deranged patient, should be to catch his EYE and stare him out of countenance. The dread of the eye was easily imposed on every beast of the field. The tiger, the mad bull, and the deranged dog all flee from it: now a man deprived of his reason partakes so much of the nature of those animals, that he is for the most part easily terrified, or composed by the eyes of a man who possesses his reason. (p. 175)

The inimical Willis style is only too apparent.

Like many doctors of this era, Rush is famous for some highly punitive measures. For instance, he introduced his own version of the tranquilizing chair (duly adapted so that ice could easily be applied directly to the head). Such blatant instruments of torture were quickly swept aside once the hospital officially committed itself to moral management for they conflicted too obviously with its avowed philosophy. Other aspects of his treatment—and these were to remain—include the use of terror, silence, humiliation, darkness, pain, and solitary confinement (see Rush, 1812). What is most telling about Rush, however, and what helps us penetrate the truth about moral management and the men who came to deliver it is that even while engaging in obvious torture, he saw himself as measured, kind, respectful, indeed as part of a humane revolution. In this respect, Rush writes:

> For many centuries they were treated like animals or shunned like beasts. Happily, this time of cruelty to this class of our fellow creatures and insensibility to their suffering are now passing away. In Great Britain, a humane revolution dictated by modern improvements in the science of the mind, as well as medicine, has taken place. (p. 243)

Herein lay the insidiousness of moral management. (Might we not say the same of all "coercive treatment"?) Correspondingly, it is against this backdrop that I turn to Pinel—the French doctor credited with liberating the mad.

There is no question but that it was a good that Pinel unchained the "mad." Also that he eschewed such blatantly torturous instruments as "the tranquilizer" (name given Rush's chair). At the same time, with Pinel we see the same general tactics, the same relentlessness, the same rationales. Consider these words by Pinel (1801/1962, pp. 60–87):

> If met . . . by a force evidently and convincingly superior, he [the madman] submits without opposition or violence. This is the great and valuable secret in the management of well regulated hospitals. In the preceding cases of insanity, we trace the happy effects of intimidation without severity, of oppression without violence. For this purpose, the strait-waistcoat will generally be found to be amply sufficient.

As Foucault (1963/1973) has demonstrated, Pinel kept his patients under perpetual surveillance. He subjected them to ongoing humiliation, used threats, as an object lesson even returned them to their chains. What we have with Pinel, in other words, is not the end to brutality as professed but a more subtle form of brutality. What we have is not medicine but a larger-than-life personality that demanded and exacted submission—the quintessential and ever watchful patriarch, taking command over his unruly children.

To a degree, albeit a lesser one, this criticism applies to Quaker moral management as well. In the late eighteenth and the beginning of the nineteenth century, first William Tuke and later his grandson Samuel opened up what were called "retreats"—the first in England, the second in America. The Quakers to their credit were significantly more adept and considerably gentler than most other moral managers. Indeed, it might be argued that one of the reasons that psychiatry eventually abandoned moral management is that lay people or minimally *these* lay people were demonstrably better at it. What characterized the Retreat was a gorgeous countryside, plentiful food, community, a belief in the spirit that resides in all of us. This notwithstanding, here too perpetual observation and intimidation was standard. In this respect, Samuel Tuke cites as an example of optimal practice one of the "keepers" following a "maniac" everywhere, stating that gratitude is owed, constantly threatening the young man that he would be shackled again if he did not behave. Correspondingly, as Foucault demonstrated, with the Quakers, too, the model is that of the formidable patriarch ruling over his family (for details, see Tuke 1813/1996; for both critical and enthusiastic views on the Retreat, see Foucault, 1961/1988 and Whitaker, 2002, respectively).[10]

One final figure I would mention in passing and arguably the most tender-hearted of the moral therapists is Dr. John Conolly. In the nineteenth century, Conolly brought moral management to a large English hospital. At Colney Hatch, he introduced good food, outdoor walks, comfortable quarters. Be that as it may, after his death, Conolly was in manner of speaking succeeded by his son-in-law Dr. Henry Maudsley, who had utter contempt for such practices, who saw "madness" as brain degeneration pure and simple.[11] So ended the era of moral treatment.

One has to wonder what would have happened had the community gotten solidly behind this "revolution." This notwithstanding, it is a mistake to idealize moral treatment. It never resolved—nor could it resolve—the thorny issue of coercion at its core. Correspondingly, despite the emphasis on the relationship, even at its best, it was hardly a dialogue. The mad, note, were to be *managed*—not *listened to*.

Medical Advances, Professionalization, and the State

The late eighteenth century was a critical period for Western medicine proper. Access to corpses allowed them to actually see where organs were situated, how disease processes worked. With good use put to the knowledge thereby gleaned, the nineteenth century in turn was a veritable breakthrough era. Continuing to study anatomy and inventing more and more instruments to extend its observation, it further progressed as a science. What was particularly important—and the significance of this cannot be overstated—as Szasz (1976/1988) points out, it progressively *conceptualized* like a science. Most especially, it put aside impressionistic concepts of what constituted a disease, adopting in their stead concrete criteria based on observation. Instrumental in this regard was physician Rudolf Virchow, who introduced a standard henceforth embraced by the medical community.

According to this new understanding, pain or discomfort per se no longer sufficed for something to qualify as a disease. Real *lesion*, real *cellular pathology* observable directly or by tests was to be the standard. While disease might be hypothesized and temporarily entertained in the absence of pathology, to be clear, it was discoveries of pathology alone which confirmed them. With Virchow criterion, medicine had essentially crossed the science threshold and found its "gold standard."[12]

A second and not totally unrelated fact about medicine during this period is that for better or worse, it continued to professionalize. There was greater standardization of education. Progressively, specialized professional journals appeared. Correspondingly, professional associations manifestly committed to the advancement of its members sprouted up. In this regard, in 1847, the American Medical Association was formed—an organization, as Conrad and Schneider (1980, p. 9 ff.) demonstrate, whose overarching raison d'être was to gain monopolistic control of the medical turf (translation: get rid of the competition, now known as "irregulars"). Throughout the Western world, correspondingly, progressively, the medical profession pressured for and to a sizable extent won exclusive jurisdiction. Compelling examples of such successful politicking in America include convincing state legislatures to limit medical practice to practitioners "of a certain training and class" (p. 10) and encouraging the state to criminalize abortion—an activity at the heart of "irregular" or nonheroic practice.

Psychiatric Professionalization, Racism, and the End of the Women Healers

While medicine continued to grow specifically *as a science* throughout the nineteenth century, the truth is, except for the external trappings, the same cannot be said of psychiatry. Albeit psychiatry theorized itself as medicine, wildly different theories about the nature and cause of insanity proliferated—some related to the body, some not, many stated as if definitive—none, significantly, based on scientific observation. On the basis of conjecture alone, for example, Rush (1812) located the seat of mental disturbance in the blood vessels going to the head. By the same token, albeit *sounding* more scientific, Maudsley (1876) but declared mental illness a brain disease. Correspondingly, in the absence of physical indicators, a plethora of different phenomena were asserted to be causal—love, hate, civilization, gender, species degeneration, masturbation (for details, see Showalter, 1987; Szasz, 1978/1988; and Porter, 2002). In the same vein, with *no physical indicators*, and with what underlie them *transparently of a different nature*, various diseases were proclaimed into existence, some of these constructions appearing and disappearing rapidly, others lingering. Often the social purpose and origin are painfully apparent.

An example of a disease whose social construction is particularly obvious is "anarchia" (see Rush, 1812)—a disease said to infect colonists, the symptom being too great a zeal for liberty. Another—and this one illustrates the unbridled prejudice that so readily enters into the construction of such impressionistic diseases—is "drapetomania."

First articulated in the prestigious journal *New Orleans Medical and Surgical Journal*, of this second disease, Dr. S. Cartright (1851, pp. 691–715) writes:

> Drapetomania is from "drapetes" a runaway slave, and "mania," mad or crazy . . . Its diagnostic symptom, the absconding from service is well known to planters and overseers. The cause, in most of cases, that induces the negro to run away from service is as much a disease of the mind as any other species of mental deterioration.

Significantly, the proposed "treatment" was whipping. It is not only that racist ends are involved here. It is that racism *alone* underlay the construction of the "disease."

Whether or not the social purpose of the alleged disease was this obvious and whether or not systemic oppression was involved—and it often was—what we blatantly see here is social control medicalized. If we look carefully enough, moreover, we see a chasm opening up between medicine proper and psychiatry. The metaphoric and impressionistic approach long discarded by general medicine continued to dominate psychiatry. What disguised this fact, ever more scrupulously, psychiatry used the language of medicine. Indeed, some alienists used the language of *observable physical signs*, albeit no such signs existed. For example, drawing on what was soon to be known as the Virchow criterion, Cartright proclaims that both drapetomania and "Dysaesthesia Aethiopis" (another "mental disease" contracted only by Blacks) are accompanied by "physical lesions" (see Cartright, p. 691 ff.).[13] Ignored is the fact that there is no recorded evidence of anyone seeing such a lesion. Colleagues are simply assured that they have often been observed. Herein lay one version of a formula that was to be followed repeatedly: (1) proclaim a new "discovery"; (2) describe "the disease" in medical terms; (3) announce that reliable physical indictors have been found.

Just as they couched "discoveries" in medical terms, alienists (now called "psychiatrists") painstakingly replicated the external trappings of medicine.[14] *Ambulances* were to deliver people to asylums. Penal objects like bars were to be avoided. Henceforth, words like "patients," "symptoms," and "diagnoses" were to be employed, words like "lunatic" scrupulously avoided. Correspondingly, with the state now solving social problems by institutionalization, and with ever more public institutions built, psychiatrists did what their colleagues in medicine proper were doing—progressively lobby for and receive a more extensive turf, together with formidable control. The consequences were ever greater institutionalization, additionally, a substantial shift in *who* was "treated." Moreover, at long last the male doctors utterly edged out their competitors. Again, let us look at the English example.

As Showalter (1987) and Hunter and MacAlpine (1963) document, by the mid-nineteenth century for the first time poor patients outnumbered the rich and women outnumbered the men—a direction that was to continue and accelerate. Correspondingly, bit by bit women practitioners were pushed out. To quote Showalter (1987, p. 53), "[B]etween 1854 and 1870 about one out of five provincial licensed hospitals and about one out of four metropolitan houses still had female proprietors, but the claims of the medical profession that . . . only doctors were qualified to treat the insane gradually forced women into marginal . . . or volunteer roles." Indeed, in 1859, the Commissioner of Lunacy stated that it was considering restricting new licenses for private establishments to doctors only, additionally, that women were discouraged from applying.

The routing of the women professionals was even more decisive in the public hospitals. It was facilitated via a mixture of legislative acts and policy shifts. An early example of one such piece of legislation was the Madhouse Act of 1828, which stipulated that public hospitals for the insane had to have a resident medical superintendent, also that weekly visits by doctors to all public hospital "patients" were mandatory (for details, see Showalter and Porter). The cementing of authority is obvious. Over time, rigid subordination followed. The central and time-honored role of the matron in the hospital—and this had often been the male superintendent's wife—was severely curtailed, and the doctor assumed almost absolute authority.[15]

In this regard, England, like Germany and America, ended up adopting the Heinroth model. The male doctor was to be the unequivocal head, ruling like absolute potentate over patient and staff alike. The physician, specifies Heinroth (1818/1975, p. 413), is "God," and "his instructions are binding on everyone."

Examine all the shifts, and a story about oppression is evident. Progressively commodified, women (once respected healers) and the poor were now the primary objects of "mental help." Correspondingly, the reins of authority went to the (male) psychiatrist, henceforth vested with God-like powers.

Mid-nineteenth Century: Brain Theory, Heredity, and Degeneration

As the century progressed, two theories which were to have enormous consequences for psychiatry and society at large gained prominence—both associated with the somatic claims of the profession. The first relates to the Virchow criterion, according to which for something to qualify as a disease, a cellular abnormality in an organ must be found. While to be clear, mad doctors had long claimed physical causality of some nature, there had been little or no consensus about processes or the organ involved. What changed during this period is that progressively, mad doctors—with Maudsley (1876) taking the lead—identified the brain as "the seat of mental disturbance." That is, they defined mental problems as "brain diseases"—this, in line with one aspect of the Virchow criteria (the need to identify a specific organ). The claim was that while they could not demonstrate brain abnormalities now, the time would come when the necessary proof would materialize. Predictions about future proof, of course, do not constitute proof, and as such, the Virchow criterion was being skirted. Nonetheless, herein lay a working hypothesis around which this fledgling profession could rally.

The second of the theories was social Darwinism. Emphasizing Darwin's concepts of selection and evolution, social Darwinists argued that insanity was hereditary and people must take care or degeneration—going backward in evolution—would set in. Insanity, accordingly to this theory, was overwhelmingly the product of degeneration. Families could be prone to it. Injudicious mixing of strains could lead to it.

Early Darwinists of note include Mercier, who elaborated on the concept of de-evolution; Lombroso, who argued that criminality was predicated on it; and Maudlsey, who stressed prevention (significantly, Maudsley was also the psychiatrist most responsible for the widespread acceptance of the brain as the seat of insanity; see, respectively, Mercier, 1890; Lombroso and Ferrero, 1895; and Maudsley, 1876). Maudsley in particular advised men to inspect prospective wives for "physical signs that might betray degeneration of the stock . . . any malformations of the head, mouth, teeth and ears" (Maudsley, 1876, p. 276).

Albeit this was to take the better part of a century to happen, social Darwinism was eventually condemned as junk science, moreover, as immoral. Indeed, the vast majority of psychiatrists today would be shocked by such views. This notwithstanding, herein lay the origins of the concept of hereditary madness, also of a predisposition to madness—concepts absolutely integral to modern psychiatry. Obviously also, herein lay the precursor to the virulent racism of eugenics—soon to be unleashed.

Women as "Patients" and the Rise of the "Nervous Disorders": 1850–1900

What stands out about women as patients during this period are the huge number "treated" (see preceding section), the ease with which women could be committed, the disempowering nature of the "cures." What stands out most about psychiatry per se, correspondingly, is the gradual stretching of the notion "mental disorder." These phenomena are intricately related.

Mental disorder came to be seen as an almost inevitable by-product of women's anatomy (e.g., the exhausted state to which women are reduced by menstrual and reproductive cycles). What parallels this and what was to have long-term consequences, with the appearance of "nerves theory," the threshold of what counted as a mental disorder dramatically lowered. People no longer had to be "raving" to be a candidate for treatment. They need only have "bad nerves." This shift was to prove enormously lucrative for the industry, resulting in the proliferation of special clinics, resorts, and spas (see Whitaker, 2002; Showalter, 1987).

Women in particular were seen as susceptible to "bad nerves," thereby disproportionately contracting "nervous disorders," later called "neuroses." What belies any simple class analysis, educated women were seen as in special jeopardy, psychiatrists like Maudsley (1876) arguing that women were working against their own nature by engaging in intellectual pursuits, thereby endangering their strain. A critical component as well as a consequence of this discourse was the articulation of three "female maladies" that progressively came to dominate this period. These were hysteria, anaesthesia, and anorexia.

A diagnosis that dates back to antiquity, albeit no longer theorized in relation to the uterus, hysteria remained a stereotypical women's disease, with an unprecedented number of women now diagnosed with it.[16] It was characterized by what men saw as emotional outbursts, a certain vulgarity, swoons, and the trademark hysteric gasp. The most famous of the early psychiatrists specializing in hysteria was French psychiatrist Jean-Martin Charcot. Enter the psychiatrist as manipulator, as dramatist. Charcot posed his women, installed a photography unit in his asylum precisely to capture women succumbing to "hysterical" and highly erotic swoons, exhibited his women and his photos. Herein we see voyeurism, the sexualization of women, and the power of suggestion all in one. And herein lies an object lesson in how disease could be "manufactured" and "packaged."

"Anaesthesia," the second of the major women's disorders, was overwhelmingly diagnosed in upper-class women. Regarded as a response to the demands of advanced civilization, it was characterized by general anxiety, a tendency to paralysis, alternatively, helplessness, or "excessive independence" (in other words, either living up to gender role expectations or defying them). The third of the disorders, anorexia, was "starving oneself" or the "excessive" pursuit of thinness. In a society in which overt protest by subordinates was not tolerated, all three "disorders," I would suggest, could be legitimately seen as an indirect form of female protest (see, in this regard, Burstow, 1992).

Of all the approaches to women's "maladies" during this era, the rest cure initially and later on the sleep cure are especially important, for forced infantilization is evident. Forbidden to do anything, not even allowed to turn over in bed without the permission and assistance of the physician as savior, intellectual women were reduced to child-like dependence and ultimately bored into compliance—that is, into accepting the diminished role allotted them under the patriarchy.

Women were in special jeopardy as daughters, given the combined patriarchal power of father and doctor (Showalter [1987] explicitly identifies hysteria as the "daughter's disease"). Arguably, the married woman was in more jeopardy still. The point is, for the entirety of her married life, hanging over her was the combined authority of doctor and husband—an ever-present threat, significantly, backed by the state. What is telling in this regard, as late as 1860, in the United States a woman could be committed on the request of her husband alone (see Szasz, 1987). "Mental derangement," that is, in no way had to be established. Even where insanity was technically insisted on, anything objectionable to the husband typically constituted a sufficient criterion.

Protest was generally snuffed out and ruthlessly so. Nonetheless, on the societal as well as subterranean level, there was a war going on—over who owned women, more generally, over rights over one's own mind, whatever one's gender, race, ability, demeanor. Mrs. Theophilus Packard (Elizabeth Packard) was an early figure in this war.

Mrs. Packard was confined for years in Jacksonville State Mental Hospital at the behest of her husband Reverend Packard as a consequence of religious differences. She herself astutely notes that the most modern control mechanism was simply being used against her, that had this drama played out a couple of centuries earlier, she would have been turned over to the Inquisition (see Packard, 1865/1974). Correspondingly, after being confined a second time (this time in her own home), she initiates a writ of habeas corpus—a landmark act often cited as the beginning of the patients' rights movement. I leave you with examples of the two competing discourses involved in the skirmish—that of the psychiatrist who testified against Mrs. Packard and her own reflection.

At the trial which ensues, the psychiatrist Dr. J. W. Brown testifies as follows:

> I have written down in order, the reasons I had, to found my opinion on, that she was insane... 1) that she claimed to be in advance of the age of 30 or 40 years; 2) that she disliked being called insane; 3) that she pronounced me a copperhead... 4) an incoherence of thought... 5) her aversion to the doctrine of the total depravity of man; 6) her claim to perfection or near perfection in action and conduct; 7) her aversion to be called insane; 8) her feeling toward her husband; 9) her belief that to call her insane and abuse her was blasphemy against the Holy Ghost; 10) her explanation of this idea; 11) incoherence of thought and idea; 12) her extreme aversion to the doctrine of the total depravity of mankind. (see Packard 1865/1974, p. 130 ff.)

Ignore the muddled repetition, and the main thrust of the argument is that Mrs. Packard is crazy because she finds Dr. Brown stupid; because he himself is unable to follow her logic; because she dares to disagree with her husband; because she respects herself and insists on respect; because she does not accept the doctrine of the total depravity of man. While I am in no way claiming that most people in Mrs. Packard's situation are as reasonable and articulate as her or that all psychiatrists are so obvious in their deficiencies, I ask the reader to contrast these confused utterances with the clarity and good sense evident in this statement by the soon-to-be victorious Mrs. Packard:

> It has always been my fortune... to be a pioneer... therefore I am called crazy... I freely accord to... my enemies the right of opinion in believing me to be an insane person and so long as these opinions do not lead them to trespass against my *inalienable* rights, I have no right or desire to interfere with them... But since my opinion

> is as dear to me as those of my enemies are to them and since we have no right to do wrong, therefore, when the opinions of my enemies lead them to *kidnap* my accountability, by placing me on a level with beasts for opinion's sake merely, the law of self-defense compels me to resist. (p. 17)

Telling, I would add, that it took a travesty this obvious for the woman to prevail.

Classification and the Emergence of "Schizophrenia"

If medical appearance was key to psychiatry's success as a regime of ruling, no element was more important than classification. By classifying in ways that ostensibly mirrored medicine (with discrete disease entities subsumed under overarching medicalized categories), by creating "official diagnoses" accepted by all, the entire psychiatric enterprise could be placed on a more secure footing. Correspondingly, by normalizing "revision," classification could be adjusted as needed without credibility sacrificed. The practitioner most responsible for setting psychiatry on this path was German psychiatrist Emil Kraepelin—a dominant figure in the late nineteenth and early twentieth century. With him, the center of international psychiatry shifts from England to Germany.

While psychiatrists had classified before, not with Kraepelin's precision nor his dedication to a particular type of system. With the aid of his disciples—and with him, classification started to be a collective effort—he deposited into a box observations on patients—symptom clusters etc.—and out of these notes, classifications complete with diagnostic criteria emerged. Ever honing his schema, he came up with new editions of his textbook every time he revised his schema (as with the DSM currently). His various decisions, correspondingly, were to significantly shape psychiatry as we know it.

One decision was creating and centering the category "functional psychoses" ("psychoses" with no known physical correlate). A still more important decision—and ultimately, these were *decisions* not *scientific findings*—is the creation of two new diseases—"manic-depression" and "dementia praecox" (the first a unification of various "manias," together with melancholia, the second utterly new). These "diseases" continue to dominate psychiatry. "Manic-depression" is now "bipolar." In the hands of Eugen Bleuler—Kraepelin's disciple—"dementia praecox" became "schizophrenia"—the category of insanity henceforth most integral to institutional psychiatry. Kraepelin is generally credited with "discovering" these disorders, with Bleuler also listed for "schizophrenia." As Szasz (1976/1988) points out, what such discourse renders invisible is that no medical discoveries were involved, that despite the fastidiousness of the classification system, disease entities were virtually being proclaimed into existence. Practically, conceptually, this lack of foundations is a problem. What is also a problem, the respective symptoms Kraepelin and Bleuler specify for schizophrenia differ so greatly that they do not appear to be addressing the same phenomenon. Kraepelin's symptomology for "dementia praecox," significantly, includes involuntary movement, whereas Bleuler's "schizophrenia" does not, leading Szasz (1976/1988) to conjecture that many of the patients that Kraepelin diagnosed with dementia praecox may well have been men suffering from the late stages of syphilis. Additionally, the so-called split personality elaborated by Bleuler and which became emblematic of schizophrenia is absent in Kraepelin. Indeed, the two sets of patients diagnosed with this allegedly identical disease seem to have little in common.[17] These diagnoses, nonetheless, remain intact, indeed, with the label "schizophrenia" in particular for all intents and purposes functioning as a license to intrude.

A related and more fundamental decision of Kraepelin's, which was to likewise have profound consequences, and indeed, one of a more broad sweeping nature, was totally sidestepping etiology by defining it as unnecessary for classification purposes—a highly strategic move given the difficulty listing or at least convincingly listing causes for what were speculative diseases at best. Paving the way for what was without question a bold new move, Dr. Kraepelin (1907, p. 117) reasons as follows:

> Judging from our experiences in internal medicine it is a fair assumption that a similar disease process will produce identical symptom pictures, identical pathological anatomy, and an identical etiology. If therefore, we possessed a comprehensive knowledge of any one of these fields,—pathological anatomy, symptomatology, or etiology,—we at once have a uniform and standard classification of mental diseases. A similar comprehensive knowledge of either of the other two fields would give not only just as uniform and standard classifications, but all of these classifications would exactly coincide.

He proceeds to articulate a largely etiology-free schema. He bases it, to be clear, on the "assumption" of an unerring parallelism between symptoms, etiology, and prognosis. He makes no attempt to back up his "assumption." He simply defines his assumption as fair. Nor does he take note of the fact that he is comparing diseases for which there is some type of physical marker with ones where there are none—minimally, a questionable equation. In defining etiological knowledge as unnecessary, correspondingly, he has artfully sidestepped a fundamental problem—the inconvenient but critical truth that there is no biological bases for the "functional" diseases. He has also, I would add, made the profession appear far more unified than it is. The point is that differences between schools of psychiatry are most obvious when etiology enters the picture. Fetishize categorization and treat etiology as if largely superfluous and an appearance of unity is possible. Over time, this fetishization and this evasion, I would add, was to prove highly serviceable for institutional psychiatry. Just *how serviceable* will soon become evident.

Paresis and Its Significance

Toward the end of his career, Kraepelin was to inadvertently make a pronouncement which helps us understand how psychiatrists became caught up in their own vision, perhaps also helps us sympathize. The context was the spread of paresis: Between 1890 and 1920 paresis or paralytic insanity displaced masturbation as the paradigmatic cause of insanity. What underlay this shift, as Szasz (1976/1988) points out, is that most male patients at the time presented with paralytic insanity features. Paretic patients swelled the ranks of the institutionalized; and tragically, these men inevitably got worse. During Kraepelin's career, it was discovered that paralytic insanity was late stage syphilis; and to everyone's relief, not long after this discovery, a cure for syphilis was found. Applying what materialized here to the rest of psychiatry, Kraepelin (1917/1962, pp. 151 ff.) writes:

> The nature of most mental illnesses is now obscured. But no one can deny that further research will uncover new facts in so young a science as ours; in this respect the diseases produced by syphilis are an object lesion. It is logical to assume that many other types of insanity can be prevented even cured—though at present we haven't the slightest clue.

With the memory—the traumatic memory—of the terrible days of paralytic insanity lodged deep in the psychiatric psyche, one can understand how the paresis model came to be embraced. Optimism had been sparked. However self-interested, the hope was that real diseases would be found to underlie all of the profession's "speculative" diseases—a "best of all possible worlds" development that would benefit both psychiatry and the suffering multitude.[18]

That psychiatrists made this leap of faith and continued to search for biological causes is understandable. If I may jump into the future—that they refused to take "no" for an answer is bad science, if it be science at all. That they ended up "cooking" research and announcing that they had found physical indicators, correspondingly, is fraud.[19]

Summarizing and Concluding

We began this chapter with Shorter's depiction of the rise of psychiatry as the triumph of the liberatory, the humane, and the scientific. Bit by bit, we have demonstrated that this depiction is inaccurate on every count. What materialized was not humane but brutal. The psychiatric state which emerged did not spell liberation but confinement on an unprecedented scale. Finally—and this is fundamental—as we saw clearly, psychiatry consolidated its power and harnessed the newly acquired credibility of medicine not by being scientific but by *mimicking* the outward trappings of science and medicine.

The close of the nineteenth century brought a new twist. With the ascendance of Kraepelin, we witnessed the emergence of a highly medicalized classification system, complete with detailed "symptomology" and "prognostics." Correspondingly, on the basis of *prediction alone*, we saw it so leveraged as to stand in for etiology and proof, in the absence of both. Without question, a strategic move. What we are encountering is, as it were, a gambit—as you can see, a very tricky one. What exactly are the implications of the gambit? What was this fledging discipline to do if the answers counted on never panned out? And—something which is already telegraphed earlier—how would the dynamics witnessed here play out in the long run?

For these and related questions, the reader is referred to the chapter that follows.

CHAPTER 3

Modernity (1890–2014): A Journey through Time, Part Two

In Chapter Two we witnessed the beginnings of professionalization (e.g., the formation of professional bodies; the standardization of education; the privileging of medical terminology). In this chapter, as we step into the modernity, we are faced with rampant professionalization and all that it entails.

This is the era of professionalization. Before long and increasingly, the center of international psychiatry shifted to the United States with the Association of Medical Superintendents of American Institutions for the Insane relabeled "the American Psychiatric Association" (APA) and aggressively promoting psychiatry. A plethora of "mental health" bodies sprouted up (e.g., National Institute of Mental Health or NIMH), some directly branches of government, some not. As spelt out in Whitaker (2002), publishing and research output likewise increased exponentially. At the same time, the role assumed by the state—in the United States especially—shifted in a subtle yet profound way, with the head of the American state himself actively engaging in pro-psychiatry campaigns. Dynamics which were to prove of particular significance and hence are explored in special depth include: the rise and fall of psychoanalysis, the advent of the brain-damaging "therapies," eugenics, the creation and marketing of the DSM, and "the pharmacological revolution."

In this chapter, I begin by probing the role of psychoanalysis in the evolution of psychiatry. I proceed to eugenics, affording it greater emphasis than is typical, for as will become increasingly evident, in a variety of ways, eugenics and the era that gave birth to it materially shape current practice. Naturally, special attention is paid to the pharmaceutical revolution, including the capitalist dimension, for more than any other single factor, it is manifestly on this development that contemporary psychiatry rests. Emphasized as well is scientific misrepresentation and the degradation of inquiry.

Questions explored most extensively in this chapter include: Why was psychoanalysis such a threat to this fledgling profession? What is the relationship between psychiatry and the Holocaust? How is it that Kraepelinian principles were revived? What institutional purposes were served by the dramatic changes made in third edition of the DSM? How are we to understand the "pharmacological revolution"? How was research "worked" in order to support the biological claims? What is the role of big business? What is the relationship between such out-of-favor practices as lobotomy and the widely accepted treatments of today?

Psychoanalysis and the Emergence of Talk Therapy

The first half of the twentieth century witnessed two very different—one might say conflicting—"therapeutic" developments. While the specifics were new, the tension is one that you will surely recognize from Chapter Two—between the somaticists and the more psychologically oriented. Albeit in profoundly different ways, both of these therapeutic developments were to substantially impact future practice and indeed the very dynamic of professionalization. The more famous of the two is alternately known as "psychoanalysis" and "psychodynamics."

The brainchild of Sigmund Freud, psychoanalysis originated in Germany at the turn of the century. Its central motifs include: the role of sexual repression in neurosis, the unconscious, the Oedipal complex, and transference; and its modus operandi is "talk therapy," with the interpretation of dreams prioritized. While not as popular in Europe, over the decades, it was to sweep America. Correspondingly, by the late 1940s and early 1950s, its adherents held demonstrable power in professional bodies and were substantially impacting psychiatric training on this continent. Significantly, in the 1940s and early 1950s, successive heads of the American Psychiatric Association were all analysts, and in 1952 the APA and the national body of medical educators released a report asserting that every competent psychiatrist had to comprehend "the principles of psychodynamics" (for details, see Shorter, 1997, p. 145 ff.).[1]

With psychoanalysis, something profoundly new had appeared on the landscape. The psychological itself had become focal—something that we saw only glimpses of with moral management. What distinguished psychoanalysis from moral management, the patient's words were seen as meaningful—their language, their thoughts, their dreams as a code to be interpreted. Moreover, unlike with moral management—and in this respect, moral management was more the precursor of behavior modification—talk and *in*sight—not *over*sight—were the order of the day. However sexist and scripted the interpretations, on some level, note, the patient was being listened to.

Psychoanalysis per se is largely outside the purview of this book, for it is overwhelmingly contractual and non-carceral; moreover, it makes little claim to being medical. Nonetheless, the story of psychiatry cannot be understood without it. The point is, it represented a threat to which biological psychiatry was forced to react.

The threat arises from two key features—one intrinsic, one a development. The first is the very focus on the nonmedical. If problems in living are theorized as nonmedical, the credibility which psychiatry gleans from medicine is intrinsically called into question. What added to the conundrum, Freudians proceeded to do something unprecedented in psychiatric history—open up their practice to lay therapists (see Horwitz, 2002). The popularity of nonmedical "treatment" together with the emergence of nonmedical analysts paved the way for the proliferation of other forms of talk therapy and, by extension, other nonmedical "therapists." If such a development was unlikely to impact on psychiatry's privileged status in the *short* run, in the *long* run, it could seriously erode the monopolistic power that the doctors had literally spent centuries building up.

Much of the development of modern psychiatry can be traced to the ways in which the institution grappled with these threats. That said, paradoxically, the nonmedical nature of the psychoanalytic enterprise also held promise for a business as intent on expansion as psychiatry had always been. The point is, precisely by not positing *discrete* disease entities, precisely by conceptualizing neurosis as a continuum on which all people could be placed and thereby pathologizing everyday life, the Freudians had expanded the territory beyond the profession's wildest dreams. The "mentally ill" were now not simply the extreme few, not simply the "raving lunatic," not simply the "deviant," not even just the housewife with "bad nerves"—they were everyone. Herein lay a unique opportunity for psychiatry as a whole if it could but find a way to grab hold of it.

Psychiatry, Big Business, Eugenics, "Research," and the State

Even as psychoanalysis was beginning its ascent, major corporations began opening their coffers to fund "progressive" psychiatric research. In 1921 the Rockefeller Foundation stepped up to the plate, identifying psychiatry as the branch of medicine "most in need of modernization" (Whitaker, 2002, p. 52). Carnegie likewise contributed. What was considered progressive or modern, significantly, was anything somatic, anything involving heredity, anything of a "heroic" bent. What resulted was a groundswell of research into the brain, research into gene pools—all of it benefiting biological psychiatry, most of it highly serviceable for eugenic purposes, a frighteningly high percentage explicitly eugenic.[2] While research to varying degrees is always framed by political agendas, the agenda in this instance was all-embracing, with outcomes all but predetermined. Meanwhile, in the larger world, more and more eugenics societies sprouted up, with these same corporations playing a major role. The Second International Eugenics Conference was itself hosted by the Rockefeller Foundation and Carnegie (for details, see Whitaker, 2002).

Here is what had become of the early Darwinist theories of Maudsley, Lombroso, Galton (English scientist who coined the term "eugenics"). Come the dawn of the twentieth century, there was a zeitgeist in the air—a will to do something about "those populations" (the insane, the disabled, in some countries, the Jews, the Roma) whose gene plasma were a "threat," whose very existence had come to be theorized as a burden. An essential player, the state took upon itself the responsibility to aggressively protect its "normal" citizens from the "degenerates." The United States and Germany positioned themselves as leaders. Big business began greasing the wheels. And in what must be recognized as more than an incidental misstep, psychiatry was smack in the middle of it all.

Expectably, the influx of big money greatly facilitated what was to happen. Even before this influx, however, academics were successfully laying the groundwork. Indeed, in the United States alone, as early as 1914, "44 colleges had introduced eugenics into their curriculum" (Whitaker, 2002, p. 49). Turn-of-the-century eugenics researchers of note include American scientist Charles Davenport (1911), who argued that the "feeble-minded" were a threat to the gene pool; German physician Fritz Lenz, a strong advocate of sterilization; and American psychiatrist Aaron Rosanoff (1911), whose research on the relatives of "insane patients" demonstrates the kind of "cooking" that was quickly becoming routine in biological psychiatry. Having initially found a low rate of insanity among the relatives, significantly, Rosanoff dramatically lowered the threshold of what counted as insane, then claimed to have established the hereditary nature of insanity. Explicitly eugenics research, biologically oriented psychiatric research, and the "cooking" of research essentially came together in this, the "fascist moment." To what extent biological psychiatry did or did not free itself from this initial grounding will become clearer as the chapter unfolds.

Theoretic works that were to particularly facilitate the eugenics movement include Germany's Adolf Jost's 1885 book *Das recht auf den tod* (translation: *The right to die*), which defended the state's right to kill the "incurably ill"; and a book coauthored by a German psychiatrist and German jurist, whose title says it all—*Die Friegabe der Vernichtung lebensunwerten lebens* (translation: *The permission to destroy life unworthy of life*) (Binding and Hoche, 1920). This second book in particular is generally credited with introducing the language soon to be taken up by Nazi Germany—descriptors such as "unfit," "useless eaters," "parasites," and "unworthy" (see Lifton, 1986). Nor is it an accident that it was coauthored by a psychiatrist. Vested with police powers, this was the profession whose job it had always been to protect the "fit" from the "unfit." This was the profession who had taken the lead in the early theories of degeneration. With it progressively advocating aggressive state measures, as demonstrated by Lifton (1986), Friedlander, (1997), and Proctor (1988), correspondingly, hard though this may be to wrap one's head around—for it conflicts with our image of doctors—psychiatrists can be reasonably theorized as architects of the Holocaust.

The first state "solution" to the "problem" of "the mental patient" was sterilization, with psychiatrists not only advocating this, overseeing it, and making decisions with respect to it, but assuring patients that it was in their own best interests (see Whitaker, 2002). America was the lead country, with Indiana the first jurisdiction to pass a compulsory sterilization law. Other US states quickly followed as well as the Canadian provinces Alberta and British Columbia. Indeed, so far "advanced" did America become in its eugenics efforts that in 1923 German eugenicist Fritz Lenz berated his countrymen for falling behind America (see Lifton, 1986, p. 23). By the same token, the US Supreme Court goes down in history as the first high court in the world to rule on sterilization.[3] By a vote of 8 to 1, it held that the compulsory sterilization of the insane and the "imbecilic" was legal. The written opinion, drafted by no less a personage than Oliver Wendel Holmes, is a telling indicator of the degree of state buy-in. Holmes characterizes sterilization as a "lesser sacrifice," which these populations can be called upon to make. "It is better for all the world," he goes on to write, "if instead of waiting to execute degenerate offspring for crimes, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind" (*Buck v. Bell*, 1927).

Half a decade later the rulers of Nazi Germany took the decisive lead, introducing Nazi Germany's now infamous sterilization law—Law for Prevention of Medically

Diseased Offspring. That they pursued such a route was arguably inevitable, given their medicalized view of the state and their explicitly eugenics view of the nation. Note, in this regard, Hesse's famous dictum, "National socialism is nothing but applied biology" (see Lifton, 1986, p. 31). Here was a regime which saw the very nation as a living organism that doctors as healers/rulers were called upon to protect. And here, so to speak, was the ultimate union of *parens patriae* and police powers, of the doctor and the state. Under a regime such as Nazism, doctors indeed assumed God-like power, significantly, while facilitating a direction that they themselves had advocated. With key psychiatric figures such as Rudin (student of Kraepelin's) preparing the way, in short order an elaborate medical bureaucracy was set up, including Hereditary Health Courts, to which every day physicians reported the "unfit"—the "disabled," "idiots," "schizophrenics." Negative eugenics or curtailing "life unworthy of life" was now pursued with a vengeance, with Germany's medical profession overseeing all aspects.[4] An indicator of the initial reception which these measures received from the medical world at large—and at this juncture, it more than approved—was that at their next annual conference, the American Public Health Association mounted an exhibit of the Nazi sterilization program, characterizing it as an "optimal example" of modern medicine (see Whitaker, 2002, p. 66).

The next logical step was murder itself. America seriously flirted with the idea, a 1937 US Gallup poll, for example, indicating that 45 percent of Americans favored killing "unfit" children (see Proctor, 1988). Germany actually did it.

So-called euthanasia began in earnest in Nazi Germany in 1939 when Hitler issued a secret memo that extended the authority of doctors further, and again, in a direction that respected members of the profession had long advocated, giving them the authority to grant the "incurable" a "mercy death." The mass killing of the psychiatrized and the disabled which followed—and it did not take long—was cloaked in the medical garb that Heinroth had recommended for psychiatry years ago. Doctors dressed in white oversaw the operations, indeed, actually killed their patients *as "doctors."* Diagnoses were employed. The language, moreover, was the language of "treatment."

Determination of people's fate was made in committee on the basis of "medical" questionnaires, largely created by leading psychiatrists. The marking of a plus sign signified treatment. By contrast, a minus sign signified no treatment. Decode the discourse—and deceptive discourse had long characterized this profession—and what you discover is that "treatment" meant being put to death (see Lifton, 1986).

The most deadly of the fascist regimes, Germany was on a murderous path, each new development building on the last. It began with the individualized murder of "disabled" children by injection. Next came "insane" and "disabled" adults. The culmination was an extensive network of gas chambers and the systematic liquidation of Jews, Roma, political prisoners. And throughout it all, doctors presided like princes over a kingdom of death.

That many of the doctors were convinced that what was happening was both benign and medical is clear. What contributed to the self-delusion was an eerie shift—supported by the state, steeped in fascist ideology—in who actually constituted the patient. Note, in this regard, this explanation offered by a Nazi doctor approximately half a century after the fact—long after holding fast to the eugenics line was prudent: "Of course I am a doctor, and as a doctor . . . out of respect for life, I would remove a gangrenous appendage from a diseased body. The Jew is the gangrenous appendage on the body of mankind" (quoted from Lifton, 1986, p. 16). The euthanasia killings are particularly important in the context of this investigation, for they involved doctors murdering their own patients. That such a thing happened and that the majority of the doctors appeared to be willing participants horrifies the mind. The medical profession itself would dearly like to mitigate their responsibility. Correspondingly, there has long been talk of a "Führer decree" ordering them to murder the "unfit." The sad truth is, however, as the evidence indicates, commonly doctors did what they did because they were on a mission, because they were out to save civilization, because it matched their own "biomedical" vision. Moreover, whatever subtle pressures might have been brought to bear—and we can well imagine that such existed—no one so acted *because they had no choice*. The point is, as historians such as Proctor (1988) have clearly established, there never was a Führer decree obliging doctors to kill their patients. A memo simply "enabled" them to do this. To quote psychiatric researcher Peter Breggin (1974, p. 4) in this regard, "Doctors were never ordered to murder psychiatric patients and mentally handicapped children. They were empowered to do it." If the implication latent in this depiction feels harsh, minimally, what was happening cannot be attributed to "following orders." What is telling in this regard, after Hitler explicitly ordered the killing stopped (for documentation on this Hitler order, see Proctor, 1988), psychiatrists essentially doubled their effort. Having already murdered approximately 100,000 patients, that is, in what came to be known as "wild euthanasia," *on their own initiative*, they went on to kill a considerably larger number of "mental patients" than they had previously (for details see Procter, 1988; and Friedlander, 1997).

One final and haunting detail—with the war over and the allies liberating the camps, some psychiatric teams continued their "work." A testimonial by Abrams is instructive in this regard (for details, see Proctor, p. 192 ff.). Three weeks into the American occupation, states Abrams, he returned home to his village to find personnel in the local mental hospital killing patients. It was only at gunpoint that they were ultimately stopped.

Fortunately, this horrific era is over. Moreover, most psychiatrists today would recoil at the very sound of statements that struck them as eugenic. At the same time, the harrowing truth is that much of what is now accepted as standard psychiatric practice is a product of the eugenics era with all the telltale signs—the presumption of hereditary "mental illness"; the widespread acceptance of "schizophrenia"; biological psychiatry more generally; rampant experimentation; ever more genetic research; the proliferation of psychological testing, including the IQ (used to identify candidates for sterilization; see Proctor).[5] There is little awareness of the flimsy and indeed treacherous ground on which such practices, conceptualizations, and indeed, preoccupations rest. Nor, for that matter, is there any official acknowledgment of psychiatry's pivotal role in the Holocaust.

The Rise of "Brain-Damaging Therapeutics": Treatments in the Eugenics Era

Official eugenics aside, 1930s through to the mid-1950s was at once a productive and a perilous time for psychiatry, much of what was transpiring a close relative of eugenics. Even as sterilization was gaining popularity, significantly, a plethora of other highly experimental and highly intrusive "treatments" were introduced and they quickly became standard practice. All overwhelmed the brain's normal functioning. All inflicted injury. The treatments in question are the various "shock" therapies and lobotomy.

The shock therapies were initially intended as a cure for "schizophrenia." Predicated on the assumption that traumatizing the brains of people with "disordered thought" was beneficial—physicians introduced "cures" literally based on starving the brain, making it convulse, or both. Over this period, there were to be several changes in the "shock" repertoire—with respect to the substances employed, the damage mechanism sought, the rationale provided. The commitment to brain injury, however, remained intact. So did "the discourse of success"—progressively, psychiatry's way of presenting itself to the world. Purportedly, everything was safe and effective; each new practice an "improvement" over the last.[6]

Two of the earliest substances employed were insulin and metrazol. Insulin shock was invented in the early 1930s by Manfred Sakel—a Viennese psychiatrist. The treatment consists of subjecting the patient to an almost lethal dose of insulin, thereby depriving the brain of needed fuel and forcing it to shut down—hence, the coma. "I take my insulin patients to the doors of death," announces practitioner David Abse (1956, p. 32 ff.), "then snatch them back." Typically, patients were subjected to such comas two or three times daily, with the treatment generally continuing for months on end (an interviewee for this study was administered 115 such treatments over several months). The expectable result was extreme confusion and regression to an infantile state—all of it identified as "improvement." Even as they were damaging them, psychiatrists tended to the needy patient much as the nerves doctors in the nineteenth century tended to the "women hysterics" rendered helpless by their "treatment." The difference is that in this case, the damage was not limited to the psychological arena. Somatic results themselves include cortical devastation and cellular waste (for details, see Whitaker, 2002, p. 84 ff.).

The second of the shock therapies—metrazol therapy—was introduced by Hungarian practitioner Ladislaus von Meduna (1938), also as a cure for schizophrenia. A convulsive therapy, its mode of operation was inducing brain seizure. The untested hypothesis was that schizophrenia and epilepsy were mutually incompatible. Induce epileptic or epileptic-type attacks, correspondingly, and you cure schizophrenia. Once again, a real disorder is being created to cure a putative disorder. And once again (see Whitaker, 2002), the results were infantilism, confusion, and cellular death.

To be precise about what was happening here, it is not only that violence can be concluded—which clearly, it can—or even just that it was intentional. It was that violence per se formed the very core of the therapeutic discourse. Meduna's (1938) famous statement about metrazol and insulin therapy is instructive. Employing the metaphor of dynamite, Meduna writes, "We act with both methods as with dynamite, endeavoring to blow asunder the pathological sequences and restore the diseased organism to normal functioning" (p. 49). Observe the language: In the world of experimental psychiatry—and that is precisely the world that we are entering—"disease" (already a social construct) is being constructed as necessitating an explosion of violence, a blowing apart. The sanctity of the person, the sanctity of the soul, the sanctity of thought have no place. Paralleling the "explosion" trope and acting to support it is a vague image of "noxious" processes that "necessitate" such extreme action. These "noxious processes," it is suggested, constitute a chain that needs to be "broken": "We are undertaking a violent onslaught with either method we choose," states Meduna, "because at present nothing less than a violent assault to the organism is powerful enough to *break the chain of noxious processes* that leads to schizophrenia" (p. 49; my emphasis).

What this narrative assumes it that "schizophrenia" and the dynamics associated with it are malign physical entities to be eradicated at all costs. What it ignores is that schizophrenia was never established, that no physical indicators—"noxious" or otherwise—have ever been observed, moreover, if you unleash general violence on an organism, all of it—not just the hypothetical "noxious processes"—are affected.

In later eras, when damaging the brain was no longer "acceptable" to the public, the discourse of *damage* was replaced by a discourse of *damage denial.* At this juncture, however, it is precisely such damage that is being declared therapeutic. Indeed leading psychiatrist Walter Freeman (1940) creates an overarching category for the full slate of shock therapies plus lobotomy, giving it the unmistakable name "brain-damaging therapeutics."

Lobotomy—cutting into the brain, permanently severing one part from another—was the paradigmatic "brain damaging therapeutic," and it was contemporaneous with the shock therapies. It was invented by Lisbon neurologist Egas Monitz. Having seen research on how "cheery" research chimpanzees became when their frontal lobes were ablated, he hypothesized that such ablations might similarly "help" the "hopelessly mentally ill." With the aid of a neurosurgeon, he tested his hypothesis by resecting the frontal lobes of 20 mental patients, as he proceeded from one to another, deliberately injuring ever more perfectly healthy nerve tissue. Calling this a "study," and as Valenstein (1986) and Shorter (1997) document, in the absence of evidence, Moniz (1949) concluded that 7 had "improved." Lobotomy was thereby constituted as a success. Moreover, a "numbers game" had been introduced, which was to prove useful to psychiatry in its future endeavors. A precursor of the quality of research to come.

More lobotomies, lobotomists, and "research" followed. An early meta-study of such research tallied all the figures produced to date and concluded that lobotomy was effective "84% of the time" (see Ziegler, 1943). Again the science was faulty. The point is, the highly subjective criteria used said more about the medical staff than the patients, with behavior presenting less problems for staff qualifying as "improvement." Indeed, people who could once write poetry and now could do little but giggle were being declared better. More significantly, the scales used to measure effectiveness typically ranged from "temporarily improved" to "greatly improved." Tellingly, *the very possibility of deterioration* was absent.

In this as through a microscope, we can see writ large what psychiatric research and psychiatry as a whole had become. We see, moreover, a blatantly symbiotic relationship developing between "practice" and "research." However barbaric, any practice that supported research—and there was money for brain research—received funding and credibility. In turn, the "research" produced was so crafted as to prove whatever the doctors needed it to prove. Utterly insupportable research findings were then published in journals, announced at professional conferences, released to the media with great fanfare.

Psychosurgery quickly became the rage. It became the rage because in this the eugenics era, rendering the "hopelessly mentally ill" less troublesome by ravaging their brain seemed a reasonable tradeoff. It became the rage because research on it qualified for the Rockefeller funding. It is in this self-serving context that the American Psychiatric Association (1949, pp. 550–551) gave lobotomy the following duplicitous commendation: "Every stage in this rapidly growing field is marked by a deep sense of the primary obligation to the patient, and a profound respect for the human brain." Sadly but significantly, instead of "blowing the whistle," the rest of scientific community fell in line. Indeed, in 1949, Monitz was awarded the Nobel Prize in medicine and physiology.[7] And primed to do so—for by now the media was itself implicated in the hegemony—the media applauded, hailing lobotomy as a miracle treatment (for details, see Whitaker, 2002, p. 137 ff.). At the bare minimum, disregard for the full humanity of the "mad" and a willingness to sacrifice their integral selves are operant.

This brings us to who is arguably the single most important figure in lobotomy—American psychiatrist Walter Freeman. Freeman dramatically lowered the bar for what "warranted" lobotomy (see Valenstein, 1986, p. 218). He stated definitively that the cure was safe and effective—a phrase that we shall hear repeatedly and which serves as a linguistic replacement for proof. Correspondingly, he explicitly stipulated that *greater* brain damage was preferable to *lesser*. In this last regard, he wrote: "The greater the damage, the more likely the remission of the psychotic symptoms... It has been said that if we don't think correctly it is because 'we haven't brains enough.' Maybe it will be shown that a mentally ill person will think more clearly with less brain" (quoted from Shutts, 1982, p. 112). Lest the eugenic overtones are missed here, it is not just "anyone" that Freeman is claiming "will think more clearly" if the brain is compromised. It is the "mentally ill" or "defective."

Freeman is best known for a strategic modification in the "procedure." His operation, called "transorbital lobotomy," was performed via entering in through the eye socket with an ice pick, thereby dramatically cutting down on the time taken. Lobotomy could now be completed in a matter of minutes, thereby maximizing the doctor's profits, reducing hospital expenses, and dramatically increasing the number "served." The result was significant buy-in by the larger medical world. Indeed, come the early 1950s, of the "advanced" nations, Germany alone abstained from lobotomy, astutely observing that it smacked too much of the Holocaust (see Whitaker, 2002).

Freeman claimed a high rate of success. His own depictions of the success story—"loss of interest in self," "childlike," "cheerful unconscious and unselfconscious behavior" (Freeman and Watts, 1942, pp. 565–566)—suggest that it is precisely the reduction of the adult thinking feeling self that is being positioned as "success." Additional dimensions come to light with a closer examination of his discourse. Consider this:

> We vividly recall a Negress of gigantic proportions who for years was confined to a strong room at St. Elizabeths... When it came time to transfer her... for operation, five attendants had to restrain her while the nurse gave her the hypodermic. The

> operation was successful in that there were no further outbreaks . . . From that day after . . . (and we demonstrated this repeatedly to the ward personnel), we could grab Orestra by the throat, twist her arm, tickle her in the ribs and slap her behind without eliciting anything more than a wide grin and hoarse chuckle. (p. 29)

How Orestra came to be confined in a strong room for years, we do not know, though the anecdote invites this query. What the narrative does reveal is that in the eyes of the racist white male jailers, this large Black madwoman was a threat, something to subdue or master. When she tried to resist an inherently disabling operation, five of them held her down, albeit the story for them was not their aggression but the seemingly eerie strength of the crazy "Negress." Having profoundly damaged her brain, they proceeded to infantilize her, take liberties with her body, expose her to ridicule, and generally use her as a quasi-eroticized showpiece—which they could now do with impunity.

The eugenic feel of this story is intensified when you ask: Who was disproportionately targeted for lobotomy? The answer—at least when it comes to intent—is the Black community. While statistics for this era are hard to come by, significantly, in 1947 a plan (subsequently aborted) was formalized to perform "mass lobotomies" on all the "Negro patients" in Tuskegee State Hospital (for details, see Breggin and Breggin, 1998).

While the real effects of lobotomy were so obvious that they eventually led to its decline, much to the surprise of many of us, it was to enjoy a resurgence in the 1970s, again, as Breggin and Breggin (1998) point out, with Blacks especially targeted. The ongoing threat of massive brain damage coupled with racism is, in essence, part of the treatment's legacy. There is one further legacy that I cannot but surface here. Via an indirect route, lobotomy may be partially credited for the enormous support for biological psychiatry eventually to come from the White House.

That support first materialized in the early 1960s when President Kennedy front and centered biological psychiatry in a State of the Union Address and made aggressive support for biological psychiatry key to his administration. He thereby created a precedent for future presidents. The question arises—why did he extend so much more support than former presidents, not to mention other world leaders? Here we come face to face with a family tragedy—in this case, one with pronounced feminist meaning. In 1940, for what was then called "promiscuity," his sister Rosemary had been lobotomized. So much Freeman cut and so impaired she became that she could not thereafter care for herself. In the long run, this left the family with a painful choice all too common in psychiatry-involved families—to face up to their part in what was done, or to justify/avoid. They avoided. Part and parcel of that avoidance was throwing the full weight of the president's office behind psychiatry.[8] However else one understands what played out here—and other interpretations are possible—a long-term consequence is that henceforth the White House publicly interpreted social problems through a biological lens, more or less functioning as a propagandist for biological psychiatry (see Breggin and Breggin, 1998).

The last of the major "brain-damaging therapeutics" introduced during this eugenics era was electroshock, also called "electroconvulsive therapy." Like the other shock modalities, it was intended as a cure for schizophrenia. It consists of delivering sufficient electricity to the brain to cause a grand mal seizure.

It was invented in fascist Italy in 1938 by Italian psychiatrists Ugo Cerletti and Lucio Bini; the inspiration, hogs en route to the slaughter house being rendered docile by the application of a cattle prod. The first experiments were on dogs, with one group, note, so badly brain-damaged as a result that the inventors were obliged to discontinue (see, in this regard, Bini, 1938; and Breggin, 1979). The first human subject was a homeless man, who was dragged to the clinic against his will, then subjected to ECT. Significantly, as the jolts of electricity surged through his body, the terrified man bolted upright, shrieking, "No una seconda. Mortificare!" (not another; it will kill me; quoted from Frank, 1975/1978, p. 11). Later Cerletti himself was to confess that, at the time, he thought, "This ought to be abolished" (quoted from Frank, p. 11).

Despite the inauspicious beginnings, this was a treatment that the psychiatric world wanted. The point is, it had the advantage of not being a major "operation" (in contrast to lobotomy) and was at least seemingly far more expedient than the other shock therapies. The Nazi doctors were soon employing it on concentration camps inmates (see Lifton, 1986)—something which in itself seems to trouble the claim of it being benign. More significantly, it was introduced into the center of international psychiatry—the United States—and soon the biggest names in American psychiatry were lined up behind it.

So integrated into current practice is ECT that people tend to lose sight of the fact that it is a product of the eugenics era. This notwithstanding, this is a procedure that could only have been invented at that time; and indeed, it bears all the tell-tale signs. As Breggin (1979) documents, from the outset, it produced extreme confusion and memory loss, moreover, reduced patients to childlike helplessness and apathy. So frightening was it to patients, additionally, it began being routinely employed as a threat. More to the point, despite current claims that it does not cause brain damage, its early proponents were crystal clear. Not only did they acknowledge brain damage, as even a cursory review of early documents reveal, they embraced it as their goal. Note in this regard this statement by leading ECT pioneer Dr. Abraham Myerson (see Ebaugh 1942, p. 37):

> These people have . . . more intelligence than they can handle, and the reduction of intelligence is an important factor in the curative process. I say this without cynicism. The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia [simple-mindedness].

Significantly, the prime candidates for such treatment—that is, the people's whose brain matter was deemed expendable—were women (see Burstow, 2006).

Not surprisingly given that this was its avowed purpose, researchers soon "found evidence" that ECT causes brain damage. The only surprising part is that brain-damage was so quickly reconfigured as a "consequence" that needed to be "discovered." Early researchers who made such discoveries include B. J. Alpers and J. Hughes (1942). Of particular importance is scientist Hans Hartelius, who conducted a statistically significant double-blind study involving 42 cats. In the double-blind portion of the experiment, with one error only, on the basis solely of *pathology slides* of the brains and the damage visible in them, the pathologist was able to identify accurately which of the cats had and which had not been administered ECT (for details, see Hartelius, 1952).

From the start, ECT met with fierce opposition—hence the need to deny the damage initially proclaimed. Opposition came from patients, for the "treatment" impeded their ability to think and to remember (see Dundas, 1995). However, it also came from within the profession itself. Many psychoanalysts expressed dismay at it. Correspondingly, in a move unparalleled in psychiatric history, the prestigious GAP (see Group for the Advancement of Psychiatry, 1947) issued a report critiquing ECT practice. ECT practitioners, to their credit, did make one change to the practice—the addition of an anesthetic to prevent the back from breaking. Necessary though that modification was, however, it in no way addressed the central complaints.

In short order ECT advocates set about defending their territory. They did so, moreover, with far more rigor and at least as much duplicity as the lobotomists defended theirs. Besides engaging in the characteristically faulty research which was quickly becoming psychiatry's trademark—using only subjective measures, for instance (for examples, see Breggin, 1979)—they both dramatically altered the discourse and outright lied. "Brain damage as therapy" soon disappeared into the ether as if it had never been and the discourse became one of brain-damage denial. Kalinowsky (1959 and 1975), by way of example, repeatedly went on record stating that there is no brain damage, that ECT is "utterly harmless." He even alleged that there is no evidence whatever to the contrary, albeit as a knowledgeable practitioner, he had to be aware of it. He stated all this, note, even while naming his work "confusional treatment" and recommending that patients be treated to the point of "complete disorientation." By the same token, proponents called ECT "safe and effective," suggested that "patients" would not get well without it, and the APA pronounced the most obvious and dramatic consequence of ECT—the memory loss—"minor" and "transient" (see, respectively, Breggin, 1979; and American Psychiatric Association, 1978). So successful was the campaign that over half a century later this particular eugenics "therapeutic" is alive and well.

While ECT was the last of the major eugenics era treatments, I would be remiss if I ended this section without focusing in on one final development. The place is the prestigious Allan Memorial Institute in Montreal (a "progressive" mental health research and teaching hospital in Canada, not coincidentally, established courtesy of the Rockefeller Foundation funds). The psychiatrist at the center of the story is the renowned Dr. Ewen Cameron, head of the Allan, at various times head of both the American Psychiatric Institution and the World Psychiatric Institution, moreover, esteemed professional ethicist who sat on the Nuremberg Medical Tribunal.

As documented in Marks (1979), Collins (1988), and Gilmor (1987), beginning in the early 1950s and extending until the mid-1960s, Cameron subjected "patients" at the Allan to some very worrisome experiments that combined ECT with sleep therapy, with LSD, with the power of suggestion. The intent, as with all the eugenics approaches, was to obliterate "psychotic thinking" (translation—*all* their thinking), in this case, additionally, replacing it with new thoughts. Stage one or "depatterning" consisted of administering ECT several times daily until the mind was "wiped clean" and the patient was totally regressed. Stage two, called "psychic driving," involved implanting new ideas in the now "blank mind" via taped messages which played over and over while the patient was kept in a prolonged and suggestible sleep (months on end)—the *reprogramming* part. A telling example of one such message was: "You are a bad mother. You are a bad wife" (for details on the rampant sexism—and this there surely was—see Burstow, 2006).

Significantly, appalling though these measures look to the average person, Cameron had no difficulty procuring funding. Viewing this as a cutting-edge experiment on brainwashing, the CIA secretly funded it (code name "MKULTA"). Additionally, as the primary funder, Health and Welfare Canada awarded Cameron grant after grant.

The experiments were discontinued when Cameron left the Allan. Meanwhile, Cameron's former "patients" went about their lives, like all too many other survivors before them, human beings badly and indeed permanently injured from psychiatry's "cutting edge" procedures. Linda Macdonald, for example, was never again able to recall *any of the people* who figured in her life prior to receiving regressive electroshock—not her friends, her husband, her children. Not able to concentrate or study, correspondingly, in a way, Huard speaks for everyone when she states, "I would say it cost me my life" (see Macdonald, 1988, pp. 206–210; and Burstow and Weitz, 1988, pp. 201–205).

Decades later, as a result of disclosures by a former CIA agent, also because of nine of the survivors launching a lawsuit, details of the operation came to light. At this point, psychiatric colleagues who had intricate knowledge of Cameron's operations were highly critical of him. Significantly, however, there had been no criticism previously. Nor was this omission due to lack of awareness. Indeed, the secret funding excepted, the whole psychiatric world knew in minute detail what Cameron and his colleagues were doing, as did Health and Welfare Canada, for besides that they were outlined in the grant applications, over the years, the prolific Dr. Cameron had published numerous and very explicit articles on his methods (see, e.g., Cameron, 1956).

When news of the Allan atrocity started to break, the story which crystallized is that something secretive and totally outside normal psychiatric practice had happened. Not able to grasp that the story as they understood it was but the tip of the iceberg, writers such as Marks (1979) and Collins (1988) focused almost exclusively on two players—the CIA and Cameron—weaving a narrative, essentially, about one "bad agency" and one "bad apple." Psychiatry as a whole was not implicated—not even biological psychiatry. What this discourse renders invisible is that the CIA aside, the Allan Memorial experiment was not a secret plot, not a covert operation. It was accepted and indeed funded by both the psychiatric world and the state. Moreover, it draws on recognized psychiatric principles, reasoning, processes. Indeed, as this book demonstrates, a trajectory can be drawn from the other aggressive biological therapies (the sleep and coma therapies, lobotomy, and electroshock) to the Allan Memorial "therapeutics." In other words, when it comes to biological psychiatry, much as we might wish it were otherwise, what happened at the Allan is but a stone-throw away from "ordinary." As such, it constitutes a "wake-up" call. And herein lies its true significance.

As someone who has herself organized on behalf of these survivors, there is one worrisome query that has long haunted me and that I cannot but ask as an addendum to this story: If the CIA had never provided a small portion of the funding, if the victims were not overwhelmingly white and middle class, one of them, additionally, the wife of a member of parliament, would the world have even taken note?[9]

Enter the Pharmaceuticals (1952 onward)

While ECT was on the rise and the Allan Memorial victims were languishing in "the sleep room," a much larger battle was being waged between biological psychiatry and talk therapy. The future of biological psychiatry—ergo, of psychiatry itself—was on the line. At stake, as noted earlier, was nothing less than the supremacy that it had spent centuries building up. The point is, if the talk therapies continued to demedicalize the territory, de facto, the very need for psychiatrists would eventually be called into doubt. The problem was serious in the 1950s. In the 1960s and 1970s, with the proliferation of the talk therapies, the situation grew more dire.

Of course, self-interested though they were, these somaticists were correct that there was a major limitation in talk therapy as practiced. Albeit with some exceptions, the talk therapists were essentially serving the segment of the population least in need (for details on this complaint, see Shorter, 1997). The problem for biological psychiatry was: if the talk therapies had their limitations, they were overwhelmingly voluntary, were viewed as helpful, and were comparatively benign. By contrast, biological psychiatry was predicated on a indefensible medical model, damage, and coercion, and, as such, had nothing but damage and coercion to offer. Correspondingly, the damage was becoming increasingly obvious, the medical veneer wearing thin.

If psychiatry was to survive, the challenge was to create a convincing enough picture that the state and the public at large became totally invested in the medical model. Minimally as well, the damage needed to be subtler. If in addition, an approach could be advanced that lent itself to decarceration, a case could be made for cost effectiveness.

In 1950s, the 1960s, even the early 1970s, such a turnabout looked dubious. By 1987 biological psychiatry had won beyond its wildest dreams, not only regaining dominance but dramatically expanding psychiatry's terrain. Paradoxically, a crucial step in this was a mutually beneficial alliance with a constituency that had once been one of the medical profession's most formidable rivals—the followers of Paracelsus.

Some "early history": unlike Hippocrates, who associated illness with *humoural* imbalance, Swiss physician Paracelsus attributed it to *chemical* imbalance. Correspondingly, he produced and distributed "corrective" inorganic substances. In England, come the late sixteenth and the early parts of the seventeenth century, the rivalry between the "regulars" (university-certified doctors) and the apothecaries (followers of Paracelsus) was fierce, each seeking a larger piece of the lucrative London market.[10] Over the centuries, the relationship was to alter dramatically. While doctors gained unquestionable ascendancy as "healers," progressively, their mode of treatment was the very substances created by the apothecaries. By the twentieth century so identified had doctors become with such substances (now called "medicine") that prescribing them was the hallmark of medical practice. Herein lay a possible solution to psychiatry's dilemma. The point is, prescribe drugs and you look like a doctor, and by association, all your actions appear medical. Correspondingly, only someone with a medical degree can do it. Additionally, the inherent violence is not so obvious. Indeed, for someone with emotional problems, a case could be made that being "doped up" constituted a benefit. What added to the attraction, being more docile, a drugged "patient" could conceivably be released from hospital.

Just as such an alliance would serve psychiatry, it would serve the burgeoning pharmaceutical industry. If "psychiatric problems" were theorized as bone fide illnesses caused by chemical imbalances (and I remind the reader that chemical imbalance is *not and never was the criterion for disease*), the inevitable outcome would be a sizable new market and a dramatic increase in profits. Such profits in turn would justify "investing" as it were, in psychiatry—a "win-win" for both industries.

The way was prepared by "medicine" proper. The United States is instructive in this regard. Significantly, as Whitaker (2002) observes, prior to 1950 the AMA (American Medical Association) carefully preserved its independence from the pharmaceutical industry. Additionally, it functioned as watchdog, conducting credible independent investigations on drugs being brought to market. Then a seismic shift occurred. As a result of pressure from the AMA, the percentage of drugs requiring medical prescription dramatically increased. At the same time, the AMA abandoned its watchdog role even while increasing its economic tie-in with the pharmaceuticals. The "devil," as they say, "is in the details":

> In 1950 the AMA received . . . only $2.6 million from drug company advertisements. . . . A decade later . . . the money it received from drug companies had leaped to $10 million—$8 million from journal advertisements and another $2 million from the sale of mailing lists. As this change occurred . . . the AMA abandoned its seal of approval program and eliminated its requirement that pharmaceutical companies provide proof of their advertising claims. In 1961, the AMA even opposed a proposal by Senator Kefauver to require drugmakers to prove to the Food and Drug Administration (FDA) that their new drugs were effective. (Whitaker, 2002, p. 149)

As time went on, this disturbingly cozy relationship got cozier. The pharmaceutical companies funded ever more medical profession activities—their conferences, their journals, their education. Advertisements that transparently exaggerated the effectiveness of new drugs were allowed in medical journals. The industry additionally developed a tight relation with the very government agencies specifically designed to monitor them (for substantiating details, see Whitaker, 2002).

This development is in itself alarming. What would be more worrisome is if the pharmaceutics likewise cozied up to psychiatry. The point is, in *medicine proper*, there are credible illnesses which these substances to varying degrees address. With *psychiatry*, there are only "assumed" illnesses—with the assumption in question, significantly, never panning out. Were psychiatry and the pharmaceuticals to forge an alliance, what would be involved, to put it another way, would not be simply the skewing of facts and improper influence, it would be the aggressive marketing of mind-altering drugs for *illnesses that do not in fact exist*, with all the obvious hazards pertaining—and that is precisely what transpired.

The introduction of psychiatric drugs is traditionally accorded a place of honor next to Pinel as one of the two great liberatory acts in psychiatric history. The oft-repeated comparison is: just as Pinel removed the chains from the bodies of the insane, the drugs removed the chains from the mind (see, e.g., Shorter, 1997). Albeit admittedly, this is a minor indicator only, significantly, the name given the first *major* class of psychiatric drugs points in the very opposite direction. They were called "neuroleptics." Of Greek origin, the word roughly means "to grab hold of the nervous system" (see Whitaker, 2002, p. 144). And "grabbing hold of" connotes restraint—not liberation.

While drugs such as barbiturates had long been employed in psychiatry, the beginning of "the pharmacological revolution" is traditionally set in the early 1950s when chlorpromazine, the first of the neuroleptics, was introduced.[11] The story of its introduction is instructive, for it writes large the inherent contradictions. Moreover, the discourse constructed served as a template for future campaigns.

First synthesized in France by the inventor Henri Laboritt, chlorpromazine belongs to the phenothiazine family.[12] It was invented and initially used to calm patients in preparation for surgery. So calm did they become that almost no anesthetic was necessary. Witnessing the effect, tellingly, one of Laboritt's colleagues enthusiastically dubbed the result "a veritable chemical lobotomy," whereupon Laboritt speculated that it might be used with "mental patients."

A handful of psychiatrists took up Laboritt's invitation. These include Delay and Deniker, who proceeded to employ it with hospitalized "patients" in Paris. Lehmann followed suit in Montreal. Significantly, documents indicate that the same "lobotomy" effect was observed by all. Delay and Deniker, for example, describe the treated patients as becoming indifferent, uninterested, staring blankly into space "as if by an invisible wall" (quoted from Whitaker, 2002, p. 143). Classical lobotomy-like apathy and indifference, similarly, is evident in this description of the patient on chlorpromazine: "Sitting or lying, the patient is motionless in his bed, often pale, and with eyelids lowered. He remains silent most of the time. If he is questioned, he answers in a monotonous and indifferent voice" (quoted from Breggin, 1991a, p. 54). Lehmann (1954, p. 237) explicitly speculates, "it may prove to be a pharmacological substitute for lobotomy." The salient point here is: whether or not a type of lobotomy has been effected—and the chemical's modus operandi was not yet known—there is ample evidence that the inventors welcomed it as a new form of lobotomy or minimally as something that produced "lobotomy-like" effects.

An effect likewise noted and valued (perhaps because it made the "patient" easier to handle) is interference with motor function—something identified from the start as a form of neurological impairment. Deniker, for one, speculated that it was encephalitis—something again viewed as positive. To quote Deniker in this regard:

> It was found that neuroleptics could experimentally reproduce all the symptoms of lethargic encephalitis. In fact, it would be possible to cause true encephalitis epidemics

> with the new drugs. Symptoms progressed from reversible somnolence to all kinds of dyskinesia and hyperkinesia and finally to parkinsonianism. (Quoted from Breggin, 1991a, p. 73)[13]

None of this, note, has anything to do with correcting "chemical imbalances"—a discourse yet to be forged. Enter the pharmaceutical industry, under whose tutelage the narrative was to materially change.

The lion's share of credit for the widespread acceptance of chlorpromazine goes to one particular pharmaceutical company—Smith, Kline, and French. Initially a small operation, it received rights to market this product in North America. As Whitaker (2002) so painstakingly documents, it did the bare minimum testing necessary to satisfy the FDA. It went on to launch a massive propaganda campaign that penetrated all levels of American society.

Taking the path of least resistance, the company presented their product to the FDA primarily as an *anti-emetic*—a vomiting inhibitor. As Whitaker's figures show (2002, p. 150), it actually tested the drug on fewer than 150 "psychiatric patients." Days after receiving approval, it went into high gear, its actions all exclusively aimed at psychiatric adoption. It broadcast a national television program which hailed chlorpromazine as a new "miracle drug" that alleviated the worst aspects of "mental illness." Key features of the paradigmatic campaign which followed include: establishing a 50-member task force, with each member tasked to persuade a specific legislature to dedicate funds for the purchase of the drugs; actively wooing the media; and creating a speakers' training bureau. The purpose of the bureau itself was to teach leading psychiatrists and hospital administrators how to speak to legislators, how to handle the press. While leveraging the credibility given them as medical experts—and at all times they were to comport themselves like experts—hereafter, everyone was to be salesman (for substantiation and details, see Scull, 1977; Shorter, 1997; and Whitaker, 2002).

Here we see an appreciable shift in who is "calling the shots." We see advertising hype transparently in the service of capitalism replace fact. Every bit as significantly, we see the disappearance of an old discourse and the purposive piecing together of a new one. Irrespective of what observation indicated, no longer were the neuroleptics to be compared to lobotomy or encephalitis. They were to be presented as lifesavers with little or no adverse effects. Correspondingly—and for the first time we see specificity enter the discourse—the drug was presented as a discrete substance *specifically designed to treat schizophrenia* (see Breggin, 1991a; and Whitaker, 2002). Additionally, legislators and administrators were told that it was a cost-saving measure with the potential of emptying hospitals.

Soon all the major constituencies were on side—professionals, legislators, the general public, the press. Indeed so successful was the campaign that come the 1960s, President Kennedy hailed this humane new direction in mental health. The uncritical nature of the media buy-in, correspondingly, can be seen in these words by *New York Times* medical writer Howard Rusk (1955, p. 49), "There is no doubt of the effectiveness of these new drugs in either curing or making heretofore unreachable patients amenable to therapy."

With Smith Kline and French eminently successful, in short order other neuroleptics were brought to market. Each claimed superiority, while adhering to the same basic storyline. Meanwhile, also lending support to what was now called "the drug revolution," blatantly substandard research started being produced en masse (see Breggin, 1991a; also Chapter Seven), almost none of it double-blind or involving placebo, much of it, significantly, announcing stunningly positive results. For example, in a 1961 study using subjective measures only, the National Institute of Mental Health concluded that (a) 95 percent of the "schizophrenics" treated with phenothiazines had improved, and (b) phenothiazines were "antischizophrenic." Curiously, the investigators also concluded that several of the neuroleptics "reduced apathy" and "improved motor functions" (see National Institute of Mental Health Psychopharmacology Service Centre Collaborative Study Group, 1964). As if by magic, the discourse of damage and impairment had disappeared, and in its place was a discourse of improved function. At the same time, a general drug with lobotomy-like calming properties had been transformed into a schizophrenia-specific medication.

The next major development is especially important because of the historic path it forged, also because it clearly demonstrates psychiatry's circularity. Having declared—not proven—that neuroleptics alleviated "schizophrenia," institutional psychiatry asked how. What followed was fairly rigorous research into the drugs themselves, the intent being to discover the specific mechanisms by which they impacted the brain. As documented in Breggin (1983 and 1991a), come 1963, the answer was clear: They impeded the transmission of a neurotransmitter called "dopamine" in all three dopamine pathways in the brain.[14] This discovery in hand, essentially arguing backward, the industry now reasoned as follows: If neuroleptics alleviate schizophrenia and they operate by impeding dopamine transmission, it follows that schizophrenia is a disease caused by excess dopamine. In an attempt to support this speculation, they tried to demonstrate that "schizophrenics" suffer from excess dopamine. At various points they indeed thought that they had proven their hypothesis, for research appeared to indicate that "schizophrenics" had a larger than average number of dopamine receptors. As was soon realized, however, all that had been proven was that people treated with the neuroleptics grew extra receptors—something which the brain does in an effort to reestablish equilibrium (for substantiating details, see Chapter Seven). Essentially, what psychiatry discovered is that the "dopamine hypothesis" was untenable, moreover, that by blocking dopamine, the drugs were ostensibly forcing the brain to become "abnormal." This notwithstanding, the discourse and the practice flourished.

The chemical imbalance theory, moreover, quickly became the grand narrative by which all subsequent psychopharmacological drugs were justified. Whether self-consciously or otherwise, in essence, the formula followed was: (1) "identify" a drug as disease-specific; (2) find out what the drug actually does; (3) postulate that the "disease" in question is caused by the opposite condition. Once again, psychiatry was naming reality on the basis of what it *hoped to find*—not what it *did in fact find*—in this case, additionally, in total disregard for what research actually indicated. What is likewise apropos, even had blatant misrepresentation never occurred, which it clearly had, there is something seriously amiss with psychiatry's logic here. Significantly, the presence of "more" or "less" of a particular neurotransmitter is not a recognized indicator of disease. Correspondingly, "correlations" do not "causes" make. Moreover, there is a cart-before-the-horse logic here. Unless a condition can be *shown to be* a disease, asking what *caused* the disease is a non sequitur. Determining a disease process from the mechanisms of the "treating" substance, correspondingly, is at once circular and simplistic. It is on the basis of precisely such illogic and such misrepresentation, however, that biological psychiatry forged what was to become its master narrative.

There are two important addendums to the neuroleptic story. One relates to the early pioneers, more specifically to their speculations that neurolepticization constitutes a "chemical lobotomy," additionally their explicit adoption of it for that purpose. The discovery of how the drugs actually function confirms their speculations. Significantly, by impeding the connection between the frontal lobes and more primitive parts of the brain—and this occurs with dopamine blockage—the drugs disconnect comparable and overlapping sections of the brain as lobotomies (for confirming details, see Breggin, 1983 and 1991b). In other words, on a concrete anatomic level, it indeed constitutes a "chemical lobotomy," as Breggin (1991b) indicates, often an irreversible one. Such being the case, besides that the drugs per se qualify as brain-damaging therapeutics, the drug revolution more generally (which significantly began toward the end of the eugenics era) may be legitimately theorized as a product and extension of the eugenics era.

A second addendum is that incontrovertible proof materialized and the APA eventually admitted that neuroleptics cause both general parkinsonism and "tardive dyskinesia"—a permanent neurological disorder (see American Psychiatric Association, 1980b). Significantly, as Breggin (1991b) indicates, by various routes, both are caused by what begins as insufficient dopamine. In essence, what this means is that psychiatrists are taking patients with totally normal levels of dopamine and rendering them permanently chemically imbalanced. This larger admission, significantly, has not been forthcoming. Nor has the more guarded admission led to the discontinuation of these substances. Nor has it led to the withdrawal of the dopamine hypothesis. The discourse, in other words—and psychiatrists are themselves colonized by it—remains intact.

The launching of the neuroleptics was followed by the release of other types of drugs, all introduced with great fanfare, all purportedly safe and effective, all claiming to address a chemical imbalance, all allegedly targeting a specific condition, and in all cases with damage intrinsically involved and truth sacrificed (see Chapter Seven). The tricyclic antidepressants are a case in point (for details, see Breggin, 1979; and Bassuk and Schoonover, 1977). Correspondingly, in the mid-1980s, the medical model firmed up. Now prominent books such as Andreasen (1984) at once called "mental illness" a bone fide brain disease and stipulated that each "mental illness" is discrete and specific. Partly as result of this analysis, partly because of mounting complaints about the old drugs, and partly because new drugs yield dramatically higher profits, come the late 1980s and the 1990s still additional classes of drugs were introduced, including the "selective serotonin reuptake inhibitors" (read Prozac). At this point the new paradigm and the drug revolution were virtually unstoppable.

I would be remiss if I ended this section without commenting on a standard claim—that whatever their "complications," the drugs allow recipients to be released more quickly from "hospital." This claim was first advanced in the 1970s when accounting for the deinstitutionalization which occurred from the 1940s to the

1970s. The drugs are credited with making early releases possible, also for enabling the closing of whole institutions, which indeed did occur. What this analysis ignores is that both early release and the closing of "hospitals" was policy—essentially, a cost-cutting measure adopted independently. What is telling in this regard, as sociologist Andrew Scull (1977) has carefully documented, there were widespread "hospital" closures considerably *before* the penetration of the neuroleptics. What is likewise apropos, had the drugs been the causal factor, we might reasonably expect "medicated" patients to have been released quicker than their "non-medicated" counterparts. Curiously but significantly, however, a study by Epstein, Morgan, and Reynolds (1962) indicates the opposite.

Professionalization, Classification, and the DSM

The pharmacological revolution did not occur in a vacuum. Piece by piece, biological psychiatry had been putting in place the various components that were to eventually guarantee the success of the enterprise. Critical in this regard was a new classification schema. What biological psychiatry needed was a more convincingly medical schema, complete with medical terms and discrete disease entities. Hypothetically, such a schema would fit the new pharmaceuticals like a glove. The thing is, for every disease, at least hypothetically, there would be a tailored pill.

In 1952 the first American classification system was released—the DSM-I (*Diagnostic and Statistical Manual of Mental Disorders*, first edition), and approximately a decade and a half later, it was followed by DSM-II (see American Psychiatric Association, 1952 and 1968, respectively).[15] Constructed by the psychoanalysts—and at this juncture, psychoanalysts still wielded immense power—the manuals in question featured neither distinct diseases nor a symptoms-oriented approach. The point is that in psychoanalysis "symptoms" were comparatively peripheral for the whole point of therapy was to move beyond symptoms to uncover what lurked in the unconscious. Just by virtue of being alive, especially in advanced civilization, correspondingly, everyone was beset by neuroses, with these neuroses essentially blurring into one another (for a fuller discussion, see Horwitz, 2002)—a view that biological psychiatry urgently needed to change. The question was: Who would control the framing of the next manual?

The initial "success" of the drug revolution positioned the biological psychiatrists nicely. Other favorable factors were: (1) the low inter-rater reliability of psychiatric diagnosing to date (something that the bio-psychiatrists attributed to the "unscientific" nature of the first two manuals)[16]; and (2) the growing role of insurance companies, whose coverage, significantly, was predicated on distinct diseases. In this last regard—and psychiatry here was no better or worse than any other professionalizing industry—professionalization is ultimately about "the bottom line." With enhancing psychiatrists' earning power increasingly the goal of the APA (vice-president Paul Fink was to explicitly state, "It is the task of the APA to safeguard the earning power of its members"), and with biological psychiatry demonstrably associated with big business, the task force assembled to work on the next edition of the manual consisted of one biological psychiatrist after another.[17] An appreciable victory in itself, albeit the defining moment for biological psychiatry was the actual release of the DSM-III (see American Psychiatric Association, 1980a)—the first of the truly dominant texts.[18]

The brainchild of biological psychiatrist and taskforce leader Robert Spitzer, the new DSM did what would have been unthinkable prior to the drug revolution—it indeed medicalized the entire area. Disorders were painstakingly distinguished from one another, correspondingly, were defined down to the last detail via extensive lists of "symptoms," which served as criteria. Other critical aspects of medical discourse systemically built into the framework include such concepts and terms as: "prognosis," "course," "prevalence," "familial pattern," "predisposing factors," and "differential diagnosis." On top of this, retracing the path forged by Kraepelin over half a century earlier, the manual was officially etiology-free, now known as "neo-Kraepelinian." An overwhelming advantage of an *officially* etiology-free schema, you will recall, is that it allows biological psychiatry to sidestep the fact that there is no physical basis for the putative diseases while at the same time unobtrusively inserting the medical model via the very language and framework employed. The etiology-free schema also served an important collegial purpose. To wit, even while they were subordinating them, it enabled bio-psychiatrists to hold onto their psychoanalytic colleagues—something that would have been close to impossible had they simply replaced psychoanalytic etiology with their own.

Coupled with the commitment to an etiology-free design was the decision to be inclusive. The words of Spitzer and his team are instructive in this regard:

> Because the DSM is intended for entire profession . . . the Task Force has decided to be inclusive rather than exclusive . . . If there is general agreement among clinicians who might be expected to encounter the condition, that there are a significant number of patients who have it and that its identification is important in the clinical work, it is included in the classification. (Spitzer, Sheehy, and Endicott, 1978)

"The inclusive approach" announced here had the advantage of at once uniting the profession by indeed being useful to everyone and allowing it to present a common front. What was arguably more important still, it enabled the profession to expand. The point is, the larger the number of disorders, the more likely any given person will be covered by at least one—ergo, the larger the psychiatric turf. As such, the "inclusivity" principle set the industry on the path of massive expansion. Whatever the reasoning behind it, creating discrete disorders for the amorphous conditions identified by psychoanalysis was particularly advantageous. Given that psychoanalysis had essentially pathologized everyday life and given that all of these vague ailments were not only retained but made concrete, now virtually everyone could be "legitimately" viewed as "having" a "mental illness." Even passing anxiety, or for that matter, minor idiosyncratic tics of short duration qualified people for a full-fledged disorder (note, in this regard, "Transient Tic Disorder"). The long and the short is that psychoanalytical generality had been effectively garnered and reworked to serve the interest of biological psychiatry, now identified as the interests of the profession as a whole. And a growth process was under way.

The ongoing DSM project and the drug revolution were accompanied by other efforts to professionalize—all under the auspices of biological psychiatry, all to varying degrees linked with these two primary initiatives. One such move—and it is a common one in the industry—was systematically marginalizing high profile members whose actions jeopardized the adopted model. A strategic case in point was Loren Mosher—head of the Centre for Schizophrenic Studies at the National Institute of Mental Health (NIMH).

Mosher had created Soteria House—a drug-free lay-run facility for "schizophrenics." Within the first few years of operation, his research showed that it was producing significantly better results than comparable medical programs. As such, it constituted a threat to the medical model. The magnitude of that threat was compounded both by Mosher's high profile and the fact that he appeared to be succeeding with the one disease almost paradigmatically seen as requiring medication. NIMH responded decisively. Without providing substantiating evidence, they declared that Mosher's research "must be" flawed. Soon thereafter, additionally, they canceled the project and eased him out of his position at NIMH (for details, see Whitaker, 2010).

Instrumental as such self-policing was, overwhelmingly, it is in publishing and in the mass-marketing of the medical model that the battle for supremacy was won. Significantly, not long after the release of DSM-III, the APA created a division of publications and marketing for the avowed purpose of deepening "the medical identification of psychiatrists" (Sabshin, 1981). It also created its own press, devoted exclusively to books articulating the medical model. Taking a page from Smith Kline and French, correspondingly, it created its own television programs, produced "educational material" (e.g., medical model "fact sheets") en masse, courted the media, and established a roster of "experts" on the medical model, who appeared in the media regularly. It likewise established a public affairs department; and it ran workshops for members on "how to survive a media interview" (quoted from Whitaker, 2010, p. 273). In short, psychiatry (now defined as biological psychiatry) had become a product as well as an industry, and henceforth, it was to conduct its marketing operations brilliantly.

The Medical Model and the White House

If psychiatry had found its "white knight" in the pharmaceutical industry, it was still a creature of the state, and the state's enthusiastic support was as vital as ever. What would be optimal, of course, was a rock solid endorsement of the medical model. Throughout a good part of the world, though especially in America, which unquestionably remained the center of international psychiatry, the state did not disappoint. From Kennedy onward, the American government and indeed the American president publicly embraced biological psychiatry. Come the last decade of the twentieth century, the White House itself was virtually treating the medical model as if it were established fact. Moreover, it was aggressively promoting it.

The next highly public demonstration of White House support after Kennedy's famous State of Union address occurred in 1990 when President George Bush signed a congressional resolution declaring the 1990s "the Decade of the Brain." For all intents and purposes, this gave the medical model official status. What followed was increased funding for biologically oriented research and the proliferation of "educational" material on "mental illness." Then came the first of the antiviolence initiatives.

In 1992 the "Bush Violence Initiative" was announced. Headed by NIMH director Frederick Goodwin and implicitly racist (see Breggin and Breggin, 1998), the initiative was predicated on the unproven hypothesis that violent behavior stemmed from genetic predisposition and brain disease. Supposedly, physical markers could be found in those prone to violence. Treating this population as automatically at risk, it exclusively targeted inner city (read Black) youth. The task was to find the children with "broken brains" and chemically treat them as a preventative measure. Schools were to be used to identify children at particular risk (for details, see Breggin and Breggin, 1998).

Had Goodwin been more discrete, this planned assault on poor racialized youth would arguably have come to fruition. Indeed, the authorization and funding were in place. That it should have been conceived at all boggles the mind. That said, a remark of Goodwin's which led to the project's demise is in its own way as revealing as the project itself. In justifying such dire measures, significantly, Goodwin demonstrably borrowed a page from the likes of Maudsley—an eerie reminder of the roots of biological psychiatry. He compared inner city youth to "monkeys" in the jungle who only wanted to copulate and kill each other off, and he suggested that such youth were going backward "in evolution" (for details, see Breggin, 2000b; and Breggin and Breggin, 1998). Once again, degeneration discourse had reared its head.

The second antiviolence initiative was primarily a response to Columbine. Given the extent of the tragedy, naturally, everyone was aghast. Sadly and predictably, the ensuing discourse was one of "dangerous youth," "mental illness," "genetics," and "control."

Integral to the presidential response was a White House Conference on "mental illness." As lead-up, Mrs. Gore had already announced that one in every five Americans suffer from "mental illness" and "explained" that "mental illness" was a "physical disease" treatable by drugs (for details, see Breggin, 2000b). The star of the conference, child psychiatrist Dr. Stephen Koplewicz, explained to the professionals, to government officials, to the world at large that not even well-recognized traumas like childhood sexual abuse could in themselves cause severe emotional problems. Such problems invariably have a biochemical component and require chemical correction. Underscoring the coercive nature of what was being planned, correspondingly, were comments by first lady Hillary Clinton, who stated that the goal was to "identify and get help to children who need it, *whether or not they want it or are willing to accept it*" (quoted from Breggin, 2000b, p. 25; my italics). The conference ended with President Clinton announcing a multiagency initiative to provide the necessary training to schools and communities. Herein, I would note, we see a dramatic expansion and extension of the institution itself.

A couple of observations as an addendum to this story: Besides that this constituted a major intrusion into the lives of children and besides that it was based on unproven hypotheses—significant in itself—this antiviolence initiative like the one before it, indeed, like institutional psychiatry itself, was implicitly predicated on psychiatry's ability to predict future dangerousness. However, as all the parties would have been well aware, practically and legally the APA was already on record that psychiatry has no such ability to predict. To quote the APA's amicus brief to the Supreme Court in this regard: "The unreliability of psychiatric predictions of future dangerousness is now an established fact . . . The large body of research in this area indicates that, even under the best conditions, psychiatric predictions of long term future dangerousness are wrong in at least two out of every three cases" (quoted from Savage and McKague, 1987, p. 84). Not exactly a promising statistic and hardly one that could justify such a campaign. Moreover, another example of the fundamental contradictions inherent in the institution.

One additional observation, one of the Columbine shooters was on a therapeutic dose of a Prozac-like SSRI, and violence is a documented "effect" of these antidepressants (see Breggin, 2000b). By the same token, the sole shooter in the school shooting which had immediately followed Columbine was on a stimulant. The point is, as Breggin (2000b) suggests, the very substances that the White House turned to as a solution may well have been implicated in the original problem. Minimally, a sobering thought.

Parens Patriae and the State: The Late 1960s to Current Times

From the late 1960s onward, throughout the world, there has been a growing concern for the rights of oppressed groups. What this has meant in the psychiatric area is an increased emphasis on the *parens patriae* mandate, with protection *from* psychiatric professionals included. One consequence has been the creation of advocacy networks, one jurisdiction—Scotland—even explicitly including advocacy as a right in the mental health act (see CAPS, 2010). Another has been the funding of "consumer-survivor groups" some of whom received, as it were, a "seat at the table"—a mixed blessing, I would add, given the co-optive nature of such inclusiveness (for elucidation, see Chapter Nine). What is far more significant, states across the world have codified additional rights. To varying degrees, most legislation, for example, now includes: the right to contest involuntary confinement, the right to refuse treatment if "competent," the right to a substitute decision-maker (in Ontario, additionally, the right to be present at one's own review hearing; see Savage and Mckague, 1987; and Fabris, 2011).

Much of this development is positive. What is left intact, nonetheless, is the core of mental health law—a thing intrinsically brutal no matter how tidied up. People who have committed no crimes, note, can still be wrested from their lives and incarcerated. And people can still be forcibly subjected to damaging substances. What adds insult to injury, it permits such blatant intrusion on the grounds of "dangerousness," when the profession, as noted, is on record that it cannot predict dangerousness.

On a whole different level, useful though such constructions unquestionably are, the very concept of "mental patients' rights," popularized during this period, is curiously deceptive. The impression created is that "mental patients" now enjoy a plethora of rights. What is being obscured here is that *minimal rights* are being permitted in a context in which *basic rights* have been suspended. What further complicates this story, "rights," such as they are, come in waves. The point is, while a new dispensation for the mad—and a comparatively positive one—seemed to be in the making, in most jurisdictions the articulation of new "rights" was followed by a resurgence of the myth of "dangerous mental patient," and what inevitably attended it, regressive legislation. In the United States, what precipitated the shift are shootings by people who allegedly *might be* "mentally ill." In Ontario, Canada, it was the highly publicized killing of a reporter named "Brian" by a man identified as "mentally ill," hence the passing of a piece of legislation called "Brian's Law" (a law enabling compulsory treatment in the community; for details, see Fabris, 2011). The underlying pattern is: There is a period of "largesse," in which "mental patients" are viewed with compassion and "rights" are enhanced. Then something violent occurs—or more accurately, violent acts are cast in a new light. A handful of the folk responsible are either "identified" as "mentally ill" or suspected of being so, with "untreated mental illness" framed as causal. A backlash sets in. Correspondingly, with old stereotypes serving as justification, rights are substantially curtailed (herein lies the flaw of mere reformist agendas).

For all intents and purposes the end of the twentieth century and the beginning of the twenty-first was a backlash era. With the dawning of the twenty-first century came "assertive actions teams"—mobile "mental health" units that turn up unbidden at homes and workplaces to ensure that "patients in the community" are "complying" with treatment. Underpinning such practice is new legislation which allows psychiatry to mandate treatment for "patients" being "released" and to return them promptly to "hospital" for noncompliance—no commitment process necessary (for details on such laws, see Chapter Five). Together, these measures greatly extend the reach of psychiatry into the community. In the process, they seriously erode freedom as we know it, for whether in "lock-up" or in the community, the "patient" remains subject to psychiatric rule. An Ontario case cited by Fabris (2006) is a indicator of just how insidious this extension of psychiatric jurisdiction into the community can be.

Not long after Brian's Law came into effect, a man applying for refugee status—Amir (pseudonym)—was committed against his will. Whatever events had initially impelled him to flee his country, so appalling did he find his experiences in Ontario's "mental health system" that upon being released, he opted to return home—a choice that was intrinsically his to make. Amir was forced to remain in Ontario, however, and indeed to keep taking drugs which he found appalling. The point is, he had been released on a CTO (community treatment order) and both residency and medication compliance were stipulated in the CTO.

We are all familiar with such widening-of-the-net strategies from the criminal justice system. Inmates paroled into the community are subject to state control considerably longer than they would have been had they remained behind bars. So here, with the added uncertainty that an indefinite sentence inevitably brings.

In Reflection: Stepping Back and Summing Up

We have come a long way—from humours, to the Elizabethan poor laws, to the defeat of the women healers, to the eugenics era, to the drug revolution. We began this journey querying psychiatry's depiction of its own history as liberatory. Despite exceptions, despite decent figures such as Conolly (I would add here R. D. Laing), overwhelmingly, what has come into view confirms that suspicion. In place of liberation, we saw incarceration. In place of help, we saw control. In place of selfless professionals—and I am not denying that there are practitioners who give of themselves—we saw ruthless competition by a profession intent on marginalizing its competitors and expanding its terrain. What was perhaps most surprising of all, in place of medicine and science, we saw the outer trapping of both and what minimally borders on fraud.

By the same token, psychiatry today is portrayed as the culmination of years of progress. That we as a community should so see it is understandable for we have been primed to do so. Moreover, progress is one of Western society's grand narratives. However, besides that discourses commonly disappear and reappear, indeed, besides even that the manufacture and dissemination of misinformation is occurring on an unprecedented scale (a feature of modernity), I invite you to consider: Is the unsubstantiated theory of chemical imbalance obviously better than the unsubstantiated theory of the humours? Is brain-damage created by having volts of electricity passed through one's skull preferable to being confined in a straight waistcoat and having water poured on one's head? While understandably, this offends our modern sensibility, what makes being driven out of town by whips (also constructed at the time as "helpful") more objectionable than a chemical lobotomy? Or being the object of a CTO?

Indeed, what the last two chapters appear to demonstrate is that as overreaching as my initial cautionary remark about progress may have sounded, a case could be made that it constitutes an *under*statement. Despite certain improvements, the current situation is ostensibly more problematic. Incomparably more people are intruded on, with that number multiplying with every passing day. Surveillance of anyone who has ever seemed in trouble, surveillance of our children, of seniors is now routine. If once upon a time, one would have to appear "deviant" or to exhibit "unusual behavior" to fall under the auspices of the "system," now normal childhood qualifies as a disease. Moreover, the intrusion reaches significantly deeper than the shackles of yesteryear, into the inner recesses of the brain. It is as if psychiatry had removed the fetters from the body of the "lunatic" subject only to place more durable ones on everyone's mind. Crowning all this off, the psychiatric-pharmaceutical-academic complex has become a massive and bureaucratized industry, with profits to protect—and a global south to colonize (for a discussion of the role of the Word Bank and the World Health Organization in this colonization, see Mills, 2013; and Oaks, 2006). On a deeper level, in the name of protecting the community, a very precious part of our community is sacrificed. To the detriment of everyone, gone is that expansive Renaissance sense of the "mad" as an integral part of society, as a source of wisdom, as a reflection on human kind.

The primary purpose of the last two chapters was to better comprehend psychiatry as a regime of ruling. However the institution is judged in comparison with what came before—and inevitably people will weigh different factors differently—and however sincere and benign individual practitioners may be, we have discovered something at the core of it dishonest, self-interested, reductionistic, imperialist, and circular. We have also discovered something intrinsically violent. Note, one of the earliest acts of the mad doctors was to reintroduce the instruments of torture used in the persecution of "witches." Come the medical model, something more clinical in appearance set in, and violence was not so obvious. What all the new therapeutics have in common, however, is that in every case, an appreciably part of the modus operandi is damaging the brain.

Most histories of institutions are organized around a single defining moment. Such narratives belie the complexity of discourse and the institutions of which they are a part. There were moments in this story, nonetheless, where a turn was taken or a decision made that was to have profound long-term consequences. To name a few of these, they include: the incarceration of the "insane," the decision to abandon moral management, Kraepelin's identification of paresis as a model for biological psychiatry, Maudsley's pinpointing the brain as the "seat of mental illness," the introduction of the "brain-damaging therapeutics," the embracing of the drugs. To this list, I would add the decision to proceed as if problems in living were bone fide diseases—discrete, describable, treatable—this, while claiming to be etiology free—a step initially taken by Kraepelin, later to be given institutional sanction with the drafting of DSM-III. Add these together, and a disturbing picture emerges of where we are and how we arrived. A more partial image of what is amiss may also be found in the Nazi era, and it is to this that I would like to return—for in the extreme, the flaws of the typical are writ large.

What we see in the Nazi era—and we would do well to heed the warning—is what becomes possible when the medical profession are functionaries of the state. By the same token, we see what can happen when the pretense of medicine replaces real medicine. If the murder of the body is a feasible solution to society's woes, is "treatment," how much more readily can one medicalize "menticide"—the murder of the mind! We also see writ large a puzzling contradiction that has to varying degrees plagued this story from start to finish—what would appear to be a confusion or waffling over who constitutes the actual patient. With the exception of epidemiology, note, in almost all branches of medicine, the patient is easily identified—it is *the individual being treated*. In psychiatry as in Nazi medicine, first and foremost, it is the community, the people, the volk. Indeed, the contradiction evident here is built right into the two state powers that have underpinned the management of madness from classical antiquity onward—*parens patriae* and police powers. The two are treated as if they automatically mesh. However, cannot the intent behind these very different powers be at odds with each other? What happens when we simply pretend that they coincide? When measures for the protection of the community—mistaken or otherwise—are presented as if in the best interests of the "patient"? When doctors become jailers and vice versa. Indeed, is not being a doctor as it is normally understood, incompatible with being a jailor? A transparent violation of the Hippocratic oath?

There is one additional problem that the case of Nazi Germany helps to illuminate. And it was with this observation that I would end: Nazi Germany, according to its own postulates, was a biocracy (see Lifton, 1986). Psychiatry is in its own right a biocracy complete with incarceral capacities and police powers. In both instances, ruling is predicated on biological differences—real or imaginary. Indeed, what psychiatry is doing, in essence—when it comes to the "psychotic disorders" in particular—is attributing physical difference to one segment of the population, then interpreting that difference as a mark of inferiority, warranting correction. Such a construction, I would argue, is itself a close relative of racism and indeed of all oppressions which locate inferiority in the body of "the other." Under the gaze of the psychiatrist, the embodied psychiatric subject is constituted as "lesser than." In other words, even before what we would recognize as systemic oppression sets in, the very mode of perception that underlies virulent racism and sexism informs psychiatric thought. As such, it is intrinsically problematic.

CHAPTER 4

Probing the Boss Text: The DSM—What? Whither? How? Which?

Walk though any teaching hospital, visit any graduate school where psychiatry or clinical psychology is being taught and you will see practitioners-in-the-making avidly thumbing through an extremely large book. Some are memorizing definitions. Some are preparing for tests—perhaps a test on the "anxiety disorders." They pour over the book nervously. They quiz each other. Advance further into the hospital and peek into an open office, and you may also catch sight of a more seasoned practitioner in the midst of writing a report. At one point, she searches out a section in an abbreviated copy of the very same book. She nods, then begins writing again. At all of these junctures, you have caught glimpses into the world of the DSM—a world that we but briefly touched on in the last chapter.

The text in question—the DSM—and the flurry of activities surrounding it are of singular importance for the text underpins the psychiatric regime. It is the official holder and arbiter of the diagnoses. It is these diagnoses—and note, in *the precise manner in which they are articulated in this book*—that are recognized by law, that are the basis of insurance claims, that serve as entry points into the psychiatric system, that act as coordinators of the system. However they may view it, learning to activate the text "properly," to "recognize," as it were, the diagnoses in those who present themselves, correspondingly, is the goal of every practitioner-in-training. By the same token, ongoing mastery of the manual is an integral part of each clinician's claim to competence. Given that the purpose of the current inquiry is to understand this system, this regime of ruling, and given the centrality of the DSM, we too need to intimately fathom this text. More particularly, we need to understand the text as practitioners would understand it as they go about their daily work *and as average practitioner would be most unlikely to understand it*. Gleaning such multilayered understanding is the purpose of this chapter.

The first question that presents itself to me when I consider probing the DSM is: Which DSM? The fact that I am led to this question itself brings to light an unusual truth about the manual—one which distinguishes it from a manual on medicine proper—in rapid succession new editions keep being released. Indeed, as documented by DSM scholars such as Horwitz (2002), Kirk and Kutchins (1997 and 1994), within months after the release of one version, work on the next one commences. On the surface of it, such rapid revisions seem unproblematic. As discoveries are made, is not revision expectable? Indeed, are not such revisions evidence that major scientific progress is being made? Probe deeper, however, and it becomes evident that what is happening is not a matter of "discoveries" but a matter of course. What relates to this, the alterations in question greatly exceed what might be called adjustments or "minor modifications." Nor are major modifications restricted to a handful of diagnoses. Significantly, unlike with manuals listing bone fide diseases, each new rendition of the DSM typically involves the appearance and disappearance of a large number of diagnoses. More importantly, the majority of the retained diagnoses are altered in substantial ways. For example, come DSM-III, the heretofore pivotal concept "neurosis" is entirely stricken from the body of the manual (see DSM-II and DSM-III). At the same time a major new category of diagnosis appears—the "anxiety disorders." One of the new disorders listed under this new classification is Posttraumatic Stress Disorder (PTSD). The most significant criterion for PTSD is criterion A, which in DSM-III (p. 238) specifies that a precipitating event is experienced that is "outside the range of usual human experience." By DSM-IV, said precipitating "event" (p. 427) could be plural (e.g., "events"); it need not be "outside the range of usual human experience"; nor need it be directly experienced. By DSM-5, correspondingly, PTSD is no longer even an "anxiety disorder" but a disorder of an essentially different nature. While I will be limiting this next example to two DSMs only, by the same token, there is a dramatic change in "antisocial personality disorder" (a "personality disorder"), say, from DSM-III-R to DSM-IV-TR. Criteria A (of which the patient must have at least three to qualify) now features such items as "deceitfulness" and "consistent irresponsibility as indicated by the repeated failure to sustain work behavior or honor financial obligations" (DSM-IV-TR, p. 706). Neither criterion would have remotely qualified a person for this disorder or in any way typified the disorder a decade earlier. If you can imagine the majority of diseases with which you have been familiar all your life appreciably altering every seven, eight years—measles, whooping cough—you can begin to appreciate the strangeness of the process at hand. In its own right, herein lay an indicator that not only does the diagnostic system not rest on science, science is peripheral. To put this another way, dramatic ongoing changes are a "given." Research, such as it is, is not the driving force of change but rather the justification or rationale.[1]

There are a number of consequences to this way of proceeding. One—and the profession hardly draws attention to it—is that the vast majority of the research that the institution has itself conducted either on or with the aid of these categories is thereby stripped of valid reference. The point is, by the time research results are published, the criteria sets on which they rest are "officially" obsolete. Hardy a minor consequence—for it essentially means that psychiatry's "knowledge claims" will not hold, albeit no one in the psychiatric world draws attention to this fact. Another consequence—and this is of immediate relevance—the research of the critics is likewise undercut. As critics have noted, just as soon as research demonstrating the flawed nature of the current categories is published, a new DSM is released. A sleight of hand, as it were, has occurred by which the critic is robbed of her critique. The effects of this sleight of hand is amplified by the industry calling attention to the transitory nature of the DSM. To be clear, while treating the DSM as definitive—and herein lies a massive contradiction in its own right—at strategic points the framers stipulate that the current DSM is anything but "definitive." In the introduction to DSM-III-R, for example, the entire manual is depicted as but "one still frame" in an "ongoing process" (xvii)—an artistic way of thinking about it, for sure, but hardly compatible with an official document on which practitioners are drilled, which passes as evidence in courts of law, which claims the authority of science. The DSM process and such depictions together serve to neutralize critique, making critique appear less significant. The DSM is positioned, as it were, like a moving target, which you cannot hit—hence my question: Which DSM?

Turning all such phenomena into data, as evidenced earlier, this chapter begins precisely by problematizing the process by which the DSM is created/recreated. What follows is a methodical analysis of the disorders themselves both as they appear on paper and, more importantly, as they are activated. While the overall diagnostic framing will be most focal, several diagnostic categories (e.g., Posttraumatic Stress Disorder and the personality disorders) will be investigated in detail. Questions that I will be exploring in particular depth include: How viable are the definitions? How are disorders created? And why? How are they activated? What conflicts of interest pertain? As practitioners go about their work, what derivative texts are activated—and toward what end? What is sacrificed by employing these constructs? And finally—and this is pivotal given the lack of scientific foundation—insurance coverage aside, is anything gained by using them?

A timely reminder: No biological sign has ever been found for any "mental disorder." Correspondingly, there is no known physiological etiology.

The New DSM Era: The Context

As noted in the previous chapter, the DSM as we know it is largely the DSM-III onward, for with this edition, a veritable revolution took place. Besides the motivation for change discussed previously—and it too was critical—what was especially pressing, this was a moment when the public was seriously questioning psychiatry's ability to diagnose. Emblematic of as well as contributing to the distrust of the diagnoses was a widely publicized malpractice suit—the Osheroff case (see Kirk and Kutchins, 1997). The case involved a man who had been diagnosed with vastly different diagnoses by different psychiatrists. Shocked by the sheer number of appreciably different disorders assigned, the public asked: Do these diagnoses have any standard meaning? Any validity at all? Further contributing to the credibility problem was one highly suggestive study.

Sociology professor D. L. Rosenhan (1973) involved his students in a labeling theory experiment which began with them individually setting up an appointment at a "mental hospital." Aside from making reference to voices which said "thud," "hollow" and "empty," they were to act completely "normal." Nor did they ever again complain of this "symptom" but were in essence "symptom-free." The question was: How would the psychiatric staff respond? As anticipated, each of the "pseudopatients" were committed; and most were duly diagnosed as "schizophrenic." Soon after the last one had been released—which, significantly, took 129 days—Rosenhan wrote up the experiment. Correspondingly, on this basis of his research he concluded that "mental health professionals" are not even able to distinguish between "real" and "pseudo" patients, and that this being the case, the entire diagnostic enterprise is suspect.

The professionals objected. Had they been warned that imposters would be sent, they countered, they could have readily distinguished the "pseudo" from the "real." Rosenhan "accepted" the challenge. A warning was subsequently issued; and forthwith, hospital staff set about the work of examining new admissions with an eye to spotting the interlopers. Of the 193 "patients" admitted to the "targeted" hospitals during this period, 41 were determined with a high degree of certainty to be pseudopatients by at least one practitioner. The staff were confident. The rub is that this time the crafty professor had sent in no one. For all intents and purposes, once again the mental health professionals had proven Rosenhan's point.[2] Sociologists among others asked: If professionals cannot even distinguish the normal from the pathological—a comparatively broad determination—how can they conceivably distinguish who has which "disorder"? It is in this climate, at a moment when the world's faith in these diagnoses was at an all-time low, that the manual as we know it started to take shape.

The neo-Kraepelians' response to the problem was a new schema, which while officially etiology-free, would feature clearly defined diagnoses, involving criteria based strictly on observation—an attempt to standardize. The concept underpinning the new system was "inter- rater reliability." To this day, the DSM is touted as sound because it allegedly has high inter-rater reliability. That is, different practitioners seeing the same client would largely make the same diagnosis. It is in this context and with reference to this measure that we must understand the DSM enterprise.

Inter-rater Reliability and the DSM: The Claims, the Research, the Sleight of Hand

So, *is* the problem solved? Is the inter-rater reliability of the neo-Kraepelinian diagnostic categories high? Is it, say, as claimed, appreciably higher than the reliability of diagnostic categories prior to DSM-III? Upon asking this question, we find ourselves faced with a curious void. While a flurry of inter-rater reliability studies figure as lead-up to the DSM-III, as Kirk and Kutchins (1992) document, there are few studies afterward. Nor is the issue of reliability much discussed. In the DSM-IV-TR, for example—and I invite readers to flip through it—reliability receives only passing reference. As Kirk and Kutchins (1994 and 1997) have pointed out, the impression created is that reliability was established eons ago and need not be focused on any longer. Given that the alleged superiority of the neo-Kraepelinian categories rests on this claim, this omission is a strange one. Probe deeper, and you discover, as Kirk and Kutchins (1997) have demonstrated, *no research has ever established high reliability* and indeed, *even under ideal circumstances, the results are far from impressive*.

Consider in this regard what may be thought of as the reliability study to end all reliability studies—the largest reliability study in history (for the official write-up, see Williams et al., 1992; for a hard hitting critique, see Kirk and Kutchins, 1997). It involved just short of 600 patients and took place in six different sites in Germany and the United States. Paired up, sets of clinicians evaluated the same clients.

Blatantly rigged to produce superior results, the clinicians were provided with the latest interview schedules—the latest approved aids—and as such, would essentially be guided to pose the same questions to the same patients or minimally to pursue the same path. Extensive training was provided before the experiment began—again so that clinicians would operate as similarly as possible—more similar, I would add, than would be likely in regular practice. Additionally, supervision was provided. If anything could produce high kappa rating (the measurement used to determine reliability), this would be it. Nonetheless, as Kirk and Kutchins (1997, p. 52) observe, "the kappa values . . . were not that different than from those statistics achieved in the 1950s and 1960s—and in some cases were worse." What compounds the problem, so as to bolster the ratings, the study counted it a match when the two raters interviewing the same patient assigned *the same class* of diagnosis as each other, albeit with earlier studies, nothing short of *the same diagnosis* qualified. By this maneuver, as Kirk and Kutchins put it, "if one of the two therapists . . . made a diagnosis of Schizoid Personality Disorder and the other therapist selected Avoidant Personality Disorder, the therapists were judged to be in complete agreement because they both 'found' a personality disorder—even though they disagreed completely on which one" (p. 53). Results, in other words, were lackluster despite the design being transparently biased in favor of high reliability findings.

Ever more blatant cooking of research, I would point out, characterize other reliability studies, with the practice in question dating back to Spitzer. For example, having reinterpreted early reliability studies—and in a way that seems purposively designed to make the ratings look as poor as possible—Spitzer contrasted these results with the results of the field trial reliability studies (conducted on the allegedly superior DSM-III diagnoses). Correspondingly, he claimed markedly superior results for the latter. It is not superior results per se but different criteria and a dramatically altered interpretive schema, however, that underlay his claim. Besides that *only identical diagnoses* counted as a match in the reevaluation studies whereas *being of the same diagnostic class* counted as a match with the DSM-III categories, the evaluative language employed in assessing the two sets was dramatically and indefensibly different. For example, concrete kappa levels described as "only satisfactory" in his reevaluation studies (e.g., .7) were deemed "very high" or "amazingly highly" when they appeared in the field trials. How is it that the identical finding—the very same number—can be "only satisfactory" in the first instance and "amazingly high" in the second? Similarly, kappa levels assigned the adjective "poor" in the reevaluation studies were characterized as "good" or "high" when they appeared in the field trials.[3] What adds to the degradation of research evident here, the inflated field trials findings become more inflated as time goes on, with results that were recorded as "quite good" in the DSM-III manual itself (p. 468) depicted a couple of years later as "*extremely good*" (my italics; Hyler, Williams, and Spitzer, 1982). High reliability, and indeed improved reliability, in short, is not a reality but a discursive product. As such, except rhetorically, they lend no credibility to the DSM categories.

Serious though this problem is, underneath it lurks one more fundamental still. For decades now psychiatry has been treating reliability as the equivalent of validity. Yet even if the reliability results were sterling and even if the reliability studies constituted sound research—and as you can see, neither is the case—inter-rater reliability would not in and of itself make these diagnostic categories acceptable or even meaningful. The fact that people can be trained to apply a label in a consistent way, note, does not mean that the label points to anything real. To use an extreme example, let us say that we want doctors to be able to identify people walking about who secretly hail from Mars. We might provide clear criteria for such people and so carefully train the doctors that they achieved a high level of agreement when making their determinations. None of this gets around the problem that there are in all likelihood no people from Mars walking the earth.

By the same token, neither the existence of a phenomenon nor 100 percent inter-rater reliability in identifying it is any assurance of the accuracy of an assessment or the adequacy of the criteria. To cite Brown's (1994, p. 395) apt example, you might decide to classify an object as a car (in the language of the DSM) if it has "four of the following eight properties: wheels, motor, headlights, radio, seats, body, windshield wipers and exhaust system." Correspondingly, given sufficient training, individuals tasked with identifying cars on this basis might well achieve 100 percent inter-rater reliability. Given that cars exist in a way that "schizophrenics" do not, it is likely, additionally, that many of the objects so identified really will be cars.[4] However, as Brown points out, some are also likely to be helicopters, planes, trucks, boats, and derricks, which equally satisfy the criteria. The point is that reliability tells us nothing about the validity of the concept or the adequacy of the criteria.

As reliability cannot legitimately function as a validity claim and no studies have established validity, it follows that at this point anyway, no foundation *of any sort* exists for the DSM categories. This is a serious issue that calls into question the power vested in psychiatry. This notwithstanding, in all fairness, it does not in and of itself mean that the constructs have no inherent value. To assess that, we must continue on with the investigation.

Investigating the Process of Construction

On the face of it, each edition of the DSM is a result of a respectable, highly professional, and carefully delineated process. A broad range of consultants are drawn on. For years, field trials test out proposed diagnostic categories and criteria. Multiple layers and levels of internal groups are involved, including: individual workgroups (each responsible for working on one of the diagnostic classes); the DSM taskforce itself (which oversees DSM operations); the Nomenclature Committee; at the top of the pyramid, the APA Board of Trustees (vested with ultimate authority)—for details, see Kirk and Kutchins (1994) and Horwitz (2002) and the DSM-5 website (American Psychiatric Association DSM Development, n.d.).

While hierarchical to be sure, the structure is in line with what we might expect of such a huge professional operation. Correspondingly, in the manual itself and on the official website, we are given what appears to be reasoned and reasonable assurances of how meticulous the process is. Consider the following, which was posted on the DSM-5 website while the current manual (DSM-5) was still in process:

> The American Psychiatric Association believes strongly in the work that is being done to revise the Diagnostic and Statistical Manual of Mental Disorders (DSM). In preparation for the release of DSM-5, experts from psychiatry, psychology, social work, neuroscience, pediatrics and other fields have committed much of the last five years to reviewing scientific research and clinical data, analyzing the findings of extensive field trials and reviewing thousand of comments from the public. (once found at: dsmfacts.org)

Correspondingly, witness this statement, which was posted after the release of the DSM (Frequently Asked Questions, n.d.):

> APA recruited more than 160 of the top researchers and clinicians from around the world to be members of our DSM-5 Task Force, Work Groups and Study Groups for this important job. These are experts in neuroscience, biology, genetics, statistics, epidemiology, social and behavioral sciences, nosology, and public health. These members participate on a strictly voluntary basis and encompass several medical and mental health disciplines including psychiatry, psychology, pediatrics, nursing and social work.

Such statements are designed to inspire confidence. Phrases like "strongly believe" assure us that the experts are confident—so *why should not we be*? We see a structure of accountability. We bump up against words like "research" "experts," "analyze," "scientific," all signaling the professional, the scholarly. We see openness reflected in the sheer fact that a number of different professions are included in the process. We may be relieved at hearing that the taskforce reviews "thousands of comments from the public"—again a statement signaling openness and receptivity. The impression created is that DSM creation is a responsible professional process in which decisions rest on evidence, which is open and rigorous, moreover, one where the interest of the public are paramount. Probe more deeply, however, and a markedly different picture emerges.

While the DSM-5 was still in process, for instance, you could find other statements designed to establish credibility and yet which serve as a clue to the informed eye that something is amiss—for example, such mandate statements as: "*The goal in developing DSM-5 is to produce an evidence-based manual that is useful to clinicians in helping them accurately and consistently diagnose mental orders*" (on site listed earlier; no longer available). We now know how to decode this language. Reliability as opposed to validity is being centered. We also know the evasion inherent in centering reliability. We likewise know what typically counts as research and so despite the language of "reassurance," we have no reason to feel assured.

Additionally, a more critical light on DSM creation is shed if we contrast the APA's official assurances with the following statement by Armstrong (1984, p. 132):

> Reading about the evolution of the DSM . . . is somewhat like reading the history of the Balkans: ongoing border wars, eruptions, skirmishes, the odd assassination,

> uprising, overthrow... To read about the evolution of the DSM is to know this: It is an entirely *political* document. What it includes, what it does not include, are the result of intensive campaigning, lengthy negotiating, infighting, and power plays. (Emphasis in the original)

Phrases like "intensive campaigning," "power plays," and "assassination," note, create a very different picture than words like "evidence," "scientific," and "analyze." Of course, political wrangling and maneuvering enter into all institutional processes to a degree. What Armstrong is suggesting, however, is not simply that such dynamics enter in but they *overwhelmingly account for* the decisions made. To help substantiate her point—and indeed, I am suggesting that she is correct—and at the same time probe the nature of process further, I would zero in on two examples of DSM decision-making. The first is the landmark decision to "remove" homosexuality *as listed* from the DSM. To be clear, I specified "as listed" here, because "homosexuality" in point of fact was not removed but hidden under new categories (for details, see Burstow, 1990).

In a world in which science and scholarship are truly prioritized—aside from the fact that gay lifestyle would not have been pathologized in the first place—a decision as momentous as "removing a disorder" would be based on scholarship. That is, it would be based on evidence new or old that a category either does not satisfy a relevant criterion or otherwise gives rise to anomalies. While criteria were indeed discussed, except for those who were intent on holding onto the diagnosis, this was largely done pro forma.

As is painstakingly documented in Kirk and Kutchins (1992 and 1997)—see also Teal (1971)—the story of the "removal" of the disorder begins with some gutsy gay activists who were systematically disrupting APA events and had vowed to continue until the offensive disorder was removed. Among other things, psychiatrists wanted the disruption stopped. What was likewise a factor, it is largely psychoanalysts who made their reputation by "treating" homosexuality, and the battle between the neo-Kraepelinians and the analysts was beginning to gather momentum. Here was a way for the neo-Kraepelinians to at once marginalize the psychoanalysts, put an end to the embarrassment, and position themselves strategically. Key dynamics and events which were to eventually unfold include: the Committee on Nomenclature agreeing to meet with the activists, the rising neo-Kraepelinian light Bob Spitzer beginning to mediate, the purposive marginalizing of the psychoanalysts, the Board of Trustees voting that homosexuality per se was not a disorder, and a petition calling for a referendum. The issue was finally resolved by a postal vote. Not long afterward, significantly, Spitzer was rewarded for his adroit handling of this issue by being appointed chair of the next taskforce—a victory for the neo-Kraepelinians. While, to be clear, it is good that "homosexuality" per se was no longer deemed a "disease" and undoubtedly some APA members were genuinely moved by the activists, what is significant here is that the "removal" of this category was accomplished not by discovery, not by research, but by disruptive protests, self-interests fortuitously coinciding, the marginalizing of opponents, a show of hands in the APA's most powerful decision-making body, and, ultimately, a postal vote.

The second example is the decision to add "Self-defeating Personality Disorder" (SDPD) to the DSM-III-R (one of a number of proposed disorders of special relevance to women).[5] APA's female members objected, arguing that SDPD pathologizes how women have been socialized to act. How did Spitzer, who was solidly behind the disorder, handle the objection? By quickly cobbling together ersatz research to show that SDPD was a disorder that clinicians recognized (for details, see Kirk and Kutchins, 1992 and 1997; and Caplan, 1995). That research itself is worth focusing on for it sheds additional light on the role of research manipulation in the DSM process. To cite one such study, a questionnaire was sent to psychiatrists who had indicated interest in "personality disorders." The questionnaire was accompanied by a letter on APA letterhead, which stated the reason for it, albeit providing such information violates research norms with respect to bias. What substantially adds to the bias, part way through the questionnaire, the practitioner encounters this instruction: "If Yes (you think that there is a need for the diagnosis of Self-Defeating Personality Disorder in DSM-III-R), check here ___and continue. If NO, check here ____and return questionnaire in the enclosed envelope" (quoted from Kirk and Kutchins, 1992, p. 17). No clearer signal could have been sent that only the "yes's" mattered, that the framers had no interest in what dissenters thought. Such "studies" were now "substantiating evidence" and were drawn on. Other significant events that transpired under Spitzer's watch include: the Feminist Therapy Institute threatening a lawsuit if APA approved the three new sexist categories; and SDPD being added to the appendix of DSM-III-R as a disorder requiring further research.

Come the construction of DSM-IV, the question was whether or not to upgrade SDPD to a full-fledged disorder. While Allan Frances (the incoming taskforce chair), appointed feminist Paula Caplan as a consultant, what followed was the systematic marginalization of Caplan. Nor was the feminist material on the subject—which was considerable—deemed relevant.[6] Correspondingly, SDPD became a full-fledged disorder. Should the reader be wondering why the male protestors associated with the first example fared better than the female objectors in the second, I would just add here that accommodating the first served the private purpose of neo-Kraepelinians, also that gender trumps more than we would care to think.

This second example itself highlights a further truth about the "disorder-creating" process. The figures at the helm are overwhelmingly white men—with the obvious bias that such a constitution brings. What is telling, the DSM-III task force had but one woman on it and not a single Black person (for details, see Kirk and Kutchins, 1992 and 1997). Herein lay a formula for powerful white men imposing their own situated understandings of normality on everyone but especially those differently situated.

I began this section by problematizing official claims about the DSM. The latest claim—and here I am specifically honing in on DSM-5—is that the process involved in creating this the latest manual is a model of transparency. The implicit message here is that while the APA may have made the odd mistake in the past—and not many—they are superseded by a process that is nothing less than model. This claim is likewise duplicitous. While for sure, proposed alterations in the DSM criteria were posted for review—only after former taskforce chairs issued scathing critiques about the unprecedented and shocking *lack of transparency* (for the critiques in question, see Frances, 2009a, b; and Spitzer, 2009). What is more telling yet, professionals appointed to the DSM-5 task force and the work groups were required to sign a disturbingly stringent confidentiality agreement. Except for official communication, it prohibits them from ever making available "*any . . . written or unwritten information in any form that emanates from, describes, divulges, or is otherwise obtained in connection with [their] work with the APA Task Force or Work Group*" (American Psychiatric Association, 2007). The point is, however compromised the process was before, it is now worse. Abject secrecy with respect to the process, it would seem, is now a feature of DSM creation—the kind of secrecy we might expect from a national security agency. One cannot but wonder: What exactly is being hidden? And to put it bluntly, what's next?

A standard feature of the DSM process with which I would conclude this part of the analysis is that it is riddled with conflict of interest. Drug companies manifestly have a special interest in the number and nature of these "disorders"; and as such, it would be highly problematic if the practitioners charged with crafting them personally had economic ties with the industry. They do. Financial conflicts of interest of taskforce and workgroup members typically include: holding patents on psychiatric drugs; consultancy work for pharmaceuticals; receiving research funding from the pharmaceuticals; owning stock in the companies, honorariums, and gifts; testifying as an expert witness when pharmaceuticals face litigation; and serving on a speakers' bureau. According to research by Cosgrove, Krimsky, and Vijayaraghavan (2006), in the case of both DSM-IV and DSM-IV-TR *100 percent* of the members who sat on either the "mood disorder" or the "schizophrenia and other psychotic disorders" workgroups had at least one such financial tie—commonly, many. By conventional business standards, note, *every last one was in a conflict of interest*. The staggering amounts of money made just by serving as an occasional consultant or speaker for the companies—Whitaker (2010, p. 321) shows annual amounts reaching half a million dollars—adds to the seriousness of what is happening here.

As a result of past exposés, members of the taskforce and workgroups for DSM-5 were required to reveal all industry ties in the three years leading up to their appointment and to divest themselves. While this may look as if it takes care of the problem, it decidedly does not. Significantly, the divestment is financial only and at that only partial. In this regard, according to The Board of Trustees Principles (n.d.), active members of these groups were still allowed to receive "$10,000" annually from "industry entities" for direct service as well as to hold shares worth up to "$50,000." Moreover, nothing stops them from returning to "business as usual" once their work on the manual is done. The question necessarily arises: What prevented them from serving the industry intentionally or otherwise in the interim—that is, in the DSM determinations which they made? Nothing. Ergo, the very fact of these historical ties is a problem.

Elementary research on the DSM-5 taskforce members gives us an incomplete, conservative, but nonetheless useful picture of the extent of the problem entering in. Using the member disclosure reports which were posted on the official DSM website while the DSM-5 was still in process (since removed), I tallied up the percentage of members who received industry funding in the three years leading up to their appointment. By these standards, 79.31 percent had a history of recent economic ties, with many having multiple ties. What is likewise apropos, many have served as consultant or speaker for a large number of drug companies, the chair of the current DSM taskforce David Krupfer alone, for example, listing Eli

Lilly, Forest Pharmaceuticals, Johnson and Johnson, Novartis, Hoffman-La Roche, among others. Factor in what has already been established—the profession itself is in the pockets of the industry—and the stage is set for the taskforce doing industry's bidding, whatever the intentions.[7]

The issue of conflict of interest points to one final truth about the DSM. It is in essence a colossal money-making enterprise—one over which the APA enjoys a monopoly, as former chair Allen Frances (2012) points out. Translated into dozens of different languages, it is used all over the world by students and professionals alike, and indeed by a variety of professionals—psychiatrists, psychologists, social workers. When you consider that each DSM sells for a couple of hundred of dollars, moreover, that every newly released DSM is accompanied by other books also considered "must buys"—the latest desk reference, case book, SCID (*Structured Clinical Interview for DSM Disorders*), you realize that the release of each new DSM occasions a flood of profits coming APA's way. Given the absence of legitimate research, one can reasonably conclude that it is the promise of these manifold sales far more than discovery, more than evading the critics too—a motivation noted earlier—that underlie the rapid turnover of DSMs. As such, the publishing business itself constitutes a conflict of interest.

A rough summary of what has been found to date: DSM categories are based on reliability studies only—a measure which in no way establishes that the disorders exist or that the criteria in question adequately capture real phenomenon. Despite the studies drawing on them being, in essence, rigged, reliability outcomes are low. Moreover, disorders are in actuality added, removed, and altered on the basis of political agendas and maneuvering. On top of all this, the process is at once secretive, systematically misrepresented, and riddled with conflict of interest. By any normal standards, in other words, it is woefully lacking in credibility. That said, it is time to crack open the manual itself.

The DSM: The General Structure

A book of approximately a thousand pages, the DSM is divided into three major sections. The first (a few dozen pages) includes introductory remarks, the all-important definition of "mental disorder," and instructions. Depending on the edition, the third section (of comparable size), holds such items as decision trees for making diagnoses and listings of "culture-bound syndromes." Correspondingly, in all cases it includes a glossary of terms and the articulation of diagnoses and other items not yet official, that is, earmarked as "requiring further study." Invariably, the bulk of the DSM is the middle section—for all intents and purposes, the body of the DSM. Herein lies the "official disorders" themselves, arranged by class.

The Definition of Mental Disorder

However "mental disorder" is defined—and the definition keeps changing—and whatever words are inserted to minimize its importance, the definition used is pivotal to the DSM, indeed, to the enterprise itself. Given that the "mental health system" rests on this definition, a minimal expectation is that the definition be viable or at least intelligible. It is especially important in a circumstance such as this where physical signs and etiology are lacking. The fact that the manual declares itself agnostic with respect to etiology, that *officially* anyway, it is not dubbing the "disorders" medical makes the definition all the more important. If these "disorders" are *not necessarily medical*, if practitioners are free to see them as medical or not medical, what claim *is* being advanced about them?

Not an easy question to answer. Significantly, most DSMs devote more space to "disclaimers" surrounding the definition than to the definition itself. For example, in DSM-IV-TR, we are told that none of the definitions are "equivalent to the concept" (xxxi). The question nonetheless arises: What is the concept? We are told, "The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition" (xxxi). Within this statement lies an assertion about medical and scientific concepts. No examples from medicine or science are provided to support the assertion. Bottom line: Given official etiological agnosticism, and given that medical-like validity is somehow being claimed for these disorders regardless, a viable operational definition is in order. That said, let us turn to the latest definition—the definition in DSM-5.

While naming all elements in their definition as "required," DSM-5 (see American Psychiatric Association, 2013, p. 20) defines "mental disorder" as follows:

> A Mental Disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning...An expectable or culturally approved response to a common stressor or loss such as the death of a loved one, is not a mental disorder.

The second line is perplexing. By what reasoning should the commonality of the *stressor* per se be treated as a factor in determining whether or not a response is "disordered"? The conundrum noted, let us zero in on the heart of the definition.

What exactly does this definition tell us? Reading it, we know that "mental disorder" refers to something internal or interactional, also that it is a subset of "syndromes." However, we know very little else. With "syndrome" not necessarily implying anything physical—and the DSM is clear on this—we have no way of knowing what makes something a "syndrome." The definition, more generally, is one in which *one unknown*—"mental disorder"—is being defined in terms of *other unknowns*—"significant disturbance," "dysfunction," "mental functioning," and "developmental processes"—with no clarity provided in the process. What is a "disturbance"? And what makes the disturbance "clinically significant" aside from the fact that people called "clinicians" call it so? Is "mental function" anything more than a reification of people perceiving and feeling certain ways? If so, what? Correspondingly, given that neither "syndrome" nor "dysfunction" nor "disturbance" nor "mental function" are delineated, how are we to understand the confusing proposition, embedded in these words, that a "mental disorder" is a *syndrome*, characterized by a *disturbance* that reflects a *dysfunction* in the processes underlying *mental functioning*? What we have here, to be clear, is circularity, mystification, and the piling up of layers of abstraction. As such, the definition is both conceptually and practically inadequate. What is also significant, insofar as the meaningful activities of human beings disappear, are replaced by abstractions, the way is paved to eliminate human existence as we know it from consideration.

Each of the referenced terms could be systemically problematized. For the purposes of this analysis, I will be focusing in on one—"dysfunction." To a degree, what is wrong with "dysfunction" is wrong with the other terms, and as such, it serves as an example. What is likewise apropos, not only is it pivotal in the DSM-5 definition, some version of this concept has figured centrally in every DSM since 1980.

How are we to understand "dysfunction"? Clearly "dysfunction" is predicated on "function." If there is no *function*, presumably, there can be no *dysfunction*. Yet the term "function" itself has various meanings, and no clue is offered over which is intended. That said, let us examine the two most common meanings.

The first—*evolutionary function*—has a reasonable likelihood of being what the framers have in mind. The point is, besides that it figures prominently in what Foucault might call psychiatry's "definitional archive," it has received broad support, with particularly strong support coming from the most powerful members of the APA (see Wakefield, 1992; Wakefield and First, 2003; Spitzer, 1999; and Horwitz, 2002).[8] Generally attributed to psychiatrist Jerome Wakefield, it is part and parcel of the argument that "mental disorder" should be defined in reference to evolution. By this understanding, an organism is said to have a dysfunction if it conflicts in some way with "natural selection." To use Wakefield's (1992, p. 236) exact words, a "dysfunction" is "a failure of a mechanism in a person to perform a natural function for which the mechanism was designed by natural selection." Further abstractions to be sure, not to mention shades of social Darwinism.

The ominous feeling of déjà vu aside, this understanding of "dysfunction" is demonstrably not viable. Natural selection, note, is itself a metaphor. Nature is not a craftsman purposefully designing or selecting. Correspondingly, while a trait's capacity to enhance survival makes it more likely to be retained, many characteristics are passed down that have no such propensity—the white color of mammal bones, for instance. Moreover, as Gould (1981) established long ago, the only organic feature itself that can be clearly attributed to "natural selection" is the huge size of our brain, which presumably makes us adaptable.

If we cannot say with any certainty what *with respect to our organs* is a product of natural selection, it is more or less impossible to make such determinations when it comes to "cognition, emotion regulation, or behavior." And indeed the very psychiatrists responsible for advancing this concept acknowledge that this is so (see Spitzer, 1999). This impossibility invalidates the concept. If we do not know what is and what is not a consequence of "natural selection," evolutionary dysfunction can neither theoretically nor practically serve as a basis for determination.[9]

An alternate meaning of "function" is Cummins function—a meaning likewise referenced by Wakefield (1992), albeit it is unrelated to evolution. By this understanding, the function of the heart is to pump blood. The function of an organ, that is, is *the role it plays within a larger system*, in the above example, in the circulatory system (for further details, see Woolfolk, 2001).

For sure Cummins function is a useful concept in medicine. The problem is one of transferability. Use of this alternate meaning involves applying concepts forged in one context to a dramatically different one—and where that difference is pertinent. While we can hypothecate a precise function for an organ, what is the precise function of thinking, feeling, hoping? Correspondingly, unlike organs, people exist in complex and highly individualized situations. Indeed, unlike organs, we are *beings who face circumstances*. Once again we appear to be dealing with a literalized metaphor—not an apt one at that.

Similar problems attend all the other abstractions. We are left in the end with a mystifying and conceptually inadequate definition. To insert a marker here, the definition section typically ends with a cautionary note. In DSM-5, that cautionary note reads: "Socially deviant behavior (e.g., political religious or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above" (p. 20). Obviously, this statement could serve as a exclusionary criterion, and as such, at least theoretically, it provides a way to distinguish disorders from nondisorders. As will become progressively clear, however, this rider functions more as a disclaimer. And *claiming* that you are not pathologizing deviance—note—does not *mean* that you are not pathologizing deviance.

Activating the Text

Despite its static materiality—its thickness, its weight, its location on a library shelf—the DSM is not so much a static object as a document-in-motion that practitioners routinely activate in the process of doing their job—a frame which determines what is attended to, what is important. The work sequence in turn determines what in the text becomes focal and how. Operating from the vantage point of critique, when I opened the DSM, I turned to the Introduction. Clearly, however, this is not how the text is typically approached in the everyday world of clinical practice. It is no more used this way than people needing to find a telephone number would begin on page one of the phone book.

The situation in which this text is most commonly activated—and it is here that we need to locate it if our understanding is to be relevant—involves a practitioner seeing or having just seen a "patient." The "patient" perhaps has complained of being fixated on certain ideas. The practitioner is tasked with providing a diagnosis. For a rough map of the situation see figure 4.1.

While hypothetically, the practitioner separates those allegedly *with* "mental disorders" from those without, in point of fact, that is neither what happens nor what the system mandates. The practitioner rather is tasked with the job of assigning a diagnosis, as depicted. As one of my professional interviewees Sabeena put it, "It is assumed that if people come to a professional, they have a disorder." Nor can they avoid this task by reasoning, say, that a diagnosis might do more harm than good. A veritable diagnostic imperative is at work that overrides the practitioner's point of view. Indeed, even practitioners who have grave misgivings about diagnosis—and there are fewer than one might like for all have been trained to think diagnostically—are *textually obliged* to diagnose. That is, they have to provide a diagnosis so as to fill out reports in ways that are deemed competent, to tick relevant boxes, to activate insurance coverage. The question then is not *whether or not* someone seeing a psychiatrist or psychologist will be assigned a "disorder." The question is *which disorder*. The practitioner observes the "patient" and asks

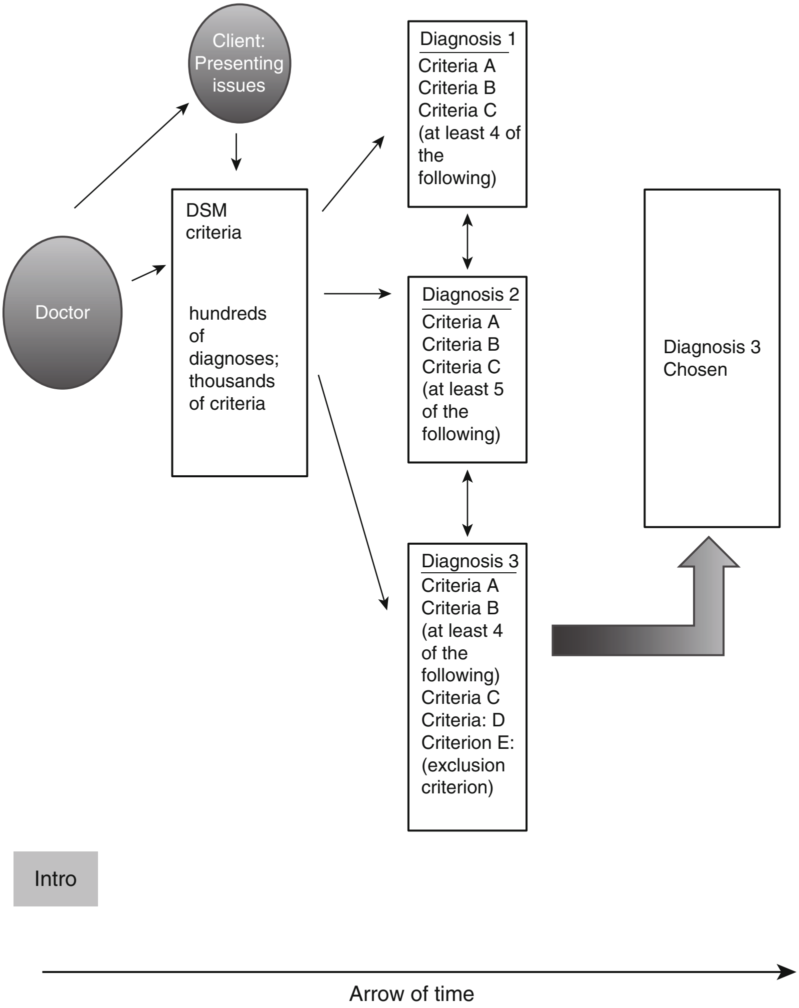


Figure 4.1 Simple diagnostic process.

questions in the interests of narrowing down the hundreds of diagnoses to a few—say, as in figure 4.1, three diagnoses. He proceeds to examine the patient in ways directly related to these diagnoses. In the end, he chooses perhaps the third and inserts it into the relevant reports. It is now official; and it follows the patient wherever she goes.

In the process, what has happened to the seeming exclusionary criterion regarding deviance? For all intents and purposes, it is not part of the situation. Hence figure 4.1 shows the introductory remarks as free-floating, as something "in left field," as something, as it were, outside the frame of reference.

That it is overwhelmingly the diagnostic criteria that the practitioner is expected to heed is signaled in the Decision Trees—a institutional tool commonly used and, indeed, included in some DSMs (see, for instance, DSM-IV-TR). More particularly, the Decision Trees (and there is a different "tree" for every class of disorder) guides the practitioner to examine the patient virtually exclusively in the light of the diagnostic criteria. Likewise serving the boss text are other institutional aids (see in particular the *SCID* and the *User's Guide for the SCID*), each performing the all-important function of helping practitioners fill the empty shell of one the criteria sets with details of the patient's life. The purpose of clinical interview per se is to arrive at the diagnosis, and this occurs by applying the boss text categories with the help of these subsidiary texts. While the patient telling his story may be under the impression that a normal or quasi-normal conversation is going on, essentially behind his back a complex text-act sequence is under way. This more detailed sequence is mapped in figure 4.2.

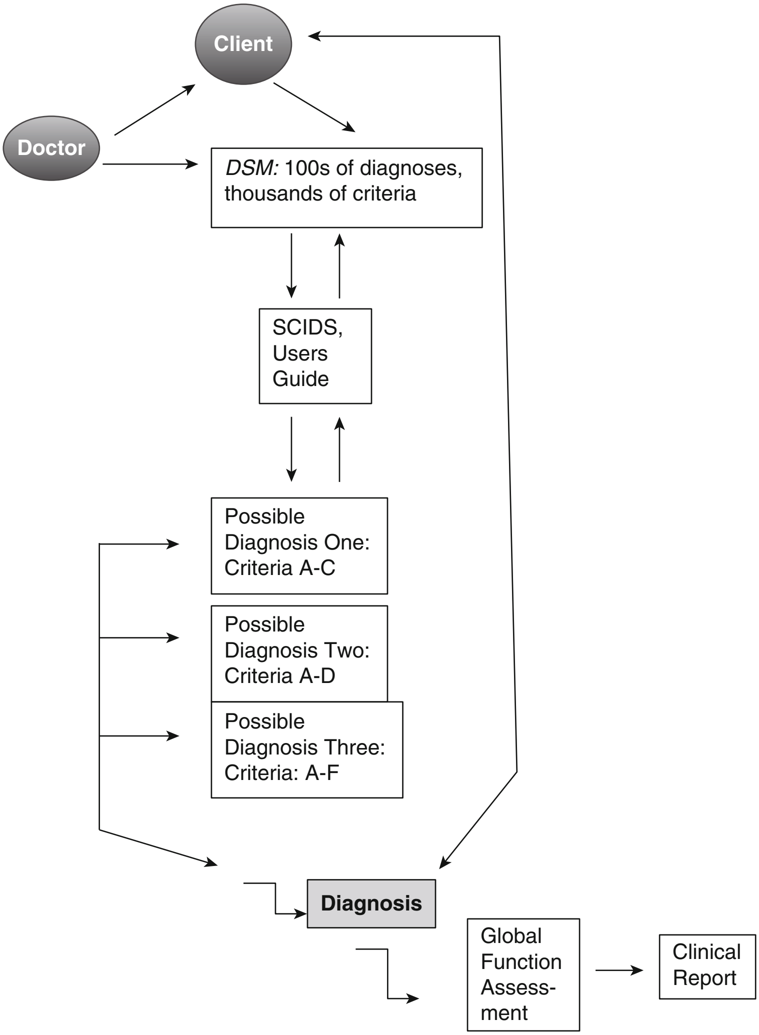


Figure 4.2 Complex diagnostic-interview process.

How do these subsidiary texts facilitate the process? The *SCID* (see First, 2001), for one, provides tick boxes, allowing the psychiatrist/psychologist to check off criteria one by one. Correspondingly, the questions provided in the *User's Guide* (see, e.g., First et al., 1997) at once focus the clinician on the diagnostic criteria and enable him to extract the precise information needed to confirm or disconfirm "relevant" criteria. By way of example, criterion 4 for Borderline Personality Disorder in DSM-IV (p. 322) reads "impulsivity in at least two areas that are considered self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)." Exactly mirroring this, the *User's Guide* first repeats the criterion, which it does verbatim, then provides the following questions/instructions:

> Interviewer Questions: Have you often done things impulsively? What kinds of things? (How about buying things you really couldn't afford? Having sex with people you hardly knew, or "unsafe sex"? drinking too much or taking drugs? Driving recklessly? uncontrollable eating?) IF YES TO ANY OF THE ABOVE: Tell me about that. (First, 2001, p. 27)

Note, one by one, each item in the criterion set is touched on—impulsive buying, unsafe sex, and so forth. It remains only for the clinician to tally up the "yes" responses.

Such a high level of textual governance is worrisome in itself. The point is, systematically, any aspect of the "patient's" reality not covered in the activated set is positioned to be either pushed aside—invisibilized, as it were—or reworked so as to fit. The sets—not the person—is focal. Dialogue, moreover, is replaced by a semblance of dialogue. In the process, the "patient" is virtually coached what to present, making the practitioner's initial hunch self-fulfilling. What we see here, to be clear, would be a gargantuan problem even if the diagnostic sets were optimal. That understood, and the absolute centrality of these criteria sets clear, it is time to turn to the sets themselves.

The Diagnoses

Open up the body of the DSM and the pretense of etiological agnosticism evaporates. Significantly, via words like "prognosis," "symptoms," even "diagnosis" itself, the impression created is that these "disorders" are indeed a subset of medicine. In this respect, the APA appears to be "having its cake and eating it too." Open up the body of the DSM, correspondingly, and the sheer number of "disorders" that you encounter (almost 300) is staggering. Begin investigating the actual disorders additionally and you quickly discover that the full range of human types and choices, including common human activities and responses, are represented here—electing not to talk in specific types of situations (Selective Mutism); being the type of human being—read "woman"—that used to be called "high maintenance" (Borderline Personality Disorder); being thrown off balance by what the DSM itself characterizes as horrific events (Posttraumatic Stress Disorder); feeling sad (any number of depressive disorders); happiness of at least four days duration (Hypomanic Episode); not paying attention in school (Attention Deficit Hyperactivity Disorder). What is evident, indeed, is that human existence as we know it is so theorized as to constitute a disorder. What further compounds the problem, despite the superficial appearance of objectivity, the criteria are subjective through and through. Take the depiction of "schizophrenic" beliefs as "bizarre" (see DSM-IV-TR). What makes a belief "bizarre" other than that someone so views it? Indeed negative projection is the very essence of the DSM process. The criteria sets at once facilitate such judgment and turn the subjective impressions of one party into objective facts about the other—in this case, the "holding of bizarre beliefs."

A related and equally fundamental problem is that the criteria are largely predicated on deviation from a statistical norm. An older woman is sadder than the norm—therefore "clinically depressed." A male teenager is on the shy side, avoids sports, never hangs out with other kids—therefore, should be considered for "Avoidant Personality Disorder." What such constructions ignore is that nature is characterized by variance. Some people are far taller than the norm, some far shorter—and there are all manner of folk in between. Would it make sense for those on the short side to be assigned a disorder like "Height Deficit Disorder"? Why then is Attention Deficit Disorder acceptable?

Besides being flawed, as it were, existentially—and we will uncover more existential problems as we proceed—the categories are also problematic from the sheer technical vantage point of construct validity. The point is, there are rules embedded in any categorization schema that determine what is and what is not included in any given category. In the DSM schema, on the other hand, even when a phenomenon blatantly fails to meet the necessary requirements, it can be assigned a diagnosis either in relation to the category or in a more free floating manner. For example, in DSM-IV-TR, the designation "NOS" (Not Otherwise Specified) could be assigned if a phenomenon bears a resemblance to the "disorders" in the class, albeit it does not qualify for any of them. Having such "grab-all" categories—and that is in essence what we are dealing with here—is at odds with the very rationale of having criterion-based definitions. This notwithstanding, NOS disorders qualify as full-fledged disorders, are assigned numbers, are included in the main body of the text. In the DSM-5, similarly, where a phenomenon fails to meet the criteria for a particular disorder, it can be labeled either "medical disorder specified," should the practitioner choose to identify a listed "disorder" that it resembles, or alternatively, "medical disorder unspecified," should the practitioner not so choose (see DSM-5, p. 707). By the same token, the standard use of "sub-threshold" disorders (a disorder is listed as "sub-threshold" if it satisfies some but not enough of the criteria to qualify) undermines the very concept of "criteria." By these maneuvers, note, something qualifies as a disorder either if it *meets* or *fails to meet* stated criteria. As such, the formulations lack construct validity. Indeed, the very impulse to create such anomalies, understandable though it may be, in itself signals that this classificatory system and possibly the very idea of a classificatory approach to human problems is unviable.

A further deficiency, and transparently a product of the attempt to look scientific, is the use of arbitrary numbers. All criteria sets are framed through the use of arbitrary numbers. In the case of Attention Deficit/Hyperactivity Disorder, as defined in DSM-5, for example, to satisfy criteria A1, the "patient" must have "six or more of the following" (p. 59). The question arises: Why six? Why not five? Why not seven? More generally, the application of science to what is not scientific inevitably results in one type of measurement problem or another. Measurements specified are either utterly vague (in which case, subjectivity is clearly involved) or precise to a fault (in which case, it is arbitrary). With regards the first, see the descriptor "*often* fails to give close attention to detail" in criterion A1a of Attention Deficit/Hyperactivity Disorder. Contrast this with the very precise "the following symptoms have persisted for at least six months" (p. 59). Again, why not five months? Why not seven?

Adding to the conceptual quagmire, the disorders lack what philosophy of language theorists (see, e.g., Acton, 1998) call "within category homogeneity." That is, the categories are so constructed that phenomena that have little or nothing in common with one another can readily be subsumed under the same category. A simple case in point is Posttraumatic Stress Disorder, as defined by DSM-IV. As Kirk and Kutchins (1997, p. 124) point out, "There are 174 combinations of symptoms by which PTSD can be diagnosed" and "it is possible for two people who have *no symptoms in common* to receive the diagnosis of PTSD" (my italics).

The other side of the equation, the categories lack distinctness. As befits a medical schema, they are theorized *as if* they were discrete, for sure, but they demonstrably are not. Indeed, symptoms and symptom clusters so crisscross between diagnoses that the boundaries between them do not hold. There is a special class of anxiety disorders, for example, and yet the reality is that most everyone who is suffering emotionally feels anxious. Indeed, as critics have established (e.g., Acton, 1998; and Jacobs, 2011), the person diagnosed with a "depressive disorder" is as likely to feel anxious as a person assigned an "anxiety disorder." By the same token, as Acton (1998) points out, the majority of people listed as "schizophrenic" would meet the criteria for at least one of the depressive disorders. Once again the underlying problem here appears to be the application of a categorical approach to problems in living. As theorists such as Woolfolk (2001) and Mirowsky (1990) have pointed out, the problems that people face quite simply do not respect the artificial boundaries of the categories created by professionals.

The APA's way of dealing with the problem of massive overlap is itself a problem. Most commonly, what the manual does is add a criterion, stating that a person should not be given the diagnosis if they better fit various other "disorders." "Hypochondriases" is typical in this regard. The core criteria (A to E) in DSM-IV-TR (see p. 507) defines Hypochondriases in such a way that it greatly overlaps with a large number of disorders. What follows is F, which stipulates, "The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder." Along the same line, the five criteria for Hoarding Disorder in DSM-5 are followed by, "the hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder"—and the list continues (p. 247). This goes beyond what can reasonably be called "differential diagnosis." The invalidity, indeed, the absurdity of it becomes evident if you imagine applying it to real medicine.

Imagine, if you will, looking up the definition for measles in an official diagnostic manual. You turn to the section on measles. To your surprise, you find a long list of highly subjective indicators—concerning, say, discomfort and lengths of time. You reserve judgment until you arrive at the end. Eventually, your eyes light on the final criterion, which reads: *Do not apply this diagnosis if the disorder better fits whooping cough, mumps, tuberculosis, or heart attack*. Reading this, would you not begin to have misgivings about the validity of the concept "measles" as articulated, not to mention "whooping cough" "mumps," "tuberculosis," and "heart attack"? Minimally, the dodge which is evident here in no way solves the problem of massive overlaps and artificial boundaries, albeit it may help practitioners feel more comfortable navigating them.

As suggested in the previous section, perhaps the single most problematic feature of all—and one which pervades the criteria sets—is that they strip people of at once context and personhood. As shall be demonstrated in the detailed examples which follow, instead of being a real agent is a real world, by virtue of these criteria, they are turned into what Jacobs (2011) aptly terms a passive "disease host." This deficiency, I would point out, is damming for insofar as these "disorders" do not address *real human beings*, their application to real human beings is by its very nature illegitimate.

Finally, and what is not surprising given what we know about psychiatry and about who has the power to name, not only do these criteria sets pathologize the everyday (see, e.g., General Anxiety Disorder) and not only do they routinely pathologize deviance (see Opposition Defiant Disorder, Schizophrenia, Borderline Personality Disorder), they are blatantly sexist, racist, classist, transphobic. Note, for example, the transphobia inherent in the very idea "Gender Dysphoria in Adolescents and Adults" (DSM-5, p. 45). Imagine a young person struggling with basic issues of identity being told that her evolving identity is a "dysphoric disorder"? What does such a label achieve except further oppress an already marginalized human being? By the same token, note the sexism inherent in the construction of Borderline Personality Disorder (an analysis of this to follow). As regards racism, arguably, the most single most common form that it takes—and it is rampant—is the hegemonic treatment of culture.

The very marginalizing of experiences and ways of being that substantially differ from mainstream North American ways in a glossary at the back is itself hegemonic. The fact that these are referred to as "cultural," moreover, signals a paradigmatic lack of awareness. The implicit assumption is that "the other's" ways of experiencing are culture-bound, whereas mainstream North American ways (as articulated in the body of the manual) are universal. In line with such hegemonic assumptions, constructions such as PTSD (to be analyzed shortly) contain "symptoms" ill fitted to "other/othered" cultures. Correspondingly, Suicidal Behavior Disorder was slipped in at the end of DSM-5 as a potential diagnosis in total disregard of the fact that in many cultures—for example, Japanese—suicide is regarded as a reasonable, even honorable act. More fundamental still—and here we approach the very core of the DSM—by definition, problems are located exclusively *within the individual*—something that itself conflicts with Aboriginal experience, not to mention that of most of the world.[10]

I have named several key defects, many of which in themselves render the constructs invalid. What follows are detailed examples of diagnoses, complete with critique. As I intend these to further open up the DSM, with one exception only, I am purposely choosing what is typical. As such, I am not highlighting either the most transparently problematic constructions or diagnoses such as schizophrenia (for discussion of "schizophrenia," see in particular Chapters One, Two, Five, Seven, and Nine). Correspondingly, in all cases, I am referencing DSM-5.

Several "Typical Disorders" and One Anomaly

To begin with a commonly assigned childhood disorder—"Opposition Defiant Disorder"—functioning largely as a disclaimer, a "note" inserted into the criteria set instructs the practitioner to factor in what is normative with respect to the individual's development level, gender, and culture. It is also stipulated that "the disturbance in question is associated with distress in the individual or others in his or her immediate social context" (Criterion B). This acknowledged, the heart of the "disorder" is unmistakably Criterion A, which reads:

> A persistent pattern of angry irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months, as evidenced by at least four symptoms observed during interaction with at least one individual who is not a sibling:
>
> 1. often loses temper
> 2. is touchy or easily annoyed
> 3. is often angry or resentful
> 4. often argues with authority figures...
> 5. often actively defies or refuses to comply with requests from authority figures or with rules
> 6. often deliberately annoys others
> 7. often blames others for his or her mistakes
> 8. has been spiteful or vindictive at least twice in the last 6 months. (p. 462)

Even on a surface level, there are problems with this formulation. We have seen this type of formulation before—vague measurements (note the repetition of the term "often") coupled with arbitrary stipulations—"6 months," and "at least four of..." What additionally compromises this definition, variations of the same criterion appear again and again—(e.g., "being angry," being "easily annoyed," "losing one's temper"). One "symptom," as it were, counts as three. What is likewise apropos and what begins to take us deeper, the very encouragement to be culture, age, and gender-sensitive are to a significant degree undermined by the "symptoms" themselves. In listing "being spiteful or vindictive at least twice in the past six month" as a criterion, for example, the DSM renders invisible the fact that teenagers in the North American context intermittently act in ways that might be interpreted as spiteful—something that, to a degree, our society has grown to expect.

Examine this construct in light of the definition of "mental disorder' articulated in the Introduction, and a still more formidable deficiency comes to light. Mental disorders are supposed to be internal—inside the person. Conflict between the person and society, hypothetically, is ruled out. This criteria set, however, simply *assumes* the origins are totally internal. What relates to this, as is the case with almost all the disorders, there is no reference to circumstances. The point is, people are not angry in a vacuum. While significant others and even the person themselves may be at a loss as to what the anger is about, people are angry about *something* and generally at *somebody*. What if the child has reason to be angry? To be resentful? To be "oppositional"? Nowhere is this possibility factored in. Insofar as the practitioner is employing an interview schedule based on the *SCID*, as is evident from the last section, nor would the diagnostic interview likely even surface such issues, for the questions are rigidly focused on the criteria set.

What adds to the problem, none of the "symptoms" need be observed by the diagnostician. They need only be observed by "one individual who is not a sibling." Besides that this curious disqualification could pose a major problem in a situation in which siblings are being surreptitiously terrorized, the question arises: What if the individual doing the observing is not credible? What if the individual in fact is in contention with the child, is the reason why the child is behaving as he is?

A sensitizing case in point: Pete, one of my interviewees (currently a photographer and member of the mad movement), was diagnosed with Opposition Defiant Disorder in 2003 when he was 10. As Pete's mother correctly explained to the psychiatrist, Pete had been yelling, swearing, and disobeying his parents. To boot, his marks were suffering. Hence the diagnosis.

The diagnosis, to be clear, was not the result of clinical error. By DSM standards, that is, the diagnosis was "correct." Indeed, not only did Pete's actions and demeanor satisfy four or more criteria, they satisfied *all the criteria*. As such, he was a "textbook case." What is also apropos at least for our purposes, albeit it was not part of the presenting problem and never surfaced, at the time of the visit with the psychiatrist, Pete had been being physically and sexually abused by his father for the last two years. The point is, Pete was *understandably* angry. Correspondingly, while this was admittedly not the whole of it, self-defense figured in his rule-breaking (he habitually hung out with friends, for example, when he was supposed to be home because, to use his words, "Like they didn't mess with me, right?") Question: What sense does it make to say that Pete suffered from a "behavioral disorder"? And how are we to understand a system where not only does such abuse not come to light and not only is it irrelevant, it is in effect "invisibilized" by the competent and proper activation of the official text?

If Pete seems like an extreme case, what about the six-year-old "lashing out" because his folks spend more time with his baby brother—which he sees as rejection? The teenaged girl who is resentful because her parents habitually argue? The sheer fact that the DSM effectively sidelines such circumstances, the fact that it makes the situation, the child's understanding of it, and the child's intentions irrelevant, the fact that anger and rebellion are turned into nothing but an internal "dysfunction" is a tragedy. It is also a general indictment of the DSM, for, alas, there is nothing extraordinary about this "disorder."

The second category which I would like to probe is the general class known as the "personality disorders." Before one looks much further, unless a person is so accustomed to such discourse that they have become immune, it is hard not to notice that not only is subjectivity masquerading as objectivity, but that both the name and the criteria strategically position the practitioner to make a markedly demeaning judgment call. Essentially, what is being suggested is that nothing less than the essence of who the person is—their very personality—constitutes a disorder. What is hardly incidental, typically this diagnosis is given to people disliked by the diagnostician—a reality that feminist therapists identified decades ago (e.g., Burstow, 1992). Being honest about that dislike is greatly preferable to declaring the person's personality "disordered." Not that what is happening here is exactly unique. Indeed, the insult evident here can legitimately be thought of as a magnification of the insult inherent in all "disorders," and as such, a window onto psychiatry. What these disorders draw our attention to is that to varying degrees all the "mental disorders" are means whereby people who are high maintenance, people who get under the other's skin—including the practitioner's, perhaps even their own—can be rendered invalid, with any conflict surrounding them, as it were, magically recast as a "symptom" of their "disorder."

The diagnosis process per se commences with the practitioner activating the general personality disorder criteria to assess if any kind of personality disorder is "present." In abbreviated form, what is listed as qualifying a person for a personal disorder are:

> A. an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture [which patterns are subsequently described with reference to "personality traits"].
> B. The enduring pattern is inflexible and pervasive.
> C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other areas of functioning. (DSM-5, p. 656)

As the reader may have already noticed, the language used is reminiscent of the language employed in the definition of "mental disorder." It is equally problematic, moreover, and in comparable ways. What we see here are layers of abstractions, reifications. Personality as normally understood, note, is a highly individual quality of being that we recognize in a person, that we attribute to a person, that may or may not intrigue us, that may or may not be to our liking. It is not, as depicted here, a reified causal agent. Correspondingly, people's lives are not mechanisms that lend themselves to "impairment" or "dysfunction." This definition, in other words, like the definition of "mental disorder" on which it is rests, is conceptually unviable.

If step one in the diagnostic process for personality disorders is determining *whether or not* a person "has" a personality disorder, step two is assessing what type. Each disorder has its own criteria set—and in each case, built-in bias and dislike are demonstrable. Take Borderline Personality Disorder (see p. 663 ff.).

The highly judgmental nature of the criteria is evident in the language employed. The criteria for Borderline Personality Disorder, for example, is populated by such obviously judgmental phrases as "markedly and persistently unstable," "impulsivity," "inappropriate, intense anger." It is also clear that misogyny enters into the construction, for several of the criteria mirror how women have been traditionally viewed under the patriarchy. I would draw attention in this regard to such qualities as enormous dependence and clinginess—or consider the following descriptors "affective instability" and "marked reactivity of mood."

Essentially, what we have writ large in the borderline diagnosis is what men have traditionally claimed is wrong with women, why women, as it were, "drive men crazy." So clear is it that the women are "the problem" and so invalidated are women by this disorder, correspondingly, as the literature suggests (see, e.g., Kirk and Kutchins, 1992 and 1997), accusations against the practitioner, including of sexual abuse, have historically been dispelled by the practitioner pointing to the diagnostic label. Alternatively, if the practitioner admits to having sex with a patient labeled "borderline," what might strike you as surprising in these days of zero tolerance, the very disorder functions as a recognized rationale. Note in this regard a refereed article by a Harvard psychiatrist (see Gutheil, 1989) wherein the author "accounts for" such boundary violations by attributing them to the legendary "poor boundaries" and inappropriate seductiveness of the "borderline" patient.[11]

With the release of DSM-5, significantly, a second approach to the personality disorders was introduced. Instead of having to choose between the disorders included in the general class, that is, the practitioner has the option of simply specifying the trait or traits deemed "dysfunctional." Herein we see an intensification of the original problem. The point is, if the construction of the "personality disorders" inherently pathologizes conflict between practitioner and "patient," making it an attribute of the "patient"—and that is precisely what I am claiming here—this tendency is magnified by the alternative schema. Consider in this regard the following vignette involving a man hypothetically a prime candidate for Personality Disorder Trait Specified:

> The patient is a 50 year-old male with chronic and recurrent major depression, as well as comorbid Type two diabetes. In addition to these major psychiatric and medical disorders, the patient tends to be difficult to work with and uncooperative with his caregivers, including being non-compliant with both psychiatric and medical regimes. In the proposed DSM-5 system, these clinically important *trait modifiers* can be recorded by noting the presence *of the trait domain of antagonism* and *impairment in interpersonal functioning* in the patient's chart. (once posted on www.dsm5.org/proposed revision; emphases in the original)

What is wrong with this picture? For one, the clinicians and indeed the author seem unaware that diabetes itself causes mood swings and that as such, diabetes could potentially account for both the "major depression" and the "irritability." Correspondingly, the diagnosis rests on such illegitimate concepts as "interpersonal functioning." That aside, let me ask: What has happened to the conflict?

Here is a man who gets depressed—and understandably so given both the reality of diabetes and his less-than-enviable situation. What is also significant, he in some way disagrees with his "medical regimen." One possibility—and I am conjecturing—is that he would greatly prefer having an injection for the diabetes, say, and does not wish to be on antidepressants at all. Be that as it may, conflict has arisen between the man and his "caregivers." By the use of the words "noncompliant," "difficult to work with," and "uncooperative," this *interpersonal conflict* is transformed into a deficiency or "impairment" *in the patient*. Correspondingly, by the use of such words as "trait" and "antagonism," it is turned into Personality Disorder Trait Specified. Once this transformation has been accomplished, I would add, there is little need to consider the "patient's" point of view. In effect, he does not have one. He has a disorder, of which being "noncompliant" is a symptom.

The reader may object that this is not a real case. Indeed, it is not. What it is, however, is at least as telling. In their final call for responses to the proposed changes to the personality disorders, the DSM-5 taskforce supplied vignettes. This was the vignette for Personality Disorder Trait Specified. Insofar as this is the APA's *own example*, it is reasonable to assume that it accurately reflects APA's intention. What we can conclude, correspondingly, is not only is this a totally invalidating class of disorders, but it is one so constructed that being in conflict with psychiatric staff comes close—indeed, perilously close—to totally satisfying the criteria. Hardly a legitimate construct. Clearly a dangerous situation. And a far cry from the scientific objectivity on which psychiatry prides itself.

My last example is Posttraumatic Stress Disorder. To give you as succinct an account as possible of the exceedingly long criteria set, Criteria A stipulates that a traumatic event or events must have occurred that involve actual or threatened death or physical injury or sexual abuse. Correspondingly, the person must have directly experienced this, witnessed it, or been repeatedly exposed to adverse details of the event(s). Criteria B specifies, "Presence of one more of the following intrusion symptoms associated with the event(s)." It then lists: (1) intrusive memories; (2) recurring distressing dreams; (3) dissociative reactions such as flashbacks; (4) intense or prolonged distress at exposure to cues that symbolize aspects of the traumatic events; and (5) marked physiological reaction to the event(s). Criteria C reads, "Persistent avoidance of stimuli associated with the traumatic event as evidenced by one or both of the following." The first list that follows is: distressing memories, thoughts, or feelings closely associated with the events and external reminders. The second is external reminders such as people, place, and conversations.

Criteria D specifies, "Negative alterations in cognitions and mood associated with the traumatic events . . . as evidenced by two of the following." What follows (and this is in abbreviated form) is:

1. inability to remember an important aspect of the event . . .
2. persistent and exaggerated negative beliefs about oneself, others, or the world
3. persistent, distorted cognitions about the cause or consequences of the trauma event(s) that lead the individual to blame himself/herself or others
4. persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
5. markedly diminished interest or participation in significant activities
6. feeling of detachment or estrangement from others
7. persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing). (DSM-5, p. 271 ff.)

While there are three additional criteria, only one is pivotal, Criterion E, which reads: "Marked arousal and reactivity associated with the traumatic events . . . as evidenced by two or more of the following." What follows, correspondingly, is the numbered list: (1) irritable or aggressive behavior; (2) reckless or self-destructive behavior; (3) hypervigilance; (4) exaggerated startle response; (5) problems with concentration; and (6) sleep disturbance.[12]

I do not wish to engage in a lengthy discussion of the deficiencies inherent in this criteria set (for this, see Burstow, 2005 and 2003a). However, I will name a few. Once again, we have a laundry list of "symptoms," with no way of assessing or understanding them in reference to the choices and dilemmas with which the person is struggling. What relates to this, ways of coping that might well be meaningful in individual circumstances are reduced to nothing but "negative" phenomena. By way of example, criterion E2 specifies "self-destructive behavior," of which activities such as cutting are paradigmatic. What belies this construction, however, is that such activities are common, useful, and recognized strategies which traumatized people employ to cope with pain (for details, see Burstow, 1992). By the same token, psychic numbing (criterion D7) appears as a negative and passive attribute, as a mere "incapacity." As explicated and documented by Lewis (1999), Gilfus (1999), Herman (1992), and Burstow (2005, 2003a, 1992), however, not only does numbing serve a useful purpose, survivors frequently choose to numb, again as a means of coping. A childhood sexual abuse survivor, say, is experiencing such intense distress from flashbacks that she has a visceral need to numb. She seeks psychic distance (misdescribed but visible in Criterion D6 and D7). Perhaps she dissociates (B3). Perhaps she opts to take a few drinks (Criterion E2). Perhaps she eats and purges, keenly aware that such methods have worked for her in the past (also E2). The point is, she is a real person struggling with difficult circumstances, and it gets her through the day. By positioning these acts as at once passive and inherently problematic, the DSM strips the woman of agency and in the process turns a strength into a deficit.

There are numerous other problems with this construct, but I will limit myself to just one. While posited as universal, it is utterly cultural-bound. World events have made the misfit with eastern cultures especially evident. A case in point is the professional fiasco which followed the earthquake in Sri Lanka. Significantly, the prototypical Sri Lankan response to community trauma—to move closer to each other—blatantly conflicts with the criteria set outlined earlier.[13] One result of the hegemonic construction, together with what might be called "psychiatric imperialism," is that the Western DSM-trained trauma counselors who descended upon Sri Lanka following the quake had no way of comprehending a people who overwhelmingly pulled together and returned to work. Correspondingly, they labeled everyone "in denial' and in so doing, demonstrably got in the way of healing (for a blow-by-blow description, see Watters, 2010).

If such defects are typical—and for sure they are—my primary reason for focusing on PTSD is that the construction nonetheless is anything but typical. In this regard, I would invite the reader to look once again at the criteria set and contrast it with the more typical disorders examined earlier—the personality disorders especially. Unlike the other disorders, note, it is not exactly insulting, and to a degree, it captures inner aspects of a recognizable phenomenon—the experience of numbing, for example, the recurring dreams, the felt sense of detachment. What is likewise apropos, it breaks with the logic of the DSM. The "mental disorders" were intended to be etiology-free. The very first criteria set for PTSD (Criteria A), by contrast, explicitly specifies the cause—the horrific event. Moreover, that cause is external to the person herself, is situated as part of the terrible circumstances in which she finds herself. In other words, some sense of circumstance pervades the definition. As such, this construction is an anomaly.

The anomaly itself is the end product of a process that began with war veterans asking the APA to create a diagnosis which would make those suffering the psychological aftereffects of combat eligible for insurance coverage. The PTSD conceptualization which emerged was not exactly what the veterans bargained for.[14] However, they did receive one critical concession—the causal link. The concept was subsequently broadened in response to trauma practitioners favoring a concept that could capture the nuances, range, and circumstances with which they worked—with the covering of childhood sexual abuse survivors in particular prioritized. Besides facilitating insurance coverage, what resulted on a practice level was a "disorder" that was appreciably more sensitive and flexible than most. What resulted conceptually was a construct that was essentially midway between a psychiatric formulation and a humanistic or phenomenological one—one, that is, that *is and is not* part of the psychiatric paradigm.

If the creation of such "in-between" constructs looks like a viable new direction for psychiatry, in actuality, it is not—not as long as APA covets medical credibility. It has retained the disorder perhaps for humanitarian reasons, perhaps because it is popular and so lucrative. This notwithstanding, it remains an outlier. Indeed, members of the APA power elite (read "men") tend to regard the disorder as an embarrassment, with many suggesting that it be relegated to an appendix (e.g., Rosen et al., 2010). That is hardly surprising given the seemingly endless expansion in criteria. Indeed, when the article just cited first appeared, according to Rosen's tally, there were 10,500 ways to meet the minimum requisite criteria in the version of PTSD currently under discussion—a reality, I would add, that provides grounds for insurance companies defunding it. Behind this curious reality is a dilemma—and not a resolvable one. The more phenomenological and the more reflective the construct is of the different situations and the manifold ways in which "trauma" is experienced, the more unwieldy it is and accordingly, the less credible as a medical disorder.

In this as through a microscope, we see the dilemma at the heart of the DSM itself. Irrespective of how "mental disorder" is defined, the more nuanced and sensitive the constructs are to the vicissitudes of human existence, the less credible they are as "disorders." Conversely, the more they resemble real diagnoses, the less sensitive and sensitizing. As such, marked insensitivity necessarily characterizes these criteria sets. Correspondingly, insensitivity and the need for it constitutes the ultimate truth about the DSM.

Concluding Remarks

Equipped with the knowledge of former chapters, we embarked on this chapter holding onto one very pertinent fact—that there is no biological basis for the "disorders." With the constructing of the DSM itself, we found a process rife with deception and self-interest. Correspondingly, we saw disorders justified by measures which bore no relationship to validity. Probing the text per se, we uncovered content that was conceptually, phenomenologically, and otherwise flawed. More explicitly, we established that the definitions are built on layers of reification and that the criteria sets are overlapping, reductionist, judgmental, arbitrary, and hegemonic; moreover, that they routinely violate the very rationale on which they rest. We proceeded to trace how the sets themselves and beyond that their activation rigidly exclude agency and circumstance.

One of the pivotal questions with which we launched this chapter was: If as demonstrated previously, these disorders have no foundation in science, do they nonetheless have value? That is, do they further one's understanding of people in distress? Except for the odd clause—and as one anonymous psychologist interviewee put it, "But if you actually listen to a person even for a few minutes, you find that out such stuff anyway"—the answer is decidedly "no." Not only are they not sensitive to people and their turmoil, they cannot be, for sensitivity itself would undermine the medical model. And not only do they not add to knowing, they intrinsically pull the practitioner away from what s/he otherwise knows and from the authentic human encounter on which knowing rests. Which is not to say that no professionals who employ them ever achieve a meaningful level of understanding—only that they have to work *against* the diagnosis and beyond that against the diagnostic setup as a whole to do so. Which ultimately means working against psychiatry itself.

One critical implication of the foregoing is that understanding is not the ultimate purpose of the constructions. On one level, the purpose is enhancing the credibility of the profession. On another, together with subsidiary texts—the SCID, the inventories, the case report—they serve the purpose of governance. In the very way the text is activated, in the circumstances defining it, indeed, lies the beginnings of what might be termed a "patient processing system." Insofar as diagnosis plays a pivotal role in the "processing system," understanding is eclipsed by one overriding goal—making a competent textually driven determination.

Through the window of diagnosis, we have seen some of the ways that texts interconnect, some of the ways that texts determine, some of the ways that texts are activated. Focusing more tightly on governance, the chapter which follows provides a detailed overview, a large-scale map, as it were, of psychiatry as a textually mediated regime of ruling.

CHAPTER 5

The Beast/In the Belly of the Beast: Pinioned by Paper

> *Irit*: One time I was working—and this is so ironic—for the Mental Health Advocate for British Columbia. I showed up at the office and got a pay cheque and ripped it up in front of her, and then was climbing the stairs to the top of the building while discarding articles of clothing. Granted, not rational behavior. Not smart. Well, the Advocate had her secretary call the police on me. And they were not nice. I was handcuffed in the ambulance with my hands behind my back and it was very painful.
>
> *Bonnie*: Why did they say they were doing that?
>
> *Irit*: As far as I know, they never tell you anything about why they do what they do. They just do it.
>
> —Excerpt from interview with Irit Shimrat

In our investigation thus far, we have unearthed worrisome practices and discovered some critical truths. We have seen two principles—*parens patriae* and protection of the peace—spawn a mammoth industry aimed at controlling people theorized as "unruly" or "in need of help," with biological psychiatry assuming dominance. We have witnessed the ascendance of rule by diagnosis, buoyed up by a research industry dedicated to manufacturing "facts." We have seen the increasing prominence of brain-damaging treatments. We have seen the development of an essentially self-interested alliance between the pharmaceuticals and psychiatry. Hard though this may be to wrap our mind around, what we have established, correspondingly, is that psychiatry's basic tenets are insupportable, that no biological basis has been established for any mental illness, that the claims of chemical imbalance lack foundation, that the profession has no ability to predict dangerousness. On a very different level, we have seen concretely how psychiatry as an institution rules through texts. Indeed, as the previous chapter drew to a close, psychiatry was beginning to reveal itself as a document-driven "patient processing system." Chapter Five picks up where Chapters One through Four left off, introducing new texts in the process.

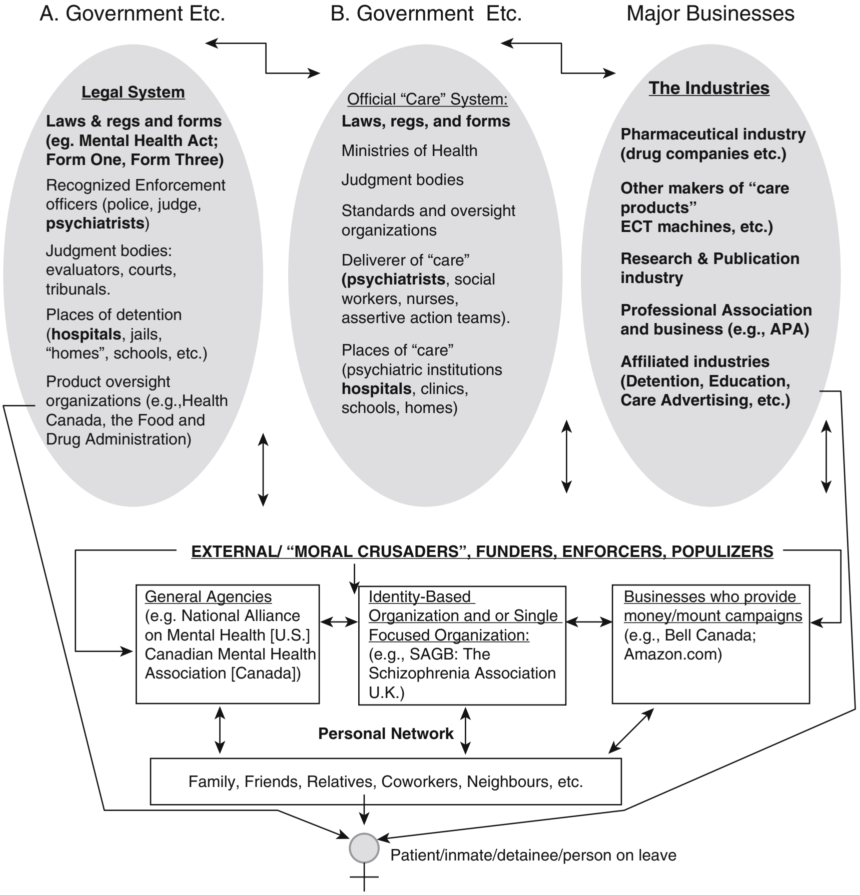


Figure 5.1 The mental health system and its conduits.

I insert figure 5.1 to help the reader acquire an overview and get their bearings. The first two oblongs are the exact same territory—"mental health" as a province of the state. The first oblong uncovers "mental health work" as a system of governance and control. The second one depicts it as it is traditionally understood (services). As a counterhegemonic inquiry into governance, this chapter situates itself squarely in oblong one, albeit oblong two may be helpful to you in recognizing the terrain.

Previous chapters focused overwhelmingly on psychiatry as a "profession," "business," and discipline. Such is represented in oblong three. By contrast, the bulk of this chapter (oblongs one and two) is concerned with mandated governance, otherwise known as "services." Despite the fact that greatly reduced hospital stays characterize the current era, with "care" in the community prioritized, this chapter takes "hospitals" and "hospitalization" as a primary focus because these places of detention constitute the ultimate truth about the regime, or to put it another way, the underlying threat. Governmental boss texts are particularly highlighted, with this chapter's vantage point being *psychiatry as an agent of the state*. As with other chapters, once again, of course, the standpoint is that of the vulnerable human being subject to this rule (see tiny figure at the bottom).

While evidence necessarily enters in, the purpose of this chapter is not so much to render proofs per se as to trace how state-mandated "mental health" governance works. Questions explored include: What are the primary governmental boss texts? What discourses are embedded therein and how are these replicated? What does it mean to "form" someone? How do "patients" enter "hospital"? What befalls them there? How are institutional accounts created and recreated? How do different workers take up the texts and reproduce the system? How are these texts used to move patients from one category to another, one spatial confine to another? How do the judicial structures mandated to protect "patients rights" hook into these documents, these discourses? How does psychiatric rule extend into the community at large? When are services not services?

A Preliminary Exploration of Key Parts of the Diagram

Oblongs one and two are THE SYSTEM *as we normally understand it*. The system includes both regional and federal legislation with the regional particularly important, for "mental health" is largely positioned as a provincial or state issue. Examples of regional acts are the various health and mental health acts. Among the most critical federal legislation is legislation of the ilk of the Food and Drugs Act (1985). The acts in question both create and grant powers to specific governing bodies. At the top of the provincial governmental hierarchy are bodies typically given names like "Ministry of Health." Particularly significant subsidiary bodies which to various degrees are ruled by the ministries of health are the hospitals themselves. Legislative acts mandate a vast army of officials to operate in specific ways both inside and outside of these bodies. Examples are: doctors, nurses, justices of the peace, tribunal members, police, assertive action teams. Alongside these, organizations with ostensibly different missions and governance structures, additionally, to various degrees mirror the mental health service organizations, with their operatives acting as a conduit into the system (e.g., schools). Both federally and regionally, at all places in the hierarchy, organizations exist, moreover, which variously conduct research and actively promote psychiatry. An American example of a high-up federal body largely devoted to creating research and promoting psychiatry is the National Institute of Mental Health. A Canadian example of a hospital that likewise serves as a hub of research and is central to psychiatric promotion is the Centre for Addictions and Mental Health (CAMH) in Toronto. While service tends to be a regional matter, product oversight is typically federal.

Setting aside the oblongs for a moment, I ask the reader to cast their eye down to the external "moral crusaders" [Becker's (1963) term, you will recall, for active true believers]. While not part of government and not wielding the same power as players located higher, the "external moral crusaders and popularizers" are an integral part of the system, moreover, one that interacts in manifold ways with all other parts. Some of these are large corporations for whom "mental health" promotion is not a central focus, but a type of charity, putatively, an example of "good corporate citizenship" (see right side). Others—and these form the bulk (see left and middle)—are specifically created to theorize, lobby, weigh in on "mental health" issues. Such groups may or may not "provide services" (counseling, detention, drug monitoring, and other oversight). The Canadian Mental Health Association is a prime example of a highly growth-oriented one which does. By definition, however, all are involved in promoting psychiatry (translation: the medical model). Those whose overriding raison d'être is psychiatric promotion tend to receive funding from the pharmaceuticals (for details, see Whitaker, 2002 and 2010). They frequently team up with the state to produce studies, conduct surveys, create "educational" material, publish "strategic plans," all of it announcing high prevalence rates (arrived at by ignoring exclusionary criteria; see Horwitz, 2002), all of it presenting the medical model as fact, much of it levering an antibias message to make the medical model appear the epitome of humanism and as such, something it is only decent to line up behind—arguably, the primary purpose of "anti-stigma" campaigns. An example of one such publication is *The Human Face of Mental Health and Mental Illness in Canada* (Government of Canada, 2006)—a piece cowritten by several government bodies and the Mood Disorders Society of Canada and which features alarmist statistics, while painting a picture of the "mentally ill" as *both* everyday folk who should not be "stigmatized" *and* as blighted souls who will end up in dire straits without compulsory treatment (see p. 53). To varying degrees, all such groups are drawn into governance.

Many of these groups are populated by family members of people deemed "mentally ill." Family in turn figure significantly in the next category "Personal Network" (see category just above "Patient/Inmate"). Just how these support systems come to be co-opted and turned into part of governance will become clearer as this chapter unfolds.

Besides advocating for services, family groups commonly assert common cause and join with professional associations (see oblong three) to push for legislation to make it easier to involuntarily confine, also to silence maverick professionals. In this regard, the Ontario chapter of the Schizophrenia Society, as discussed in Fabris (2006), was instrumental in introducing the notorious Box B criteria into Ontario's committal law (discussed later in this chapter). Correspondingly, in the United States the National Alliance on the Mentally Ill (NAMI), together with the APA, tried to have Dr. Breggin's license removed after an appearance on the Oprah Winfrey show in which he problematized psychiatric drugs. To quote from my interview with Breggin in this last regard:

> *Breggin*: The National Alliance on the Mentally Ill went after my medical license. It was NAMI and APA and the state of Maryland.
> *Burstow*: And it was explicitly for what they interpreted as an attack on drugs?
> *Breggin*: Totally.

Once again, the long reach of the pharmaceuticals is evident.

This bring us to the third oblong. I have placed oblong three (the related industries) on the same level as the other oblongs to reflect the power and relative autonomy of such organizations as the pharmaceuticals. To be clear, this is not to deny that in many respects they are subordinate to the state, at least technically. However, besides that they operate relatively independently, and on the global stage, even those aspects which are subordinate to the state are not as subordinate as it may first appear. To illustrate this point as well as to flesh out a critical part of governance, I ask the reader to turn to one item in the first oblong—product oversight organizations (see bottom of oblong).

Product oversight is regulated by acts—generally federal acts—which are in turn administered by product oversight organizations. Examples are Health Canada (Canadian) and the Food and Drug Administration (American). The official story is that these organizations diligently protect the public from unsafe and "ineffective" substances. And indeed some measure of oversight is provided. The problem is, however, the oversight organizations neither conduct their own research nor commission third-party testing. Rather, the trials whose success determines whether or not a drug is brought to market are exclusively designed, financed, overseen, and indeed interpreted by the pharmaceutical company (oblong three)—that is, *the very organization who has most to gain from the drug's acceptance*. To quote from my interview with expert Dr. Peter Breggin in this regard:

> The trials are entirely conducted and paid for by the drugs company. Furthermore, they hire doctors that are in their stable usually. Or they hire another organization to do it whose livelihood depends on coming up with good results. The drug company completely designs the trial, and the evaluation of the data is not done by the investigators who do the drug trials. It is done in the offices of the drug companies.[1]

Again, a blatant conflict of interest. The problems inherent in the conflict of interest are compounded by the flawed quality of the research itself (see Chapters Three and Seven). To what degree oversight agencies like Health Canada take in the compromised quality of the research is unclear. My interviews suggest that Health Canada officials take note of the drug companies' conflict of interest but do not concern themselves with it. Note, in this regard, this guarded but nonetheless telling admission from former Health Canada official Jack L. (pseudonym):

> *Bonnie*: While you were employed at Health Canada, was there any discussion about the conflict of interest inherent in the pharmaceuticals investigating their own products? That this was Health Canada's system?
> *Jack*: Well, people knew about it, but no, not really.
> *Bonnie*: So Health Canada officials were not worried about it?
> *Jack*: No.
> *Bonnie*: So would it be fair to say that there was a protocol that your officials follow and they don't concern themselves beyond that?
> *Jack*: I didn't work in that particular area. So, I only heard about it. But yes, I would say that was fair.

Related and equally problematic truths about these oversight bodies which surfaced in my investigation are: 6 to 12-week trials are the norm, albeit typically most harmful effects do not appear that early (see Whitaker, 2002 and 2010); two trials showing minimal effectiveness suffices for a drug to be approved; and by various routes, "adverse effects" are commonly buried.

Dr. Breggin's "watch-dog" work with respect to the pharmaceuticals is particularly informative. Breggin (2001a, p. 86 ff.) documents an erstwhile Eli Lilly clinical trials practice of recording suicide attempts by participants on Prozac as either "depression" or "no adverse effect." Having served as an expert witness in a number of court cases and so been afforded the unique opportunity to dig into company files not otherwise available, he additionally provides the following general insight into the process:

> The drug companies have huge leeway in how they look for adverse effects, how they organize them. For example, for Zoloft and Paxil, they avoided the term "akathisia," which is associated with a terrible worsening of the conditions, violence, and suicide. So they can divide say akathisia into seven different categories, which doesn't even get recognized as akathisia. There can be one for nervousness, one for restless legs, one for agitation; so it never comes out that it is causing this disorder unless someone like me goes into the records and reorganizes them. (Interview)

Put these pieces of information together and what becomes clear is that government largely rubberstamps highly compromised drug company designs, processes, analysis, and products. Or to put this in the words of one interviewee, "oversight is not oversight."

Comparable problems attend the monitoring of medical devices. For example, in North America minimally, the oversight agencies do not actually subject the ECT machines to an investigation per se. That is, they do not endeavor to discover what seems mandatory for an oversight agency to know—if the type of device on which it is pronouncing is intrinsically safe. As confirmed in an interview with an official from the Medical Devices Bureau of Health Canada (September 25, 2012), what happens is a "quality review to see if any given device is malfunctioning." That said, all devices are assigned a risk level, and as such, some level of assessment is clearly operant. The assigning of risk levels, however, appears to be done via a mental tick box similar to the tick boxes that we saw in the last chapter. What is telling in this regard, when I asked her to explain the curiously low level of risk assigned ECT machines (level 3, the same as heart monitors), she consulted her written regulations, then cited such standards as "it does not produce its own energy." Now to be fair, it may well be that machines which produce their own energy present a modicum of extra risk, perhaps because the operations cannot as easily be stopped if a malfunction occurs. Such criteria, nonetheless, glaringly miss the point.

In past chapters we came face to face with chilling reasons why people are subjected to treatments that are inherently damaging—reasons that blatantly connect up with self-interest, which speak to intolerance and fear. While a methodical exploration of product oversight is reserved to later chapters (Chapters Seven and Eight), already we see additional answers. They are subjected to such damage because protocol is inadequate, because protocol replaces judgment, more fundamentally, because government functions as a conduit, a funder, and source of legitimization. Herein then is the context for comprehending the text-action sequences core to psychiatric governance.

Introducing Two Governmental Boss Texts

Minimally, every jurisdiction has slightly different ruling texts, slightly different committal policies and procedures. As the legislation and practices in any given jurisdiction hook into each other not simply generally, but *in their specificity*, it is important to front and center one set so that the circularity is visible—hence my referencing of one jurisdiction primarily. While Ontario serves as my main reference, it should be noted, comparable laws and modus operandi exist in jurisdictions throughout North America and indeed in much of the rest of the world and as such, these findings have what qualitative researchers such as Lincoln and Guba (1985) call "transferability." A multijurisdictional example to concretize this: Interviewee and inmate/activist Irit Shimrat was incarcerated in hospitals which spanned three different jurisdictions (Ontario, British Columbia, and New York), and her experiences were demonstrably similar in all cases. In all cases she was taken to "hospital" against her wishes, in all cases in conformity with regional mental health legislation, in all cases because of similar actions that distressed others, in all cases forms which reflected this legislation were signed, and in all cases she was summarily admitted involuntarily and drugged.

Ontario boss texts of particular relevance to the matter at hand are: (1) Mental Health Act R.S.O. 1990, M.7 (abbrev: MHA); and (2) Health Care Consent Act, 1996, R.S.O. 1996, Ch. Two, Schedule A (HCCA). The Mental Health Act deals with such issues as apprehensions, detention, committal, whereas the Health Care Consent Act governs issues of consent, including the criteria and procedures by which people may be declared "incapable" to decide on treatment. Follow the ins and outs of these texts and the practices that arise from them and the governance of the "mentally ill" comes to light. Follow the logistics of the discourse, correspondingly, and you will witness the defining-into-existence of two legal entities with but limited personhood and rights—the "involuntary patient" and the "incapable person."[2]

Involuntary Admissions and the Mental Health Act

The Mental Health Act is the act whereby people who have committed no crime can be locked up initially or continue to be locked up against their will. A wraparound act, arguably, its single most important feature are the involuntary admission criteria. On the one hand, as legal clauses, they dictate which must be present for involuntary confinement to occur. On the other, they effectively construct the distressed or distressing person in a particular way. The most well known of these criteria—and every jurisdiction has something similar—is predicated on "dangerousness."

While exempting the person who is "suitable for admission as a voluntary patient,"[3] this section of the act instructs the attending physician to sign a certificate of involuntary admission if in their opinion:

> *the patient is suffering from mental disorder of a nature or quality that likely will result in,*
> (i) *serious bodily harm to the patient*
> (ii) *serious bodily harm to another person, or*
> (iii) *serious physical impairment of the patient*
> *unless the patient remains in the custody of a psychiatric facility.* (MHA. s. 20, 5)

On a general level, we have already established what is wrong with these types of provisions. To hone in on a few of the specifics, the untenable concept of "mental disorder" is herein inscribed in law. Correspondingly, perception on the part of the physician is turned into a quality of the patient, which in turn is ascribed causal power such that it can "result in," for instance, "serious bodily harm." This is one level of problems. Other levels also pertain.

Known as the "Box A criteria," these criteria jointly and severally mandate involuntary committal on the grounds of what is considered "future dangerousness." The criteria in question, that is, are based on predictive power despite the fact, as established in earlier chapters, psychiatrists have no ability to predict dangerousness. By the same token, they are predicated on "dangerousness" despite the fact that: (a) there is no evidence that those deemed "mentally ill" are any more dangerous than the general populace; (b) incarcerating people on the basis of what others worry they will do contravenes principles of fundamental justice; and (c) what is perceived as self-harm is often a valid means of coping. On a discursive level, how such realities are obscured and how the intrusive actions thereby authorized are made to look necessary is precisely by the suggestibility of the criteria themselves. Read through these criteria, and indeed the impression created is that there is a dangerous substratum of people with menacing "disorders" such that unless stopped, they will necessarily cause "serious bodily harm" to themselves or someone else or "seriously impair" themselves. There is no sense whatever that the people referenced herein are agents like everyone else who are making choices under less-than-ideal circumstances.

The first two criteria target the person perceived to be at risk of intentionally inflicting harm, thereby constructing the person as an "intentional harm-doer." By contrast, the third criterion—"serious impairment of the person"—lowers the bar so as to capture possible future inadvertent harm to self, something largely theorized as stemming from lack of proper "self-care" (another abstraction and reification). Characteristically included as "evidence" of such "lack of self-care," as legal experts Hiltz and Szigeti (2011, p. 296 ff.) point out, are such factors as not dressing well in inclement weather, thereby risking frostbite, or being belligerent and thereby placing oneself at risk of retaliation from another. What has happened here? On one hand, the legitimacy of very different standards of care—including ones that the average person may find baffling or distressing—are ignored, as is agency itself, with those differences turned into consequences of a "disorder." On another, even a distant risk to self (and again as perceived by a professional, who is very differently situated) is being defined as grounds for deprivation of liberty. Additionally, the potential bad reactions of a hypothetical third party who may decide to hurt the person has been conceptualized as a limitation of the "disordered" person. In the process the "disordered" person is constructed as "lacking" and "in need" and "incarceration" is constructed as the answer to that need.

Another criteria set, known as the "Box B criteria," may be used instead of the Box A criteria, and as such, serves as an alternate route to involuntary admission. Alternatively, they may be conjoined with the Box A criteria, thereby creating a "double whammy." Articulating this second use of Box B and identifying it as now standard, Anne R., a highly seasoned mental health lawyer whom I interviewed, clarified as follows:

> What you are suggesting, that would be the sensible thing. What makes sense is that you would not resort to Box B unless you had to, but that is not in practice how physicians do it. They will claim absolutely everything that they can get their hands on. Whether or not they mean it, they will just throw it in.[4]

Enacted in 2000 and as a result of lobbying by groups like the Schizophrenia Society, the Box B criteria likewise consist of one abstraction/reification after another, all justifying incarceration.[5] More particularly—and I have fashioned this sentence precisely to call attention to some of the discursive elements—it allows the patient not "suitable" for voluntary status (reification) and "not capable" (reification) and who in addition showed "clinical improvement" (reification) in the past when treated for a similar disorder (reification) to be involuntarily committed on the grounds of possible deterioration (reification and speculation). To quote from the section itself, it mandates involuntary admission if in *the opinion of the attending physician*, the "patient"

> (a) *has previously received treatment for a mental disorder of an ongoing or recurring nature, that, when not treated is of a nature or quality that likely will result in serious body harm to the person or another person or* ***substantial mental or physical deterioration*** *of the person or serious physical impairment of the person*
> (b) *has shown clinical improvement as a result of the treatment*
> (c) *is suffering from the same mental disorder as the one for which he or she has previously received treatment or from a disorder that is similar to the previous one*
> (d) *given the patient's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer* ***substantial mental or physical deterioration or serious physical impairment.*** (MHA. s. 20, 1.1)

As with Box A criteria, creation via discourse is demonstrably evident. Note in this regard the repetition of "likely result in" (as if this were objective) and such phrases as "clinical improvement." What makes this criteria set further problematic, unlike the Box A set, this set is intimately linked with past "treatment," indeed, is demonstrably aimed at the person who has stopped taking the "treatment" prescribed for them (so *may* end up a problem). What relates to this, while "dangerousness" as you can see, is once again embedded, the perception of dangerousness is no longer an essential ingredient; indeed a far lower standard is being authorized, as seen in the sections that I bolded. The point is, the "likelihood" of "substantial mental or physical deterioration" now suffices (at once a reification and an extremely vague concept which is left undefined). Significantly, this hypothetical deterioration need in no way be imminent—the physician need only predict that it will happen sometime in the future. Given that most putative mental illnesses are conceptualized as conditions which will deteriorate dismally in the absence of ongoing treatment and given psychiatry's tendency to see all psychiatric treatment as helping, in practice, Box B boils down to this: People can be committed against their will *simply because they are not "taking their meds,"* not because anyone remotely could depict them as dangerous or even necessarily as lacking in self-care. Given that "patients" routinely go off psychoactive drugs because they find themselves rendered unable to think, feel, or act, in effect, the criteria legitimize a never-ending cycle of interference characterized by apprehension, incarceration, and forced "treatment." In the process, I would add, it further conflates two very different issues which are already conflated—the ability to make one's own decisions on one hand with "treatment" compliance on the other.[6] Correspondingly, via the juxtaposition of the concept of "deterioration" with the concept of "previous successful treatment," it constructs the noncompliant patient as someone needing at once forced detention and forced treatment.

Examine the passage more carefully and what likewise becomes obvious is that two primary legal entities—essentially, joined at the hip—have come into being via the text: (1) the all knowing and all powerful psychiatrist who can be trusted and whose observations are law; (2) the crazy person who cannot be trusted and must be stopped. In any contest between these two, it is clear who is overwhelmingly likely to win.

Just as the Mental Health Act spells out criteria by which a person may be involuntarily admitted, it spells out the situations, the actors, and the processes by which someone may be detained and brought to hospital. These criteria hook into the involuntary admissions criteria, while additionally stipulating "past dangerousness criteria" and disorderliness. To quote as an example S. 13 (the instructions to the police officer), police are mandated to detain a person and take them to a place where they can get a psychiatric examination, where:

> *a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person*
> (a) *has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself*
> (b) *has behaved or is behaving violently toward another person and has caused or is causing another person to fear bodily harm from him or her; or*
> (c) *is showing a lack of competence to take care of himself or herself,*
>
> *and in addition the police officer is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in,*
> (d) *serious bodily harm to the person;*
> (e) *serious bodily harm to another;*
> (f) *serious physical impairment of the person.*

It should be added here that evidence that officials are permitted to use in making their assessments includes not simply what they directly observe but also what is relayed by others. The "mentally ill person" thereby becomes "an easy target."

Drawing on identical and related concepts, other sections of the act likewise authorize other practitioners to do their work, to play their role in the apprehension and commitment of the disorderly person. S. 14, for example, itemizes similar conditions by which a physician who has recently examined a patient can order the police to detain her and take her to a hospital for examination. Correspondingly, S. 16 annunciates comparable criteria which allow the justice of the peace to likewise issue an order for psychiatric assessment. What the act does, in effect, is amass a small but powerful army, all armed with instructions, all poised to take charge.

Demonstrably occupying central roles in this are two key officials—the doctor and the police. The centrality of the doctor signals that this detention is part of *parens patriae*, is conceived as a service to the disorderly person. The centrality of the police—and note that the police are textually authorized to apprehend not only on the basis of an order from specific others but also on their own initiative—signals that what is happening is in fact an extension of the police power of the state.

The Health Care Consent Act and Incapacity

The Health Care Consent Act is the act wherein "incapacity" is most clearly articulated. Findings of "incapacity" suffice to remove decision-making power from "the incapable person" in specified areas.[7] The criteria are spelt out as follows:

> *A person is capable with respect to a treatment, admission to a care facility or personal assistance device if the person is able to understand the information that is relevant to making a decision about the treatment, admission, or personal assistance service, as the case may be, and able to appreciate reasonably foreseeable consequences of a decision or lack of decision.* (HCCA, 4.1)

While technically there is a presumption of capacity, the exception is where a person "has reasonable grounds to assume that the other person is incapable" (S. 4.3)—that is, where said person seems unable to (1) "understand" or to (2) "appreciate" the reasonably foreseeable consequences (a "capable" person must pass both tests).

Suffice it to say that while "reasonable" and "foreseeable consequences" sound objective, given that health workers determine capacity, de facto, "reasonable" is what seems reasonable to them. Correspondingly, "foreseeable" is what they deem such. In other words, once again the subjectivity of the health workers is being constructed as objective. What exacerbates this problem, given that both the concept of "mental illness" and medical model "treatments" are inherently problematic (see past chapters), it makes perfect sense for someone to reject any or all of them. As will be increasingly evident, someone who does, however, has but a very slim chance of passing the "capacity" test.

A development: In 2003 Professor Starson (a "psychiatric patient") contested the finding of incapacity against him; and the Supreme Court found with him and in the process pronounced on this section of the act. In part, this landmark ruling reads:

> *A patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to his or her circumstances... If it is demonstrated that he has a mental condition," the patient must be able to recognize the possibility that he is affected by that condition...As a result, a patient is not required to describe his mental condition as an "illness," or to otherwise characterize the condition in negative terms.* (Quoted from Hiltz and Szigeti, 2011, p. 175)

On the face of it, this clearly progressive ruling seems to offer a meaningful measure of protection. Practice, as we shall shortly see, is more complicated.

And the Texts Beget Texts: "Formed"

Insofar as psychiatry is a state institution that rules through texts, it is not simply the highest level texts touched on to date that are critical. The texts one level down are absolutely essential, for they bring the boss text into play, as it were, make boss text pronouncements actionable. The texts in question are known as "forms" (for all forms listed in this chapter, see Hiltz and Szgeti, 2011). It is through these forms—and there is a mammoth number of them—that the boss texts are applied. Correspondingly, via these forms, patients' lives are made actionable—that is, "patients" are processed through the system, which in turn, via these forms, functions as a patient-processing regime. Examples are Form 1 of the Mental Health Act (which the doctor fills out to authorize the police to pick up a person and take them to hospital), Form 3 (certification of involuntary admission), Form 4 (certificate of renewal of involuntary admission), Form 45 (the community treatment order by which the "patient" leaving the hospital continues to be "ruled"). Viewing these as passive records misses the point. Look at what they contain and how they are used and it becomes clear that far from being mere purveyors of information, albeit they are also that, the "mental health" forms are events, are happenings, are transitive verbs, verbs that take an object, that *actually do something to somebody*. Indeed, this reality is recognized by psychiatric survivors, who, for example, typically describe the precipitating action that led to their abduction as "being formed." "I was at home in my bed fast asleep," stated one participant in this study, "and suddenly, there was a pounding on the door; and I got up; and it was the police, and I thought, 'Oh God, I have been formed.'"

A further and highly significant truth about these institutional forms: Pick one up, and you will immediately recognize that uniformity, that pre-selection that we came across in the last chapter. By way of example, I would call the reader's attention to Form 3 (Certificate of Involuntary Admission), which the psychiatrist fills out to admit involuntarily [Ministry of Health (2000); for a view of it, see http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-6429-41~1/$File/6429-41_.pdf].

As the reader can see if looking at it, Form 3 is essentially a series of tick boxes. The physician activating it ticks one or more boxes to indicate whether he is committing according to Box A criteria, Box B criteria, or both. Box A states the "person is suffering from a mental disorder such that it will result in," following which words, each of the boss text criteria are listed, together with their own separate tick box—"serious bodily harm to the patient," "serious bodily harm to another person," and "serious physical impairment of the person." Box B is handled similarly. The bias is the same one that we saw in the DSM chapter. Just as the diagnostic interview prompts the psychiatrist to see the distressed or distressing person solely in accordance with the symptoms associated with specific diagnoses, this form prompts the psychiatrist to see the "patient" as someone subsumable under one of the commitment criteria and nothing but that. With respect to the circumstances with which this chapter began, a psychiatrist, for example, would not be prompted to find out *why* Irit stripped off her clothes and rushed to the top of the building. He need only identify this as danger to self or others or, say, evidence of impairment—something that her being brought in by ambulance, something that the very existence of the form prompts him to do. While various other factors may of course still lead a psychiatrist to release a person so constructed (e.g., overcrowding in hospital, the person arriving in a calm and lucid state)—and in this particular case, to be clear, it did not—the point is that the work needed to understand the person is thereby appreciably sabotaged, and ironic though it may seem, in the process, the work of the institution is accomplished.

All of the other forms are similarly constructed. For example, the justice of the peace form is also a tick box form which lists the allowable criteria and in the process cues the justice of the peace to see the person as "detainable." Similarly with the form for the observing physician. The forms function, as it were, like self-fulfilling prophecies. Correspondingly, together they construct the distressed or distressing person in a way that makes them actionable. Indeed, insofar as any of the relevant boxes are ticked, by virtue of the activated form, already the institution is taking control of the person, processing the person, moving them along to the next processing stage, where they will similarly be subject to text-based observation, classification, and control.

That understood, it is time to trace the inmate's actual progress through the system.

Ending Up at the "Hospital"

There are a variety of routes by which an individual may end up at "hospital." A person in distress may be desperately seeking help, view the hospital as a resource, and "choose" to come. What is particularly significant here—hence the quotation marks—commonly what begins as voluntary or quasi-voluntary does not remain so. Another way that people may arrive is at the behest of family, often escorted by family. Oftentimes, as the literature demonstrates (e.g., Goffman, 1961) and my professional experience and interviews confirm, loved ones, who may be at their wits' end, trick the person into coming, or they may initiate the process by which a doctor or a justice of the peace issues an order—something generally experienced by the "detainee" as a betrayal. Another route is transfer from a general hospital or other type of facility—a circumstance that may or may not involve the police.

In situations where a form has been signed or someone has summoned the police, typically, the first sign that they see that their life has just taken a profound turn is precisely the sudden and horrifying appearance of the police. Recall, in this regard, the words of one interviewee, who awoke from a deep sleep to find the police pounding at her door. Where a form has kick-started the process, apprehension is automatic, for the person has been "formed." They simply deliver the person to the next stage of the processing system. Conversely, where the police have been called by a "lay" figure or alternatively, they happen upon a scene which they "recognize" from the Mental Health Act, detention is at their discretion, with the point of reference being Section 17. Albeit in this case, there is no concrete form with tick boxes, conceptually this section functions like a tick box form. That is, it prompts the police to see the person as acting "in a disorderly fashion" (tick). Correspondingly, it prompts them to hunt for evidence that the person has threatened bodily harm to themselves (tick) or others (tick), or is otherwise behaving violently (tick), or showing a "lack of competence to take care of himself" (tick), in addition to look for signs that the person has a "mental disorder" that is "likely to result" in serious bodily harm to others (tick), serious bodily harm to themselves (tick), or serious impairment (tick). Besides that these categories are problematic in ways already discussed, the highly charged circumstances, together with what is often a dramatic contrast (between on one hand, say, the comparatively "reasonable-sounding" family member who may be arguing that "something must be done," on the other, the distraught person who is terrified and/or infuriated at this abrupt intrusion, who may be shouting, pleading, spitting, wailing, cowering) all serve to heighten the probability the police will find exactly what they are looking for.

An example which illustrates aspects of this: In 2012, Lisa, an interviewee who was very much her own person, was detained by police and subsequently committed involuntarily because a niece with whom she was on bad terms had told them that her aunt had become "dangerously unhinged." More concretely, she stated that her aunt was hopelessly confused and had just threatened her own child (both untrue) that her apartment was so neglected that it constituted a health hazard (gross exaggeration), that the "situation" was "escalating." The police turned up at Lisa's door to find a two-year-old girl who showed no sign of being in difficulty. This notwithstanding, Lisa was detained and soon thereafter involuntarily admitted. What was the evidence of "committability"? (1) The word of an estranged but reasonable-sounding niece; (2) an apartment that was unquestionably messy by middle-class standards (taken as first hand evidence that Lisa suffered from a disorder such that she could not care for herself); (3) an irate woman who angrily and repeatedly stamped her feet when the police barged into her living room (possibly seen as threatening behavior). What happened here? Viewed through the lens of the Mental Health Act, dubious testimony and innocuous circumstances, much of it created by the unwanted intrusion itself, became evidence of a disorder which rendered the woman incapable of taking care of herself.

I am aware at this point that the reader may be thinking—fine, and clearly a situation where the authorities overreached, but is there not a place for such interventions—say when someone is in the midst of a "psychotic episode"? In probing this question, I would turn to a moment in Irit's life, in this case, not the one with which the chapter began, albeit that too would serve, but one that on the surface of it feels a touch more menacing, one where most people would turn to the police, and as such, which calls the system and our very instincts into question.

The "incident": Overwhelmed by the state of the world—and generally, it is social concerns (e.g., her awareness of a war spreading) that precipitates what Irit identifies as her "going crazy"—one evening Irit stripped off her clothes and began making her way down the hallway of her apartment building. As she proceeded, one by one, she would bang on people's door, yelling, "Emergency, emergency." Now Irit did as a result end up being involuntarily taken to hospital, albeit via a different route than police (the superintendent). However, besides that the specificity of the mode of force is not what is most relevant, what if the police *had been* called? Significantly, when I first told this story, I confused it with the hospitalization previously touched on—and everyone saw the intervention as appropriate. Indeed, herein lies the paradigmatic case where police are called and supposed to act—"deranged person dangerously out of control."

That noted, additionally the fact of other tenants having a right to the quiet enjoyment of the premises acknowledged, I invite the reader to step back. While admittedly, a scene such as this seems to scream out "danger," ask yourself: Just how is a naked middle-aged woman wandering the hall, tapping on doors, calling out "Emergency" a danger? Realistically, is she likely to hurt anyone? And if you find yourself conceding that she poses no danger to others, but reverting to, "but someone might, say, rape her," ask yourself: How likely is that under the circumstances? Realistically—not very. Significantly, however, it is precisely in circumstances such as this that people are apprehended. What relates to this, just as the authorities have their tick boxes, we all have stock images of the mad—the madman lunging at you from out of nowhere, a madwoman loosed from her attic showing up at your door—and when the two mesh, abduction is more or less inevitable. Which is not to say that no one ever presents a danger, but again the "mad" are not prime candidates. Herein lies our limitation and our challenge.[8]

Entering into Hospital: Surveillance, Processing, "Forming"

Whatever else may or may not be happening, at the very latest—and as we have already seen, it is generally earlier—the second that a prospective inmate steps through the hospital door, the work of transforming them into creatures of the system begins. That initial work largely consists of observation and control, all of it routinized, all mediated by texts. To make this concrete, let us walk for a moment in the institutional shoes of a distressed or distressing person who turns up in the emergency ward of a hospital.[9]

Assessment begins with the triage nurse, whose computer contains the initial intake form. As the patient talks, perhaps hoping against hope that finally someone is taking an interest in her plight, the nurse is listening very selectively in order to make a critical institutional determination—is the patient "major" or "minor" (in need of immediate attention or not)? Perhaps the "patient" does not notice. Perhaps she notices but cannot make sense of what she is a witnessing. The first of a long series of disjunctures.

The process, including the textual coordination, is visible in this excerpt from my interview with longtime emergency nurse and educator Simon Adam:

> *Simon*: The individual either comes in or is brought in. And the first contact is the triage nurse. The triage assessment involves a very quick story. Sometimes the patient is asked, sometimes it could be the parent, it could be the police—what is going on today? The triage nurse marks down a few points—whatever comes out of their mouth—then quickly assigns a code and generates a chart through the registration clerk, and that's the preliminary assessment [hospital text], which is to determine the acuity of the patient. Then a nurse either puts them in the waiting room or in a room inside. Essentially, the mental health room is just two bare walls and bare chairs that are weighted and there is a camera up high.

> *Bonnie*: So they are actually being watched via the camera?
>
> *Simon*: Yes.
>
> *Bonnie*: Observation yes. To go back to triage, triage is way of processing the patient, categorizing the patient as, "major" or "minor," determining where the patient is to be sent next?
>
> *Simon*: Absolutely. A nurse does an assessment in order to formulate an institutional intervention. So at the next stage, a nurse would do a secondary assessment. The form that guides the assessment is the Secondary Assessment Form [hospital text], and there is a small section on it for the psychosocial. And the psychosocial has tick boxes: Is the person cooperative? Are they anxious? Are they depressed? Are they hallucinating? Do they have suicidal ideation? And they are all tick/tick/ticks.

While at one time this was not so, progressively, with anything considered a "mental health complaint,' the person is automatically "channeled." That is, states nurse educator Simon Adam, "they're put into seclusion regardless of the specific nature of the complaint." Imagine a distraught person feeling anxious, feeling terribly alone, and you can begin to appreciate the horror of this. Indeed, imagine the woman that we just witnessed knocking on doors desperately trying to establish contact, frantically hunting for someone who can address a seemingly unrecognized world emergency, instead finding herself in seclusion, a camera overhead, a guard on the other side of the door.

Next comes the examination and assessment by the emergence assessment team, accomplished in typical bureaucratic fashion with the aid of tick box form (hospital text). This is a time when reports (hospital texts) are generated, potentially a diagnosis made (activation of DSM and related APA texts), frequently a global assessment of functioning rendered (via APA and APA-approved texts). The actual time spent with the patient to glean the data, estimates Adam, is about 20 minutes—and that 20 minutes, significantly, is populated with invasive questions, moreover, ones stemming almost solely from the activated texts (see last chapter for examples). Then the staff leave to complete their reports, while the "patient" remains in the room, essentially abandoned. Should the decision be to hold "the patient" for a "three day observation"—and everything to date has prepared for that decision—a Form One (boss text) is likewise filled out by the psychiatric resident, with that form, you will recall, likewise replicating a relevant section in the Mental Health Act (highest level boss text), likewise prompting the resident to view the patient a certain way. And it is here that a major transfer occurs.

The observation authorized by Form One (three days' worth) typically occurs in a psychiatric ward, with the patient duly transferred there (text-action sequence). During this time medication usually enters in. Within the space of those three days, the psychiatrist may fill out a Form Three (boss text/certificate of involuntary admission). Alternatively, he may admit voluntarily or release.

Where the person is seen as presenting an immediate problem, this entire process can be speeded up and additional methods of control built in. For example, irrespective of whether or not they came of their own accord, so long as it is recorded, the person may be placed in restraint almost instantly on entering the hospital. Waist restraints. Arm restraints. Restraints of the legs, pelvis, shoulders. Right in emergency, correspondingly, megadoses of psychiatric drugs are commonly introduced.

Likewise serving as restraint, "the goal of that sort of medication," explains Adam, "is to knock the patient out."

Albeit we have witnessed the use of quick interrogations to generate particular types of data (data that can be fit into the shells of boss texts), note, in this entire process, *no one has exactly been listened to*. Nor does the situation exactly improve. Observe, in this regard, this fairly typical exchange that I had with one elderly interviewee:

> *Steve*: I was in that room and no visiting at all. No doctor. I was very much depressed—from just staying in the room, except for going in for lunch, that was it. There was this Italian guy, he was locked into a room, and there is this glass window, and they keep looking in, and just keeping him there for days. Days. They lock him in the room, and he was half naked.
> *Bonnie*: Seclusion, yes. I am so sorry, Steve. That must have felt threatening.
> *Steve*: I was very very scared. I thought they might do to it to me. And I was very very lonely.
> *Bonnie*: So no one came and talked with you about, say, problems in your life?
> *Steve*: No, nothing.

Look closely, and what reveals itself is a modern-day brutality different than but of the same general archive of the brutality of bygone eras—brutality, in this case that is cosmeticized, medicalized, textually coordinated. To be clear, I am in no way denying that there are individual staff who are helpful, others who dearly wish they could be so. At its core, nonetheless, the hospital is a bureaucracy which mediates against sympathy, spontaneity, insight. With the wedding of the old brutality with rule by text, correspondingly, what is prioritized demonstrably is observation and control over help, prejudgment over discovery, proficiency over meaningfulness, process over people, the orderliness of paper over the messiness of real lives.

From Lockup to Lockup: Another Route into the Psycho-prison

One additional hospitalization route that I would note in passing is the forensic. At the discretion of the crown, a criminal case may be diverted into the mental health system (for details and analysis, see Pollock, 2009)—a situation that may or may not work to the advantage of the person charged. Alternatively, an individual charged with an offence may: (1) be deemed "unfit" to stand trial; or (2) be tried, found guilty, then plead and be found "not criminally responsible" (NCR). The first almost invariably creates what criminologist Julia Sudbury (2004) calls a "transcarceral" situation, where the patient/inmate hopelessly drifts between different types of lockup. The second may as well. Additionally, invariably, the second gives rise to a special kind of stigma and jeopardy. Correspondingly, both leave people at the mercy of the psychiatric system.

To zero in on NCR, and to quote interviewee and mental health lawyer Dan Brodsky:

> There is a huge stigma around NCR. And there is no way to remove it. When you are found NCR, you are subject to the Review Board. The Ontario Review Board are like innkeepers. They get to decide what room you get to stay at in the hotel, and whether

> you get day passes. Eventually, when they think that you are not a risk to the community, they can discharge you absolutely. What they cannot do is find that you are sane. (Research interview)

NCR is predicated among other things on the hegemonic belief that while prisons punish, mental hospitals help, minimally, that transfer into the psychiatric system is intrinsically humane—something, I suspect, that we would all like to believe. The NCR plea itself is typically a product of bad lawyering—a well-intended but naive lawyer who harbors such beliefs and may additionally be convinced that their "mentally ill" client would benefit from "treatment." Marginalized populations are in special jeopardy of ending up NCR, given how their way of life is conventionally viewed. The story of Leonard offers insight into how easy it is for members of marginalized populations to be found NCR and the both regrettable and predictable consequences of such a finding.

Leonard is a homeless man. One day he was urinating in someone's yard, and a woman noticed. Shortly thereafter, both of them boarded the same bus. The woman proceeded to tell the bus driver that Leonard had sexually assaulted her—perhaps a reaction to having seen his genitals. The bus driver immediately called the police, who put Leonard in a cell. Hours passed. By the time the police discovered the truth and came to release him, so furious had Leonard become that he spat on the officer. He was now charged with assault on a police office. He was tried and found guilty. On the advice of attorney, Leonard pleaded NCR. He thereby entered the psychiatric system. And here Leonard remained for many years—a prisoner of the psychiatric system, forced to take its treatments if he was ever to be released. All this, initially, because he urinated where he was not supposed to! (research interview data).

What is especially horrifying here, and what this case exemplifies, the plea of NCR transforms a sentence which has an end point (indeed one that may well involve nothing but "time served"), into an indefinite sentence. Moreover, it is an entry into and traps the person in the psychiatric system. This particular route "in," note, begins with someone presumptively committing a "transgression," perhaps an utterly innocuous one, as in Leonard's case, perhaps a direly serious one, often something in-between. It proceeds to a guilty finding, followed by the NCR designation. It ends with the patient/inmate escorted to the prescribed "hospital." And the door slams behind him.

Being an Inpatient: Treatment, Infantilization, Institutional Rule

Living inside the ward is to a significant degree a continuation of what we have already seen—aloneness, deprivation of freedom, redefinitions of the world, chemical and physical restraint, relentless intrusion into one's inner space, the imposition of uniformity. Inmates are moved in blocks—now for lunch, now to get their meds. If they "mess up"—and as Goffman (1961) points out, what constitutes "messing up" is solely at the staff's discretion—they may be given extra medication or placed in seclusion. They are continually asked intrusive questions, continually observable and observed. If key to this ruling are the boss texts, the most obvious manifestation of the ruling—and it is time to focus in on it—is the ever present "patient's chart."

The Patient's Chart

The longer the inmate's institutional history, the larger this chart becomes. Contained herein are forms, observation notes, assessments, evaluations, a great many of them populated by tick boxes. Just as the specific forms explored to date predispose the staff to see the "patient" in a certain way, progressively, the contents of the chart as a whole establish a narrative, a truth about the inmate—official reality. Indeed both because this is the case *and* in order to make it the case, the chart is constantly being activated. Nurse educator Simon Adam describes the chart's omnipresence and authority as follows:

> You don't interact with the patient without the chart. You don't. The chart is official. If you want to know something about the patient, go to the chart. (Research interview)

A common scene on a ward is a staff member talking to a patient, chart in hand. A common result is what Goffman (1961) calls a "looping effect." "Incidents" that the inmate thought were known to one staff only, to their dismay, are mysteriously thrown in their face by another, for all staff know about it by virtue of its inscription in the chart. As such, defeated is the compartmentalization on which we all depend—including one's ability to keep mistakes or personal foibles relatively hidden. What it is likewise critical to take in if you are to fathom the chart's significance, as discourse analysis demonstrates, it is not *reality* that is recorded, but *selective reality*, moreover *a particular view of reality*, that itself constructs reality.

Indeed, a careful scrutiny of such charts—and I analyzed 16—reveals a specific kind of emphasis, a selection principle as it were. Everything that the inmate does that might be seen as backsliding or undesirable is prioritized. With context typically absent, additionally, "bad" actions are constructed as personal qualities. For example, D's (interviewee) chart states that he threw a chair. We know *what* he threw, *when* he threw it. However, not a word is recorded about what happened that frustrated him so—an omission, significantly, which makes aggressive institutional "responses" seem "necessary." Curiously, even phenomena so common as to be innocuous are given the appearance of a disorder. Note, in this regard, the following descriptor in R.S.'s file—"this elderly bespectacled patient." How is this phrase different from the seemingly equivalent one, "This elderly man, who wears glasses"? Primarily this—the latter does not connote anything amiss. Use of "bespectacled" serves to at once distance the staff/subject from the patient/object and contribute to the sense of disorder.

Often, indeed, even what would normally seem a good quality is constructed as a problem. Note the following passage in D.W.'s chart (hospital chart): "He is obsessed with the idea that his life has been too soft . . . When discussing any object or philosophical concept he feels compelled to discuss it in a very exhaustive manner, considering it from all sides, weighing the pros and cons." The word "obsessed" instructs other professionals to see his focus as unfortunate, albeit all that might be happening here is a middle class young white man becoming aware of his own political privilege. By the same token, linking up with "obsessed" in the first sentence, the term "compel" in the second makes the youth's conceptual thoroughness appear involuntary and negative—indeed like an obsession, albeit rigorously considering issues from "all sides," and "weighing the pros and the cons" is the hallmark of an intellectual. Thereby, a way of being normally construed as desirable becomes something for which treatment might be sought, something "actionable."

By these devices more generally a "disability narrative" is generated. Permeating such narratives, correspondingly, is a master narrative that runs through most all charts. That narrative goes roughly as follows: The patient has an disorder that grew steadily worse until properly diagnosed. It is hereditary, with various family members similarly afflicted (recall Kevin's files). The patient will always have the disorder but his condition can be controlled if he would only be "treatment compliant."

Correcting, Controlling

The object of hospitalization is to correct or keep in check what is seen as wrong. In practice that means discouraging certain behavior, encouraging other. A good part of the inmate's life inside, correspondingly, is being told what to think and do, moreover, being rewarded for good behavior (called getting "privileges") and punished for bad (sometimes called "sanctions," sometimes called "treatment"). In essence, the inmate is being treated like a child, generally a recalcitrant one, with the institution as all-knowing parent. Indeed, even when one has not ostensibly broken any rules, being talked to as if you were a child is an intrinsic part of the daily reality of inmate life. "Stop it right now. You don't have to raise your voice," stated a nurse to a woman who was in no way yelling. "No more ground privileges for you," states a doctor to a man who had simply shaken his head (data directly observed by researcher). This dynamic, of course, is heightened where the inmate *actually is a child*.

If the essence of hospitalization is imposing control on the person seen as out of control—and since Goffman (1961), that has been a sociological "given"—at this juncture nothing is more central to that control than the treatments themselves.

Treatment—the Law, the Actuality: The Myth of Informed Consent

Most everyone on the inside is administered treatment—a frightening reality given the truth about the treatments already in evidence. Technically, protection is provided by virtue of the consent criteria in the HCCA (see beginning of this chapter). Note, the "incapable" person or their substitute decision-maker may refuse the treatment. Moreover, consent must be informed—that is, states the act, the person must be told:

1. *The nature of the treatment*
2. *The expected benefits of the treatment*
3. *The material risks of the treatment*
4. *The material side effect of the treatment*
5. *Alternative courses of action*
6. *The consequences of not having the action.* (HCCA. s. 12, 3)

Given what is on the face of it good criteria, the question arises: how is it that most everyone on the inside is on such demonstrably harmful "treatments"? There are several answers to this question.

The first relates to the problematic conceptualization of capacity. As already noted, it is defined in such a way that the person who sees a treatment as unacceptable is at the bare minimum in enormous jeopardy of being "found" incapable (more on this issue later). A related problem is the current conflation between involuntary admission and incapacity. More fundamental still—and it is time to tackle this—is the proverbial "elephant in the room"—the quality and quantity of the "information" provided.

We have already seen how flawed the official claims about the treatments are, beginning with the research underpinning them. Insofar as people are given "information," predictably, it is precisely the *misinformation that we have seen manufactured* (see Chapter Three)—for that is official. Moreover, as interviewee after interviewee observed, generally, but slim "information" is provided. To wit:

> *Bonnie*: What did the psychiatrist tell you about the ECT?
> *Mel*: Just that it is good for me.
> *Bonnie*: Were they any more specific? Did they go through any benefits and risks?
> *Mel*: No. Just take the electroshock, he said, and you'll feel better. (Interview data)

Correspondingly, being offered no alternative (violation of criterion 5) is not unusual. A case in point:

> *Bonnie*: You are saying that was the only treatment offered?
> *Steve*: That's right.
> *Becca*: So daddy, no one suggested any form of talk therapy?
> *Steve*: No.
> *Bonnie*: Or psychiatric drugs?
> *Steve*: Absolutely nothing but ECT was offered.

By the same token, in the extensive four-day-long public hearings into psychiatric treatments held in Toronto City Hall in 2005, overwhelmingly, recipients testified that they were told virtually nothing. They were simply advised that their prognosis would be poor otherwise, in some cases, with information about the diagnosis similarly withheld (for the testimony in question, see Inquiry into Psychiatry, 2005). Note Tim's story:

Tim's father was killed by a drunk driver. Overwhelmed, Tim was admitted to a psychiatric facility. There he was diagnosed with PTSD and placed on a medley of psychiatric drugs. At the time, he was totally compliant. Upon getting out, he remained compliant. He proceeded about his life, slipping in and out of hospitals. With significant complications later arising, he subsequently laid charges and demanded and received a copy of what proved to be a very telling report. "Then and only then," observes Tim:

> did I realize that I was actually diagnosed with schizophrenia. Now I disagreed with the diagnosis. Nonetheless at no time was I told of this second diagnosis. The

> doctor who diagnosed me with that told me that I was being medicated for post-traumatic stress disorder. He didn't inform me at any time that those drugs had a "withdrawal"... Because he chose not to inform me, at no time was my treatment consensual... There's no one to watch the doctors. There is no one to force them to inform anything and because they hold the level of credibility they do, there is no one to challenge them. (Inquiry into Psychiatry, 2005, Psychiatric Drugs, tape 1b, p. 24)

Tim's words shed further light on how people "choose" to take the "treatment" proffered. Factor in an inherently coercive environment where people are scared to appear noncompliant, where additionally, they cannot keep up what is being thrown at them (or are too exhausted or confused by the psychiatric drugs currently on to make sense of anything presented to them), and you begin to get a picture of how consent comes about.

Finally, I would factor in the elusive but formidable institutional ethnography dimension. Consider in this regard the following clause in CAMH's ECT Consent Form (which a prospective recipient is asked to sign): "The nature of the procedure, its risks and benefits and those of alternative available treatments have been explained to me by Dr.________________ and I understand them. All of my questions regarding this procedure have been answered" (Centre for Addictions and Mental Health, n.d.). On the face of it, such clauses are exactly what we might hope for—something that reassures us that all necessary care is being taken. That, however, is to confuse "avowed intention" with "institutional function." The point is, by mirroring, even exceeding the HCCA requirement, this form effectively turns the giving of the mandated information into a legal fact. Whatever your intention, successfully induce a "patient" to sign this form and by definition, she has been "adequately informed." Sign this form, additionally, and a sequence of institutional events begin to unfold: The nurse slips it into the chart, the doctor orders an assistant to schedule the procedure, and the treatment date is set. Question: Has the patient truly received the extensive information mandated? Significantly, asking such a question is not part of protocol. That understood, were one concerned, one obvious safeguard would be replicating the information on the form itself. Significantly, not only is the information as a whole not replicated therein, nowhere on this form does one find *any* concrete information—not even a single instance of a "risk." In IE terms, the words are empty shells. The fact that the "patient" signs such statements is itself an indicator of how institutionalized patients become. Not surprisingly, several interviewees who spoke of the dearth of information had signed forms precisely like this.

While some jurisdiction are a bit better, some worse, essentially, such is consent as it plays out institutionally—demonstrably, a manufactured product. Everyone does their job, and in the process, what is typically a hollow "informed consent" is "accomplished."

The Drugs

If ultimately, the hospital is about seizing control over the "deranged" mind, at this point in time there is one primary means—psychopharmacology. Whether they are medicated for the avowed purpose of stabilizing them or for what is known as "maintenance," navigating their way about in a drugged stupor or semi-stupor is the inmate's daily reality. Watch carefully, moreover, and you will see evidence of the drug imperative right from the start. Why was the person involuntarily confined? Typically, failure to "take their meds." What commonly befalls the distressed or distressing person even before they are formally committed? Chemical restraints. What happens afterward?: First they are "stabilized," which in the case of those seen as psychotic means being knocked out by a cocktail of different drugs. Then what is considered the correct "maintenance" or "therapeutic dose" is "found." The point is, however it is theorized, drugging in one form or another is a constant. Correspondingly, whether they be called "restraint" or "treatment," as substances which impede people's ability to think, feel, act, these drugs constitute a form of incarceration in their own right.[10] Just as the police seize upon the inmate, drag them to hospital, and just as the hospital confines, the drugs seize upon the nerves (you will recall, this is the *literal meaning* of "neuroleptic"); they place the brain into forced detention. Indeed, the purpose of modern psychiatric facilities is precisely to ensure that those mental bars are secure, after which the patient can be released—hence the comparative brevity of current hospital stays (true with civil commitment only).

Contrasting hospitalization under civil law in the late 1970s with hospitalization now, veteran Irit Shimrat offers this window onto current practice:

> *Bonnie*: So you had all these experiences in different jurisdictions and times. What do you think is different about the late 70s and now? Both positive and negative?
>
> *Irit*: What could be seen as a positive change is that they don't keep you for eight months or a year. Aside from that, I think, everything else is worse.
>
> *Bonnie*: What comes to mind when you say it has gotten worse?
>
> *Irit*: The primary thing that comes to mind right away is polypharmacy. In 1978, at Branson Hospital, I was given Haldol—and *all I was given* was Haldol (besides the Cogentin given for side effects). During my second incarceration, at Mount Sinai, I was given Nozinan and then, after that was discontinued, Stelazine. And of course the Cogentin. And *that's all.* And I was actually completely off the neuroleptics when they released me from Mount Sinai.
>
> *Bonnie*: That wouldn't happen today.
>
> *Irit*: Definitely not.
>
> *Bonnie*: How many drugs were you put on when incarcerated in later life, say that occasion that you mentioned previously?
>
> *Irit*: It was two neuroleptics at once—and that's very common now to have people on two or more—the side-effect drug (which, as you know, has its own bad effects), a "mood stabilizer," and a minor tranquilizer—so that's five. At various times in my later incarcerations I was also given Zopiclone, which is classed as a hypnotic, but which I just found out is also a benzodiazepine [same class of minor tranquilizers as valium]. So that's *six* drugs. Including two neuroleptics and two benzos *at once.* (Research interview)

Coupled with polypharmacy, reveals Irit, is the staggering dosage of drugs, especially at the beginning and especially with people brought in by police—a calculated move that translates into the inmate losing consciousness:

> Irit: Even though I was brought in forcibly in 1978 and 1979, I wasn't knocked unconscious for the first few days. That did happen with subsequent incarcerations.

> For the first seven or eight days, I wasn't there. When I would first become conscious, those earlier days would be a complete blank. And I would come to in solitary confinement.

Irit goes on to describe the modern ward as a place where everyone is on huge dosages of multiple drugs, where children stagger about, "fall down on the floor from lithium."[11]

This rampant drugging—this is the current reality of life on the ward. And it is precisely this that psychiatry is calling "progress."

Getting Out: "Passing," CTOs, Etc.

If appearing out of control lands one inside, looking like one is "in control" or "under control" is the route to getting out. That means not "messing up." For the most part, this means no longer being committable involuntarily—that is, no longer striking the doctor as being of danger to self or other or unable to care for oneself. How is this achieved? Some have little trouble, whether because they are now duly subdue(d) or they have temporarily benefited from a "time-out," or because triage has happened and beds are needed. By contrast, many of my interviewees speak of having to watch themselves at all times, trying to curb the "madness." Even more speak of faking it, of "passing as normal," as Mills (2014) puts it. What is particularly important—and one's attitude to the drugs is so pivotal that you can virtually trace an inmate's progress through the system with reference to it—it is imperative to look like you have "insight into your illness" (translation: "appreciate" the need to take your meds), as their attorneys are well aware. Witness in this regard these words by lawyer Dan Brodsky:

> What I tell my clients is that there's legal advice and there's medical advice. Medical advice? Don't take any medication because there's nothing wrong with you, but I am not a doctor. I am a lawyer. And the lawyer in me says, "Look, you want to get out of the hospital? Tell the doctor he is wonderful and take the medication, tell the doctor you're getting better, and wait for him to open the door—because he will." (Interview)

Those unable to pull this off convincingly are likely to linger longer. Then there is conditional release—something long utilized in the criminal justice system and progressively employed with the civilly detained. This brings us back to the Community Treatment Order or CTO (called "Outpatient Commitment" in the United States; see Chapter Four).[12]

Section 33.1 (3) of the MHA stipulates that a physician may issue a CTO if the criteria spelt out in Section 33.1 (4) are satisfied. In a nutshell, these are that within the last three years, a patient *either* has been an inpatient on two occasions *or* has for at least 30 days *or* has been on a CTO; the physician has examined the patient in the last three days; the person is suffering from a mental disorder such that in the absence of the care spelt out in the Community Treatment Plan (CTP) they would be committable involuntarily. Additionally, they must be seen as able to comply with the accompanying treatment plan; and the necessary services in the community must be available.

As with other sections in the MHA, the CTO section licenses others to intervene in the person's life—for example, for the police to forcefully bring them to a doctor for examination if there is reason to believe that they are not complying with the treatment plan. By the same token, as with sections previously examined, parts of this section are replicated in a series of forms which likewise assemble armies of "helpers," likewise involve tailored "choices," likewise can be readily activated (e.g., Form 45, the Community Treatment Order itself; Form 47, Order for Examination). As so it is that textually mediated ruling continues—tick boxes and all.

Significantly, as long as the criteria are deemed to be met—and once again this is in the eyes of the doctor—the CTO can be renewed *indefinitely*. Not surprisingly, additionally, as Fabris's (2011) research indicates, the accompanying treatment plan routinely has as one of its stipulations ongoing medication.

An observation: Understandably, the reader may be thinking that CTO release is at least preferable to staying in—the "committable" person's fate otherwise. That noted, I would ask you to consider this: (1) Committability is not a fact but an institutional creation—and who is to say whether in the absence of the CTO phenomena, the person in question might not be released outright?; (2) While being on a CTO may well be preferable in the short run, in the long, it sets up a situation where being subject to ongoing control is the new norm. (3) The CTO as a phenomenon demonstrably serves the institutional purpose of extending psychiatric rule into the community.

Life after Release

Upon release, inmates are generally in rough shape and a precarious position. As Fabris's (2011) riveting accounts draw home, second by second, they may be monitoring themselves, terrified of landing back in, perhaps repeating the mantra taught them, "I am a schizophrenic." To varying degrees, those who had been confined against their will are struggling with the profound trauma of having been stripped of freedom and subjected to daily indignity. In contrast with the popular belief that psychiatrization saves lives, themes arising from my interviews indicate that many are so devastated that they contemplate killing themselves should it ever look as if the institution is about to get hold of them again. "It is not that I am suicidal," states Li, "but being subjected to that horror again—staff tackling me, that drugged haze—I mean, how could I face that again?" Another common theme is being financially stretched, with those most targeted by the institution—women, people of color, youth, street people, sex workers, the trans population—particularly likely to be destitute. Added to their former difficulties, to be clear, are the multiple problems institutionally caused (e.g., being poor(er), no longer believing in oneself, iatrogenic brain damage, being so strung out on drugs that one cannot think). What goes along with this, upon release many find themselves desperately in need of assistance (automatically reconfigured by the institution as "services"). Herein lies the hook, for generally the "assistance" provided promotes dependence over interdependence, and even where valuable—and for sure some are—as part of a coordinated system, they overtly or covertly hook the person into the system as a whole.

Socialized to do so, some inmates accept all "services" offered, indeed may want and even need more of the available services than the system is willing to grant them (a different kind of problem); they may live two blocks from hospital, attend group, see their psychiatrist weekly, accept the intrusion of the Assertive Action Team—essentially live the life of a "mentally ill person." Others want only *certain kinds* of services, maybe only one service. If it is counseling, the rub is a growing percentage of counselors are now obliged to use psychiatric concepts, together with tick box forms. With the advent of case management, more currently of the "linked model" (you do not get lodging, for instance, unless you accept the whole package), moreover, even the person diligently trying to keep the system at bay and who is seeking nothing but lodgings can thereby be edged back into the system. To quote longtime peer worker and agency director Lana Frado with respect to the "linked model," for instance: "With the linked model, there is a conflict of interest. The agency rep, they are standing right there with your lease in one hand, and whatever "services" you have agreed to in the other. They are both the landlord and the service provider, right?" (interview). Many survivors drift in and out of hospital for decades. Over time, a number break loose, quietly wean themselves off the drugs, disappear into society (see Fabris, 2011). Whether they "just get by" or thrive, all are forced to live with the enduring harm that has been done them (see Chapters Seven and Eight). Moreover, to varying degrees, all remain vulnerable to the system.

On the Community Treatment Order

Of those "released," few are subject to more stringent wraparound control than the inmate on the Community Treatment Order (CTO), for that person remains a detainee—essentially, property of the hospital. Significantly, as Fabris (2011) demonstrates, the Community Treatment Plan (CTP) typically controls multiple aspects of the detainee's life. Take Lorna (interviewee), for instance.

The CTP to which Lorna is subject (a 43-year-old Black woman diagnosed as "schizophrenic") stipulates: (a) meeting with a member of her Assertive Action Team three times a week; (b) turning up to her weekly appointment with her psychiatrist; (c) regularly taking her neuroleptics—(drugs, note, proven to be harmful); (d) not smoking; and (e) being home each night before 11:00 p.m. Additionally, despite the fact that she finds him overbearing, it stipulates living with her brother. Of this, note, she says: "We never got along; and I am sick to death of him, but what choice do I have? You know," she went on: "Sometimes I dream I'm on a ship and am traveling to a distant land. My big escape, right? Then I wake up and remember that I can't go anywhere. And you know, he's always watching me. I know that sounds paranoid, but it isn't. And for fuck's sake, I'm 43 already, right?" (interview data). As might be intuited from this, CTOs commonly place power over the detainee in the hands of a family member. Irrespective of whether this measure is welcome by all parties, some, or none, herein lies a heretofore unprecedented level of institutional capture. By inserting the family into CTOs, the system catches in the institutional net not only the inmate but the family member in whom it vests authority, for all intents and purposes, "deputizing" him or her. As such, it enables psychiatry to colonize the family, turns the family into the eyes and ears of the doctor, and, in the process, it once maximizes inequality, thwarts authentic relating, and further compromises what may already be fraught family relations.[13]

These "Plans," significantly, have teeth. Deviate from the Plan—even be suspected of deviating from it—and you can be "formed." The point is, whether you are compliant or resisting, you are forced to live under constant threat. While this threat is implicit, I would add, just as Pinel warned inmates that they can be clamped back in chains if they "misbehave" (see Chapter Two), doctors today similarly leverage the threat implicit in the CTO. Note, in this regard, these words by a Toronto doctor: "She hates the medication. So what do I do? . . . Use the CTO as a bit of a harness for her. So she'll skip doses once or twice a week, and then we just raise the scepter [specter?] of the CTO and she gets back on" (quoted from Fabris, 2011, p. 162). Behind the tactic is the FORM (Forms 45 and 1). Behind the form is the POLICE. And in back of it all looms THE HOSPITAL.

An addendum: Officially, CTOs result in "patient improvement" (see Fabris, 2011). In point of fact, effectiveness studies are inconclusive; moreover, they are hopelessly circular, with, for example, progress used to justify forced "compliance" and compliance in turn serving as indicator of progress (for details, see O'Brien and Farrell, 2005).

One Additional Piece of Governance

A final and very important piece of governance that it is crucial to examine are the "counter-balancing" judicial or quasi-judicial ones—that is, the very processes intended to keep a check on psychiatric rule. Every system involving such deprivations of freedom necessarily provides a route whereby an individual may challenge what is happening to them. Given the enormous infringement on liberty, how could it be otherwise? Americans largely use the court system. While courts enter into the Ontario system, the Ontario system is based on administrative tribunals. The question here is not so much whether the routes are adequate—though as shall shortly be obvious, they are demonstrably not. Nor is it so much whether or not the various players are competently doing their job, which, with exceptions, they are. Indeed, most of those that I encountered were both capable and "conscientious." The issue rather is one of governance. What will be demonstrated in this leg of the institutional ethnography journey is the ways in which these governmental instruments are themselves fashioned by and implicated in psychiatric rule.

The Tribunals: A Brief Overview, the Statistics, the Question

In Ontario (the situation is parallel in other Canadian provinces), there are two different tribunals with jurisdiction over the "mentally disordered." One, the Consent and Capacity Board (CCB), is civil and falls under general health and mental health legislation. The other, the Ontario Review Board (ORB), falls under the criminal code and applies to people found not criminally responsible or unfit to stand trial. In both cases: (a) appeals can be made to the courts; (b) panel members are drawn from a working group appointed by the provincial cabinet; (c) panels are chaired by members of the legal profession; (d) hearings occur at the hospital where the detainee resides (ORB hearings are also commonly held in court rooms). Correspondingly, in both, the legal and the psychiatric professions are dominant, with a full CCB panel, additionally, having a community member.

In the ORB system, the first panel before which the "accused" appears makes the initial disposition—whether the person is to be discharged or not, where s/he is to be kept and under what conditions. A system geared for long-term maintenance, dispositions are reviewed only every 12 months. This is the moment when the entire package of constrictions is reviewed. By contrast, civil hearings are highly specific and more frequent. Typically, they are predicated on a recent "finding" of involuntary status or incapacity, both of which the inmate has the option to contest. The typical pattern is: A certificate of Involuntary Admission (Form 3) or Certificate of Renewal (Form 4) is issued and/or the person is "found" incapable. The inmate is duly informed; a rights advisor explains the right to contest; and the inmate either contests or does not.[14]

What are the inmate's chances of prevailing? To their enormous frustration—for who wants to be controlled forever?—the sense of almost all the inmates whom I interviewed was that losing was more or less automatic. Insofar as this perception is correct—and here we touch on a fundamental issue—again, the entire system is called into question. Inmates, I would add, are hardly alone in this perception. Note in this regard the following comments by longtime defense attorney Dan Brodsky:

> There is a huge turnover of lawyers who appear before the Review Board. How come? One of my colleagues Paul B. put it this way. "Why would you want to practice before the Review Board, Dan?" "What do you mean, Paul?" I asked. "Well, you almost always lose, and when you win, the Crown appeals and *then* you lose. So why would you want to work in a system where you always lose?" (Research interview)

What exactly do statistics tell us? Figures by researcher Philip Taucher (email, November 12, 2012), indicate that in 2010–2011, someone appearing before the Ontario Review Board was 17.26 times more likely to be "conditionally" discharged or not discharged than *absolutely discharged*. In that same period, only 2 out of 24 court appeals led to absolute discharge (less than 1 in 10). Worrisome figures especially when you consider that few of these are *new* inmates but rather are *inmates that have already been held for, say, two, ten, twenty, thirty years*.

A clearer picture may be formed of the CCB, for in line with my request, numbers have been carefully categorized.[15] In 2011: (a) 10 percent of involuntary confinement reviews resulted in the certificate being rescinded; and (b) 5 percent of treatment incapacity reviews resulted in the finding being overturned (personal email from CCB registrar, October 24, 2012). Essentially what this means is that a detainee contesting the finding of involuntary confinement has but one chance in ten; moreover, someone contesting a finding of incapacity with regards treatment has but half of that (a difference which in itself suggests that keeping people on their drugs is paramount).

Losing, clearly, is not automatic. Nonetheless, it is so close that it is hardly a mystery why it is so viewed. What adds to the seriousness, these already tiny percentages would be considerably smaller were it not for the inclusion of inmates winning on technicalities—a form not filled out properly or not delivered at the appropriate time. As pointed out in Hiltz and Szigeti (2011) and as my observations of hearings confirm, where inmates do prevail, that is typically the reason. What adds to a conundrum that is becoming progressively evident, as confirmed by my interviewees who are attorneys as well as by direct observation, where a detainee wins on a technicality, say, on an "involuntary" certificate, commonly, for example, they stay "voluntarily." Why? Otherwise the expectable next step is for the inmate to be "re-formed." In other words, to echo attorney Paul B., even when you win, you lose.

The inevitable IE question is: Given that the "rulings" behind these statistics do not "occur naturally" but are rather a product of a system, precisely how does the system function so as to produce results such as these?

Focusing in on the Consent and Capacity Board

To focus in at this juncture on the board most central to this inquiry, technically, the CCB process seems like perfection—even-handed and transparent. Hearings happen in a very timely fashion. The model is: more or less at the time designated, the chair declares the hearing open and welcomes everyone. Following that, the chair explains the issues being considered, clarifying additionally that the onus is on the doctor to prove his case. Unless a preliminary matter intervenes, what follows is itemization of the documentary evidence (the exhibits). Then presentations and cross-examination begin. The doctor presents evidence why a finding of involuntary or of incapacity should be upheld. The detainee's lawyer has the chance to cross-examine, as do panel members. Both sides may call witnesses, with the cross-examination of each happening similarly. Correspondingly, the detainee is allowed to make a statement. On the face of it, a model process.

Set foot in these proceedings, however, and you will quickly discover that they seldom play out this way. One unproblematic reason why is that commonly a technicality intercedes. That is, the lawyer for the detainee introduces a technical matter, such that if deemed correct and serious enough (beyond a typo), the determination in question must be quashed. Another factor equally capable of shifting what happens—and here we begin to get a glimpse of the reality that the inmate is facing—the lawyer for the detainee, the detainee, and doctor are talking (I have seen hearings delayed for close to an hour while this serious last minute ritual unfolds). When they return, commonly, they have reached a compromise, leading to the withdrawal of the motion. When this occurs, chairs habitually frame this as an admirable outcome. "Here we see the process working at its very best," stated one chair. What this construction obscures is that no decision by the psychiatrist has been quashed and typically, the outcome is a far cry from what the detainee wanted—in the case of one of the hearings that I attended, for example, the detainee was still held involuntarily, was still "incapable," was still on the drug that she found objectionable, though the doctor agreed to lower the dose. So why would a lawyer resort to and advise the client to accept such a deal? Explained one lawyer (interviewee) following one such negotiated agreement—a deal I would add, that she worked very hard to get—"I took one look at the panel and I knew that my client did not stand a chance." A good outcome, in other words, but *only* *under the circumstances*. Two other common occurrences that similarly disrupt the simple narrative are: (1) the detainee on their own accord withdraws their application at the last minute and (2) something has happened to the detainee, necessitating a postponement.

What follows are examples of these last two points. I introduce these, note, not so much to probe issues of adjournment or cancelation per se—but as a window onto larger issues.

The Case of the Drugged Client: Window onto How the Inmate Is Made to Appear

Research exhibit: An excerpt from my observation notes on a hearing (public) which I attended on October 25, 2012:

> 10:00 o'clock: Lawyer R states that the hearing may not be able to proceed because there had been an "incident." [Speculative note: As researcher, I am concerned by the word "incident," for it is a shell term which invites the panel to suspect the worst. I am getting the sense however, that there is no choice, that this is the term which the institution uses.] R further states because of the incident, a couple of hours ago, the doctor medicated his client, that he is not questioning the doctor's treatment but his client may be too sedated for the hearing to proceed at this time, that we will have to wait and see if he recovers sufficiently. We wait. Approximately 10:30, a young Black man, ostensibly, the detainee, appears. He is wheeled in by two security guards. He is placed in a chair. He is demonstrably unable to walk or speak, appears to be drifting in and out of consciousness. He sits there slumped over with his head down. At no time does he register any awareness of where he is or open his eyes. At the lawyer's instigation, the hearing is adjourned and the date for a new hearing set.

To be clear, R is a first-rate lawyer and he did exactly what he needed to. That understood, what does this "non-event" tell us? It is a reminder that minimally right up to the moment of the hearing, the doctor is "calling the shots." While one may initially think this acceptable given that the "patient" is "under his care," I remind the reader that the doctor is the opposing party in a legal proceeding. Albeit I am not questioning the institution's need to attend to disturbances, look at what has happened here—contrary to normal practices of jurisprudence, the adversary in a legal proceeding is able to drug the complainant. Among other things, this turn of events unmistakably marks the situation as first and foremost "clinical," with drugging to the point of oblivion also so identified, and with the doctor as arbiter. In the process, the doctor emerges as authoritative helper and the inmate as in need of control. Nor are the other effects of this action minimal. What if the young man had revived just enough to be able to utter a few semi-coherent words? The hearing would have proceeded. In what universe, however, could we say that the young man is able to comport himself as well as someone not reduced to a drug stupor?

This example writes large a more general dynamic. "Incident" or no incident, typically just prior to a hearing, the inmate's "medication" dosage is raised—

moreover, appreciably so. Note in this regard this revelation by defense lawyer Dan Brodsky:

> *Brodsky*: The hospital will *not* say that we drug people to make them docile at the board hearing. What they *will say* is that the board process is very stressful. And so they increase the medication before the hearing.
> *Burstow*: So as a lawyer who represents people at such hearings, you are telling me that they actually do it? They actually increase the medication before the hearing?
> *Brodsky*: Over and over again.

Indeed in the majority of cases that I observed, so drugged were inmates that they arrived slurring their words and staggering. One interviewee—Mel—provides us with this insider view:

> I was totally drugged. They sat me down. I put my head on the table and I didn't hear a word that they were saying; I just cried and cried and cried; and all I was thinking was: God help me. God help me. God help me. God help me.

Even where the drugging is not this extreme, the point is that extra drugging is standard. Whatever the intention, one consequence is that panels become so accustomed to seeing inmates in such altered states, it becomes easy for them to associate the confused state of the "patient" with the supposed "illnesses." To put this another way, the institutionally created appearances bolster the doctors' case precisely by making the detainee seem like as a poor candidate for release, indeed, for any manner of freedom.

Other common institutional dynamics that likewise construct the detainee as highly problematic right from start are: bringing them to the hearing in shackles, the presence of guards that never leave their side, holding the hearing in the hallway just outside the seclusion room in which the person is being held (with the inmate's testimony audible through the open door). In this last regard, a CCB chair explained, "If someone is being held in seclusion, we can't say, 'That person must come out of seclusion.' That's up to the doctor—a clinical judgment. But we can proceed" (interview data). Transparently, the explanation itself is at once a product of and reinforces institutional rule.

Last Minute Decision to Withdraw: A Window onto the Lawyering

My second example of a dramatic early shift comes from another hearing that "did not happen." Witness the following section from my observation notes (for reasons of confidentiality, time and place specifications have been eliminated):

> Persons present: the three panel members, the recorder, the Lawyer L, an as yet unidentified man, two observers (myself and my research assistant.) The case concerns J.P., a young man contesting a finding of involuntary admission. J.P.'s lawyer—L—keeps coming in and out of the room with said unidentified man noted above, the two of them exchanging smiles. After a while L states J.P. may not wish to attend, moreover, that when she spoke with her client earlier this morning, he

> indicated that he wishes to withdraw. However, she had better make one final check for "he changes his mind every five minutes" (verbatim recording). It now becomes clear that the unidentified man with whom L is friendly is the treating psychiatrist. The psychiatrist says he personally checked back in with J.P. in the last couple of minutes and his patient definitely does not wish to proceed. L nods and announces that her client is longer seeking a review. The chair pronounces review terminated. Addendum: The deliberations at an end, I ask the lawyer why she thinks that people withdraw like that at the last minute. She states, "young psychotics like my client" (verbatim) seldom withdraw. However, that her guess is that "with the medication beginning to have an effect, people start to have insight into their illness." (Verbatim)

We have no way of knowing what was going on with J.P., albeit like many an inmate, he may well have been intimidated by the very thought of the hearing. What these notes do uncover is worrisome lawyer dynamics. Question: How can it not undermine one's client to tell the body in whose hands his fate lay that he "changes his mind every five minutes?" How can someone represent their client if they so buy into the system that they view their own client as "a young psychotic" pure and simple? If they quietly believe that without drugs, he does not "have insight into his illness"? If they treat the psychiatrist as a coworker and accept at face-value his assessment of the client's legal wishes? What we have here is an attorney operating out of psychiatric hegemony in a way that could easily have ended up detrimental to her client.

To be clear, there are truly exceptional mental health lawyers who function as a knowledgeable and "fearless advocate for what the client wants" (interview with Anne R). This notwithstanding, historically, there have always been mental health lawyers who largely identify with the psychiatrist or adversary. What further complicates representation, however capable the lawyer, the practices in which they necessarily engage are themselves a slippery slope. Note, getting on good terms with the psychiatrist tends to be a "must," for likely their clients' daily existence will continue to depend on him/her—and yet that way danger lay—getting co-opted, succumbing to "institutional think."

A very different type of difficulty which likewise complicates mental health lawyering—a factor once again that is institutionally created—are problems arising from the funding system itself. With most inmates poor, their representation is generally funded by Legal Aid; and Legal Aid covers alarmingly few hours of preparation time. To quote lawyer and interviewee Anita Szigeti in this respect: "In the Ontario Review process, you get ten hours before your first day of hearing and eight hours before the second day, and after that, no more preparation time. With the CCB, you get up to 13 hours before the first day and 2 hours between every day of hearing after that" (interview data). Consider the literally hundreds of pages of hospital files to peruse, the need to scrutinize all forms, possibly, arrange for an independent assessment, the importance of networking with the doctor—and you begin to get a picture of how tragically inadequate these hours are. Indeed, given such sparse coverage, necessarily, one of two things happens: (1) the lawyer is forced to put in dozens of hours for which they receive no compensation (and to their enormous credit, some do); or (2) the client is represented by a lawyer who in the final analysis is ill prepared.

And Psychiatry Reigns and the Circularity Continues

The prioritizing of the doctor and of "institutional knowledge" becomes increasingly clear as the hearing unfolds. Technically, the onus is on the doctor to prove his case. The reality is that the credibility, the momentum, the foundational underpinning lie squarely with the doctor. Significantly, the doctor writes the summary report that the panel peruses before commencing. Typically, moreover, the doctor begins. And drawing on the governmental boss texts (the Mental Health Act and/or the Health Care Consent Act), and using all the apparatus at his disposal—the DSM, reams of written observation—the doctor sets the frame. Herein lies the "evidence" that everyone else is forced to address. Brodsky describes the game-shifting dynamic evident here, as follows:

> The way they get around onus is to say: Of course we have the burden of proof. So we'll start the hearing. The doctor will say, here's why the person is dangerous or whatever. And the tribunal will say, well, it is clear that the doctor has the onus but it has now shifted because of what the doctor has said, and it up to you to disprove it. (Interview data)

What is the doctor's proof? Interpretations of actions observed directly, or once or twice removed. With the mental health legislation and professional texts as always acting as shells into which incidents in the person's life are inserted, once again the psychiatrist acts as the text's agent, turning subjective observation into fact while squeezing it into the relevant criteria. Overwhelmingly, evidence takes the form of various paper "exhibits" on which the doctor draws, weaving them together into a compelling clinical narrative. And what are those exhibits? Significantly, the very documents whose problematic nature have been demonstrated throughout this book—summary reports, diagnostic assessments, completed mental health forms, observation notes, global assessment of functioning, choice selections from the case file. This is now THE CASE, which the psychiatrist can further support by calling live witnesses and which everyone else is forced to address. Given this circularity, for all intents and purposes, as long as the psychiatrist demonstrates that he knows the relevant criteria, more generally, as long as all bases are seen to be covered, the hospital prevails.

Where is the tribunal in all of this? They are safeguarding the integrity of the process. They are weighing the "evidence." Likewise serving the master texts, and likewise an agent of the state, their work follows the doctor's like a magnet. In the end, it boils down to this: Has the doctor followed the proper processes? Activated the right text? Ticked relevant boxes? Exactly how mechanical this process is, how nicely it fits into the circularity may be gleaned from these words of a senior CCB lawyer (chair): "We don't assess at any point. We don't do a second opinion. I am certainly not trained to do that. We hear the evidence that the doctor gives and decide whether he has told us enough to convince us that the process is correct and the finding is established" (research interview). All CCB representatives with whom I have talked take pride in the system. Well intended, all try to treat the detainee respectfully. All likewise feel that the various panels diligently do the job set them. For the most part, indeed, they do—however, *that is precisely how the statistics witnessed earlier come about*. The point is, however separate technically, they are part of the same system, their words, part of the same archive—and however it is named, justice is procedural, not substantive. Inherently institutional, their job *is precisely* to line up the texts, to make sure all the "I"s are dotted, and insofar as they are, to rule in accordance with "established" psychiatric "knowledge." Nowhere is this more obvious, I would add, than in cases of treatment capacity.

As we have seen, the essence of "modern psychiatry" is keeping people medicated. And for the most part, people dislike the chemical incarceration—hence both the phenomenon of "going off meds" and the incapacity hearings. Now the test for capacity, you recall, is twofold: first, the person must understand the "relevant" information; second, they must appreciate the personal consequences of not taking the "treatment" (HCCA, 4.1). As discussed in Hiltz and Szigeti (2011), historically, review boards have ruled that minimally people fall short of passing the second part if they don't "appreciate" that they themselves have the "disorder" in question and that it will deteriorate without the "medication"—all of which clearly presumes that psychiatry is correct. The horror of this is that to be deemed capable, you have to believe in the efficacy and value of substances that have been shown to be both ineffective and harmful (see Chapters Three and Seven). Moreover, ironically—and this is a palpable contradiction—you have to agree with the psychiatrist in order to "capably" disagree with him.

So what has happened to the breakthrough Supreme Court Starson ruling discussed earlier, the ruling that "a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to his or her circumstances . . . The patient must be able to recognize the possibility that he is affected by that condition" (quoted from Hiltz and Szigeti, p. 175)? While this ruling indeed looked as if it would revolutionize the area, transparently, it has not. The point is you still have to recognize the possibility you have "a condition." And you still have to entertain the possible benefit of the drugs. Indeed, it would take a person with the articulateness of Professor Starson to navigate the narrow path the "patient" is forced to tread. What contributes still further to the problem and what, significantly, brings the psychiatric nature of the CCB more keenly into view, albeit the Supreme Court ruling did in a variety of ways give the Board more leeway to strike down findings of incapacity, progressively, CCB boards have narrowly interpreted Starson, and in a way highly favorable to psychiatry. States mental health lawyer Anne R. in this regard: "The Board is now saying that it is not good enough that my client recognize the 'possibility' that the medication might benefit her. My client has to also personally 'recognize the benefits of the medication.' Otherwise, she is 'not understanding the parameters of the decision'" (interview data).

Reasons for Decisions: Honing in on Ruling and Reasoning

The last stage of the CCB process is rendering a decision, and where requested, writing up "Reasons." Those written reasons, minus the inmate's name, are subsequently posted on the Canadian Legal Information Institute website [for bibliographical reference, see Canadian Legal Information (n.d.)]. I invite the reader to peruse the site http://www.canlii.ca/en/on/onccb/index.html, and I turn to those postings now, for in them one can see as through a microscope the workings of the Board.

The first thing that is apparent is that these are not natural accounts but "institutional accounts." Everything is written in language that reflects the law, with the relevant criteria spelt out and all exhibits identified. Correspondingly, the inmate is demonstrably made to appear a certain way, a way which justifies the decision, moreover, one psychiatrically framed, with all that leaves out and distorts. One consequence is that it becomes difficult to catch a glimpse of the actual person—one can but conjecture. A related consequence is that overwhelmingly, subjects keep looking as if they *should be locked up*, that is, as if they are of *real danger to themselves or others*. What such constructions invisibilize is that the vast majority of those, including ones in the roughest shape, are minimally far less dangerous to anyone than psychiatry is to them.

It is beyond the scope of this book to provide you with a detailed overview of the manifold problems which lurk behind and between the words of these official "accounts." I would like, however, to draw attention to the general invisibility of race—problematic given how commonly racism is implicated. I would also call attention to the rampant sexism, with the fact of a young woman being raped, for instance, being accepted routinely as evidence she has a disorder which places her at risk of "physical impairment" [see, e.g., TT [Re] (2011)]. What has happened to the hard won advances of feminism when women are once again judged for being raped? By the same token, adultism is pervasive, with children habitually judged by adult standards (for instance, the sixteen-year-old cited here was judged delusional not only for magical thinking, but also for believing that she would become a world-famous singer—and since when is practical realism (as opposed to daring to dream) the sine qua non of youth? For the purposes of understanding, additionally, I would like to focus in on one case.

Reasons for Decisions: The Case of Ms. H

The case before us is a capacity hearing of a 15-year-old woman. The CANLII document is listed as "H (Re), 2011 CANLII 63119 (ON CCB)." The "Reasons for Decisions" begins by clarifying the governing legislation—the HCCA—and specifying the hospital. Having identified the place and date of the hearing, the parties, those present (significantly, the detainee is not), and the issue under review (capacity to consent to treatment), it itemizes the exhibits (which includes, for instance, clinical reports from a Dr. Henderson and two CCB summaries, one prepared by Dr. Henderson and one by Dr. Norris). The bulk of the document carefully explicates "the evidence" and walks us through the Board's analysis. In typical fashion, it ends with the Board's finding, which reads, "For the above reasons the Board confirmed the finding that H is not capable with respect to treatment" (p. 7). All official sounding, all conducted according to the rules, the totality of it, we are invited to believe, credible.

So, who is this young woman? It is clear that she is a vegan with deeply spiritual beliefs. What is also clear, like many a young woman in this society, she is anorexic. What seems to position her differently than most of her peers, she is quite anxious and depressed and dwells on suicide. It is likewise clear, as she herself acknowledges, that she has what would normally be thought of as compulsions (e.g., "touching a pencil in a certain way"). In other words, she is troubled.

How did H end up in the system? And what befell her there? She was brought to emergency on a number of occasions, often because of the troubled eating, generally at the instigation of her parents. While she was originally voluntary, after what was construed as a threat on the psychiatric director's life, she was "formed." The major "treatments" provided include: the incarceration itself and what is obliquely described as "psychological intervention"—something pronounced by the doctor as unsuccessful. Be that as it may, as all parties agreed, her problems continued to get worse. The doctor's solution was to administer psychiatric drugs—a route which everyone was well aware she deeply opposed—hence the finding of incapacity. Horrified by what was about to happen, H appealed to the Board.

Legally, the "Reasons" represent the Board's deliberations on the matter. On the level of critical discourse analysis, they are themselves an exhibit, one that illustrates how people and findings are constructed. To a degree, such construction begins with the diagnoses. Throughout the document we find specific clinical words that together construct the young woman as having a host of serious "mental disorders." It is clear that these words were first pronounced by one or more doctor, then picked up by the board (in what might be called an echo or doubling effect). By repeating these words (diagnoses) verbatim and attributing them to the doctors as experts, moreover, as truths spoken about H (the patient), the Board at once legitimates the doctors and delegitimates the "patient." The words in question are "major depressive disorder of severe subtype with possible psychotic features," "obsessive-compulsive disorder," "Parent Child Relational Problems," "social anxiety," "eating disorders not otherwise specified." There is reference additionally to H being triaged at one point for "suicidal ideation" (aspect of a disease entity) and her being "formed" for threatening to kill the psychiatric director.

I will not be problematizing the diagnoses, for what is wrong with such constructs have already been analyzed at length. I would only point out that the situation in which this young woman finds herself would look far less extreme were she described instead as coping by not eating, of thinking of killing herself, of being in conflict with her parents, as currently losing ground. To address briefly additionally the one thing that makes her look dangerous to others, she did indeed say that she would kill the doctor in question. Now as Irit would put it, "This was not a smart thing to do." This notwithstanding, we have no reason to believe that H harbored or was expressing an "intent"—only that on a single occasion she blurted out an admittedly menacing statement, arguably "blowing off steam," as youth are wont to do. In other words, the statement was emotive, not declarative. Given this flare-up happened right after the director suggested that she be on a vegetarian rather than her customary vegan diet and given she was a highly devout vegan, we can surmise what that flare-up was about. Significantly, neither the context nor this more probable meaning are factored in.

I would also like at the outset to touch on the issue of suicide. It is easy to justify anything on this basis. The point is, however, while the doctors and the Board present this youth as afflicted with "severe suicidal ideation," look carefully and you will see that her own words make abundantly clear that she in no imminent risk. With respect to suicide, that is, she states pointedly that she "is not ready to disappear" (p. 3). In other words, again, while the woman is demonstrably in trouble, the urgency of the crisis is a clinical creation. This bring us to the issue at hand—the

Board's handling of H's rejection of the medication "option" and the concomitant finding of "incapacity."

What we see here, indeed, what we see throughout the "Reasons" are the twin processes of legitimation and delegitimation. Specific words are brought together to construct the young woman as both not able to *understand* and as not able to *appreciate* (the two-part test for capacity), moreover, as unreasonably obstinate. All of the words in question, significantly, originated with the doctors, are attributed to the doctors as authorial experts, and are simply repeated by the Board. They include depicting her as "unable to delineate," as "unable to grasp," as "steadfastly refusing," as "oblivious," as "lacking the cognitive ability." In the same manner, her alleged inability to understand is constructed as part of her "disorder." Note in this regard the Board's picking up of the statement, "Ms. H's thought disorders render her unable to foresee the reasonable consequences of a decision to reject the proposed treatment" (p. 7). The finding thereby is constructed as reasonable and the confirmation of the finding as likewise reasonable.

Now to be clear, as shown to date, and as we will further explore in Chapter Seven, a person can have a reasonable objection to these substances. What is additionally apropos, whether we understand their reason or not, we should be wary of telling people what they can or cannot put in their own body. What is especially telling about these "findings" however is that the average person can easily appreciate H's reasons.

So what is this young woman's understanding? Why does she not want to take the drugs? As is fairly standard in such write-ups—and herein lies the ultimate method of both the doctor and the Board—that is not easy to answer, for only obliquely do we hear from H personally—a reality, I would note, while exacerbated when the "patient" is not present, is a factor at the best of times. Only, to be clear, when the Board makes reference to the doctors' position, only, moreover, when her words are inserted into a context wherein they serve as evidence of incapacity—do we actually hear this young woman speak. This precisely is the discursive method of the Board. Whether or not the detainee is present, operating institutionally, panels routinely at once "decontextualize" (strip the person of their context) and "recontextualize" (place words and actions in institutional contexts).[16] Essentially, the words of the patients are engulfed by those of the doctors, with the patients' words thereby stripped of authority and their selves of authorship. In this particular case, we never, for example, encounter a statement of the form "H objects to the drugs for the following reasons." Rather the Board states that "Dr. Norris continued variously as follows: She is afraid of psychiatric medications because she is worried it would change her thought" (p. 3). Eliminate the engulfment, however, and it becomes clear that H is asserting the following: She objects to the medications because "medications are unnatural." What goes along with this, she does not wish to artificially alter her thoughts because in her words, "My thoughts are all I have" (p. 3). A cogent reason, I would suggest, and hardly a reason that we need a mythical illness to account for.

What does H want instead? She is asking that she be allowed to continue to try what the institution calls "psychological methods." A reasonable alternative on the face of it, especially given that there is hardly just one or two "psychological methods" but literally dozens of forms of psychotherapy and so to date her "helpers" have hardly scratched the surface of what is available.

What is the doctors' and concomitantly the Board's response to her alternative? It is to continue to frame this response and indeed all her responses as proof of incapacity. The method is visible in following passage in the "Evidence" section:

> Dr. Norris said that he explained to Ms. H "at least 50 times" the nature of the medications proposed and the consequences of not taking them, but that her "complex set of beliefs" has closed her mind to "treatment options that involve medication" . . . Standard practice in such cases would be to look at medication as a means of augmenting treatment that she receives from her individual and family therapist. [Ms. H] does not seem to appreciate this link and remains steadfast and adamant that she will not take medication.

Witness: The doctor is positioned as kindly expert, patiently "explaining" (albeit given the phrase "at least 50 times," it sounds more like browbeating). By contrast, the "patient" is positioned as stubborn, more significantly, as not being capable of *UNDERSTANDING* because her mind is "closed," moreover, of not APPRECIATING the link (the two-part capacity test). Using the metaphor of "the link" to denote combining drugs and talk therapy, significantly, is itself strategic, for it nominalizes the combining, making it appear both natural and necessary, thereby giving extra weight to what, note, is already constructed as authoritative via the term "standard practice."

To insert some realities here that fall outside the circularity, nowhere is the specific drug or even the general class of psychiatric drug under consideration specified, as if they were all of one type. Though we have no way of knowing for sure, given the emphasis on depression, of course, we might reasonably conjecture that antidepressants are being considered. What is significant in this regard, far from constituting part of any kind of "standard practice" internationally, most of the antidepressants used with children in North America have actually been prohibited in England for use on anyone under 18. Why? Because they have proven to lead to suicide (see Chapter Seven; see also Breggin, 2000b; and Whitaker, 2002). Nor is use of antipsychotics "standard." Such realities, however, are outside the frame, for all intents and purposes nonexistent. H's truths are similarly nonexistent. What should come as no surprise given psychiatry's history with respect to competitors (see Chapters Three and Four), so are the actions of nonmedical professionals—who have for decades utilized various forms of psychotherapy alone, including with clients like H (see, for instance, Burstow, 1992). What exists are only North American psychiatric frames and what they construct.

What has happened here is that the doctor has technically met his burden of proof because he has observed due process, because he is part of and is versed in the ruling discourse, because he knows the two-part capacity test and is able to word the narrative accordingly. The Board for its part has dutifully followed the doctors' lead. To quote from the analysis section so that you can see the work of governance up close, they write:

> As to the first criterion, it is the evidence of both Dr. Temple and Dr. Norris that although Ms. H appears to recognize that she is suffering from depression and anxiety and wants to get well, she has not in fact grasped the full extent of her condition and

> is therefore unable to understand her condition and the need to treat it in the manner proposed. Individual and family therapy constitutes one form of treatment and medication is another treatment and Dr. Norris testifies that Ms. H does not grasp the necessary link in her circumstances between the two types of treatment . . . and since Ms. H's constitution is that which prevents her from "understanding the impact these illnesses have on her" she lacks the cognitive ability to understand all the relevant information in relation to herself. (p. 7)

By such devices, H is "found" to fail the first part of the capacity test.

Proceeding to the second part and quoting Starson, as boards now routinely do (a device, significantly, that serves to legitimate their own ruling), the Board states:

> The evidence shows on a balance of probabilities that Ms. H lacks an adequate understanding of the parameters . . . particularly with respect to the "foreseeable benefits and risks of the treatment in question" and the "expected consequences of not having the treatment." It is the evidence of both Dr. Temple and Dr. Norris . . . that she has not in fact grasped the full extent of her mental conditions and that it is that disability that impairs both her understanding of the information provided to her and her ability to understand the consequences of a failure to treat the condition through appropriate medication. (p. 7)

Note, in this regard, that the phrase "mental condition" serves to reify H's struggle, which nominalization in turn is positioned as a "disability" that "impairs thinking." By contrast, the doctors' wishes are positioned as "appropriate"; their beliefs constitute "evidence"; and their ideas of what will befall her if she does not comply is characterized as "the consequences of a failure to treat the condition through the appropriate medication." It is precisely through such discursive means that the "patient" is constructed as "incapable."

What is ironic in all this is that had H "thrown in the proverbial towel" after the fiftieth explanation, even while maintaining the exact same views, she would have been deemed "capable." What is tragic is that, as feminist therapists like Lawrence (1989) and Orback (1988) long ago established, anorexia is about control. A woman who feels that she has no control asserts control over one of the few things that she seems able to—her intake of food. In what is a fight for her life, H is coping through controlling her food intake, additionally by safeguarding the integrity of her own thought processes, fraught though they may be. Via the use of these texts and via these discursive techniques, the doctors and the Board together have just done what this young woman most dreads. I would remind the reader here of her impassioned plea, "My thoughts are all I have." Whatever may or may not be gained in the short run, in the long run what they have succeeded in doing is making H's already difficult struggle appreciably harder. What goes along with this, she now stands a frighteningly good chance of becoming one of those folk habitually dragged to hospital in accordance with the Box B criteria.

An addendum: There is one further absence that haunts these "Reasons." We know that H's lawyer was in attendance for besides that she had to be, she is included in the list of people present. Not once, however, is she quoted or even again mentioned. What is apropos here, a rough principle of discourse analysis is that you can judge the credibility being attributed to different parties by the percentage of times they are quoted (see, e.g., Teo, 2000, p. 18 ff.). Albeit this particular lawyer may well have said little—hence the marginalization—read through a number of the official "Reasons," and you will find that typically, at least when it comes to substantive issues, but slim attention is paid the detainee's lawyer. They are constructed as more credible, to be clear, than the detainee, but they are not "the experts," their words not, as it were, worthy of repetition.

Such is the doctor-centric nature of these deliberations. And such is government-provided "check" on psychiatric rule.

Reflecting, Summarizing, Concluding

In this chapter, we inquired into psychiatry as mandated governance. In the process, a very complex apparatus came into view—an extensive network of laws, forms, organizations, agents, procedures, all of a transcarceral bent, all of it circular, all of it facilitating psychiatric rule. We saw oversight agencies like Health Canada, whose operations not only do not appreciably protect, but overwhelmingly rubberstamp the wishes and products of industry. We saw popularizers like the Canadian Mental Health Association. Using Ontario as an example, we saw how all parts hang together to the benefit of the system and the detriment of survivors. We identified and problematized the governmental boss texts—the Mental Health Act and the Health Care Consent Act—demonstrated how various passages are replicated in tick box forms, correspondingly, explicated how such texts orchestrate the work of key operatives—namely, doctors, lawyers, justices of the peace, the police. We saw the various routes into hospital and how they hook into the legislation. We probed the working of the emergency ward, the hospital chart, demonstrated how they function as part of governance. In contrast with governmental claims about the community approach increasing personal liberty, what we saw with the community approach was the progressive colonization of the community, coupled with progressive chemical incarceration. Correspondingly, with reference to all of this, but particularly the activation of documents, we traced *precisely how* psychiatry rules, how "patients" are controlled, how "patients" are "processed." What we witnessed, indeed, is a vast system of control, with chemical control at the center, with chemical control in the community as the desired end, with "hospital" as backup, indeed with services themselves essentially consisting of chemicalization with "add-ons" (Fabris, 2011). Finally, we saw clearly and in detail how even aspects of the system purportedly designed to protect "patients" from "psychiatric excesses"—the Consent and Capacity Board, for example—are predicated on and overwhelmingly reinforce psychiatry.

Various thoughts crowd in on me as I ponder the insidious nature of this system. I leave you with just two. The first is that we have designed an institution so relentless as to never let go. We have designed, to put it another way, a trap. This is evident in the drugs on which people become hooked, commonly for life, always requiring just that extra adjustment. It is evident in the linking of "services." More fundamentally, it is evident in the very laws and legal frameworks—the inclusion of such phenomena as community treatment orders that can be renewed indefinitely, appeal processes designed to fail, indefinite incarceration itself, involuntary admissions criteria that uniquely single out the person who has even but once accepted or been subjected to a treatment.

My second reflection concerns the "helpers" themselves and the work which they invest to keep the whole operation running. While as demonstrated previously, the converging interests of psychiatry and the pharmaceuticals, together with the prioritizing of those interests is an overriding factor in what is transpiring—and we forget that to our peril—what is most obvious in the chapter, also perhaps most distressing, the business of madness is substantially accomplished by everyday people diligently doing their job: By the emergency nurse ticking the "appropriate" box, the psychiatrist filling out the form, the police picking up the alleged "disturber of the peace," the tribunal member weighing "the evidence," the assertive action team scrupulously turning up at the apartment of the person who has missed their appointment. Harsh though this reference is—and to be clear, I intend it more as a heuristic than a judgment—I am reminded here of Hannah Arendt's (1963) insightful phrase—the "banality of evil"—an explanation in itself.[17] The question, nonetheless, arises: But how can this be? How is it, say, that individual "mental health" workers, a large percentage of whom chose their avocation at least partially, presumably, out of a heartfelt impulse to help, many of whom, additionally, are deeply concerned with ethical issues, continue to cooperate with, be actors in, and perpetuate a system such as this?

Full stop—for this is the subject of a separate chapter.

CHAPTER 6

The Psychiatric Team

> One day a youth entered the institution. He wasn't walking, talking, or toileting. I thought: Good. This is a place to be away from whatever made him retreat. To me it was clear that he had gone within, and something in his environment had caused this. We can provide a cushion of safety. What happened? Within 48 hours he was ushered off for ECT. I brought this up in report, asked why this had happened. I was told: Why do you have to bring that feminist stuff in? And I wondered: How is it feminist to wonder why a youth is being sent to have electricity shot through his brain? We don't even know why he isn't walking or talking. Anyway, days later, I was lectured for not going along with the plan. And I thought: Who wrote the plan? Did *he* write the plan? Who consented to the plan? I also remember the family coming in. The mom had flat affect. The siblings were clingy, without boundaries, were hanging onto the nurses, every second trying to talk to us. The father noticed, and the siblings did not turn up again. With all my years as a public health nurse, I sensed something being hidden. Perhaps abuse. And this little boy was discharged back to that family, no attempt made to find out anything. Actually, I phoned you on the way home that day, Bon, pulled over to the side of the road and phoned. And I said: I can't do this any more. I can't participate in this. I tried to speak up, but the power of the script is too big for me.
>
> —Cheryl G., nursing professor and interviewee

In the last chapter, we witnessed the workings of a massive industry. We saw boss texts in operation, a massive army of functionaries, institutional discourse and processes, all functioning to keep the control tight, all overpowering the individual called "patient." Correspondingly, we walked in the institutional shoes of the distraught person from the time of being picked up through their posthospital existence. Professionals' activation of forms was central to the narrative of that chapter. By contrast, this chapter zeroes in on the personnel themselves.

The subject of this chapter is a very particular subset of mental health workers—professionals dominant in the operations of the hospital, those typically theorized as the "mental health team." The intention here is neither to vilify nor to individualize. It is to add a special layer to the understanding—to ferret out the institutional truth of what is known as the "multidisciplinary team." This dimension is significant, among other reasons, because of the presumption that the diversity of the players offers a measure of protection, a type of balance. Critical questions taken up include: Who is the team? How "different" are the members? What are the primary disciplines involved? What are their respective understandings of "mental health"? Of the role of their profession? How do the diverse members operate in terms of one another? Come to understand themselves as a professionals? What do they do when faced with cognitive dissonance? Contradictions? Horror? Shame? How do they become competent speakers of their respective discourses? Committed institutional actors? More fundamentally, given the untenable nature of the "treatment," given the violence that we have witnessed, and given that most people enter a helping profession at least partially out of a heartfelt impulse to help, how do the discourse(s), the regime, the various discipline(s) so "educate," so construct the "mental health worker" that daily, routinely, everyone does what they do?

Like the ones before it, necessarily, the chapter is largely about power—an uncomfortable vantage point given our common sense understanding of "helpers." As Foucault is the quintessential philosopher of disciplinary power, several Foucauldian concepts and principles were kept in mind in penning it. I invite the reader likewise to keep them in mind. The first is: "Analysis should not concern itself with power at the level of conscious intention or decision . . . What is needed is a study of power at its external visage" (Foucault, 1980, p. 97). The second is: "Individuals . . . are always in the position of simultaneously undergoing and exercising power . . . They are not only its inert . . . target. They are also the elements of its articulation" (p. 98). The implications for this chapter is that intentions are at very most secondary and professionals will be investigated not only as power holders but as people who transmit power, moreover, as beings who are themselves "controlled." Finally, I kept in mind and I leave you with this Foucauldian thought together with its institutional implications: "There can be no possible exercise of power without a certain economy of discourses of the truth . . . Power never ceases its interrogation, its inquisition, its registration of truth: It institutionalizes, professionalizes, rewards its pursuits" (pp. 90–93).

The "Mental Health Team" as "Team": Its Members, Its Institutional Reality

The principal members of the mental health team are: doctors (psychiatrists), psychologists, mental health nurses, and clinical social workers. All are professionals—indeed, certified members of "regulated" professions. All are granted specific authority in various legislation (in Ontario, for example, the HCCA entitles nurses to conduct certain kinds of evaluations relevant to capacity finding).[1] All have their own professional identities—associated with years of schooling, specialized bodies of knowledge, professional codes of ethics. At the same time, all have a global identity as "mental health workers." More concretely, by virtue of the conditions of their work, all see themselves and are encouraged to see themselves as part of a multidisciplinary mental health team. What is particularly significant—and what detracts from any balance that multidisciplinarity might offer—it is a team expected to act in absolute unison. Utter cohesion, to be clear, is the one of the most dominant themes that arose from my data and it connects with all other themes, including—and this connection has significant explanatory value—violence.

While cohesion is stressed in medicine generally—and there is a plethora of studies on how to enhance team cohesion (see Tuberman and Carlson, 2012)—the special emphasis on mental health team cohesion is at least partially a response to what is constructed as "dangerous," as "other." To put this another way, at the same time as a person is constructed as "the patient," as "dangerous," as "violent" as "in need of control," the team is constructed as a unit that must stand together, that must back each other up, that must jointly take control. Whatever else is involved, the cohesion in question indeed serves the purpose of controlling "the patient"—a dynamic dramatically epitomized in the signal given for all available staff to rush to a scene and to manually subdue an inmate. However—what is less visible but intrinsic to its operation—it also controls team members. Such is the nature of institutional rule.

This dual function, this "doubling effect" was most manifest in my interview with Cheryl G., once a member of such a team, now a nurse academic. She states:

> A palpable division exists between the persons that we were to be providing care for—"them"—and "us." And "us" would be nursing, psychiatry, psychology, and social work. And the language of the team was used to *enforce* compliance. I questioned shock and immediately I was *called on the carpet* for not being a team player.

Focusing exclusively on the control of the team members, correspondingly, Nadia T., an advanced doctoral psychology student, garnered this principle from her placement, "DON'T QUESTION WHAT THE TEAM THINKS."

In an atmosphere where "we" must hang together, where "they" are "violent," where some staff violence is called "treatment," where all of it is called "necessary," despite the discourse of caring, even despite actual caring, which at times transpires, the scene is set for rampant and multidimensional staff violence. What contributes to this, from the outset the team is, as it were, socialized to violate. In what might be called "cosmeticized violence," for example (examined later in this chapter), students are socialized to give and force damaging treatments on people. They are also socialized to perform acts that most laypeople would recognize as violent, frequently, moreover, to do so in unison.

To focus in on the latter, subduing an inmate, learning the ins and outs of laying hands on an inmate is introduced very early. In this respect interviewee after interviewee spoke at length about how in their first week in a new job or placement, they were schooled in the art of how to subdue—a practice, significantly, which they were subsequently called on to engage in not just *occasionally* (which could conceivably carry a different meaning) but *routinely*. Describing this training, nurse academic Cheryl G. states: "There is a certain number of things that you had to accomplish in orientation. One was called 'self-defense.' You were taught how to restrain people. How to hold their hands down. We had to practice these grips, and these holds, and these twists." Naming this "self-defense," in effect, exonerates the staff person, assures that staff person that they are only doing what is "necessary." More generally, via the diametrically opposite framing of staff acts and inmate acts, the professional is reassured that they as staff are not "really" being violent. Indeed, not only in orientation, but throughout their working career, staff are encouraged to tell themselves stories that normalize, even heroize various acts of theirs that would normally be construed as aggression. As they tackle a person, jab with a needle, secure restraints, they tell themselves that it cannot be helped, that the person is upsetting other "patients" and their duty is to keep the ward safe, that once the full effect of the meds has kicked in, the "patient" will thank them. Chris Chapman (a social work professor who once worked in a locked residential treatment center "serving" Aboriginal youth; 2014, p. 24), offers this insight into the psychology involved and nurtured:

> It's not that we didn't acknowledge that these restraints were traumatic for the children being restrained or for other children witnessing them, but we were the protagonists in the stories that we told and believed. Our violence was ever a response to their violence. The possibility of imagining their individual violence as a response to our structural, epistemic, *and* individual violence— . . . institutional . . . adultist and . . . racist—was not available to us. And so they were the initiators of violence . . . There were nothing *we* could do to prevent it . . . We had nothing to do with their violence until it erupted and our only role was to keep everyone safe.

Chris's story is instructive. It demonstrates the slippage that routinely occurs after a staff member is hired, more or less irrespective of their intentions or analysis. Significantly, Chris began his job as an avowed antiracist, intent on making a difference. He imagined "watching John Wayne movies with the children and collectively critiquing their racism. (p. 22). He soon found himself routinely subduing these very children. Predictably, he was initially upset at having to inflict such pain. Slowly, methodically, however, he was socialized to accept it. Central to this socialization were debriefing sessions, which took place after every "major incident." Such debriefing, states Chris, served the multiple purpose of helping staff at once deal with the trauma of their own violence, reframe that violence, and project all the violence onto the children. Soon Chris found himself earnestly urging the youth to "accept responsibility," to "see" that it is *their* actions and *theirs alone* that were "the problem." Fortunately, Chris eventually realized that something was amiss and left, and once out of the institution, bit by bit, he was able to unpack the process—hence the piece that he penned. Few workers achieve this level of awareness. The point is, these are profoundly successful indoctrinating institutions (another central theme). However staff enter them, whatever their intentions or beliefs, over time they are so immersed in the work of the institution that the majority continue to commit daily acts of violence while constructing this as "treatment" or "the only option." Albeit they may have niggling doubts—and on some level, people do—however we define "belief," mostly, they come to "believe," as Chris came to believe, *what the institution socializes them to believe*—and they learn to keep mum about the rest.

And what becomes of the animal sympathy that one creature instinctively feels for another being harmed? One interviewee who became *more critical rather than less* as her placement progressed provides this insight into the inevitable desensitization:

> *Bonnie*: What was the worst part of working in an institution where staff perpetuated such violence?
>
> *Nadia*: Watching myself adjust to it. You know, the object of the response, they were often just kids who were confused and frightened. Initially, I would sob every night when I came home. Later on, I would still have moments of heartbreak, but

> I was able to turn it off. I even said to people when I had these moments: I never want to lose this. I want to make sure that places like this always affects me this way, but as time went on, it became par for the course. I saw the restraining, the injury, the disrespect so often that it was just the status quo. You know, I can see how people can get sucked into it. The thing is, if someone like me who is highly critical and who gets intensely emotional about people suffering can let go of it to this extent, what about people who are far less critical?

If desensitization to the brutality is an integral part of the story, so is the timing of the training with respect to it. Indeed, the timing itself sheds a critical light on what is happening. As already clarified, whether they be placement student or permanent staff, interviewees identified the initial orientation as the point when they were taught restraint techniques. Correspondingly, almost all spoke of being ordered to and having to restrain "patients" in the first week. While, to be clear, I am in no way suggesting that these are equivalents, what is happening here parallels what happens in gang initiations. Watch any movie about gangs, look up "gang initiation" on an online dictionary, and you come face to face with this fact: The test, the "qualifying act" demanded of an incoming gang member is they get their hands dirty—knife someone, "rub someone out." Once this is accomplished, the newbie is now a bone fide member of the gang; and bonded by the stark reality of transgression, they cannot easily break with their confreres.

Different though these situations demonstrably are, the resonances are instructive. Whether the "newbie" be a nurse, a doctor, or a social worker, usher a new staff member through the "rite of passage" of "subduing the patient," involve them in the holds and the twists, and their hands, as it were, are dirty. They are now part of the team. Involve them additionally in the epistemic violence inherent in the standard rationalizations, and you at once give them a way to cope and you solidify their allegiance.

Other Aspects of Conformity; The Hospital and Psychiatric Supremacy

In the hospital per se, this principle of team conformity extends to all aspects of the work. Plans. Opinions expressed. While written reports legally constitute the considered clinical position of the professional and so it is assumed that they reflect individual judgment, to varying degrees it extends to the writing of "professional" reports themselves—a fact that may account for how readily the hospital files support the hospital's case at hearings (see Chapter Five). Psychologist-in-training Nadia provides this window onto the construction of such assessments: "You see it even in the risk assessment. The whole team would contribute to the report, and there was this strong suggestion: Before you write your piece, read what everyone else has written, and make sure that you are not saying anything appreciably different." One social worker interviewee (J) put the issue of differing this way. "A team member can voice a different opinion, right?—but only within understood parameters." Correspondingly, psychologist Li delineates the implicit limits on divergence as follows:

> You can't take issue with an accepted psychiatric treatment—period. Full stop. While you can contribute ideas, especially if this is your area of expertise, generally only when asked. Two other things: It's not wise to make a fuss about the

> "agreed-on" treatment plan. And irrespective of your take on it, you cannot write that someone is, say, *low* risk, when you are clearly being told that the person is high or medium risk.

Herein lies another disjuncture. The multidisciplinary nature of the team figures in government discourse as a "selling point," a reason presumptively to trust the system. The question arises: How multidisciplinary are these teams *in effect*, when team members are transparently being silenced? Correspondingly, what is happening to individual responsibility here? Professional standards? Personal accountability?—all dimensions on which trustworthiness depends.

A related and more fundamental problem becomes apparent as you probe how the "team" actually functions. The point is, psychiatrists invariably head these teams and as interviewees from all the other disciplines noted, psychiatrists overwhelmingly determine what the "team thinks." In this regard, to quote from my interview with Nadia:

> *Bonnie*: And the psychiatrist would head the team?
> *Nadia*: Every team in the hospital. They are the only one with freedom, with independence. They have all the power, make all the decisions, and everything funnels down through them. And there is not much discussion between members of the team.
> *Bonnie*: Correct me if I am getting you wrong, but are you saying that often the psychiatrist would be disinterested in what other professionals had to say? Or if interested, only insofar as these professionals were answering the question that the psychiatrist posed to them.
> *Nadia*: Yeah, yeah, that's it. Generally. Though I have seen it work both ways. I have seen it be more of a dialogue. Even here, though, there is a clear sense of who is running the show. The meeting cannot start until the psychiatrist arrives. They have their laptop there. They open the meeting. They close the meeting. Minute by minute, they direct. And if you have a good psychiatrist on your team, they may ask you your opinion of someone you are working with, but if you don't, they might not. And regardless, if you have something to offer and they disagree, well, then (lengthy pause)
> *Bonnie*: Then you are wrong?
> *Nadia*: Then you are wrong.

The difference between what Nadia is calling a "good" and "bad" psychiatrist may make for a happier or less happy team. Nonetheless, whether "good," or "bad," the supremacy of the psychiatrist is clear. Significantly, even the wish of a differently placed "team member" to carry out an assessment that they are uniquely trained and legally credentialized to make is contingent on the psychiatrist's approval. Note, in this regard, these comments by Nadia: "Say, I want to get a cognitive test, for example, to see if there is something happening—you can't do that as a psychologist. You would have to make your case to the psychiatrist." With the "bad" psychiatrist, the subordination is particularly obvious. You see it, for example, in the disrespect shown other team members—a dynamic, note, that curiously parallels how inmates are treated. "They are totally overbearing with everyone," testifies Lisa. "How can anyone keep their job when they behave this way?" asks

Nadia: “They order us around, say, ‘get this’ and ‘move this.’ ‘go there.’ The rolling of the eyes, the complete dismissal of other human beings—both patients and colleagues. This huge sense of entitlement.” The “good psychiatrist,” however, likewise “calls all the shots,” including where the law does not require it. Herein we find the quintessential patriarch whose victory we witnessed in the history chapters. Whether in a despotic or a gentler collegial fashion, the doctor rules. And who might in earlier eras have been his competitor (now called “nurse,” “psychologist,” “social worker”) is scrupulously subordinate.

To complicate the picture, while psychiatry is unequivocally at the top, there is a more general hierarchy, with medicine prioritized. The psychiatrist-in-training, note, has considerably more authority than the seasoned nurse. In addition to the official hierarchy, correspondingly, is the *implicit* hierarchy—who is listened to. According to my data, irrespective of discipline (psychiatry excepted), the more versed workers are in psychiatric discourse, the more likely they are to be listened to. Correspondingly, states nurse educator Cheryl G., “the more closely one is aligned to the medical model, the more credibility a team member has.”

What relates to this, irrespective of discipline and despite the “inclusion” of the “psychosocial,” the medical model is overwhelmingly prioritized. As most all professionals whom I interviewed agreed, it is the sine qua non, and adherence to it is imperative. *To a degree*, this medical model imperative conflicts with the training and belief set of all other team members, especially those in psychology and social work. This notwithstanding, the conflict is not as big as one might imagine, for besides that these are related or “cognate disciplines,” progressively, they are fields colonized by psychiatry. That is, progressively, they have inherited the curriculum of psychiatry.

To the extent that this is the case, protection is illusory. Correspondingly, this being the case, if we are to truly come to terms with how it is that everyone does what they do—how they medicalize the nonmedical, how they diagnose, how they subject inmates to endless scrutiny and control—it is necessary to step back, to begin earlier. What follows, correspondingly, is a brief account of the educational journey associated with each of the major disciplines. As psychiatrists too are socialized to believe what they believe, I necessarily include psychiatry.

The Professions

Psychiatry

The training to be a psychiatrist is long and arduous—a fact that in itself helps explain some of the certainty which psychiatrists project. Go through a training of this length, one, moreover, where everything with which you come into contact—books, articles, nurses who take orders from you—fixes in your mind that you are the expert, and you end up seeing yourself, your colleagues, and “your patients” in a certain way.

While there is a degree of variance between schools—and the reader might want to look up various departments of psychiatry—roughly speaking, the average training regimen involves: first pre-med (undergraduate degree), then medical school to become a physician (typically, three, four years), half of which is called “clerkship” and involves rotations through major specialties. Last is psychiatric residency (generally five years).

Since medicine is an applied discipline, a student both in medicine and later in their specialty—in this case, psychiatry—works in different medical specialties. These are called "rotations" because the students quickly "rotate" from one to another. Residency is the specialized work that follows becoming an MD. Doing work under these specialties essentially means being an employee of the hospital and being attached to the department in question, all while receiving supervision. Eventually, psychiatric residents are attached more directly and more consistently to psychiatry.

The very fact that one goes through medical school in order to work with people deemed distressed establishes the frame—fixes "emotional problems," as it were, as "medical." So do the plethora of general medical courses that one takes. As psychiatric resident and interviewee Craig R. points out, "Medical school is half anatomy and physiology." The implicit message is that emotional problems are intrinsically "of the body" and need to be approached as such. The "fact" that you are first and foremost a doctor, the "fact" that "mental health" is inherently "medical" is subsequently reinforced in residency. Significantly, in first-year residency, the student is still rotating through nonpsychiatric fields, gradually working their way into psychiatry, with psychiatry thereby constructed as *built on that medical edifice* [for a detailed picture of one such curriculum, see the website for the faculty of medicine at University of Toronto (medicine.utoronto.ca)]. To quote Craig in this regard: "Most rotations would be non-psychiatric in the first year. Palliative care, internal medicine—what else? Neurology. Another month in cognitive neurology, which is things like Alzheimer's, Parkinson's—so a little more like psychiatry." In later years, the rotations are largely within psychiatry, with the psychiatrist-in-training transparently conducting himself as a psychiatrist. Working in a psychiatric hospital or on a psychiatric ward, he is playing the part. He has memorized the DSM, taken workshops on psychiatry and the law, learnt the ins and outs of different psychiatric drugs. He is diagnosing, "treating," signing government forms, writing reports, involuntarily admitting—in the process frequently overriding what would normally be construed as rights. Indeed, the setup is such that the resident is virtually inundated with such tasks. Walk into admitting in a psychiatric institution, and you will discover that the front line work of the psychiatrist is overwhelmingly shouldered by the residents, who are conscientiously going from one person to another, "processing" five, six people a night. "The ones who make the decisions," points out interviewee and psychiatric supervisor Jason S., "are the psychiatric residents because it is they who do the front line work." Small wonder that by the time psychiatrists become credentialized, all such work and with them orchestrating it is par for the course.

In the process, it becomes ingrained that some folk are inherently dangerous to self or other, moreover, that they the psychiatrist are uniquely qualified to judge. *That man* is psychotic, *this woman* incapable because they deem it so. What goes along with this, by virtue of the very strictness of the hierarchy, an attitude of condescension to "lesser" team members is enabled—part of what interviewee and psychiatric supervisor Jason calls the "hidden curriculum." While often subtle, indeed, such attitudes were evident in the responses given by residents whom I interviewed. "We are more qualified to do therapy than psychologists and social workers," stated interviewee and resident Wing B. Along a somewhat different line, I ask readers to consider this statement: "The first person to see a client in emergency is the resident" (Craig).

A variant of this statement was made by every resident that I interviewed. The remark is at once curious and suggestive, for long before a potential "patient" is seen by a resident, they are seen by a nurse. How is it that residents do not notice this obvious fact? Because intrinsic to the socialization is the understanding that, necessary though the nurse's "legwork" may be, the nurse and "her" work do not quite count.

If the educational setup overall establishes the primacy of the medical model and the psychiatrist, naturally the psychiatric texts play a pivotal role in medical model socialization. Significantly, albeit written as if merely conveying information, such texts are of the type witnessed in previous chapters, with all the problems pertaining. There is the DSM (see Chapter Four). Texts that provide details on the "corrective actions" of the psychopharmaceuticals (e.g., Meyer and Quenzer, 2005). General psychiatric textbooks such as the *Shorter Oxford Textbook of Psychiatry* (Cowen, Harrison, and Burns, 2012), which "trace" distress to chemistry and genetics. Correspondingly, the historical texts encountered typically present a tale of liberation and progress, in the process instilling professional pride and orienting the resident to embrace the "biological revolution" (e.g., Shorter, 1997). The texts, together with the processes in which the trainee is actively engaged, draw residents into the discourse, provide them with key images, formulae, turn them into competent practitioners of the discourse.

I would note in passing one additional dimension that adds to the medical model socialization—the incentives to emphasize biology. Pharmaceuticals may already be funding the resident's education. The resident attends conferences where gifts are dispensed. Inevitably, correspondingly, just by looking around them, the resident is aware that pharmaceutical companies and their concerns are the route to lucrative research grants (for details, see Whitaker, 2010).

That noted, far from being simply self-serving (a gross simplification), my data suggests that overall, residents are optimists who harbor a real excitement about psychiatry—a belief in the current state of the field and the prospects for the future. One resident/interviewee, David, waxed eloquent about what is being discovered about the brain—it functions, its putative "dysfunctions." Another, Michael, excitedly declared that a profound change is happening. "While mistakes were made in the past, psychiatry is rapidly changing;" he pronounced. "It is open now, and as a science, it is far more rigorous; and my colleagues and I, we are prepared to work for that change." Other interviewees echo Michael's sentiments. Marveling at what is now possible, correspondingly, Craig said this about ECT, "I have seen people with postpartum depression—no depression earlier, and nothing seemed to work—and ECT raised them from the dead."

On one level, it is clear that whatever else is involved, these are passionate young people on a mission. To a degree, one can understand their enthusiasm. Who would not want to "raise people from the dead?" To be part of a humane revolution? At the same time, the fact they believe and indeed are encouraged to believe such discursive creations is precisely what allows them to ignore what is staring them in the face—the naked brutality, the vacuousness of the claims, the damage. What is particularly important from a discourse perspective, such sentiments need to be understood historically. Since the eighteenth century, the standard depiction of the "state of psychiatry" is precisely that a new day is dawning, that psychiatry is breaking from the error of bygone days and a revolution is happening, characterized by sound science, more humanity, and openness. The reader is reminded here of these words by Benjamin Rush (1812, p. 243)—ironically and tellingly, inventor of the torturous "tranquilizing chair": "Happily, the time of cruelty to this class of our fellow creatures and insensibility to their suffering are now passing away . . . A humane revolution dictated by modern improvements in the science of the mind, as well as medicine, has taken place." The point is, such sentiments are standard parts of the psychiatric archive. To put this another way, the enthusiasm and the optimism is itself one of the discursive elements of psychiatry, one that camouflages violence, one, moreover, into which residents are being socialized just as their predecessors were—again, it would seem, successfully.

And how is it that people being trained as scientists come to place faith in findings based on research of the quality demonstrated in Chapter Three? Further research would be required to answer this question. What my limited investigation seems to suggest, however, is that the methods of investigation being taught students themselves impede critical inquiry. In this respect all resident interviewees backed up some position that they were advancing by citing the percentage of confirming studies on that topic in the "Cochrane data base"—a standard way of operating conveyed by the psychiatric faculty.[2] "There are over twice as many studies in the data base which establish that ECT is effective than claim to have proved it is not," argued Craig with seeming conviction. What goes along with this, none could provide details on a single study. Significantly, relying on a single data base necessarily biases research—in *this* case, against context, personal accounts, and longitudinal studies.[3] Correspondingly, insofar as the level of research literacy being fostered has students dependent on abstracts and tallying up percentages of published papers (a clear example of research illiteracy), as practitioners, they are in no position to evaluate the research—something that would safeguard any discipline, but plays a special role in an area wherein by traditional standards, the bulk of the research is fundamentally flawed (for quality of research, see Chapters Three, Seven, and Eight).

This brings us to practice per se. The question is: How do residents deal with the cognitive dissonance that inevitably arises when they prescribe the standard treatment and see people's lives impoverished? When assessments or working principles say one thing, and what materializes before one's eyes, another? Jason, a psychiatric supervisor who witnesses the dynamic first hand, offers this insight:

> *Jason*: To avoid cognitive dissonance or to avoid a sense of shame, psychiatric residents unconsciously deny a lot. They manage not to think of certain things.
>
> *Bonnie*: So what *do* they tell themselves?
>
> *Jason*: Whatever they were told that made them feel good about it.

In line with this observation, all residents whom I interviewed had a handful of "success stories" that they drew on for reassurance; and all rationalized. Examples of rationalizations that explicitly surfaced in the interviews are: "Researchers who conclude that ECT is ineffective probably don't have access to good data"; "nothing is illegitimate; everything is just a treatment that can be offered"; "ECT is new and improved"; "but hospitals have policies on the use of restraints"; "everything has side effects"; "I give very little medication compared with my colleagues"; "people that I treat against their wishes commonly thank me when they get well."

And what about those who are both diligent and meticulously honest?—who face what is before them—the discrepancies, the cover-ups, the observable damage? Some leave, though very few, for the investment is huge. Most compromise, sometimes horrendously. A number eventually find niches in which they can operate more ethically—commonly, private practice. Albeit some struggle internally for reform, generally not for long, for the cards are stacked against them. Correspondingly, despite critique, very few will go so far as to expose. That noted, there are two additional aspects of the socialization that I would touch on, for along with self-interest, they help explain why so very few residents or psychiatrists ever break rank. These are: (1) forcing residents to "get their hands dirty"; and (2) keeping residents in line through threats and sanctions.

To end with an example that illuminates both, as with restraints, residents (also mental health nurses) are to a person initiated into the ritual of ECT—significantly, the most controversial treatment in the repertoire. Predictably, many have serious qualms, whether intuitively or on the basis of scientific knowledge. Correspondingly, this being a rite of passage in its own right, the refusal to participate is not tolerated.

For a first hand view of the dynamic, I leave you with this reflection of Breggin's (1985, p. 9):

> As I look back on my career . . . one shame seems unforgiveable—my involvement with electroshock. As a resident, I prescribed electroshock, I supervised a ward on which patients were given the treatment, and for a time I personally administered it. Why did I do it, even when I knew it was wrong? . . . One of my fellow psychiatric residents refused to give the treatment, and he was summarily fired.

An object lesson effectively communicated—moreover, one that can be repeated if as a full-fledged hospital psychiatrist, one, say, steps too far out of line.[4]

That Breggin did not rationalize—that he continued to know what he knew—is exceptional. At the same time (and herein, once again we see the coercive power of the institution), even the reformer who knew better succumbed.

Psychology

While a clinical psychology credential does not bestow anything like the power enjoyed by the psychiatrist, in most jurisdictions, it legally entitles the psychologist to perform a number of the same functions—to do therapy (an area no longer open to all), to diagnose, to conduct tests, progressively, to prescribe "medication."[5] Correspondingly, the journey to be a clinical psychologist is arguably at least as long and arduous as the journey to be a psychiatrist, with the investment and the corresponding inducement to rationalize likewise significant. It begins with three degrees, complete with thesis and placements, the last generally taking five, six years, and bestowing either a doctor of philosophy or a doctor of psychology (the latter, in the United States only). In most jurisdictions, following this is two years of practice under the supervision of one or two certified psychologists, duly approved by the board. Last is a series of very grueling exams presided over by the board [for minute details on one such process, see The College of Psychologists of Ontario (www.cpo.on.ca)].

Commonly, clinical psychology students in North America seek credentialization not only with their local professional body (without which they are not allowed to practice at all) but also with the American College of Psychologists; ergo, they are forced to satisfy the criteria of more than one professional body. Over time these boards have come to dictate not only the general "expertise" that clinical psychologists must have but also the content of the university curriculum, including the nature of placements and internships. Schooling and learning, in other words, largely revolve around the requirements of the College of Psychologists. Indeed, in one doctoral program with which I was associated, the major preoccupation of my colleagues was ensuring compliance with the licensing board. One result was that in an already overcrowded curriculum there was room for but one elective, all other courses being "required." Herein we see a profound encroachment on both self-direction and academic freedom. Also a professionalization that parallels what we witnessed with psychiatry.

Indeed, the story of psychology in recent decades is one of rampant professionalization. To coexist with psychiatry, to similarly acquire an advantage over competitors, psychology followed the path set by law and medicine and professionalized. While this, of course, is most worrisome from the perspective of "clients," its first impact is on those entering the field. For students grounded in a desire to help, the experience is one of profound disjuncture (a departure from expectations and a mismatch with self-identified learning needs). "I was really surprised and I continue to be surprised," states Nadia, "by the complete professionalization of psychology, the immense amount of schooling and testing and licensing—things that have nothing to do with being with people." "While there are exceptions," states Sabeena (postdoctoral student), "most of the stuff that I learnt that was actually helpful in working with people was *extra*—generally things I had to seek out myself."

Albeit once again, more research would be necessary to arrive at any conclusions, my data appears to suggest that students encounter a curriculum at odds with their deepest instincts. Soon and in most cases, the inner voice that guides them is dimmed. While some like Sabeena quietly rebel, most go along—and everyone to varying degrees is socialized. The close-to-uniform curriculum prepares students for the uniformity to come. The dictated curriculum prepares them for how to view and treat "others" in distress.

And what *are* the areas on which training focuses? While there is unquestionably a degree of variance, the Ontario College of Psychologists (reasonably typical), stipulates: psychology assessments, psychological interventions, professional ethics and standards, and two of: biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, and psychology of the individual (e.g., "abnormal psychology" and psychopathology). Albeit therapy as we know it assuredly does enter in, the emphasis is overwhelmingly on assessment, biology, diagnosis, and professional comportment.

It would be a mistake to attribute the totality of the scientific bias evident here to the influence of psychiatry. In its own right, psychology has always had a scientific bias (note the rat experiments). Moreover, as shown in Chapter Three, it has always placed a unique degree of faith in tests. Nonetheless, with the growing authority of biological psychiatry, a seismic shift has occurred. To claim a privileged place at the table, what psychology has essentially done is accept psychiatry's terms. To quote one interviewee, "The message is: We can do what psychiatry does and more—with the emphasis on 'what psychiatry does.'" Correspondingly, in psychology departments throughout North America, gone are the humanistic touches of yesteryear—training in gestalt, say, or transactional analysis. Now, except for the typical inclusion of Cognitive Behavioral Therapy—and CBT is standard in psychiatry likewise—what passes as science largely dominates, with the medical model at the forefront (for an example of a typical introduction to psychology text, see Santrock and Mitterer, 2006).

Mirroring the shift in the discipline, a strategic shift occurs in the midst of the educational journey itself. "When you enter the doctorate," points out Nadia, "[there is] a real honing in, a real focusing on the medical model." In compulsory courses, students are drilled on the ins and outs of the DSM. "We had to learn a section a week," explains interviewee Sabeena. "Like one week it would be the psychotic disorders, another the anxiety disorders. We'd be given this scenario and we had to pick out every single symptom." They become skilled users of the SCID (see Chapter Four). They gain proficiency in conducting tests, in differential diagnosis, in writing reports. In the process, they largely learn to think and act like a psychiatrist.

What is intrinsic to this, the concepts and terminology of psychiatry become the air that the student breathes. Psychology student Tomoko explains the effects of the socialization as follows: "If you use this language day in, day out, it becomes how you think. It ends up living in you." By the same token, Nadia states:

> The psychiatric language and jargon, it became the main means of communication about case conceptualization or talking about people. It became how students understood everything. I mean people can be critical but critical within the confines of that language and those conceptualizations. And you know, most students just ended up following along. It became normal, right?

Given that all disciplines legislate and normalize, here we encounter a doubling effect. More significantly, herein we see the engulfment of one discipline by another. A profession that once had a more independent character has been colonized. Correspondingly, as with all colonization, whether it be India by the British or one discipline by another, elite members of the group being colonized are instrumental in the process—producing colonizing standards, inculcating, using rewards and punishments to ensure compliance. Witness, in this regard, the following exchange:

> *Bonnie*: So are you saying that as a psychology student, you feel unsafe expressing yourself outside the medical model and medical model language?
> *H*: Totally.
> *Bonnie*: What makes it unsafe?
> *H*: This is the basis of how you register, of how your competence is evaluated. And you are in this space where there is a huge power dynamic, where you need these people to give you grades, pass you along, keep you moving, give you references.

The crux of the training is the practicums and internships—likewise sites of psychiatric domination. Besides that the medical model tends to dominate regardless, students are under enormous pressure to do a placement and an internship in a hospital itself (translation: directly under the rule of psychiatry), with the probability of getting certified as a clinical psychologist if they do otherwise drastically reduced. The "hospital imperative" in turn affects the journey as a whole, impacts how students shape their learning. States Nadia here:

> It is a conversation that I have been intensely engaged in over the last year because I have done the hospital placement and now I am ready for the internship. And from year two onward everyone is thinking: How do I build up my experience so that I am attractive enough and competitive enough to get into the hospital setting? Because if you don't, everyone will tell you from your peers, to your supervisors, to your professors, you are going to have an incredibly challenging time at registration.

Once in the hospital placement or internship, the psychology student is part of the "mental health team," which operates in the ways delineated, with all the controls pertaining. Added to the dynamics already discussed is the special precarity of the psychologist in this setting and their concomitant need to keep differing opinions to themselves. ECT critic Terra Dafoe describes the inevitable silencing of the hospital psychologist as follows:

> We have seen psychologists mysteriously disappear—you know, like early retirement. As a psychologist . . . you understand that something is happening behind the scenes. . . . And psychiatry makes all the decisions . . . And so people wonder: Why is psychology even here? . . . And in psychology, people have fears about speaking [up]. We have seen psychology disappear in hospitals throughout America. So . . . there is a real fear of saying anything against the grain, let alone coming out against a treatment.

"You know," she pointedly adds, "people will lose their jobs. They've lost their jobs for a whole lot less; and I've seen it happen (from Burstow, 2011).

So how is it that psychology "team" members conduct/come to conduct themselves as they do? Suggests the data, because they are in a profession that has professionalized, and in the process, cast its lot in with psychiatry. Because they are steeped in the medical model. Because for years, they have been drilled in diagnosing, filling out forms, ticking boxes. Because they have been socialized to believe and to conform. Because they have an investment to protect. Because they hold onto the hope that they can do good. Moreover—and in the long run, it is far from clear that professionalization has worked to their advantage—because as workers who are *like psychiatrists and yet not psychiatrists*, they are keenly aware of the precarity of their position.

Psychiatric Social Workers

Albeit the education to become a social worker is extensive, it is nowhere near as formidable as with psychiatry or psychology, and with concomitant less power accruing (social workers can do therapy but are not entitled to diagnose or prescribe). While the odd person may get a doctorate in social work, moreover, besides that the doctorate affords them no further power, the doctorate is never required in practice, indeed, is coveted only by those whose sites are set on academia. The practitioner social work degrees per se are the four-year bachelors (BSW) and the two-year masters (MSW). The sought-after degree, the one almost invariably required by hospitals and which, predictably, opens doors is the MSW. As one recent graduate/interviewee put it, "So you know what my prospective employer said? You have a DSW [Doctor of Social Work]. Okay. We can live with that. But you do have THE DEGREE?" (meaning the MSW).

Given that the very title points to the social, we could reasonably expect that in social work, the social construction of human problems will be front and center. In practice, however, social work has long been divided between a social justice and a personal deficit model. The inherent tensions are long standing and remain. Additionally, in recent years the personal deficit model has demonstrably gained the upper hand. In the 1980s and early 1990s, when I taught in this field, "structural" or "radical" social work, which was deeply rooted in critical analysis, was a growing phenomenon (see Moreau, 1979; and Carniol, 1992). Now it has all but disappeared, with social work divided between "anti-oppression practice" on one hand (also known as "social justice") and "clinical social work" on the other, with anti-oppression social work significantly less political than the structuralist and with clinical social work transparently dominant—in the United States especially.

The vast majority of social work schools throughout the world and more or less all the ones in the United States are known as schools of *clinical* social work. And it is here that a student would go who wanted to work in the area of "mental health." With clinical overwhelmingly dominating, like psychology, the discipline of social work today is an area highly colonized by psychiatry. To be clear, while the clinical social worker is trained to attend to social practicalities—for example, help a person find lodgings or secure financial support—like everyone else with advanced degrees in "clinical," clinical social workers receive extensive training in the DSM and accept this as foundational. Moreover, despite social workers' avowed ethical obligation to protect autonomy and fight for justice (see National Association of Social Workers, 2008), one of the primary duties of the psychiatric social worker is precisely to work with "patients" and "their families" to ensure "treatment compliance." "One of the main difficulties that the psychiatric social worker might encounter with psychotic patients," states the first item on a popular web list of psychiatric social worker interventions, "is to help them take medication and maintain treatment" (once found at http//:wwwslidesharenet/RouhaanDils/psychiatric-social-work-intervention).

Much of this shift may be traced to professionalization. Despite the protests by the more radically minded, like psychology, social work has rigorously professionalized over the years. With professionalization has come greater emphasis on clinical and what goes along with this a closer relationship with psychiatry. What is part of the package, correspondingly, is a move toward competency-based practice and teaching—a factor strongly pushed for by the professional bodies—and the concomitant influence of those bodies on social work education.

The influence in question happens indirectly. That is, regulatory associations use membership fees to further their agenda. However, it also happens directly—with their presence visibly at work within the school itself. To quote from my interview with social work faculty member B.N. in this regard:

> *B.N.*: The CASW [Canadian Association of Social Work] is the umbrella association for all the Canadian provincial regulatory bodies. And the associations across all the provinces are fighting really hard to influence schools in the direction of just teaching micro-skills and completely removing any kind of critique.
>
> *Bonnie*: And what influence do the provincial bodies have?
>
> *B.N.*: Huge. So in our school of social work, besides faculty members, we have a layer of colleagues called "professional staff." And those are MSWs that come and do the student advising. And these are all people who are part of the different boards within our regulatory bodies. And so the issue of competency-based learning is alive and well at our university.

Social work being a practitioner degree, the crux of the education is the placement. Insofar as placements are largely clinical, moreover seen as "real world" experience, they are particularly formidable in pulling the student in a medical model and social control direction. In this regard, social worker educator and recent graduate Rhonda L. states: "Unlike most of my colleagues, I have a critical bent. Students listen at first, but once they step into the hospital, they just roll their eyes at the critiques which I teach. It's as if I am just this out-of-touch radical who does not understand the real world." By the same token, social work educator Brenda LeFrançois states:

> There is this overwhelming psychiatric bias. The students, they are enormously influenced by the psychiatrist, who is the head of any team in the hospital. And it is important to understand that some social work educators incorporate radical ideas, but as soon as students get into their placements, it is gone. They may be excited by the radical analyses that you present, but then they enter the placements, and when you teach them again, you find that they have totally bought into what they have been taught in the placement.

All this being the case, despite the references to social mission, the educational journey largely prepares the clinical social work student to assume their place as a helpful and nonproblematic member of the mental health team. Social work education so constructs the social worker, that is, that they are hardwired to operate in conformity with the medical model, to lend their efforts in controlling the "patient," to cede to psychiatric authority. Which is not to say that social justice concerns and indeed the contradictions may not nag away at the clinical social worker from time to time—something recent studies appear to suggest.[6] And herein lies the promise.

Nursing

Nursing education is typically a four-year program, a sizeable part of it in placements. In most collaborative programs, the first two years are in a community college and the second two at a university. Unless they are pursuing certification as a psychiatric nurse—now a protected title—nurses-in-training are unlikely to come across much about "mental health" in their textbooks; and what they do come across is decidedly medical. For example, in the most popular of the Canadian nursing textbooks (see Lewis et al., 2010), only a few paragraphs and three diagrams are devoted to "mental health," in contrast with "systems" like the digestive system, which are afforded 100–150 pages. At the same time, "mental health" is theorized as a system precisely like the "digestive system," which can similarly have "system defects" or malfunctions. Correspondingly, where nurses do advanced studies, they come across textbooks such as *Psychiatric Mental Health Nursing for Canadian Practice* (Austin and Boyd, 2010), which while identifying the nursing orientation as "holistic" (to a lesser extent, the same claim is made about the psychiatric orientation in psychiatric texts), nonetheless, replicates and emphasizes the biological.[7] As such, the nursing student interested in "mental health" is set up to have a bifurcated consciousness. Note, she is the health professional arguably most associated with emotional care—and yet she is ever being pulled back into the biological (considered primary).

The nurse's relationship with the doctor writes large the relationship of all other team members (my reason for reserving it to the end). The point is, it is the paradigm of what nurse educator Simon Adam (2014) calls "a sub-collegial relationship." To wit, the nurse exists to serve the doctor. In their education, correspondingly, nurses are socialized to defer. The gendered nature of both professions is clearly implicated here. The man (the doctor) rules, the woman (the nurse) assists. In the process, she protects the doctor from the daily reality of the "patient's" existence. She rouses the inmates in the morning, dispenses the "meds," ensures compliance. Herein we see what has become of the woman healer. She has in essence been turned into a serviceable underling.

Significantly, there can at times be a marked discrepancy between what the nursing student "learns" in the two very different settings in which she finds herself, and where that happens, one has clear precedence over the other. Studying ethics in school, for example, she may read in her association's code of ethics that she is to attend to the whole continuum of care, that she has an obligation to not only treat clients with respect but to report any colleague who does not (see, e.g., American Nursing Association, 2001; and Canadian Nurses Association, 2008). By the same token, an enlightened nursing curriculum (to be clear, the exception) may emphasize advocacy, social dimensions, may even to a degree sideline the medical model. However—and here we find both the contradiction and the hierarchy—as with social work, whatever enlightened transpires in the classroom is routinely nullified in the placement. To quote nurse educator Cheryl G in this respect:

> When psychiatric nurses branch out and start to create their own models, there are lots of creative models that take into account the social determinants of health, quality of life, but when the rubber hits the road, the default is right there. The model is still an inherited one, and it is ascribed. We might in some innovative curriculums try to detach ourselves from that lens of a deficit model, of a labeling model, of the DSM, of all the pathologization—and at my program, we try to use something called "client-centered care," where it is not cookie-cutter. Nonetheless, when we send our nurses to a placement, it is all gone. They say to us, "What you are teaching us, that's not reality. That is not what is happening out there."

The language is instructive here. "Placement" equates with "out-there," which equates with "reality." What is learned in placement is "what is real," what needs to be taken seriously. Conversely, whatever conflicts with the placement (e.g., a progressive, less medical model, less subservient, more agent-oriented curriculum) is "not reality." Herein rests the *real* curriculum, and it is to this that we must turn if we are to understand the nurse's socialization.

Placements typically commence in second year, with the last year of the program overwhelmingly spent in placement. In all areas, along with the medical model, the emphasis is on obedience, on following orders. The hierarchy is clear and formidable. Indeed, the nursing student is inserted into and subjected to *two* hierarchies: An educational hierarchy, in which she is subordinated to the nurse preceptor (clinical supervisor); the institutional hierarchy (student nurse at the bottom, followed by nurse preceptor, then head nurse, then psychiatrist). Lower than everyone else, and primarily overseen by other nurses, the nursing student is told what to do, what is and is not true, and is expected to comport herself accordingly. In the process, critical thinking and indeed understanding per se are largely bypassed.

The student doing a community health rotation in a psychiatric area is likely to spend much of her time ensuring medication compliance. She may be involved in subduing patients. At the same time, she is learning the fine art of filling out forms, how to handle the tick boxes, how to observe, to do what she can to ensure that the unit is running smoothly. Moreover, whatever the specific duty may be, the student is taught to perform their role efficiently—for with nurses representing the largest segment of the health workforce, it is on nurses' activities that government efficiency measures are focused.[8] In the process, not only the inmate but the student too is subjected to institutional rule—and in highly concrete ways.

To give you a taste of the actuality of these placements by "dropping in" on one, note this interchange with nurse educator Simon Adam:

> *Simon*: I did a mental health rotation as a student. I remember the first shifts. I was told not to engage the "close observation patient." "Close observation patients" were explained to me as patients that need to be seen every 15 minutes and documented on a log every 15 minutes. The clinical rationale is that they are high risk—that is, patients dangerous to themselves or others—and that they needed to be watched.
>
> *Bonnie*: So Simon, were you told *why* you shouldn't talk to them?

Simon: No, but thinking back on it, I suspect that it was because I was inexperienced. So it was more to protect *me*. Hmm. Now I am wondering: To protect me from what? I think that it was more of a barrier to protect me from the potential dangers presented by these patients. Yes, yes. "So here is the clipboard. So watch them from behind the glass, but don't engage them."

Bonnie: Behind–the-glass surveillance, yes. And precisely what were you to record?

Simon: What they were doing—their activity. So close observation was also called the "Q 15 minute observation." It is every 15 minute observation. So what we had was a clipboard with the patients' names on them, and the pre-printed every-15 minute interval was on it. What the form prompted me to insert was just a check mark every fifteen minutes—that I saw the patient, and there was a small little remark space for me to record whatever they were doing—walking about, sitting in the lounge, watching TV, eating—that's the observation.

Bonnie: At the time, did you have a sense of the meaning of the meticulous recording?

Simon: No, you don't know the meaning. I mean as a clinician—what the hell? It is a form; and you are filling it out, right? It is a form. It is a preprinted matrix. Picture a table with a whole bunch of rows for patients' names and three or four columns. One column is the time, another is the check mark.

Bonnie: What do the staff do with those Q 15s?

Simon: Oh, Bonnie, I don't know. As a scholar, I now have an analysis, but then I was a nursing student, and we get marked on this, and so like all my peers, I just did what I was told.

Bonnie: And what is your sense looking back on it now?

Simon: I haven't done any research and I can't prove it empirically—but I strongly believe that they are to monitor the actions of the nurse, to see that the nurse is actually watching the patient. For the nurse to prove that he or she is watching the patient.

Bonnie: So you were also under observation?

Simon: Oh yeah. There was a high level of surveillance going on and different levels happening at the same time.

Bonnie: Okay. So let's briefly revisit the patient/student nurse dynamic in hindsight. You were put in a placement. Your job was to subject people to 15 minute observations, but never approach them. What do you think you were being asked to believe about "mental illness" by what you were asked to do?

Simon: What I came to believe was not as a result of being *asked* but being *told*.

Bonnie: Okay. So if you could concretize that for me, what were you told?

Simon: This is how things are. There are a certain number of patients who are violent, about 30 percent, and so as a nurse, this is what you have to do.

Herein we see the nursing student socialized to "observe," to accept as truth any explanation given by a superior, to operate in the absence of understanding, to fill out forms meticulously, to view the "patient" as "dangerous," to do as one is told without questioning. Add to this the monitoring of drugs, helping to subdue, accompanying "patients" to get ECT, correspondingly, and we see the production of the mental health nurse—obedient, efficient, medical model, in short, a "made-to-order" team player.

Besides that any given nurse is "expendable," besides that the very fact of them does not quite register (recall the interviews with the psychiatric residents), it stands to reason that the professional thereby constructed will do exactly as asked—will follow orders, subdue "as needed," tick the "appropriate" boxes, impress on the patient the importance of "treatment compliance." The point is that s/he has been scrupulously trained to do so.

Such is the team.

Pulling Together, Concluding, Reflecting

We began this chapter with a pressing question: How is it, we asked, that helpers who enter their profession at least partially out of a heartfelt impulse to help come to act in the problematic ways in which team members do? What we have discovered in probing is an expectation of rigid conformity. We unmasked this as tight psychiatric rule, shaped by a "we-them" division, with "we" as experts and "them" as both "mentally ill" and dangerous. At the same time, we witnessed a team that is not a team, a multidisciplinary group that in the final analysis is not multidisciplinary. We found the colonization of all cognate disciplines by the most powerful one, moreover, by the one with most to gain—to wit, psychiatry. Dynamics with particularly strong explanatory value include: enticement, self-interest, pressure, rationalization, the power of discourse, overt and covert threats, routinization, desensitization, an extensive investment, rites of passage.

What sets all this up, as we likewise found, are very special as well as lengthy educational/socialization processes—ones that largely subvert critical thinking, that instill, as "needed," subservience, entitlement, or both, which are so regimented, so scrupulously monitored that they constitute a rite of passage in their own right. These highly professionalized educational routes serve to foster allegiance to the profession. They prioritize the medical model. They privilege placement over classroom, the repetition of tasks over understanding, action over reflection, indeed are so famed as to replicate the ways in which the professions operate. In the process, they produce the various members of the team as we have come to know them—the psychiatrist, the psychologist, the social worker, the "mental health nurse."

In light of the education, in light of the more general socialization, it is expectable that members and the team as a whole operate as they do. Having been taught to do so since the early days of rotations, though especially in residency, the psychiatrist rules. Correspondingly, having been socialized to do so in placements and internships, everyone else obeys.

To break this down more minutely, the psychiatrist presides over the hospital just as when a resident, he presided over emergency—prescribing, producing findings of incapacity, signing forms, "rallying the troops," delivering orders. Having been socialized to be obedient and at the same time having been equipped with a particularly extensive knowledge of the DSM—one, indeed, that exceeds the psychiatrist's—as the most obvious competitor, the psychologist is at once subservient and busy "out-psychiatrizing" the psychiatrist—diagnosing meticulously, producing exceptionally detailed reports. "Whereas the psychiatrist writes two, three-page reports," explains Sabeena in this regard, "the psychologist produces twenty-page reports." The social worker realizes their marginality, knows they are greatly outnumbered, being the only such worker on the team. They have learned that their primary role is to provide assistance in the transition to the community. Correspondingly, they assess the relocation possibilities as directed, make arrangements, work at ensuring that the "patient" and the family are committed to treatment compliance, perform other duties at the behest of the team. The nurse by the same token does precisely what the placement prepares her to do, what the job requires her to do. One of many, part of the primary workforce, she meticulously carries out the orders of all "superiors" At all costs, she keeps peace on the ward—which commonly means restraining, even when she suspects that sitting with the person would suffice to calm them down. "If they were to take time to sit with the person, they would be so far behind on what they are required to do, their own team would be mad at them," points out Nadia. She completes forms, methodically moves people to the next processing station, ensures that she is acting in accordance with the latest economizing directives.

To be clear, I am not suggesting that difference, special moments, helpful exchanges never happen. They do. However, that does not result in lasting change, not even for the specific inmate involved. In the words of one interviewee, "As an individual, you can work with someone and try to create change, but that does not change a thing. That person interacts with five thousand other people in the system who do not share your view." Moreover, irrespective of viewpoint or intention, there are routinized work processes in place. The point is, overwhelmingly, everyone knows their role and performs it. Correspondingly, what is especially important to take in, given the self-monitoring, self-validating, and self-reinforcing nature of the systems as we have witnessed them, these systems and professionals are set up to continue replicating themselves.

That understood, and Foucault and institutional ethnography factored in, the question nonetheless arises: To what extent is the average team member aware of the problems inherent in what they are doing? In a purely Foucauldian universe, note, people are not aware at all, for no one can step outside the discourse in which they dwell. There is truth in this, as evidenced by the difficulty we all have thinking outside of the medical model. Correspondingly, in the case of the average practitioner, so ingrained are these beliefs and practices that an external vantagepoint is likely to seem perplexing, plain wrong, bizarre. I am reminded here of these words by nurse educator Simon Adam, "Bonnie, when you initially encouraged me to avoid the word 'disorder,' really, I thought you had two heads." Moreover, at the moment when a practitioner is pondering which drug to administer, their focus is overwhelmingly on the "purpose" of the drugs, the known "side effects," the various examples in their head, the well-trod path used in making this decision. Anything outside the standard tick boxes, as it were, does not figure. That acknowledged, let me suggest the issue of awareness is not that simple. On a direct level, people who falsify research or who exceed, say, a certain level of conflict of interest, know that they are doing so, even know a number of the implications. People who opt to hold onto their jobs rather than blowing the whistle on an "incident" that keeps them up at night, also know. On a less direct and far more general level, the very fact that people rationalize means that on some level and to some degree they know that there is something to "explain away," indeed, may even know it at the actual moment when deciding on a drug.

The concepts of "open secrets" and "bad faith" have explanatory value here. An "open secret" is a truth that everyone knows but does not acknowledge publicly. Everyone knows the secret; everyone knows that *everyone else knows the secret*, but except for the odd "maverick" who can readily be dismissed, everyone respects the secrecy. Let me suggest that there are a number of open secrets in the mental health field. Open secrets that suggested themselves to me as I interviewed practitioners—mainstream practitioners especially—include: There is something wrong with the drugs. There is something wrong with much of the research. There is something wrong with the very way that we are all operating.

"Bad faith" is a concept of Sartre's (1943/1956). A person is in bad faith when they inwardly pretend *either* not to know what they know *or* to know what they do not. To be clear, this is not the same as lying. The person who is lying is *fully* aware that they are engaging in an untruth. The person in bad faith is not even close to being fully aware. They are aware, that is, but do not allow themselves to be *aware that they are aware*. To put this another way, a person in bad faith makes a point of not reflecting on what they are aware of, and as such, keeps themselves from the awareness. A somewhat dated example of Sartre's is the conservative young woman on a date who is comporting herself and defining herself as unaware that the young man's hands have drifted to her sexual parts. A more well-known example—and one curiously apropos—is of Pierre the waiter. He defines himself as nothing but a waiter, nothing but the role that he performs when on some level he is aware that being a waiter *does not define him*, that he has freedom, that he is not a waiter, that is, in the way that *an inkwell is an inkwell*.

Much of what is happening in the mental health area, in the team itself, I would suggest, is enabled by bad faith. When nurses, doctors, social workers, psychologists subdue an inmate and tell themselves that this cannot be helped, that it is "the only thing that they can do," on some level, they know that they are acting expediently; they know that there are other and likely better options. Given that such awareness conflicts with official credo, indeed, with their very image of themselves and their profession, however, they make a point of not reflecting on it. They define their response as "necessary," may even, as in the case of the facility where Chris worked, create debriefing sessions to reinforce the bad faith belief (significantly, so tenacious are bad faith dynamics, in the very process of articulating an otherwise penetrating analysis of the punitive actions of himself and his colleagues [Chapman, 2014, p. 24], Chris nonetheless states, "the possibility of imagining their individual violence as a response to our . . . violence . . . *was not available to us*"). By the same token, when professionals pronounce ECT safe and effective, when they call an underling "on the carpet for not going along with the plan," they are making a point of sidelining the disasters that they have seen, ignoring the reduction of self, and as such, are operating out of bad faith. On a personal, as opposed to an institutional, level—albeit the two connect—herein is the crux of the problem. Herein likewise lies a basis for knowledge insurrection, for at the very base of bad faith lies the awareness that is being suppressed.

These dimensions noted, I would end this chapter on the psychiatric team with two reflections. The first concerns professionalization. In Chapters Two–Five, it emerged as a means of marginalizing competitors. What we saw repeatedly in this chapter is that it additionally cuts the professional off from authentic knowing and relating. It at once distances the professional from the "othered" person, nullifies the humanity of both, and subverts understanding, turning "help" into mini-tasks, in which one can have "competencies." It serves the profession only (when too many professions are converging on the same territory, of course, it can backfire—hence the special predicament of psychology). And inevitably, it damages those hypothetically being served. And people know this. Indeed, the fact that there is something amiss with professionalization, more fundamentally, with rule by professionals per se, is itself an open secret.

My second reflection brings us back to the overt violence with which this chapter began. In revisiting it, I would quote a passage from my interview with Nadia for in it the connection between violence and "treatment" clearly comes into view:

> So many of them did not want to be taking the treatment that they were forced to take, but they had absolutely no choice. But the thing is, *it is the substances they were taking that were creating all the problems*. Much of the violence that I directly witnessed centered around taking or not taking medication, and in most cases people were coming in off the streets incredibly confused and scared. And in that initial assessment, people are given a whole host of medication to subdue them so that they can be integrated. So in that moment of someone coming into the institution and the staff forcing meds on people, people can get violent—largely because they are terrified. You know, I have often seen people just trying to discuss not wishing to take the medication, where this initial attempt by the person is not violent. It's just standing up for oneself, respectfully sometimes. Then something happens in the back-and-forth, and the patient ends up being held down and forcibly injected.

What is significant here—and other interviewees confirm Nadia's observation—what generally underlay the inmate's "violence" (which in turn becomes the impetus for greater staff violence), is precisely the felt need to fend off a threat—an unwanted intrusion—something one's bodily instinct for self-preservation instructs one to do. What we are seeing, that is, is self-defense. To reconfigure this in human rights terms, however it is expressed—whether coherently or incoherently, whether calmly or in a frenzy, whether respectfully or aggressively—the inmate is in essence asserting their right to decline the "treatment." This would be significant and a compelling truth to ponder even if the "treatment" were intrinsically benign. As we have already seen, however, irrespective of motivation, the treatment is not benign, indeed, constitutes a seizure of the person in its own right.

In Chapter Three, we began probing the inherently violent nature of these treatments—what they actually do to the person, to the body, to the brain itself. In the chapters which immediately follow, we shall be probing these treatments in greater detail.

CHAPTER 7

Marching to "Pharmageddon": Psychopharmacy Unmasked*

The focus of this chapter is the kingpin itself—psychiatric drugs. Indeed, to a degree, all along, this journey has been about psychiatric drugs, with the picture becoming progressively clearer that psychiatric drugging is the very essence of psychiatric "treatment," moreover, that the role of the pharmaceuticals is duplicitous and deleterious. In the very first chapter, significantly, we probed the situation of a young man called Kevin, who killed himself because of the plight to which psychiatric drugs had brought him. Kevin's story, you will recall, functioned not merely anecdotally but as a disjuncture. In typical IE (institutional ethnography) fashion, we proceeded to use Kevin's story as a entry point into the system. Come Chapter Three, we saw the drugs emerge as a guarantor of the medical model, which in turn guarantees medical dominance. In this and subsequent chapters, correspondingly, we explored the contours of the drug revolution, the pharmaceutical industry-generated conflicts of interest, the nature of the underlying research on which pharmaceutical dominance is built, the place of the pharmaceutical industry in the "mental health system." This chapter rests on what has been already established.

To reiterate critical aspects of what has to date been established:

- Psychiatric drugs are neurotoxic (Chapters Three and Five).
- Psychiatric treatment and psychiatric drugging are virtual equivalents (Chapters Five and Six).
- With the construction of ever more psychiatric disorders, with the deployment of epidemiology studies designed for maximum capture, and with pharmaceutical money "greasing the wheels," the spread of these substances has reached epidemic proportion (all preceding chapters).
- Drug companies overwhelmingly "call the shots" in the "mental health system" (Chapters Three–Six).

- Conflicts of interest are intentional, systemic, carefully nurtured (Chapters Three–Five).
- While the justification for psychiatric drugs is that they correct a chemical imbalance, despite over half of century of trying, no such imbalance have ever been shown to exist. Rather, they have been shown to *cause* chemical imbalance (Chapters One, Three, and Five).
- Government regulators "rubberstamp" more than regulate (Chapters Three–Six).
- Drug research is overwhelmingly controlled by the industry and is manipulated (Chapters Three–Five).
- Psychiatric drugs belong to the repertoire of brain-damaging treatments in psychiatry (Chapters Three and Five).
- Psychiatric drugs are central to and epitomize psychiatric seizure and control (Chapters Three, Five, and Six).

This chapter could profitably be devoted to delving further into any one of these areas. Conflict of interest is especially significant to be on top for it is a recognizable motivator and it implicates a high percentage of operatives, extending not only to key psychiatric organizations such as the APA but to academic researchers, the psychiatric journals, parent groups, even, as demonstrated in Chapter Four, entering into the framing of the DSM itself. We might likewise profitably focus on the advertising for it is pharmaceutical framing that establishes the medical storyline. Given what has already been articulated in previous chapters and given the fastidious work by other scholars on these issues, I would instead refer the reader for additional details on such issues to Whitaker (2010 and 2002). While inevitably, conflict of interest and promotion are threads which weave through this chapter, this chapter focuses more broadly and more narrowly on two very specific domains—ones that do not so decisively enter into popular knowledge but that it is critical to understand if we are to get the measure of what we are dealing with. These are: (1) the research-to-approval process, and where this leads; and (2) the precise actions of the drugs themselves. The chapter begins with the research-to-approval process. It proceeds to an examination of the major classes of psychiatric drugs. It ends by revisiting the situation of Kevin.

A far-reaching chapter, this chapter problematizes at once the claims about the drugs, the process, and the underlying discourse. In the process, it draws on the work of many researchers, especially highlighting those whose role as expert witness in liability suits affords them special access (e.g., Breggin and Healy). Compelling questions addressed include: Is the pharmaceutical industry's emphasis on randomized double-blind studies and statistical significance the mark of good science? How are we to understand the discourse of evidence-based medicine? What does the research-to-approval process look like? What do the processes in question distort? Make disappear? How is that academic journal articles report what they do? How do the neuroleptics "work"? The antidepressants? The stimulants? What is meant by "compensatory mechanisms"? What are the short- and long-term consequences of taking these drugs? And if, as critics claim, these drugs are overwhelmingly harmful, why do some folk feel better on them?

The chapter is written with a profound awareness of the myriad of people (and you will hear from them shortly) whose lives have been chemically diminished, also of the multitude of "patients" like Kevin whose death were a product of these drugs. It is written likewise with the awareness that there are people (both "patients" and loved ones) whose lived experience seems to suggest that these drugs are life-savers, if not for others, at least for them. In this last regard, this chapter is likely to be alienating, even exasperating for some. My hope is, nonetheless, that to varying degrees it will say something to everyone, maybe provide a single useful piece of information, perhaps shed light on a half-forgotten enigma. My invitation? Entertain the various revelations as they present themselves, and see where the path leads you.

Starting at the Beginning: The Approval Process, the Discourse

The research-to-approval process marks the beginning of a drug being marketed for a specific condition, also the framing of the drug per se. At the same time, for all intents and purposes, it places an official stamp on the disorder. If a drug is being licensed to correct a condition, *officially*, the condition exists—a reality of singular importance in an area where medical conditions are *putative* only. Correspondingly, it sets the stage for conflating the "nature" of the putative condition with the actions of the drug itself (for an example of this, see Chapter Three).

Gaining approval and a protocol for a new drug or a new use for an "established" drug[1] is a complex process involving at once the drug company, the regulatory body (instrument of the state), and a research firm ("independent" third party). The latter is seen as guaranteeing objectivity. This notwithstanding, what stands out about the approval process, even at first glance, is how much of it is in the hands of the pharmaceuticals themselves. Peruse, in this regard, figure 7.1.

Insofar as the drug in question is a new product and the pharmaceutical company wishes to bring it to market, typically, the process begins with tests on animals (see top of figure 7.1). The human studies that follow form the start of the approval part of the process. They are randomized trials (subjects are randomly assigned to either the treatment group or the control group); they are double blind (neither subject nor researcher knows to which group a subject has been assigned); and they include use of placebo (more or less sugar pills) and often also contrast drugs (drugs for the "condition" already on the market).[2] The aim is to establish that the product being tested is more effective than placebo and products already on the market, to demonstrate this, moreover, at the level of statistical significance—the accepted gold standard in scientific research. Correspondingly, it is to satisfy the regulators that there are no significant adverse effects (commonly known as "side effects").

An abbreviated walk through the process: As you can see if you glance at the top of the diagram, the trials per se are conducted by the third parties. And initially, many such trials are conducted. The trials generally last 4–6 weeks. The data thereby generated is submitted to the drug company. The drug company proceeds to analyze it. It typically picks two or three studies to present to the regulatory body (bottom part of diagram). "Presenting to the regulatory body" means: creating and submitting a summary report (bottom of diagram); releasing other data

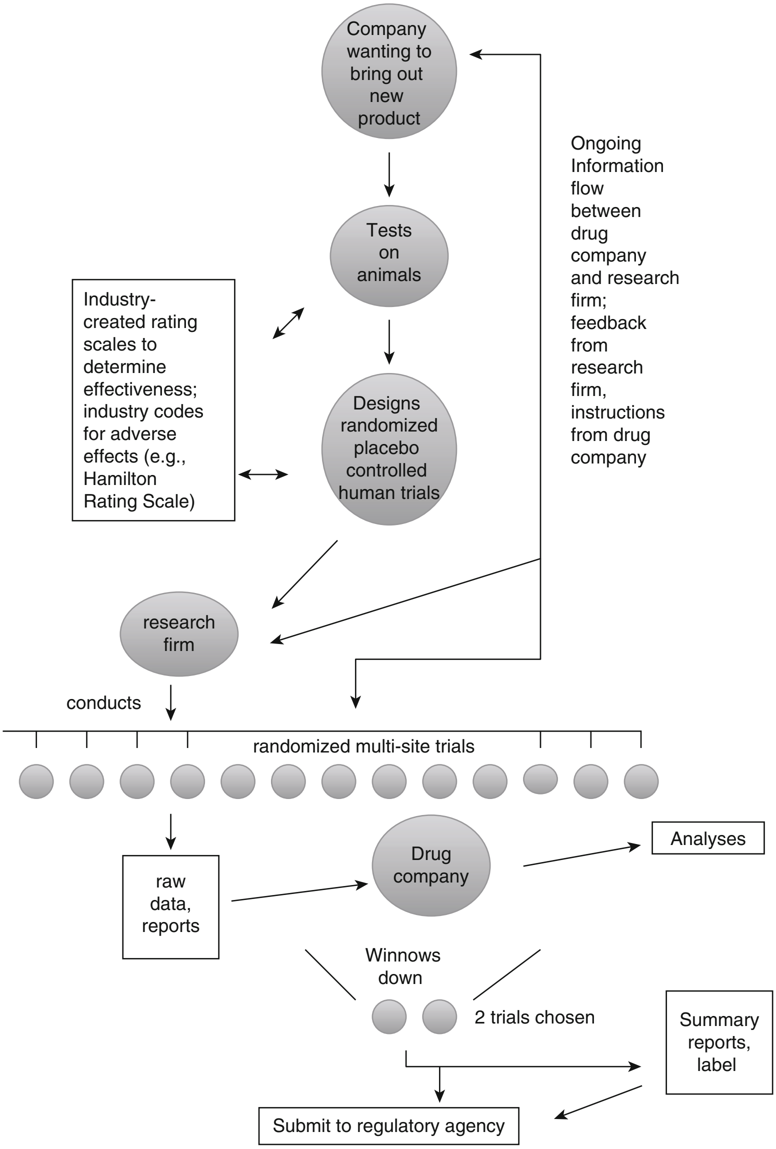


Figure 7.1 The regulatory process in action.

as required; and providing a provisional draft of the label (the information insert, which includes such items as side effects and warnings).

On first blush, this may seem like a credible process. After all, third parties—not the pharmaceutical companies directly—are conducting the trials. And a government oversight body is empowered to accept or refuse. Even before we delve further, however, worrisome factors are evident. Note, in this regard, the drug company gets to choose which trials to present—a setup, as it were, for "cherry-picking." Correspondingly, the trials are designed by the pharmaceuticals themselves. Moreover, analysis happens in the office of the pharmaceutical companies. What further contaminates the process, the putative third parties are in the hire of the drug companies and are likely to do the bidding of the drug company if they want to keep receiving lucrative contracts (for details on these dynamics, see Healy, 2012; Moncrieff, 2009; and Breggin, 2008a and b). As you can see from the diagram, moreover, when it comes to the trials per se, the drug companies are hardly at arm's length. Information is at all times traveling back and forth, which means that strategic new instructions can be delivered at any point. Additionally, findings that prove problematic for the drug company can be reworked at any time—and routinely are. Lilly's instructions to its investigators on how to deal with adverse effects serves as an indicator of how deep this control goes and how it can skewer results. In a Prozac trial, Eli Lilly, note, instructed its investigators to code all evidence of drug-related adverse effects as symptoms of the original depression (for verification and details, see Breggin, 2008b, p. 389 ff.). If such blatant tinkering "crosses the line," what "crosses the line," as shall become progressively evident, is nothing more or less than the standard process edged one stage further.

To put a marker here—and we will return to the issue of process shortly—hypothetically, a flawed process can be "cleaned up." What cannot be cleaned up are faulty foundations. And ipso facto, faulty foundations means untrustworthy results. Moreover, they will likely interact in manifold ways with whatever conflicts of interest exist. This brings us to the methodological *foundation* of the research itself.

Evidence-Based Research

These trials claim to credibility is they constitute "evidence-based research." Evidence-based research is precisely empirical research involving randomized double-blind trials and use of control group (there are two general kinds of control groups here, ones given a placebo and ones given a contrast psychopharmacological substance). Correspondingly, results are established at level of statistical significance. The attempt is to show that the substance being tested is effective—indeed, more effective than other substances on the market—and to rule out placebo effects (translation: benign effects which happen independently of the chemistry).

On the face of it, the "evidence-based research" protocol would appear to offer an appreciable measure of protection against manipulation as well as error. Randomization of subjects is an established safeguard against skewed results. The epitome of what is seen as constituting sound science—use of placebos—gives us reason to believe that it is actually the product or process being investigated that produces the changes in question. Correspondingly, having statistical significance as the standard appears to guarantee that the findings are "rock solid," are beyond anecdote, are generalizable. By the same token, having the research double-blind" ostensibly safeguards against not only deliberate manipulation but such unintended skewing as happens with the placebo effect. As such, the foundations would appear to be sound.

An initial caveat: As Healy (2012) documents, the drug companies themselves are among the major proponents of "evidence-based research." This, of course, hardly invalidates the use of such concepts and standards. At the same time, given what we already know about the pharmaceutical industry, the fact that the industry has come to uniformly embrace and tout them is a development that should give us pause. While I would not wish to overstate the significance of this, the reader is likewise reminded that these concepts were employed by the psychiatric residents (interviewees) referenced in Chapter Six, and in those instances, the allusion to evidence-based research served as a means of sidestepping analysis entirely. That noted, the question arises: What are we to make of the discourse, of the measures, of the use to which it is being put?

To start with what looks unassailable, the use of placebo groups and of double-blind studies seems utterly unproblematic—that is, if the situation were *truly* double blind. Herein lies our first disjuncture. The reality is, given that the drugs have recognizable effects (pronounced sedation, for example) and given that the placebo used has none, both subject and investigator are likely to know within hours to which of these groups she has been assigned. As such, we appear to be dealing with appearance only—not carefully constructed research as normally understood. Other elements of the standard design likewise minimally to raise questions: What is achieved by large randomized trials that last four–six weeks only? What exactly does the achieving of statistical significance demonstrate? And why are drug effects being divided up between two categories—the effect being measured (inherent in the concept "effectiveness") and "adverse reactions"? As we probe these questions, the credibility of the process begins to evaporate while at the same time, the institutional manufacture of findings comes into view.

Significantly, effects which take time to develop, such as tardive dyskinesia, would never appear in four- to six-week trials (for a detailed discussion of "tardive dyskinesia," see Breggin, 2008b, pp. 55–68). Nor indeed would most other dire effects. Short trials in this regard serve to invisibilize inconvenient facts. Creation of randomized short trials and the concomitant valorizing of the process as the "gold standard," correspondingly, avoids the unfortunate discoveries that might be made by tracking individuals over an extended period. In this regard, I would invite the reader to compare short placebo-involved trials based on statistical significance to the once common physician practice "challenge, dechallenge, and rechallenge." The latter works as follows: A physician who wishes to ascertain what effect a drug has on a patient administers said drug to the patient, observes what happens (challenge), takes the patient off it, notes what now transpires (dechallenge); places the patient back on the substance to see if the "effects" return (rechallenge). Real observation, the real work of "figuring out," is happening here. Which method is superior, as Healy (2012, p. 72) suggests, depends on what you are looking for. Be that as it may, the downgrading of such procedures as something less than "evidence-based research" and the concomitant sidestepping of direct observation and retests creates a space for arbitrary, mechanically produced, and manipulated numbers to replace the evidence of the senses, common sense, and genuine analysis.

An equally formidable problem emerges with the practice of dividing the impact of the drugs between the "effectiveness" category (which relates only to the effects sought) and "adverse reactions" (essentially, "side effects"). Albeit this is fairly standard in medicine—so much so that we do not blink an eye at it—it begs the question. Quite simply, "side effect" is not a property in nature, not a quality of the drug per se, but a social construct. What the artificial division accomplishes is to define some effects as inherently primary, others inherently secondary, in the process, privileging one side of the equation—not coincidentally, *the side that culminates in increased pharmaceutical profits*. Now there may at times be a legitimate reason to use such a conception in medicine proper where, for instance, the "effect" being sought demonstrably addresses an underlying imbalance. By contrast, with psychoactive drugs (and with these, note, there is no proven condition, no imbalance), use of such distinctions is misleading. It functions to create the appearance of a disease, while illegitimately downplaying both the reality and the importance of the "undesirable" effects. In the process, there is an equivocation on the concept of the drug "working"— itself a discursive product. Question: Exactly what does "work" mean? If a substance *only minimally* produces benign effects while producing lamentable effects in abundance, additionally, if those minor benign effects have nothing to do with a presumptive therapeutic action of the drug, by what standards can one claim that the drug "works"? Add the fetishization of statistical significance to the mix and the scene is set for making certain effects appear and others disappear. Herein we see the trickiness of the statistical significance measures.

The point is, include enough people in a study and use advantageous measuring criteria, generally, you can easily construct some minor degree of "effectiveness." Note, if you have hundreds or thousands of subjects—and as Moncrieff (2009) reminds us, huge multisite trials are now the norm—a trivial degree of effectiveness over placebo suffices to reach the level of "statistical significance." It does not even matter if in your combined trials, placebo outperforms the drug, for you need only present two trials to the oversight agency, and naturally, you present the ones in which "statistical significance" are "established." The drug thereby becomes officially effective and acceptable. This is so *even if all of the following pertain*: the difference in effectiveness is so small as to be inconsequential; for all intents and purposes, the placebo results in substantially less "adverse reactions"; and what counts as effective has nothing to do with the putative "therapeutic action" of the drug. Conversely, by the power of numbers, you can make highly worrisome "adverse reactions" disappear.

How in fact does this play out?

Revisiting the Process

I would ask the reader to cast their eyes again on figure 7.1. Observe the large number of trials conducted (the little circles toward the middle). Contrast this with the small number of trials (two or three) presented to the regulatory agency. What accounts for this seeming discrepancy? The trials not presented have results which would not benefit the pharmaceutical company—hence their removal from the equation. Now look higher and observe how studies in general are conducted. In typical institutional fashion, to produce effectiveness, rating scale documents, complete with pre-established categories, are activated and the results tallied up. These are commonly the same documents used to measure "the disease" in a clinical context. And they work largely like the tick box documents already witnessed and problematized (see Chapters Four–Six).

The example in the diagram is the Hamilton Rating Scale (for details, see Hamilton, 1960). To hone in on it for purposes of elucidation, this is the standard rating scale for measuring "depression," and it is employed fairly routinely in antidepressant trials. The point of so employing it is to demonstrate that the antidepressants lower depression more than placebo, moreover, to establish this at a level of statistical significance. And indeed "official" antidepressant trials (those presented to the oversight agency) so demonstrate and establish this. Besides that once again what we are seeing here is an assessment conducted exclusively by someone other than the person being assessed (and a totally quantified one to boot), and besides that once again nuance, particularity, and meaning totally disappear, the measure even by totally conventional standards will not hold. Once again the devil is in the details. Healy's (2009) analysis of a group of antidepressant trials is telling in this regard. In the combined trials, indeed, 50 percent of those assigned to the antidepressant group improved (translation: had a lower rating of depression on the scale). Correspondingly, they outperformed the placebo group (40 percent improvement), at a level statistically significant. The rub?

1. Even if we accepted the concept of improvement uncritically, we have no way of knowing what degree of the improvement (possibly all) to attribute to the "extra" placebo effect (the effect that comes from recognizing that you are in the drug group). Since we are dealing with an "inert" placebo (one with no active properties) and so the researcher too can tell what group everyone is in, by the same token, we have no way of knowing what is attributable to researcher bias.
2. Irrespective of point one, the difference is hardly substantial. Large numbers were involved, thereby making statistical significance easy to achieve.
3. The sedative effects of the antidepressants—and sedative effects figure prominently in the rating scale and therefore the calculation—all by themselves suffice to account for the small difference in the two groups (for charts and other substantiating details, see Healy, 2009, p. 55 ff.; also Moncrieff, 2009, p. 139 ff.).

By these standards, we could likewise prove that nicotine and most of the antihistamines (all, significantly, with sedative effects) are "effective antidepressants."

The antidepressant trials are hardly unique. Along the same line, as Moncrieff (2009, p. 95 ff.) demonstrates, large trials and a rating scale that factors in sedative effects accounts for the findings of statistically significant with respect to several neuroleptics.

Just as opportunistic statistical significance calculations are used to establish effectiveness, they are used to minimize or hide "adverse reactions." A case in point are the various SSRI (selective serotonin reuptake inhibitor) trials. Despite worrisome suicidal acts and ideation occurring in the drug group, the fact that these did not prove statistically significant meant no warning was initially required on the label. Correspondingly, in the hands of the pharmaceutical company, lack of "statistically significance" (an artificial mathematical calculation) turns into a concrete "finding"—namely, that there is "no evidence of suicidality."

"Findings," as you can see, are constructed—not discovered. With the odd variation, the process of creating such a finding may be mapped as in figure 7.2.

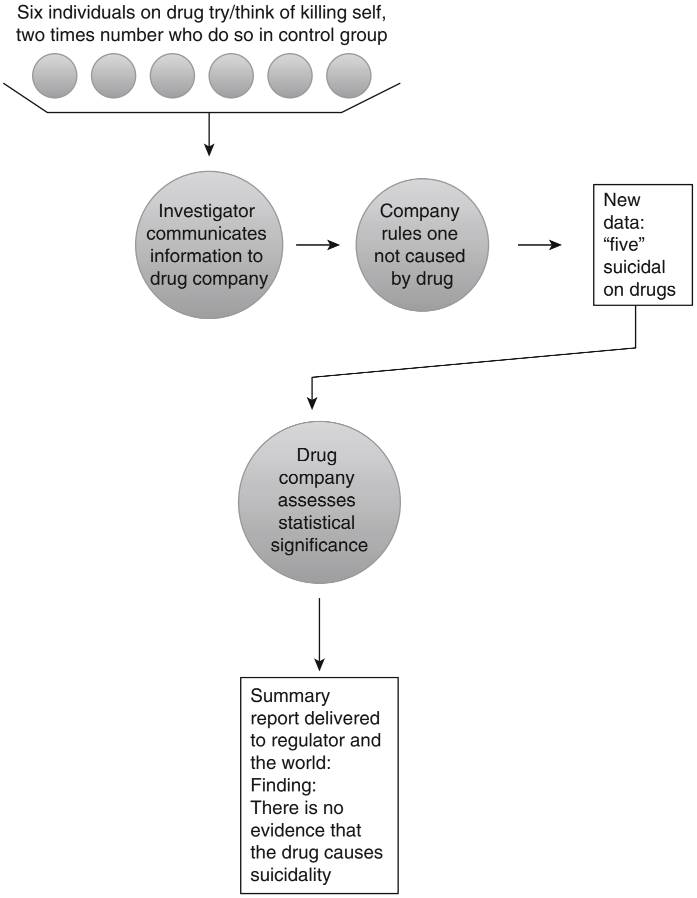


Figure 7.2 Manufacturing safety: how adverse reactions disappear.

The upshot in the SSRI story per se? Given the massive promotion and essentially the "hype" around the SSRIs, these new "blockbuster" drugs started being dispensed liberally. Fast forward: Within a couple of years, a rash of suicidal events were reported to the government regulators (e.g., the FDA), who in turn began to take note. And in the early 1990s suicidal acts on the SSRIs began hitting the news. At this juncture, Lilly defended its leading SSRI drug Prozac in an article that reiterated the original conclusion—that Prozac carried no more risk of suicide than placebo. In the process, they provided hard numbers as a way of substantiating their calculation. Here we see the power of statistical significance calculations up close. Writes Healy (2012, p. 212) pointedly, "Smack in the middle of the article are the figures, six suicidal acts in 1765 patients on Prozac versus one in 569 patients on placebo." This constitutes a *doubling of the risk*. What happened with the 1987 calculation, subsequently to be repeated here? By the magic of statistical significance, six suicidal acts and a doubling of risk disappeared. "No risk" thereby becomes the official story. Correspondingly, no suicide warning appeared on the released label (see bottom of figures 7.1 and 7.2).[3]

There is a telling addendum to this story. As documented in Healy (2012) and Breggin (2008a), it eventually came to light that cheating had occurred, that the solitary suicidal act in the placebo group had happened *before* the trials commenced. Attributing it to the placebo group in other words was a clear violation of the rules—a strategic way of ensuring that the calculations fell short of statistical significance. An observation: It is tempting to spin this sleight of hand as the "real story." There are *two* critical stories here, however. One is that the drug companies break the rules when convenient. The other becomes apparent if you ask: What if *there really had been* one bona fide suicidal act in the placebo group? Would that have made the "finding" acceptable? And with this question, the process as a whole is discredited.

Pharmaceutical Tricks

As the reader can see, the research process as designed is itself a strategic maneuver which produces what it purports to find. What is up and above this, as needed, trickery joins with the official process and the two work together to construct the products as "effective" and "safe." Documents released under Freedom of Information or which have materialized in discovery make manifest just how extensive and serious such tricks may be. For example, company memos written by Eli Lilly employee Claude Bauchy indicate that to his chagrin, he was obliged to do nothing less than miscategorize the suicidality that occurred in the drug group. Writes this distraught worker (and to no avail), "I do not think that I could explain to the BGA [the German Regulatory Agency], a judge, a reporter, or even to my own family why we should do this especially on the sensitive issue of suicide and suicide ideation" (excerpt from memo of November 14, 1990, from Eli Lilly employee Claude Bauchy to six Lilly administrators).[4]

Examples of typical tricks and evasive maneuvers documented by expert witnesses like Breggin (2001a and 2008b) and Healy (2012 and 2009) include:

- hiding disorders created by the drug being tested by splitting up symptoms;
- hiding suicide under misleading categories (e.g., as noted in Breggin [2008b, p. 394], in a Paxil trial, suicidality on the drug was tucked away under the category "emotional lability");
- invisibilizing bad "side effects" (e.g., anxiety) in the treatment group by also giving the group sedatives (note, besides obscuring the adverse effects, this action likewise makes a mockery of all effectiveness figures, for there is no way of telling which drug accounts for the "effectiveness");
- systematically eliminating those subjects from the placebo group who are faring well;
- giving markedly different amounts of medication to the drug group and the control group;
- *abruptly* withdrawing people from other drugs when placing them in the control group, thereby creating withdrawal effects that can subsequently be labeled "adverse reactions";

- releasing the "good parts" of a trial only;
- keeping raw data off the mainland so that it cannot be subpoenaed.

The Summary Report and the Label

The research culminates in the creation of two primary documents: (a) the drug company's "summary report"; and (b) the "label" or information package. The process leads to these documents, indeed revolves around them, as depicted in figure 7.3.

The trajectory mapped out here begins with the trials, proceeds through the "scholarly" literature, through consensus conferences, through approval, with the

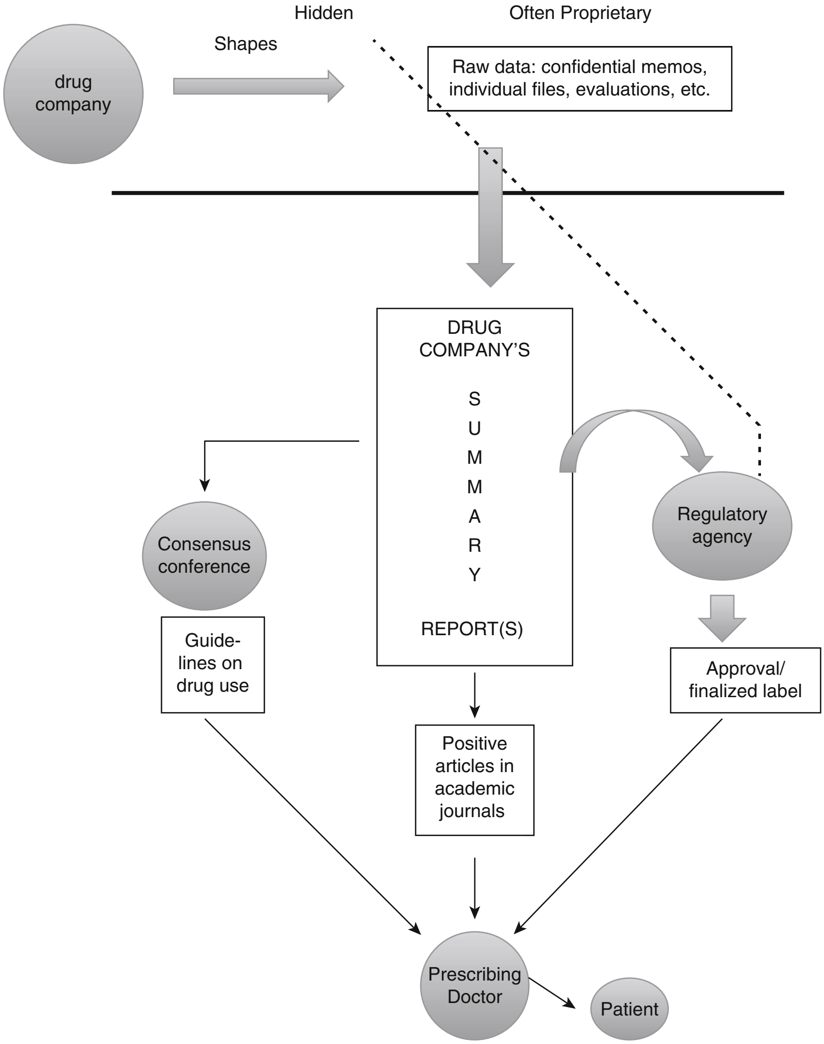


Figure 7.3 How prescriptions come to be.

process culminating in the doctor prescribing the medication. Outside operatives, including psychiatrists and scholars, are scrupulously kept away from the original data. What replaces the hard data and forms the epicenter from which all flows is precisely the label and the summary report—the analysis, the "spin" which the company places on the trials. As the process unfolds, progressively, these documents function like boss texts.

The summary report is the document most immediately influential and constitutive. Significantly, while the regulatory agencies receive other data, they largely focus on it, using it to judge the adequacy not only of the trials but the first draft of the label itself. Insofar as this is the case, the drug company is not only manufacturing data but manufacturing the template by which this data is evaluated.

The summary report more generally stands in for the data. On the basis of the summary (which makes no mention of the unfavorable trials), and without access to raw data (which is duly hidden), scholarly articles seen as definitive are penned and published. These tend to be attributed to leading scholars—hence the certainty of influence. Significantly, studies show that over half of the articles in question, including those in the most prestigious journals, are in actuality written by ghost writers in the drug company's employ (for details, see Blumsjohn, 2006; and Healy and Cattell, 2003). By the same token, medical journals—and these are the primary publishers of academic articles on the psychiatric drugs—are funded by the drug companies, with the result being that articles critical of the trials stand little chance of being accepted (see Healy and Cattell, 2003, pp. 22 ff.; and Healy, 2012, p. 119 ff.). What is hardly surprising under the circumstances, scholarly articles almost uniformly portray the trials favorably. Moreover, irrespective of conflict of interest, the invisibilizing of the raw data leaves all scholars (both the paid-for and the independent) with only one position readily available to them—to wit, the one contained in the summary report. By the same token, the summary report figures as the central document in "consensus conferences" (conferences involving all major players—psychiatrists of all persuasions, academics, representatives of government—whose role is to come up with practice-oriented conclusions and to establish guidelines). Significantly, critics are invariably invited to such conferences. With little but the summary report serving as data, however, they routinely and predictably come to the same conclusions as everyone else—conclusions, willy-nilly, that benefit the company seeking support for its new drug (for details on the summary report's role in such conferences, see Healy 2012, p. 136 ff.).

The second of the boss texts—the label—more directly and profoundly impacts the public and the prescribing doctor. To trace the sequence of creation and activation, like most everything else, it begins as a product of the drug company and, as such, bears its mark. It is initially drafted in the offices of the drug company, moreover, precisely in accordance with the problematic principles witnessed to date. Warnings, for example, do not tend to appear on the label unless statistical significance has been concluded. The draft label thereby constructed is sent to the regulatory body (e.g., Health Canada or the FDA). This means an assessment by a body not in its employ. This notwithstanding, it is assessed largely via the lens of the summary report—and here we see the pharmaceutical boss texts functioning to reinforce each other (activation and creation). Once the label is successfully "negotiated" between the drug company and the regulator—and as Breggin

(2008a) illustrates, this is more a negotiation than an independent ruling—the substance, together with the label, is released. The label, the articles, and the consensus guidelines, correspondingly, inform the position of the doctor. Using these as data (activation), the doctor proceeds to prescribe (see bottom of figure 7.3).

Question: Why did doctors in the late 1980s and early 1990s not warn their "patients" of the suicide risk presented by the antidepressants? Not only because of conflicts of interest, though to varying degrees, these inevitably play a role, but more substantially, because there was no warning on the label signaling such a problem. In other words, so successful is the claim to science that when evidence-based research conflicts with what is before one's eyes, what is before one's eyes disappears. That this happened, that it continues to happen is itself an indicator of the power of the industry. It is an indicator, moreover, of how far psychiatry's love affair with the drugs and the trappings of science has gone—and at what cost.

The Regulatory Agency and Its Role

But how, you may ask, are we to wrap our minds around the regulatory body's perfunctory role in all of this? These, after all, are organizations presumably established to attend to our safety; and this is *our government*. One answer is the IE answer—that officials, as it were, tick off the boxes in the forms in front of them. Which is essentially the case. A further answer is that they are intricate parts of systems wherein they have partners—partners whose agendas they substantially share, whose interests they protect.

Basic organizational development (OD) principles pertain here. Insofar as we apply concepts like Argyris's and Schon's (1974 and 1978), the regulators' true mandate is what they *actually do* as opposed to what they *espouse* (and undoubtedly, on some level, believe). At this point the confusion, albeit not the contradiction, disappears. The mandate is twofold:

1. Partner with industry in the co-construction of technically "safe and effective products," while safeguarding industry and maximizing their profits
2. Protect the public by reining in the industry, as necessary

Mandate one represents normal operations, mandate two what is done in extremis, while also serving as the official conceptualization.

To be clear here, I am not suggesting that *no protection* is afforded the public. Insofar as the regulatory agencies identify a crisis, they indeed rein in industry. For example, after hundreds of reports of SSRI-related suicidal incidents and after harrowing testimony at hearings, the FDA required that a black box warning about suicidality in children and young adults be added to the antidepressant labels (for details, see Breggin, 2001a and 2008b; and Breggin and Cohen, 2007). Such extreme situations notwithstanding, however, business as usual, especially in North America, largely means co-constructing the products as safe and effective in accordance with the processes mapped.[5] Indeed, in line with this, so as not to cause an undue hardship on industry, regulators routinely and knowingly accept trials where the company has broken the rules, blatantly compromising the research—such as it is—in the process (for abundant instances, see Breggin, 2001a, 2008a, b). Correspondingly, even where they feel compelled to rein in industry, they find ways to protect it.

The ongoing protection afforded the SSRIs is instructive in this regard. Significantly, when the FDA started requiring suicide warnings on the labels, it required *all antidepressant labels* to include such warnings, this despite the fact that there were no indicators that non-SSRI antidepressants pose such a problem. In so doing, they ensured that the industry leaders—the SSRI manufacturers—would not be at a competitive disadvantage, moreover, would continue to maximize profit (note, as the newer drugs, the SSRIs yielded far higher profits).[6]

Indeed, at times regulatory agencies like the FDA even outdo the industry in the protection of the industry. Prozac is a case in point. Significantly, Lilly's drug trials showed that depression is a "frequent" adverse reaction, and the draft label which it submitted reflected that fact. As documents released under Freedom of Information have brought to light, faced with this conundrum, the FDA *on its own accord* struck "depression" off the label (for details, see Breggin, 2001a and 2008b). In so doing, it at once gratuitously helped out Eli Lilly and protected the industry from the anomaly of a category of drug which "frequently" causes the condition it is alleged to address.

Bottom line: The regulatory agency is itself the legitimating part of a system that is self-reinforcing and self-protecting.

In Summation

What has surfaced in our inquiry into the approval mechanism are concepts and processes which have one overriding function—to construct psychoactive substances as "safe and effective"—in short, a legitimation process. What we have seen are procedures and measures that fly in the face of common sense, the invisibilization of data, oversight bodies that provide little oversight, maneuvers, ploys. Add to this: aggressive promotion; the concerted buy-in of the regime as a whole; layer upon layer of vested interests; the fact that no chemical imbalance has ever been established for any of these putative disorders (see Chapters Three–Six)—herein is the context is which the psychopharmaceuticals enter society.

The Psychiatric Drugs Themselves

So what do these drugs actually do? Before we tread further, I would introduce two considerations and ask the reader to bear them in mind. The first is how complex and interrelated the brain and its parts are. A galaxy in its own right, it contains, to quote Whitaker (2002, p. 70), "100 billion neurons," "150 trillion synapses," hundreds of neurotransmitters, and a multitude of interacting systems. This being the case, all positions vested in the drug having a simple effect or impacting a single system constitute a gross simplification. The second consideration is that given that these substances alter brain chemistry, and given that the people being treated for "mental illnesses" in point of fact have "*normal*" *brain chemistry*, it stands to reason that these substances themselves create imbalances. Herein is our entry point. To wit, the secret to understanding the actions of the drugs is to get to the bottom of the imbalances created and the brain's response.

As the neuroleptics are allegedly schizophrenia-specific—and as schizophrenia is the one "condition" that the public at large feels confident is a bone fide disorder—neuroleptics are the obvious starting point.

The Neuroleptics

The neuroleptics are divided into two groups—the older or regular neuroleptics and the "atypicals." Examples of the first are: Haldol, Mellaril, Thorazine. Examples of atypicals are Abilify, Resperidal, and Zyprexa. What most distinguishes the atypicals is that there is more than one neurotransmitter that they are recognized as impacting; additionally, they are touted to have less "extrapyramidal" effects (the extrapyramidal is the part of the brain associated with physical movement). However, as Breggin (2008b) documents, the atypicals likewise target the dopamine system, and where comparable dosages of atypicals are administered, the extrapyramidal effects are roughly equivalent.

"Schizophrenia" is the peg on which the neuroleptics hang. Use of the neuroleptics with "schizophrenia," correspondingly, hinges on the dopamine theory of schizophrenia (that schizophrenia is caused by surplus dopamine—an explanation which itself arises out of the action of these drugs). The first hypothesis to this effect was that in the "schizophrenic brain" too much dopamine (specifically D2) is released into the synaptic cleft (space between neurons through which a nerve impulse is transmitted). Now dopamine in the cleft cannot directly be measured; but were this hypothesis true, HVA (the metabolite into which dopamine breaks down) would be comparatively higher in "schizophrenics" than in the general population. Studies establish that the amounts are equal (see Knable, Kleinman, and Weinberger, 1998, p. 592). With this hypothesis shown to be invalid, a second hypothesis was advanced—"schizophrenics" have extra dopamine receptors. The second has likewise been disproved. To be clear, it is indeed the case that some have extra dopamine receptors. What has been shown, however, it is the drug—not the putative disorder—that accounts for the difference. Indeed, rodents placed on the neuroleptics likewise have 30 percent more dopamine receptors than their fellows (for studies, see Davis, Ko, and Davidson, 1991). That noted, clearly the neuroleptics do something dramatic to the dopamine system. What? And how?

Figure 7.4 is a before-and-after picture. It is virtually identical to what proponents of the drug might create. The point is, as established in Chapter Three, the neuroleptics are recognized dopamine-blockers, this their alleged therapeutic property.

Represented at the top of the picture is standard dopamine transmission. Dopamine is released into the synaptic cleft, where it binds to the dopamine receptors. Represented in the lower part is what emerges upon taking the neuroleptic. Once the neuroleptic is taken, the dopamine released into the synaptic cleft is blocked from attaching itself to the receptors because the neuroleptic (marked "H" for Haldol) is competing for the site. Significantly, if the person indeed had excess

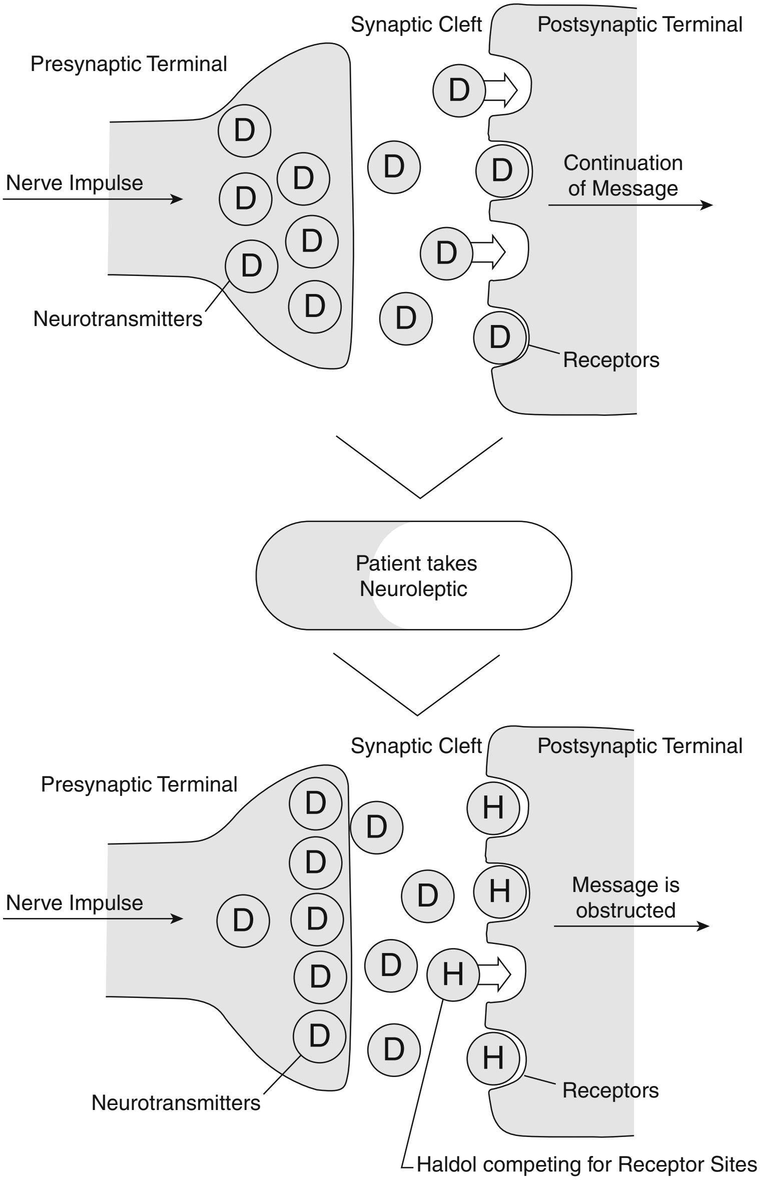


Figure 7.4 The dopamine system and neuroleptics.

dopamine (read: "too much transmitted or too many receptors"), creating such a blockage could constitute a corrective action. Given, however, that they have a "normal" level, necessarily, they are thereby rendered dopamine-deficient.[7] Follow the "dopaminergic pathways," and you can trace the consequences.

There are three primary dopaminergic pathways. One is the nigostriatal; it originates in the basal ganglia and controls motor functions. The second is the mesolimbic system; it goes from the midbrain to the limbic area and it controls feelings. The third is "the mescortical"; and it proceeds from the ventral tegmentum to the frontal lobes (related to thinking and will).[8] In blocking the dopamine to all three pathways, a deactivation in all these areas occurs.

The blocking of the nigostriatal pathway translates into shuffling, shaking, twitching, the various movement problems which predictably and routinely beset people on the neuroleptics (the extrapyramidal effects). Called "side effects"—and note the use of language here—significantly, many of these constitute what have come to be called "Parkinsonian reactions." And what causes Parkinson's Disease? Insufficient dopamine (for more details, see Whitaker, 2002, p. 162 ff.). In essence, artificial Parkinson's Disease is created.

Irit's words about Haldol draw home the consequence of this particular deactivation:

> The effects . . . were . . . horrendous . . . My body was in spasm constantly . . . Some part of me would always be twitching—my feet or my hands . . . I developed a way of walking with my arms up in the air in front of me . . . I remember visitors coming and telling me, why don't you walk normally? . . . And I was very very frustrated and upset because I couldn't help the way I was walking. (Irit, from Burstow, 1994)

Paralleling this: Flatness, apathy, the blunting of emotions, cognitive impairment, and the classical zombie-like feeling (see Chapter Three) are created by the deactivation of the mesolimbic system and of the mesocortical. It is these effects, you will recall, which were identified in Chapter Three as a "chemical lobotomy" and which occasioned the original use of the substance with "schizophrenics." These effects too are dramatic and recognizable. "When I wake up, I don't feel like doing anything," states Boissoneault. "All I want to do is sleep" (quoted from Boissoneault, 1988, p. 226). Breggin (2008b, p. 34) aptly coins the concept "deactivation syndrome" to describe the effect of blockage in all the dopaminergic pathways and he defines it as "a continuum of phenomena variously described as disinterest, indifference, diminished concern, blunting, lack of spontaneity, reduced emotional reactivity, reduced motivation or will, apathy, and in the extreme, a rousable stupor."

Here the picture at once complicates and grows more dire. As a living organism, as neuroscientists like Hyman (1996) have carefully demonstrated, the brain seeks equilibrium. With it now being dopamine-deficient, correspondingly, it endeavors to compensate for the drug's effect. Compensatory actions include:

- the presynaptic neurons release more dopamine into synaptic cleft;
- the density of the dopamine receptors are increased;
- in a process called "up-regulation," additional receptors are created (a phenomenon, you will recall, mistakenly and opportunistically attributed to the putative "disorder").

Further problems arise from this tug of war itself. The extra receptors may never disappear. Additionally, in short order, many of the compensatory mechanisms start to break down. The presynaptic neuron, for example, becomes less able to release extra dopamine. Nonetheless, the person may be so flooded with dopamine by virtue of the compensatory mechanism that, paradoxically, they are never able get off the very drug that itself occasions the compensatory process (for these and other substantiating details, see Hyman, 1996; Whitaker, 2002 and 2010; and Breggin, 2008b).

On a simple level, a "normal" brain has been transformed into an *"abnormal" structure* and a chemistry which is *permanently out of balance*. This permanent imbalance, significantly, more than anything else accounts for "the revolving door syndrome," the persistent drug level tinkering, the putative "relapses." Another inevitable consequence is brain shrinkage. Additional common albeit not uniform complications include: akathisia (an agonizing restlessness; an inability to live in one's own skin); tardive psychosis (which befalls 30 percent of those on neuroleptics for a sustained period); neuroleptic malignant syndrome (a crisis which can lead to death), and tardive dyskinesia (TD). The last is a severe and disfiguring neurological disorder generally irreversible and which, according to APA's (1992) own figures, will afflict 15 percent of patients in the first three years exposure to a neuroleptic, with the risk rising with each additional year of exposure, quickly hitting the 40–50 percent level. Ironically, what is used to treat TD is the causal agent or neuroleptic itself—for it serves to mask the problem. In this manner users are propelled into a potentially endless downward spiral (for details, see Breggin, 2008b, p. 56 ff.).

Withdrawal from neuroleptics is difficult because the drugs mask the damage. A more pressing albeit related factor is the persistence of compensatory actions. What is significant here, the compensatory actions do not stop immediately upon discontinuing the drug. To use Whitaker's (2002 and 2010) metaphor of a car, it is as if the accelerator pedal had been floored and had stuck there. The point is that the brain continues to "compensate" for a hypothetical reduction of dopamine, albeit the reduction in question has ceased. The result? Especially where cold-turkeying is the withdrawal method, the person is virtually flooded with dopamine—a formula for psychosis. Predictably, correspondingly, what ensues tend to be interpreted by everyone (the doctor, loved ones, oftentimes the patient) as the return of the "illness," correspondingly, as proof of a preexisting disorder for which the medication is needed, generally for life.

In some cases the masking effects of the drugs is increasingly needed. In such instances, indeed, the person cannot get free of the drug because the drug itself has rendered escape impossible (for details, see Whitaker, 2002, p. 106 ff.). An iatrogenic tragedy and a classical example of being "trapped."

Which brings us to the "million dollar question." Obviously, it is not TD and it is not the compensatory operations that are deemed therapeutic. So what is it? What precisely constitutes the sought-after effect? The answer to this question has been staring us in the face from the very beginning: the initial obstruction of normal brain function—the deactivation itself.

To break this down, overall, the deactivation of all three dopamine pathways subdues the person, makes them more manageable, and as such accounts for much of what is deemed desirable. It is specifically, however, the deactivation of the mesolimbic and the mescortical system that is being interpreted as "therapeutic." A person unable to fully think or feel, whose brain parts are unable to connect with one another, will ipso facto largely be unable to hear voices, to engage in complex delusions, to substantially upset others or themselves. The *brain damage* per se-more particularly, damage to those areas associated with higher functioning—in essence *is* the therapeutic effect. People are being relieved of their distress, to put this starkly, by being relieved of brain function. On top of all this, the damage can be such that it renders the person unaware of the damage, oblivious, as it were, to the reality they are not functioning well. A frightening development, which will be explored in more depth in the next section and to which Breggin (2008a and b) gives the name "intoxication anosognosia."

Longitudinal studies of effectiveness give us insight into how disadvantageously these tugs of war play out in the long run, and as such, further validate the chemistry. In Harrow's (2007) longitude study of "schizophrenia" patients and long-term antipsychotic use, by the two-year mark, patients not on the drugs had marginally better global functioning than the med group. By the end of five years, 39 percent of the off-med group were "in recovery" and more than 60 percent were working as contrasted with 6 percent of those in the med group being in recovery and almost no one working. By ten-year follow-up, the discrepancy between the two groups was larger still. By the same token, in Rappaport's (1978) study of "schizophrenics" discharged from the hospital on antipsychotics, in three-year follow-up those who took themselves off the drug after discharge fared considerably better than those who had continued. Correspondingly, the group that fared the worst are those who had remained on the entire time. With results at least as telling characterizing the World Health Organization studies (see Hopper, 2000), it is clear that these drugs are inherently deleterious, with staying away from them entirely producing the best outcome.

The Story of Marcia

Marcia's story illustrates several of the neuroleptic attributes articulated in this chapter. Marcia is an intelligent 31-year-old woman, who loves music, who is afflicted by involuntary movements of the tongue and mouth (TD). At 19, while out for a walk one evening, Marcia was assaulted. So traumatized was she by what had happened that every time she left her house she would think she was seeing the assailant. After a couple of months she dropped out of university. Upon consulting a psychiatrist, she was put on the neuroleptic Zyprexa. "A short stretch on that, and no fooling, I thought my skull was going to explode," she stated (a well-known Zyprexa "side effect"). Taken off the Zyprexa, she was put on Risperdal (neuroleptic). "Except for the odd twitch, it seemed just fine," Marcia explained. "Like it really did reduce my anxiety (dulling of emotions). It is just that I couldn't well, think quite as clearly" (slight cognitive impairment).

Three years passed, and ostensibly, Marcia was doing well. She landed a part-time job in a retail store. She returned to university, finished all but her last year. Then a reversal set in. More and more she was having trouble concentrating (more pronounced cognitive impairment). And she became progressively upset (unresolved trauma). At her parents' behest, she agreed to go into hospital for a week, during which time her dosage was increased.

The shaking was now getting worse (extrapyramidal reactions). Additionally, states Marcia: "I couldn't sit, couldn't stand; couldn't stay still. All day long, I would be getting up, sitting down, pacing back and forth. Like the sheer physical agony, it was grinding right into my sinews [classical akathisia]. And boy, did I want to get off that med!" Marcia again withdrew from university. A few months later, she started to imagine she was seeing the assailant again (unresolved trauma), and once again her dosage was increased. Two years after that she was diagnosed with TD. At which point, she tried to go off the drug, only to find her symptoms worsening (need of drug's "masking" effect; compensatory complications).

The rest of Marcia's life story remains to be written. This intelligent woman still hopes to return to university. Also to get off the neuroleptic. Of this Marcia states:

> Funny—not ha-ha funny. You start off thinking you can always go off. And the med, it does seem to take the edge off the pain, distract me, whatever. In fact, had you talked with me six years ago, I'd have told you it was helping. I see things very differently now. The thing is, you're like a babe in the woods. You don't have a clue what it's gonna do to you, what it *is* doing to you. Maybe I'll get off some day. That's what I dream of, but I am kind of thinking that I can't. You know, I tried once. But God help me, going off, it's not that easy [compensatory actions]. And Bonnie, I mean, just look at me. Just look at what it's done to me!

The SSRI Antidepressants

The SSRIs (selective serotonin reuptake inhibitors)[9] are the best known of the antidepressants. Examples are Prozac, Paxil, Zoloft, Celexa, Lexapro, and Luvox. As with the neuroleptics, these drugs are prescribed for a presumptive biological disorder whose existence has never been proved. To be clear, I am not denying that people get depressed, some, severely so. Depression is a fact of life. As already established, however, that is a far cry from it having been *proven to be* a disease, or indeed, it *constituting* a disease (for details on the various unsuccessful attempts at proof, see Breggin, 2001a and 2008b).

A physical cause for the putative disorder has been hypothesized. The hypothesis is that people are depressed because they have insufficient serotonin—hence the administration of SSRIs.

Serotonin is a neurotransmitter whose major effect is activation or stimulation. Serotonin nerve bodies are located in the lower part of the brain. They stimulate neurons in *every lobe of the brain* (see Breggin, 2001a). As such, despite medical depictions, their action is not "selective" but global, their effect widespread.

Reuptake is the brain's mechanism for protecting itself from excessive stimulation. Serotonin reuptake is a transport system which carries excess serotonin out of the synapse back into the presynaptic neuron. Enter the SSRIs. What these drugs do parallels what we witnessed with the neuroleptics. They block the normal progress of the neurotransmitters by inhabiting spaces intended for them. The difference is that instead of blocking the receptors—and we are going in the opposite direction here, because too little as opposed to too much of a transmitter is presumed—they populate the reuptake transport system, clog it up as it were, thereby impeding reuptake. The consequence is that serotonin that would otherwise be taken back up into the presynaptic neuron remains in the synaptic cleft then moves on to

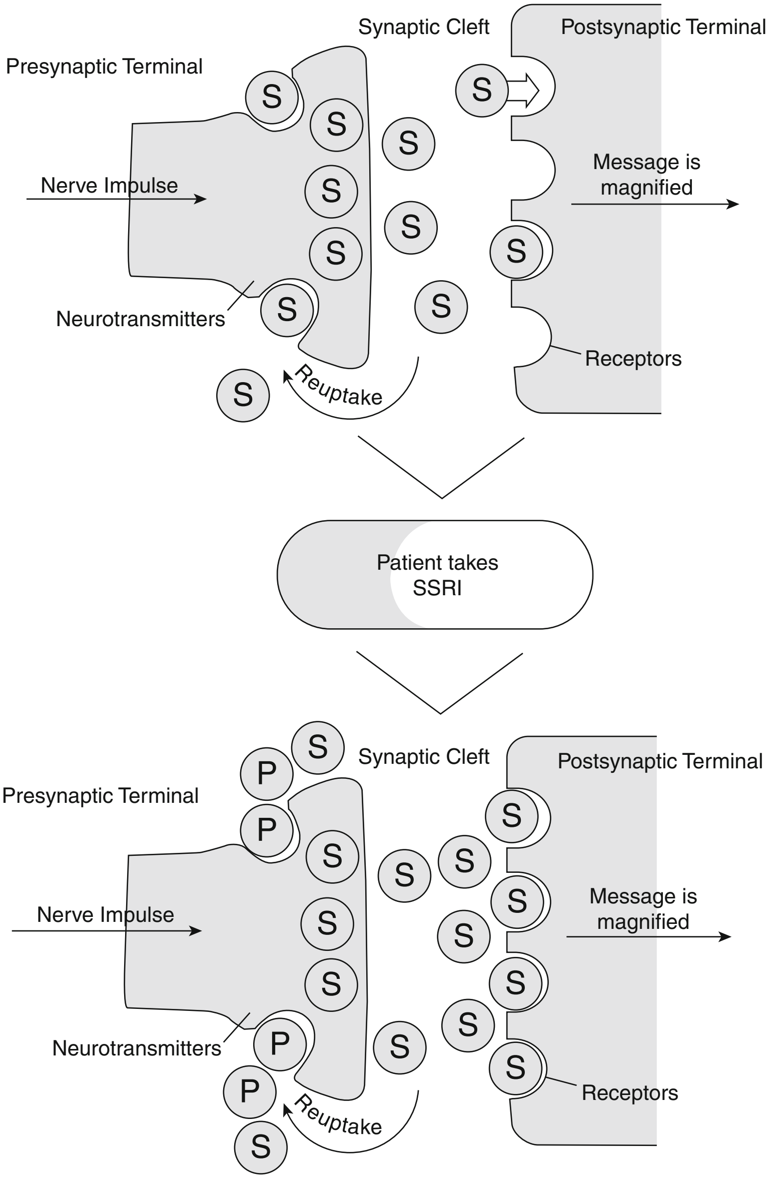


Figure 7.5 The serotonin reuptake system and the SSRIs.

the receptors. The disruption of the reuptake mechanism translates into additional serotonin. This process is illustrated in figure 7.5.

Observe the reuptake of the serotonin (marked S). Observe the blockage of the reuptake by the Prozac (marked P). And note the concomitant buildup of serotonin in the cleft.

Now if the depressed person were indeed suffering from a condition caused by insufficient serotonin, what is happening here would indeed be corrective. If, on the other hand, there were no such deficiency, we could reasonably expect that the synapse would be flooded with an overabundance of serotonin and the brain would thereby become overstimulated. Additionally—and here is the telltale sign—the brain's compensatory mechanism would kick in. And that is indeed what happens. Studies referenced by Healy (2012 and 2009) and Breggin (2001a, 2008a and b) show conclusively that such overstimulation is routine. Correspondingly, studies such as Wegerer et al. (1999; an animal study in which young rats were given serotonin) demonstrate that even in instances where the dosage is low, the brain's compensatory mechanisms kick in. The brain, as it were, fights back.

Compensatory actions that happens on SSRIs—and all are well documented—include:

1. The autoreceptors in the brain stimulate the presynaptic neuron to produce less serotonin. As Breggin (2001a, p. 34), puts it, the brain "shuts off" its production of serotonin.
2. The reuptake transport system grows denser (translation: there are additional "chemical transporters").
3. In what is called "down regulation," also "die-back," in an attempt to reestablish equilibrium, the brain destroys into own serotonin receptors, in some regions, wiping out up to 40–60 percent of them (for details and verification, see Walmsley et al., 1987).

Further problems attend this tug of war. Irrespective of what actions are taken later, no one knows if the serotonin receptors will grow back.[10] Additionally, the compensatory mechanism quickly begins to break down. For example, as documented in Whitaker (2010, p. 80 ff.), the autoreceptors in the presynaptic neuron speedily begin to decline in number, the result being that the feedback mechanism is partially disabled. The long-term consequence is a brain that is damaged (besides the die-back, abnormal growth sets in), a brain unable to monitor itself, a brain permanently out of balance—hence the relapses, the ongoing tinkering with dosage. What goes along with this, given that compensatory actions continue, once again, withdrawal is exceptionally difficult.

Overstimulation is standard. Other related and highly common effects are akathisia, irritability, paranoia, delusions, confusion, and impulsivity (see Whitaker, 2010; and Breggin, 2001b, 2008a and b). Mania can likewise set in—a direct consequence of overstimulation. By the same token, the SSRIs can worsen depression and lead to suicidality, hence this mandatory warning on the antidepressant label, "Patients of all ages who are on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior" (PDR Network, 2013, p. 1324). Other related effects include hypomania, fury, and violence itself.

In this last regard, Moore, Glenmullen, and Furberg (2010) studied adverse events reports submitted to the FDA in the years 2004–2009, focusing on violence against others. The authors pointedly concluded, "antidepressant drugs showed consistently elevated risks . . . when compared with antipsychotics and mood stabilizers." The point is, overstimulate the brain, agitate the person in the process, and you create a situation in which violence can readily erupt.

A young man with experience on the antidepressants, Ashley's story is informative here. Speaking out at a public hearing on psychiatric drugs, he testifies:

> I went from being a really shy individual to . . . an almost obnoxious person . . . I would pick fights with anyone who crossed my path . . . I tried killing myself at least five times, including trying to slit my wrists . . . I ripped the whole house apart for no apparent reason. I just woke one day, got up, went to my living room, and just started throwing all the books from the shelves . . . I had this urge in me that just said, "Rip up the living room"—and I did it. And that's what drove a lot of my behavior . . . I would snap at people for no apparent reason and I could never explain why . . . until I kind of put 2 and 2 together and realized that the drug was causing me to be . . . violent . . . Once I got off the drug, I went back to my normal self—shy, generally reserved. (Inquiry into Psychiatry, 2005, Psychiatric Drugs, tape 4B, p. 108)

To be clear, I am not suggesting that all or even most folk on such substances become violent, only that the SSRIs by their very nature overstimulate and this correlates with a disproportionate level of violence.[11] In line with this, as documented by Breggin (2001a, b, 2008b, and 2000b), a high percentage of the US school shooters were on a "therapeutic" level of SSRIs. At the time of the Columbine massacre, Harris, for example, was on a therapeutic dose of Luvox. What is at least as worrisome, Luvox was implicated in a large number of mania and aggression reports in the two years leading up to Columbine (for details, see Breggin, 2000b). In other words, warning signs were there. Examples of other school shooters on the SSRIs include: Toby Sincino, shooter at Blackville-Hilda High School, who was on Zoloft; Luke Woodham, shooter at Pearl High School, and Michael Carneal, shooter at Heath High School—both on Prozac; Elizabeth Bush, of Bishop Neumann High School—on Paxil; Jason Hoffman, shooter at Granite Hills High School, who was on Celexa; and Jesse Carrizales, shooter at Fresno (on Lexapro)—and the list goes on.[12]

Ashley's closing comments serve as a window onto the phenomenon. At the end of his testimony, he candidly adds:

> I'm bringing this up right now because of . . . what we've been hearing in the media the last little while in terms of school shootings and murders of parents by their children . . . It comes out later they were on antidepressants of one sort or another. I can . . . very much relate to some of this behavior because I can tell you that when I was on the medication . . . if I had a gun at my disposal, it could have gotten pretty nasty. (Inquiry into Psychiatry, 2005, Psychiatric Drugs, Tape 4b, p. 108)

Food for thought.

So why do some folk feel better on these blatantly toxic substances? How is it they strike themselves or others as faring better? In part, as Moncrieff (2009) documents, SSRIs have antihistamine, and as such, sedative properties. Additionally, an appreciable part of what is experienced as benign relates specifically to the activation. Activation gets people moving (as does the culminating disorder akathisia). On the face of it, a person who is moving may seem like they are doing better than a depressed person who cannot drag themselves out of bed. Moreover, given the overall activation of the brain, the SSRIs, as noted, create euphoria. Euphoria feels better than severe depression, albeit it is actually a manifestation of brain dysfunction. That same dysfunction, correspondingly, accounts for the tragic unawareness of full blown SSRI-induced mania.

Breggin's (2008a and b) concept of "intoxication anosognosia" is useful here. The point is, the SSRIs themselves render people unaware of the impairment. Moreover, insofar as their actions are problematic (and not everyone's on these substances are), it renders them oblivious to this fact. In this regard, a brain flooded with serotonin is rather like a brain drenched in alcohol. Both can result in a "good feeling." Correspondingly, both can result in impaired judgment, aggression, impulsivity, moreover, an awareness so impoverished that the person has little appreciation of their own state or of the dubious quality of their actions. Hence, the temper flare-ups so common in "patients" on SSRIs. On the extreme end, hence the rampant violence sprees documented in books like *Medication Madness* (see Breggin, 2008b), all by people who feel "driven" (clear stimulant effect), all by people who perceive themselves as on a "mission."[13]

The Stimulants

Stimulants are so named because, like the SSRIs, they have an activation or stimulant effect. Examples are: Adderall, Dexedrine, Desoxyn, Gradumet, Ritalin, Concerta, and Metadate, the first four being amphetamines; the last three, amphetamine-like. All are cocaine-like substances—hence, classified as Schedule II narcotics by the Drug Enforcement Administration (n.d.). They are primarily administered to children—and as a medication *specific to ADHD* (Attention Deficit Hyperactivity Disorder). Significantly, no such medical disorder has ever been proven to exist. Correspondingly, a special consensus conference on ADHD concluded that despite the claims to the contrary, there is no data linking this diagnosis to brain dysfunction (for details, see Colbert, 2001, p. 74). To be clear, it is indeed the case that there are children who do not pay attention, who get distracted, some dramatically so. Being distracted and having a medical disorder, however, are not equivalents.

There is no widely accepted theory as to what "causes" this putative disorder. Nothing equivalent, that is, to the dopamine theory of schizophrenia. Nonetheless, ADHD is constructed as a disease caused by sluggish neurotransmission, with a *sluggish dopamine* system most commonly cited as causal—this, again, because of the drug's action.

What do the drugs actually do? They increase the presence of dopamine in the synaptic cleft. They likewise increase the presence of two other neurotransmitters—norepinephrine and serotonin. More concretely, in a double-barreled action that activates much of the brain, they:

1. stimulate the respective presynaptic neurons to release more of the neurotransmitters in question (dopamine, norepinephrine, serotonin); and
2. block the reuptake of these neurotransmitters (for details, see Breggin, 2001b, p. 63 ff.; and Whitaker, 2010, p. 216 ff.).

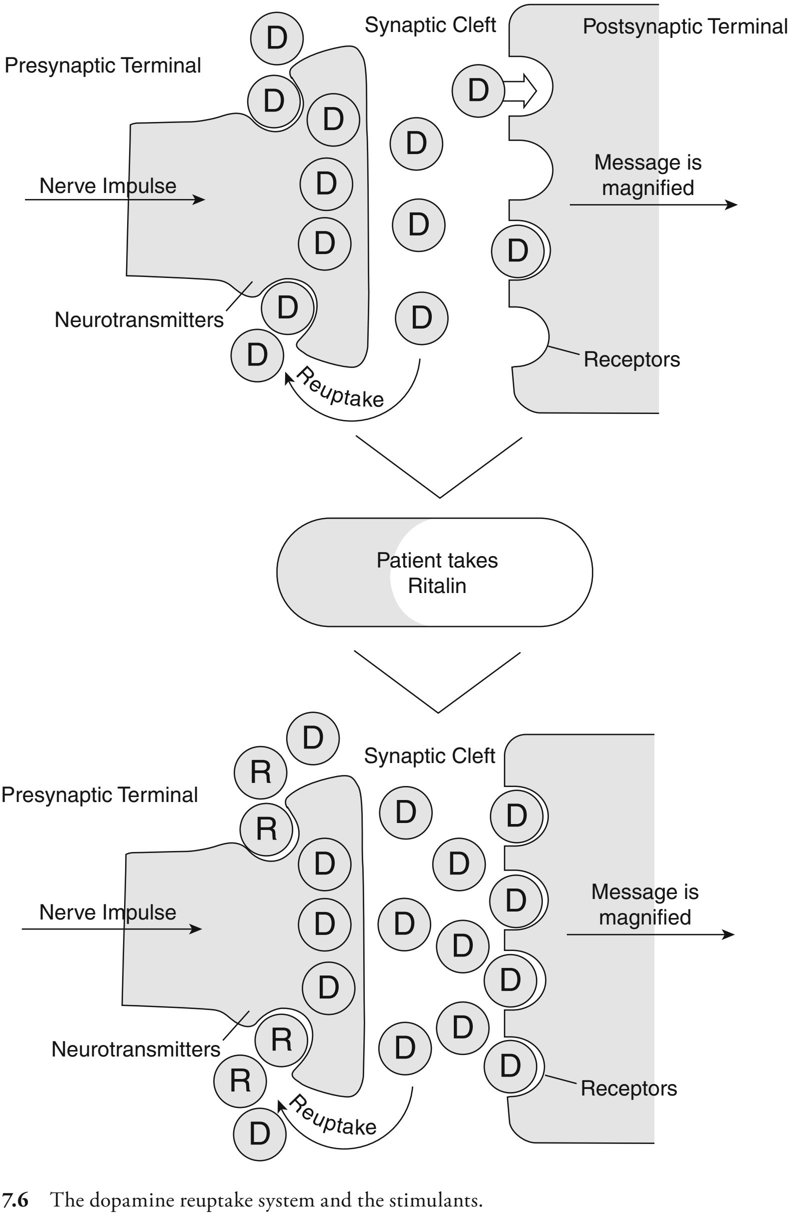


Figure 7.6 The dopamine reuptake system and the stimulants.

In figure 7.6, you can follow what happens in the dopamine system. Then extrapolate to norepinephrine and serotonin.

Now once again, the "corrective action" would be corrective if there were indeed neurotransmitter imbalances in the first place. Besides that there is no evidence to this effect, the compensatory actions of the brain indicate otherwise. In what is by now a recognizable pattern—an attempt at equilibrium—the receptor densities decline; there is die-back; correspondingly, the respective presynaptic neurons begin pumping out less of the neurotransmitter. All of which renders the brain chemically imbalanced and structurally compromised (for details, see Whitaker, 2010, p. 222 ff.).

Predictably, a partial breakdown of the compensatory mechanism soon sets in, with all the attendant complications. The "patient" is negatively impacted by the breakdown, which translates into extra stimulation. At the same time, the continuing *compensatory action* likewise causes problems. For one thing, abnormalities and withdrawal problems are thereby created. For another, as the effects wear off later in the day, the full force of the compensatory actions are felt. This translates into a rebound reaction (a more intense version of the original "condition"). This phenomenon in turn is seen as an indicator that the individual (generally a child) is in need of the drug (for details, see Breggin, 2001b).

Given the extensive reach of the various neurotransmitters involved, the effects are manifold and complex. To draw on Breggin's (2001b, p. 64) formidable list, to varying degrees, they cause dysfunction in:

- the cerebral cortex (impairing higher mental activities);
- the frontal lobes (impairing initiative, autonomy, social awareness, insight, and judgment; also potentially causing emotional blunting);
- the limbic system (leading to indifference and robotic behavior);
- the basal ganglia (which causes robotic behavior, which can lead to movement disorders);
- the temporal lobe (impairment to memory);
- parietal lobe (affects integration and sense of self);
- cerebellum (can lead to discoordination);
- hypothalamus (which affects temperature, appetite, hormones);
- pituitary gland (hence the classical stunting of growth)[14]; and
- reticular activating system (diminished self-awareness and responsiveness).

With children, the most noticeable effects at a low dosage are robotic actions, overfocusing, sedation, diminishment of spontaneity. Herein is the touted therapeutic effect—what is seen as the child improving, the drug as it were, "working." Children pay more attention in school, stop getting distracted, mechanically attend to the task in front of them. On the surface, this strikes the adults around them as "improvement"—teachers especially, who now see the children hunkering down, doing the work—hence the educational system's extensive involvement in ADHD testing.[15] In the process, the spark, the live intelligence is sacrificed. The children so conduct themselves, moreover, not because an imbalance in the brain has been corrected but because a dysfunction has been created such that they are *unable to act otherwise.* "I don't know how to explain it," states interviewee Kunlee. "It's like I couldn't do anything but this memorizing, right? Didn't even feel like talking to my friends." By the same token, animal studies (e.g., Arakawa, 1994; and Mueller, 1993) establish that rats placed on such substances engage in little but overfocused repetitive actions (called "stereotypy").

Another very common effect of stimulant use is addiction—something duly recognized in the classification of the stimulants as Schedule II narcotics. Hence this black box warning on the amphetamine label (from PDR Network, 2013, p. 2274):

> Warning: Potential for Abuse.
>
> Amphetamines have a high potential for abuse. Administration of Amphetamines for prolonged periods of time may lead to drug dependence. Pay particular attention to the possibility of subjects obtaining amphetamines for non-therapeutic use or distribution to others.

Significantly, a person who has been on stimulants is three times more likely to take cocaine (see Breggin, 2001b). Correspondingly, an extensive study by Lambert (1998) establishes that use of stimulants in childhood is positively correlated with cocaine dependence, smoking, and lifetime use of both cocaine and stimulants.

If dulling and subduing are the obvious effects in the short run, in the medium and long run what is most obvious is precisely the overstimulation. People on these substances can become highly agitated, commonly vacillate between overactivation and "crashing." A typical result is dual diagnosis (most commonly a "bipolar" designation) and the addition of such medications as "mood stabilizers" (for details, see Whitaker, 2010; Baughman and Hovey, 2006; and Breggin, 2001b). Given the overstimulation, irritability is likewise common. Correspondingly, in the extreme, as with the SSRIs, stimulants can lead to psychosis, mania, fury, suicide, and violence. In this last regard, it should be noted, as with the antidepressants, a high percentage of the US school shooters were on stimulants—to name a few, T. J. Solomon, the sole gunman in the Heritage High School shooting; Barry Loukatis, of the Moses Lake Washington killing; each of the shooters in the massacre at Westside Middle School in Arkansas. Significantly, some of these youngsters had little or no memory of the event, were virtually described by professionals as having "no mind."[16] Which brings us once again to Breggin's concept of intoxication anosognosia or "medication madness."

Albeit they may crave the "medications," overwhelmingly, as Colbert (2001) documents, children administered stimulants *do not like them*, except when euphoria sets in—itself self-explanatory. Commonly, their caregivers, by contrast, do like them, this because they interpret the stereotypy and overfocus as improvement. The adult may also feel good about the slightly higher marks that these overfocused children initially have, and specific adults (the educators) value the quieter classrooms. The upshot, as documented by Baughman and Covey (2006), is that schools have become both a conduit to the medication and an enforcer. That noted, the scientific literature establishes that stimulants lead to *no long-term* academic improvement (see, for example, Barkley, 1974). Therefore, even "effectiveness" as psychiatry itself understands it cannot be claimed.

Other Classes—Mood Stabilizers and Minor Tranquilizers: Brief Comments

The two other primary classes of psychopharmaceuticals are the mood stabilizers and the minor tranquilizers (also called "anti-anxiety medications"). There are several different types of minor tranquilizer, with benzodiazepines the most prescribed. They include such well-known products as Ativan, Valium, and Librium. They are administered for the putative disorder "anxiety"—and overwhelmingly to women. Indeed, they may be seen as the current manifestation of a tradition that dates back to the sleeping cure and all the sexism that it implies (see Chapter Two). They affect the neurotransmitter GABA (gamma-aminobutyric acid), binding to the GABA receptors (which exist throughout the brain). GABA *inhibits*, with the benzodiazepines enhancing the inhibitory effect. They thereby produce a general CNS depression (the therapeutic effect), which in the extreme can culminate in coma—hence their use as sleeping aids or "hypnotics."

Why do some people on benzodiazepines like them?—and in the case of these particular drugs, many do. Because like alcohol itself, they have a pleasant sedative effect. What relates to this, they help people sleep, can temporarily take the edge off problems. That acknowledged, as documented by Breggin (2008b), there is no indication that anxious people not so medicated have any chemical imbalance; however, there is proof that these substances create brain damage. Common effects which connect with the brain-damaging dimension of these drugs include: depression, disorientation, hypersomnia, paranoia, and, paradoxically, anxiety. What is likewise significant, they are the most quickly addictive of all the psychiatric drugs.

The biggest long-term problem associated with benzodiazepine use—and it can be a problem for life—arises from the brain's compensatory mechanism. The brain responds to the insult to its system by decreasing the output of GABA, with all the structural abnormalities that this involves. GABA no longer putting a damper on neuron activity, the neurons begin firing "helter-skelter" (Whitaker, 2010, p. 136)—often at an alarming rate. Consequences can include: intense anxiety, panic, paranoia, and derealization. Predictably, such problems are most pronounced with attempting to withdrawal.

Last by not least: The mood stabilizers are prescribed for putative disorders like "mania"—this, again on the basis of unproven chemical imbalance. By far the most common of the substances is Lithium—an "antimania" agent. Much like the stimulants, lithium suppresses exploratory action. It similarly leads to intellectual deficiencies and memory problems. It bears a distinct resemblance to the neuroleptics (also sometimes thought of as mood stabilizers), in that it "works" by massive deactivation. Highly neurotoxic, studies show that lithium disrupts "every measurable cellular activity pertaining to nerve transmission," leading to a "*nonselective diminution in neuron activity*" (Breggin, 2008b; see also Wilson, Schild, and Modell, 1975). The standard result (the "therapeutic effect") is the classical apathy of the neuroleptics, diminished responsiveness to the environment, a toning down of the volume of life. Other significant effects include: enlargement of the brain, the proliferation of abnormal brain cells, especially in the hippocampus; extrapyramidal disorders; and given the inevitable compensatory actions, acute mania upon withdrawal.[17]

Noah's Story

At age 19 after struggling with a bout of depression, Noah, a quiet shy young man in northern Ontario, was placed on Zoloft (SSRI antidepressant). Within the first ten days, he found himself agitated (activation). His doctor duly lowered the dosage. Noah began feeling calm (sedation effect), saw himself as doing well, was happy with the results. Months passed. Then something unexpected happened. For reasons that he could not understand, one day, he found himself extremely agitated (activation syndrome, SSRI-induced mania). He forthwith got up, more or less raced to the closest store, bought matches, then set fire to a neighbor's barn. "I had never done anything like that before—I mean, I was just a regular fellow—but it made absolute sense at the time," stated Noah (intoxication anosognosia). The next day, he was apprehended. He served over a year in jail, during which time he was diagnosed as bipolar and put on Depakote (mood stabilizer). "It knocked the stuffing right out me," Noah commented, shaking his head. "Now I didn't feel like doing squat. I'd just sit there sort of blanking out" (sedating effect; deactivation; chemical lobotomy effect). They likewise put him on an antipsychotic.

Noah has been out of jail for the last year and has been staying with his parents. For the first couple of months, he did little but lie around. It looked as if watching television and sleeping would constitute his existence henceforth. Then the family began to talk. With their help, Noah started rethinking his life, and slowly but surely, he has been able to wean himself off all the drugs. Commenting on his experience, he has this to say:

> Besides that hair-brained act—and yeah, I know I have to take responsibility—I'll tell you where I got it wrong. I should have never taken any med. I should have told myself and my folks that I'd get through it. You know, when they originally put me on that first med, I mean, once they got the dose straightened out, I was relieved. Like there was now something between me and what I was feeling, right? I don't think you can do that, though. In life, I think you have to just accept the highs and the lows.

Toward a "Grounded" Psychiatric Drug Paradigm

While clearly there are differences between psychiatric drugs, what has surfaced in this inquiry is broad similarities. This raises the possibility of a psychiatric drug paradigm that could be used as a guide to understanding. So: How do these drugs, *taken as a whole*, "work"? What, in other words, would a "grounded"[18] psychiatric drug paradigm look like?

To spell out key aspects, as they have emerged: All psychiatric drugs "work" by obstructing normal brain function, causing dysfunction. All substantially interfere with normal thinking and feeling. All alter the brain's chemistry and structure, to varying degrees, fundamentally damaging the brain. All alter the size of the brain, making it (or some part of it) either expand in size or shrink. All are addictive. All work in ways that make withdrawal difficult, in some cases, arguably, impossible. All cause dysfunctions (and in some cases disorders) in various parts of the body. All work by "deactivating" to some degree, though some primarily activate. What is experienced as improvement, correspondingly, is invariably one or more of: sedation, stimulation, and the placebo effect. The drugs to varying degree inherently mask the very dysfunctions that they create. They obscure people's appreciation of their psychic state, and by extension, of the damage. What goes along with this, there is a perilously close relationship between the purported "therapeutic effect" and the "toxic effect," with the two at times being identical. The toxic effect itself can manifest itself in mania and psychosis. Generally, the "therapeutic effect" is neither more nor less than the initial dysfunction as created. Typically, the drug's action on one or more neurotransmitter systems marks the beginning of the damage, also known as the "therapeutic effect." By creating an imbalance, typically within one or more such systems, the drugs kick-start a process which inevitably leads to ever increasing damage, whether noticeable or not—a downhill spiral. As such, the action of the psychopharmaceuticals may be identified as one of unfolding damage; and the process itself may be conceptually mapped.

The impairment per se—and we have seen it with drug after drug—begins with the taking of the psychopharmaceutical. The drug interferes with normal chemistry, generally via tampering with one or more neurotransmitter systems (blocking transmission, blocking reuptake, etc.). This interference causes imbalance (too much or too little of the neurotransmitter taken up by the receptors). The imbalance in turn creates dysfunctions, generally involving multiple parts of the brain. As a result, full blown syndromes can also develop, some of which can be fatal (e.g., neuroleptic malignant syndrome).

Being a self-regulating organ (an organ which seeks equilibrium), the brain almost immediately responds by initiating a series of compensatory actions (e.g., thickening or narrowing a transport system, up-regulation and down-regulation). The compensatory action results in structural brain abnormalities in their own right (e.g., thickened transport systems, too few or too many receptors). A partial breakdown of the compensatory mechanism soon sets it, thereby both enabling the initial imbalance to continue and depriving the brain of the wherewithal to adequately self-regulate.

Continued compensatory actions continue to culminate in "abnormalities." They likewise culminate in rebound and withdrawal problems, oftentimes rendering withdrawal impossible. More generally, continuing imbalances—and such is the primary reality—continue to create disorders. Where the drug is taken for an extended period, additionally, irreversible neurological disorders commonly set in (e.g., tardive dyskinesia).

Whether they are experienced as helpful or hurtful—and both are possible—such is the nature of these drugs. Such the actions and the reactions.

Revisiting the Kevin James Story

We have arrived back at the beginning. This inquiry began with the tragic story of Kevin James—a young man who was placed on psychiatric drugs in 1997 at age 15. Kevin, you may recall, killed himself in 2008 because of the horrific state to which the various psychopharmaceutical agents reduced him. We noted in Chapter One that the major drugs on which Kevin was placed (Dexedrine and Adderall) were stimulants; also that research had established that stimulants create the very problems with which Kevin came to struggle: depression, extreme agitation, addiction, confusion, paranoia, mania, psychosis, suicidality itself. We likewise noted the FDA warning against prolonged use of stimulants. We concluded that the drugs themselves were causal agents in Kevin's decline and eventual suicide. The findings of the current chapter solidly confirm that conclusion. Given our added knowledge of the chemistry, correspondingly, we are now positioned to understand what happened with greater chemical precision.

What we now know is that the drugs mask the very effects that they create, and so Kevin's seemingly good few years are deceptive. The point is, "doing well" on a stimulant is illusory. We likewise know that the "crashing" which Kevin experienced is the hallmark of the stimulants.

In our initial investigation of Kevin's story, we zeroed in on the stimulants per se. That was appropriate for besides that they were the primary drugs prescribed, as already noted, they largely account for Kevin's experience. What can be added to the earlier picture is our new knowledge of the reach of these drugs. To be clear, as a result of stimulant use alone, dysfunction and some degree of damage can be suspected in the following areas of Kevin's brain: the cerebral cortex, the frontal lobes, the limbic system, the basal ganglia, the temporal lobes (including hippocampus), the parietal lobe, the cerebellum, the hypothalamus, the pituitary gland, the reticular activating system. That noted, it is time to scrutinize some of the auxiliary drugs on which Kevin was placed, beginning with the SSRI antidepressants.

Given what we know about stimulants and SSRIs, it is worrisome, even alarming, that SSRIs were introduced. The point is, SSRIs are also stimulants, that is, also drugs whose primary effect is to *superactivate the system*. Both, correspondingly, are known to create mania, suicidal thoughts, psychosis, delusions, extreme agitation, and addiction. Ergo, Kevin was in essence subjected to "a double-whammy."

Common though this may be, what is likewise alarming, Kevin was not just on one or two classes of psychopharmaceuticals, but all the major classes (stimulants, antidepressants, neuroleptics, minor tranquilizers, mood stabilizers). The interference with his brain at this point greatly exceeds what is calculable. Minimally, two additional areas would have been affected—the ventral tegmental area and the brain stem. And a large number of neurotransmitter systems would have been disrupted, including dopamine, serotonin, GABA, norepinephrine. Moreover, Kevin's brain would have been in a perpetual tug of war.

Consider in this regard the simple fact that neuroleptics and stimulants create opposite effects—activation and deactivation. Now probe that reality with reference to just one of the neurotransmitters—dopamine: The primary drugs on which Kevin was placed—the stimulants—stimulate the presynaptic neuron to release additional dopamine. Moreover, they block the reuptake of dopamine. In such a situation, the brain compensates—hence a tug of war. That is, the presynaptic neurons begin pumping out less dopamine; the receptor densities decline; and there is die-back.

Significantly, neuroleptics function in the diametrically opposite fashion. They *impede* the transmission of dopamine. The brain in turn responds by initiating compensatory actions which are likewise in the opposite direction (e.g., spouting *more* receptors, *increasing* the density of the receptors, releasing *more* dopamine into the synaptic cleft).

What we have here, to put it simply, is a brain wherein dopamine is at once stimulated and impeded, a brain assailed by drugs that pull in the opposite direction, a brain whose compensatory mechanisms are triggered now to do one thing, now to do the opposite—and this with respective to one neurotransmitter system alone. Besides widespread dysfunction, inevitable consequences are abnormalities and self-regulating systems that are hopelessly broken. Hence the psychoses, the disorientation, the paranoia, the suicidality.

The situation grows more dire when you consider that these various parts and systems are not discrete. They affect one another, albeit at this point, we cannot trace the manifold ways in which they do. You may be able to acquire a felt sense, though. Imagine, if you will, the 100 billion neurons, the 150 trillion synapses which comprise the human brain. Now imagine hundreds of neurotransmitter systems—all chemical messaging systems, with neurons firing. Now imagine all the parts of the brain, beginning with the basal ganglia. Now keeping in mind what you already know about the actions of the various drugs, introduce into the equation the following laundry list of brain-disabling drugs (drugs on which Kevin was placed) and ask yourself *what becomes of that brain*: Dexedrine (stimulant); Adderall (stimulant); Ritalin (stimulant); Celexa (SSRI antidepressant); Paxil (SSRI antidepressant); Effexor (serotonin-norepinephrine reuptake inhibitor antidepressant); Wellbutrin (serotonin-norepinephrine reuptake inhibitor antidepressant); Remeron (tetracyclic antidepressant); Risperdal (neuroleptic); Topamax (mood stabilizer); Ativan (benzodiazepine minor tranquilizer); Imovane (sedative/hypnotic; more or less same class as the minor tranquilizers).[19]

We can none of us know the agony that led Kevin to kill himself. There is, however, no need to conjure up a history of "mental illness" to explain what happened here. We see it in the preceding list of drugs. We can see it in the manifold parts of his brain that would have been impacted. A chemical colonization. We see it in the various compensatory mechanisms which necessarily would have kicked in and could only have left him trapped.

In short, as awful as it is to entertain this, it is tragic but not surprising that Kevin killed himself. Such is the legacy of the psychopharmalogical revolution.

Concluding Remarks

This chapter joins with the other chapters in laying bare the reality of the psychiatric drugs. Its ultimate purpose was to issue a wakeup call so that we as a society can take ourselves off the road to "Pharmageddon." Its more pointed scholarly purpose was to fill in two gaps in the account thus far—to flesh out (1) how these drugs come to be approved; and (2) how they "work." In the process of filling those gaps, we further developed several of the key themes in this manuscript, including: "subjugation," "deception," "groundlessness," "damage," "conflict of interest," and "institutional product."

What we discovered in the first leg of our investigation is that the trials which form the basis of the approval process are predicated on assumptions that are inherently flawed, moreover, in ways that inherently serve the industry. More particularly, the discourse and the institutional operations serve to at once invisiblize and/or trivialize negative effects and to produce positive findings—a "made-to-order" institutional account. While cheating is endemic, even when followed faithfully, the process is so designed as to create what it is alleged to find. Indeed, the unvarnished truth is, it functions more as a massive advertisement for the industry than a check on it.

Having mapped the process, we proceeded to drill into the major classes of psychiatric drugs, investigating the neuroleptics, the SSRIs, the stimulants, the minor tranquilizers, the mood stabilizers. In each case, we demonstrated that despite widely accepted claims to the contrary, there is no physical disorder before taking the drug, that the drug per se creates a chemical imbalance, which in turn leads to ever increasing brain damage. Correspondingly, step by step, we traced the damage as it unfolds. The chapter culminates in a psychiatric drug paradigm, based on brain dysfunction and brain damage. What is central to the findings, psychiatric drugs do not simply *inadvertently* damage the brain—a "side effect" as it were. For all intents and purposes, the initial obstruction and damage *is* the therapeutic effect.

In the process of the inquiry, we repeatedly touched on why some people who are themselves or whose loved ones are on these substances value them. To be clear, it is understandable that the average person who perceives some benefit favors them, this irrespective of the professional rationale or the truth of that rationale. Life is hard, and people do what they can to get by. Moreover, there are those who minimally appear to fare well on the substances. This notwithstanding, what is most significant here, the various answers to the question "why," like a boomerang, keep bringing us back to where we started—with the damage. Note, they are valued because they calm and/or subdue (and they do this by creating dysfunctions and ongoing damage); and they are valued because they activate (also a form of obstruction and damage). This being the case, irrespective of intention, damage emerges as the sine qua non of these substances.

Strip away the medical veneer, and what we have here are substances given for nonexistent disorders, all of which by their nature create chemical imbalances, all of which disable, a number of which are associated with violence, all of which profoundly damage the brain. Add to this the false claims (which are endemic and strategic), conflicts of interest, routine manipulation, the lives devastated—and their prescription by doctors (never mind their enforcement) falls considerably short of being ethical. Nor would placing an onus on professionals to address the false claims suffice. Besides that the entire system militates against this, there is a more fundamental implication here. To wit, people who call themselves doctors should not be prescribing such substances. Now to be clear, I do not dispute that there is a legitimate place for drugs that "take the edge off"—hence people's use of such substances as alcohol and street drugs. The difference is: No one is claiming that it corrects a chemical imbalance; no one is calling it medical; no medical practitioner is prescribing it; no officer of the state is enforcing or promoting it (indeed, quite the opposite); and daily fixes at predesigned intervals is not the social vision.

The position which I am taking here emerges from the data and from what "medical" means. It is not to be confused with the more conventional position "psychiatrists overmedicate"—which misses the point. Note, for "overmedication" to occur, a substance must be "medical," must be addressing a physical condition. By the same token, for there to be "too much" of a medication, there must be a "right amount." Given that these substances address no physical condition and given that their modus operandi is the creation of damage, what these findings suggest is that there is *no acceptable medical amount*.[20]

Insofar as this analysis has validity, a massive societal rethinking and restructuring is in order. A discussion of what this might look like is reserved for Chapter Nine. To touch at this juncture on some more circumscribed questions that likewise arise from the data, I would invite the reader to ponder the following: Is damage as treatment the best that we can do? Is a society of rampant iatrogenic damage acceptable? What kind of society *do* we want? How do we defend ourselves against an industry which turns every criticism against it to its own advantage? Into an advertisement ploy? Whose drugs trials are recognized as meeting the "gold standard" (evidence-based research)? Which is part of governance? Which is in "partnership" with government? How do we rein in an industry when historically all attempts to regulate further empower them?

Correspondingly, on a personal note, I would invite you, as applicable, to ask yourselves:

- Is the use of these drugs with children compatible with my understanding of childhood? Their use with seniors compatible with what we owe the elderly?
- The institutions and industries surrounding them aside, what in my estimation makes these drugs different than other drugs that "take the edge off"? And if indeed, they are not different, how do I feel about society treating them as if they were different?
- How do I feel about the fact that these substances are overwhelmingly administered to women? To the impoverished? To people of color? To the old? To the very young?
- How do I feel about schools and teachers serving as an entry point into the world of psychiatric drugs? Indeed, as enforcers?
- Did I buy "a bill of goods" when I told myself that a single drug couldn't hurt? That a small dose couldn't hurt? That taking it on a trial basis could not hurt?
- What do I think of polypharmacy?
- Has my "psychosis" meaning? What would happen if I did not drug it away?
- If I knew these facts about the drugs before I or my loved ones had gotten in over our head, would I have interpreted any signs differently?
- What makes a tradeoff worth it? Are *these* tradeoffs worth it?
- As I reconsider my own, my daughter's, my mother's ongoing struggles in light of this new information, what do I think now?

In ending, I would draw attention to the fact that something significant has been accomplished in this chapter. The point is, the pharmaceuticals are the kingpin, the mainstay of the regime of ruling. Successfully problematize that and the edifice crumbles. In this chapter, to an appreciable degree, that has happened, for in the final analysis, however much people may cling to them—and I am in no way denying that there are people who regard them as a lifeline—no medical credibility can be attached to a substance that is not medical, that addresses nothing medical, that gives rise to medical disorders, and whose modus operandi is dysfunction and damage.

CHAPTER 8

Electroshock: Not a "Healing" Option

In 2005, a public hearing was held on ECT—part of an event called "Inquiry into Psychiatry." Numerous survivors bore testimony. Explicitly addressing memory, Wendy testified, "I returned home to a family I had no memory of . . . My social work career had vanished" (Inquiry into Psychiatry, 2005, Electroshock, tape 1). In a different vein, articulating what became of her vibrancy and sense of connection, Paivi stated, "The deep emotions . . . that . . . were part of my life . . . had disappeared. It is as looking through a window, watching the activity going on inside, trying to be a part of that but never really being able to connect—and I have felt like that ever since" (Electroshock, Tape 2). By contrast, focusing on the in-hospital experience, Chris testified:

> I was exposed to the usual propaganda . . . that ECT is now safe and effective. I was shown a short video in the hospital. The video . . . showed the person . . . being shocked . . . The video did not show the person awakening in the recovery room alone and disoriented. (Electroshock, Tape 2)

And four years later, still urgently trying to sensitize the general public to the brutal reality, shock survivor Linda Andre (2009, p. 1) invited readers to entertain the following:

> Imagine you wake up tomorrow with your past missing . . . You may not be able to recognize your home or where you bank accounts are . . . Eventually you realize that years of your life have been erased, never to return.

The voices above are the voices of folk who have been there, who had ECT, some "willingly," some not, some at a moment of crisis, most over minor problems, all after having been duly assured that there is no reason for concern, that ECT is now safe and effective. The very presence of such voices minimally would appear to suggest that something terribly wrong is happening. They attest to damage, to extensive and permanent memory loss, to the erasure of skills, to decreased cognitive ability, to loss of connectedness, to no longer having the same wherewithal to navigate life. I ask the reader to bear them in mind as we step through this chapter. In institutional ethnography terms, they and the myriad of voices like them constitute this chapter's disjuncture. Correspondingly, their transparent clash with the official line that shock is new, safe, and effective is precisely the problematic. The question is: How is it that people like Linda, Wendy, Chris, Paivi experience what they do? And how does an official account so at odds with their lived experience come about and in turn engender that experience?

As evident in the forgoing, the subject of this chapter is electroshock (also called "electroconvulsive therapy" or "ECT"). Some elementary information by way of grounding: ECT is a procedure which involves passing 100–200 volts of electricity through the brain, by design, more than sufficient electricity to produce a grand mal seizure—hence the name "electroconvulsive therapy." People given it are administered a muscle relaxant (to prevent fractures), an anesthetic, and oxygen—the major modifications covered by the term "new and improved." These modifications, while otherwise a good thing, raise the seizure threshold, thereby necessitating a higher voltage. Placements of electrodes differ, some practitioners delivering "bilateral shock" (electrodes are placed over both hemispheres), others, "unilateral shock" (both electrodes placed over the nondominant hemisphere). Typically, an EEG machine monitors brain waves during and after the procedure. Treatments are given in a series, generally three times a week—twice weekly in England—with six–twelve treatments per series being most common. While primarily associated in the ECT literature with depression, including suicidality, electroshock is likewise administered for "mania" and "schizophrenia." Such details, I would add, are common knowledge and are not in dispute.[1] What is in dispute are the effects, the "therapeutic" mechanism, the nature of the enterprise.

This chapter picks up on what is already in evidence. That is, it builds on what our inquiry has already established. To reiterate some of the key findings at this juncture:

- Explicitly introduced as a brain-damaging therapeutic, ECT was initially hailed precisely for those brain-destroying properties that are currently dismissed as misconceptions, as propaganda. The reader is reminded here of Myerson's pronouncement (see Ebaugh 1942, p. 37), "These people have . . . more intelligence than they can handle, and the reduction of intelligence is an important factor in the curative process." Only once damaging the brain was no longer viewed as acceptable was such damage denied (see Chapter Three).
- In a major scientific study, as early as the 1950s Hartelius (1952) established brain damage at the level of statistic significance (see Chapter Three).
- ECT has been proven to impair memory long term (see Chapter Three).
- Psychiatric residents are forced to give ECT, can lose their jobs if they do not comply (see Chapter Six).

Just as this chapter probes the institution to see how the contradictions come about—and such is a major thrust—it probes the procedure in depth. It also explores the aftermath—the impact on actual human beings. We begin with the industry—the official structure, the hidden dynamics, the discursive techniques, the quality of the research referenced. What research establishes is examined next. We proceed to the question of what ECT actually does, in short, the mechanism of the damage. The apex of the chapter is a detailed examination of the impact on real lives, as articulated by survivors themselves.

Critical questions investigated include: What does ECT actually do? And why is it given? Who are the major figures in the ECT world? How have they constructed the industry's understanding of ECT? What are the processes, mechanisms, devices by which ECT is constructed and marketed as "safe and effective"? What do EEGs reveal/conceal? What does research actually establish? What are the short- and long-term effects? If ECT is truly as injurious as critics suggest, why do some people seek it out? Regard it as life-saving? And finally—given what has come to light, as a society, what do we do?

The chapter ends by returning us to the larger argument which is the subject of this book.

Bringing the Institution into View

For an overview of the shock industry, I would invite the reader to peruse figure 8.1.

As evident, there are broad based similarities with the psychopharmaceutical complex. There are a variety of professionals with vested interests. Researchers (inside the large circle on the right) are major and indeed strategic players. Professionals recognized as experts wield exceptional power. Professional organizations like the American Psychiatric Association are intricately involved and extend their influence by forming task forces, issuing position papers. Correspondingly, government regulatory agencies (see bottom third of diagram) hypothetically at least serve as gatekeepers.

The electroshock industry is in its own right a major money-making enterprise, especially in current times with ECT on the rise.[2] Obvious profit-makers are the traditional capitalists—the owners and distributers of the shock machines, the owners and distributors of the accompanying paraphernalia, including the videos referenced by Chris. Likewise reaping profits are: professionals who administer ECT; educators who deliver workshops; producers of books and journals; the burgeoning ECT research industry, with professors such as Sackeim, for example, landing lucrative research grants (see Andre, 2009).

Critical differences between the shock and the pharmaceutical industries are the size of the practice (only about one-fifth of psychiatrists in North America administer ECT), the size of the industry (with the major products reusable, the ECT industry is appreciably smaller), and what follows, the amount of money involved (see Andre, 2009). One consequence of these differences is that unlike the pharmaceutical industry, the industry is not especially well positioned to buy off the mental health system—a reality that partially explains the need for the punitive measures referenced in Chapter Six. Another formidable consequence is the proverbial "big fish in a small pond" phenomenon—namely, anyone recognized as an authority is positioned to wield extensive influence.

The shock machine manufacturers and the relationships formed with them are pivotal. Make and market a shock machine, and you can substantially influence

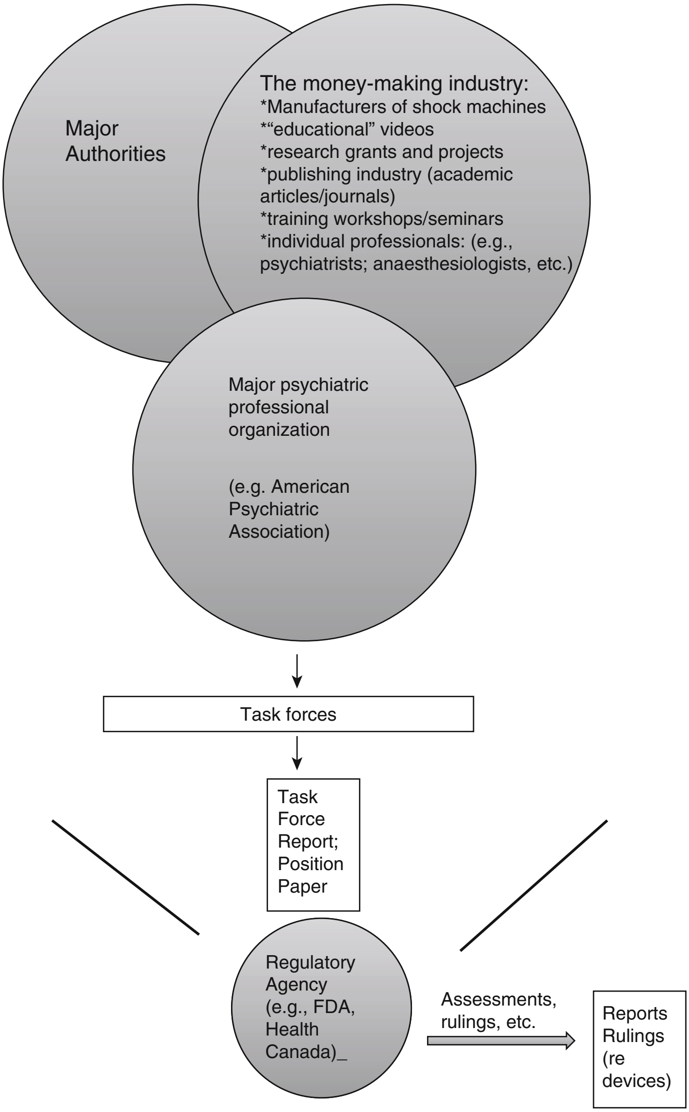


Figure 8.1 The electroshock empire.

how shock is delivered. Consult for a shock machine manufacturer, and you at once influence the design and have a hand in determining the nature of the procedure.

In the early days of shock, the most respected names in the field were promoters like Myerson and Kalinowsky (for further details, see Shorter and Healy, 2007; and Breggin, 2008b and 1979). For decades now, it has been two particular psychiatrists—shock advocates Max Fink and Richard Abrams. Hailed as the grandfather of American ECT, over the years Fink (1957, 1979, 1999, and 2009) has authored a plethora of highly influential books and articles. Correspondingly, initially a mentee of Fink, Abrams (2002) has written what is widely accepted as the standard textbook on electroshock, now in its fourth edition. While the official stance on ECT has been a "team effort," more than any other current figures these two authorities may be credited with ruling out permanent memory loss, dictating what the science "says" (no brain damage), and establishing the "safe and effective" narrative. Other central figures include Richard Weiner and Howard Sackeim. I would note in passing, a professional relationship with Fink would appear to open doors in the ECT world, which in turn further centralizes Fink. A case in point: Shorter and Healy's (2007) history of shock was almost instantly treated as definitive. Not coincidentally, they were invited by Fink to write it, and it mirrors and constructs as official the recognizable Fink position.

The influence of the dominant ECT promoters extends into the APA, which is impacted by them and which in turn magnifies their impact. Significantly, when the APA set up an ECT task force in the late 1980s, Fink and Sackeim were placed on that task force. Fink was likewise on the 1978 task force. Abrams served as a key commentator on the 1990 task force report. Correspondingly, Abrams and Fink are quoted and referenced extensively in task force reports. In the 1990 report, for example (American Psychiatric Association, 1990), nine publications of Abrams's are referenced. Abrams thereby emerges as the primary authority and his textbook, for all intents and purposes, as the boss text.

The role of APA more generally is pivotal. Not the capitalists directly but the APA has taken on the task of representing the industry to the government regulators. This includes trying to impel the FDA to classify the shock machines in ways more favorable to the industry (petitioning the FDA, meeting with the FDA, making deputations, submitting reports). In the process, professionals who serve as its spokespeople (e.g., Richard Weiner) become central figures in the ECT universe (for details, see Andre, 2009).

The Approval Process and the Professional Bodies

In contrast with the approval process investigated in the last chapter, what is most conspicuous about the shock machine approval process is what is missing—not what exists. In the bottom third of figure 8.1, you can we see the government regulators (e.g., FDA, Health Canada, etc.) on whose approval use of shock machines depends. What we don't see—and you may already have picked up on the absence—are trials—either ones conducted or ones presented to the regulators. To be clear, as already noted, there is an extensive research industry surrounding ECT. This notwithstanding, unlike with the pharmaceuticals, trials are not part of the approval process. What has happened here? Quite simply, shock machine manufacturers are not required to conduct trials on either human or animal subjects. Nor do they. On the basis of cursory tests, a cursory report, and a simple set of comparisons, rather, shock machines are approved for distribution.

An indicator of how perfunctory the approval process is was witnessed in Chapter Five. A reminder: I asked a Health Canada official why ECT machines were assigned a low risk level (level three), and the answer was that "it does not produce its own energy" (see Chapter Five). The point is, performance evaluations only are involved. What the regulator is trying to assess is *not* whether or not ECT intrinsically harms but whether or not the machines function *as they were designed to function*, alternatively, whether or not they fall *within certain predetermined parameters*. Is it delivering the correct amount of electricity? Does it involve a substance entering the body?—broadly speaking, such are the nature of the concerns. That someone like Wendy might wake from a "treatment" to find years of her memory wiped out appears, as it were, nowhere in the tick boxes (a disjuncture).

In the United States (as in Canada), the regulatory agency's principal action with respect to the ECT machines is to assign the *class as a whole* a risk level. Once risk is established, that level, hypothetically, dictates how the machines in that class will be treated. In Canada, ECT machines are licensed for use under the Medical Devices Regulations (see Health Canada, 2007 and n.d.) and are considered level three (second highest acceptable risk level). That this is not intended to signify an appreciable risk is evident by what else is assigned level three—for instance, *all non-latex* condoms.

FDA similarly lists electroshock machines as level three. In the United States, on the other hand, level three has a very specific and very serious meaning: The highest of the risk levels, it signifies that trials *should be conducted* as part of the approval process. That is, the machines so classified should be subjected to "pre-market approval" (see Food and Drug Administration, 2011, p. 8 ff.). Tellingly, no such trials have ever been conducted or required. Instead the machines are treated as if they were Class Two risk and so simply needing what is called a "pre-market notification" or "510k." And premarket notification, significantly, involves nothing more that issuing a report indicating that the device in question is the rough equivalent of a product already on the market—that is, is used for the same purposes and can be expected to have the same "effectiveness" and "risks" (Food and Drug Administration, 2011, p. 8). Although shock machines have been subsumed under a class which requires trials, in other words, they have been granted an exemption. As such, it does not matter what danger ECT machines pose (e.g., whether or not the recipients recognize their daughter) as long as any new ECT machine is roughly the equivalent of the old ones. A contradiction—and arguably, a formula for damage.

Historically, this contradiction first emerged in the mid-to-late 1970s when the Medical Devices Amendment to the Food Drug and Cosmetics Act was enacted and exemptions were created for devises already on the market (see Andre, 2009). The result of the contradiction has been ongoing struggles between shock survivors and their allies on one hand and the APA on the other. The APA has repeatedly petitioned for the rating to be lowered (which would make the anomaly and the prospect of having to conduct trials disappear), whereas survivors have asked for the rating to remain as is and for the mandatory trials to be ordered. The last major battle on this front was triggered by the Government Accountability Office (GAO), which recommended that the FDA rid itself of the anomaly by either lowering the risk rating or requiring premarket approval (see Food and Drug Administration, 2011). What followed was the usual FDA process of reports and hearings. What happened as a result? A continuation of limbo. That is, the rating was not lowered. Neither was a ruling issued requiring testing in the future.[3]

The actions of two professional bodies over the years—the FDA and the APA—are informative. While the FDA has shown some openness to survivors, the systematic privileging of the industry is clear. On its own initiative, for example, at one point the FDA announced its intention to consider lowering the rating of the machines—blatantly, an industry-friendly initiative. Correspondingly, in its 1990 report on shock, FDA virtually mirrored the recently submitted APA position paper, replicating APA misinformation in the process. For example, the landmark study by Avery and Winokur (1976) was misrepresented first by the APA and subsequently by the FDA as supporting the position that ECT lowers the suicide rate.[4] By the same token, whatever its rulings with respect to risk classification—and it would be hard to justify lowering it given the substantial documentation provided by survivors and their allies—FDA has consistently protected the industry from having to conduct trials, even at the expense of breaking its own rules. As such, FDA is largely functioning as a partner of industry.[5] Not that I am in any way suggesting that conducting such trials would materially alter the lay of the land given what we already know about research manipulation.

Which brings us once again to the APA. Whenever APA taskforces assess the latest studies and release a position paper on ECT, the impression created is that it is functioning as an arm's-length objective professional body trying to deliver a fair assessment—which in turn sets its findings up to be read as definitive. As already seen, the reality is the APA is intrinsically tied to the ECT industry, indeed, represents the industry. Hence the active lobbying. Hence the nature of its publications. Hence members like Abrams's (2002, p. 12) objection to "requiring manufacturers to undertake . . . enormously expensive . . . trials." Correspondingly, whether they serve directly or provide expert commentary, APA's task forces are invariably dominated by leading ECT proponents—figures like Fink and Abrams. There is a circularity here. The promoters dominate the APA task forces. The APA task forces repeatedly quote the promoters (legitimation technique). The FDA in turn activates and replicates the APA references, which again means constructing the promoters' words as authoritative. While worrisome in itself, the circularity evident here acquires a whole new dimension when you factor in the larger ECT empire.

Revisiting the ECT World

Feast your eyes once again on figure 8.1. In the first circle, we see the lead ECT "experts." In the one next to it is the for-profit industry. Significantly, these categories greatly overlap. It is not just that the experts have the usual vested interests—that is, that they make money from administering shock or delivering workshops. The experts (who, again, largely determine ECT practice) are also the arch-capitalists, with conflict-of-interest writ large. Bottom line: There are exactly two companies that produce and market shock machines in North America—Somatics and MECTA. Abrams is one of two co-owners of Somatics. By the same token, Max Fink, who has been on ECT taskforce after taskforce, makes money from producing educational videos on ECT, which videos in turn are distributed by none other than Somatics, co-owned by his protégé Abrams. Correspondingly, Richard Weiner, who for decades spearheaded APA's effort to have the shock machines reclassified, served as the electrical engineer who designed the shock machines for MECTA, and he would eventually come to work for Somatics. The principal experts, in other words, who have served on task forces, who have been instrumental in producing reports for the American Psychiatric Association ARE THE CAPITALISTS, are the people who benefit most from the conclusions and the decisions that they have been so instrumental in making—allegedly, distinterestedly.[6]

The circularity evident here and the centrality of capitalists/experts to the validation-to-delivery process may be mapped as in figure 8.2.

Capitalists/scholars own the shock machines, design the machines, consult for the companies, create the ECT videos, serve on APA task forces. They likewise sit on the boards of legitimating journals. Correspondingly, their publications are seen as the official word on ECT. APA and by extension the FDA, accordingly, quote said capitalists. With all these processes coming together to manufacture consent—and you can follow this visually in figure 8.2—the capitalists successfully market the products (shock machines, the videos, etc.); the hospital purchases the machine and the video, typically from the same company; the hospital uses the video to "educate" staff, though more significantly, to bring potential recipients to accept the "treatment."

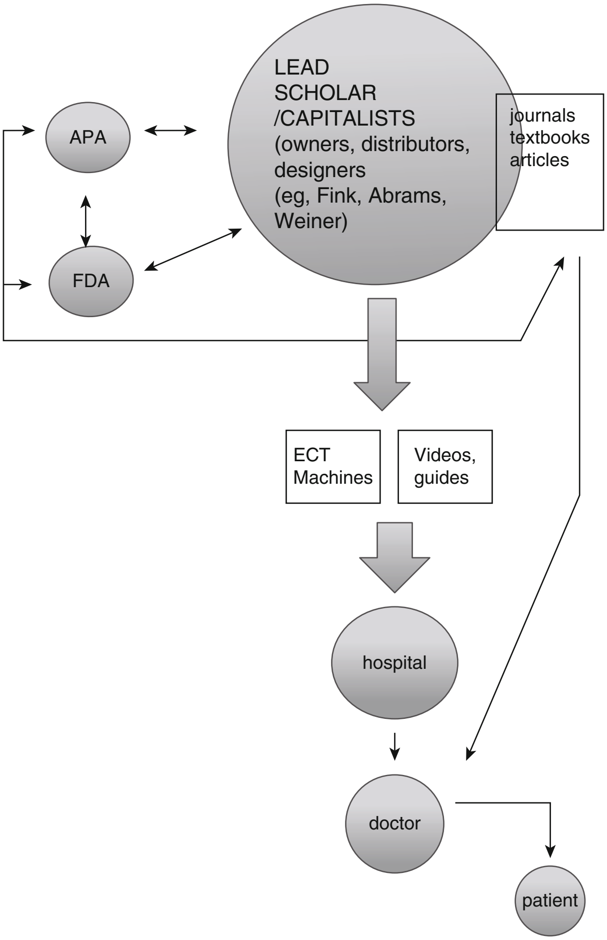


Figure 8.2 Rule by ECT scholar/capitalists.

Such processes, I would suggest, go a long way to explaining the disjuncture that shock survivors experience.

Speaking and Writing ECT as Safe and Effective

Albeit on a very different level, likewise contributing to the disjuncture is the use made of discursive techniques. The point is that the official picture of ECT is itself a discursive product, with utterances so framed as to construct the "treatment" as safe and effective. To a degree this framing is "scholarly" in that academic concepts are employed and it largely originates with the scholars. At the same time, the discursive devices are activated by practitioners and officials everywhere—in talking to the press, explaining the "treatment" to recipients and their families, penning official descriptions for general circulation.

The discursive methods employed include:

- assuming authorial credibility and stating emphatically that something is or is not the case (e.g., this statement on p. 115 in Fink's 2009 guide, "The controversy is based on the belief that inducing seizures by electricity permanently damages the brain . . . That belief is unfounded");
- ignoring or invisibilizing literature/research that shows that shock is injurious and or ineffective (e.g., Shorter and Healy, 2009; the APA 1990 task force report);
- where the findings of a landmark study is inconvenient, when referencing it, dramatically altering the finding (recall the APA's handling of the landmark Avery and Winokur study about ECT and suicide);
- taking what is at worst a minor defect in an "inconvenient" study and acting as if it invalidates the entire study (by way of example, Devanand et al., 1994, dismisses Hartelius's 1952 study by noting that one group of cats was given shock at two-hour intervals and ignoring the fact that cats shocked every four days exhibited the same pattern of damage);
- invisibilizing overwhelming defects in "onside" studies (e.g., Shorter and Healy, 2007 fail to mention that most of effectiveness studies that they draw on as credible proof involve no control group and vague or no definition of recovery);
- use of "life-saving" language and references to ECT as a " last resort";
- ad hominem attacks: the purpose of the ad hominem is to validate the procedure by invalidating the critic; for example, Kalinowsky (1959), dealt with patients attesting to extensive memory loss by claiming they were liars and/or neurotic;
- "contrasting the new with the old"; employed by all shock proponents, this device constitutes an essential part of the official narrative; it involves referencing that shock broke bones in the 1940s, calling it old shock; contrasting it with a hypothetical "benign present," correspondingly, associating current practice with such words as "new," "improved," and "modified." These descriptors work together to create the impression that all problems with ECT were in the past;

- writing as if enormously different consequences attend different modes of delivery, in the process defining one method as exempt from all criticism;
- insinuating that critics are relying on outdated depictions by repeatedly commenting on the depiction in "One Flew Over the Cuckoo's Nest"—albeit the critics themselves never bring up the movie[7] (e.g., Shorter and Healy, 2007);
- sheer repetition of descriptors like "safe and effective" (all ECT advocates).

ECT: A Procedure Propped Up by Bad Research

That ECT is safe and effective is presented as established fact. Probe the research in question, however, and you find that most of it is illegitimately framed so as to produce positive results and is in other ways substandard.

Witness, for instance, the effectiveness studies that purportedly validate use of ECT. Most lack controls (groups given *simulated* ECT). Overwhelmingly, the evaluation of effectiveness is made by "health professionals," who themselves favor ECT, almost never by the recipient. Correspondingly, in most cases no criteria of effectiveness is stipulated.

By way of example, with respect to all four of the effectiveness studies positively referenced by Shorter and Healy (2007), research analysts Read and Bentall (2010, p. 334), uncovered the following:

> Three of them (Kalinowsky, 1944; Myerson, 1941; Smith et al., 1941) had no control groups, vague or non-existent definitions of "recovery," and the people assessing "recovery" were either the hospital staff or unidentified . . . In the fourth (Tillotson & Sulzback, 1945) . . . there was no definition of "improved" and no mention of who decided who was "improved."

Having no criteria for effectiveness is a surefire method for finding what you want or expect to find. Correspondingly, to understand the significance of the evaluation being made by hospital personnel one need only look at the disconnect between the survivors' words at the start of this chapter and the professional contention that ECT is safe and effective. The point is, even where honesty is being attempted, the difference in perspective is huge—and professionals are unlikely to see what their theory rules out. I would reference in this regard the findings of a perspectival study by Van Daalen-Smith (2011), which involves both "patients" and nurses. Significantly, post-ECT patients unanimously assessed the impact on their cognitive ability as "devastating." No such problem was so much as mentioned by the nurses who care for them.

Examples of other flaws include: In contravention of the rules of research, subjects are tallied up *across* studies as if part of the same study (e.g., Janicak, Davis, and Gibbons, 1985). What is so common as to be typical—there is no follow-up after the treatment period (e.g., West, 1981)—which means that ultimately, irrespective of the "finding," we do not know how these people fared. Likewise typical, CAT scans and MRI results are treated as if they can rule out brain damage (see Pande et al., 1990; and Bergsholm, 1989), this, despite the fact that it is well known that brain scans are unable to pick up microscopic damage (for elaboration, see Breggin, 2008b, p. 242). Correspondingly, what is fundamental, the same problems with the effect/side effect division that plague the drug studies plague these—it trivializes the "adverse effects." Additionally, while control groups are used in what is considered "the best studies" and while their inclusion would appear to make the findings credible, given that the standard method of delivering simulated shock is to put participants to sleep, within hours of the first treatment, both subject and evaluator can tell to which group the subject was assigned. The point is, the subject in the control group would not wake up confused and disoriented; would not have a splitting headache. Ergo, not even "single blind," never mind "double blind" is accomplished. What follows, for those receiving ECT, there is necessarily a doubling of the placebo effect.

That noted, we can indeed draw some conclusions on the basis of ECT research. Here, however, we shift to the other side of the disjuncture.

Zeroing In: So What Has Been Established?

Proof of Brain Damage and Cognitive Dysfunction

The official position on ECT (Fink's *current* position) is that there is no evidence whatever of brain damage. Contrast this with Fink's (1978, p. 7) earlier position, "Brain tissues have been reported to show increased gliosis, diffuse degeneration, petechial hemorrhages in the midbrain and evidence of fat embolism and in itself edema, and subarachnoid hemorrhage."[8]

In point of fact, neurologists have long observed visible brain damage in post-ECT patients, together with behavior indicative of brain damage. So recognizable and consistent is the damage that neurologist Sidney Samant incorporates brain damage into very definition of ECT, writing:

> As a neurologist and an electroencephalographer, I have seen many patients after ECT . . . ECT produces effects identical to those of a head injury . . . Electroconvulsive therapy may in effect be defined as a controlled type of brain damage produced by electrical means. (Quoted from Breggin, 1991a, p. 184)

Triangulating with the observational data, credible studies over the years have repeatedly established brain damage, whether this be hemorrhage, the creation of ghost cells, or brain shrinkage. To reference but a few: Hartelius (1952), in a large animal study which involved a major double-blind component, established brain damage at the level of statistical significance, with that damage including gliosis, hemorrhages, and brain shrinkage. Weinberger (1979) compared CT scans of "schizophrenics" who had ECT with nonshocked "schizophrenics" and found significantly more cerebral atrophy in the "shocked schizophrenics." In a CT study, Calloway (1981) found that frontal lobe atrophy was significantly more extensive in ECT than in non-ECT recipients. And Dolan et al. (1986) compared brain scans of 101 "depressed" patients who had received ECT with scans of 52 subjects who had no ECT. They found twice as much measurable loss of brain tissue in the frontal area of the ECT recipients, with the difference additionally being statistically significant. What is especially informative about this last study, the design includes the investigators checking for other factors, and tellingly, the brain damage correlates *with the administration of ECT only*, to quote from the article, not with "family history of mental illness, age at the time of the diagnosis, or severity of the mental illness" (p. 775)—in other words, the study credibly points to the "treatment" as casual.

Cognitive dysfunction is expectable with brain damage and indeed is identified in the Samant reference. Examples of studies themselves which provide evidence of general brain dysfunction and cognitive impairment are: Templer, Ruff, and Armstrong (1973), which establishes general intellectual impairment; and Templer and Veleber (1982), which indicates permanent brain pathology.

Memory Loss Explicitly

Despite the claims of professionals that memory loss is minor and transient, on the basis of controlled studies, Janis (1950) and Janis and Astrachan (1951) found memory impairment persisting at one-year follow-up. Squire and Slater (1983) questioned patients seven months after treatment; blocks of missing time surrounding the treatment averaged twenty-seven months; correspondingly, at three-year follow-up, half of those who had received bilateral shock reported poor memory. And in a study investigating both, Templer, Ruff, and Armstrong (1973) established memory loss, together with cognitive impairment.

Introducing the 2007 Sackeim Study: Its Findings and Significance

While there was ample evidence of brain damage and memory and other cognitive impairment prior to the Sackeim study, Sackeim et al. (2007) is momentous. Sackeim et al. (2007) is the largest and most ambitious study in ECT history. A longitudinal, multi-cite, and multi-instrument study, it involved 7 different community cites, 347 shock recipients, and included six-month follow-up. What likewise contributes to its importance, it investigated *all methods of delivering ECT in current use*; and it employed an extensive battery of tests (e.g., the Modified Mini-Mental exam, the Buschke Selective Reminding Test, and the Columbia University Autobiographical Memory Interview). At a level way beyond what is required for a finding of statistical significance, the study found significant memory impairment with respect to *every single type of ECT*, with respect to all ages and each gender, with the inability to remember details of one's own life being especially pronounced. Correspondingly, with respect to all types of ECT, all ages, and each gender, at a level of statistical significance, the study found persistent "global" cognitive dysfunction; in other words, the recipients were cognitively impaired over a wide range of mental faculties. The authors concluded, "This study provides the first evidence in a large prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings" (p. 253).

Several factors make this study critical. To touch on a few—and I will be identifying more later—the very fact of Sackeim's being one of the leading shock *promoters* lends a special credibility to these findings. The authors of the article clarify quite correctly that the study demonstrates that the "official line" on ECT is wrong—and who better to put this forward that a member of the inner sanctum? More pointedly, the study shows that ECT is harmful in precisely the ways that survivors and critical professionals have been suggesting for years. On a different level, the study effectively undercuts the claims that only certain types of ECT are problematic. Correspondingly, it establishes that the various types of memory loss commonly reported by shock recipients (and denied or minimized by professionals) are more or less as reported, that is, are indeed extensive and ongoing, including: retrograde memory loss (inability to remember events, people, and skills before shock) and anterograde memory loss (inability to retain new information). Additionally, albeit shock advocates like Sackeim, expectably, avoid terms like "brain damage" and "permanent cognitive function," in effect, the combined tests indicate brain damage (for a detailed explication, see Breggin, 2008b and 2007). By the same token, permanent cognitive dysfunction is suggested. Note, many recipients had persistent abnormal EEG readings at six-month follow-up. Correspondingly, as Breggin (2007, p. 83) points out, "If traumatic damage has persisted for six months, it is likely to remain stable or even grow worse." Moreover—while again the authors do not spell this out—the data indicates that not just some but that *a high percentage of ECT recipients* became seriously cognitively impaired. The point is, the probability statistics provided (p < .0001 on ten tests and .003 on the eleventh) would be impossible were this not so.

Additional statistically significant findings of note are that women suffer greater cognitive impairment than their male counterparts, especially with respect to autobiographical memory. Correspondingly, the elderly suffer more cognitive impairment than the young. It bears mentioning that these are the very populations who are disproportionately shocked (see Weitz, 2009 and 2013)—all of which bolsters the feminist and antiageism critiques (e.g., Burstow, 2006; and Orr and O'Connor, 2005).

If the Sackeim study reveals ECT as seriously harmful—which it blatantly does—I would add, it likewise sheds light on the ECT promoters. Despite the fact—more likely *because of* the fact—that the study definitively disproves the official ECT line, it has been ignored by the shock establishment. An informative example: When the Canadian Psychiatric Association came out with its position paper on ECT in 2010, albeit it contained manifold ECT references (see Enns, Reiss, and Chan, 2010), in line with the strategy of ignoring inconvenient findings, this study—*the largest study, you recall, in shock history*—was not mentioned.

Sackeim's response to his own study is likewise telling. Having hitched his wagon, as it were, to ECT futures and yet having remained keenly aware as a psychologist of the effects on memory, he has made a career of at once advocating for shock and suggesting ways to "improve" it. Correspondingly, in this very article—one, note, based on research that has produced damning results—besides that he diligently steers clear of certain words and concepts, continued tinkering constitutes the only recommendations.

Effectiveness

It has been argued that all of the tradeoffs are worth it given ECT's effectiveness—a worrisome position in itself. That noted, besides that there are problems with the measures and concepts employed in efficacy studies, even taken at face value, the results are incompatible with the official claims. In this regard, a double-blind study by Lambourne and Gill (1978) showed that one month after shock, there was no difference in improvement between the ECT and the placebo group—leading the researchers to conclude that all efficacy was probably due to placebo. Research by Johnstone (1980) and research by Crowe and Johnstone (1986) arrive at similar findings. Correspondingly, in an exhaustive review of the literature on the use of ECT with depression, Ross (2006, p. 18) concludes that *no study* has ever demonstrated that ECT is superior to placebo except during the time it is being administered, and "that even during the time it is being administered, real ECT is only marginally superior to placebo."

By the same token, Avery and Winokur (1976) and Black et al. (1989) demonstrate that ECT has no effect on the suicide rate. Correspondingly, a Danish study by Munk-Olsen et al. (2007) examined deaths of "mental patients" over a 25-year period and found that in-patients who had been treated with ECT had a marginally *higher risk* of dying by suicide than other in-patients. Now, admittedly, it is very possible that this slightly elevated risk is attributable to the recipients being more suicidal to begin with. Minimally, however, efficacy with respect to suicide is not upheld.

The Findings "in a Nutshell"

So what in point of fact does the research establish? In short, that ECT is a profoundly injurious treatment that damages the brain, that substantially impairs memory, that gives rise to global cognitive dysfunction—and in the final analysis, it has no lasting efficacy.

Tracing the Damage and Impairment

ECT, you will recall, involves: (a) passing electricity through the brain and (b) a grand mal seizure. There are various mechanisms by which the damage is produced. One is the convulsion. As any doctor who has tried to prevent an epileptic attack is aware, grand mal seizures damage the brain—and as Breggin (2013) demonstrates, ECT seizures are of far greater intensity than epileptic seizures. The multiple seizures, in essence, exhaust the brain and result in nerve cell death. The hippocampus is particularly compromised. In this regard in a study which employed electric shocks with mice, Zarubenko et al. (2005) illustrated cell death in the hippocampus, with the number of cells in CA1 and CA3 "inversely correlated with the intensity of convulsions."[9] To put this in layman's term, the more intense the convulsion, the fewer neurons that survive. As the hippocampal area is strongly associated with memory, herein we see an explanation of the standard memory problems.

The second mechanism of damage is the current. Electricity itself being primary, the average treatment utilizes *two and half times* the electricity needed for a grand mal seizure. The upshot? The brain overheats; a massive tension builds up, causing the blood brain barrier to break down and blood vessels to spasm; this in turn can result in oxygen and other nutrient deprivation—ergo, additional damage (see Breeding, 2007; and Breggin, 2013).

EEGs tell their own story. Fink (2009, p. 95) describes the readings during treatment as follows:

> The electrical waves show a sharp buildup of waves and amplitudes, then the frequencies slow, mixtures of slow brain waves and sharp spike-like waves appear, with ever higher amplitudes and slower waves in runs and bursts. Suddenly, the frequencies cut off and the record becomes flat.

The point is, the brain flatlines (no detectable electrical activity). To appreciate the seriousness of what is happening the reader is reminded of the meaning of the heart flatlining. Flatlining constitutes or prefigures the death of an organ. Now allegedly, shortly after the treatment, the EEG readings return to normal (p. 94). In point of fact, as we have already learned, EEG readings are commonly abnormal in six-month follow-up—and as Breggin (2007) indicates, a brain abnormality which persists this long generally remains stable or worsens.

The patient awakes with organic brain syndrome—hence the classical confusion and disorientation. In some cases euphoria temporarily sets in (a common "side effect" of brain damage; for details, see Breeding, 2007).

Once again, there is a one-to-one relationship between the damage and impairment on one hand and the "therapeutic" effect on the other. Early statements by Fink (when brain-damage was "acceptable") are instructive here. In explicating a unified theory of action for lobotomy, tranquilizers, insulin coma, and ECT, Fink (1957, p. 197 ff.) states, "Alteration in cerebral function [read: cerebral dysfunction] is an essential prerequisite of behavioral change in each of these therapies. Such alteration is neither a 'complication' nor an 'untoward effect' but is the sine qua non of these therapies." Correspondingly, in explicating ECT, Fink, Kahn, and Green (1958, p. 113) write, "When a depressed patient, who has been withdrawn, crying, and has expressed suicidal thoughts, no longer is seclusive and is jovial, friendly and euphoric, denies his problems and sees his previous thoughts of suicide as 'silly,' a rating of 'much improved' is made."

It is clear what is being deemed "therapeutic" here. Iatrogenically created dysfunction. Diminished capacity. Lobotomy-like unawareness. The euphoria caused by brain trauma. Additionally, anosognosia—the cognitive impairment that involves inability to recognize that one is impaired. Compliance itself.

In the very probing of the damage, I would add, we have unearthed several reasons why professionals, loved ones, occasionally the person themselves see ECT as helping. We shall be exploring the issue in detail later. What I would highlight now—and I will end with this—is the role of memory impairment. A person who has no access to the thoughts, images, and experiences underlying their distress may for a time feel better, seem freer. Indeed, many ECT practitioners quietly favor ECT for *precisely this reason*. A case in point: when I was testifying at a review hearing for a "patient" who was not eating, at one juncture her psychiatrist pulled the patient's lawyer aside, asked that he be allowed to give the woman ECT—for afterward, he stated, she would not remember why she was not eating. Forgetting one's problems can indeed initially lead one to feel better, perhaps act more "normal." The tragedy is that the person is stuck with the damage; moreover, as every therapist who has actually worked with ECT survivors is painfully aware, the problems seemingly eradicated continue to exert an influence but are now beyond reach.

Focusing in on ECT Recipients: Real Effects on Real Lives

We began this chapter with a disjuncture. We have traced how it is created and recreated, in the process unearthing some frightening truths about ECT. To both add to and better comprehend those truths, let us turn at this juncture to the voices of survivors. The value of centering these voices is self-evident: There are questions never posed in studies, framings that never happen, complexities that cannot otherwise be fathomed. That noted, I would like to make the evident *more evident* by touching on a moment in an interview with Marte—a shock survivor in her fifties whom I have long known.

Taking the lead, Marte spoke with great precision about the events in her life leading up to ECT. She periodically checked her notes, as survivors commonly do. As we neared the end of the interview, after recounting her experiences in the hospital immediately following shock—and again in exceptional detail—she looked up from her notes and remarked, "The thing is, I don't remember anything." The conversation continued thusly:

> *Bonnie*: So your memory cut out...
> *Marte*: Almost totally.
> *Bonnie*: So it didn't cut out *before* the ECT? I know a lot of people have amnesia.
> *Marte*: I cut out. The *twenty years before are totally missing.*
> *Bonnie*: I don't want to misunderstand here. So let me try to get this right. These things you've been telling me, are *some* of these things that you remember?
> *Marte*: I *don't* remember. I am telling you from the notes. It's all very well documented.

I had long been aware that survivors commonly cope by making notes, also by actively researching. What I had not taken in is that "knowing" may be an issue not so much of the reliability of memory as the soundness of the documentation. Except for trauma and vulnerability, nor had I fathomed how very different our respective processes would be sitting down for a "mutual" conversation—the nonsurvivor assuming that "know" connotes something direct, the survivor holding fast to the indirect, in essence, making the indirect stand in for the direct. If this interview deepened my felt sense of the survivor world, what is likewise important, my initial blunder—and clearly there was a disconnect here—serves as a reminder that survivors' minute-by-minute experience, including how they navigate life, constitute the ultimate truth about ECT. The point is, if we want to understand what ECT does, ultimately, we must turn to them. What follows, accordingly, is an articulation of the major themes present/presented in survivors' accounts.

Survivor Themes

Types of Impairment and the Lived Consequences

No theme arises so often nor is as integral to survivors' stories as memory loss. Moreover, such loss is generally more dire and routinely more complex than anything that surfaces in traditional six-month follow-up studies. As seen in Marte's account, vast stretches of time can be obliterated. Such a loss, survivors clarify, is not to be confused with bad memory or traditional lapses. ECT survivor Connie Neil clarifies, "The difference between these kinds of memory loss and the ordinary memory loss when you can't remember somebody's name is that it is *entirely wiped out*" (Ontario Coalition to Stop Electroshock, 1984, p. 87; emphasis in the original).

People's lives are essentially obliterated—erased. It is as if they had been rendered instantly "unlived." What is involved here is loss of people (see Funk, 1998; and Macdonald, 1988); loss of ideas, images, and experiences; loss of skills, whether it be playing the piano (Connie) or something as basic and "taken-for-granted" as the ability to read (see Jacqueline's testimony in Inquiry into Psychiatry, 2005). What adds to the problem, many survivors are unable to reacquire information precisely because new memory is likewise compromised—hence the need to go through life taking notes.

If your skills are gone, if you cannot recall what has happened from one day to the next, you are likely to end up with a fairly menial job; correspondingly, if you are unable to absorb and/or retain new information, your life prospects are drastically diminished. States child survivor Hugh in this regard: "I was going to be the second one in our entire family to finish university. Everyone knew that. Now I can't finish grade 12 . . . There is something wrong with my head . . . I've tried grade 12 now seven times" (Ontario Coalition to Stop Electroshock, 1984, pp. 62 ff.). A related theme is loss of identity. Eradicate someone's experiences, and indeed, the basis for their identity disappears. "Your memory is not a component of your self like your hair color," points out survivor Linda Andre (2009, p. 1 ff.). "Your memory is the sum total of all you have ever seen, smelt, learnt, and done in your life—is your self."

Memory and cognition work together—hence Hugh's repeated unsuccessful runs at finishing grade 12. As such, memory impairment and general cognitive impairment intertwine. Other cognitive impairment which commonly figures in survivor accounts include: loss of IQ; inability to concentrate; having to work far harder to arrive at the same place (see, respectively, Rice in Andre, 2009; Starkman and McKague's testimony in Inquiry into Psychiatry, 2005).

An additional theme—and one intrinsically connected to cognitive impairment is the flattening of the emotions, a loss of intensity, the disappearance of the creative spark, a removed quality to experience. For a felt sense of this, I would reference these haunting words of shock survivor and erstwhile artist Paivi:

> The deep emotions that were part of my person have disappeared. It feels like a part of my being has been wiped away, lost somewhere. It is as if looking through a window, watching the activity going on inside, trying to be a part of that, but never really being able to connect—and I have felt like that ever since. (Inquiry into Psychiatry, 2005, Electroshock, tape 2)

What is common to all of the "effects" articulated to date? Besides that they are undesirable—in a word, loss or personal diminishment (overarching theme). Identifying diminishment as the overriding effect of ECT, indeed, shock survivor

Connie Neil, as it were, turns the standard claim of effectiveness inside out, reframing it thusly:

> What I had was... modified shock, and it was seen as effective. By "effective," I know that it is meant that they diminish the person. They certainly diminished me. (Phoenix Rising Collective, 1984, 20A–21A)

And forcefully drawing home the point, Wendy Funk (Inquiry into Psychiatry, 2005, Electroshock, tape 1) testifies:

> When you hear that ECT is new, improved and safe, it's an obvious lie. When you hear that they don't know exactly how ECT works, it's a lie. But when you hear that it is effective, well, it's true. It is very effective in causing closed head injury/memory loss, which inevitably alters lives.

More Themes: Battery, Trauma, Fear, Torture, Degradation, Punishment, Control

A sense that the harm is intentional is conveyed in the preceding quotations. In survivor testimony, additionally, something of the nature of battery is being suggested (for detailed analysis, see Burstow, 2009). Indeed, survivors commonly depict the entire process as a form of assault—being dragged into a room, being unable to breathe, being rendered unconscious, being brain-damaged. "It can feel like a brutal assault on who you are," states one woman in a landmark study by Johnstone (2002–2003, p. 46). "I feel like I've been gotten at, bashed, like my brain's been abused," states another.

More generally, battery, trauma, dread, a sense of imminent annihilation, degradation, animalization, a sense of being led to the slaughter, a sense of powerlessness, and torture all come together in the testimony. "I felt as if I were a non-person and it didn't matter what anyone did to me," stated a woman in the Johnstone (2002–2003, p. 49) study. "I felt like an animal" and "they strip you of your self-worth," states another; "I never felt so helpless in all my life," exclaims a third (see Froede and Baldwin, 1999). "Your heart's a muscle," observes Connie, "and your lung's a muscle, and all of the muscles stop, and each time, you feel like you are dying" (quoted from Burstow, 1994).

Just as survivors, being victims of brain injury, are forced to live with the cognitive aftermath of blunt force trauma to the brain, as victims of psychological trauma, they are forced to live with the psychological effects of *having been so "gotten at"*—the memory of the violence, the abiding fear—which, accordingly, likewise figure prominently in survivor testimony (for an analysis of ECT as trauma, see Burstow, 2006). Reflecting on her own experience, Connie for one explicitly states, "But the biggest thing I think is the business about the terror and the violence... This just does not go away" (quoted from Burstow, 1994). Correspondingly, in what is transparently an indictment of the entire ECT industry from the hospital staff to the state, Sue Clarke asserts:

> All the therapy in the world is not going to erase the scars of being dragged into a room, having a band on your head and having your brains fried. People suggest that

> there is no torture in Canada. That's pure bullshit. And excuse my language, there is torture being paid for by the Ministry of Health. (Quoted from Burstow, 1994)

Related to ECT as torture/assault is ECT as punishment. "It was meant to be punishment," testifies Connie (quoted from Burstow, 1994). By the same token, women in the Johnstone (2002–2003, p. 49) study report having wondered what they did to deserve being punished so.

Related to all these depictions and more extensive than any of them is ECT as a form of control. Iatrogenic memory loss itself emerges as a subset of control—and I would remind the reader here of the psychiatrist who wanted to control the client's eating by forcing her to forget that she did not want to eat, also of Cameron's replacing wiped-out memory with such blatantly manipulative messages as "You are a bad mother; you are a bad wife" (for details on Cameron, see Chapter Three).

Likewise figuring in the testimony is the very specific social control inherent in ECT as threat. Connie's words once again are instructive:

> The biggest thing . . . is the business about the fear and the violence. This is something that doesn't go away. All I did was have a baby. And look at what they did to me. Now if I really did something, what would they do to me next? So you be very very careful. You be very very quiet . . . You fit in. You play a role. (Quoted from Burstow, 1994)

Even inmates never subjected to ECT testify to the threat surrounding it—a threat activated every time they are forced to witness the line-up for ECT, every time they encounter a fellow inmate who has just had shock and now recognizes no one. "It was never stated but it was implicit," commented one psychiatric survivor (quoted from Ontario Coalition to Stop Electroshock, 1984, p. 161). "It was a threat to all of us . . . to get our act together really quickly or else this was going to happen to us."

The fact that survivors so experience ECT, I would suggest, is minimally an open secret, and whether reflectively or prereflectively, that knowledge is being leveraged. More deliberate use of the punitive dimension, additionally, is in ample evidence. Dr. H. C. Tien, for example, refers to using ECT as a "mental spanking" (for documentation, see Breggin, 1991a). Herein we see the link with the eighteenth-century alienist, who employed his own devices to terrify patients into "behaving" (see Chapter Two).

Commonly, whether implicitly or explicitly, the control reveals itself as inherently patriarchal, with domination of female (read: *patient*) by male (read: *doctor*) writ large. Witness these words by survivor Velma Orlikow:

> Every time I saw him coming down the hall, I'd shake with fear . . . I'd say, "I can't take it any more. I don't think this is doing me any good. I feel worse." And he'd walk down the hall a little way and put his arm on my shoulder and say, "Come on now, lassie, you know you're going to do it." (Quoted from Burstow and Weitz, 1988, pp. 202–204)

In women's stories specifically, additionally, ECT emerges as a means of enforcing sex roles stereotypes. For example, Wendy's doctor "explained" to her that her "problem" arose from "feminist-type" and "neglecting" her house and her husband (Funk, 1998, p. 48). By the same token, survivor Sheila Gilhooly describes her experience thusly: "I told my shrink I didn't want to be cured of being a lesbian. He said that just proved how sick I was. He said I needed shock treatment . . . Nineteen shock treatments, and I still didn't want to be cured of being a lesbian" (quoted from Blackbridge and Gilhooly, 1988, p. 45). The purpose of the ECT, it would seem, was to make Sheila forget her preference for women—that or to "pummel" her into compliance.

Finally, a particular common theme (subset of control, memory loss, and enforcement of sex role stereotype) is use of ECT to turn married women into "better wives." The explicit focus of Tien's "marital therapy," note, was to cure problems in the marital relation by making the wife submissive, with therapy ending with the duly shocked, brain-damaged, and infantilized wife being bottle-fed by her husband (see Tien, 1974). While Tien assuredly is an extreme, survivor testimony as a whole points to an intent to alter the behavior of wives. Wendy, by way of example, reports the following interchange between her doctor and her husband:

> Can't you tell her to spend more time at home?" Dr. King asked.
> I try but she doesn't listen to me," Dan joked.
> So you can't control your wife's behavior?" Dr. King asked. (Funk, 1998, p. 15)

It was immediately after this exchange that the doctor suggested that Wendy's problems were caused by "feminist-style thinking." And shortly thereafter, she received ECT.

Bringing the Themes Together

Put these themes together and a very worrisome picture emerges. What ECT does is damage and impair. Inherently patriarchal, control is integral to its purpose, with the control of women writ large. And it achieves its effects by cognitive impairment, punishment, and threats.

Sue's Story

Sue was a teenager who was being abused at home. Fleeing the abuse, she ended up on the street. At the suggestion of a school psychologist, she went to Royal Ottawa Hospital for help with the trauma. Here she was diagnosed "schizophrenic." She subsequently found herself in Brockville (small Ontarian city), where against her wishes, she was administered 5 ECT treatments. So strenuously did she object, they had to "manhandle" her to make it happen. States Sue in this regard (quoted from Burstow, 1994), "I remember kicking and screaming as they pulled me into the room" (terror; assault; violence).

Sue got out of hospital and eventually managed to make a life for herself. What she could not do is get back her pre-ECT existence. A middle-aged woman, she suffers to this day from acute memory impairment. "I had a great memory," Sue explains: "I never had any problem with learning and now I do. I have lots of memory lapses . . . Like I'll be talking to you today, and like tomorrow, it's very hard for me to recall . . . our conversation . . . And . . . it takes me twice as long to learn anything" (quoted from Burstow, 1994). Additionally, she is plagued by the memory of ECT (trauma, abiding fear) and explicitly labels it "torture."

Connie's Story

When she originally found herself facing ECT, Connie was not suffering from insurmountable life problems. Nor was she someone "barely getting by."[10] The reality is that she was an accomplished vibrant young woman with very exciting prospects (theme: good prospects before ECT). She was an up-and-coming actress on whom awards had been showered. She had completed radio studies at Ryerson. She had the lead in a play at Banff School of Fine Arts, where she also studied playwriting. And she was a first-rate pianist. Shortly after graduating, she married, and shortly after that, she became pregnant and gave birth. And here is where a problem set in.

Albeit it was not diagnosed as such, Connie blatantly had postpartum depression. Suffering from what was likely temporary moods swings—for we know that postpartum depression lifts—and admittedly, awkward in her new role, she was deemed not to be acting like a proper mother—first by her mother-in-law, who, it is significant, was a well-connected nurse, subsequently by the doctor to whom her mother-in-law sent her (sexism; arguably also ageism). States Connie, "He gave me one of those lectures. Why don't you care for your baby? Why don't you care for your husband? What don't you smarten up?" (sexism plus intimidation).

The doctor decided that ECT was "necessary." This Connie was not keen on, but access to her baby had already been restricted by her mother-in-law, and she feared what would happen if she did not comply (intimidation, irrespective of intentions). And so it is that ECT was initiated.

Connie first had ECT as an outpatient. After what was considered a "bad reaction," she was hospitalized. The ECT continued. She had 19 treatments in all. She characterizes the experience of getting ECT as follows (quoted from Burstow, 1994): "It was meant to be punishment. They put a muscle relaxant on us . . . And your heart's a muscle and your lung's a muscle. And all of your muscles stop. And each time, you feel like you are dying" (combined themes: punishment, sense of annihilation, terror). Connie reports feeling utterly helpless following ECT. She did not know who she was. She was dependent on other patients to lead her around (disorientation, organic brain syndrome). She came out of hospital with an amnesia which spanned 8–15 years (retrograde amnesia). Additional memory loss and cognitive impairment made it almost impossible to navigate life. Connie's depiction of the seemingly "simple" act of buying a tin of peas is especially informative:

> I would go into a grocery story and . . . stand by the peas trying to make a decision. I had no basis on how to do anything . . . It would take me half an hour because there were these . . . different cans of peas . . . and even when you learned which tin of peas it is you want, the next time you go to store, it's gone again because it affects both your short term memory and your long term memory. (Quoted from Burstow, 1994)

The problems persisted. Decades passed—and she still did not have her memory back.

Over time, Connie assuredly did get on her feet. Being on one's feet, however, is a far cry from getting her life back. The long and the short? Bright though she clearly is, Connie has to take notes to get by (memory loss). She is unable to play the piano, unable to write scripts (loss of skills); correspondingly, she went from being an up-and-coming young actress with a promising future to someone confined to menial work (diminished prospects). "I work as a payroll clerk for the Public Works Department," Connie explained to the Toronto Board of Health. "I write little figures . . . and this is . . . all I can do now [cognitive impairment; diminishment]. And it's a direct result of the treatment" (quoted from Phoenix Rising Collective, 1984, p. 21A). She was likewise left with the traumatizing effects of the violence. To highlight Connie's exact words here:

> But the biggest thing is the business about the fear and the violence. This is something that does not go away. All I did was have a baby. And look what they did to me! Now if I really did something, what would they do to me next? (Quoted from Burstow, 1994)

While it is beyond the scope of this chapter to tease out what could have averted this tragedy, if one focuses on the moment when Connie's life began to fall apart, it is not hard to imagine what might be helpful to someone in her circumstances. Bottom line: As someone in a powerless position, Connie needed an ally, not "treatment," for the problem was not with Connie—new mothers commonly have mood swings—but with the setup. Possible components of a "solution" include: protection of the mother-child relationship; a redistribution of power in the family; addressing the sexism and ageism; support for Connie and indeed for the family as a whole as she became accustomed to her new role.

A sad comment on our "civilization" that we brain-damage people instead.

The Credibility of the Testimony

A number of factors come together to make these stories credible. For one thing, the stories hold together, as it were, make sense. For another, of all the parties in the ECT controversy, here are the players with the least conflict of interest. Note, survivors' livelihood does not depend on the image of ECT which they project; nor are their reputations embellished by it. What is especially important, these are anything but isolated accounts. Such stories are legion and are typical—hence the long-standing international movement by survivors to stop or otherwise curtail the treatment. So common are certain components, moreover—not recognizing friends, reduced to taking notes incessantly—so overlapping the stories that dynamics attested to are readily recognizable. On top of all this, these stories are solidly supported by the credible empirical research (e.g., Sackeim et al., 2007; and Templer, Ruff, and Armstrong, 1973). By contrast—and it is critical to keep this difference in mind—the official position (e.g., safe and effective; two weeks of memory loss only), as already demonstrated, blatantly conflicts with the research.

Why Do Some People Feel ECT Has Helped Them?

So what about the *other* survivors—the ones who see ECT positively? If ECT is so injurious, why do some folks feel that it has helped them? Think it has saved their lives? There are a plethora of answers to this question, and not all pertain to everyone. As we step through them, I ask the reader to take note that the vast majority bring us right back to the damage for it is precisely damage and impairment on which they rest. As such, conceptualizations like "ECT works for some and not others" beg the question.

A compelling reason, as already noted, is precisely the memory impairment. Whether one is conscious of it or not, memory loss can feel like a respite, especially when one has been plagued by inner demons. Your problems, as it were, are "out of mind." Alternatively or additionally, some people initially feel better because of the euphoria that attends head trauma (see Breggin, 2008b). What I suspect is also occasionally a factor, albeit rare, a person with a brain "firing on all cylinders" may experience the damage as settling, as a relief—a possible way of comprehending the *Electroboy* story (a popular memoir by a man who feels that ECT helps him with "mania"; see Behrman, 2002). As with all treatments, other factors include: the placebo effect, the extra support that the person may now be receiving, being one of those lucky ones who have sustained less damage at least this time around.

What is perhaps most significant of all, when you contrast recipients who are positive about ECT (the minority) with recipients who are critical (the majority), as those of us who work closely with survivors quickly pick up, one very telling factor accounts for the difference—the passage of time. The more distance between the person and their last treatment—and it can take several years—the more likely they are to view it as negative (see, e.g., Van Daalen-Smith, 2011). Why? For one thing, with the passage of time, recipients begin to find ground under their feet and can think more clearly. Also, they are not so desperately trying to please the people around them. There is a related but more critical factor here, though—and we lose sight of it at the expense of misunderstanding the ECT experience: It takes time for the reality of the damage to sink in, still longer for it to be faced. The point is, in the first few years, it is commonplace, maybe even necessary for survivors to deny or minimize the damage. States Ardra:

> The doctor told me that within a few weeks—a month tops—my memory would be right as rain. I kept making that story fit, I mean, even though it didn't fit. Telling myself it was all coming back. Like at first you honestly don't know. You're simply dreadfully confused. Then you kind of know, but you'd rather not. Funny—I could have been a poster girl for ECT, all the stuff I kept repeating. The thing is I so wanted to believe, because Bonnie, facing, really facing what had become of me, it was just too horrible. (Research interview)

A reality, note, that sharply contrasts with psychiatrists' claims that patients exaggerate or imagine the damage. Moreover, an indicator that not only can seemingly positive outcomes not be taken as face value, but—and the ramifications of this are huge—they are themselves a possible and potentially probable sign of extensive damage.

Summing Up and Reflecting

We began this chapter with a disjuncture—voices of shock survivors whose horrific tales trouble the "inherited wisdom" about ECT. We proceeded to investigate. We systematically pieced together how that disjuncture is created and recreated. At the same time, we delved into the nature of ECT per se, interrogating the procedure, the scientific facts, the lived effects.

The ECT empire, we found, is riddled with conflicts of interest. The authorities most influential in framing psychiatry's position on ECT are themselves the arch capitalists who receive the primary benefit. We likewise discovered that claims are made with little regard for truth, that in essence the treatment is buoyed up by shoddy research and research flagrantly misrepresented. By contrast, good research and research interpreted according to accepted practices demonstrate that ECT damages the brain and results in permanent cognitive impairment. Moreover, even by conventional standards, after four weeks, this brain-damaging treatment is no more effective than placebo. To put this in stark terms, people are, as it were, being brain-damaged for nothing.

If the scientific research establishes damage of an enduring nature, survivor testimony gives us a felt sense of the damage. The most pervasive themes that surfaced in this regard are: memory loss; cognitive impairment; loss of skills, prospects, ability to function, connection itself, with diminishment of the person emerging as an overarching theme. More psychological themes include: trauma, torture, and punishment.

Control is of the essence. Other dynamics of note are: women and the elderly are the primary targets, as well as the people most harmed by the treatment. And the vast majority of those subjected to ECT end up minimally with grave misgivings, a frightening number ruing the day when they (or their substitute) consented to ECT.[11] Which leads us to the inevitable question: What do we do about this treatment?

To be clear, certain of the dynamics (some of the conflicts of interest, the lying, the consciously punitive dimensions) could hypothetically be corrected. I say "hypothetically" because the success of the enterprise depends on many of these features persisting in one form or another. Indeed it is difficult to see how an industry built on deception could flourish in its absence. Be that as it may, what ultimately cannot be corrected is the nature of the "treatment." Electricity shot through the brain and convulsions *by their nature* damage. Once again, correspondingly, there is a one-to-one ratio between the therapeutic effects and the damage. The point is, as with the drugs, the impairment *is* the therapeutic effect. And as with the drugs, the implication is obvious.

To put it simply, the issue before us is far more fundamental than whether or not the ECT machines should be tested or which style of ECT should be standard. Insofar as ECT is not medical in nature, insofar as what is called "working" is precisely the damage, it should not be paid for by our ministries of health; nor should it be offered by medical practitioners. In short, with whatever accommodations need to be made for those dependent on it, it should be phased out.

I am aware in saying this that there are people who would concur with the general critique while asserting the need for ECT in cases of extreme suicidality. Even while acknowledging that ECT has no special efficacy with suicide, some argue that there simply has to be something that can be resorted to with people in desperate straits. Claims that typically accompany such as a position are: If ECT does not prevent suicide in the long run, as something that works fast, it averts it in the short run; correspondingly, desperate people need to be offered something, and there are people urgently wanting to try ECT (arguments advanced by several interviewees who were professionals).

A clarification: If something cannot properly be called "medical," the desperation of the people who seek it does not make it so. The fact of a "treatment" accomplishing its effects quickly, moreover, does not make it "effective." Nor does the understandable sense that "something needs to be done" mean that anything is reasonable to try. That said, as a way of probing this issue, I would introduce one final story—the story of C.

A kind man, C was one of the survivors who testified at the 2005 Toronto hearings. He had undergone three series of ECT earlier in life. The circumstances which culminated in ECT, I am not privy to. This I do know. Come the late 1990s he had come to see ECT as profoundly damaging. What I likewise know is that C had gotten on his feet, had made something substantial of his life. He had completed a master's degree. And for approximately 13 years, he was an able counselor. Correspondingly, on a personal level, for a long while, his life was on an even keel. Then suddenly, the bottom came out from under. He started sounding and behaving in ways normally thought of as irrational. On one occasion, minimally, he was hospitalized involuntarily. He went in and out of psychological agony. This continued for approximately a year.

I will not be commenting on this part of the story. My focus is on how the story ended.

Weeks before starting to pen this chapter, I received an email from C. He stated that he would be coming to Toronto soon and would like to visit. Having always been fond of him, I readily agreed. Three weeks went by with no further word. Then I heard what I little expected. In short, C had killed himself. This tragedy took my breath away. What equally took my breath away was what I learned next: In the days leading up to the suicide, this man who was adamantly opposed to ECT had signed to have it. ECT was indeed administered—after which he left "hospital," drove to his place in the country, descended the basement stairs, and hung himself.

I urgently needed to understand what had happened here. I began by having a second conversation with a close friend of his. Also, I revisited my history with C bit by bit. Ultimately, my attempts to grapple with it, among other things, led me to check out two very particular items. The first was the Munk-Olsen et al. (2007) study already referenced. What it shows, you may recall, is that in-patients treated with ECT had a marginally higher likelihood of dying by suicide than in-patients administered other treatments. Now as already noted, a marginally higher suicide rate means little especially given that ECT is administered for depression. Nonetheless, niggling away at the back of my mind was a vague recollection that the researchers had articulated a more formidable finding. The second item that I checked was C's own words—his testimony at that hearing itself. If anyone could make sense of what happened to C, it was surely C himself. Between the two documents—the article representing the study and the transcript of the hearing—a measure of clarity about what happened to C did indeed emerge. That clarity in turn sheds light on the question at hand.

The relevant passage in the article (p. 437) focuses on effects of ECT during the week that it is administered. It reads, "Patients given ECT in the last week had a *greatly increased risk of suicide than other patients*" (my emphasis). "Greatly," by definition, is not negligible. The finding appears to tell us something about the state to which ECT reduces people. Minimally, it invalidates the standard rationale that ECT is a treatment that can be reasonably used to quickly avert suicide—for if anything, it seems to do the exact opposite. All this being the case, C's suicide, note, is not an anomaly. It is congruent with the research.

Question: What was going through this man's mind as he proceeded to his family's house? And to back up further, given his history, why had he accepted ECT? Realistically, these questions cannot be answered with any certainty. This notwithstanding, the 2005 hearing provides clues about the two choices that he was to make eight years hence.

C began his testimony by making pointed reference to "the person" awaking after the treatment "alone" and "disoriented," and while the transcript does not show it, he had tears in his eyes and his voice was quivering—all indicators that in accordance with the rules of the proceedings, he was talking about his own experience. He then made a statement about consent which reverberates in manifold ways with what was to unfold. He stated forcefully and unambiguously, "I want to say very clearly that when you are in a state of complete terror, absolute despair, and utter isolation...when you are in such great pain that suicide seems like the only reasonable way to escape...you cannot be said to give consent" (Inquiry into Psychiatry, 2005, Electroshock, tape 2).

Again, while we cannot know for certain, what I am getting at is that C appears to have landed in precisely the situation that he had commented on eight years earlier. Insofar as this is so, he forecasted at once his own demise and his consent to ECT. Additionally, he instructed us how to interpret them. A desperate "treatment" choice was "made"—and by a despairing man in such pain that he was willing to try "anything" (read ECT) *despite what* he knew about ECT or alternatively *because of what* he knew about ECT. His pain was thereby compounded, for he was left facing additional damage. To what extent accepting electroshock was itself a suicidal act and to what extent suicide was a response to the electroshock is hard to know.

We come now to the hardest part of the story—the method of C's passing. He may well have intended his final act in life to be read as a statement about ECT—as in: *Look at what ECT has made of me*. Again—unknown. This much, nonetheless, is clear: C's timing has meaning. Suicide and ECT were closely aligned in his mind, both connoting escape. Moreover, his chosen method of passing was far too iconic to be incidental.

To allow C himself the final comment, addressing what to do when a frantic and suicidal person actively requests or appears to consent to ECT, C stated:

> The only ethical thing is to avoid any extreme intervention. Support and compassion do not cause brain damage. (Inquiry into Psychiatry, 2005, Electroshock, tape 2)

That noted, we are back where we were before the specter of suicide was raised. To reiterate, ECT has no legitimate place in the medical repertoire. It has none, note, not simply because it damages—as psychiatrists correctly point out, many worthwhile treatments in some way damage—but because damage is the sine qua non of the treatment. To put this another way, damage is at once the mechanism, the aim, and the overriding outcome. What relates to this, far from being healing, it tears into shreds the fabric of people's existence—the connection with themselves, their connection to the world, their being-with others. On top of this, as we have found, what seems like the most cogent argument for retaining it—that it is a means of quickly averting suicide—is seriously—one might say *fatally*—mistaken.

Stepping Back and Picking Up the Larger Problematic

ECT being the last of the critique chapters, it is time to step back and pick up the overarching argument which is the subject of this book. Beginning with the tragedy of Kevin's death and ending with the horror of electroshock, we have investigated this institution facet by facet. We have delved into psychiatry's history, seen the opportunism, the degradation of human life. Methodically, step by step, we have placed under a microscope theory, practice, and lived consequences. And the verdict is clear. While in the final analysis readers must reach their own conclusions, what the logic of this investigation indicates—and indicates powerfully—is that not just parts of psychiatry, but the discipline and the regime as a whole is epistemologically flawed and ethically unacceptable. Nor is it "fixable," for the problems are fundamental, at the core. My invitation, accordingly, is that we as a society do what may have once seemed unthinkable—that we acknowledge that our approaches to problems in living and to "problematic others" are tragically misguided and muster up the courage to begin again.

Of course, psychiatry is the "devil we know"—and the reader may be asking, if we free ourselves from the grip of this institution, what do we put in its place? More concretely, what do I do when my daughter is so depressed that she cannot function? Or when she is screaming uncontrollably? Or when one encounters the proverbial "mad woman" pounding on the door in the middle of the night?

All legitimate questions. For the beginnings of answers, the reader is referred to the next and final chapter.

CHAPTER 9

Dusting Ourselves Off and Starting Anew

> I keep going back to this concept of what it might look like if we lost everything we have now, if we lost all of our electricity, if we lost all of our internet, if we lost our ability to communicate with everyone—we would be thinking about how to build our lives by looking at the people who live in the houses next to us, getting together, working together, making sure that everyone has enough to survive, and those people who have certain skills working in those certain skills for the benefit of small communities. You know if we went back to that communal way of living, there would be far less distress to start off with.
>
> —From interview with Brenda LeFrançois

Chapters One–Eight constitute a comprehensive critique of psychiatry—indeed, of the entire "mental health" system—and beyond that, a call to action. One conclusion that has already been reached is that the institution of psychiatry must go. Minimally, that is, it must not in any way be supported by the state, whether economically, legally, or discursively. What relates to this, in the long run, the larger regime of ruling known as the mental health system must be replaced, superseded, rendered obsolete.

Herein, once again, I am departing from and asking the reader to think beyond the positions typically advanced by other critics. To be clear, though I well understand how people end up where they do, for the most part, however radical the language or benign the general direction, what other writers have called for is a kind of tinkering. Indeed, the question of "what to do" is largely approached in a minimalist manner. Critics, including very astute critics, call for more empathic therapy services or point to the tradition of moral therapy and suggest that "services" be more in this tradition (see, e.g., Whitaker, 2010). All humane tinkering as far as it goes, but tinkering nonetheless. Bottom line, it is not good enough to simply replace one "service" for another, however comparatively decent that service may be. As surfaced in chapter after chapter, the problem runs deeper. As we saw only too clearly, it is inherent in the underlying principles on which the entire edifice is built—*parens patriae* and police power. It is inherent in coercion and in the very operationalizing of power-over. It is inherent in the sheer existence of these regimes of ruling. It is part and parcel of standardization. It can be seen in the routine ways in which functionaries create, recreate, activate texts, including "independent practitioners." Even when conducted in a sensitive way, it is inherent in the financialization and commodification of help.

One obvious direction that has surfaced is freeing ourselves from our frightening over-belief in and fetishization of science—the privileging of positivism, evidence-based research, and instrumental reason. What goes along with this and is likewise pivotal, we need to free ourselves from rule by "experts." Throughout history, note, lay people and volunteers have provided assistance to those in emotional distress, and while this too is often institutionally compromised and otherwise problematic, as a rule it has been more humane and more successful than the service of experts. Witness the Quaker retreats and the women who made room in their homes (see Chapter Two). In modern times, compromised though this inevitably is, we have even seen nonprofessionals operating comparatively well within the "belly of the beast." The volunteer program in which the young Peter Breggin participated is a case in point. Working with 14 individuals who had essentially been dismissed as hopeless, without drugs, formal training, or supervision, Breggin and his fellow students managed to help 11 of the 14 get and stay out of "hospital" (see Breggin, 2000b, p. 265 ff.). Similarly, in the 1970s, I was part of a group of lay workers in an organization called "AIS," which worked largely with "in-patients" in a Toronto psychiatric "hospital." Based on our common identity as human-beings-in-the-world, we listened to and befriended people, indeed, "hung out with" people. So well did folk fare when approached in this more humane and less hierarchical fashion that a year after "discharge" only 10 percent of those who had "worked" with the nonprofessionals ended up "readmitted" as distinguished from 90 percent in the case of all others.[1]

That noted, cutting back on experts hardly suffices. Nor is insertion of peer workers into the current system. Such measures cannot simply be add-ons to an inherently injurious system. Moreover, even if we rid ourselves of psychiatry and even if we dispensed with mental health services as we now know them—indeed, even if we drastically reduced our reliance on all associated workers—we would not have gone far enough.

The point is, you cannot simply separate out a part of a gestalt, part of a discourse—and our entire society is penetrated/constructed by regimes of ruling. Correspondingly, matching the commodification of "emotional" services is the commodification of society, of life itself. Besides that the larger context will willy-nilly impact whatever we create, the type of world that we inhabit plays a pivotal role in the disconnect and angst we all feel. In a world of ever increasing commodification and standardization, in a world geared to the global maximization of profits, in a world where are we divorced from others and from nature itself, in a world in which "the commons" (what we all share together) is progressively eroded, in a world wherein pollution is destroying the very web of life, it is expectable that more and more people will feel alienated, will appear to lose their selves, their inner core.

In this regard, as environmentalists such as Bookchin (1982), Berry (1999), and Macy (Macy and Johnstone, 2012), feminists such as Piercy (1976) and Federici

(2012), and philosophers such as Hardt and Negri (2004) have long been alerting us, the social world, indeed, the very planet is in crisis. Like the disappearance of basic life forms, the advent of ever more people floundering is itself, as it were, one "symptom" of that crisis. In this respect, the "mad" are like the canaries in the mine,[2] a sign of danger, a warning that we as a species have gone astray—and herein, inadvertently, lies one of their greatest gifts. The more sensitive among us-the mad, the poets, the dreamers—are the first to fully sense the "wrongness," in many-a-case, to understand it—hence Irit's response to the spread of war by stripping herself of the trappings of "civilization," pounding on neighbors' doors in the wee of the night, and announcing an emergency (see Chapter Five), for such was the precipitating factor. Of this, I shall write more shortly. At this point, suffice to say that we cannot make any appreciable mileage on the issue before us unless we dramatically alter how we are with each other, with other species, as the Aboriginal community puts it, with "all our relations." Such is the understanding on which this chapter is built.

The intent in this chapter is to move beyond what is wrong and start piecing together a direction. To be clear, the suggestions offered are in no way meant as definitive but as the opening words of a critical conversation in which we as a community are called upon to engage. That the issue be approached jointly and dialogically, I would add, is essential for in the final analysis, the crisis is all of ours.

This chapter is necessarily both highly visionary and highly practical, for without vision, we inevitably reproduce tyranny and in the absence of practicality, we are woefully unprepared for the real exigencies of life. Questions explored include: What kind of a society should we be building? How should we be governing ourselves? Relating to the environment? Responding to "individual" crises? How are we to understand emotional troubles? How do those in trouble—whether ourselves or others—fit into such a society? What might decent care look like? And how might it come about? The long term and the societal is most focal. At the same time, the chapter is written with an eye to the very different positionalities as well as the pressing concerns that different readers bring. Accordingly, we will likewise be touching on highly specific questions like: What concretely might we do in the here-and-now? As a helper who wishes to do better, what should I be asking myself? With my family tied in knots, where might we turn now?

As a vision of a better society is not secondary but primary, not an add-on but a loadstar which can guide us, I necessarily begin here. If the seeming "ideality" of what emerges starts to worry you, be assured—bit by bit, the more challenging aspects of human existence enter in.

Daring to Dream

Commonly in modernity, the words "utopian" and "utopia" are used dismissively as if this were idle thinking, as if entertaining a radically different kind of world were synonymous with make-believe—a strange perspective given that throughout history societies and cultures have organized themselves in profoundly different ways. The devaluation of dreaming, the fitting of ourselves into standardized modes of thinking and acting is of course part of what has landed us in the current predicament. If step one in disentrenching ourselves is getting back in touch with our humanity and our creaturely rootedness in the universe, step two is taking back our right to imagine and again daring to dream. That noted, anarchist theorists have drawn a very useful distinction between "utopian" and "eutopian" thinking. A Greek word, "u-topia" literally means "no place"; as such, a utopia could be pure fantasy, not anchored in what is given, a kind of "nowhere," something ungrounded in facticity and consequently, unachievable. An example is a Peter-Pan world in which people sprinkled with fairy dust can fly. "Eu-topia" (spelt with an "e"), by contrast, signifies "a good place" (see Simon, 1986). It is not "nowhere" but somewhere, not fantasy but a subset of the "possible and desirable."

While it is hardly the totality, eutopian thinking is necessarily central to this investigation—thinking rooted in what we actually know about human beings. Such thinking draws on the past while having a special care for and pulling us into the future. In the process, it allows us to enter into the present in a new way. In this regard, approaching the visionary as something far off that offers no possibilities in the here-and-now is to misunderstand it and to squander the moment. The point is, for time immemorial, visionaries have leveraged openings in the here-and-now to realize key aspects of their vision, whether these be in experimental communities like communes or the launching of an alternative school. In this spirit, I ask the reader to peruse what unfolds with an eye toward seeing the possibilities latent in the present and as feasible, adapting, and implementing.

Some basic guidelines and principles:

- Our means are as important as our ends, indeed, *are* our ends;
- community and the commons are our base;
- everything is interconnected;
- hierarchy is inherently problematic, whether it be human beings over the environment, one species over another, one gender or race over another, adults over children, *any* human being over *any other* human being;
- direct self-government *is* democracy; in representative government, by contrast, our lives are placed in the hands of elected officials and bureaucrats;
- nobody is expendable; everyone has their own gifts; and everyone deserves respect;
- everyone has rights, including the right to choose ways of life that worry us;
- everyone is accountable to each other, including those now deemed "mad";
- it is at least as easy to make the case that mutual cooperation and symbiosis accounts for evolution as that "natural selection" does, and insofar as we have all but destroyed ourselves emphasizing the latter, it is time to privilege the former;
- the well-being of the environment is paramount;
- difference and plurality is to be respected, accommodated, and celebrated; herein lie the abundance that is the stuff of life;
- what works for one community or one individual may not work for another; and what works at one time may not work at another;
- whatever else they may be, codification, reification, disciplines, professionalization, financialization, and institutionalization constitute traps.

A Better World

In the world that I am suggesting we need to strive for, no one would be living luxuriously, but everyone would have enough to eat, would have adequate shelter, would be attentive to the environment; and everyone would be an integral part of the decision-making process. The privatization of the commons would have been reversed so that more and more the bounties of nature and of our social creation would be the inheritance of all. Protection of the commons—in particular, the water, the land, the air—would replace pollution. Sustainable living would replace unabashed affluence on one hand and poverty on the other. Agriculture would take the form of subsistence farming—a practice which is inherently ecological and far from being impractical is currently practiced by women throughout the world—an activity, significantly, which accounts for over half the world's food and more or less none of its pollution or soil erosion (see Shiva, 2010). No one would be able to "own" types of seeds, indeed, any part of nature. In line with traditional Aboriginal worldviews, attention would be paid to the impact of decisions on "all our relations" up to "seven generations" hence. Equality would replace hierarchy. Mutual cooperation would largely replace competition, albeit competition would likely be deployed as a safety valve for aggressive tendencies. Correspondingly, though interpersonal problems will surely continue to exist, as will transgressions, jails as we know them and psychiatric institutions would be but a distant memory. To be clear, it is not that we would be freeing ourselves from the human condition and all the messiness that goes with it—not remotely possible or even, for that matter, desirable—but that we would be finding ways to maximize what is best in humanity, leveraging our capacity for openness and acceptance in the process.

People would largely operate within small communities—an arrangement which would help facilitate cooperation, participatory governance, and environmentalism. Fishing together in the same stream (the commons), attending or cocreating the same symphony performance (the commons), drawing and improvising on the informal rules that guide their living together (the commons), people would work together, aspire together, make communal decisions, with, at the same time, emphasis placed on individual freedom. In this last respect, as Hardt and Negri (2004) have so eloquently articulated, we need to get beyond treating collectivity and individuality as irreconcilable opposites and to find ways of holding the two together.

Both personal boundaries and work would have a very different meaning in such a society. People would be more loathe to infringe on the being of others. Rape as such would be a rarity. By the same token, with both structures and principles militating against it, people would be less likely to directly or indirectly exploit the labor of others for everyone would be seen as interconnected. Not that there would be no transgressions. And not that greed, jealousy, and malice would magically disappear.

Produce would largely be local, albeit different communities would make mutually beneficial arrangements with one another. In this respect, communities would exist within concentric circles. And to varying degrees, everyone would operate with an eye to the welfare of each constituency, whether it be an adjacent community on the same level, a subsidiary community such as the immediate family, or the large community to which we all belong as creatures of the earth, with the successor(s) of Skype or technological breakthroughs still to be imagined potentially facilitating distant communication.

With everyone jointly owning and managing the means of production, employment as we know it would be a thing of the past. There would no longer be employers and employees but people organizing themselves in an ongoing way to get the work done and to eke out a good life. Some folk might rotate between a variety of different types of jobs. Those seen as having a special gift might focus on one line of work—whether it be welding, composing music, tending to children. With the current and ongoing well-being of the community paramount, conservation and preservation would be prioritized. Gift-giving—not exchange—would be the model. Correspondingly, reproduction (e.g., agriculture, the preparation of food, tending to children)—work traditionally relegated to women—would become everyone's job and would take priority over production. To varying degrees, such work would additionally be arranged in ways that overcome alienation and fold back into the commons. Examples of such arrangements currently—for inroads are being made—are urban gardens and communal kitchens (of special note are the Brazilian compounds wherein women cook and share housework together; see Federici, 2012, p. 147 ff.).

In the spirit of cooperation, there would be an emphasis on team work. At least as fundamental would be a prioritizing of the largely unplanned and unplannable brilliance which happens when one person on their own initiative takes up the work of another and improves or builds on it. An example with which we are all familiar is the spontaneous co-creating that happens with abandon on the Internet. Witness, in this regard, Wikipedia—which consists of entries that are freely picked up by and scrupulously worked on by one person after another. Significantly, the quality of this spontaneous "commoning" is such that Wikipedia entries are now commonly referenced in dissertations.[3] Practices such as this stand in sharp contrast to the old model wherein knowledge production is almost the exclusive prerogative of experts and where the multitude and the individual are treated as polar opposites.

Compassion, empathy, and acceptance would be among the cardinal virtues. Difference would not be construed as a sign of danger but as part of the diversity to be embraced. Nor would actual danger be met as it is now. The point is, there would be no police as such, and irrespective of what has or has not transpired, a premium would be placed on mutually addressing and mutually caring.

Leadership would be shared. Everyone, correspondingly, from the child to the senior would be seen as both a learner and an educator. What goes along with this, everyone would be schooled in the interpersonal skills facilitative of participatory democracy (e.g., conflict resolution, group facilitation, peacebuilding, active listening—including how to understand those who experience life differently).

Living alongside toddlers, youth, and the middle-aged—seniors would be an integral part of the community. With the concept of retirement nonexistent, they would continue to contribute at whatever pace and way felt right. They would be cared for when sick and feeble. They would be recognized holders of knowledge, commonly turned to for advice, this not only by their kin but by everyone. Indeed, the elderly, as it were, would constitute a commons in their own right—a fount of wisdom, a reservoir of lived experience that the community protected and shared.

Augmenting the immediate family, the community at large would play a central role in child rearing. Irrespective of gender, everyone would "mother," "father," and "grandparent." And children would be respected as separate individuals with their own knowledge and agency. What relates to this, a modified version of the Aboriginal principle of noninterference would be the norm. That is, unless they had good reason to interfere (as in: the child is intruding on the rights of others or is jeopardizing their own safety), adults would honor the child's freedom and right to find their way (for a discussion of this Aboriginal value, including its limitations, see Ross, 1992/2006). The upshot? It would be rare to see parental figures reprimanding children, doling out punishment, lecturing them. Rather parenting would take the form of modeling how to live a good life, while offering love, nurture, and acceptance. Correspondingly, the primary message given to children would be the importance of treating every being—themselves included—with loving kindness, empathy, and respect.

Gender, sexuality, identity itself would be more fluid. Life would be an adventure. Fun, together with the release of pent-up pressure would be understood as a basic human need, and so spontaneous celebrations would be encouraged. By the same token, just as society—early societies in particular—have always had festivals wherein, in a spirit of shared irreverence, the community turned the current order on its head—(e.g., the wild and wonderful Twelfth Night celebrations which for centuries swept Europe)—these societies would have their own cherished moments of role reversal, where in a playful manner, individually and collectively, people broke with official decorum.

In a society where everyone teaches as opposed to a small coterie of community members called "teachers," schools would likely continue to exist; however, schools as institutionalized processes would not. In line with the theorizing of existentialists like Dewey (1970), critical theorists like Illich (1971) and Freire (1970/2005), and anarchists like Goodman (1962/1977), education would be liberated and liberating, experiential, more open, oriented to the skills most useful in navigating life. Apprenticeships would be common. Rather than being governed by a standard curriculum (and as such, subject to a regime of ruling), students would be encouraged to follow where their curiosity led them. The counterhegemonic and the experiential would be emphasized. Correspondingly, instead of slaving over such subjects as trigonometry, which few will ever again encounter, children would be introduced to such vital skills as active listening, the giving and receiving of empathy, facilitating, conflict resolution, surviving in the wilderness, thinking outside the box, dealing with crisis, peace-making. Classes (were such a concept to remain) would commonly take place outdoors. They might take the form of trips to the museum or the art gallery, assisting in a healing, helping repair a neighbor's roof. Correspondingly, far from being defined as a problem, daydreaming would be recognized as an integral part of the creative process. Given such a framing, I would point out, concepts such as ADHD would literally have no meaning. However benign our intentions, note, it is only when we interfere with childrens' natural creativity and freedom, only, that is, when our expectations are fundamentally at odds with childhood and selfhood that concepts of this ilk emerge.

Herein then are the beginnings of a direction and a reference point.

Honing in on People Who are "Distressed" and/or "Distressing"

What we can see straight away is that the ever growing number of alienated or traumatized souls that are a product of current society would not be a product of this one. Why? Because the rupture from nature would begin to heal—and that rupture is itself traumatic and is one of the fundamental causes of alienation (see Burstow, 2003a). People would be joined in community, indeed, joined to all our relations. As such, the felt sense of belonging would be heightened. No one would be substantially benefiting from exploitation. And while some traces of oppression would likely continue to exist, whether it be sexism or racism, and while regardless, we would still have to deal with power-over, it would not be of the dimensions that we see today. Additionally, no one would be squeezed into those dehumanizing categories and practices imposed on us by regimes of ruling. Correspondingly, with everyone allowed and encouraged to be themselves right from the earliest years, the interpersonal disconnect which is likewise central to trauma, alienation, and what we call "madness" (see Burstow, 2003a) would be substantially diminished.

On a different level, with no industry benefiting from labeling people and with a society highly accepting of difference, people would less often be seen as problematic. Children who daydream, as already noted, would be accepted as possible visionaries or minimally as doing what they need to. By the same token, it would be understood that some people see visions, some are wordsmiths who invent new words (currently a "symptom" of "schizophrenia"). Correspondingly, the hearing of voices would be accepted as natural, a way in which some people at certain times converse with themselves—again, part of the diversity of life. By the same token, it would be understood that people have different ways of coping, and so with few exceptions, as long as others are not intruded on, actions associated with these would be respected—in the case of adults, self-injury included. The point is, if we live in a more humane, relational, pluralistic, and accepting way, people will neither experience as much personal tribulation nor be as readily seen as "having" or "being" a problem. By the same token, insofar society as a whole is not "othering" them, people in emotional distress would be inclined to adopt a more accepting view of themselves and, as a result, fare better.

These would be natural consequences. These consequences could in turn be magnified by building in relevant knowledge and processes. For example, in line with the emphasis on diversity and acceptance, part of everyone's schooling could be co-investigating the dangers of projecting our fears onto others and concomitantly, the harm done by labeling. What could in turn open our minds to different conceptualizations and approaches would be studying how different cultures have thought of and responded to people in distress. Coupled with that would be studying the gifts bestowed on us by people considered mad, the various meanings of madness, and how society undermines itself when it invalidates the knowledge of the differently oriented. In this respect, stories, legends, and literature are a key resource, already at our disposal. Take, as an example, the myth of Cassandra.

To wit: According to Greek mythology, the god Apollo bestowed a gift and a curse on Cassandra, princess of Troy. The gift was the gift of prophecy; Cassandra could read the future with complete accuracy. The curse was, despite the accuracy of her visions, they would be uniformly disbelieved. Her combined gift and curse played out thusly: Cassandra's defining prophecy—what made her and her story what they are—was the fall of Troy. For ten long years, the Greeks had been battering away at the city walls and could not get through. The Trojans had become confident that the walls were unassailable, and as such, there was no need to worry. In Cassandra's vision, nonetheless, the Greeks conquered Troy. As a responsible member of the community, she alerted those around her, perhaps thinking that with preparation, what she foresaw could be avoided. In line with the curse, of course (which itself correlates with the overconfidence that had pervaded Trojan society), not a soul believed her. As time passed and the moment of the catastrophe neared, she became increasingly distraught. Her hair flying in all directions, the highly concerned woman began running through the streets urgently warning her fellow citizens about the impending disaster, only to be dismissed as unhinged by everyone. Ultimately, she was imprisoned in a citadel (precursor of hospitalization) so that no one would have to hear her lunatic rants. Her "wild" prophecies continued. Indeed she even recognized the trick inherent in the "Trojan horse" ploy (the Greeks placed a gigantic wooden horse at Troy's gates, allegedly as a gift; and the unsuspecting Trojans brought it into the city, unaware that Greek warriors were hidden within). In line with Cassandra's prophecy, when night fell, an army of fully weaponized Greeks emerged from within the wooden horse; the Greek soldiers did battle with the unprepared Trojans; and as prophesied, Troy fell (for details on this myth, see Graves, 1960).

What makes the Cassandra myth a particularly useful educational tool is that it opens up in manifold directions—each one making palpable a compelling truth about "madness." To touch on a few, on one hand, what is being interpreted as Cassandra's madness is a knowing that goes beyond and is in conflict with societal beliefs—a dimension which problematizes the very concept of madness. On the other, it is clear that there is a confusion between madness and error. By this understanding, irrespective of whether or not Cassandra is mad, she is *not wrong*. Still another possible meaning is that given her predicament, the truth-seeing Cassandra was driven mad precisely by being disbelieved, or to put this another way, by the crazy-making setup in which she found herself.

Such stories shed a critical light on the societal-individual divide. Additionally, what stories of this nature connote and what people could be encouraged to co-explore is the profound and often tricky relationship between madness and social awareness. To quote Irit Shimrat in this regard (after reading about a war spreading, Irit, you will recall, a Cassandra-like seer in her own right, stripped off her clothes and pounded on people's doors in the middle of the night, yelling, "Emergency"):

> My thoughts had roots in some kind of social consciousness. I think that's a very important thing to keep in mind, and look at, and educate people about—and not just in college—that education should start much earlier. And I certainly don't claim that everyone who is crazy is having a fabulous spiritual experience or can necessarily be useful to others, spiritually, at that time. But very many people who go crazy, or

> who become depressed, go through things that others would benefit from if only they could listen to what those experiences were really about.

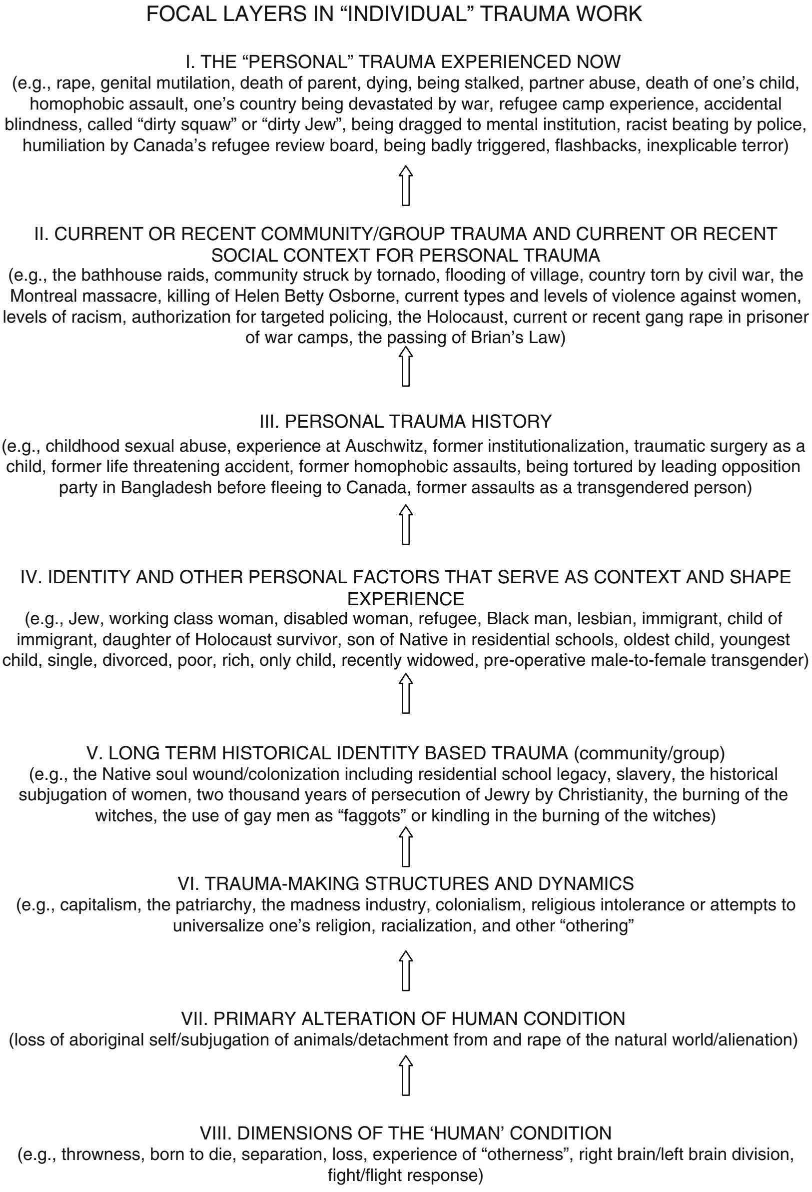
This perspective—and we will entertain others shortly—turns the traditional orientation to madness on its head, reframing it as a possible aid to community healing, a possible antidote, as it were, to society's ills, as opposed to always and only a problem. What goes along with this, education of this ilk could help people in any culture—now or in the future—face the unacknowledged problems lurking in the community.

An equally important educational direction would be turning to the mad themselves for guidance on how to understand madness—and what better authority? Ideal would be gatherings wherein thoughtful and highly articulate people like Irit were invited to present and answer questions. This might be supplemented by readings in the growing field of mad studies (see, e.g., LeFrançois, Menzies, and Rheume, 2013) or visionary novels like Piercy's (1976) *Woman on the Edge of Time*.

What would likewise further the agenda before us and could easily be taken up in such a society are educational initiatives for the express purpose of helping people comprehend "mad" or seemingly "meaningless" utterances. As someone who specializes in this area, people frequently approach me with some version of this question: "But what am I to do when she starts speaking gibberish—and Bonnie, be honest, it's not that I am trying to be mean, but at times, it *is* gibberish." For sure, communicational impasses can be exasperating, especially when life circumstances have left almost no one with breathing room—and we are all of us aware how overtaxed family members can become. This notwithstanding, the point is, if "insane" utterances lack meaning in the eyes of "sane," this is not because they have no meaning—but because in a meaningful way, a very different language is being spoken, and at the moment at any rate, there is no one around who can translate. This tends to be the case even in instances of real brain damage—never mind concepts like mental illness. After suffering a stroke, my brother, for example, kept asking people to bring him a sun that was not the sun, and nurses kept ignoring him as if he were speaking nonsense. In point of fact, albeit he had lost the word for it, he knew exactly what he needed—a lamp.

How would such knowledge be factored into education in our eutopia? From their earliest years, community members would be taught to read "mad utterances" just as the young are now taught additional languages such as French, or html, or how to read poetry. With decent tutoring and a desire to learn, I am suggesting, the average person could become "mad literate." What is involved here is learning to open one's mind to different ways of processing—for a good part of what underlie what may seem like nonsense are different ways of processing and/or expressing thoughts and feelings (see Diamond, 2013). The challenge is learning how to decipher the imagistic, the inductive, and the metaphoric—the literalized metaphor in particular (for assistance here, see Laing, 1959/1965). The added bonus of such education is that it would help community members who embrace the challenge become more sensitive in general, more imaginative, better able to think outside the box. Obviously, it would also help them be more compassionate and empathic. Additionally—and this flies in the face of institutional logic—it would inadvertently enhance their own personal safety. The point is, what creates safety is the opposite of what our institutions assume, our legislators dictate, our newspapers popularize. Neither locking up nor drugging more and more people make us safe—if it did the average person today would enjoy an unprecedented level of safety. You, I, and everyone are safer rather the more people that we fold into our circle of empathy and compassion.

On top of this, learners would be tutored on the link between the individual and the social. In such a society, it would be understood that individual problems are



FOCAL LAYERS IN "INDIVIDUAL" TRAUMA WORK

I. THE "PERSONAL" TRAUMA EXPERIENCED NOW
(e.g., rape, genital mutilation, death of parent, dying, being stalked, partner abuse, death of one's child, homophobic assault, one's country being devastated by war, refugee camp experience, accidental blindness, called "dirty squaw" or "dirty Jew", being dragged to mental institution, racist beating by police, humiliation by Canada's refugee review board, being badly triggered, flashbacks, inexplicable terror)

⇧

II. CURRENT OR RECENT COMMUNITY/GROUP TRAUMA AND CURRENT OR RECENT SOCIAL CONTEXT FOR PERSONAL TRAUMA
(e.g., the bathhouse raids, community struck by tornado, flooding of village, country torn by civil war, the Montreal massacre, killing of Helen Betty Osborne, current types and levels of violence against women, levels of racism, authorization for targeted policing, the Holocaust, current or recent gang rape in prisoner of war camps, the passing of Brian's Law)

⇧

III. PERSONAL TRAUMA HISTORY
(e.g., childhood sexual abuse, experience at Auschwitz, former institutionalization, traumatic surgery as a child, former life threatening accident, former homophobic assaults, being tortured by leading opposition party in Bangladesh before fleeing to Canada, former assaults as a transgendered person)

⇧

IV. IDENTITY AND OTHER PERSONAL FACTORS THAT SERVE AS CONTEXT AND SHAPE EXPERIENCE
(e.g., Jew, working class woman, disabled woman, refugee, Black man, lesbian, immigrant, child of immigrant, daughter of Holocaust survivor, son of Native in residential schools, oldest child, youngest child, single, divorced, poor, rich, only child, recently widowed, pre-operative male-to-female transgender)

⇧

V. LONG TERM HISTORICAL IDENTITY BASED TRAUMA (community/group)
(e.g., the Native soul wound/colonization including residential school legacy, slavery, the historical subjugation of women, two thousand years of persecution of Jewry by Christianity, the burning of the witches, the use of gay men as "faggots" or kindling in the burning of the witches)

⇧

VI. TRAUMA-MAKING STRUCTURES AND DYNAMICS
(e.g., capitalism, the patriarchy, the madness industry, colonialism, religious intolerance or attempts to universalize one's religion, racialization, and other "othering"

⇧

VII. PRIMARY ALTERATION OF HUMAN CONDITION
(loss of aboriginal self/subjugation of animals/detachment from and rape of the natural world/alienation)

⇧

VIII. DIMENSIONS OF THE 'HUMAN' CONDITION
(e.g., throwness, born to die, separation, loss, experience of "otherness", right brain/left brain division, fight/flight response)

Figure 9.1 Layers of trauma.

never just individual; besides that we are all of us connected and so willy-nilly will be affected, social problems commonly underlie private woes and invariably exacerbate them, whether this be systemic sexism, other types of power-over, or simply inadequate planning.[4] This being the case, students would be encouraged and helped to read such problems as a possible warning that something may be amiss in, say, the immediate family, the apartment complex, the community at large.

By the same token, with the aid of exercises and concrete examples, learners would be helped to trace the existential and social creation of what presents itself as individual problems. The layers of trauma model (figure 9.1) is one example of the type of models that might be employed.

Accompanying all such education would be experiential education on the psychological entanglements in which we can all find ourselves and the plurality of ways of dealing with them. Minimally, such education would give people more options, make them better able to cope. And with this, the stage would be set for accepting distress as part of the vicissitudes of life, correspondingly, for affirming a common humanity wherein it is understood that we all have bad moments—that at times we all lose our balance, may be in need of a listening ear and a helping hand. Herein we begin to enter into the domain of "assistance" but in an entirely different vein.

Care or Help

Some service-related principles that might be implicit or explicit, depending on the community's needs:

- services should be voluntary not just technically but actually;
- help arising naturally out of a need tends to be better than help abstractly planned;
- bottom line: insofar as feasible, what is given should be what the person in question wants—whether we fully comprehend the preferences or not;
- people should not be "fitted into" prepackaged services; rather services should be continually invented and reinvented to match the individual;
- services are grounded in the community and are accountable to the community;
- people tend to do better when supported by and/or supporting others who have undergone or are facing similar life circumstances—peer support, accordingly, should be core, never just an add-on;
- everyone is both a giver and receiver of emotional support;
- so long as everyone is included in their own circle of care—and self-care needs to be prioritized—everyone is richer, no one the poorer for giving of themselves.

If we are to develop such a society, if we are to provide truly meaningful services, one of the first things that we need to do is overcome our biases toward pat answers. The education outlined earlier will help. Nonetheless, the transition will not be easy. Our default mode in modernity is to conceptualize in terms of a small handful of answers which hypothetically covers all situations, essentially works for everyone. In this tick box universe, we want there to be a "correct way" to proceed, the recommended "treatment" as it were, one that can simply be implemented; and we believe *because we want to believe* that if we so proceed, despite admittedly difficult tradeoffs, almost everybody is better off. This mindset needs to be altered—fundamentally. And it is not just that we need to free ourselves from rule by experts—albeit as has been shown, this is demonstrably the case. Even if every expert on the face of the earth miraculously disappeared tomorrow, as long as we continued to standardize and absolutize, as long as we fetishized cause and effect, as long as we allowed models to take the place of genuine human relating, the very most that we could accomplish is to replace one tyranny with a gentler one. The point is that life is full of contradictions, life *is* messy, people and situations are more complex than the approaches that we invent; and this needs to be accepted. More generally, operating in a rule-bound way separates us from the individuality of people and renders us insensitive to context, specificity, nuances. When it comes to those we now regard as "mad," fixed procedures are especially problematic, for the processes that we come up with and reify into laws and official guidelines are almost invariably based on the exception—for example, the "mad attacker" who will murder us in our beds.

In our ideal community—and many of these facets could be incorporated into our communities now—it would be understood that people lose their grips for any number of reasons, that people differ in what they need or want; correspondingly, a variety of radically different forms of help would be available—with no hierarchy existing between them. In this, the routing of differently situated helpers (e.g., astrologers, wise women, herbalists) that set in toward the end of the seventeenth century would be reversed. With the understanding that food and food allergies often play a role in distress, there would be people to turn to for nutritional help. Holistic approaches would be available—yoga, mindfulness, massage. Pluralism and difference assumed, there would be sweat lodges, wilderness trips, dream quests, shamans, humorists, storytelling, art. With an atmosphere conducive to it, peer groups based on common experience would spontaneously form—leaderless groups, for example, to help people deal with loss. People needing to come to terms with repressed memories or anything else that they had been stuffing down for years (and I am in no way suggesting that this is the best course for everyone) would have safe places where they can retreat and explore, including if they so opted, allowing themselves in a limited way to "go mad." Invariably, there would be a range of centers (whether this be a spare room or a dedicated building) where people can go for emotional healing or for immediate help in a crisis, with close attention paid to what the person wanted, whether it be being listened to attentively, engaged in meditation, or folded into someone's arms. Again, with a "commoning" of services, this would be provided by the community at large, not professionals, with everyone taking their turn as "befrienders"—with those particularly gifted in this line of work perhaps making it their major contribution. Insofar as professional "helpers" existed, I would add, they would be fewer in number, would be accountable to the community, and would have no decision-making power beyond that enjoyed by everyone else.

Given that it is the community not professionals who are in charge, the community would figure out on an ongoing basis what its various needs were. If a number of people were known to be in crisis at any particular time, there might be a doubling up of "befrienders." Minimally, an effort would be made to ensure that there were always befrienders on call who could come to a distressed person's house, sit with them, listen to them, where needed, intervene on their behalf. By the same token, there would be people on call who could provide conflict mediation and other assistance to all parties involved in or affected by a difficult situation, whether it be families or entire communities.

Whatever is offered, proceeding from a place of care and compassion would be a given—and the importance of that cannot be overstated. The legend of the Fisher King is apropos here: According to medieval legend, the Fisher King ruled over a once bountiful territory that had fallen into decay, indeed, become a wasteland. Nothing grew; the vegetation was wilting; and the streams were drying up. At the same time, the Fisher King himself was ailing—from a terrible wound. He was considered too sick to live and too well to die (I suspect that many of us can relate). According to a well-known prophecy, one day a stranger would appear and ask the Fisher King the one question that would heal him—and by extension, possibly, the land. Years went by, without the prophecy fulfilled. One day, the much celebrated knight Parsifal from King Arthur's court happened upon the Fisher King. The king invited him to sup at his court, and Parsifal accepted. Sitting among the courtiers, Parsifal could plainly see how sick the poor king was, could smell the terrible odor emanating from his wound but knew not what to do. Nor did he see it as his place to make any type of inquiry. Now Parsifal had been the first stranger to arrive in a long while, and so everyone kept thinking that he might be the liberator told of. As such, whenever Parsifal glanced in the king's direction, a hush descended over the courtiers. Could the moment of healing have come? Alas, to the disappointment of all, Parsifal retired to his chambers without asking a thing.

When Parsifal arose from his slumbers the following morning, the Fisher King, the court, and the courtiers had vanished. Seeing no reason to tarry, the knight forthwith made his way back to King Arthur's court. As he had been away on a much heralded heroic adventure, throughout Camelot everyone immediately began celebrating his homecoming—everyone except one—a wise witch. She chided Parsifal for not thinking to ask the Fisher King what was wrong. Whereupon, realizing that he had behaved badly, Parsifal fell into a depression. Years passed, and in vain the brave knight searched for the Fisher King. One day, he found him, now more ill than ever, his suffering palpable. The king was groaning piteously, and the stench from the wound was so strong that it was painful to be in his presence. Parsifal immediately approached the Fisher King and with caring in his heart asked the king what ailed him. So moved was the king that Parsifal cared so that color returned to his cheeks; the wound was healed; and the wasteland sprang back to life.[5]

Stepping into the General

If I may step away from our eutopia per se and generalize for a moment, many a lesson can be gleaned from this story—for example, not to let slip an opportunity to come to the aid of another in distress; and that the suffering of one is the suffering of all (witness, in this last regard, the curious relationship between the king and the land). The message that arguably comes forward loudest and clearest, however, is that first and foremost, people who are hurting desperately need compassion—a quality that can neither be faked nor bypassed. Herein, I would suggest, lies the foundation for anything decent we could ever hope to create. People who are suffering (everyone) need to know that someone really does care, someone really does want to hear their plight. And the presumptive helper (potentially anyone) needs to know that when another is in distress, it is always her/his place to lend a helping hand. With care-for-the-other as the base, the skills outlined earlier can then enter in (e.g., active listening, mad literacy). An experience salutary not only for the recipient but for the helper.

By the same token, when suffering, people need to be approached as subjects, not objects, what Buber (1958/2000) calls a "thou" and not an "it." Moreover, we need to be addressed as if we were intelligent rational human beings. You might ask: But what if the individual is not rational? I have two related answers. The first is, rationality or the lack of it are irrelevant to being a "thou." The human being is still every inch a human being—and the onus is on the helper to reach for the humanity, to reach inside to join with the suffering person.[6] Indeed, ultimately the primary basis of connection is not rationality but what we share by virtue of our creaturely existence—being thrown-into-the-world; learning; love, joy, fear, trepidation; having moments of profound ecstasy; having moments of devastating aloneness; being on a trajectory toward death. Second, when interacting with a highly distraught person, including one who strikes us as "seriously psychotic," arguably, the biggest mistake that we can make is to assume that there is no rational person inside. Besides that it is incorrect, it is a self-fulfilling prophecy. The point is, separateness, as we currently understand it, is an illusion. We are inherently beings-in-interaction; and interaction is characterized by feedback loops. Ergo, whether because of our *expectations* or our *influence*—when we behold another, we tend to find exactly what we expect to find (or alternatively, what we have thereby set in motion). Freud's "patients" for example, were typically visited by classically Freudian dreams, whereas the dreams of "Jungian patients" are replete with Jungian archetypes and "shadows." Bottom line: We are people who dwell in the context of each other—what others see, how others interpret, what others expect—and our responses are shaped accordingly. So it makes all the difference in the world whether people are treated as psychotic or as rational.

For a glimpse into this dynamic, witness this statement by Tanya:

> I am not sure this makes sense, but when "professionals" approach me—you know, with that "what-have-we-got-here?" look and that insufferable voice they put on—I kind of find myself going bonkers. Admittedly, once in a while, I am doing it on purpose—I mean, who needs that shit? Mostly, though, it's like I am being pulled there. As for being able to help me out of a "delusional state" which I've become trapped in, well, when they approach me like that—forget it.

A reminder that "crazy" is not so much a quality that resides inside an individual as it is a relationship between human beings.

Providing greater direction is a story which Irit tells about one of the times she went "crazy." It was one of the occasions when she had been forcibly picked up, incarcerated, and drugged. As she languished on the locked hospital ward, at this juncture, she was paradigmatically "a lost soul," someone whom the average human being would see as having "slipped" out of reality—and with no obvious way back. Clarifying the extent of the disconnect, Irit specifies, "I actually believed that I was in a space ship operated by Iranian terrorists." That noted, let's change lens and look at this on a human level. Putting aside the specificity of the nationality of the terrorists—and "delusions" are seldom politically correct—we can all of us understand why someone being manhandled and imprisoned might feel as if they were being besieged by terrorists. By this understanding, what Irit needed is someone to take in what it means to feel "alien-ated," to validate the fact that she was indeed being attacked by folk who do not understand her. This much, I suspect, most readers would grant me. But what if I were to suggest that it is possible to engage this ranting person in a totally rational conversation? Moreover, so engaging them was not contingent on months of preparatory work but could be done immediately. My claim, I suspect, would sound preposterous, at the very least, naïve. Yet this is precisely what happened when she was visited by members of MindFreedom—a network of psychiatric survivors. States Irit in this regard:

> When they came to visit me, I was rational. It was like I was a different person because there were people who understood. And it wasn't that people were listening to my ravings. Because I *wasn't* raving. We had "normal"—bad word—but we had reasonable political conversations, and not just about my situation. And they were so sweet and warm and understanding, it really helped.

Exactly how and why did this seemingly unlikely transformation occur? Very simply: The MindFreedom visitors did not rob Irit of her liberty, did not drug her, did not look down on her. Although she had never personally met any of them previously, they were part of an organization with views similar to her own; many had individually undergone overlapping experiences, and as a result, they could pick up on her predicament, knew from whence she came. They were understanding, sweet, compassionate. Moreover, they did not for one second assume that Irit was simply "irrational." What they assumed is that there was a rational person inside that could be reached. Ergo, they addressed her like she was rational fellow human being and she responded in suit. To be clear, I am not suggesting the basic human approach outlined here will by itself always suffice, but this much is clear—it is always called for; and it is always a good beginning.

An example closer to home—and I touched on this incident earlier—one day I learned that an old friend named Ted had been institutionalized in a psychiatric facility in England. I immediately went for a visit. Upon arriving, I was warned by the staff to expect nothing. My friend, they informed me, was totally oblivious to what was going on around him, was "hopelessly catatonic." Suddenly, I spotted Ted shuffling down the corridor absent-mindedly. With his eyes glazed over, he indeed looked as if he were aware of nothing, as if "unreachable." Nonetheless, something did not "sit right." What I was being told, the prepackaged interpretation of what was before my eyes did not square with the man that I knew. The remainder of the story played out thusly:

Aware that he was an avid chess player, as he passed, in what was transparently a leap of faith, I called out, "Ted, pawn to Queen Four." Ted whirled around to face me, recognition in his eyes, and without a moment's hesitation responded, "Knight to king's bishop three." A well-known and respected chess opening for Black. I proceeded to ask this man (who was allegedly incapable of perceiving anything) how he had been doing. Ted explained that he vehemently objected to the treatment that he was receiving—perfectly rational when you consider that they kept alternating him between cold and hot baths (a form of hydrotherapy). I nodded sympathetically and as he expounded further, expressed due horror at what he was being put through—and I promised I would get him of here (which I subsequently did). Then I inquired why he had not been responding when others addressed him, albeit in my heart of hearts, already I knew the answer. He replied, "I don't like them."

Ted had retreated within, essentially, because people were treating him in an intrusive, indeed abusive manner—"standard treatment" though it was. He was not willing to talk to people who so treated him. On a deeper level, he had protected himself by becoming "unreachable"—on the face of it, a feat not difficult to pull off since it was in line with his "helpers'" expectations. Additionally, on still another level, he did the one thing he felt able to do—take the path opened up for him. None of which, note, is "irrational"; none of which, admittedly, is optimal; and none of which we are in any position to help a person move beyond if we do anything less than meet them where they are and open up to the human being in their entirety.

Such then are the basic services—more aptly termed "caring for one another." And such is the basic orientation.

Entering a New Level

Complex though they seem on the surface and much as they befuddle the current system, let me acknowledge that the examples drawn to date are comparatively simple cases. As those of us who struggle to assist people in difficult states are painfully aware, conundrums that we end up facing can be considerably trickier. Sometimes the distressed or confused person is trampling on the rights of others, whether minimally or substantially. Sometimes the person truly seems in need of some measure of protection. And sometimes compassion and active listening are blatantly insufficient. In all of which cases, versatility is critical. The challenge is for the vast majority of community members to become sufficiently knowledgeable and attuned that they have a sense of what they are encountering, that they can be flexible, that irrespective of circumstances, they proceed in a way which does not overreach, does not create what it purportedly finds, and which neither sacrifices the interest of the person to those of the community, nor vice versa.

What follows then are examples of somewhat more perplexing situations, together with reflections on the directions to which they point. They are chosen with an eye to both drawing on what we already know and forcing us to think further, indeed, to be creative. With minor alterations here and there, they are based on actual events. In the very process of engaging with these scenarios, I would add, we have already begun building our better society, for in "eutopia," a component of everyone's education would be struggling with a range of scenarios precisely as we are doing now.

Scenarios

Man Being Choked

> A young man named "Mark" has just called one of the community helplines. While the presenting problem is new, Mark phoned this line once before and is known to have been battered by his father as a child. He tells you that someone is strangling him, that there is a hand around his throat. You can hear him choking. And his desperation is so palpable that you can almost taste it. You ask him who the assailant is. He responds that he can't see anyone but that he can feel this hand choking him. You inquire how long the hand has been choking him. Coughing and sputtering, barely able to utter anything, he gasps out that it's been going on for hours. Everywhere he goes—down the street, into a restaurant, he wails, the assailant is right next to him, choking him.

Question: What is happening here? How might it be handled? And what does this tell us about what we need to build in?

Discussion/Reflection

I chose to begin with this example because I am aware that many will interpret it as calling for a radical intervention. In this respect, it is typical of the manifold cases wherein we feel justified intruding. We so feel because we pick up—and indeed *correctly*—that compassion and active listening will not suffice. Also because we see him as "deluded" and fear what a person with urgently felt delusions will do. That noted, catastrophizing does not help here. Nor do such concepts as delusions. Correspondingly, it is important to keep in mind that the fact that he is seeking help does not make it okay to trick him or to intrude on him. Nor does our totally legitimate worry that he might land in trouble or make an unfortunate decision. Our right and our lot as human beings is to make imperfect decisions—at times foolish ones—including on bases that would make sense to no one else.

That understood, obviously, this is an emergency in that a very upset human being is frantically calling out for help. Exactly what manner of emergency remains to be clarified.

Arguably, the first thing that one would need to do as befriender is to make a heartfelt connection, assure Mark that you hear him, make it abundantly clear that you are staying on the line as long as needed. Next is to try to ascertain in one's own mind whether or not a concrete external assailant is present. In a situation like this, short of new and unexpected information surfacing—and obviously, on some level one has to remain open to this—that possibility can be fairly quickly ruled out. Note, if an "other" (read: "material" other) were literally choking him, Mark would not still be walking around, would not be intact after all this time. Moreover, given that he has been frequenting public places—if his account can be taken literally—someone would surely have noticed and rushed to his defense.

The mistake that most people make at this juncture is to scare themselves with unhelpful words like "hallucination." A prelude to summoning the police or an ambulance. As this was a real situation, and I was the one on the line with him, let me clarify what I did instead.

Concerned that Mark might hang up or pass out and keenly aware of the felt urgency, I figured that I had but little time to be of help. So it made sense being at once practical and more directive than is my wont. Taken this as a given, I very quickly went with my hunches. My hunch was that Mark incorporated aspects of his father, that just as his father hurt him, he was hurting himself now, but he was doing so at least on some level unaware. In other words, "unbeknownst" to him, one of own hands was choking him. Other hunches were: If I shared what I was thinking at this juncture, I would unduly scare him; also that it might be possible and useful to bring the other hand (the one holding the telephone) into play. Here then is how I chose to proceed.

First I invited Mark to breathe with me, assuring him he could do it. The purpose was to help him feel more grounded, also to solidify our connection. After a number of assurances, I asked him to wedge the phone between his shoulder and head so that he could continue to speak while now having one freed-up hand (his right, as it happened). I proceeded to guide him to flex it, one by one to move each of the fingers so that he could feel the blood coursing through them, progressively feel his command of that hand. Once he felt that, I asked him to use that hand to remove the assailant's hand from his throat. This whole sequence was accomplished in a matter of minutes, and the sigh on the other end signaled that the intervention was successful. To be clear, regardless of whether my interpretation was right or not, it could have failed, even backfired. In which case, I would have quickly used the feedback thereby gleaned to eke out another path.

My sense at that juncture? Here was a man with unfinished business, possibly related to his childhood. This was work that hopefully he might at some point choose to engage in and hopefully, someone would be there to assist him. Another place, another time. While I hinted in that direction, my job right now was to try to ensure that he was safe and as comfortable as possible, minimally for the rest of the evening and throughout the night. This in mind, I reminded him of the power of his right hand, reminded him that if the intruder's hand returned, he could always remove it. Also, that he could always call back. I additionally suggested that in general he keep in mind that not everyone would respond well if he spoke about the assailant and so it would probably be a good idea to choose carefully who to share such details of his life with and who not. To be clear, I took no position whatever on the existence of a separate and concrete assailant. What I told him was that my guess was that for whatever reason, others would not see the assailant, that they might interpret what he was saying as crazy—and why place himself in that kind of jeopardy? The phone call ended with our figuring out together the safest place for him to spend the night—for clearly he had been through a terrible ordeal, and it was not good for him to be alone. He called the following day, I would add, to probe further what kinds of things it was or was not generally safe to talk about.

What happened here? Two things primarily. First and foremost: A person received the immediate help that he needed—and this without being intruded on.

Secondarily—and this is also important—a person vulnerable to interference was introduced to a concept which had the potential of helping him protect himself.

What does this example tell us about the extra skills that befrienders need? Skills at tapping into their intuitions, some knowledge of how people internalize others, knowing how to stay level-headed and practical, an ability to decastrophize. Finally a very particular attitude toward alternate experiences that will serve them well.

Overall, helpers need skills in validating the figurative truth of people's experience—something that the MindFreedom visitors intuitively did in the earlier example. Generally, leaving aside what is literally true while reaching for the figurative truth is the way to go. In *this particular* case—and this will at times be so—it was helpful to leave untouched the figurative itself, that is, to attend only to the practical problem at hand—being choked. Ergo, learning how to make such judgment calls is critical. What is likewise evident, befrienders need skills in helping people visited by alternate realities know how to protect themselves from interference. Specifically, they need skills in helping people become more proficient in deciphering how various people may react to some of their utterances or actions, to be able to distinguish, for example, which people can or cannot be trusted with certain kinds of sharing. In this regard, just as the "sane" typically lack the skills needed to read the mad, commonly the "mad" are lacking in a skill pivotal to their safety—what might be called "sane literacy" (for the article which introduces this concept, see Burstow, 2003b).

Some final comments: This example makes manifest how much easier it would be to serve distraught people in the better society that we are trying to approximate. In most of our communities as they now exist, we are at a marked disadvantage because the people we are trying to serve don't know us and we don't know them. As such, in my efforts to help, I had to operate almost solely on the basis of hunches—for hunches literally was all that I had. In our "eutopia," wherein everyone knew everyone, there would be more grounding for our conjectures for they would be embedded in the knowledge that arises from long-term and multifaceted relationships. What is likewise significant, the need for "sane literacy" would be far less pressing, if it were needed at all, for others would also have some understanding of the person, and beyond that, would not be inclined to either pathologize or intrude.

Using the Example Entrusted to Us by Irit

> A naked middle-aged woman is pounding on people's doors in the middle of the night, yelling, "Emergency, emergency." Soon, she has aroused almost the entire apartment building. And still she is pounding. Still she is yelling out.

We are back where we were chapters ago, back to a moment that we keep revisiting. So paradigmatic is this type of situation, it is almost a litmus test. The point is, if we as a society cannot handle it humanely, there is something profoundly wrong with us. That said, optimally, how might a situation like this be approached?

A good beginning is to recognize that this is not a situation fraught with danger—just a vulnerable person reaching out, urgently trying to convey a truth which she fears no one is aware of or has taken to heart. Obviously, it is important to invite the woman in, maybe offer her tea or something else comforting, listen to her attentively, reach beyond the literal to the deeper meaning. Do not negate, but insofar as feasible, validate her overall sense of urgency (remember that on a profound level, she is 100 percent correct). This in turn could lead to an honest conversation about what might be done in the community or the world at large, also about her current situation. Handling the crisis respectfully and compassionately, as one caring intelligent human being to another will likely suffice. At another time when she is not frantic, you might ask for her help in understanding how her concerns ended up bringing her to this place, also what she needs at such moments—for besides that she inevitably has insight into her own experiences (and possibly everyone else's), she has clear expertise on what helps her and what does not.

That stated, it should be acknowledged that none of us relish being raised from our slumbers. Nonetheless, in our eutopia, a disruption of this nature would not be the "inconvenience" that it is today. Everyone being our relation, part of the human family, we would accept that people in distress might wake us up, much as we accept now that children wake us when they get frightened in the middle of the night. What is also significant, if we approached such matters in a more welcoming manner, the consequence to the other tenants would be minimal. Note: Despite the fact that the woman knocking initiated the action, the immediate outcome for the other residents (an entire apartment building being disrupted) owes as much to the fact that no one responded helpfully as it does to her actions. What if the first or second person whose help she sought let her in and made her welcome? That in itself would dramatically alter the dynamic. Instead of rousing the whole apartment building, she would have woken up a few households only. Now admittedly, not everyone would have the luxury or wherewithal to sit with the woman for long—which is fair enough. But that only signals the type of systemic changes needed.

Each apartment building being a mini-community in its own right, it would make sense to have one or more people on call at any given time—a person whose task it was to deal with personal emergencies. Again, who was on call would rotate. Correspondingly, the befriender would have received the training needed, would be prepared to assist, also to pick up on the implicit learning for the community as a whole—spiritual and otherwise.

In this example, in all of the examples explored lie answers for the average citizen, including those that we currently intrude upon on the grounds that they are "seriously mentally ill"—and at a fraction of the cost. That said, exceptional situations do sometimes arise that present deeper quandaries.

Brenda's Story

When I raised the last example with interviewee Brenda LeFrançois, she immediately countered with an example of her own. So did Rebecca—a member of a focus group—and both involved a gender shift. A signal that there is something here that needs theorizing.

Brenda tells the following story:

> I was living in a bedsit in a cheap boarding house, right? So it's like the poorest of the poor who aren't living on the street. And I was a student doing my PhD at the time,

> but most of the others were people who had considerable problems in life. And every five, six days, at one, two o'clock in the morning, this very large very strong man—drunk as a skunk—would be pounding on my door. And for me, you know, I think he is looking for sex. And I am not opening the door. It was interesting that it was always **my door** that he was pounding on. He was not pounding on anyone else's door. And everyone knew—okay, he is pounding on Brenda's door again. And at the time I was a young woman who didn't look bad. And I was scared. And you know, eventually, I did call the police.

Not a man, note, that would characteristically be labeled "mentally ill." Nonetheless, an important twist on the last example.

Here—and for the first time—we have a genuine dilemma. The rights of others are seriously being intruded on. And prejudices aside, whether or not danger was actually present, what was happening was objectively menacing.[7] That said, in a real community—and that is what we are trying to build—this situation would be handled differently, though it is on the community as a whole not the person being menaced—on whom the onus falls.

Ideally, the community would never have allowed the problem to reach this level in the first place. The very first time that it occurred somebody—preferably one of the men on that floor—would have led the man back to his own room. Correspondingly, once he was sober again, albeit while being careful not to shame the man, the neighbor would have engaged him in a serious conversation—perhaps about drinking, perhaps gender, perhaps about his own life. Be that as it may, to pick up the story as Brenda recounts it, whoever hears that Brenda's door is being "pounded on again" would alert the on-call person. Optimally, at least two people would come. One would tend to the woman who has been threatened. Is she okay? Does she need someone to sit with her? In as kind a manner as possible, the other(s) would guide the menacing man back to his own room, give him a chance to "sleep it off." Here, significantly, *if* necessary (and if approached sensitively, generally it would not be necessary), a minimal degree of force could legitimately enter in, for the community has not only the right but an obligation to stop people from intruding on others.

Eventually, the community itself would have to grapple with the issue together—which community, note, *includes* the man who has transgressed. At the bare minimum, they need to process what happened, how it might be avoided, to struggle with gender-specific issues, and to work out together what should be done in the event of a "repeat." The very fact that consensus is reached and that the man himself had a hand in working this out, I would add, makes it easier for those on call to proceed confidently should the situation arise again.

One additional factor that I would zero in on, for it has broad implications and it is neglected at the expense of shortchanging everyone: *Something has happened* to this woman. Her sense of safety has been diminished—and this, directly by the act of another. It is not accurate and it does not serve anyone to take the position that because of the state that he was in, it "could not be helped." Good societies and good lives cannot rest on such a foundation. While there are circumstances here that mitigate responsibility, in the final analysis, he is responsible, and he has to be helped to accept that. Moreover, as someone who has eroded another person's sense of safety, the onus is on him to give something back, to help make the apartment building safer for her, indeed safer for all the women residents again. Herein concepts like restorative justice come into play (in this regard, see Pepinsky and Quinney, 1991; and McLean and Pepinsky, 1993). What would make the situation "right" would need to be worked out by all those affected, including the man himself.

Speaking more generally, this example illustrates the importance of a concept and principle that we ignore to our peril. With the "mental illness" model, by virtue of the same logic by which the "insane other" is robbed of his freedom, he is, as it were, "let off the hook." "He could not help what he did," people state, "because he's 'mentally ill.'" There are mad-identified souls, by the same token, who see nothing as their fault—more or less by definition. In our eutopia, on the other hand, people need to be recognized and treated as responsible. Which does not mean that there are no mitigating circumstances—only that such circumstances almost never nullify responsibility. The challenge is to help people who may indeed feel powerless own their power and come to terms with their effects on others. This same principle, I would add, pertains even where alternate realities and/or voices are at play. Which brings me to an incident that played out in the mad community just as I was readying myself to pen this chapter.

The Frankie Dilemma

A resident of LA, Frankie (pseudonym) is an extremely intelligent young man in the mad movement. He hears voices regularly, moreover, is known to be vulnerable. He was someone whom his confreres knew as mild mannered, as respectful, and as having a keen political analysis. Then something happened that substantially shifted the dynamic—a threat to the continuation of his community center work, arising from what he saw as an arbitrary rule. He immediately became upset. Not long thereafter, in the presence of others, he launched into a highly personal racist and homophobic diatribe against the bearer of the bad news. Those who witnessed the event were horrified and furious. Most responded initially by expressing their outrage and then shunning him. Distressed by the anger and the shunning, Frankie in turn protested that he was innocent, that "the voices made him do it."

There are two polar opposite mistakes that can be made here—and both are alarmingly common. The first is to scrap everything one knows about Frankie and indeed people in general and see him as nothing but a bigot. The second is to decide that he is not responsible. The first trivializes the very fraught reality which this man inhabits, diminishes him, and further marginalizes him. And the second robs him of moral agency as well as failing to honor the needs and rights of the person attacked. The problems attending the first, I would add, are exacerbated when the person is shut out. To be clear, while the community member who was the target of this diatribe has every right and may well need to shut Frankie out of their life—and such a decision needs to be respected—the community as a whole is a different question. Casting someone out of the community when he errs defeats the very meaning of community.

What was needed here? Engagement rather than disengagement. Holding onto and using as clues what everybody knew about Frankie, instead of treating the new piece of information as the "ultimate" reality. Compassion for everyone—for the man who suffered the traumatic attack; for Frankie in the lonely and desperate place in which he finds himself. Reaffirming antiracist and antihomophobic principles. Holding fast to the knowledge that we all err, that given the right circumstances, we are all capable of acting badly. Figuring out what it was about that fateful announcement that threw Frankie so (and it wouldn't be hard, for so filled with precarity is Frankie's existence, that he in essence was being deprived of one of his sole lifelines). Questioning whether regulations should ever be so hard and fast. Last but not least, helping Frankie own responsibility for the racism and homophobia, for—bottom line—he *is* responsible.

In this last respect, after learning of the incident from Frankie, I agreed to intervene with his cousin—one of the many people not talking to him—also, I was aware, a major anchor. At the same time, I stated clearly that he owed everyone an apology. When he told me that others insisted he had made up the story about the voices, I empathized and acknowledged that he and he alone was privy to what went through his mind. Then I returned to the question of the apology. The conversation continued thusly:

Frankie: But I apologized.
Bonnie: The apology people need to hear is one that does not include you saying "I couldn't help it; the voices made me do it."
Frankie: But it *isn't* my fault; the voices did tell me to do it; I didn't do anything wrong.
Bonnie: But Frankie, you had choices here and it is not *the voices* but *you* that acted.

In all honesty, initially, our conversation did little but upset Frankie further. Nonetheless, by the next day, he was beginning to assume responsibility, albeit not consistently—which is to be expected. By the same token, some of those who were not talking to him resumed, while others did not. A baby step for sure, but a step in the right direction.[8]

Pushing a Previous Example One Stage Further

As already noted, the extreme situation should never be used as any kind of model. In that direction, disaster lies. Nonetheless, it is helpful to have a sense of what might be done in extreme, once-in-a-lifetime situations. With that cautionary note, I invite the reader to consider the following: What if the drunken man in the previous scenario broke down Brenda's door and raped her?

At this point, I am aware, many would want to lock the guy up and throw away the key. A knee-jerk reaction and not good enough. Like the mental health system, the criminal justice system is hardly a solution befitting our ideal society. This is hierarchical text-driven state rule, note, not the community working out difficulties together.

While I will not be fleshing out this scenario in detail, many tasks face this community. In the long run, minimally, they need to ask themselves what is being conveyed about women—also what were the missed warning signs? More immediately as well as in the long term, helping the woman and her loved ones with the horrendous trauma is critical. And restorative justice is again an issue. The challenge is to enhance the safety of the woman and indeed all the women in the building while not disrespecting or abandoning the man. Women clearly would have to be centrally involved in determining the consequences, as to a degree, would the man himself. Examples of partial solutions that might be entertained is restricting the man's access to specific floors; alternatively, excluding him from the community (albeit not from the assistance of elders) until he has accomplished certain tasks, perhaps including being one-year sober.

Which brings us to the larger question: In our eutopia, what mechanisms might we create to deal with conflict, whether it involves blatant transgressions such as the one given here, or the everyday conflict of life?

The Community as a Site for Conflict Resolution

The early education outlined earlier having paved the way, ideally, well before reaching adulthood, people would be actively involved in conflict mediation—as helpers, as helpees, as people mutually trying to forge paths together. Peace-building per se would happen in many different ways and on many different fronts—with and without a mediator. Correspondingly, it could be applied to mini-communities like the family, large communities like the neighborhood, even the world community.

To use the family as an example, imagine the power of everyone letting go of their anger toward each other, sitting down together, and asking: What does everyone really need here? While other questions too, of course, would figure, even this very simple approach can be amazingly fruitful, including with those ostensibly lost.

An example from my own practice: I once saw an uncle and niece—both adults—who were in deep conflict with one another. Agnes inhabited a world where all that exists is sentient (the street, the pavement, the chairs, the very air that we breathe)—clearly a woman with a strong spiritual bent. Jack was a practical man—an engineer who had been left money by his dead brother to take care of Agnes. Agnes liked being around Jack. Jack was fond of his niece but had one serious grievance. She kept making him late for events. How so? Every step she took, she needed to first stop and ask the permission of whatever it was she was treading on—the street, the sidewalk, the stairs into the house. It would literally take hours to go a few blocks. Jack found the whole process absurd and would say as much. He had frequently hospitalized his niece. He was now threatening to do so again—a prospect that horrified her. It was under these circumstances that they came to see me.

As was quickly evident, what was needed in the short run was "striking a deal." Each of these people had legitimate needs—Jack, to arrive where he was heading on time, Agnes, to be allowed her freedom and her spirituality. The compromise worked out is that she would only accompany Jack when he was not in a hurry. Moreover, in instances where they were both expected somewhere at a time Jack was in a rush, Agnes would have to get there on her own, setting out earlier if she chose to be on time. Conversely, Jack would accept that his niece had a different set of beliefs and priorities and would neither criticize nor hospitalize her. Striking such a deal, I would add, was possible by virtue of people agreeing to abide by two guidelines that I stipulated—and in general, recommend:

1. Everyone's needs are important.
2. No one's reality is to be questioned.

Obviously, just a holding action, but one that provides relief. Moreover, one that begins to equalize power and shift the dynamic.

More generally, in our eutopia, it would be an everyday event for people to turn to third parties for help with a conflict. And a large variety of models would be broadly known. While the forms taken could vary greatly, in matters where a clear violation has occurred, a full-fledged community meeting would likely be called. A common format might include: A facilitated circle in which the "transgressor," the victim, and close friends of each are present, together with anyone else who might shed light. Everyone would take turns talking, with the facilitator summarizing, asking questions, guiding. Examples of questions that the gathering might be asked to wrestle with include: What happened? What led up to this? What other factors does anyone think that we have to know? What are the personal and other consequences? What is owed? What is needed to make the community whole? What is needed to make each of the parties whole?

If we as a society pursued such a direction, would we avert all tragedies? In a word, no—albeit we would likely have considerably less of them, and in the vast majority of cases, people's lives would be significantly more meaningful. Part of maturing as a people is to accept that we do not have that kind of power, that tragedies will happen no matter what we do, that the goodness of a society is not vested in accomplishing the impossible but in the basic decency with which we face the precarity of life—individually and collectively.

This same principle, I would suggest, applies when thinking of those alarming incidents specifically involving the mad that occasionally hit the news (e.g., Vince Li, who in 2008 beheaded another passenger on a bus). Utterly extraordinary though such incidents are, they trigger our innermost fears, and as such, our biases, leading us to forget everything that we know in our more enlightened moments and to call for broad sweeping regressive measures. The point is, however, besides that the "mad" are no more dangerous than the "sane," and besides that we are monumentally unsuccessful in preventing such isolated incidents now, in our aggressive efforts to forestall them, we at once create widespread misery and exponentially multiply the jeopardy. Understandable though our dismay is, in other words, what we are doing serves no one. Far better that we proceed humanely, attending to what comes our way, in the process accepting the very real limits on our ability to predict.

The Question of Interference

Following the precepts and guidelines outlined thus far, we would but very rarely interfere with anyone's choices—and except in instances where the protection of others unequivocally required it, force would more or less never be deployed. Using the past as a warning—and they might dub the current period "the days of the mental illness tyranny"—every community member would take it as a sacred duty to ensure that exceptions remained the exception, did not lead into a slippery slope. Correspondingly, a clear distinction would be made between harming oneself and harming another, with the understanding that people have a right to make decisions regarding themselves, whether others are comfortable with those decisions or not—up to and including about when and how to die. That said, life is complicated; and situations inevitably arise when we as caring people are called upon to think again, to qualify even our own absolutes.

Question: In a better future, would adults *ever* be prevented from harming themselves? Herein, the issue of how far society has evolved is critical. The point is, currently, irrespective of the answer given, this question is a "no-win." Currently, note, albeit society is hypothetically against intrusion, we have laws permitting it. Such laws come equipped with "safeguards"—standardized processes which are routinely activated. These procedures technically protect everyone's rights. In reality, as witnessed, they are the very mechanisms by which people's rights are routinely violated—at that, legally. What this suggests is that such interference should never be permitted. The problem is, such a position would leave those most vulnerable with little protection—a lose-lose.

By contrast, in our eutopia wherein respect for choice is everyone's lived reality, where communities grapple long and hard together over any exception made, besides that exceptions would be rare indeed, being open to exceptions would be viable. In this regard, I would ask the reader to imagine the following scenario:

> A woman with advanced Alzheimer's—let's call her Cora—habitually ventures out without shoes and socks into the wintery night. The last time this occurred, she contracted severe frost bite.

In our eutopia, as opposed to following scripts, we would begin by trying to find out what was going on for the woman, to see if there she had a reason for going out barefoot. If, for example, we discovered that being barefoot in the snow was part of her martial arts exercises—something that our knowledge of her might lead us to suspect—we might suggest safer ways of doing the same thing, while respecting that the choice was hers. If the issue was one of forgetting, we could together institute a process of gentle reminders. If forgetting was not the issue, if, say, she was simply not making the connection, other avenues that we would likely pursue are: gentle persuasion, explanation, perhaps calling in friends with whom she has a special rapport. Correspondingly, we would all of us continue to look for what compromises might be possible. If all this failed—albeit only if we were convinced that frostbite was not in itself something that she either sought or found acceptable—making the choice for her would be necessary—the best, as it were, of bad options in an unfortunate situation. Again we would be careful that what started as an exception did not turn into slippery slope. For instance, we would not permit other areas of decision-making to suddenly become lost to this person.

As it happened, a helpful take on this scenario emerged in a focus group which I convened to ponder it. To wit, Professor Jamie Magnusson made the distinction alluded to earlier between an Alzheimer's patient who wanted to go out barefoot as part of her martial arts exercises and one who can simply not hold onto the connection between her actions and frostbite. Leveraging this distinction, correspondingly, she suggested that Cora be asked:

1. Do you want to go out barefoot?
2. Are you okay with having frostbite?

Let's say that Cora responds yes to both queries. While there may still be need for further discussion, at the bare minimum, we would not so obviously be entitled to intrude. By contrast, what if Cora answered yes to the first and no to the second and saw no connection between them? At this point, we would be faced with a conundrum. If we worked hard trying to help her grasp the connection—and there is a clear onus on us to do so—she might well arrive at a place where she could make her own decision—obviously, the optimal outcome. If not, the contradiction remains. Whereupon safeguarding this vulnerable human being from contracting frostbite would appear to be the most decent course of action.[9]

That said, in the small, tight, and respectful communities that we inhabited, safeguarding a person by making choices for them would be so rare that it would be witnessed perhaps once in a lifetime. Correspondingly, it would be understood that the sheer fact that we are leaving ourselves open to such exceptions obligates us in a number of ways, this despite their rarity. First and foremost, we are obliged to introduce practices whereby every community member is regularly asked for directives about what to do in the event of extreme mental deterioration. What are their preferences? What should be avoided? Who should be empowered to make decisions on their behalf? There could conceivably be a once-a-year check-in, with the entire community participating, in which everyone clarified their current preferences, elaborated on their current sense of the matter.

Additionally, there would be an onus on the community as a whole to do what they humanly can to assist people with compromised cognitive ability to think through and make their own decisions whenever and wherever possible—labor-intensive though that work is likely to be. Aiding in such an endeavor—and it cannot just be the immediate family doing it—would be seen as an honor, a "mitzvah." And receiving such help would be a right. By the same token, where freedom is interfered with *on one front*, community members would take it as their obligation to find ways to increase the person's power and maximize their decision-making *in other areas*, whether it be in relation to the food served or more personal issues. As such, however imperfectly, a kind of balance would be struck. More generally, people in such situations would continue to be approached as sources of wisdom and they would be understood as potentially having more to teach the community than the community has to teach them.

Herein then is our eutopia. Not a *make-believe* land, but a *possible* land. Not a "no-place" or "u-topia," with no problems, but a "better place."

Social Change/Eutopian Openings

So what can we do to bring about a society of this ilk? As everyone, I am sure, is aware, to suggest that we could easily simply implement such a eutopia here and now would be an exercise in make-believe. Besides that change is slower than that, there are structures and interests at play that militate against this. By the same token, suggesting that one part at a time could be introduced while all around it remains the same minimizes the organic nature of change, the fact that societal shifts are of a piece, that they mutually support one another. This acknowledged, paradigm shifts do occur in part as a result of individual changes, which shifts, in turn, give rise to additional changes. They happen, as philosophy of science theorist Thomas Kuhn (1962) established over half a century ago, when enough people are sufficiently unhappy, or to pick up on Kuhn's discourse, where more and more individuals view "resolving" the "anomalies" of the current system as a dead-end. If we look at the worldwide antiglobalization protests, the popularity of the Idle No More movement, the rampant spread of self-publishing, the instant ridicule with which each new DSM is met, it surely appears as if we are entering one of those pivotal moments.

While, obviously, this is not everyone's calling, one way of influencing the direction is by assuming an activist role and joining in the protests. Whether it be in the antiglobalization, the environmental, or the antipsychiatry movements, there are ample groups out there to join. A word of caution: Groups commonly make compromises that seem sound at the time, which may even appear to be bold new initiatives, but which in the long run undermine the very changes sought. For example, in the United Kingdom, psychiatric survivors negotiated with the state to get "a seat at the table." They indeed received what they requested. The result was minimal change, together with a profoundly coopted movement. States one interviewee and direct witness to this development:

> *Interviewee*: I moved to the U.K. in 1994. I was quickly immersed in the survivor movement. In the period 1995 to the present, many of the demands of the psychiatric survivor movement started to be listened to in the U.K. while they were being ignored in Canada. So they were given a platform—and this terrible cooptation happened. So you have all these psychiatric survivors on boards and on steering committees and being hired as peer researchers in universities—and actually *nothing happened*.
>
> *Interviewer*: How did the mechanism of cooptation work?
>
> *Interviewee*: By employing and taking on the language of the movement in a way that fits the government. And you know, this huge silencing went on for a period of over fifteen years. I don't think they know what hit them.

The point? Neither big government nor big business will make the changes for us. In short, to quote a groundbreaking book, "the revolution will not be funded" (see Incite! Women of Color against Violence, 2007), and if people act as if it will, in the long run, they will not only lose the battle, they will undermine their more scrupulous colleagues in the process—for they now have *their own* vested interest to protect. Nor does it make sense joining with seemingly more benign organizations like Canadian Mental Health Association. Significantly, they receive huge funding from the state to do its bidding, and as such, constitute an integral part of the ruling regime.[10] Correspondingly, their biopsychosocial model, as already shown (see Chapter Five), is essentially the biological model with add-ons, or to put this another way, the biological model made-palatable.

Working outside the system offers a greater measure of protection. The hope lies in the movements of people—not states, not any part of the industrial complex.

And even here, it is easy to misstep, and so scrutiny is critical. An example of the kind of process thinking needed is evident in these psychiatry abolition guideline/questions:

1. If successful, will the actions or campaigns that we are contemplating move us closer to the long-range goal of psychiatry abolition?
2. Are they likely to avoid improving or giving added legitimacy to the current system?
3. Do they avoid "widening" psychiatry's net?[11]

If protest-style activism is one route, simply building what we can build is surely another. And herein, everyone can become involved. While for sure, the system is not designed to support this, and there will at times be push-back, as long as we are not looking for government or corporate assistance, there is nothing stopping us from introducing various aspects of what has been outlined into the nooks and crannies of current society. A good start is letting yourself truly know that we are in a wasteland, then asking the healing question: What ails us? That asked, you might take it upon yourself to try to introduce environmental and nonhierarchical principles into one or more organizations of which you are a part. You might make a point of talking to more of your neighbors, perhaps the man that you now just exchange nods with, perhaps the woman you have not spoken with in years. You might suggest a block meeting with a few issues of mutual concern on the agenda. If bit by bit, we get into the practice of getting together with our neighbors to mutually address common problems, if we introduce such experiments as community problem solving, street celebrations, community kitchens, we can turn quasi-communities into real communities. By the same token, there is nothing stopping us from raising our children in accordance with the principle of mutual noninterference, from centrally involving our seniors, from embracing diversity, from creating befriending networks, from turning to one another instead of experts. Indeed, if we truly set our minds to it, there is nothing even stopping us from becoming "mad literate."

Extending our concept of family is particularly pivotal. If we shut out others because we are focused on one small group only—this tiny constellation known as the nuclear family—we perpetuate the very disconnect at the roots of our problems. By the same token, by fetishizing the family, dear though our family may be, members of this mini-group tend to implode. Correspondingly, when serious problems set in, we find ourselves resource-deficient, and the family can quickly become overburdened—a reality that once again leaves us turning to experts.

With this, we come to the final focus of this chapter—suggestions for specific groups struggling in the here-and now.

Suggestions for Specific Groups

"Implicated" and Concerned Families of Psychiatrized Individuals

Throughout the world, with pressure from both society and "the system," and often at their wit's end, families are "settling," accepting a lesser existence for their psychiatrized loved one. Maybe as caregiver, you yourself are functioning as an agent of the state and enforcing community treatment orders. Alternatively, maybe you are simply relieved that your loved one is staying on his drugs, hint in that direction, pray that he never again goes off. As someone who grew up the daughter of a man labeled "manic-depressive," someone whose father, for example, would at times persistently scream at her even when she was not present, I empathize with the turmoil that may have brought you here. At the same time I hope that this book has offered you a view into how psychiatry may be creating and/or exacerbating many of the problems that your loved one faces and is impelling you to think again.

Not an easy shift. Perhaps in the past, you have seen your loved one become seriously "incoherent," and while you know only too well that the pharmaceuticals diminish her, that diminishment seems an acceptable price to pay. That said, my guess is that beneath that certainty—that certainty you seemingly dare not let go of—lies doubt. Maybe also guilt. To let in that the drugs that you have encouraged her to take might themselves be a sizable part of the problem, additionally or alternatively be merely masking the problem, is particularly threatening, for it means facing that guilt. My invitation is to face it all, work through it, then let it go—for you surely did not create this situation single-handedly, are in your own right a victim of the system—then begin as a family to address the problems together.

What concretely can you do? Hard though this may be for any number of reasons, respect your family member's right to make her own decisions. Should she be in need of protection, find out who the best mental health lawyer in the area is and offer to make the necessary arrangements. Trust in her processes and encourage her to do the same. Make room for difference. Support your loved one if she wants to taper off the pharmaceuticals (for withdrawal tips, see section following). Work to understand her ways of coping and see if you can validate some of the ones that you may have once wanted to drug away. With the aid, say, of the examples in this book, but most especially with the aid of your loved one, become mad literate. Be willing to apologize for your part in her psychiatrization. Ask for, even insist on what you yourself need—for *your needs* must also be factored in, and they may well have been run roughshod over for eons. In the spirit of the uncle-niece example discussed earlier, see what deals can be struck. Most importantly, when problems arise, don't go it alone. Ask friends, relatives, grandparents, where applicable, members of your spiritual community, if they could lend a helping hand.

If the family as a whole or the member in question put a premium on experts, minimally, there are better practitioners out there—my invitation is to see what you can find in your area and discuss the options together. In most localities, there are, for example, nonmedical practitioners skilled in listening and respectful processing, who factor in context, who have a political analysis—feminist therapists in particular come to mind. There are a large variety of approaches which different practitioners use—gestalt, transactional analysis, mindfulness—and you might investigate some of these. Other routes that some have found valuable are naturopaths, homeopaths. Additionally, the family as a whole might consider visiting a nonbiological family therapist. One with a systems approach could conceivably serve, for if skilled, they could help members see how power operates in the family and might facilitate a shift such that the psychiatrized member stops being "the identified patient" (for such concepts, see, e.g., Minuchin, 1974; and Foley, 1974). Particularly consonant with the message of this book would be network therapists.

A word of caution, if the practitioner won't stop using words like "dysfunctional family" or "mental disorder" or should mother-blaming be the default mode, give yourself permission to leave.

A promising approach for loved ones and their families where the person is seen as in the grip of a "psychosis" involves open conversations between the client, the therapists, and the family. Finland's Open Dialogue has been particularly successful. Herein, for example, therapists come to the home when a problem sets in, consider themselves guests, allow people to retreat as needed, facilitate both individual and family conversations, as the opportunity arises (for details, see Whitaker, 2010, p. 336 ff.).

That said, it should be acknowledged that there is a far greater range of services available to those with the money to pay. Correspondingly, what the state provides overwhelmingly hooks in with psychiatry. Part of the reality of medical rule.

A very different kind of choice—and these are not mutually exclusive—is turning to others in the same situation. There are self-help groups—different ones tailored to different life problems. There are community groups more generally where people congregate and talk. What is especially promising where the family as a whole is seeking answers and validation, groups comprised of families who are highly critical of their experiences with psychiatry have begun to spring up, mostly self-led—a fount of useful information, validation, and support. You might join or form one or simply get together with other families with overlapping experiences, and see what comes of this.

Additionally or alternatively, the family might consider embarking on their own journey of discovery. What is involved, insofar as safety needs permit, is discussing your own dynamics as a family as openly and honestly as possible. In this regard, questions that you might wrestle with together include:

- What do we most appreciate and what most irritates us about each other?
- What are the unique gifts that each member of this family brings??
- How are decisions made in this family? And who makes them?
- Where is power held?
- Who is listened to the most? The least?
- When we truly hear one another, how does this happen? When communication fails, how does this happen? Are there situational guidelines that we can come up with? Translation-like guidelines?
- Who sides with whom and against whom? And why?
- What unimportant issues might we give up fussing over?
- Who supports whom? Who hinders whom? Who compensates for whom?
- Who is keeping this family together and how? Can we imagine other ways?
- Individually, how are different members being served? Being short-changed?
- Is everyone held accountable? If not, how is that?
- Does everyone contribute equitably? Is everyone afforded their own special days? Cut slack when needed? Celebrated? Treated with love and respect?
- How do inequities of gender, age, ability, race play out in this family?
- What are our open secrets? Betrayals of trust? Can we begin talking about some of these now? If we need help with these, where might we turn?

- How does it feel always being seen as the one "with the problem"? Conversely, how does it feel always being regarded as the "responsible one"?
- What helps each of us when we are having a particularly bad day or are otherwise "losing it"? What hurts us at such times?
- Generally, what extra care and support does each of us need?

People Currently on "Psychiatric Treatment"

One of the most difficult aspects of writing this manuscript has been my ever-present awareness that it may leave people who view psychiatry as having saved their lives feeling disrespected. Let me reiterate at this juncture that no criticism of you is intended, also that I am aware that we all make choices under less-than-ideal circumstances. That said, my hope is that irrespective of the dramatic differences in our positions, you have nonetheless picked up some useful information, whether about the working of the drugs or alternate routes.

For survivors, by contrast, who would dearly love to pursue another direction but are convinced from bitter experience that nothing else "works"—I would introduce two realities that might give you a bit more breathing room. One is that, as shown earlier, in the vast majority of cases, what is seen as "the illness returning" is in actuality a drug reaction—whether a short-term rebound reaction or complications arising from long-term psychopharmaceutical use (for details, see Chapter Seven). The other is that people's sense that they have "tried everything," albeit perfectly understandable and an admittedly terrible place to find oneself, might be mistaken. By way of example, people often tell me, "I tried talk therapy; and it didn't do a thing." However, besides that there are options other than "therapy" and besides that there are dozens of very different kinds of "talk therapy," unlike drugs, human interaction is not a commodity that can be evaluated independent of who the human may be. There are more and less skilled therapists. There are people—professionals and otherwise—with whom we feel a rapport, who have a way of being able to reach us, when others who are technically applying the same principles cannot. This being the case, what is perhaps both good and bad news, there are likely other avenues out there to explore.

For those in the process of trying to break free and are finding themselves afraid, I in no way would suggest that there is nothing to fear here. At the same time, let me just say that over my lifetime, I have come across literally thousands of people who have done so successfully. Also, I have known others for whom this is not possible—disproportionately, people who have been on the pharmaceuticals a very long time. What I would encourage you to do if in this situation is get in touch with folk from the survivor movement, see what helped them, listen to their stories, consider your options. You might begin by visiting, say, the MindFreedom website (Mindfreedom, n.d.), then take it from there.

Finally, for those intent on getting off the psychotropics and who are seeking counsel, I leave it to others with specialized knowledge to advise you. That said, what I can pass on just to get you started is the inherited wisdom (advice over the years provided by doctors associated with the survivor movement).

In short, the inherited wisdom is: While of course solicit input, ultimately, the decision to either begin or to continue a withdrawal process is yours alone. Know that it will not be easy, and so where at all possible, have 24-hour support around—folk that you know that you can count on—that is, will neither desert you nor hospitalize you during the difficult moments. While people's reactions and drugs themselves differ, well-documented withdrawal effects that everyone needs to be aware of include: nausea, vomiting, indigestion, fear, sweating, flu-like symptoms, hallucinations, sleeplessness, what is known as the "wet blanket sensation," occasionally psychosis. It is greatly preferable if a sympathetic doctor were involved. Except where withdrawal has been necessitated by a medical emergency (in which case, seek medical help immediately), proceeding slowly is a "given." Otherwise the extremity of the rebound reactions is magnified. Approximately one month of withdrawal for every year on the drug. A different and age-old formula—and it has been "kicking around" since the 1970s—is the "Dr. Caligari" one-tenth rule (cut back on the dosage one-tenth at a time; see Richman, 1987). While there are no absolutes here, people might be best served by keeping both in mind and seeing what feels right for them. Only progress to a lower level once the current dosage is tolerated. If your suffering gets too bad, go back at least for the time being to the last previously tolerated level. One drug at a time. Where a second drug has been administered to deal with the "side effects" of a primary drug, that primary drug should be tapered off first. And during the entire process, avoid junk food and be sure to get plenty of minerals and vitamins.

For a more extensive and very helpful account of withdrawal—and anyone considering such a move would be strongly advised to find out more—see Breggin and Cohen (2007).

Concerned "Mental Health" Professionals

"Mental health professionals" intent on making a difference can surely be part of the solution but insofar that we also recognize ourselves as part of the problem. Not an easy thing to do for as demonstrated in Chapter Six, everyone involved has vested interests and there are consequences with breaking rank. A good beginning, to use Becker's (1967) famous phrase, is to decide "whose side you are on." Then comes the hard work. In this regard, professionals need to become research-literate and they need to free themselves from beliefs held in either ignorance or bad faith. On a more structural level, we need to disentangle ourselves to the extent possible from the psychiatric system. This includes but is not limited to: not employing psychiatric language, not being complicit in hospitalizing people or otherwise depriving them of their rights, solidly rejecting brain-damaging therapeutics (psychiatric drugs, electroshock). More fundamentally, it means not operating as part of institutional psychiatry (e.g., except perhaps as an outstated maverick, not working in the "mental hospitals," in the labs, in mental health branches of the government, indeed in any organization pivotal to or controlled by the regime of ruling).

Of course, the question arises: Where does that leave us? Many have tried to solve this and related conundrums by going into private practice and doing supportive nonpsychiatric work with their "clients." In some cases, the work is additionally politically literate. While for sure this has merit—besides that you are still in hundreds of little ways activating boss texts and doing the work of the regime, minimally on a level of social change, it leaves something to be desired.

More politicized work might include educating others about the dangers of the system and finding ways to support the movements against it, whether this be by equipping your waiting room with pamphlets problematizing the pharmaceuticals, joining organizations like Healthcare Professionals against Electroshock, or talking to the press (for detailed suggestions, see Burstow, 2004). In itself, and to a degree, a good move. This notwithstanding, even when so politicized, the private practice route misses the point. One problem, of course, is the monetary one, this together with what goes along with it—the abandonment of universal services—but that is hardly the whole of it.

The point is—and this critique applies as well to most of those doing agency work—while there is surely a place for people with specialized knowledge and expertise in a better future, as already discussed, the fetishization of experts (something epitomized in the very practice of regularly going to "experts" with one's problems) is incompatible with any kind of eutopia. As such, albeit I am in no way advocating that people close shop, it behooves all of us to try to think further.

Even kind, empathic, and progressive professionals are not the answers to life's dilemmas and insofar as we think we are, we inevitably remain part of the problem. Turning this around entails giving up power and decentering oneself. A good beginning is always remembering that in the long run it is better that people in emotional crisis turn to each other than turn to any kind of professional. Additionally—and I will end here—on a regular basis, I would invite my colleagues to ask themselves this:

- How can I minimize myself and increase the perceived credibility of survivors? Of the everyday person struggling with their problems? Of helpers lower down on the hierarchy?
- How can I transfer my skills, my knowledge, my work itself to the commons?
- How can I help individuals and families who come to see me build community and approach life problems in a collective, pluralistic, and egalitarian way?

Concluding Remarks

After nine thick chapters, hundreds of pages, a plethora of individuals heard from, we arrive at the end of a long and complicated journey. We began this journey with a disjuncture—a talented young man called Kevin who had been so profoundly injured by the psychopharmaceuticals on which he had been placed that he could see no way to continue, and so he left his parents' house then killed himself. This opened up into a larger problematic—the ever growing number of lives intruded on and harmed. At the center of the problematic was institutional psychiatry—a regime of ruling, at once a partner and a function of the state. Investigating the problematic, in Chapters One through Eight, bit by bit we traced how this regime of ruling came about, who the key players are, how the various parts interact, how the regime as a whole "works." We saw the systematic medicalization of what is not medical, the routing and eventual colonization of all other workers ministering to the distressed or distressing. We saw the opening of a transcarceral dynasty that stretches between prisons, psychiatric institutions, and the hidden lockdown which occurs in psychiatrized people's brains. We saw the spread of an industry geared to physician power and the maximization of industry profits at all costs. We saw a huge bureaucracy, indeed, saw a tick box universe characterized by the gaze of the physician and the systematic activation of texts. We saw assault in one form or another and the empty rationales that accompany them. We saw treatments that are synonymous with injury, saw iatrogenic brain damage spread like an epidemic. And we came to the only conclusion possible—that this industry has no foundation, in no way serves us, and that psychiatric rule needs to end. Such is the mainstay of the book, such the position reached.

Finally, come Chapter Nine, we asked: Given that psychiatry is blatantly not the answer to life's woes but indeed, one of the causes thereof, and given that there will always be some need for extensive emotional support, what do we put in its stead? What we concluded is that tinkering will not serve us, that not only must we break with psychiatry, we have to rid ourselves of rule by experts, we need to stop "othering," we have to stop imprisoning, and beyond that, we need to fundamentally alter how we live with one another. What followed was the articulation of a better world—a vision based on small communities, the spread of the commons, environmentalism, egalitarianism, plurality, participatory democracy, compassion, respect for difference and for choice—a world, moreover, wherein services arise organically from the community itself. Herein lies the challenge.

Long after you have closed this book, I am hoping that you continue to interact with the messages, images, challenges. When you encounter a scraggly stranger on the street who goes between muttering to himself and "ranting," perchance you will approach him in a new way. When you hear words like, "It's a disease like any other," how about seizing the opportunity to introduce a very different discourse, trusting in your ability to do so with care? Perhaps even now you are noticing figurative truths where once you saw "illness." Maybe if you permit it, you will find yourself shuddering and seeking to intervene constructively rather than feeling reassured when the police arrive on the scene—if not, just think of Irit. Moreover, on a whole different level, in the spirit of commoning, there are doubtless places that you can go with the various analyses that intrinsically connect up with your own insight, your own wisdom, your own passion—and should you find yourself drawn there, who knows what contributions you may make? In short, whatever form it takes, I am inviting you to allow this book to "live" in you. Correspondingly, whatever your positionality—whether you are a survivor, a family member, someone who has never concerned yourself with such issues—I invite you to take up the larger challenge.

As individuals and communities, the overriding question staring us in the face is this: Are we going to sit by as our planet continues to be ravished? As our connection-with-one-another is progressively eroded? As our birthright—the commons—disappears? As society moves closer and closer to "Pharmageddon"? As our children are placed under a microscope and labeled ADHD? As people like Kevin throw up their hands in despair and kill themselves?

The job which lies before us is the time-honored task of altering the world, in essence, of standing up for life. Despite appearances, the state will not help us here. Neither will industry—for it runs counter to their interests. With the well-being of our planet, our society, our loved ones, ourselves in the balance, the onus is on us.

Truth be told, it always was.

Notes

1 Introduction to the Study: Unveiling the Problematic

1. For examples of movement writing, see LeFrançois, Menzies, and Reaume (2013) and Burstow and Diamond (2010).
2. The term "archeology" comes from the philosopher Michel Foucault (1969/1989 and 1980), and it refers to the activity by which you arrive at the various statements that are made possible or refused by a specific discourse.
3. In most jurisdictions, the signatures of two psychiatrists suffice to commit someone involuntarily. See, for example, *Mental Health Act* (1990), R.S.O.
4. To be clear, I am in no way questioning that there are significant differences between the different schools of psychiatry. The point is, however, they all believe in mental illnesses, use the same diagnoses, enjoy the same powers, and draw on the same resources.
5. For an important analysis that unpacks and critiques the concept of committing suicide as well as other psychiatric concepts, see Smith (1990).
6. Polypharmacy is the prescribing of many drugs at once.
7. The full interview is available in my transcripts. For parts of it, including the statement quoted in the main text of this chapter, see Burstow (1994).
8. For an intricate look at these and attending problems, see Chapter Four, which is itself wholly dedicated to the DSM categories.
9. For one of the early thinkers who attributed mental illness to brain disease, see Meynert (1885). For the book that first convinced the public that mental illnesses were brain diseases, see Andreasen (1984). For an example of a psychiatrist who vehemently asserts that schizophrenia is a brain disease just like multiple sclerosis, even while acknowledging the "lack of an abnormality in brain structure or function which is pathognomonic for schizophrenia," see Torrey (2002). For more general elucidation on the lack of proof, see Szasz (2007/2010), Colbert (2001), and continue reading this book.
10. An example of a conference is PsychOut. See, in this regard, Burstow and Diamond (2010) (http://individual.utoronto.ca/psychout/). For the magazine on whose editorial board I served, I would refer readers to *Phoenix Rising*, which can be found on the Psychiatric Survivor Archives of Toronto website (www.psychiatricsurvivorarchives.com).
11. For these hearings, see Ontario Coalition against Electroshock (1984), Burstow et al. (2005), and Weitz (2005).
12. Maximum variation is a sampling procedure intended to maximize the amount of variation in the sample; stratified purposeful sampling allows for categories that can be

easily compared (e.g., "survivors" and "practitioners"). A case is "critical" when it has the potential of substantially moving theory forward. Opportunistic sampling occurs when you take advantage of the fortuitous. For a discussion of these and other forms of purposive sampling in qualitative research, see Patton (2000, p. 171 ff.).

13. An IE study that illustrates this well is Adam (2011). Significantly, while this excellent IE work scrupulously traces how it is that seniors receive inferior hospital care, within a year of the completion of the research most of the documents on which it rests were no longer in use, albeit the problems persist.
14. For an example of a book of Foucault's in which such ethical judgments are evident, see Foucault (1961/1988).
15. Facticity is what might be described as the "givenness" of things, what is "already there." For an elaboration on this existential concept, see Sartre (1943/1956).
16. Labeling theorists were a tour de force in the 1960s and 1970s and to this day profoundly influence current sociological accounts of institutions like psychiatry and prisons. They hold that designations like "not normal" are attributes projected onto people, often at the behest of and in the hands of experts—not something inherent in the person per se. For a particularly helpful account of labeling theory, see Becker (1963).
17. Having obtained permission to unchain the "lunatics" at Becêtre and Salpêtrière, French psychiatrist Phillipe Pinel proceeded to "liberate" several male patients only—an act now seen as the freeing of "the mental patients" and emblematic of psychiatry's liberatory nature. For a critique of this depiction, see Chapter Two. For an example of a leading male theorist not "noticing" that something inherently gender-specific was happening, see Foucault (1961/1988).

2 The Evolution of "Madness": A Journey "through Time," Part One

1. For further details, including the selling and buying of the rights to control the property of the insane, see Kittrie (1971) and Penfold and Walker (1983).
2. Once again, physical treatment is being used to address imbalances that cannot be detected. For a detailed discussion of the claims of neurotransmitter imbalance, see Chapters Three and Seven.
3. For later understandings of hysteria and for other "female maladies," continue reading this chapter. See also Showalter (1987).
4. For details, see Southworth (1998).
5. Bridewells were houses of correction for "minor offences"—a response to the widespread poverty caused by social restructuring. For details, see Kittrie (1971), MacDonald (1981), Conrad and Schneider (1980), and Southworth (1998).
6. In testifying *against* the women, it should be noted, the doctors likewise rid themselves of competitors (for a discussion of this other side of the equation, see Mies, 1999). The point is, opposite though the positions were on the face of it, such were their constructions that whichever one doctors took, they were increasing their own power.
7. For Pinel's account, see Pinel (1801/1962).
8. Following tradition, both Whitaker (2002) and Foucault (1963/1973), it should be noted, begin here. While Foucault focuses on major problems with moral management, Whitaker, by contrast, tends to theorize moral management as the ideal.
9. For these and related details, see Hunter and MacAlpine (1963).
10. I include Foucault here because his critique is important. A cautionary note, nonetheless: In what is at best sloppy scholarship, he quotes Samuel Tuke's famous statement about fear out of context such that Tuke appears to be asserting *the very position that he is opposing* (see Foucault, 1961/1988, p. 245).
11. For these and other details on Conolly, see Showalter (1987).

12. For highly informed commentary on the Virchow criterion and its significance, see Ackerknecht (1953) and Szasz (1976/1988).
13. "Dysaesthesia Aethiopis," it is significant, was "identified" as overwhelmingly contracted by "free Negroes"—that is, Blacks who had no benevolent white master to care for them. The implicit message is—emancipation is to be avoided at all costs. For further analysis, see Szasz (1987, p. 307 ff.).
14. "Psychiatry" or "psychiatrie" is a German word coined by Reil in 1808. For more details, see Szasz (2007/2010, p. 90).
15. For details on the matrons, see Showalter (1987, p. 55 ff.).
16. For details on these "diseases" overall, see Showalter (1987). For the eventual "discovery" of "male hysteria," see p. 167 ff.
17. For Kraepelin's articulation of schizophrenia and his classification more generally, the reader is directed to Kraepelin (1907); for Bleuler's articulation, see Bleuler (1911/1950). For Szasz's highly insightful account of the introduction of "schizophrenia," see Szasz (1976/1988).
18. The "fly in the ointment" of course—and psychiatry tends to ignore this—is that they would not then be "mental" illnesses. For further discussion, see Chapter Six.
19. For these activities, see Chapters Three–Eight.

3 Modernity (1890–2014): A Journey through Time, Part Two

1. See Freud (1953/1974). I am highlighting only Freudian psychoanalysis here, I would clarify, because it was the only institutionally dominant form of psychoanalysis.
2. It is somewhat arbitrary, note, to distinguish between psychiatric research that is eugenic and other psychiatric research of a biological nature, for as Maudsley exemplifies, there is no clear differences in the explicitly *biological* claims per se—only in the social claims. Correspondingly, while not all biologically oriented psychiatric research is intended to support a eugenics vision, all lends itself to eugenics.
3. Actually, no other high courts ever ruled on this.
4. To clarify, *negative* eugenics (eradication of the "undesirable") was contrasted with *positive* eugenics (raising the birthrate of "Aryans"). For overviews of both, see Hillel and Henry (1976), Lifton (1986), Friedlander (1997), and Proctor (1988).
5. The IQ test was used to identify "candidates for sterilization." Today, psychologists continue to administer these, and other such tests, have made a business of "testing."
6. For a particularly good critique, see Whitaker (2002, p. 73 ff.).
7. Far from correcting this mistake in later years, the Nobel Foundation compounded the injury by justifying it—see Szasz (2007/2010, p. 163).
8. For a detailed account of Rosemary's story, see Szasz (2007/2010, p. 152 ff.).
9. The wife in question is Velma Orlikow, partner of David Orlikow.
10. For this and other details on Paracelsus, see MacDonald (1981, p. 188 ff.).
11. While the early 1950s marks the beginning of the massive use of psychiatric drugs, to be clear, there were a number of earlier psychiatric drugs, many of which remained in use (e.g., lithium and the barbiturates). For details, see Breggin (1991a) and (1983), Whitaker (2002), and Szasz (2007/2010).
12. Phenothiazines were compounds in use in the 1930s as an insecticide, also as an animal tranquilizer. For details, see Breggin (1991a).
13. Dyskinesias are disorders involving involuntary movements. "Hyperkinesia" refers to an increase in muscular activity culminating in an increase in "abnormal" movements. "Parkinsonianism" is a category of neurological disorders characterized by involuntary movement and slowness of movement. For further clarification, see Breggin (1991a).

14. The three prominent dopamine pathways are the nigrostriatal, the mesolimbic, and the mesocortical systems. For clarification and details, see Chapter Seven.
15. Referencing of specific DSMs in this book will be by their edition number, as this is the customary way to reference them. For DSM-I, DSM-II, DSM-III, DSM-III-R, DSM-IV, DSM-IV-TR, and DSM-5, see, respectively, American Psychiatric Association (1952), (1968), (1980a), (1987), (1994), (2000), and (2013).
16. Inter-rater reliability is the degree of agreement between professional diagnosticians. If, say, different psychiatrists tended to give the same person the same diagnosis, this would be an instance of high inter-rater reliability. The argument that the biological psychiatrists were advancing is that the "badly constructed diagnoses" in DSM-I and DSM-II (i.e., the *psychoanalytic* constructions) were responsible for the low inter-rater reliability in the industry. For more on this issue, the reader is referred to the next chapter.
17. For the Fink quotation, see Breggin (1991a, p. 360). For other details on the above, see Whitaker (2010).
18. For details, see Chapter Four. For accounts by others, together with extensive substantiating references, see Kirk and Kutchins (1997) and (1994) and Horwitz (2002).

4 Probing the Boss Text: The DSM—What? Whither? How? Which?

1. There is reason to believe that the trend in question will not only continue but escalate. Note, in this regard, the following statement (no longer available), which was posted on DSM website when DSM-5 was still in process:

   > Roman numerals have been attached to the DSM since the second edition of the manual . . . But in the 21st century, when technology allows immediate electronic dissemination of information worldwide, Roman numbers are . . . limiting . . . Future changes prior to the manual's next complete revision will be signified as DSM-5.1, DSM-5.2 and so on. (http://www.dsm5.org/about/Pages/faq.aspx)

   I would add at this juncture, I will occasionally have reason to refer to the DSM-5 website *as it appeared at a specific point during the development of the* DSM-5. In those few instances where the document or words in question have been removed from the site and are longer locatable, I will be noting this fact directly in the text.
2. For details on the Osheroff case, see Kirk and Kutchins (1992); for Rosenhan's detailed accounts of his own experiments, see Rosenhan (1973).
3. For details, see Spitzer and Fleiss (1974) and Kirk and Kutchins (1992, p. 56 ff.).
4. I am in no way denying there are people with problems in living that, say, "hear voices." Nor am I suggesting that the concept "car," like everything else, is not on some level a social construct—only that it is one with a comparatively clear referent and with criteria that are not subjective and arbitrary.
5. The primary other disorders were "paraphilic rapism" (as in the rapist could not help it) and "perilutial phase dysphoric disorder" (essentially PMS). For details on these proposals and their reception, see Kirk and Kutchins (1997).
6. Such material was not deemed relevant under Spitzer's stewardship either. For further details, see Caplan (1995).
7. At the time when these disclosure reports were available on the DSM-5 website—and they have since been removed—I printed them out; and I have retained copies. Anyone who wishes to check my figures or to do a more detailed conflict of interest analysis should be able to obtain these individualized reports through Freedom of Information.
8. Spitzer himself, it should be noted, has climbed on what might be called the "evolutionary dysfunction bandwagon" to the point of clearly stating that "he [Wakefield] was right and I was wrong." For further details, see Spitzer (1999, pp. 430–431).

9. Aside from the obvious dangers inherent in psychiatry's yet again summoning up theories of evolution—and to be clear, those are only too real—what makes the popularity of this definition unfortunate is that once again psychiatry is grounding itself in what is *not known*, what it simply *trusts that science will establish*.
10. For a particularly good book on the cultural hegemony of the DSM and the harm done by "the globalization of the American psyche," see Watters (2010).
11. It bears mentioning that the Gutheil article was published not just in *any* refereed journal, but in the *American Journal of Psychiatry*—the official journal of the APA, which in turn is responsible for the DSM.
12. For the full set of criteria—and I have abbreviated here and indeed left out F and G—see DSM-5 (pp. 271–274).
13. To a degree, there is a misfit with community trauma more generally. See in this regard Erikson (1995) and Burstow (2005).
14. The veterans, significantly, never wanted *any* "symptoms" listed. For these and other details, see Kirk and Kutchins (1997).

5 The Beast/In the Belly of the Beast: Pinioned by Paper

1. For further details on the process, including revelations that have come to light in the course of legal proceedings, see Breggin (2001a and b). See also Chapter Seven.
2. For the actual legislation, together with amendments and expert commentary, the reader is referred to Hiltz and Szigeti (2011). For repeated reference to "incapable persons," see both acts, and, in addition, the Substitute Decisions Act 1992 (S.O. 1992, c. 30), which is likewise replicated and explicated in Hiltz and Szigeti.
3. No definition of "voluntary patient" is given in the act, albeit the courts have decided that someone can be voluntary if they made a "capable decision" to consent to voluntary status. For further discussion of capacity, see the Health Care Consent Act and continue reading this chapter. For a discussion of this point more specifically, see Hiltz and Szigeti (2011, p. 294).
4. Claiming more has the added advantage of reducing the possibility that an involuntary admission decision will be struck down. Use of Box B, moreover, accomplishes the additional job of declaring the "patient" "incapable." For further discussion of "capacity," continue reading this chapter.
5. This amendment was introduced as part of the backlash discussed in Chapter Three, and it was part of a more general backlash that swept the world. For details on how the Ontario backlash played out, see Fabris (2011).
6. The Starson case is a ruling to the contrary. For details, continue reading this chapter.
7. A person may appoint someone else to make decisions for them in the event they are declared incapable. This notwithstanding, while the substitute decision-maker is supposed to respect prior capable wishes, significantly, the relevant wishes may be unknown. Moreover, the substitute decision-maker may appeal to the Consent and Capacity Board for permission to render decisions contrary to what the person wanted when "capable." For these and related issues, see Hiltz and Szigeti (2011).
8. For ideas how such crises might be more meaningfully approached, see Chapter Nine.
9. The emergency ward that forms the prototype for this description is in a large Ontario hospital, whose spaces and forms I additionally had an opportunity to study.
10. Fabris's compelling book (2011), significantly, is largely based on this concept.
11. For a discussion of the ever increasing drugging of children, see Chapters One, Three, Seven, and Nine.
12. Additional types of leave include very temporary "leaves of absence" and absence without leave. For further information, see Hiltz and Szigeti (2011, p. 305 ff.).

13. According to Frado (interview), where people are not closely connected with family, they are *less likely* to be on CTOs. I say this not to blame family members, but to begin to raise the problems and dilemmas faced by families. We ignore to our detriment the plight in which families find themselves, and how readily in the absence of real support, family themselves become victimizers—and victims.
14. For details on administrative tribunals generally and the CCB in particular, see Hiltz and Szigeti (2011).
15. These figures were created in accordance with these specifications: Only those who proceeded with the hearing were counted, with the CCB's global figures broken down into "incapacity with respect to treatment" on one hand and "involuntary status" on the other. My gratitude to CCB registrar Lorissa Sciarra for agreeing to pull figures from the data bank according to these specifications.
16. For a detailed discussion of legitimation, delegitimation, decontextualization, and recontextualization, see critical discourse analyst Norman Fairclough (2001).
17. This book (Arendt, 1963) philosophizes the Eichmann trial, probing the circumstances in which normal people do terrible things, while viewing their own actions as everyday matter-of-fact events.

6 The Psychiatric Team

1. In this regard, see HCCA., s. 1.
2. The Cochrane data base is a data base of what is called "evidence-based medicine." See, in this regard, The Cochrane Collaboration (n.d.).
3. Why I have included "longitudinal" here is that despite what is gained by prioritizing randomness, in so prioritizing it, a high percentage of longitudinal studies necessarily will not qualify. For details on the criteria used in the Cochrane Collection, the reader is referred to the website cited in note 2.
4. Significantly, I have asked several hospital psychiatrists why they never expose the hospital on those occasions when it demonstrably and seriously breaks the law. The most common answer is they risk losing their privileges.
5. Over the past few decades, various jurisdictions have authorized psychologists with the requisite training in pharmacology to prescribe. In North America, the first such jurisdiction was Hawaii and dates back to 1985. At this point, many states in the United States and some Canadian provinces have followed. For details, see Anonymous (2012).
6. See, for example, Wu et al. (2012), whose study suggests a degree of unease, even while approving of hospital measures.
7. For this claim by psychiatry, see, for example, Cowen, Harrison, and Burns (2012).
8. For details on efficiency measures and their impact, see Adam (2011 and 2014).

7 Marching to "Pharmageddon": Psychopharmacy Unmasked

* "Pharmageddon" is in quotation marks because it is part of the title of Healy's groundbreaking book on the drug approval process. See Healy (2012).

1. To clarify, pharmaceutical substances may be employed by doctors for purposes and populations other than those for which they were approved and indeed, they commonly are. Without such approval, however, the pharmaceutical company is prohibited from advertising the drug for that purpose.
2. Contrast drugs enter into the design insofar as the company is attempting to show the drug in question is more effective or has fewer adverse effects than comparable drugs

on the market. For example, the trials of the atypical neuroleptics often employ Haldol (typical neuroleptic) as a comparison drug.

3. With reports of suicides skyrocketing, FDA eventually required a warning about suicide to be placed on all antidepressants labels. For details, see Breggin (2008a).
4. This is one of a number of in-house memos found in discovery, which point to drug company manipulations and the disregard even of protests from within the ranks. For this quotation and a detailed discussion of the circumstances surrounding it, see Breggin (2008b, p. 388 ff.). More generally, for worrisome memos found in discovery, the reader is referred to Psychiatric Drug Facts (n.d.).
5. Note, while all regulatory agencies are inherently problematic—not equally. The contrasting responses to the SSRI scandal is illustrative: While the United States and Canada continued to allow the use of SSRIs with children, with the exception of one SSRI, Britain totally banned the practice. For an interesting account of these very different determinations, see Breggin (2001a and 2008b).
6. For substantiation and details, see Healy (2012) and Breggin (2001a, 2008a and b).
7. To be clear, again I am employing words like "normal" and "deficiency" in a functional sense only; I am in no way implying superiority or inferiority.
8. For details on these pathways, see Whitaker (2002, p. 162 ff.) and Colbert (2001, p. 53 ff.).
9. The word "selective" in "selective serotonin reuptake inhibitors" is misleading, for more than one area and inevitably, more than one type of neurotransmitter is affected. For details, see Whitaker (2010).
10. For a particularly revealing study of the compensatory actions, the quickness with which they set in, the brain abnormalities that result, and the concomitant dangers posed, see Wegerer et al. (1999); see also Breggin (2001a and 2008b).
11. I am drawing on Ashley's testimony, to be clear, because it is evocative. That said, it should be acknowledged that while Ashley specifies that he was on an antidepressant, it is not clear from the transcript which type.
12. Above are examples from a larger list compiled by Wood (2013a and b).
13. For good or for ill—and I suspect that it is both—this quality of the antidepressants has been recognized in courts of law, as has the defense "intoxication anosognosia." For details, see Breggin (2008a and b).
14. The stunting of growth is dramatic. While the industry has tried to discount it by attributing it to the "disorder," a study by Swanson et al. (2007) compares children labeled ADHD who are on stimulants with children so labeled who are not on stimulants, and it establishes that the impeded growth can only be attributed to the stimulant.
15. Schools have become an extension of the psychiatric system, moreover, a major entry point in its own right. In this regard, teachers have lists of symptoms (read tick box items) by which they "identify" students who might "have ADHD." Schools pressure parents to allow their children to be "tested" for ADHD (more tick box forms). And where parents refuse to go along, they have reported the parents to authorities, often resulting in the removal of the children from the home (for a detailed account of this alarming development, see Baughman and Hovey, 2006).
16. For details on these various shootings, I would refer you to the various Wikipedia accounts, which can readily be found on the Internet. I am indebted additionally to Breggin (2000a, 2001b, 2008a) and to the research of Wood (2013a and b).
17. For particularly cogent accounts of the mood stabilizers and the anti-anxiety pharmaceuticals, see Whitaker (2010) and Breggin (2008b).
18. I am using the term "grounded" here much like the original grounded theory theorists (see Glaser and Strauss, 1967) use it. The point being made is that the paradigm which follows is "grounded" in what we actually know.

19. This list was assembled by combing through the Kevin James documents (for details, see Chapter One).
20. To be clear, I am referring to their use in "mental health" only. If they have a legitimate use in a different area, that is a separate question. Also, I am in no way recommending that people who have been rendered dependent on these substances be denied access. Bottom line: We have landed people in these impossible positions, and we cannot leave them stranded. Nor am I suggesting more generally that such product removed from the market—only that their prescription by doctors and their claim to being medical come to an end.

8 Electroshock: Not a "Healing" Option

1. For verification, see Enns, Reiss, and Chan (2010), Abrams (2002), Electroconvulsive Therapy Review Committee (1985), Breggin (2008b, 1991a, 1979), and Van Daalen-Smith (2011).
2. For highly divergent accounts of the upsurge in ECT, see Breggin (2008b) and Shorter and Healy (2007).
3. I wrote to the FDA asking for clarification of their next step. I received no reply.
4. A variety of other studies were likewise identically misrepresented in both, with the representation of the animal studies especially problematic. For the reports per se, see American Psychiatric Association (1990) and Food and Drug Administration (1990).
5. Regulators tend to be frighteningly lax when it comes to monitoring ECT machines, admittedly, not equally. Regulators in Germany have been known to disallow specific ECT machines; see Andre (2009) and Breggin (2008b).
6. For verification and details on the various conflicts, also on the invisibilizing of conflicts of interest, see Andre (2009) and Breggin (2008b) and (1991b).
7. *One Flew Over the Cuckoo's Nest* is a 1975 film based on a novel of the same name (see Kesey, 1962). The hero McMurphy is shown undergoing shock. The film is blamed for giving ECT a bad image precisely because the central character is seen experiencing ECT without anaesthetic and grimacing. While, indeed, this was unmodified shock, and while, admittedly, the few-second clip of McMurphy undergoing shock is distressing, ironically, the movie significantly *understates* the problem. McMurphy, note, is alert and joking as he emerges from the "treatments." Contrast this with the reality of extreme confusion and disorientation.
8. "Gliosis" refers to a change in the glial cells in response to central nervous system damage. "Edema" refers to swelling.
9. Clarification: "CA" refers to a series of areas called "Comu Ammonis" that make up the hippocampus proper.
10. I am specifying that Connie was not in terrible shape only so that you can better appreciate the degree of damage. I am no way implying that damaging the brains of people floundering is an iota more acceptable.
11. ECT, it should be noted, is also imposed on people—frequently a husband signing for his "incapable" wife, a legal body authorizing it, a parent signing for a child (for details, see Jones and Baldwin, 1996; Warren, 1988; and Burstow, 2006).

9 Dusting Ourselves Off and Starting Anew

1. "AIS" was a Local Initiative Project (a subset of youth projects) in Canada in the 1970s (for a discussion of the Local Initiative Projects, see Jackson, 2000). While it operated out of Queen St. Mental Health Centre, its employees were not hospital employees and

not accountable to either the hospital or the ministry. As such, the staff were free to "hang out" with "patients," to take them to movies, just to listen—hence the high "success rate." Now it might be argued that the success is attributable to the amount of time spent with people, not the nature of what is offered. While that is no doubt partially the case, that reality in itself speaks volumes about what is needed and what is not.

2. For anyone unfamiliar with this allusion, it was once standard practice for coal miners to bring canaries into the mine shaft. If dangerous gases were present, being sensitive to them, the canaries would quickly die, at which point, the miners would speedily evacuate. For details, see Canaries in a Coal Mine (n.d.).
3. For a particularly useful discussion of the larger societal significance of what has come about on the Internet, see Hardt and Negri (2004).
4. An example: Facing the devastation that naturally attended Hurricane Katrina is one type of problem. A problem of a different dimension exists if in the midst of this natural disaster, you are afforded skimpy service because you inhabit a poor black district.
5. It should be acknowledged that there are very different versions of the Parsifal legend See, in this regard, see Sir Percival's Worthy Approach (n.d.). For an account very similar to mine, see Macy and Johnstone (2012).
6. Albeit an investigation into this dimension is beyond the scope of this book, a parallel claim, of course, may be made with reference to our relationships with nonhuman animals.
7. I am referring to our predisposition to be afraid of large strong men who are "acting strange"—something that can be patently unfair to the men. That stated, it is clear that women have been given reason to fear men, especially ones whose actions they cannot interpret (or can interpret only too well) and ones who could readily overpower them.
8. One of the sticking points in the impasse between Frankie and his community is that others did not believe the story about the voices. My position? I don't know what is in someone else's head and wouldn't presume to. More importantly, in the short run anyway, the question itself is something of a "red herring." Frankie is responsible for his actions either way. Moreover, if he makes up a false story about the voices, that is itself a further indication of how very desperate the man is, how in need of understanding.
9. A important distinction: While Cora superficially resembles the person who habitually rushes into the middle of traffic because he thinks he is Christ (ergo, indestructible), there is a critical difference. What we are dealing with in the second instance is a belief system that may, if we could but understand it, serve the person tolerably well, and as such, interference is objectionable. To be clear, we would of course look for openings by which we might influence his actions, but it would be wrong to physically prevent him so proceeding. By contrast, it is not a belief system that is at issue with Cora but the much needed ability to hold onto a connection.
10. In this regard, CMHA are key players, even overseeing such intrusive instruments as community treatment orders. For confirmation, see, for example, Canadian Mental Health Association Toronto (n.d).
11. For detailed commentary on these questions/guidelines, see Burstow (2014).

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