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The Politics of Psychiatric Experience

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The Politics of Psychiatric Experience

A Thesis Presented

by

SHUKO TAMAO

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ABSTRACT

THT POLITICS OF PSYCHIATRIC EXPERIENCE

MAY 2014

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This paper examines the correspondence, manuscripts, and speeches of ex-mental patient activists. I obtained much of this material through original archival research. I chronicle the activities of the emergent psychiatric survivors movement in the early 1970's focusing on the work of the Boston based activist, Judi Chamberlin (1944-2010). This paper examines how mental patients in post-war America, specifically between the 1950's and 1980's, began to organize in order to have their voices included in the process of their own recovery. It also looks at how the successes of this social movement ironically led to the prevalence of today's diagnostic models of treatment that rely heavily on pharmacological methods and highly regimented evidence-based psychotherapies while still excluding patients' voices. The voices of mental patients both in the asylum era and today have been excluded from the treatment process.

The first section of the paper illustrates how patient resentment towards psychiatry emerged in post-war asylums. In doing so, I first examine the conditions in post-war American asylums. What were everyday interactions between doctors, workers, and patients like? I focus on Judi Chamberlin's experience as a mental patient in 1966. In addition, I argue how the social dimensions of diagnoses influenced the daily lives of ex-

patients through the rise of psychiatric social workers in the early twentieth century to show how the asylum system was not only a medical institution but a complex system where social, economic, and political interests intersected.

The second section chronicles the emergence of advocacy groups in the early 1970's and their achievement in voicing their experience of treatment, culminating in testimonies before a Senate Subcommittee in 1975. To what extent did the public accept the patient experience in the asylum as a legitimate concern? I also pay attention to interdisciplinary scholarly analyses of madness to investigate how discussion of the subject influenced ex-patient activists, as well as whether or not the ex-patients' narrative reciprocally influenced the scholarly discussion about madness.

The third and final section examines how the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published in 1980 once more discredited the ex-patients' narratives by enforcing a symptomatological mindset on treatment, effectively turning the narrative of people's experience into an insignificant factor in the process of treatment, creating functionalistic therapeutic environments where the science of adjustment-maladjustment decided the direction of patients, urging them to adapt to oftentimes oppressive environments.

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Chapter 1

THE SUBJECTIVE EXPERIENCE OF HOSPITALIZATION

Introduction

No, anger is not ‘nice,’ but it’s real, it comes from the gut, and not to be angry at being shit upon is being dead – which is exactly what shrinks and their kind want us all to become. That’s why they lock us up, drug us, cut into our brains with electricity and with knives if they possibly can – because our anger is POWER, and THEY ARE AFRAID OF US. And anyone who is not angry at what they do to us is as much as our enemy as the shrinks themselves.

But anger is exhausting, and being put down for our anger is destructive. What we need is to be able to turn to one another for strength, for support, for understanding. There is a group in Boston called Mental Patients’ Liberation Front that does this.

—Judi Chamberlin¹

For a brief period in the 1970s, ex-patients in the psychiatric survivors movement reclaimed their collective voice, telling the public about the experiences of forced drugging, shock treatment, and seclusion that the psychiatric system had subjected them to. In the above quote, Judi Chamberlin, an activist for the Mental Patients Liberation Front (MPLF), expressed frustration to her ex-patient colleague about how well-meaning but controlling mental health professionals were unintentionally trying to de-legitimize the ex-patients’ emotions and deny their voice during the third annual human rights and psychiatric oppression conference in 1975. She thought that the conference did not reflect a feeling of constructive anger from the ex-patients due to the presence of the professionals there. While acknowledging that uncontrolled anger is not constructive, she argued that patient anger was a legitimate expression since it resulted from the inhumane,

¹ [Judi Chamberlin, A 1975 letter to Tom, Conference on Human Rights and Psychiatric Oppression, Third]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

degrading treatment that they received during hospitalization. She believed this anger could be a driving factor for change. During the era, patient advocacy groups fought on behalf of mental patients' human rights. In order to achieve some degree of self-determination over their lives, organizers like Chamberlin worked against involuntary commitment and in favor of informed choice in treatment as well as on behalf of patient-run alternatives. The movement's goals included having their experiences both heard and believed while receiving acknowledgement of their human rights from the wider society.

An enormous problem facing patients was that they were considered unreliable and their accounts were therefore discredited precisely because they had had treatment. The public dismissed patients as "crazy" just because they had previously been hospitalized. Furthermore, the ex-patients argued that the psychiatric system denied the legitimacy of their narrative. Ex-patients wanted to have their experiences heard and believed by the wider society and to receive affirmation of their human rights. By reclaiming their voice, they were able to win back a degree of self-determination that the psychiatric system had previously taken away. Influential ex-patient organizers worked against involuntary commitment and in favor of informed choice in treatment and patient-run alternatives.

Why was it important for ex-patients to reclaim their voice? The patients believed that loss of voice meant loss of power, and that, consequently, this loss of power had enabled abuse to occur. Therefore ex-patients saw their collective voice both as the most effective weapon for destabilizing the inhuman system that had abused them and as the foundation for establishing a more humane patient-run alternative approach. They believed the alternative system would in turn allow them to challenge their diagnoses and

reclaim their dignity in the wider society. In spite of their efforts, the process of delegitimizing the patients' experiential narratives continues today in the age of de-institutionalization where pharmacological treatments associated with the *Diagnostic and Statistical Manual of Mental Disorders* are in widespread use.

The Asylum, 1960's Style

Angry at your shrink? Resisting therapy.
Like your doctor? Positive transference.
Nurses piss you off? You're hostile.
Cut your wrists? Acting-out again.
Not hungry? Could be anorexia.
Listening to the summer birds sing? Hope she's not going to catatonic!
Can't stand Bingo? Antisocial.
Won't be intimidated? Dissociative reaction.
Make a joke your doctor can't understand? Thought processes disturbed.
Think no one takes you seriously and they're condemning you to a life as a social outcast? Paranoid and more paranoid!
We Only Want to Help You—It rings like an ironic anthem of despair, over and over, in your ears and head, until you choke and gasp from the help and scream, "Okay. You win. I've no more heart to fight."

—Janet Gotkin²

In this section, I chronicle ex-patient activists Judi Chamberlin and her long-term activist partner, Ted Chabasinski's experiences during hospitalization to explain how life at an asylum--or "total institution" as Erving Goffman called it--meant that a patient's voice was discredited as a symptom of their disease. Chamberlin argued that the severe depression that led to her involuntary commitment in psychiatric hospitals in the late 1960's came from the pressure to adapt herself to society's idealized image of how women should be. Through the process of voicing her subjective experience of treatment, Chamberlin revealed how the scientific explanation of mental illness caused by a

² Janet Gotkin and Paul Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry* (New York: Harper Collins, 1992), 103.

chemical imbalance in the brain negated the presence of the underlying social structure as a source of her distress. Embodied in the psychiatric system, society was what suppressed one's will to be an emotional human being, inadvertently pressuring her to adapt to an oftentimes oppressive environment which coaxed her to take excessive doses of antipsychotics. I present Chamberlin's experience as a mental patient as being representative of the "rootlessness" that many post-war women experienced. Chamberlin's work as an ex-patient activist presented one aspect of the overall struggle on the part of mental patients to claim their place in a wider society.

After a miscarriage at the age of twenty-one, Chamberlin experienced severe depression. A psychiatrist prescribed Thorazine and Stelazine after her first outpatient visit. After a few months with no improvement, the psychiatrist suggested she should be hospitalized. Like many white middle-class American women during the Cold War era who eagerly sought psychiatric or psychological help in order to adapt to their assigned role in society, Chamberlin never questioned that psychiatry would free her from her distress.³ She first committed herself to a psychiatric hospital on a voluntary basis in 1966 and was eventually committed to six different psychiatric hospitals in New York. Her commitment to Rockland State Hospital was on an involuntary basis. After seven months, this experience with the psychiatric system left her with a diagnosis of chronic schizophrenia that required life-long custodial care.⁴

The social consequence of her diagnosis came four years later after a series of hospitalizations. After a divorce, Chamberlin lost custody of her only daughter on the

³ Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era* (Basic Books, 1988), 167.

⁴ Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (Lawrence: National Empowerment Center, 1977), 39, 55.

grounds that she was “too mentally ill to be a fit mother.”⁵ Based on her medical records the court ruled that: “The mother has a long history of mental illness of depression, suicidal and homicidal feelings and has been confined to four hospital [sic] for treatment of psychiatric conditions. Her behavior is not that of a stable person to bring up a child.”⁶ The document further mentioned her relationship with Ted Chabasinski, a Berkeley based activist/ attorney who is an ex-husband and long time friend of Chamberlin: “The mother has been divorced twice and is now married to her third husband, a former mental patient at Rockland State with a history of dementia praecox and inability to get along with people. The court observed him and considered him bland.”⁷

The influence of a diagnosis was not confined to the medical sphere; the diagnosis controlled the patient’s everyday life ranging from daily routine to crucial life choices, bolstering the socially constructed notion of disability.⁸ Patients who became dependent on the psychiatric system felt the social consequences of their diagnoses were so stigmatizing that many hid their experience in order to try to “pass” themselves as people who had never been treated for mental illness. Ted Chabasinski recalls how he used to “cover up” his psychiatric history to gain employment: “When I was younger and looking for jobs, applications routinely had questions like ‘Have you ever been treated for mental

⁵ [Testimony of Judi Chamberlin at the U.S. Senate Subcommittee to Investigate Juvenile Delinquency Series2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

⁶[Family Court of the State of New York City of New York: County of Kings, *Judi Chabasinski, petitioner, For Determination of Custody of Julie Ross Chamberlin, An Infant, against Robert H. Chamberlin, Respondent*]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

⁷ Ibid.

⁸ Derby Penney, Interview with Judi Chamberlin, www.community-consortium.org/projects/chamberlin-judy.pdf, 39.

illness?’ Of course I said no, and there was no way for them to check.”⁹ The ex-patients said “no” because the consequence of revealing one’s diagnosis was a social death sentence. Even though Chamberlin’s psychiatric history ended four years before the court ruling, the social stigma of the diagnosis deemed that she was unfit to be a mother for the rest of her life.

In 1966, sociologist Thomas Scheff examined mental illness from a sociological aspect, arguing that “deviants” who broke social rules were labeled as mentally ill. While arrest records between 1945 and 1948 obtained from mental hospitals in New York showed that the crime rate was “much lower” among former mental patients than the rest of the population, viewers of television and readers of newspapers associated violent crime with former mental patients because of biased coverage by the media. An unwarranted association between violence and mental illness stole into readers’ everyday colloquial conversations and permeating popular imagery of mental illness and its symptoms.¹⁰ This connotation suggests the “incurability of mental disorder; that is, it connects *former* mental patients with violent and unpredictable acts.”¹¹ No matter how much mental health campaigns advocated for the rights of mental patients, the stereotypical visual imagery would label them as an “incurable deviants,” who “belong to a fundamentally different class of human beings or perhaps even a different species.”¹²

The stereotype of a mental patient as someone belonging to a different species could trace its root to the late nineteenth century. Influenced by the Darwinian theory of

⁹ Ted Chabasinski, “Our Backs Are Against the Wall, so There’s No Way to Go But Forward,” *Mad in America*, accessed November 28, 2013, <http://www.madinamerica.com/2013/10/back-wall-theres-way-go-forward/>.

¹⁰ Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory* (New York: Aldine Publishing Company, 1984), 58.

¹¹ *Ibid.*, 63.

¹² *Ibid.*, 61.

evolution, a German psychiatrist Emil Kraepelin saw his patients as if they were passive carriers of symptoms. By popularizing the diagnosis of *dementia praecox*, a precursor of schizophrenia, he instilled the notion that mental patients were “immoral, perverts, psychopaths, almost a species apart.”¹³ Since he deemed that dementia praecox patients were a species born apart from human beings, there was nothing to bring the patients “back” to the rest of humanity.

Because of the stigmatization of mental patients as a non-human, ex-patients faced discrimination in returning to their former social status or even trying to find a new social position through employment or getting married. Some ex-patients hid their medical history in obtaining employment, thus indicating that the discrimination they experienced was largely due to such a stigmatized image of being violent and unpredictable rather than their behavior during a job interview.¹⁴

In the late 70’s, the debate about the social construction of mental illness was widely argued by social theorists and ex-patients. In the early years of the psychiatric survivors movement, many activists rejected the medical model based explanation of mental illness. Instead, they argued that the notion of mental illness was a socially embedded concept. For them, the extreme emotional states they experienced were a spiritual transformation or a natural reaction to an extremely stressful condition often posed by an oppressive environment.¹⁵ To support their arguments, scholars argued how the notion of mental illness could be contingent upon the specifics of the social structure in which a patient was placed. Language like “wards of the state” reflected the

¹³ Roy Porter, *Madness: A Brief History* (Oxford: Oxford UP, 2002), 184-185.

¹⁴ Scheff, *Being Mentally Ill: A Sociological Theory.*, 66.

¹⁵ Fred Pelka, *What We Have Done: An Oral History of the Disability Rights Movement* (Amherst: U of Massachusetts P, 2012), 283.

institutionalized nature of psychiatry. Embedded in everyday assumptions, people casually made a connection between mental patients and their dependency on state sanctioned social service agencies.¹⁶ Like children under the tutelage of guardians, mental patients' voices were not considered credible; their anger and humiliation were largely dismissed as "symptoms" even though these feelings came from shock therapy and other inhumane treatment they received in asylums. Non-patients regarded the presence of such emotions as meaning that patients were paranoid and/ or had abnormally erratic feelings.

To observe the social world of mental patients, sociologist Erving Goffman carried out fieldwork at St. Elizabeth's Hospital in Washington, D.C. between 1955 and 1956. Based on this study, he coined the term a "total institution" where the members of a certain institution must remain in a place of residence within an apparent, either physical or symbolic, boundary for a continuous period of duration. By working at the hospital as a staff worker he captured the viewpoint of "hospital inmates"; he wanted to be as close as possible to their subjective experience.¹⁷ Viewing the asylum as a structured stage where the roles of actors were preconditioned, he observed the social interaction of inmates within the asylum, arguing how the outside society's view of hospital inmates was dominated by the medical based explanation of mental illness. The reasons for starting a "career" as a mental patient in an asylum were contingent upon a variety of environmental factors ranging from the availability of resources to family troubles:

Some of these contingencies in the mental patients' career have been suggested, if not explored, such as socio-economic status, visibility of the offense, proximity to

¹⁶ William H. Sewell JR., *Logics of History: Social Theory and Social Transformation* (Chicago: U of Chicago P, 2005), 356-7.

¹⁷ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), ix.

a mental hospital, amount of treatment facilities available, community regard for the type of treatment given in available hospitals, and so on. For information about other contingencies one must rely on atrocity tales: a psychotic man is tolerated by his wife until she finds herself a boy friend, or by his adult children until they move from a house to an apartment; an alcoholic is sent to a mental hospital because the jail is full, and a drug addict because he declines to avail himself of psychiatric treatment on the outside; a rebellious adolescent haughtier can no longer be managed at home because she now threatens to have an open affair with an unsuitable companion; and so on...

The society's official view is that inmates of mental hospitals are there primarily because they are suffering from mental illness. However, in the degree that the 'mentally ill' outside hospitals numerically approach or surpass those inside hospitals, one could say that mental patients distinctively suffer not from mental illness, but from contingencies.¹⁸

For example, a woman consented to let a social worker examine her husband because the social worker detected "signs of mental disturbance" that might require him to be committed to an asylum. Apparently uneducated, the woman did not acknowledge her husband's early signs of mental illness; she recognized his "crankiness," but she thought it was due to "the way he was made." She only agreed to let the social worker examine her husband because she thought "she would be better off without him." For her, her husband's "incurable laziness" was mere peculiarity, not a sign of mental illness. Sending him to an asylum happened to be one of the ways she could get rid of him.¹⁹

Seventeen year old Jonika Upton was deemed mentally ill by her parents and doctors and was sent to Nazareth Sanatorium in Albuquerque in 1959. She ran away to California with a twenty-five year-old artist boyfriend that her parents assumed to be "homosexual." While she was with the boyfriend, she developed a peculiar speech habit and began carrying "Proust" with her. After receiving electroshock on sixty-two

¹⁸ Ibid., 134-35.

¹⁹ Richmond, *Social Diagnosis*, 67.

occasions, she completely forgot about her boyfriend and stopped carrying Proust. The cure was complete.²⁰

While the hospital inmate's role as a mental patient was delineated by broader social contingencies, the hospital workers also acted upon the role given by "society's official view." Gestures of maladjustment -- incomppliance, rejection, and resistance by hospital inmates to accepting the "institution's view of what and who he is" -- were by and large regarded as symptoms by the mental health workers. Hospital management "may construe this alienative expression as just the sort of symptomatology the institution was established to deal with and as the best kind of evidence that the patient properly belongs where he now finds himself."²¹

When she was first hospitalized, Judi Chamberlin thought that only "crazy" patients went to the seclusion rooms because the people who went there looked as if they were out of control. It seemed illogical that screaming and banging on the door would lead to being released from the room. However, after experiencing the seclusion room, she suddenly felt that kicking and banging the door was a *logical* action:

Although I had seen patients locked into seclusion from time to time, it was not something I thought could ever happen to me. Patients in seclusion were "crazy" – they screamed and banged on the door. Now it was me, and suddenly banging and kicking became logical. I had attempted to be reasonable, to explain myself – and this was what they thought of me. My anger mounted. I was not only a prisoner, I was a caged animal. Suddenly nothing was important except freedom. And freedom lay on the other side of a locked door.²²

²⁰ Robert Whitaker, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (Cambridge, MA: Perseus Publishing, 2002), 100-101.

²¹ *Ibid.*, 306.

²² Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 37.

Goffman explains why Chamberlin had such a primal reaction while she was in the seclusion room with no furnishing and why nurses injected tranquilizers immediately after her reaction:

The more inadequate this equipment is to convey rejection of the hospital, the more the act appears as a psychotic symptom, and the more likely it is that management feels justified in assigning the patient to a bad ward. When a patient finds himself in seclusion, naked and without visible means of expression, he may have to rely on tearing up his mattress, if he can, or writing with feces on the wall – actions management takes to be in keeping with the kind of person who warrants seclusion.²³

Willfully or not, an inmate at a total institution acquires various modes of adaptation to accommodate him or her to the environment. In ordinary circumstances, “playing it cool” or “keeping out of trouble” will suffice to “get by” in a total institution.²⁴ However, when a situation like confinement to a seclusion room comes, no ordinary person can keep his or her cool.

A patient, who refers to herself as “we schizophrenics,” explains how terrifying it is for patients that doctors cannot understand what they are feeling and thinking, and how invalidating it is that doctors do not take patients’ words into account:

Patients laugh and posture when they see through the doctor who says he will help but really won’t or can’t...They try to please the doctor but also confuse him so he won’t go into anything important. When you find people who will really help, you don’t need to distract them. You can act in a normal way.

I can sense if the doctor not only wants to help but also can and will help...

Patients kick and scream and fight when they aren’t sure the doctor can see them. It’s a most terrifying feeling to realize that the doctor can’t understand what you feel and that he’s just going ahead with his own ideas. I would start to feel that I was invisible or maybe not there at all. I had to make an uproar to see if the doctor would respond to me, not just his own ideas.²⁵

²³ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 306-7.

²⁴ *Ibid.*, 64-65.

²⁵ M. L. Hayward and J. E. Taylor, “A Schizophrenic Patient Describes the Action of Intensive Psychotherapy,” *The Psychiatric Quarterly* 30 (1956): 211.

The psychiatrists and workers able to understand the inner world of patients, but they are trained not to take their words into account. The words of mental patients are regarded as beyond the comprehension of non-patients and thus belonging to a terrain of pathological delusions. Radical psychiatrists such as R. D. Laing, whose works influenced some of the ex-patients in the movement, urged his patients to embrace their psychotic experience as a journey to recovery even if such experience belonged to the “‘pathological’ zones of hallucinations, phantasmagoric mirages, delusions.”²⁶ The majority of the mental health professionals regarded the inner experiences of mental patients as illegitimate.²⁷

Nosology dominated the doctor’s decision making – that is: using the patient’s somatic presentation as the basis of diagnosis in order to define insanity. The diagnosis technique was based not on listening to patients’ stories but on looking at their behavior from an objective, almost god-like, bird’s eye perspective. However, Freud, rejecting the idea of “looking” at a patient, developed the knowledge and technique of psychoanalysis to “listen” to the patient’s unconscious.²⁸ While the psychodynamic approach dominated the field in post war psychiatry, a small group of psychiatrists with a conventional biological approach criticized psychoanalysis as “a religion rather than a science.”²⁹ The psychiatrists who opposed the hegemony of the psychodynamic and psychoanalytic approaches formed the Society of Biological Psychiatry in 1946. The members tended to prefer somatic approaches such as electroshock and psychosurgery, as well as neuroleptics in the 1950’s because they deemed psychotherapy as a time-consuming,

²⁶ R. D. Laing, *The Politics of Experience* (New York: Pantheon Book, 1967), 27.

²⁷ *Ibid.*, 167.

²⁸ Sander Gilman, *Seeing the Insane* (New York: John Wiley & Sons, Inc., 1982), 223.

²⁹ Gerald Grob, *From Asylum to Community* (Princeton: Princeton UP, 1991), 293.

labor intensive, and impractical intervention for public asylums which housed thousands of chronically mentally ill people.³⁰ Thus, Freud's discovery was an unwanted offspring for clinical psychiatrists using the biological approach who worked all day with patients with schizophrenia and manic depression. The introduction of shock therapies such as insulin and metrazol shock therapies in pre-war asylums was the psychiatrists' countermeasure against Freud's psychoanalysis theory.³¹

In 1974, British psychiatrists Richard Hunter and Ida Macalpine argued that psychiatry had taken a wrong turn: "Patients are victim of their brain rather than their mind. To reap the rewards of their medical approach, however, means a reorientation of psychiatry, from listening to looking."³² For Roy Porter, the two psychiatrists essentially deemed that "the language of the mentally ill is an irredeemable babble."³³ Not only Psychiatry and also medicine have a long history of relying on visual observation as an objective diagnostic tool. Even King George III's well recorded fantasies during his bout of alleged insanity were regarded as uttering by his doctors.³⁴ His words lost the authority of the King. In front of the doctor's gaze, every patient has "democratically" lost the legitimacy of his/ her inner experience.

Seeing the symptoms and signs of illness was an acquired skill obtained through vigorous medical training. The process of noticing the symptoms and signs by looking at the patients became essential, and somewhat esoteric, medical knowledge for eighteenth

³⁰ Ibid., 292-93.

³¹ Laura Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century* (New Brunswick: Rutgers UP, 2009), 24.

³² Roy Porter, *Madness: A Brief History* (Oxford: Oxford UP, 2002), 156-57.

³³ Ibid., 156.

³⁴ Ibid., 157.

century doctors, Michel Foucault argues. Backed up by institutional support, the European doctors enjoyed an unobstructed, dominating gaze which gave the “power of decision and intervention” over his patients in the hospital.³⁵ It was no coincidence that this medical space embodied the ideal social space the Revolution dreamt of. At the same time, the state also dreamt of medicalized communities where doctors would be organized like a network of clergy.³⁶ This medicalized, penetrating gaze needed to expand beyond the walls of hospitals. The architecture of discipline --prisons and hospitals--encapsulated the ideal, orderly space.³⁷ Once the theory of discipline and control was tested in the form of architecture, town planning could refer to architectural theory. One could argue that Haussmann’s mid-nineteenth century Paris planning was something akin to the creation of the ideal medical and disciplinary space.

When a medical gaze is applied to the human mind, one wonders how psychiatrists can *see* the mind of patients. What constitute the visible symptoms and signs of mental illness? Without even minimally describing the inner experience of a patient, how does a doctor record the “abnormality” of patients? In recording madness, doctors focused on somatic representations of their patients in detecting symptoms and signs of madness. For example, Philippe Pinel, a late eighteenth and an early nineteenth century French physician and a founder of moral therapy, used drawings to combine visual information and explanatory observation for educational purposes.³⁸

³⁵ Michel Foucault, *The Birth of the Clinic* (London: Routledge Classics, 1963), 45,109.

³⁶ *Ibid.*, 35-36, 44.

³⁷ Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books, 1975).

³⁸ Foucault, *The Birth of the Clinic.*, 138-39.

Until Pinel published *A Treatise of Insanity* in 1801, medical illustrations of madness were nonexistent. While illustrations for treatment procedures and visual description of asylum conditions were widely seen, pictures were not used as diagnostic tools. In compiling an educational, illustrated atlas demonstrating the signs and symptoms of mental illness, Pinel and his former student and colleague Jean Etienne Dominique Esquirol paid particular attention to the facial expressions of their patients. Physiognomy -- which gained an association with eugenics theory in the contemporary imagination-- was the first line of the diagnostic process.³⁹ In diagnosing patients with mania and demonomania (a condition where a patient believed he/ she was possessed by evil spirits), Esquirol's graphic atlas paid particular attention to their facial expressions. Because of his attention to this particular detail, "the patient is seen, as in the illustrations, devoid of context. The stark portraiture in the engravings, the absence of any background, the detail of position and mode of treatment (where employed) create an image of the insane as the object of a Linnean study, categorizable by external appearance."⁴⁰ By creating a pure space devoid of any contextual information, patients' symptoms and signs of madness were abstracted from their body and mind and presented as the visual truth of an illustration in an atlas. In the early nineteenth century psychiatry, the facial expressions of the mad were a pure sign of mental illness with nosological distinctions.

With the arrival of psychiatric photography in the mid-nineteenth century, visual nosology of madness gained further acclaim as an objective diagnostic apparatus. With the aid of this new technology, an English psychiatrist Hugh Welch Diamond developed

³⁹ Gilman, *Seeing the Insane*, 73.

⁴⁰ *Ibid.*, 81.

psychiatric photography. Through this photographic gaze, Diamond sought to capture truth, the “parallel between mind and body, between the appearance of the insane and his mental state.”⁴¹ Diamond believed the visual documentation of his patients was superior to recording the spoken words of his patients. By “listening” to what was captured in photographs, the psychiatrists were able to decipher the “silent but telling language of nature.”⁴² With the arrival of photography, the historic order where image was subordinate to text was reversed. Photography meant that words became merely "parasitic on the image" because photography was regarded as a pure replication of the truth.⁴³

Is the gaze a value free mediation between the patient and objective medical truth? Psychiatric photography envisioned that the doctors' gaze was as pure as the doctors' precise and therefore “objective” observation of his patients. However, photography is not a value free enterprise. Esquirol's drawings intentionally framed his patient in a plain background. The same practice is observed in Diamond's photographs. In the blank space, he abstracted the photographed subject from any attached values that might cloud the diagnostic process. Roland Barthes explains how a photograph is believed to be “a mechanical analogue of reality, its first-order message in some sort completely fills its substance and leaves no place for the development of a second-order message.”⁴⁴ However, even the first-order message can be a culturally constructed

⁴¹ Ibid., 164.

⁴² Douglas Nickel, “From the Manor House to the Asylum,” *The Art Institute of Chicago Museum Studies* 31, no. 1 (2005): 66.

⁴³ Roland Barthes, *Image-Music-Text* (New York: Hill and Wang, 1977), 25.

⁴⁴ Ibid., 18.

connotation, Barthes continues. The said realism of photography can be an “elaborate ideological construct and not a transparent window onto reality.”⁴⁵

Once the premise that patients are in an asylum because they are mentally ill is firmly attached to patients, they are expected to play the role given by “society’s official view.” In order to be released from the asylum, patients are expected to navigate through multiple restraints from society, hospital staff, and the patient himself.⁴⁶ Goffman argued that asylum patients are like players on a stage performing the spectacle of mental illness twenty-four hours a day, seven-days a week under the psychiatrists’ gaze. According to this view, doctors and health care workers are spectators who are eager to justify the reason of their existence in a given mental health system. Therefore, any deemed noncompliance by patients may be considered as symptomatic evidence of their pathology. In order to be released from the hospital, the patient has no choice but to accept their new environment and adjust accordingly.

Because her private hospital doctor considered that Judi Chamberlin needed long-term custodial care, she was involuntarily sent to Rockland State Hospital after a series of commitments during 1966. The hospital architecture was intimidating, and the series of locked doors and key-operated elevators blatantly signaled that now she was in a “prison.” The barren, open ward was a nightmarish scene reminiscent of the 1948 movie, *The Snake Pit*. In an austere dayroom with barred windows, clad in shapeless “state clothes”

⁴⁵ Peter Buse, “Polaroid to Digital: Technology, Cultural Form, and the Social Practices of Snapshot Photography,” *Continuum: Journal of Media & Cultural Studies* 24, no. 2 (April 2010):220.

⁴⁶ Erving Goffman, *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates*. (Garden City, N.Y.: Anchor Books, 1961), 386.

with the faded letters “RSH” across the back, Chamberlin was overwhelmed by the idea that she was going to stay there for the rest of her life.

Back in the big, noisy dayroom I sank down on one of the wooden benches, drew up my knees, wrapped my arms around them, lowered my head, and began to cry quietly. A woman sat down beside me and leaned toward me. “Don’t do that,” she whispered. “They’ll think you’re depressed.” The consequences were unknown but ominous. I dried my eyes, straightened up, and looked around for something to do.⁴⁷

Doctors and workers were observing her somatic presentation of mental illness in order to find evidence confirming that she needed long-term custodial care. Chamberlin quickly learned to hide her gestures of distress--what Goffman defines as “secondary adjustment,” --so she could get out of Rockland State Hospital “physically and psychologically undamaged.”⁴⁸ To escape the penetrating gaze of workers and doctors eager to capture any and all signs and symptoms of mental illness, patients quickly learned the subtle tactic of not being seen as mentally ill by hiding their true feelings and emotions.

After dropping out of a prestigious women’s college in New England, Janet Gotkin started her “career” as a mental patient in 1962 following a suicide attempt at her psychiatrist’s office in Manhattan. Janet was sent to Oceanville Hospital in Belville, New York, “a repository of well-to-do misfits.”⁴⁹ In contrast to Judi Chamberlin at Rockland State Hospital who quickly learned not to act like a “depressed” person, Janet learned how to act as a young adult mental patient at Oceanville Hospital. She deciphered signs and symptoms to “fit in” to her immediate environment. During sessions with a sympathetic resident psychiatrist, Dr. Steber, Janet thought he could *see* beyond her

⁴⁷ Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 41.

⁴⁸ Goffman, *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates*, 64-65.

⁴⁹ Gotkin and Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry*, 76.

layers of adopted symptoms. She fervently told Dr. Steber that her stay in the hospital had made her sicker than before:

“Listen,” I said. “I am not a disease and I’m not a child and I’m tired of being humiliated and talked down to and turned into a helpless invalid. This place is a goddamn school for psychosis. If you didn’t know the symptoms before you come in, you learn them, fast. And you adopt them, you start acting sick because you want to fit in and after a while this is the only place you have any hope of fitting in. If you’re not suicidal when you come, it doesn’t take long to get that way.”⁵⁰

Janet hoped Dr. Steber might be the one person who *listened* to his patients. However, he told Janet that she could not be released from the hospital because he saw she was trying to appear much less depressed in order to leave the hospital. Soon after the conversation, Dr. Steber left Oceanville Hospital for another hospital to complete his last year of his residency. Janet later learned that one of Dr. Steber’s patients had committed suicide two weeks after her discharge.⁵¹ If he had not *listened* to patients’ experiences, would he have made a “correct” decision - in this case, keeping his patient for a longer period than he actually did? If his patient remained in the hospital, would she have still committed suicide?

On the other hand, patients can use their symptoms in a cynical way either wittingly or unwittingly. Several patients in a large state hospital told Thomas Scheff “in confidence” how they had used their given symptoms to scare new personnel, to avoid doing unpleasant work details, and so on. “Yet, at other times, these *same* patients appeared to have been sincere in their symptomatic behavior. Apparently, it was sometimes difficult for the patients to tell whether they were playing the role or the role

⁵⁰ Ibid, 99.

⁵¹ Ibid, 112.

was playing them.”⁵² Whereas a psychiatrist like Thomas Szasz might have described a patient’s behavior as “malingering,” considering that a patient had made an individual choice in maneuvering inside of a system, Scheff analyzes the involuntary nature of role-playing in explaining some patients’ uncertain behaviors. By referencing Ganser Syndrome (which is now described as a form of Dissociative Disorder) and Lemert’s sociological explanation of “secondary deviation,” he argues that even the patient him or herself could be confused with the role given to them by the institution; thus the dissociative or deviant action was either a defensive, offensive, or adjusting reaction to the immediate surroundings.⁵³ Scheff shows the negotiation process within the self; how one navigates between one’s expected role in the given social system and the self, and how patients often lose their grip in the asylum by failing to navigate this treacherous terrain. Rather than focusing on how patients came up with coping strategies in an oppressive psychiatric environment, Scheff, Goffman, and Foucault stressed how the system treated the patients as if they were a passive carrier of symptomatology. Their argument is somewhat concurrent to the protagonist’s fate in Ken Kesey’s *One Flew Over the Cuckoo’s Nest* where the protagonist McMurphy’s attempt to maneuver between the penal and psychiatric systems failed due to the involuntary, oppressive nature of psychiatry. As soon as a person found him/ herself in the system, he/ she lost the ability of self-determination. The passive, hollow imagery of mental patients was represented by McMurphy’s lobotomy scar.

The psychiatric gaze represented by photography and drawings attempts to create a pure space on paper. In this two-dimensional abstract space with no depth, even doctors’

⁵² Scheff, *Being Mentally Ill: A Sociological Theory*, 50-51.

⁵³ Scheff, *Being Mentally Ill: A Sociological Theory*, 51.

words are deemed to be secondary in value. The patients' stories of their subjective experiences are meticulously eliminated as noise that might impede the diagnostic process. "Seeing" is an acquired technique that systematically removes cacophonous and often delusional impurities. By referencing a systematized symptomatology, a specific somatic intervention is applied to patients without ever listening to their inner turmoil in order to make an accurate diagnosis.

Social Diagnosis: the Rise of Psychiatric Social Workers

In this section, I briefly refer to Nina Ridenour's 1961 book, *Mental Health in the United States: A Fifty-Year History* to provide a quick summary of the conditions of asylums as well as trends in mental health advocacy during the first half of the 20th century. Then I examine how trends in prevention and early detection of mental illness lead to the rise of social work during the same period.

In explaining the origins of these new trends in psychiatry, Ridenour refers to Clifford Beers' mental hygiene movement, showing how Beer's movement promoted reformation among Americans, notably in the subject of child psychiatry from the grass roots level of a public awareness campaign. While Laura Hirshbein would later criticize the mental hygiene movement in her 2009 *American Melancholy*, stating that the movement was saturated by the "language of consumerism," Ridenour in 1961 considered it an educational, social movement that would improve Americans' mental health.⁵⁴ She stressed how "mental hygiene" meant a body of knowledge concerning the preservation

⁵⁴ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*.

and promotion of mental health.”⁵⁵ A growing number of mental health professionals, such as the psychiatric social workers who emerged in the beginning of the twentieth century, saw educating the public as the best tool in the early detection and prevention of mental illness.

In the first half of the book, Ridenour concisely demonstrated the emergence of psychopathic hospitals which at the time of publication were taking over from the custodial-care based “insane asylums.” Borrowing the 1920 phrase of Dr. Salmon’s “Cinderella story,” she explained how the concept of psychiatry was at that point a newly discovered discipline in the medical world. The emergence occurred because of an increasing public interest in mental illness between 1900 and 1914, and she suggested that the growing number of people with mental illness, new social reforms, and scientific and medical discoveries were some of the reasons for this emergence.⁵⁶ Along with the mental hygiene movement, new forms of somatic treatment arrived in the US. Therapies such as insulin shock, metrazol, and the electroconvulsive therapy (ECT) were introduced in the US by the late 1930’s. Drugs such as chlorpromazine (Thorazine) were considered dramatic breakthroughs in the early 1950’s. However, she concluded that these treatments were “overrated” as they did not “cure” illness; rather they simply sedated the patients.⁵⁷ Psychosurgery (Lobotomy) was also introduced in the same period. Regarding this procedure, she noted a “certain amount of controversy” that questioned the efficacy of the surgery.⁵⁸

⁵⁵ Nina Ridenour, *Mental Health in the United States: A Fifty-Year History* (Cambridge, MA: Harvard UP, 1961).

⁵⁶ *Ibid.*, 27-28.

⁵⁷ *Ibid.*, 33.

⁵⁸ *Ibid.*, 32-33.

Ridenour discussed the need for child psychiatry. It is curious to see how she addressed the subject of juvenile delinquents in the context of the mental hygiene movement immediately alongside a discussion of the importance of establishing new facilities for the “mentally retarded.”⁵⁹ Nonetheless, Ridenour was optimistic that citizens’ actions such as the mental hygiene movement would bear fruit in reforming post-war American mental health. She also focused on the need for community based, flexible, “open door” hospitals, and outpatient facilities, predicting the arrival of the deinstitutionalization of the mentally ill in the next decades.⁶⁰

Jacques Donzelot analyzed the psychiatrists’ interest in controlling the juvenile court system in post-war France in his 1979 book *The Policing of Families*. He argued that the juvenile court system and the auxiliary psychiatry-social work system were a chimerical institution where medical, educational, socio-economic, political, and judicial distinctions intersected and blurred, a situation which many industrialized post-war nations experienced in common. In this bureaucratic machinery, socio-cultural values and norms were “made to float in relation to one another, enabling the individual to circulate back and forth between them, to play them off against each other” without ever being caught by specific agencies’ values or norms.⁶¹ In this chimerical, bureaucratic *Tutelary Complex* where multiple state and non state agencies’ responsibilities were obscured by design, state-sanctioned social agencies sneaked into the autonomy of the post-war working class family.^{62,63}

⁵⁹ Ibid., 35, 50.

⁶⁰ Ibid., 135.

⁶¹ Jacques Donzelot, *The Policing of Families* (Baltimore: The Johns Hopkins UP, 1979), xxiv.

⁶² Ibid., 168.

⁶³ Donzelot argued in the context of the post war French working class families but the ongoing Justina Pelletier case happening in Boston suggests the *Tutelary Complex* is still well and alive in modern day

Since the early days of the privately funded asylums in late seventeenth century Europe, the asylum solution was “the site of myriad negotiations of wants, rights, and responsibilities, between diverse parties in a mixed consumer economy with a burgeoning service sector.”⁶⁴ The line between private and public in social welfare was not clearly delineated. Social work was not an exception. Referring to a legal scholar Dean Roscoe Pound’s notion of “social” as something intermediary between public and individual affairs, Mary Cromwell Jarrett --a founder of American psychiatric social work-- and Elmer Ernest Southard argued that social workers were an ideal intermediary who could navigate between “public service on the one hand and the ideal of individual service on the other.”⁶⁵

Donzelot examined how social work stemmed from private philanthropy. The sudden proliferation of social work in America was due to the personnel shortage in neuro-psychiatric hospitals for the care of World War I soldiers. The theory and practice of social work were systematized during this time in order to train women in new social work programs.⁶⁶ Jane Addams established her Hull House in 1889 after two years of travel in Europe. American social workers argued that in alleviating poverty, a shift from philanthropy to social work represented a sophisticated progression, because they believed that giving charity to the poor did not solve social problem at their root.⁶⁷ However, philanthropy should “not be understood as a naively apolitical term signifying

America. For detail please refer to:

<http://www.bostonglobe.com/metro/2013/12/15/justina/vnwzbbNdiodSD7WDTh6xZI/story.html>

⁶⁴ Roy Porter, *Madness: A Brief History* (Oxford: Oxford UP, 2002), 98.

⁶⁵ Elmer Ernest Southard and Mary Cromwell Jarrett, *The Kingdom of Evils* (New York: MacMillan Company, 1922), 385-87.

⁶⁶ An Experiment in Social Work Education, 1954, Mary C. Jarrett Papers, Sophia Smith Collection, Smith College, Northampton, Mass.

⁶⁷ Southard and Jarrett, *The Kingdom of Evils*, 390.

a private intervention in the sphere of so-called social problems,” Donzelot argued. It “must be considered as a deliberately depoliticizing strategy for establishing public services and facilitating at a sensitive point midway between private initiative and the state.”⁶⁸ Since its formation as a discipline, social work was also “the site of myriad negotiations of wants, rights, and responsibilities,” where the boundary between private and public was blurred, constantly making reference from one to the other.

In analyzing the Tutelary Complex, Donzelot paid particular attention to the growth of an invisible, “extrajudicial jurisdiction” of psychiatry that grew outside of a penal jurisdiction:

In the last third of the nineteenth century, psychiatrists began to refuse the terms according to which they were asked to offer their opinions regarding a particular defendant, even when adults were involved. To declare whether a criminal had acted in a state of insanity appeared pointless and metaphysical to them... They wanted to be able to concern themselves more with minors than with adults, more with petty offenses than with major crimes, more with the detection of anomalies, with orienting those sentenced to a particular mechanism of correction, than with grading the responsibility of those accused. They proposed to go beyond their minor function in the judiciary and achieve an autonomous position as prime movers in the prevention and treatment of delinquency, which in their eyes had become a mere symptom of mental aberration... A shift of interest that made possible *the transition from restricted psychiatric expertise to generalized psychiatric expertise.*⁶⁹

Psychiatric agencies developed an interest in intervening in the politics of the family through their expertise in the prevention of juvenile delinquency. Together with regulatory but non-coercive psychoanalysts, psychiatrists and social workers formed the “tutelary administration of families.”⁷⁰ Overseen by psychiatrist-psychoanalysts, social workers functioned as an intermediary agency between families and the Tutelary

⁶⁸ Jacques Donzelot, *The Policing of Families* (Baltimore: The Johns Hopkins UP, 1979), 55.

⁶⁹ Donzelot, *The Policing of Families*, 126-27.

⁷⁰ *Ibid.*, xxiv, 168.

Complex. “Without getting their hands dirty, the psychoanalysts marks out the threshold from which his reign becomes possible.”⁷¹

Like a detective doing their leg work, a social worker, traditionally a female profession, would collect evidences for her supervisors.⁷² To arrive at a social diagnosis of her client, she would visit her client’s home as if she went there to enjoy conversation with the investigatee. As a “friendly visitor,” she would try to detect signs of transgressions such as unsanitary conditions of the dwelling or promiscuities of family members through enjoyable conversation. Inspection of food stocks could be done by raising “the lids of a few cooking pots” as if they were housewives exchanging cooking tips each other.⁷³ Mary E. Richmond, a pioneer in American social work, theorized about how to gather a wide range of evidence through inspection: “In social case work, real evidence is any item of evidence had by first-hand inspection. The appearance of a client’s home is real evidence as to the conditions under which he lives; the meal on the table is real evidence that his family is not without food; and so on.”⁷⁴

While psychiatrists gave medical diagnosis to the patients, a social worker also gave *social diagnosis* to her clients. Coined by Richmond, social diagnosis had a versatile nature that could be an “adjunct in the fields of medicine, education, jurisprudence, and industry.”⁷⁵ Unlike medical doctors and psychiatrists who looked for signs and symptoms to arrive at their diagnosis, social workers saws signs of their clients’ maladjustment as being *social symptoms*.⁷⁶ Richmond explained that social and medical diagnoses were

⁷¹ Ibid., 168.

⁷² Gerald Grob, *From Asylum to Community* (Princeton: Princeton UP, 1991), 115.

⁷³ Donzelot, *The Policing of Families.*, 124.

⁷⁴ Mary E. Richmond, *Social Diagnosis* (New York: Russell Sage Foundation, 1917), 56.

⁷⁵ Ibid., 26.

⁷⁶ Unemployment was a major sign of social symptom.

complimentary to each other. As non-medical workers, social workers were not expected to make medical diagnoses, but were expected to refer to a medical authority who oversaw the routine of social work for the sake of early medical diagnosis.⁷⁷ In addition to identifying and reporting any physical and mental breakdown, social workers also bore the role of educators for advocating the prevention and early detection of illness.

The arrival of social work in the American mental health system signaled an interesting discussion in how female workers negotiated between their working-class clients on the one hand and doctors or judges on the other. Unlike psychologists, social workers (and psychiatric nurses) in the first half of the twentieth century did not challenge the authority of psychiatrists. In theory, they accepted a subordinate role as female professionals. They were not supposed to challenge the male-dominated field of psychiatry.⁷⁸ By focusing on the premise that their profession was an intermediary agency, Jarrett and Southard advised that a young social worker should recognize herself as someone akin to a “professional layman.”⁷⁹ They advised that these professional women should embody an “ideal being,” someone with a flexibility to take measures suited to the occasion. Within the specialty of social work they advised that these women should occupy their own ground.⁸⁰ By keeping neutrality from the medico-judicial sphere, they believed these women could obtain a certain amount of autonomy:

She stands in that middle ground, untrammelled by the laws and regulations of the public service and beyond the control in essential ways of the physician. So far as law and medicine are concerned, she is on rather neutral ground. In critical and limited phases of her work she is, to be sure, governed and guided by judge and

⁷⁷ Richmond, *Social Diagnosis*, 211.

⁷⁸ Grob, *From Asylum to Community*, 115.

⁷⁹ Southard and Jarrett, *The Kingdom of Evils*, 388.

⁸⁰ *Ibid.*, 389.

physician, but she has every chance to push on to crises and limits that may not be necessary and may not represent the 'one best way.'⁸¹

While the ideal social worker negotiated between the medico-judicial terrain and the welfare of her working class clients, foster families with adopted children saw social workers in another light.⁸² Born in 1937, Ted Chabasinski was adopted by a family in the Bronx. When a social worker from the child welfare agency determined he was also suffering from mental illness like his biological Polish immigrant mother, he was sent to Bellevue Hospital in 1943. He was six year old. He became one of the first test subjects for child neuro-psychiatrist Laretta Bender who tested the efficacy of Electric Convulsive Treatment on children in treatment of childhood schizophrenia. The first use of the ECT on adult patients in the United States was in 1940.⁸³ Before she started working as a staff psychiatrist in Bellevue Hospital in 1930, she had been a renowned psychiatrist who developed the Bender-Gestalt Visual Motor Test in 1923. She became a senior psychiatrist who oversaw the Bellevue Children's Service for twenty-one years, researching the etiology of childhood schizophrenia as well as child suicides and violence.

The following is Ted Chabasinski's testimony explaining how the social worker's zealotry for the early detection of mental illness led to an experience beyond description:

Psychiatrists and social workers had already decided before I was born that I was going to be a mental patient. My natural mother had been locked up just before she gave birth to me and was locked up again soon after. The social worker from the Foundling Hospital told my foster parents, as they put it, that my mother was "peculiar," and Miss Callaghan soon had them looking for symptoms in me, too. Every month Miss Callaghan would come and discuss my "problem" with my foster parents. If I only wanted to stay in the back yard with my sister and make

⁸¹ Ibid., 387.

⁸² For the relationship between post-war foster families and state institutions, see also: Michael D'Antonio, *State Boy's Rebellion* (New York: Simon and Schuster, 2005).

⁸³ Leonard Roy Frank, ed., *The History of Shock Treatment*, 15.

mud pies, this was a sign that I was too passive and withdrawn, and my mommy and daddy were supposed to encourage me to explore the neighborhood more. When I started to wander around the neighborhood, I went to a neighbor's garden and picked some flowers. The neighbor complained, and Miss Callaghan held a long session with my parents about curbing my hostile impulses.

I knew that my foster parents were afraid of the Foundling Hospital lady, but I didn't understand why...

When Miss Callaghan had discovered enough symptoms, I was sent to the Bellevue children's psychiatric ward, to be officially diagnosed and to be made an experimental animal for Doctor Bender, I was one of the first children to be "treated" with electric shock. I was six years old.⁸⁴

The autonomy of family was compromised for the sake of the early "detection of anomalies." The social diagnosis was made by social workers by referring to the child's family history and to the "peculiarity" of a child's behavior as the signs of schizophrenia. Lost in the nightmare of the Tutelary Complex where psychiatrists in an autonomous position had absolute power over him and his foster family, Chabasinski was physically and sexually abused and underwent repeated electroshock "treatment" as a part of Dr. Bender's experiments.⁸⁵

...It took three attendants to hold me. At first Doctor Bender herself threw the switch but later when I was no longer an interesting case my tormenter was different each time.

I wanted to die but I really didn't know what death was. I knew that it was something terrible. Maybe I'll be so tired after the next shock treatment I won't ever get up, and I'll be dead. But I always got up. Something in me beyond my wishes made me put myself together again. I memorized my name, I taught myself to say my name. Teddy, Teddy, I'm Teddy...I'm here, I'm here, in this room, in the hospital. And my mommy's gone... I would cry and realize how dizzy I was. The world was spinning around and coming back to it hurt too much. I want to go down, I want to go where the shock treatment is sending me, I want to stop fighting and die...and something made me live, and to go on living I had to remember never to let anyone near me again.⁸⁶

⁸⁴ Ted Chabasinski, "The Other Half," *Madness Network News*, June 1974, 1.

⁸⁵ Ted Chabasinski, "A Child on the Shock Ward," *Mad In America*, July 2012, <http://www.madinamerica.com/2012/07/a-child-on-the-shock-ward/>.

⁸⁶ Chabasinski, "The Other Half."

Until he was released from Rockland State Hospital at the age of seventeen, he spent the majority of childhood and adolescent years in the psychiatric system. In 1955 Laretta Bender received the Adolf Meyer Memorial Award for “her contributions to the understanding of schizophrenic children.”⁸⁷

In this chapter, I examined how the experience of hospitalization left a negative mark on ex-patients’ lives by looking at ex-patients’ testimonies and scholarly works about the psychiatric institutions. The subjective experiences of extreme emotional distress did not weigh at all in understanding a patient’s inner world. Instead, their behavior was interpreted out-of-context to warrant why they needed treatment. The label of being a mental patient dictated their perceived identities, making them unable to escape from the social consequences of diagnosis. I explained how the labeling process was produced by looking at the history of psychiatry and social work in the early twentieth century. I paid particular attention to how the social worker’s well-intentioned mission to save working class children from chronic mental illness often led to traumatic experiences for the children. In the next chapter, I will examine how ex-patients in the early 1970’s organized themselves to fight against the psychiatric label.

⁸⁷ Joan Cook, “LAURETTA BENDER A PSYCHIATRIST, 88,” *New York Times*, January 17, 1987, <http://www.nytimes.com/1987/01/17/obituaries/lauretta-bender-a-psychiatrist-88.html>.

Chapter 2

TO CLAIM THE LEGITIMACY OF OUR VOICE

We are mental patients. We believe that we have “gone crazy” because we live in a society that puts wealth, property, and power above the basic needs of human beings. We have been locked up in institutions, rendered powerless to control our own lives, told we are incapable of making our own decisions because we do not know what is in our “best interests,” and subjected to various forms of “treatment” meted out by a psychiatric elite.

We believe that mental hospitals do not meet basic human needs. Treatment such as drug therapy, electroshock, behavior modification and even psychotherapy are used to depoliticize and to force us to conform to the status quo.

—Mental Patients Liberation Front⁸⁸

The Mushrooming of Patient-run Groups in the Early 1970's

Ex-patients advocacy groups, such as the Mental Patients Liberation Front, began to organize with the aim of reclaiming the legitimacy of their voices but had to contend with a public that generally regarded ex-patients narratives as unreliable. This public generally believed that: “mental patients are supposed to be mentally ill, out of touch with reality, their testimony carries little weight.”⁸⁹ However, due to a wide range of activism in the 1960s and 1970s, “psychological disorders were understood more in social and political (less in strictly individualized) terms.”⁹⁰ In 1975, ex-patients gained landmark achievements through their national-level political action.⁹¹

In the summer of 1971, Judi Chamberlin joined the newly formed Mental Patients Liberation Project (MPLP.) Started by Howard Geld, aka Howie the Harp, in April 1971,

⁸⁸ [Mental Patients Liberation Front, *Statement of the Mental Patients Liberation Front*, Series 2 Organization: Mental Patients Liberation Front]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

⁸⁹ Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 122.

⁹⁰ Michael Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980* (Chicago: U of Chicago P, 2011), 2.

⁹¹ The Senate Subcommittee on Juvenile Delinquency and the Supreme Court ruling of *O'Connor v. Donaldson*.

the MPLP was one of the first patient-run organizations advocating for the rights of mental patients.⁹² The Insane Liberation Front, started in 1970 in Portland, Oregon, was the earliest advocacy group in the US. The Mental Patient Liberation Front (MPLF) in Boston that Judi Chamberlin later joined started in 1971, almost simultaneously with the MPLP.

Many ex-patients tried to hide their history of commitment in order to “fit into” the society, unable to share their experiences of inhumane treatment with other ex-patients. After Chamberlin was discharged from Rockland State Hospital in 1966, she tried to look as “normal” as possible. She moved to Pennsylvania with her husband and had a daughter, Julia, in 1968. While she was in Pennsylvania, she came in contact with the counter-culture through a poet at the Pratt Institute in Brooklyn who was working on publishing a psychedelic art book. After 1968, she enrolled in colleges in Pennsylvania and New York City but did not complete a degree. During this time, she came in contact with women’s groups and decided to leave her husband in 1971 and divorced him the next year. Until Chamberlin learned about the MPLP from *The Village Voice*, she did not realize there were many people like her, people who had been committed to mental hospitals and who had received forced treatment and suffered countless humiliations. The MPLP gave Chamberlin a sense of liberation and empowerment. Just as Chamberlin had gained a sense of self-determination from the women’s liberation movement, other members in the MPLP had also been involved with other human rights and civil rights movements. Ted Chabasinski, who also joined the MPLP just prior to Chamberlin, had joined the NAACP in 1959 through a local chapter in the City College of New York

⁹² Howie the Harp (Howard Geld) learned how to play the harmonica while he was institutionalized as a child.

where he graduated in 1961. The son of a Polish Catholic and a Russian Jew, he took the plight of the black people in the South as something very personal. His leadership in organizing came from a shared sense of oppression he experienced due to his commitment to Bellevue Hospital at age six: “I did it (taking an active role in the NAACP) because I recognized that their oppression was just like mine. Here are these people being pointed to, ‘They’re not human, they don’t deserve any respect, we’re going to treat them like dirt.’”⁹³

While he was in Harvard University, David Oaks was committed to McLean Hospital in Belmont, Massachusetts in the early 70’s. As a third generation Lithuanian who had grown up in the South Side of Chicago, he studied and worked hard to lessen the financial burden on his family while he was in Harvard. He later recognized the amount of stress he was under triggered the “extreme” states of mind he experienced. He saw visions that other people did not see or sense: “I would look at technology as a kind of an alien force on the planet: electricity and telephones and computers and radio and machinery. I would be riding in an airplane and become convinced that my mind could somehow affect the bolts in the airplane. That I had these superpowers.”⁹⁴ After he was released from McLean, Oaks joined the MPLF in 1976 during his senior year. He recalls how they operated their meetings in the same way leftist organizers and women’s advocates would.⁹⁵ The discussions about prisoner’s rights, gay rights, racism, sexism, and class issues were frequent topics for the survivors since they thought

⁹³ Pelka, *What We Have Done: An Oral History of the Disability Rights Movement*, 292.

⁹⁴ *Ibid.*, 298.

⁹⁵ *Ibid.*, 299.

psychiatry had been targeting those who were regarded as vulnerable.⁹⁶ With tactics, theories, and philosophy gained from various human rights movements, the ex-mental patients were ready to start their own civil rights movement.

Leaving New York City for Vancouver, British Columbia in 1974, Judi Chamberlin began experiencing a sense of overwhelming distress again. Ending her relationship with Ted Chabasinski left her with an overwhelming sense that she would die.⁹⁷ After a turbulent but powerful transformational experience at the Vancouver Emotional Emergency Center, she moved to Bellingham, Washington. She tried unsuccessfully to establish an ex-patients group in Bellingham. In spite of her unsuccessful attempt, 1975 was a transformational year for survivors involved in ex-patients advocacy groups. For example, the Supreme Court ruling of *O'Connor v. Donaldson*, a case brought by an ex-patient, decided that even if one presented symptoms of mental illness, a state could not involuntarily commit a non-dangerous individual to a psychiatric hospital.⁹⁸ The Court determined that there was a constitutional right to liberty in the case. Kenneth Donaldson was involuntarily committed to a state hospital in Florida in 1956 because his father worried that his son, who was visiting from Philadelphia, was showing signs paranoia. Over the next fifteen years, Donaldson received a series of drug and shock therapies that often reached the level of malpractice.⁹⁹

For Chamberlin, it was also a crucial year; she began writing a book, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* to promote the ex-

⁹⁶ [Suggested Workshop Topics, Series 2 Conference: Conference on Human Rights and Psychiatric Oppression, fourth, 1976]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

⁹⁷ Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 56.

⁹⁸ *O'Connor v. Donaldson* (1975).

⁹⁹ Kenneth Donaldson, *Insanity Inside Out: The Personal Story behind the Landmark Supreme Court Decision* (New York: Crown Publisher, 1976).

patient controlled alternative to psychiatry. The American public was also undergoing a transformation in 1975; the release of the movie *One Flew Over the Cuckoo's Nest* helped raise awareness about abuse in psychiatric hospitals to a broader audience.

1975 Senate Subcommittee on Juvenile Delinquency

In August of that year, Chamberlin testified as an ex-patient for the Senate Subcommittee on Juvenile Delinquency chaired by Birch Bayh. With other ex-patients and freelance writers such as Janet Gotkin, Wade Hudson, and Anthony Brandt, she spoke to the public about how Thorazine gave her an overwhelming sense of fear, anxiety, and jitteriness.

The subcommittee was investigating the use of neuroleptics (antipsychotic drugs such as Thorazine, Prolixin, and Haldol) at Juvenile Institutions. A medical journalist Robert Whitaker argues that this was the moment when ex-patients persuaded legislators and the public that the experience of neuroleptics was inhumane because it turned patients into “zombies.” In oral testimony and writing they eloquently told the public about their subjective experience of neuroleptics.¹⁰⁰ Chamberlin testified to Senator Bayh how a vicious cycle of medication during the time of her hospitalization created drug dependency. While she was in the psychiatric system, she was administered Thorazine, Stelazine, Mellaril, Elavil, Cogentin, Doriden, and Chloral Hydrate.¹⁰¹ In order to explain the cycle of drug dependency ex-patients had fallen into as well as the experience of over-medication, she referred to the Physicians' Desk Reference which stated that to compensate for the drowsiness caused by Thorazine, a doctor should give

¹⁰⁰ Robert Whitaker, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (Cambridge: Perseus Publishing, 2002), 175-78

¹⁰¹ [Judi Chamberlin's testimony, Committee on Judiciary, 166 Series 2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

Dextroamphetamine, an addictive stimulant. When a patient experienced uncontrollable tremors caused by Thorazine, the doctor would prescribe Cogentin to control the muscular spasm. Cogentin's side effect is "intensification of mental symptoms, mental confusion and excitement, visual hallucinations, and dry mouth." To suppress those unwanted effects, more Thorazine was administered. She concluded that the vicious cycle of drug dependency she experienced during hospitalization made her less determined to improve her life situation.

Another survivor with a diagnosis of "chronic schizophrenic," Janet Gotkin explained how her dependency on drugs as well as on her psychiatrist, Dr. Sternfeld, forced her to make a humiliating gesture to him: "I went down on my hands and knees for higher dosages of the drug...I believed I was mentally ill, and I believed I needed drugs:"¹⁰²

"Please I need something."

"Then beg for it."

Down on my hands and knees on the rug, my face buried in the dust. Can I go any lower? "Why are doing this to me?"

"I want you to see how you lower yourself to get what you want."

This is therapy, this groveling humiliation? No. Something is very wrong. He is smiling, almost.

"I will call the ward and order an increase."¹⁰³

The more Dr. Sternfeld wrote prescriptions the more "merciful" he appeared to be. Totally subjugated by the power of her psychiatrist, Gotkin even thought about how generous he was; Dr. Sternfeld prescribed 1,500 mg of Thorazine for her anxiety, Kemadrin for relaxing the muscles that became stiff by the side-effect of Thorazine,

¹⁰² "Ex-Mental Patients Tell of Drugging," *The Washington Post*, August 19, 1975, sec. A.

¹⁰³ Gotkin and Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry*, 202.

Compazine for stomach nausea, and Prolixin for her depression.¹⁰⁴ Her ten year career as a mental patient caused her to have an extensive prescription list. At the testimony to the Subcommittee, Gotkin itemized what she had taken: “Over the years I took almost every drug on the market: Thorazine, Mellaril, Taractan, Compazine, Stelazine, Serax, Prolixin (Permatil), Valium, Librium, Miltown, Doriden, Nembutal, Seconal, Tuinal, Chloral Hydrate, Sodium Amytal (by injection), Dexamyl, Kemadrin, Tofranil, Elavil. You name it, I took it; often in combinations; mostly at very high dosage.”¹⁰⁵ In 1970, Dr. Sternfeld prescribed 2,000 mg of Thorazine, such a high dosage that she had convulsions.¹⁰⁶ After the incident, he reduced it to 1,800 mg.¹⁰⁷ Currently the FDA determines that the doctors can gradually administer up to 2,000 mg or more a day to some hospitalized patients if deemed necessary, but also advises the prolonged dosage of more than 1,000 mg a day has little therapeutic benefit.¹⁰⁸ What would a patient on 2,000 mg of Thorazine look like? While she was committed, Chamberlin saw a patient with the prescription. A “walking zombie,” she described the patient because she walked in whatever direction her shoulder was pushed towards. To make her turn the corner, others would push her shoulder harder.¹⁰⁹

¹⁰⁴ Ibid., 314.

¹⁰⁵ [Janet Gotkin's testimony 3-4, Series 2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹⁰⁶ [Janet Gotkin's testimony, 4, Series 2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹⁰⁷ Gotkin and Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry.*, 342.

¹⁰⁸ “Thorazine (Chlorpromazine),” *RxISK*, accessed March 6, 2014, https://www.rxisk.org/Research/DrugInformation.aspx?DrugID=64&ProductDrugID=2140&ProductName=Thorazine#3_0_0_0_0_0.

¹⁰⁹ [Judi Chamberlin's testimony, Committee on Judiciary, 182, Series 2 Organization: Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

The side effects of those drugs left Gotkin physically and mentally unable to manage her daily life. It made her so drowsy that she fell asleep during the day. She could not concentrate enough to finish reading a novel or watching a movie. She felt her tongue was so heavy that she was barely able to speak. Her eyesight was so blurred. Those everyday tasks required such an effort that she always felt exhausted. The drugs made her put on weight. To control involuntary hand and leg movements the doctor also prescribed Kemadrin. To reduce the unbearable skin sensation, Benadryl was administered to stop the itching.

Recollecting her years as a mental patient, Gotkin testified how she had become disconnected from herself by all of these prescribed medication. She realized what she really needed was to look into her life problems:

In all the years I took these drugs never, once, did they in any way help me to solve my problems or come in touch with my feelings. Quite the contrary. I never had to face any problems because they were all called “symptoms” and I was given drugs to deal with them. I became alienated from my self, my thoughts, my life, a stranger in the normal world, a prisoner of drugs and psychiatric mystification, unable to survive anywhere but in a mental hospital. The anxieties and fears I had lay encased in a Thorazine cocoon and my body, heavy as a bear’s, lumbered and lurched as I tried to maneuver the curves of the outside world.¹¹⁰

Gotkin broke her ten-year cycle of drug dependency after a five-day coma caused by a suicide attempt in 1970. Gotkin’s husband, Paul Gotkin wondered if his wife might have gone through a “mysterious and profound change” while she was in her coma. As soon as she recovered from the coma, Paul Gotkin noticed how she was in “good spirits,” able to concentrate and to sleep like she had been unable to for the last ten years. He

¹¹⁰ [Janet Gotkin's testimony, 5, Series 2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

conjectured that during the five-days, all the antipsychotics were flushed out of her body.¹¹¹

In order to complete his book project about the mental health system, a freelance journalist named Anthony Brandt committed himself to the Judson River State Hospital in Poughkeepsie, New York. By feigning that he was hearing voices of his separated wife, he experienced what it would be like to become a mental patient. At the testimony, he spoke about rampant, indiscriminate use of neuroleptics during his eleven-day voluntary commitment to the hospital. He conjectured the use of such drugs was not to treat symptoms but to manage patients' behavior. Through the interview projects, Brandt learned that an ex -patient from Binghamton State Hospital in New York was administered liquid Thorazine. Everyone on his ward had the drug "out of a bucket." Everyone had the same dosage regardless of their diagnoses.¹¹² Chamberlin also took undiluted liquid Thorazine while she was in Rockland State Hospital in 1966. The manufacturer warned nurses to wear gloves while handling the liquid to avoid skin irritation.¹¹³ The drug burnt her throat, and the humiliation was so grave that she would often cite the experience in her speeches.

Administering liquid Thorazine was a standard operation for many state-run hospitals. Andrew Palmer who was in Gaebler Children's Center in Waltham, Massachusetts in the mid-70's recalls how nurses gave him liquid Thorazine mixed with cranberry juice. The "thorazine cocktail" in a small plastic cup was administered

¹¹¹ Gotkin and Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry.*, 354-55.

¹¹² [Anthony Brandt's testimony, 5, Series 2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹¹³ Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 43-44.

three times a day.¹¹⁴ Each time he swallowed, the liquid burnt his mouth. He had no choice but to take the cocktail; nurses demanded that he open his mouth to make sure he had swallowed it.

Judi Chamberlin was able to improve her life circumstance by stopping taking any drugs and by voluntarily seeing a skilful, confident, and empathetic psychologist.¹¹⁵ At first, Chamberlin thought she was so “hopelessly mentally ill” that she hesitated about seeing Dr. Jonas. Chamberlin thought that only custodial care in an institution suited her because she had an “abnormality” in her brain. Skeptical about her claim, Dr. Jonas asked Chamberlin to give signed permission to release her hospital records. After looking through the records, he explained to Chamberlin how the diagnoses she had received during her hospitalization came from observations by inexperienced trainee doctors whose judgments were clouded by their own egos:

“Everything in here,” he told me, “was written by young doctors just out of medical school. They like to use these big words but don’t know what they mean. Who would you rather believe—them, or me, a doctor who’s been in practice for years?” “What about my diagnoses? I’ve seen some of them—that I’m a schizophrenic, that I have a character disorder.” “Nonsense,” he told me.¹¹⁶

At the subcommittee, Chamberlin also brought attention to Tardive dyskinesia (TD), an irreversible syndrome caused by the prolonged administration of high-dose neuroleptics. In the most severe cases, TD resembled “in every respect known neurological diseases such as Huntington’s disease, dystonia musculorum deformans, and

¹¹⁴ Andrew Palmer, “Gaebler, Hell and Back,” accessed March 11, 2014, <http://www.madpride.org/VFC10GaeblerHellandBack.htm>.

¹¹⁵ [Testimony of Judi Chamberlin at the U.S. Senate Subcommittee to Investigate Juvenile Delinquency, Series2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹¹⁶ Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, 55.

postencephalitic brain damage,” a National Institute of Mental Health physician noted.¹¹⁷

Chamberlin explained that the somatic presentation of TD is what “one would most expect to be crazy-looking. These repetitive, unpleasant looking movements are not symptoms of so-called mental illness. They are the direct result of long-term administration of Thorazine.”¹¹⁸

In summarizing the questions surrounding the drug use in these institutions, Gotkin concluded that the answer did not belong to scientific or medial explanations. She saw it as *political* in nature.¹¹⁹ Gotkin observed how the way drugs were dispensed represented a power game between a doctor and a patient. Because she was dependent on the drugs, she showed total submission to Dr. Sternfeld. She felt that power politics were particularly fierce at prisons and schools for children with intellectual disability: “The people who run them have been virtually free of any outside scrutiny or constraint on their behavior and have fought hard to maintain that closed status.”¹²⁰ For people who survived psychiatric experience, the stories of abuse were nothing new, but because of the closed nature of those institutions, the public had little idea about what was happening inside of the walls of the *total institution*. Convinced by the testimonies of ex-patients, Senator Bayh called indiscriminate administration of neuroleptics to mental patients “chemical straightjacketing.” He concluded: “We cannot sit by and let children in the nation, because they are without parents or troubled or handicapped be boxed up, shipped

¹¹⁷ George Crane, “Clinical Psychopharmacology in Its 20th Year,” *Science* 181 (1973): 124-28, quoted in Robert Whitaker, *Mad in America*, 190-91.

¹¹⁸ [Testimony of Judi Chamberlin at the U.S. Senate Subcommittee to Investigate Juvenile Delinquency, Series2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch], [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹¹⁹ [Janet Gotkin's testimony, Committee on Judiciary, 11, Series2 Organization: Committee on Judiciary. Subcommittee to Investigate Juvenile Delinquency. Bayh, Birch]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹²⁰ *Ibid.*, 8.

off and held captive with medical or chemical handcuffs.”¹²¹ Because ex-patients like Chamberlin and Gotkin eloquently spoke about their subjective experiences of commitment before the 1975 subcommittee, the public began to listen to their stories and regard their testimony as credible.

The political aspect of involuntary commitment was a key issue for ex-patient advocates like Chamberlin. Like the scholars in the anti-psychiatry movement, Judi and her colleagues saw psychiatry as a monolithic entity that possessed absolute power to determine the course of people’s lives. They saw psychiatry, and subsequently the state, in a black and white way in order to use this stark contrast to unite themselves as survivors of the psychiatric system. They argued that if patients were held in psychiatric hospitals on an involuntary basis, they had no right to refuse “treatment.” From the patient’s perspective, the function of involuntary commitment to a psychiatric hospital was not to treat one’s acute psychiatric distress but rather to prevent the patient’s social transgression and maladjustment. An array of specialists assessed how likely a patient’s pathological behavior was to cause danger to themselves or to others as well as whether this behavior could be contained by keeping the patient under custodial care at a state hospital. Recollecting the memory of hospitalization, ex-patients showed resentment towards a phrase like “you are here because we want you to get better.”

For ex-patients, “getting better” was an ironic justification of the psychiatric system by mental health professionals. One ex-patient, Dorothy Nissen Sibley, satirically drew an illustration of a male doctor whose right hand is about to turn on the ECT

¹²¹ “Drugs Make Some Patients Zombies,” *Wisconsin State Journal*, August 19, 1975.

machine while a female patient is lying on the table. The doctor tells her: “I’m only doing this for your own good.” The patient looking blankly at the ceiling wonders: “What would you do to me if you were trying to hurt me?”¹²² By experience, they felt that the primary function of involuntary commitment was not “getting better” but rather to keep them under the observation of trained specialists.¹²³ Voicing their discontent or even showing a strong gesture of resentment by patients was taken as proof that they needed more care.

What does “getting better” mean? The psychiatric survivors argued that the psychiatric hospital was not a medical institution but rather akin to a seventeenth century “house of confinement” where the act of transgression justified confinement. A San Francisco based group, the Network Against Psychiatric Assault (NAPA) reviewed Michel Foucault’s *Madness and Civilization* as a “good historical account of the origins of psychiatric oppression by a liberal professional.” While they pointed out Foucault’s failure to challenge the very concept of “madness,” they agreed with his interpretation of the large scale confinement of the masses as representing “no medical advance” but rather accommodating the “needs of a rising capitalism.”¹²⁴ As explained by Foucault, these “prisons of moral order” contained the double role of policing and church politics. Since Sloth represented rebellion in Christianity, the reluctance to work was thus indicated not only as idleness but also as an active moral incomppliance. Moral and economic activities inherently entwined with each other, the idler was involuntarily sent

¹²² Frank, *The History of Shock Treatment*, 91.

¹²³ Janet Gotkin and Paul Gotkin, *Too Much Anger, Too Many Tears: A Personal Triumph over Psychiatry* (New York: Harper Perennial, 1975), 98-100.

¹²⁴[*Psychiatry as Social Control: An Annotated Bibliography*, Series 2 Organization: Network Against Psychiatric Oppression]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

to forced labor at the house of confinement to correct his/ her moral disorder. In society, the degree of morale was measured by employment. According to this measure, unemployment and madness –the embodiment of savage-like unreason–were aligned closely together in the terrain of moral corruption.¹²⁵

The Rise of Anti-Psychiatry Scholars

Until the early 1970's, psychiatric patients, by and large, did not have a voice in their treatment because psychiatrists rarely valued their agency in describing their experiences. Gaining popularity in the 1960's, the scholars in anti-psychiatry questioned the conventional practices of psychiatry such as "invasive" treatments like electro-shock, tranquilizers, and deep-freezing from an academic standpoint and provided an intellectual framework for the ex-patient activists. The proponents of the movement looked at how psychiatry had been harming the development of a "*natural way of healing our own appalling state of alienation called normality*" in the words of R.D. Laing, one of the proponents of the movement.¹²⁶ The supporters of Antipsychiatry argued that rather than coaxing the individual to "adjust" to society through "treatment," the society that thrust conformity upon people needed to be interrogated and changed.¹²⁷ Created by the psychiatrist David Cooper in his 1967 *Psychiatry and Anti-Psychiatry*, the term Anti-Psychiatry was used to explain the works of Michel Foucault, R. D. Laing, Thomas Szasz, Franco Basaglia, as well as Erving Goffman.¹²⁸ In this section, I will focus on three works from scholars from the 1960's associated with the anti-psychiatry movement:

Michel Foucault's *Madness and Civilization* (Published in French in 1961, translated in

¹²⁵ Michel Foucault, *Madness and Civilization* (London: Routledge Classics, 2001), 50-60.

¹²⁶ Laing, *The Politics of Experience*, 167.

¹²⁷ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*.

¹²⁸ David J. Rissmiller and Joshua H. Rissmiller, "Evolution of the Antipsychiatry Movement into Mental Health Consumerism," *Psychiatric Services* 57, no. 6 (June 2006): 863.

English in 1967), R.D. Laing's the *Politics of Experience* (1967), as well as Thomas Szasz's the *Myth of Mental Illness* (1961).

Michel Foucault

Madness and Civilization was the first major work of French historian and philosopher Michel Foucault. Published in French in 1961, the work interrogated the transformation of the relationship between power and madness in classical era Europe. Through the work, he demonstrated the temporality of the concept of madness. When explaining the fear of madness inherent to post Revolution Paris, Foucault wrote that “the awareness of madness is on the contrary accompanied by a certain analysis of modernity, which situates it from the start in a temporal, historical, and social context.”¹²⁹ Examining the period between the opening of the *Hôpital Général* in 1657 during the so called “Great Confinement” to the “moral” treatment carried out by Philippe Pinel in the Bicêtre Hospital in 1794, Foucault argued how the awareness of madness outlined a similar landscape of society, explaining how a practice related to “the mad” was influenced by notions engendered by society.¹³⁰

In explaining how the mode of containment of the mad was influenced by an institutional character peculiar to a certain time frame, Foucault started from the disappearance of leprosy houses (leper colony) in France, England, Scotland, and Germany at the end of the Middle Ages.¹³¹ However, the imagery attached to the exclusion of leprosy survived, gaining a new symbolic adherence to “poor vagabonds, criminals, and ‘deranged minds.’”¹³² During the Renaissance, the “Ship of Fools” captured the artistic

¹²⁹ Foucault, *Madness and Civilization*, 201.

¹³⁰ *Ibid.*, 33, 59.

¹³¹ *Ibid.*, 1.

¹³² *Ibid.*, 5.

sensibility of the Rhine-Flemish region. The ships actually existed as a mechanism of the cure and exclusion of the mad where they were seized as “pilgrims.”¹³³ The long-standing symbolic adherence to the therapeutic quality of water kept resurfacing throughout the history; the quality of ablution and impregnation dominated the discourse of madness cures from the end of the seventeenth century. Water was believed to cool the boiling blood of the mania and frenzy.¹³⁴ The same notion of hydrotherapy was used until the 1970’s to calm agitated patients. The patients were routinely kept in water for eighteen hours a day.¹³⁵

The awareness of madness underwent a radical change in the classical period. Foucault argued that the socially invented space of confinement was “an institutional creation peculiar to the seventeenth century.”¹³⁶ Instead of excluding the mad through embarkation, now the docile bodies of the poor, unemployed, prisoners and the insane were sent to the “house of confinement,” sharing the same space with each other.¹³⁷ In explaining the historic event called the Great Confinement, he explained how the imagery related to the mad affected the practice. The mind of delirium used to belong to darkness. In this dream-like state of landscape, man’s reason was dazzled. Since his relation to truth was darkened, it signified that he was in the domain of unreason; in the age of reason, madness meant unreason.¹³⁸ Unlike the Renaissance where the mad freely walked around town, the madman in the classical age were regarded as something that had to be

¹³³ Ibid., 7.

¹³⁴ Ibid., 158-166.

¹³⁵ Alex Beam, *Gracefully Insane* (New York: Public Affairs, 2001), 77.

¹³⁶ Foucault, *Madness and Civilization*, 59.

¹³⁷ Ibid., 35.

¹³⁸ Ibid., 94-102.

confined, to be looked at. The madman's animal-like image gained an association with cages, bars, and chains.¹³⁹

In the Age of Enlightenment where the "blindness of madness" signified the milieu of unreason and moral fault, the objective of the hospital shifted from physical restraint to moral correction.¹⁴⁰ By bringing the cure of madness to the realm of guilt, Foucault states, "Psychology, as a means of curing, is henceforth organized around punishment. Before seeking to relieve, it inflicts suffering within the rigor of a moral necessity."¹⁴¹ In the era of early nineteenth century positivism, the madman who had been deemed as the object of unreason became one of corrupted morals. Now the mad became the object of scientific observation.¹⁴²

In post Revolution Paris, where a series of humanitarian reforms were carried out, the practice of confining the mad and prisoners in the same space was regarded as "degrading." A physician Philippe Pinel freed the insane chained in the dungeon of Bicêtre Hospital in 1793, then became a chief physician of the Salpêtrière Hospital in 1795.¹⁴³ Like the English Quaker William Tuke, who recreated the idealized view of the bourgeois family in his York Treatment in 1796, Pinel also attempted to recreate and reinvent the microcosm of his idealized society in correcting the mad.¹⁴⁴ Inside of Pinel's moralistic space, madness was punished because of its moral failure. Instead of the physical confinement of the classical era, the "madman" now became a prisoner of

¹³⁹ Ibid. 61-69.

¹⁴⁰ Ibid. 150.

¹⁴¹ Ibid. 173.

¹⁴² Ibid. 187.

¹⁴³ Ibid. 224.

¹⁴⁴ Ibid. 252.

himself trapped in a moral world. In Pinel's space, madness is the "very symbol of the confining power."¹⁴⁵

While *Madness and Civilization* was filled with Foucault's curious explanation of the "imaginary landscape of qualities" where madness was explained through the concept of bile, humor, vapor, spirit, sympathy, and fiber inside of a body, his work also became a target of criticism.¹⁴⁶ For example, an American historian David J. Rothman criticizes Foucault's lack of awareness of temporal and geographical differences in his 1990 introduction of *the Discovery of Asylum*:

Foucault was a moral philosopher whose own construction of the historical process became the text on which he grounded a series of discourse on the nature and exercise of power and authority in western civilization. He was not by temperament, by training, or by practice a historian – that is, he not only eschewed archival research but had little respect for the nuances of time...or for nuances of place. Perhaps his most glaring deficiency, however, was an unwillingness to distinguish rhetoric from reality. For Foucault, motive mattered more than practice.¹⁴⁷

It is interesting to observe the approaches of the two in analyzing history. As Rothman points out, Foucault's explanation of the historic figures or historical events are limited, omitting the historical and geographical temporalities. However, the discourse of Foucault captures a poetic quality that invokes the fantastic imagery of Hieronymus Bosch's the *Ship of Fools* and Francisco de Goya's the *Mad House*, providing a tremendously imaginative work to readers interested in the history of madness.

A British historian, Roy Porter also criticized Foucault's explanation of "great confinement" as "simplistic and over-generalized," ignoring the subtlety of time and

¹⁴⁵ Foucault, *Madness and Civilization.*, 216.

¹⁴⁶ *Ibid.*, 135.

¹⁴⁷ David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (New Brunswick: Aldine Transaction, 1971), xix.

geography.¹⁴⁸ In contrast to the centralized operation of the seventeenth century French asylum, Porter explained how other European countries like Russia and England did not have systematized, publicly funded asylums until the nineteenth century. Porter also questioned Foucault's argument that moral therapy installed a bourgeois work ethic in patients. Porter found little trace of organized labor in the early asylum. On the contrary, those asylums were often criticized as "dens of idleness."¹⁴⁹

In addition, Porter found Foucault's premise that the insane asylum functioned as a milieu of social control too simplistic. For Porter, the asylum was not an apparatus to instill the work ethic of burgeoning industrial society. Instead, it was the "site of myriad negotiations of wants, rights, and responsibilities, between diverse parties in a mixed consumer economy with a burgeoning service sector."¹⁵⁰

However, the major function of Foucault's work was not to describe historic events and practices with precise accuracy. Scottish psychiatrist, R. D. Laing acclaimed his work as an exceptional book that challenged the "assumptions of transitional psychiatry." Foucault's role was to provide a new intellectual framework to the history of madness and civilization.¹⁵¹ For the proponents of anti-psychiatry, the function of Foucault's work was not to look at twentieth century psychiatry as an unchanging practice based on absolute truth but to interrogate such a premise by looking how modern psychiatry, like any other social institution, had been influenced by the temporality of thought, knowledge, and practice.

¹⁴⁸ Roy Porter, *Madness: A Brief History* (Oxford: Oxford UP, 2002), 93-95.

¹⁴⁹ *Ibid.*, 98.

¹⁵⁰ *Ibid.*, 98.

¹⁵¹ R.D. Laing's preface from *Civilization and madness*.

R. D. Laing

Published in 1967, R. D. Laing argued that the fragmentation and alienation of modern human beings was caused by their dismissal of “experience” in the *Politics of Experience*. As he was interested in the growing influence of Zen on the domain of psychotherapy, the piece was dotted with mysterious Zen conundrum-like discourse: “The common bond between Us may be the Other,” “We are They to Them as They are shadows of each other.”¹⁵² Such cryptic phrases dotted the entire book. His imagery was influenced by psychotropic agents. After his initial LSD trip in 1961, he provided his clients with the substance for therapeutic purposes.¹⁵³ In the book, he attempted to distinguish between experience and behavior as between inner and outer, or between imagination and perception. Laing showed a concern for modern society where people’s inner experience, which used to be called the “Soul,” was alienated.¹⁵⁴ The rich landscape of dream-like fantasy was the farthest place where a “normal” mind could reach, but he was afraid that alienation of experience led to the damnation of intimate fantasy. Laing argued: “If you do not know the boundary of fantasy, how would you know where to find ‘pathological’ zones of hallucination, phantasmagoric mirages, delusions?”¹⁵⁵ Fantasy was a way one could relate to the inner experience and the world.¹⁵⁶ He also questioned the limitation of psychology: “How could one ever study the experience of *the other*?” He continued: “Natural science knows nothing of the relation between behavior and

¹⁵² Laing, *The Politics of Experience*, 92, 98.

¹⁵³ Daniel Burston, *The Wing of Madness: The Life and Work of R. D. Laing* (Cambridge, MA: Harvard UP, 1998).

¹⁵⁴ Laing, *The Politics of Experience*, 18.

¹⁵⁵ *Ibid.*, 10.

¹⁵⁶ *Ibid.*, 14.

experience.”¹⁵⁷ Since one’s experience was in the domain of inner milieu, no other person could see through the subjective experience that was only observable through a person’s behavior. “My experience of you is always mediated through your *behavior*,” Laing explained.¹⁵⁸

In terms of alienation of genuine relationship and the slight of authentic communication between the two, Laing also criticized the concept of modern family. Laing regarded family as merely a machine for creating a *one-dimensional man*.¹⁵⁹ For him, family was the unit where brainwashing was carried out. Family was where children could be “indoctrinated” to society so that they could adapt to a wider society. Hence, Laing showed a strong resentment towards the expected role of modern families as the smallest unit of society where children could learn how to adapt to the wider society: “Adaptation to what? To society? *To a world gone mad?*”¹⁶⁰ “Whether it is the exposure to sham, the spatialization and quantification of experience or the massive economic irrationality of the whole system,” he believed the late 1960’s was a highly fragmented and alienated society.¹⁶¹ He would have referred to the source of alienation from the postwar social structure in terms of a change where a nuclear family became the norm of society.

Laing celebrated the intimacy of a therapist and a patient in the therapeutic process where the patient could understand the relationship between the two persons. The patient regained the context between experience and behavior within the “relevant

¹⁵⁷ Ibid., 4-5.

¹⁵⁸ Ibid., 9-10.

¹⁵⁹ Ibid., 65.

¹⁶⁰ Laing, *The Politics of Experience*, 65.

¹⁶¹ Ibid., xv.

contextual social *systems*.”¹⁶² Hence he showed a rejection of Freud’s “metapsychology” where there was a lack of language in explaining relations. Laing deemed the awareness of relation as the essential process. Where Freud objectified the system of therapy; Laing attempted to “see man as an object of natural scientific investigation.”¹⁶³ Laing further extended the criticism to Behavior therapy, despising the method as a “technique of non-meeting, of manipulation and control,” simply repressing the mere symptom of the illness.¹⁶⁴

In the *Politics of Experience*, Laing explicitly showed his hatred towards behavior therapy, mentioning the depersonalizing aspect of Freud’s psychotherapy where he recognized the lack of phrases in explaining interpersonal relation in Freud’s theory. Laing carried his analysis over to game theory, objective-relations theory, and transactional electronic systems, summarizing them as a dangerous analogy where man and machine were analyzed in the same tableau. As he extended his concerns to behavior therapy, stating that it was based on “schizoid theory,” derogating the mechanical nature of the therapy as a replication of behavior without experience. Laing believed that behavior therapy sabotaged building a relationship between a therapist and a patient. It was an anti-therapy, a mere “technique” that simply masked the root of alienation.¹⁶⁵ In such a mechanical relationship, the patient felt detached from or even became unaware of his/ her innermost feelings. By boiling down the explanation of human behavior to the level of environmental stimuli, the experience was placed out of context, cast into oblivion. The core of experience, or as Laing would put it, the Soul, became a Pandora’s

¹⁶² Ibid., 28.

¹⁶³ Ibid., 29.

¹⁶⁴ Ibid., 32.

¹⁶⁵ Laing, *The Politics of Experience*, 31-32.

Box that nobody, even the “owner” of the box, should look at. If behavior was detached from the subjective experience of feelings and emotions, how would it even be possible to place one’s inner experience: sadness, anger, joy, creativity, desire, and pleasure into a relationship between “I” and “you”?

Herbert Marcuse’s seminal work, *One-Dimensional Man* touched upon the political implications of a therapeutic enterprise where the cognitive function of human behavior was placed on the center stage of treatment. For Marcuse, a therapist’s office was a factory that cranked up the well *adjusted* one-dimensional man. The existential reason of such a man was to satisfy the operational needs provided by the prevailing system, in Marcuse’s argument, the advanced industrial society. Advertisements guaranteed that satisfying such operational needs was equivalent to self-fulfillment, hence the satisfaction of such needs signaled one’s liberty. Marcuse argued that “economic freedom would mean freedom *from* the economy--from being controlled by economic forces and relationships; freedom from the daily struggle for existence, from earning a living.”¹⁶⁶ On the other hand, in a society where economic freedom meant “free choice between brands and gadgets,” the commercialized pleasure was a tool for mass submission.¹⁶⁷

For Marcuse and Laing, the seemingly non-political, scientific therapeutic enterprise was indeed the political machinery that produced a well greased one-dimensional man. Apparently benevolent help to acclimate one’s patients to their

¹⁶⁶ Herbert Marcuse, *One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society* (Boston: Beacon Press, 1964), 4.

¹⁶⁷ *Ibid.*, 7, 75.

surrounding by observing and then modifying behaviors deterred one's capacity to question those surroundings:

(C)ognitive concepts transcend all operational context, but their transcendence is empirical because it renders the facts recognizable as that which they really are...

Where these reduced concepts govern the analysis of the human reality, individual or social, mental or material, they arrive at a false concreteness--a concreteness isolated from the conditions which constitutes its reality. In this context, the operational treatment of the concept assumes a political function. The individual and his behavior are analyzed in a therapeutic sense--adjustment to his society. Thought and expression, theory and practice are to be brought in line with the facts of his existence without leaving room for the conceptual critique of those facts.¹⁶⁸

In an environment where the analysis of cognizable behavior satisfied the pursuit of human reality, one's treatment progress was measured by his/ her adjustment to society.

A questioning attitude towards the surrounding environment became sidelined. In the United States, humanistic and existential psychologists like Rollo May also criticized the one-dimensional aspect of behaviorism, encouraging his clients to explore beyond the operational goal they or a therapist thought they ought to reach:

...the lack of an adequate concept of the nature of man has made the definition of health inevitably empty, and into that vacuum rush such imposters as "adjustment," "fitting in," "according one's self with the realities of the society," and so on. This tendency, I believe, increases radically with the recent emergence of "operant conditioning" forms of psychotherapy which are based on an outspoken denial of any need for a theory of man at all beyond the therapist's assumption that whatever goals he himself and his society have chosen are the best for all possible men.¹⁶⁹

In response to modern psychology's fixation with "adjustment," Martin Luther King, Jr., posed a concept called "creative maladjustment" in a 1963 speech. He envisioned creating *The International Association for the Advancement of Creative*

¹⁶⁸ Ibid., 106-107

¹⁶⁹ Rollo May, *Psychology and the Human Dilemma* (New York: W. W. Norton & Company, 1967), 117.

Maladjustment where the maladjusted men and women would be like the prophet Amos.

Modern psychology, particularly child psychology blurred the importance of being adjusted as early as possible in one's life. But you need to question, King asked the audience, do you want to be adjusted to a society where injustice is the norm?

...there are certain things in our nation and in the world which I am proud to be maladjusted and which I hope all men of good-will will be maladjusted until the good societies realize. I say very honestly that I never intend to become adjusted to segregation and discrimination. I never intend to become adjusted to religious bigotry. I never intend to adjust myself to economic conditions that will take necessities from the many to give luxuries to the few. I never intend to adjust myself to the madness of militarism, to self-defeating effects of physical violence...¹⁷⁰

Laing, Marcuse, May, and King's angst towards the creation of the well-adjusted individual represented what was happening in the 1960's. A military psychiatrist named Lloyd Cotter carried out a behavioral experiment on schizophrenic patients and autistic children in the Bien Hoa Hospital in South Vietnam. Using a technique invented by a Behaviorist B. F. Skinner, the aim of the therapy was to modify the unfavorable behavior of a subject through "positive" and "negative" stimuli using "conditioning." According to a news report in 1967, some patients who were associated with undesirable behavior were deprived of food for days. Cotter administered ECT without anesthetics or muscle relaxants, something which had been illegal in the US. While Cotter claimed the treatment was beneficial, the news reports of the hospital treatment served as proof of the "US imperialist cause in Southeast Asia."¹⁷¹

¹⁷⁰ Karen Steinberg, "Dr. Martin Luther King on Creative Maladjustment and Modern Psychology," *Possibility Practice*, accessed March 14, 2014, <http://thepossibilitypractice.com/martin-luther-king-jr-on-creative-maladjustment/>.

¹⁷¹ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 124-125; Until 2011, the Judge Rotenberg Center in Canton Massachusetts also carried out A *Clockwork Orange* like "treatment" where children with developmental disability were strapped with a backpack with a shock device.

Concerning schizophrenia and the experience of psychosis, R. D. Laing analyzed the label of schizophrenia as something that was pinned on other people “under certain social circumstances.”¹⁷² He believed the cause of schizophrenia relied on the social context where the patient was placed. His reference to the work of anti-psychiatry fellow, Erving Goffman was particularly compelling in confirming Laing’s statement. An American sociologist, Goffman argued there was no clear cut line between sanity and insanity. Working as an assistant physical therapist at a psychiatric hospital in Washington DC, he introduced the concept “total institution” where a patient was regarded “as a non agent, as a non-responsible object.”¹⁷³ Published in 1961, Goffman’s book *Asylums* explained how patients’ behavior was analyzed out of context in order to prove their “pathologic” behavior; in the asylum, if a frustrated patient banged chairs to show his/ her rejection of the institution, the workers simply defined the person as having a psychotic symptom.¹⁷⁴ In discussing schizophrenic experience, Laing suggested a connection with an initiation ceremony. Instead of stopping his/her “voyage” to their inner world by “treatment,” Laing argued there should be “*a natural way of healing our own appalling state of alienation called normality.*”¹⁷⁵ This transcendental experience could be a breakthrough for a patient, not a breakdown.¹⁷⁶ As a psychiatrist, Laing must have pictured himself as a guide or shaman in assisting patients through an initiation experience.

Critics of Laing pointed out that he romanticized psychosis as a transcendental experience, while weaving a “psycho-political” message into a person’s “mental

¹⁷² Ibid., 70.

¹⁷³ Laing, *The Politics of Experience*, 110.

¹⁷⁴ Ibid., 111.

¹⁷⁵ Ibid., 116.

¹⁷⁶ Ibid., 93.

misery.”¹⁷⁷ Based on his experience in a hippy commune in British Columbia and subsequent hospitalization with a diagnosis of schizophrenia, Mark Vonnegut published his autobiography *The Eden Express: A Memoir of Insanity* in 1975. A son of the counter-culture writer Kurt Vonnegut, Vonnegut had been a fervent follower of R. D. Laing and Thomas Szasz. However, his disillusion towards such radical psychiatrists hit him during the hospitalization. Prior to the publication of *The Eden Express*, he wrote an article titled “Why I Want to Bite R. D. Laing,” explaining how he became disillusioned with Laing while he was committed to a hospital for schizophrenia in 1971:

He's said so many nice things about us: we're the only sane members of an insane society, our insights are profound and right on, we're prophetic, courageous explorers of inner space, and so forth... But what I felt when I found myself staring out of the little hole in the padded cell was betrayal. I did everything just like you said, and look where I am now, you bastard.¹⁷⁸

Laing's “Madness need not be all breakdown. It may also be breakthrough” became a slogan of the counter-culture but at the same time the phrase went out of his control.¹⁷⁹

To experience the “breakthrough,” some took LSD to induce hallucinations; Judi Chamberlin's colleague Sandra Ruffner argued that Mark Vonnegut was one of the Laing devotees who “believed in one popular interpretation of R. D. Laing's book *The Politics of Experience*.”¹⁸⁰

¹⁷⁷ Bob Mullan, *Mad to Be Normal: Conversations with R.D. Laing* (London: Free Association Books, 1995), 9.

¹⁷⁸ Mark Vonnegut, “Why I Want to Bite R.D. Laing,” *Harper's Magazine*, April 1974, quoted in Ross V. Speck, *American Journal of Orthopsychiatry* (accessed from <http://laingsociety.org/biblio/critique/speckreviews.htm>).

¹⁷⁹ Laing, *The Politics of Experience*, 133.

¹⁸⁰ [A book review of *the Eden Express* by Sandra Ruffner, Series 1 Vonnegut, Mark]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

The romanticized interpretation of mental illness in *The Politics of Experience* had serious implications for people with the diagnosis of schizophrenia.¹⁸¹ In response to Chamberlin's review of *The Eden Express* that criticized Vonnegut as a "good mental patient," Vonnegut fiercely refuted Chamberlain's biting remarks: "There are a number of exceptionally cheap shots that make me just want to say 'fuck you.'"¹⁸² He thought popular scholastic arguments about madness—that mental illness was a myth (Szasz) or that it was a natural reaction to the unjust society (Laing)--were self-perpetuating tools tinged with whatever political camps they were in:

I feel that most psychiatrists should be taken out and shot. Szasz and Laing included. I'm fed to the teeth with theoreticians [*sic*] of all stripes and colours using mental illness and mental patients to push their own theories and prestige [*sic*]. Everyone's swarming to whatever theory they find congenial. No one or damn near no one gives a damn about what really helps people.¹⁸³

While her rebuttal was fierce, Chamberlin agreed with Vonnegut about Laing's romanticization of madness: "madness (or whatever) is not a romantic adventure. It hurts."¹⁸⁴

As the advocator of a patient-run alternative to psychiatry, Chamberlin also had a "real quarrel" with Laing's position as a psychiatrist. In the Laingian therapeutic environment, no matter how anti-authoritarian the psychiatrist was, the role of a "psychiatrist" and a

¹⁸¹ Laing, *The Politics of Experience*, 133.

¹⁸² [A book review of *the Eden Express* by Judi Chamberlin, Series 1 Vonnegut, Mark]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

¹⁸³ [January 31, 1977 correspondence from Mark Vonnegut to Judi Chamberlin, Series 1 Vonnegut, Mark]. Ibid.

¹⁸⁴ [November 25, 1981 correspondence to Karen. Series 2 Conference: New York Civil Liberty Union Conference of the Rights of Mental Patients]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

“schizophrenic” was rigidly fixed. Chamberlin thought such fixed roles did not create a mutual, equal place for support, understanding, and healing.

Thomas Szasz

Foucault found the coercive, moralistic roots of asylums in the trinity of policing, church, and judicial power through philosophical inquiry. As a radical, alternative psychiatrist, Laing drew an idealized therapeutic environment by portraying himself as a modern-day shaman. In contrast to those left-leaning scholars who became iconic figures of the counterculture, psychiatrist Thomas Szasz approached the politics of involuntary commitment from the medico-judicial perspective. On the grounds of castigating the systematic control of one’s liberty, Szasz, a civil libertarian, divulged the relationship between judiciary and psychiatric systems, gaining support from populist and intellectual audiences.¹⁸⁵ In his influential book *The Myth of Mental Illness* published in 1961, Szasz declared: “I am opposed, on moral and political grounds, to all psychiatric interventions which are involuntary; and, on personal grounds, to all such interventions which curtail the client’s autonomy.”¹⁸⁶ For ex-patients in the 1970’s, Szasz was the most influential scholar working on behalf of patients’ rights. Claiming that those who were regarded as “mad” were in fact nonconformists who could not play the game of societal status-quo, his argument was readily adopted by a wide-range of activists.

As a libertarian, Szasz castigated the liaison between the state and psychiatry, arguing that the former was corrupting psychiatry. The government seized on psychiatry as a tool of social control, legitimizing coerced treatment upon people who were labeled

¹⁸⁵ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 101-2.

¹⁸⁶ Thomas Szasz, *the Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper Perennial, 1974), 261.

as mentally ill. Szasz argued that since there was no visible brain lesion, schizophrenia's classification as a disease was a "fiction perpetrated by organized psychiatry to gain power."¹⁸⁷

While Szasz argued mental illness was a myth propelled by psychiatry, he also believed that people who were perceived as mentally ill were either consciously or unconsciously playing a "strategy for evading responsibility and/ or exercising power in the games of interpersonal interactions."¹⁸⁸ In *Being Mentally Ill*, Scheff focused on the involuntary aspect of such role-playing.¹⁸⁹ Goffman sympathetically observed how hospital inmates were committed due to social factors, but Szasz simplistically interpreted mental illness as a strategy for helping patients avoid responsibility. He was obsessed with the idea of "personal responsibility." For example, he interpreted the popularity of the insanity defense from the 1950s onwards as a medical game where patients – or "malingerers" as he called them – essentially exploited the psychiatric and judicial systems for their own ends.¹⁹⁰

The scholars in the early 1960's anti-psychiatry movement brought the discussion of madness and of the psychiatric system to the table of political and philosophical discussion. Foucault and Laing argued from the left-leaning standpoint, while Szasz did so from the libertarian point of view. The theories of these scholars became a highly charged philosophical and political debate over *man's search for meaning*. On the other hand, ex-patients' reactions to these arguments varied, creating controversial discussion within the community.

¹⁸⁷ David J. Rissmiller and Joshua H. Rissmiller, "Evolution of the Antipsychiatry Movement into Mental Health Consumerism." 864.

¹⁸⁸ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 104.

¹⁸⁹ Scheff, *Being Mentally Ill: A Sociological Theory*, 50.

¹⁹⁰ Thomas Szasz, *the Myth of Mental Illness*, 236.

Conference on Human Rights and Psychiatric Oppression

At the end of 1975, Chamberlin moved from Bellingham, Washington to Boston to join the Mental Patients Liberation Front (MPLF). She would later call the MPLF “the purest, clear, radical group.”¹⁹¹ Many of the original members were from the political left who had been engaged with other civil rights movements. The name, the Mental Patient Liberation Front resembled the National Liberation Front of Vietnam. “It was meant to shock, it was meant to get people’s attention,” Chamberlin later explained in her interview.¹⁹² The organization had a practical, effective strategy backed up with the philosophy of the civil rights movement. When Chamberlin joined the group, they were focusing on in-hospital organizing by distributing a booklet called *Your Rights as a Mental Patient in Massachusetts* to the patients in state hospitals. In the mid 1970’s, the MPLF focused on organizing at Boston State Hospital. Once a week, the members and the hospital patients met in the hospital to discuss patient rights. A volunteer at the hospital invited the MPLF members to be guest speakers at a “current event group.” Since the patients wanted to talk about their rights as a current event, the MPLF members were able to organize the group for months without administrators being aware of their activity. Once the hospital staff noticed the presence of the MPLF members, they were asked to leave, but the patients were able to invite them back by organizing a petition.¹⁹³ Allied with the Greater Boston Legal Services, the MPLF also assisted with multiple lawsuits regarding forced medication and seclusion.¹⁹⁴

¹⁹¹ Penney Derby, Interview with Judi Chamberlin, 2002, www.community-consortium.org/projects/chamberlin-judy.pdf, 24.

¹⁹² Pelka, *What We Have Done: An Oral History of the Disability Rights Movement*, 288.

¹⁹³ Derby, Interview with Judi Chamberlin, 24.

¹⁹⁴ Pelka, *What We Have Done: An Oral History of the Disability Rights Movement.*, 289.

Volunteers were a medium between the activists and patients. When guards at Bridgewater State Hospital discovered that a volunteer teacher was distributing the MPLF pamphlet, they regarded the group as “outside agitators,” with one guard showing his disgust by saying that “sick puppies here don’t need this shit.”¹⁹⁵ As evidenced by the guard’s strong reaction, the pamphlet was a powerful tool for making the patients’ voices heard in a difficult situation. The handbook aimed to protect patients’ rights by showing them how to navigate through the judicial system if they were involuntarily committed. The handbook gave direct, practical advice. For example, in the section titled *Civil Commitment*, the MPLF advised patients: “Remember, the judge will be influenced by your appearance and attitude. Try to look your best. If you wear your own clothes, you will look less like a ‘mental patient’ than if you show up in hospital pajamas.”¹⁹⁶

Since 1973, ex-patients groups in North America had been organizing a national level conference every summer. The first conference was held at the University of Michigan. Organized by a psychologist and the Mental Patient Liberation Project (MPLP), the conference agreed that an ex-patient led model of recovery was necessary for their liberation.¹⁹⁷ Chamberlin did not attend the first conference, but after the second conference held in Topeka, Kansas, she attended almost all the conferences until the conferences ceased in 1985.

Fifty-one “psychiatric inmate organizations” joined the 1974 Kansas conference. From England, the Philadelphia Association which had operated R. D. Laing’s Kingsley

¹⁹⁵ Tom Ryan, *Screw: a guard’s view of Bridgewater State Hospital* (Boston: South End Press, 1981), 69.

¹⁹⁶ Mental Patient Liberation Project, *Your Rights as a Mental Patient in Massachusetts: A Handbook for Patients (In-Patients, Out-Patients, and Pre-Patients) by Ex-Patients* (W. Somerville, MA: Legal Project/Mental Patient Liberation Front, 1974), 18.

¹⁹⁷ Judi Chamberlin, “The Ex-Patients’ Movement: Where We’ve Been and Where We’re Going,” *Journal of Mind and Behavior* 11, no. 3 (Summer 1990), accessed from <http://www.power2u.org/articles/history-project/ex-patients.html>

Hall joined. Groups from Canada, New Zealand, and France also joined the conference held in a campground.¹⁹⁸ The participants marched at Topeka State Hospital; the rallying became a custom for the conference participants.¹⁹⁹ The third conference was held in San Francisco in July 1975. Sponsored by the Network Against Psychiatric Assault (NAPA), the conference was attended by “former mental patients, activists in patients’ rights and anti-psychiatry organizations, workers in Bay Area ‘alternative’ therapies, other ‘mental health’ professionals, including a few practicing psychiatrists, and considerable number of the concerned and merely curious.”²⁰⁰ The conference was held at the International Museum of Erotic Art in the downtown area.²⁰¹

The rallying target for the third conference was St Mary’s Hospital where the NAPA members had carried out a series of investigations revealing the forced treatments at their McAuley Neuropsychiatric Institute. An anonymous registered nurse who had worked at the institute testified that “(t)he place is like a prison and I felt more like a warden than a person who was there to help.”²⁰² When Laura Grandin was hospitalized at the institute, she went through so called “harassment therapy” to “mobilize her anger.” The first program was to scrub the outline of a linoleum square block on the floor with a toothbrush counter clockwise from seven in the morning to eleven in the evening. When the first regimen of the therapy was deemed a failure, her cleaning task became more unpleasant and Spartan; the rules became more and more cryptic. Another task was to

¹⁹⁸ Derby, Interview with Judi Chamberlin, 29.

¹⁹⁹ Ibid., 27.

²⁰⁰ Judi Chamberlin, “Fighting Psychiatric Oppression,” *Northwest Passage*, August 28, 1975.

²⁰¹ The museum was operated by psychologists Dr. Phyllis and Eberhard Kronhausen. The museum closed its door approximately three months after the conference due to rising operational costs. <http://news.google.com/newspapers?nid=1755&dat=19750929&id=JOohAAAAIABAJ&sjid=H2cEAAAAIABAJ&pg=4704,6415732>

²⁰² [Correspondence from NAPA June 6, 1975. Series 2 Conference: Conference of Human Rights and Psychiatric Oppression, Third, 1975]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

memorize a book about the life of Theodore Roosevelt words by words, including punctuation.²⁰³

Another “treatment” was “sheeting.” By wrapping a patient tightly with seven sheets, he/ she was immobilized and then strapped to a bed. David Paul, a McAuley staff person testified for the NAPA that sheeting was used against disobedient patients. The disobedience included hitting a person, screaming, pacing, or refusing staff request to take medication. Sheeting was an “essential deterrent to noncooperation.”²⁰⁴ In August 1974, one doctor administered a “special sheeting program” by wrapping a patient ten to seventeen hours a day for five days. During the five days, he was under a drug induced state of sleep. During the sleep therapy, the doctor administered four to eight hundred milligram of Thorazine orally to the patients three times a day. The patient was also given “generous dosage of Librium, Mellaril, Stelagine, Sodium Amytal, Haldol, Cogentin, and Colace.”²⁰⁵

In addition to the Electro Convulsive Therapy, the McAuley Neuropsychiatric Institute also used the Indoklon Convulsive Therapy (ICT). Introduced by John C. Krantz, Jr. in 1957, a volatile liquid substance Indoklon was either inhaled or injected to induce convulsion.²⁰⁶ At the institute, the ICT was carried out on an experimental basis.²⁰⁷ While she was committed to McAuley, Paula Fine noticed a disproportionate number of female patients were subjected to ECT. Before leaving the hospital in

²⁰³ [Harassment Therapy, Series 2 Conference: Conference of Human Rights and Psychiatric Oppression, Third, 1975]. [Judi Chamberlin Papers]. Ibid.

²⁰⁴ [Documentation and testimony, Series 2 Conference: Conference of Human Rights and Psychiatric Oppression, Third, 1975]. Ibid.

²⁰⁵ Ibid.

²⁰⁶ Frank, *The History of Shock Treatment*, 175.

²⁰⁷ [Testimony of Paula Fine, Series 2 Conference: Conference of Human Rights and Psychiatric Oppression, Third, 1975]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

December 1973, she checked the past six months' list of patients of ECT and confirmed that many more women had received the treatment than men. Out of seventy-two patients, fifty-one were female, which was over seventy percent.²⁰⁸

On Friday, July 4th, the participants of the conference rallied and marched around St Mary's Hospital. Starting at Union Square in downtown San Francisco, the march walked for over three miles chanting, "What do you want? FREEDOM! When do you want it? NOW!!" "Two, four, six, eight. Smash the therapeutic state." "Join us – it could happen to you."²⁰⁹ At the hospital, the San Francisco police force was guarding the hospital property because the NAPA members had successfully entered a locked ward before. Because of the police order to remain quiet in a hospital zone, the marchers decided to rally on the sidewalk outside. While they were not sure their chants could reach the patients in the locked wards, they chanted a "message of support," and repeated the NAPA's telephone number so the patients could later contact the NAPA. They ended the march by singing *We Shall Overcome*.²¹⁰

During the San Francisco conference, Chamberlin became more and more aware of the division between mental health professionals and ex-patients. While those professionals were well intentioned people who wanted to improve the condition mental patients were under, Chamberlin could not bear their controlling attitude masked under benevolent intentions. At the conference, the mental health professionals were trying to pacify the ex-patients' anger that came from their experience of forced treatments, drugging, and seclusion. As a result, Chamberlin felt those well intentioned professionals

²⁰⁸ [No One Should Receive ECT, Ever! by Paula Fine]. Ibid.

²⁰⁹ Chamberlin, "Fighting Psychiatric Oppression," 8.

²¹⁰ Ibid., 9.

were trying to discredit her feelings and opinions. For the professionals, ex-patient anger was something to be checked and controlled. In fact, this desire to control ex-patient anger was a prime source of the ex-patients' anger. Chamberlin and her colleagues' saw it as a matter of human rights:

The whole idea of "objectivity" is an example of the elitist professionalism that pervaded so much of the Conference. The result of enshrining objectivity as a prime virtue was to deemphasize and discredit the passion and anger of those Conference participants who live with the consequences of psychiatric oppression every day of our lives—former psychiatric inmates. Our individual expression of anger and dissatisfaction were put down by some of the professionals present (supposedly our "allies")...²¹¹

Chamberlin was sick and tired of being discredited as an unreliable narrator of her own experience. Like anyone else, she was an expert of her own experience. Why did professionals discredit her experience? This was a decisive moment for her realizing that ex-patients needed an alternative system run completely on their own.

At the end of the 1975 conference, Chamberlin and her colleagues set up an ex-inmates' Caucus. The next conference in 1976 would be held in Boston sponsored by the Mental Patients Liberation Front. In December 1975, Chamberlin moved from Bellingham, Washington to join the MPLF.²¹² The Caucus's decision for the Boston conference was to divide the four-day conference into two sections: the first two days were exclusively for current and former "psychiatric inmates" and non-professional, non ex-patients who were active in the movement. The workshops on those days focused on "theory and practice in the mental patients liberation movement."²¹³ The rest of the two days was open to the general public, which included mental health professionals. The

²¹¹ Ibid., 8.

²¹² She remained in the Boston area until her death in 2010.

²¹³ [Conference on Human Rights and Psychiatric Oppression, Series 2 Conference: Conference on Human Rights and Psychiatric Oppression, Fourth, 1976]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

workshops on those days were geared towards educating the general public. All the workshops were decided on the first day of the conference. Prior to the conference, workshop topics were “suggested”; those topics included “Relating to the Prisoners’ Movement,” “Working with Liberals,” “How to Talk Back to Your Shrink,” and “How to Get Off Drugs.”²¹⁴

On a late May weekend, the conference was held in Tufts University. Just as the previous conference in San Francisco marched around St. Mary’s Hospital, the Boston conference targeted the Massachusetts Mental Health Center and the Harvard Medical School. They considered the former “as a symbol of psychiatric oppression” and the latter “as a symbol of the ruling institutions in this country, which put wealth, property, and power above the basic needs of human beings.”²¹⁵ With signs bearing the slogans “Smash Psychiatric Oppression!!!” and “I am the Expert of My Own Head,” over a hundred people rallied in front of the Massachusetts Mental Health Center.²¹⁶ At the entrance, they chanted “Patients united will never be defeated.”²¹⁷ While the demonstrators were exchanging words with hospital psychiatrists and the police, a woman on the third floor seclusion room called to them: “If I had a chance, I’d take my own life...because they’ve treated me so bad I’m not worth two cents.” The patient, Selma was in the seclusion room so long that she wanted to call her daughter. She was also unable to go to the bathroom.²¹⁸

²¹⁴ They also proposed workshops regarding the relationship between psychiatry and race, class, gender, and sexual orientation. [Suggested Workshop Topics, Series 2 Conference: Conference on Human Rights and Psychiatric Oppression, Fourth, 1976]. Ibid.

²¹⁵ [Conference on Human Rights and Psychiatric Oppression, Series 2 Conference: Conference on Human Rights and Psychiatric Oppression, Fourth, 1976].Ibid.

²¹⁶ Neil Miller, “Marchers Seek Mental Patients’ Rights,” *Gay Community News*, June 12, 1976.

²¹⁷ Susan Abrams, “Psych Warfare: Patients or Prisoners?,” *Boston Phoenix*, June 22, 1976, 24.

²¹⁸ Ibid., 24.

I remember a bunch of the Mass. Mental staff were gathered blocking the door, like they were afraid we were going to storm the place. And the patients were able to look out the window and see us. We were having conversations with them, yelling back and forth, and there was this one woman who was in a seclusion room, yelling out the window to us that she had been yelling for the staff to come unlock the door so she could go to the bathroom. And so we began chanting: “Let Selma go to the bathroom! Let Selma go to the bathroom!”

It was really a very exciting moment, because it all comes down to these very simple issues of human dignity.²¹⁹

By the mid 1970’s, the ex-patients were rapidly gaining legitimacy for their collective voice. The ex-patient activists had learned tactics to organize their own civil rights movement by joining their predecessors in other human rights movements. By the mid 1960’s, the scholarly discussion of the social context of madness gained legitimacy not only in academia but also with the public. Based on those intellectual discussions, the emergence of patients rights’ organizations in the early 1970’s gained a political legitimacy, able to disclose the inhumane nature of forced treatment and to win over the general public through their own testimonies. In the next chapter, I would like to discuss how the psychiatric survivors movement after 1976 faced challenges posed by the prevalence of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* and the biological explanation of the etiology of mental illness.

²¹⁹ Pelka, *What We Have Done: An Oral History of the Disability Rights Movement*, 289-90.

Chapter 3

PATIENTS' STORY, SYMPTOM, AND DSM-III

One by one various clinicians approached me starting with the doctor in charge, and gradually working their way down in the ladder. Each fired a series of questions at me. Each seemed little concerned with who I really was inside; they just seemed intent on getting their questions and I remained silent. They sat me in a wheelchair and wheeled me over to a corner, while they decided what to do next. Meanwhile a young corpsman, the lowest ranking “clinician” in the emergency room, stopped over to see me. He looked at me in a caring, focused manner. It was clear in his eyes that he cared about the me deep inside. In a very gentle voice he then said, “Hi, my name is Rick. I can see that you are in a lot of pain. Could you nod your head if you can hear me?” I nodded in affirmation and felt that I could return to living with other people.²²⁰

-- Daniel B. Fisher, M.D., Ph.D.

While survivors were advocating for an alternative to the medical model based explanation and treatment of mental illness in the mid 1970's, the mental health system was also radically transforming itself in a direction ex-patients like Chamberlin did not like. Ex-patients were claiming the legitimacy of their voice, but at the same time, symptomatology was gaining more power in the process of diagnosis. Robert Spitzer was appointed as the chairman for the DSM-III taskforce in 1974, and he aimed to put the diagnosis process through a drastic change. Under his system, the etiology of illness--whether caused by biological, genetic, or even social factors--was not a determining factor; by excluding the possibility of considering those potential underlying causes, he established the system that symptom was the best, and the only, clue to diagnose.²²¹

However, because virtually all the psychiatrists and other mental health workers in the

²²⁰ [Reflection on the HRA-Sponsored Recovery Workshops on March 10, 1992 by Daniel B. Fisher, MD, PhD Series 2 Conference: Adult Survivors of Child Abuse in the Mental Health System]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

²²¹ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 38.

United States used the DSM, the manual became a great supporter of the medical model based explanation of the cause of mental illness.

The discussion about the etiology of madness has been split between the medical and the social model explanations. The rise of the anti-psychiatry movement in the 1960's invigorated the discussion that people experienced an extreme state of mind because the social pressure coaxed them to conform by playing an expected role in their community. Rather than trying to adjust to the environment, the proponents of anti-psychiatry argued, society needed to change.

However, from the 1980's onwards, the medical model explanation of madness began occupying the discussion about mental health and illness. Michael Staub's 2011 book, *Madness Is Civilization: When Diagnosis Was Social, 1948-1980* explains that this medical and social "tug-of-war" has been "unsettled and unresolved." This cyclical argument goes like a see-saw; one side gains legitimacy while the other goes down.²²²

The proponents of the medical model argue people suffer from mental illness because of the imbalance in the way their brains function. For example, established in 1979, the National Alliance on Mental Illness (NAMI) is a patient and patient's family advocacy group which supports the medical model explanation of mental illness: "A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life."²²³ As a person with Diabetes

²²² Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 193.

²²³ "NAMI | What Is Mental Illness?," accessed March 22, 2014, http://www.nami.org/Template.cfm?Section=By_Illness.

mellitus type 1 needs insulin to sustain his/ her life, the NAMI states a person with serious mental illness--“major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder”-- can recover by the help of pharmacological solutions.²²⁴

In this chapter, I will explain how the medical model explanation of mental illness gained legitimacy by explaining the Rosenhan Experiment in 1974 and the subsequent conception of the DSM-III in 1980. To illustrate how the DSM-III tried to gain scientific legitimacy, I look at the works of Sigmund Freud for psychoanalysis, Robert Spitzer for the DSM-III, and B. F. Skinner for Behaviorism. I will then continue explaining how the arguments by the social and medical model camps were affected by the federally led de-institutionalization programs. I end this chapter by illustrating how Judi Chamberlain found a wider support from the cross-disability advocacy movement in the midst of the prevalence of the medical model based explanation.

Biological Model vs Social Model: DSM-III and Rosenhan Experiment

In comprising the DSM-III, there was a reason why Spitzer’s radical approach in diagnosis was deemed necessary by psychiatry. A year prior to Spitzer’s appointment, a psychologist, D. L. Rosenhan published an article called “On Being Sane in Insane Places,” and the American Psychiatric Association fell under serious criticism over the legitimacy of its diagnoses. In his experiment, Rosenhan sent eight “sane” people to twelve psychiatric institutions. The pseudo-patients complained “they had been hearing

²²⁴ Ibid.

voices” and were admitted to psychiatric wards.²²⁵ Aside from one of the pseudo-patients, all the rest were diagnosed with schizophrenia and discharged from the hospital less than a few months after because their symptoms were determined to be “in remission.”²²⁶

Rosenhan argued that the label of schizophrenia had a social resonance; once the label of schizophrenia was applied, the person lost his/ her identity as a human being: “Once the impression has been formed that the patient is schizophrenic, the expectation is that he will continue to be schizophrenic.”²²⁷ An example of this was Chamberlin’s experience in losing the custody of her child due to her psychiatric record. The label took on its own life, taking over one’s personality. Based on the result of his experiment, Rosenhan’s article concluded that only a very few mental health professionals are willing to know about the experience of their former patients possibly because “they distrust information coming from the previously insane.”²²⁸ Rosenhan questioned the validity of the diagnosis of schizophrenia because of the mental professionals’ unwillingness to learn from the experiential narrative of their patients. In this way, the treatment of mental illness can be compared to the way that the behavior of pre-lingual children falls under a physiological explanation where the narrative of the children’s inner experiences is not a factor for consideration in treatment.²²⁹ Effectively, caregivers treat patients’ narratives of their inner experiences as equivalent to the gibberish of young children.

The result of Rosenhan’s “prank” exceeded his expectations. After the result of the experiment went public, he announced to the hospitals staff that he was going to send

²²⁵ D. L. Rosenhan, “On Being Sane in Insane Places,” *Science* vol. 179 (1973): 251.

²²⁶ *Ibid.*, 252.

²²⁷ *Ibid.*, 253.

²²⁸ *Ibid.*, 251.

²²⁹ Hans Gerth, C. Wright Mills, *Character and Social Structure: the Psychology of Social Institutions* (San Diego: A Harvest/ HBJ Book, 1953), 18.

more pseudopatients to gain admittance. In order to outwit Rosenhan's scheme, they diagnosed dozens as prank, despite the fact that Rosenhan had not sent any additional pseudopatients.²³⁰

A more shocking result for Rosenhan was that many pseudopatients reported to him that they felt as if they were "going crazy" while being admitted to the asylums. Some told "how life on a mental ward damaged their self-worth. Some became anxious, wondering how they had managed so effortlessly to be admitted to a mental hospital."²³¹

The Rosenhan Experiment questioned the subjectivity of diagnosis. Rosenhan and his pseudopatients demonstrated how just entering the asylum with a fabricated mental distress warranted the person needed treatment. Because of the question that arose from the Rosenhan experiment over the subjectivity of diagnosis, Spitzer in the DSM-III taskforce paid particular attention in achieving a systematized, streamlined diagnostic process. He skillfully used Rosenhan's work to deconstruct the conventional diagnosis process. While he disregarded the Rosenhan Experiment as "junk," it was a convincing tool to justify why psychiatry needed a radical reform.²³² To undermine the works of anti-psychiatry, the DSM taskforce paid particular attention to arrive at a systematic, objective diagnostic criteria. The arrival of the DSM-III in 1980 further propelled the notion, deeming the source of mental illness as one's biochemical irregularity.²³³

Laura Hirshbein's 2009 book, *American Melancholy: Construction of Depression in the Twentieth Century* explains how the increase in diagnosis of depression in recent decades from the perspective of a practicing clinical psychiatrist. She chronicles how the

²³⁰ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 178.

²³¹ *Ibid.*, 178-179.

²³² *Ibid.*, 182-183.

²³³ *Ibid.*, 8.

diagnosis of depression has expanded in the last decades due to the expansion of the definition of clinical depression and the increased availability of commercialized solutions to one's mental distress. The increase in the number of diagnoses has been not only influenced by aggressive marketing tactics by pharmaceutical companies but also by psychiatrists' interest in a certain mode of professional conduct.²³⁴ In order to achieve the objective of having all psychiatrists arrive at the same diagnosis, Spitzer categorized disorders by observable symptoms.²³⁵ Psychiatrists in the 1980's adopted Spitzer's stance on the validity of symptoms in diagnosis. For example, in treating depression, they "assumed that symptoms were more valuable than stories to compare patients and their treatments." They underestimated "the value of human interactions in their reduction of stories to statistical data."²³⁶ While ex-patients advocates were claiming the legitimacy of their experiential narrative, more and more patients who believed that depression was like the "common cold" of mind welcomed the quick "symptom-based criteria and checklists."²³⁷

In Search of Scientific Explanation of the Human Mind

As scientific disciplines, psychiatry and psychology are meant to view human behavior with objectivity. However the path to objectivity is not a natural course. In order to gain the reputation of objectivity, Sigmund Freud as a psychologist, Robert Spitzer as a psychiatrist, and B. F. Skinner as a psychologist/ behaviorist intentionally removed the social and cultural contexts from their analysis. In order to establish the self-evident explanation and diagnosis of their mental illness, they thought the socio-cultural factors

²³⁴Laura Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century* (New Brunswick: Rutgers UP, 2009), 4.

²³⁵ *Ibid.*, 38.

²³⁶ *Ibid.*, 54-55,

²³⁷ *Ibid.*, 65, 68.

were subjective, hence unscientific variables. Freud did so in order to prove the ubiquity of the unconscious in human behavior. Spitzer similarly omitted these contexts in order to provide standardized diagnostic criteria. B. F. Skinner deducted the socio-cultural human conduct as a “response” to “contingencies.”

Sigmund Freud

In *Civilization and Its Discontents* published in German in 1930, Freud argued that civilization imposes conflict between the person’s ego and society. When “the boundary lines between the ego and the external world become uncertain or ... they are actually drawn incorrectly,” the person enters a pathological state of mind.²³⁸ When we confront “the superior power of nature, the feebleness of our own bodies and the inadequacy of the regulations which adjust the mutual relationships of human beings in the family, the state and society,” one becomes neurotic.²³⁹ Freud determined that a “civilized” person enters a pathological state when he has confronted the third criteria of suffering; the uncertain boundary line between private (the ego) and public (society).

Published in 1953 and 1956 respectively, a sociologist Philip Rieff wrote “History, Psychology, and the Social Sciences” and “The Origins of Freud’s Political Psychology” during his eight year marriage with Susan Sontag.²⁴⁰ In “History, Psychoanalysis, and the Social Sciences,” Rieff explains Freud’s therapeutic use of analogy in human illness. Freud used analogy not only to provide explanation for one’s psychological processes but also for society, history, religion, art, and politics.²⁴¹ Under his theory, the relationship between private and public are nullified since the sickness of an individual is the sickness

²³⁸ Sigmund Freud, *Civilization and Its Discontents* (London: W. W. Norton & Company, 1961), 33-34.

²³⁹ *Ibid.*, 33.

²⁴⁰ Robert McFadden, “Philip Rieff, Sociologist and Author on Freud, Dies at 83,” *New York Times*, July 4, 2006, <http://www.nytimes.com/2006/07/04/us/04rieff.html#>.

²⁴¹ Philip Rieff, “History, Psychoanalysis, and the Social Sciences,” *Ethics* 63, no. 2 (1953): 108.

of society. Freud devalued the social and historical context of an individual's illness in order to provide an objective explanation of the subject's psychological process. Therefore, Freud regarded a human being as a passive carrier of the unconscious, unaffected by the temporality of time and space. Rieff argues that because Freud was "aware that history could proceed outside the consciousness of its actors," he disregarded the meaning of human actions.²⁴²

In "The Origins of Freud's Political Psychology," Rieff explains Freud's attempt at analyzing politics through psychology. Freud's pathological gaze on the masses began germinating during his visit to Paris in 1885 where the memories of the Revolution and the Commune were still fresh. Borrowing the ideas from Gustave Le Bon's *The Crowd* published in 1895, he believed that the unconscious revealed itself when the individual lost his/ herself in the crowd, and that the unconscious was "an inaccessible madhouse of desire" that belonged to "the revolutionary mob."²⁴³ Through the explanation of unconsciousness, Freud analyzed the psychology of "being ruled" without historical reference.²⁴⁴ Because of its vulnerability to manipulation and agitation, he deemed mass behavior as open to the influence of "suggestion." On the other hand, Freud actively used "hypnosis" as a therapeutic tool. However, through the practice, he began to distance himself from hypnotic technique since he came to see it as "the art of being ruled."²⁴⁵

Freud's discomfort towards the ruthless mob comes from his theory that civilization represses one's aggression. As a result, the person's aggression becomes

²⁴² Ibid, 115.

²⁴³ Philip Rieff, "The Origins of Freud's Political Psychology," *Journal of the History of Ideas* 17, no. 2 (1956): 238, 239.

²⁴⁴ Ibid, 249 .

²⁴⁵ Ibid, 248.

“introjected, internalized.”²⁴⁶ One’s conscience (which he calls the *super-ego*) plants the sense of guilt to repress the person's aggressive impulse, thus creating the sense of anxiety.²⁴⁷ Humanity’s destructive instinct is held at bay because of his conscience, but what if he places himself in the crowd, the space where people enter the state of high suggestibility? Freud was afraid of the moment when humanity’s repressed aggression turned to the destructive ruthless mob mentality.

B. F. Skinner

While post-war anti-psychiatry scholars such as Michel Foucault, R. D. Laing, and Thomas Szasz discussed the relationship between madness and society from the context of philosophical, psycho-political, and medico-judicial discourses, psychologist B. F. Skinner endeavored to establish an ideal society where there was no sense of alienation or emotional distress by applying his scientific inquiry of behavior. Through the *right* application of the technology of “behavior modification,” Skinner envisioned that a well controlled but content society would be realized.²⁴⁸ Along with his predecessors, John Watson, Ivan Pavlov, and Edward Thorndike, Skinner’s school of “radical behaviorism” became a major force of post-war psychology.²⁴⁹ A professor of psychology at Harvard University, Skinner’s Behaviorism was widely employed in a therapeutic setting where “getting adjusted” to one’s environment became the synonym of “getting better.” In order to transmit the benefit of Behaviorism to the general public, he published a utopian fiction, *Walden Two* in 1948. Through the description of a fictional intentional community in Massachusetts, he explained how human behavior was determined by

²⁴⁶ Freud, *Civilization and Its Discontents*, 70.

²⁴⁷ *Ibid.*, 70-72.

²⁴⁸ B. F. Skinner, *Beyond Freedom and Dignity* (New York: Alfred A. Knopf, Inc., 1971), 125, 150.

²⁴⁹ “Behaviorism (Stanford Encyclopedia of Philosophy),” accessed March 20, 2014, <http://plato.stanford.edu/entries/behaviorism/>.

environment, arguing how an ideal, content society like *Walden Two* could be realized through the right application of Behaviorism.

In his 1971 *Beyond Freedom and Dignity*, he boiled down the mechanism of human behavior to a “stimulus,” a “response,” and a “reflex.”²⁵⁰ Skinner regarded human emotion and feeling as “by-products” of “contingencies” determined by a given environment.²⁵¹ Feelings can provide an “informed guess,” hence subjective, unscientific explanation of a certain behavior, but he urged that psychologists should analyze the contingencies, a socio-cultural environment codified by its norms and values. He argued that psychologists’ preoccupation with analyzing human behavior through “feeling and states of mind” was obscuring them from finding a scientific, hence observable and empirical explanation of human behavior.²⁵²

Unlike the assertions of anthropologists, sociologists, and non-behaviorist psychologists, the premise of *Beyond Freedom and Dignity* is that man is *not* free, purposeful, or responsible.²⁵³ Skinner pointed out that Freud’s theory is dotted with determinism and that Freudian therapists would tell their patients “they are free to choose among different courses of action and are in the long run the architects of their own destinies.”²⁵⁴ Moreover, Skinner warns those who believe in human potentiality: “The escape route is slowly closed as new evidences of the predictability of human behavior are discovered.”²⁵⁵ Given that predictability, Skinner argues that man is “better to be

²⁵⁰ Skinner, *Beyond Freedom and Dignity*, 17.

²⁵¹ *Ibid.*, 135, 146-147.

²⁵² *Ibid.*, 146-147.

²⁵³ *Ibid.*, 21.

²⁵⁴ *Ibid.*, 22.

²⁵⁵ *Ibid.*, 22.

controlled.”²⁵⁶ He criticizes that the specialists in social sciences lack scientific insight, thus forcing them to view “all control as wrong and to misrepresent many of the advantages to be gained from a social environment.”²⁵⁷ “The problem is to free men, not from control, but from certain kinds of control, and it can be solved only if our analysis takes all consequences into account.”²⁵⁸

If we are going to create a well regulated, controlled society, people's behavior should be moderated by administering the technique of good reinforcement, Skinner proposes.²⁵⁹ The sense of alienation a youth may feel is manifested as a maladaptive behavior to his/ her immediate environment. He points out that a youth behaves that way because he/ she lacks a positive reinforcement (ie: receiving encouragement) to adapt to a new environment or because he/ she has experienced a negative reinforcement in the past. However, analyzing or listening to his/ her life story is not a chief concern for Skinner. He urges that “we must go directly to the contingencies if we want to be sure, *and it is the contingencies which must be changed if his behavior is to be changed.*”²⁶⁰

At Walden Two, the habitants adhere to the Walden Code which controls their behavior. While the Code can be changed by a democratic procedure, “if the Code is too difficult for anyone or doesn't seem to be working to his advantage, he seeks the help of our psychologists. They're our ‘priests’ if you like,” a resident explains.²⁶¹ Like the outside society, an individual’s sense of maladjustment at Walden Two is modified

²⁵⁶ Ibid., 39.

²⁵⁷ Ibid., 43.

²⁵⁸ Ibid., 41.

²⁵⁹ Ibid., 43, 125.

²⁶⁰ Ibid., 146-147.

²⁶¹ B. F. Skinner, *Walden Two* (New York: MacMillan Company, 1948). 162, 199.

through a psychologist's intervention. Strong, negative emotions are deemed destructive at Walden Two: "The productive and strengthening emotions--joy and love, But sorrow and hate--and the high-voltage excitements of anger, fear, and rage--are out of proportion with the needs of modern life, and they're wasteful and dangerous."²⁶² If the Code is applied in a democratic way, no adjusted residents should feel excessively frustrated by the control.

Walden Two is an egalitarian community where the sense of competition is unheard of. The people experience no sense of volatile sense of jealousy, fear, and anger. The children of *Walden Two* go through the technology of behavior engineering from the moment of their birth. The children develop a tolerance for negative feelings such as frustration by slowly having obstacles introduced that fall within the limit that they can handle.²⁶³ Positive reinforcement "preserves a personal sense of freedom," free from the threat or force from authority.²⁶⁴

A question arises; is *Walden Two* an egalitarian, ideal utopia or a totalitarian dystopia where the positivistic and insidious behavior modification technology dictates its inhabitants' behavior? A popular interpretation of Behaviorism often focuses on the negative reinforcement as a tool of brainwashing. A notable case is the depiction of the Aversion Therapy where a patient is conditioned to deter a certain behavior by associating it with an unpleasant stimulus. A 1962 novella and a subsequent 1971 movie *Clockwork Orange* satirized the Aversion Therapy through the fictional *Ludovico*

²⁶² Ibid.

²⁶³ B. F. Skinner, *Walden Two* (New York: MacMillan Company, 1948), 98.

²⁶⁴ Ibid., 263-264.

Technique where the protagonist Alex's violent and sexual impulses are neutered by associating these sensations with nausea.

Skinner argues that in creating a good society, the technology of "behavior modification" is essential.²⁶⁵ He reminds us that technology is an "ethically neutral" tool; it depends on the holder of the technology.²⁶⁶ For example, if a certain mode of control is questionable, countercontrol should naturally regulate the unfair or excessive control. Skinner warns when control is occupied by the "organized agencies," the equilibrium of control and countercontrol would be lost. "Hospital for psychotics and homes for retardates, orphans, and old people are noted for weak countercontrol, because those who are concerned for the welfare of such people often do not know what is happening."²⁶⁷ As Goffman's *Total Institution* illustrates, such closed institutions are highly prone to abuse. Skinner is aware the possibility of the technology being misused, but he still explains that in any circumstances, a man is merely responding to the stimuli from the surrounding environment: "The misuse of a technology of behavior is a serious matter, but we can guard against it best by looking not at putative controllers but at the contingencies under which they control. It is not the benevolence of a controller but the contingencies under which he controls benevolently which must be examined."²⁶⁸

Robert Spitzer

In overseeing the third edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), Robert Spitzer worked to create an efficient, systematic diagnostic manual comprised of quantitative data. The goal of the manual was to create a set of

²⁶⁵ Skinner, *Beyond Freedom and Dignity*, 150.

²⁶⁶ *Ibid.*, 150.

²⁶⁷ *Ibid.*, 171.

²⁶⁸ *Ibid.*, 187.

objective diagnostic criteria where there was no room either for inference or for the unconscious bias of practitioners. The first edition of DSM was published in 1952. Hirshbein regards the 1980 publication of DSM-III as the moment where depression was clinicalized among psychiatrists. The diagnoses of depression increased because DSM-III simplified the category of depression into only one: “Major Depressive Episode.”²⁶⁹ Through the efforts of establishing diagnostic criteria, Spitzer and other American psychiatrists such as Alan Stoudemire distanced themselves from psychoanalysis and attempted to make their diagnostic criteria out of social and cultural context.²⁷⁰ However, DSM-III misses how patients in different social and cultural settings manifest their anxiety or depression accordingly. For example, Richard McNally cites the work of Arthur Kleinman to explain how Chinese patients focus their somatic presentations of depression out of a sense of cultural shame attached to mental illness.²⁷¹ If a psychiatrist does not consider the cultural context particular in China and strictly adheres to the guideline of DSM, he/ she may arrive at a different diagnosis than depression.²⁷² What is interesting to note is that Freud also regarded his psychoanalysis theory as devoid of the social, cultural, and historical contexts of his subjects.²⁷³ Those opposing concepts intentionally omitted the social and cultural context of the patients for the sake of objective analysis and diagnosis.

Because of the simplified diagnostic criteria, depression now has reached the point of epidemic; thirty to forty percent of the American population has experienced or

²⁶⁹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (Washington, D.C.: APA, 1980), 210.

²⁷⁰ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 53.

²⁷¹ McNally has been an advisor to DSM

²⁷² Richard McNally, *What Is Mental Illness?* (Cambridge, MA: Harvard UP, 2011), 131.

²⁷³ Rieff, “History, Psychoanalysis, and the Social Sciences.” 109.

will suffer from mental illness in their lifetime. Hirshbein questions whether American society is this diseased or whether the definition of mental illness has been absurdly expanded.²⁷⁴ She points out the historical contingency of a diagnosis of depression, regarding that depression is a product of the recent construction of “social, professional, cultural, and gender forces.”²⁷⁵ As the disappearance of homosexuality from “sexual deviations” in the DSM-III shows, something that was once thought to be a psychiatric illness has been influenced by shifting medical and social practices.²⁷⁶

A historian William Sewell explains how a prevalent notion can be socially constructed and ingrained in our everyday customs and decision making, to the point of causing an out of control situation like the inflated diagnoses of depression:

Its main analytical thrust is to provide an historical account of how some notion was so widely institutionalized, so thoroughly engrained in habit, so built into the assumptions, vocabularies, and landscapes of the social constraints and mechanism that so frequently bend our actions to ends that we do not seek.²⁷⁷

No matter how much researchers in mental health may regard that their works are based on objective, scientific observation, they are not free from their expectations and assumptions.²⁷⁸ Hirshbein further argues that their socially structured views on the relationship between gender difference and mental illness have caused gender imbalance in the diagnosis of depression.

Hirshbein questions why modern American women are more pathologized in the diagnosis of depression. Modern researchers in the field do not question the “facts” that

²⁷⁴ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 5.

²⁷⁵ *Ibid*, 6, 101.

²⁷⁶ McNally, *What Is Mental Illness?*, 21.

²⁷⁷ William H. Sewell JR., *Logics of History: Social Theory and Social Transformation* (Chicago: U of Chicago P, 2005), 357.

²⁷⁸ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 101.

women are twice as likely to be depressed as men.²⁷⁹ Research since the late nineteenth century has documented women's vulnerability to such mental illnesses as hysteria, involuntional melancholia, and depression as their biological destiny. Hormone therapy in the 1930's, electroconvulsive therapy (ECT) in the late 1940's, as well as medication trials starting from the 1970's targeted female patients because of their deemed susceptibility.²⁸⁰ However, Hirshbein refutes this idea of the greater susceptibility of women to depression arguing that these wide-spread "facts" are based on a shaky circular concept. In the clinical trials, women are chosen more than men because of this notion, and their dominant presence in trials confirms for researchers that women are more clinically depressed than men.²⁸¹

On the other hand, Hirshbein shows her concern for how American women have been avid supporters of consumption-oriented solutions to depression.²⁸² Pharmaceutical companies use aggressive direct marketing techniques to sell their products. She particularly points out the marketing tactics used in promoting Prozac in the late 1980's as "notorious."²⁸³ Popular magazines have been repeatedly promoting the message that depression is a disease; it should be monitored and controlled like other physical illnesses by urging female readers to be wise consumers. Through the commodification of distressed feeling, women in the last few decades are seeking to externalize their causes of distress. Thus they choose to be treated with medication.

²⁷⁹ Ibid, 77.

²⁸⁰ According to Rudorfer, Henry, and Sackeim, 71% of ECT was administered to depressed female patients in the UK in 1986: Rudorfer, Henry, Sackeim, "Electroconvulsive therapy," *Psychiatry*, Second Edition (2003): http://media.wiley.com/assets/138/93/UK_Tasman_Chap92.pdf; For the topic women and ECT, please refer to 1948 movie *The Snake Pit* performed by Olivia deHavilland

²⁸¹ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 90-92.

²⁸² Ibid, 102.

²⁸³ Ibid, 123.

The researchers in psychiatry have been unwilling to factor race, ethnicity, and class into their work because they are hesitant to be involved in heated public arguments. Instead, they have regarded sex as a safe, self-evident biological variant.²⁸⁴ The framers of the DSM also intentionally excluded social and cultural context from a patient for more objective, scientific diagnosis. As xenophobic sentiments prevailed between the late nineteenth century and the early twentieth century which bolstered the rise of the “pseudo-science of racism,” race and class were regarded as subjects better not discussed.²⁸⁵

By looking at the works of Freud, Skinner, and Spitzer as well as recent critical works about them, I illustrated how psychiatrists and psychologist have been concerned with objectivity in establishing credibility in their disciplines. It meant they discredited the potentially rich experience of human emotions in the healing process and slighted the effect of socio-cultural temporality in the way patients exhibit their distress. Freud’s pathological gaze on the masses and Skinner’s naïve elitism disregarded an ordinary person’s role in determining his/ her life course. Hirshbein and McNally argue the diagnosis process according to the DSM is also subject to the socio-cultural conditions the patient and clinician are under. The way the patient exhibits symptoms would vary by culture or gender, and the way the clinician interprets the supposed symptoms could be affected by his/ her background.

1980’s Onwards

The publication of the DSM-III in 1980 signaled the resurgence of the medical model based description of one’s distress. In a conference held in 1993, Judi Chamberlin

²⁸⁴ Ibid, 79.

²⁸⁵ E.J. Hobsbawn, *Nation and Nationalism since 1780* (Cambridge: Cambridge UP, 1990), 91.

stated that the “Economic/ Social Model” most succinctly explained the distress she had experienced in 1966. Because the repressive 1950’s environment where “racism, classism, sexism, and heterosexism” enforced her and her colleagues to follow a path of conformity, she argued their emotional well-being was jeopardized. Recollecting over twenty years of experience as an ex-patient advocate for the alternative self-help system, she pointed out that a person could not help another human being unless he or she devoted themselves to listening to the other’s experience: “We cannot help a person unless we listen to his or her own perceptions of what is happening, and what things would be helpful (or unhelpful).” In contrast to this sharing, mutual experience, she explained how the medical model concept placed people’s distress out of context by sorting it into “little boxes called ‘symptoms.’” In order to recover from such an inhumane process, Chamberlin argued that ex-patients needed to regain their voices by “recontextualizing” the memories and everyday experience that had once been “decontextualized” by the psychiatry system.²⁸⁶

Coinciding with the rise of anti-psychiatry and the psychiatric survivors movement, deinstitutionalization was one of the social transformations that changed American’s attitude towards the mentally ill. Starting from the mid 1950’s to the 1980’s, states dramatically reduced the numbers of state hospital patients. In 1955, more than 550,000 patients were in state hospitals. By 1985, the number went down to 110,000; an eighty percent drop in thirty years.²⁸⁷ During that time, the responsibility of the care of the mentally ill was shifting from state level to federal level. In 1956, an amendment of

²⁸⁶ [Judi Chamberlin, a conference speech for Training Faculty and Field-site Supervisors Curriculum Training Conference]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

²⁸⁷ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 183.

the Social Security Act expanded the eligibility for the Social Security Disability Insurance (SSDI) program. In 1972, the Social Security Act provided the Supplemental Security Income for the Aged, the Disabled, and the Blind (SSI) to the people who had not been eligible for the SSDI.²⁸⁸ Those entitlement programs encouraged moving state hospital patients to community based group homes.

However, the flow of subsidies to support deinstitutionalization abruptly halted with the inauguration of Ronald Reagan in 1981. To reduce taxes, Reagan carried out drastic budget cuts to federal domestic spending. Access to programs supporting independent living became more and more limited. For many long-term state hospital patients, being denied access to public housing meant homelessness because they had little skill to live outside of the hospital. The people with mental illness fared the worst in the SSDI cut. When the Regan administration cut eleven percent of the total number of SSDI recipients, thirty percent of the people with mental disability were denied further assistance.²⁸⁹

While contemporary scholars agree that the budget cut by Regan was the culprit in the increasing number of homeless with a history of mental illness, the opponents of anti-psychiatry and the psychiatric survivors movement in the 1980's blamed the counter-culture's "rosy visions of fellowship and liberation that became prevalent in the sixties." Their love of freedom consequently harvested the sense of distrust towards any institutional arrangements, they argued.²⁹⁰ A medical doctor Gerald Weissmann published an essay "Foucault and the Bag Lady" in 1982, blaming Foucault, Laing, and

²⁸⁸ Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994), 290.

²⁸⁹ *Ibid.*, 301.

²⁹⁰ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980*, 185.

Marcuse for bolstering the ongoing homelessness crisis and the brutal budget cut caused by their “therapeutic reforms of bourgeois liberalism.”²⁹¹

In regard to deinstitutionalization, the patient advocates who were in favor of the medical model also criticized the proponents of the social model. A medical doctor E. Fuller Torrey stated that advocates like Judi Chamberlin encouraged patients to evade their responsibility towards the rest of the public for the sake of claiming their right to choice. At the Choice and Responsibility Symposium at Albany, New York in 1994, Torrey argued why *we* have an obligation not only to protect people with mental illness from the potential harm but also to protect the rest of public from the people who were in an active psychotic state: “For example,” Torrey continued “in a New York City study of individuals who push random people onto subway tracks in front of trains, it was reported 19 out of 31 of the individuals doing the pushing were actively psychotic at the time.”²⁹²

In the symposium, Torrey further argued that the public should discuss the need to revive the asylum solution. Since deinstitutionalization began, Torrey cited, the rate of children whose mothers were “psychotic” had tripled. One third of those children were raised by their biological mothers. He further referred to a 1992 study by a New York psychiatric hospital that 3.4 percent of the patients admitted to the hospital were HIV positive. He implied those mothers were sexually promiscuous, irresponsible women who evaded the responsibility to rear their children in a traditional family setting for the sake of protecting their right to self-determination. Hence, he concluded, some ex-patients were better suited to return to “asylums which protect both the individual and the public.”

²⁹¹ Ibid., 185-186.

²⁹² [E. Fuller Torrey, M.D., Protecting the Rights, the Person, and the Public: A Biological Basis for Responsible Action, 6. Series 2 Conference: Choice and Responsibility Symposium, 1994]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

He concluded his speech: “Those who can think clearly have an obligation to do so when considering the needs of those who cannot think clearly. This is not paternalism. It is merely humane care.”²⁹³

To refute Torrey’s claim, Chamberlin argued how the discussion of the etiology of mental illness as something with a biological origin justified psychiatrists’ “power to lock people up and treat them against their will, or to overrule their personal life divisions.” By employing Szasz’s theory, Chamberlin stated that it was erroneous to deprive one’s liberty according to medical decisions; “These are legal, and ultimately moral decisions,” she concluded.²⁹⁴ Psychiatry had no right to force psychiatric interventions on potential patients because it was known that they were “vulnerable to ‘mental illness.’” For Chamberlin, this paternalistic assumption justified involuntary commitment and coerced treatment because psychiatrists thought they held “the superior wisdom of those who have the power to make the definitions, and enforce the consequences” to others.²⁹⁵

After the 1980’s, activists in the psychiatric survivors movement began to lose hope of claiming their right to self-determination. Rae Unzicker, a South Dakota based mental health reformer felt “(t) he medical/ psychiatric/ disease/ social control model is deeply entrenched. *All* of medicine has become extremely technological at the expense, I believe, of human contact.”²⁹⁶ Because of the scientific nature of pharmacological intervention, Unzicker felt the function of diagnosis became more and more promoting

²⁹³ Ibid., 7.

²⁹⁴ [Judi Chamberlin, the Right to be Wrong, 8 Series 2 Conference: Choice and Responsibility Symposium, 1994]. Ibid.

²⁹⁵ Ibid., 3.

²⁹⁶ Rae Unzicker, “On My Own: A Personal Journey Through Madness and Re-Emergence,” *Psychosocial Rehabilitation Journal* 13, no. 1 (July 1989): 75.

“the ‘us against them’ position,” justifying why people with mental illness needed chemical intervention so they could “join” the rest of the society.²⁹⁷

Chamberlin also felt discouraged during the 1980’s. The patients’ rights movement gained mainstream status, but it also meant many participants were not as passionate as Chamberlin and her colleagues.²⁹⁸ While she was speaking for the 1988 Alternatives Conference in Utah, she was disappointed to realize that so many audiences were not sure why they were listening to her speech:

There were all these people there who had literally been bused in from some program and who had no idea where they were, why they were there, and when they were going home. They were just sitting there smoking cigarettes. They weren’t going to meetings or anything. You know, they were going to meals and sitting outside smoking cigarettes wondering when the van was coming to take them home. I just thought that was the cruelest thing.²⁹⁹

From the 1980’s onwards, the psychiatric survivors movement began to transform. While some continued calling themselves survivors, some began to identify themselves as consumers of mental health services. The survivors like Ted Chabasinski felt now they were conducting advocacy work in order to gain funding from a governmental organization like the National Institute of Mental Health (NIMH). He felt that ex-patients’ primary goal was no longer voicing the oppression and assault they had experienced in psychiatric hospitals nor explaining the ignorance and indifference they received in their everyday lives.³⁰⁰

²⁹⁷ Ibid., 76.

²⁹⁸ Sally Zinman “Force and Coercion,” Undated, www.mhselfhelp.org/.../Force%20and%20Coercion%20Background.pdf, 7.

²⁹⁹ Derby, Interview with Judi Chamberlin, 33.

³⁰⁰ Ted Chabasinski, “The History and Future of Our Psychiatric Survivor Movement,” *Mad in America*, accessed August 18, 2013, <http://www.madinamerica.com/2012/08/the-history-and-future-of-our-psychiatric-survivor-movement/>.

Shortly after the Americans with Disabilities Act was enacted in 1990, Judi Chamberlin became actively involved with cross-disability advocacy work. By meeting a prominent disability rights activist Justin Dart, Chamberlin realized a great parallel between her advocacy work in the psychiatric survivors movement and his work in the disability rights movement. The disability rights advocates had been educating the public about how the concept of disability could be socially constructed. “The disability is not a medical condition. It’s not something wrong with you. It’s not something that resides in the individual. It’s society making assumptions about certain people based on characteristics. It’s just like racism,” Chamberlin explains in her 2002 interview with Derby Penney.³⁰¹

In the later years of her career, she acknowledged the works of activists who believed mental illness was a brain disease. “I’m not going to kick them out,” she jokingly said. As long as they worked for “human rights for people labeled mentally ill,” she thought they were her allies. “We’re small enough as it is.”³⁰²

Her contribution to the 2000 federal report of the National Council of Disability, *From Privileges to Rights* was a major benchmark in cross-disability activism. She died in 2010 in Arlington, Massachusetts. Even while she was in a hospice, she kept updating a blog, *Life as a Hospice Patient*, to communicate with her readers. Her last entry was four days before she passed away.³⁰³

Still residing in Berkeley, Ted Chabasinski is active in the psychiatric survivors movement. He is now involved with the Justina Pelletier Case in Boston. In February

³⁰¹ Derby, Interview with Judi Chamberlin, 39.

³⁰² Ibid., 51.

³⁰³ Judi Chamberlin, “A Minor Scare,” *Life as a Hospice Patient*, January 12, 2010, http://judi-lifasahospicepatient.blogspot.com/2010/01/minor-scare_12.html.

2013, parents in Connecticut lost custody of their teenage daughter on account of medical abuse. While Justina's doctor at Tufts Medical Center diagnosed her with mitochondrial disease, a team at Boston Children's Hospital diagnosed her with somatoform disorder caused by her parents' psychological abuse.³⁰⁴ Chabasinski closely relates Justina's experience with his experience as a ward of the state, frequently traveling between both coasts to question the legitimacy of psychiatric authority as well as to meet young activists in Boston. He is currently writing an autobiography chronicling his life as a ward of the state, an activist, and an attorney.

³⁰⁴ Neil Swidey and Patricia Wen, "The Justina Pelletier Case: A Medical Collision with a Child in the Middle - Metro - The Boston Globe," December 15, 2013, <http://www.bostonglobe.com/metro/2013/12/15/justina/vnwzbbNdiodSD7WDTh6xZI/story.html>.

Chapter 4

CONCLUSION

We believe that our pain, problems and the way we act are related to our lives in an often unjust society – men have power over women, whites over people of color, people are expected to fulfill unsatisfying roles, a few corporations (and the people who control them) are making a fortune, while many of us are unemployed, poor, can't get what we need or find we are just unrespected cogs in a wheel (working for purposes we don't believe in) at our work. Psychiatry does nothing to change these people-destroying situations. In fact it supports these situations by trying to convince us all people's problems are personal and profiting by our pain.

--Mental Patients Liberation Front³⁰⁵

I chronicled the early years of the psychiatric survivors movement by focusing on the life of Judi Chamberlin and her colleagues in order to show how ex-patients saw reclaiming the ownership and validity of their voice as the fundamental reason for organizing themselves for collective action. Because the psychiatric profession and the larger society systematically discredited the voices of those survivors, countless abuses of power were allowed to happen in asylums. Psychiatric survivors saw the façade of the asylum as the visual symbol of their oppression. In the early years of the psychiatric survivors movement, the psychiatric system used to be readily identified by the walls of an asylum. However, in last few decades state hospitals have undergone deinstitutionalization and many have been left abandoned, demolished, or converted into for-profit developments. The grand asylum on top of the hill on the outskirts of the town proper became an image from the past. On the other hand, the core of the system that was rooted in these old buildings has not gone away. Patients may no longer be confined to

³⁰⁵ [Mental Patients Liberation Front, *Mental Patients Liberation Front Statement*]. [Judi Chamberlin Papers] ([MS 768]), Special Collections and University Archives, University of Massachusetts Amherst Libraries.

the walls of an old asylum, but they are still not liberated in the sense that Chamberlin and her colleagues envisioned. The old system of custodial care has transformed into a more abstract, insidious form where the patients' medical histories are collected and maintained electronically. The community based care model has proven insufficient to prepare for the long term custodial population many of whom ended up becoming homeless or incarcerated.³⁰⁶

Meanwhile a diagnosis still dictates the person's identity within the current system, and this is true more than ever in the era of the DSM-5. A patient's voice is still dictated by the diagnosis of psychiatrists who rely on labels obtained from the DSM in order to prescribe medication; bereavement has now been included as a Major Depressive Disorder in the DSM-5.³⁰⁷ Between 1996 and 2001, primary care physicians dispensed eighty percent of the entire anti-anxiety drug prescription, sixty-five percent of anti-depressants, and twenty percent of antipsychotics in the United States.³⁰⁸ While the availability of medication has become easier, patients' agency in determining the nature of their own treatment is more and more contested. Contemporary psychotherapy focuses on short-term treatments, suggesting that more structured forms of therapy have been deemed more effective only because they fit into the limited time frame available from clients' insurance plans.³⁰⁹

In looking back the anti-psychiatry movement, Staub explains how Laing's argument that people experienced psychosis because of the incessant pressures to adjust

³⁰⁶ Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994), 1, 305.

³⁰⁷ American Psychiatric Association, "Bereavement Exclusion Fact Sheet," 2013, www.dsm5.org/.../Bereavement%20Exclusion%20Fact%20Sheet.pdf.

³⁰⁸ Joseph Lieberman III, "The Use of Antipsychotics in Primary Care," *Primary Care Companion J Clin Psychiatry* 5, no. 3 (2003): 3.

³⁰⁹ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century*, 3.

to the unjust society has been “frequently dismissed and denounced as a sure sign of the counterculture’s loopy excesses.”³¹⁰ The derogatory remarks made by Harvard psychiatrist Allan Hobson and medical journalist Jonathan Leonard depicting Laing and Szasz as members of the “lunatic fringe,” as well as Goffman as a figure who worsened the already negative image of mental hospitals are still largely unchallenged.³¹¹

Unlike the anti-psychiatry movement which saw society as the cause of mental illness, the DSM provided a systematic, objective diagnostic criteria. The arrival of the DSM-III in 1980 further propelled the notion, deeming the source of mental illness as one’s biochemical irregularity.³¹² However, Staub also looks at the resurgence of the “social diagnosis” of madness. New research shows the relationship between childhood trauma/ stress and the onset of schizophrenia, relooking at how environmental factors affect one’s mental health as much as one’s DNA sequence.³¹³

A new study by Martin Harrow and Thomas Jobe published in 2013 questioned the efficacy of the long-term administration of antipsychotics.³¹⁴ After a longitudinal study spanning twenty years, Harrow and Jobe concluded that schizophrenia patients who discontinued antipsychotics experienced more relapse in the first six to ten month, but they had a better outcome in the long run. They questioned the long-term (ten or more years) administration of antipsychotics because the patients with a long-term history of taking dopamine blocking agents likely develop “a dopamine supersensitivity”; they

³¹⁰ Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948-1980.*, 3.

³¹¹ *Ibid.*, 6.

³¹² *Ibid.*, 8.

³¹³ *Ibid.*, 190-94.

³¹⁴ M Harrow and TH Jobe, “Does Long-Term Treatment of Schizophrenia with Antipsychotic Medications Facilitate Recovery?,” *Schizophrenia Bulletin* 39, no. 5 (September 2013): 962–65.

would more likely experience psychotic episodes even while they are medicated.³¹⁵

Antipsychotics have been the basis of the treatment of schizophrenia, but as the study shows, some patients and mental health professionals are beginning to pronounce that medication is not the only way to treat or manage schizophrenia. The Hearing Voice Movement is one of those new developments that proposes an alternative to the conventional treatment.

Although there are fewer asylum walls today, patients are even less in control of their voices than ever before. Gaining control over one's own voice and sharing that voice are vital because the discrediting of one's experience and reducing it to a diagnostic category is an alienating process that devalues the uniqueness of one's emotions. In a country where thirty to forty percent of the population is, or will be suffering from some forms of mental illness in their life time, the questions concerning the self-determination asked by Judi Chamberlin and her colleagues of the psychiatric survivors movement are still relevant today.³¹⁶

³¹⁵ Robert Whitaker, "New Antipsychotics 2013 | Schizophrenia | Harrow and Jobe," *Mad in America*, March 26, 2013, <http://www.madinamerica.com/2013/03/do-antipsychotics-worsen-long-term-schizophrenia-outcomes-martin-harrow-explores-the-question/>.

³¹⁶ Hirshbein, *American Melancholy: Construction of Depression in the Twentieth Century.*, 5.

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