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CHAPTER NINE

Critics of the Concept of Mental Illness

In 1961, Thomas Szasz published *The Myth of Mental Illness.* In that book, Szasz argued that the concept of 'mental illness' is a metaphor, and that as a metaphor it does not illuminate the experience or behavior of the individual to whom it is applied, but on the contrary it obscures essential features of the individual's behavior and of the human situation in general. Szasz argued that the term was used to stigmatize deviants from social norms and to deprive them of their democratic rights and responsibilities.

Since Szasz's work first appeared, numerous books and essays have been published attacking the premises of what has come to be termed 'the medical model' of human psychology. I believe that these critical works demonstrate that the medical model in psychology lacks any kind of scientific or humanistic justification.

There are a number of variations of the medical model. All are based on the same simple formula. The two medical models that dominate in the field today are the psychoanalytic model and the biochemical imbalance model; the former is rapidly losing ground to the latter. Most mental-health workers accept an amalgam of the two. Thomas Scheff succinctly describes the psychoanalytic-medical version: "The basic model upon which psychoanalysis is constructed is the disease model, in that it portrays neurotic behavior as unfolding relentlessly out of a defective psychological system contained within the body."[1] In the case of the biochemical model, one would say that it portrays neurotic or 'sick' behavior as unfolding relentlessly out of a defective *metabolic* or *physiological* system contained within the body. In the psychoanalytic model, the psychological system is ostensibly defective as a result primarily of traumas suffered by the individual in the first several years of his life, when he or she is said to be most impressionable. In the case of the biochemical

[1]Thomas Scheff, *Being Mentally Ill* (Chicago: Aldine, 1966), 9

imbalance model, the defective system is a result of inexplicable genetic goofs. The basic algorithm or formula of the medical model is simple: sick behavior issues relentlessly from a defective system within the individual. It is simple but problematic.

In the first place, the judgment that particular behavior is 'sick' is based on criteria that are culturally determined and questionable. The controversial nature of these judgments is disguised by using medical terms to describe behavior that the mental health establishment does not approve of. This fact has been recognized by both Szasz and Laing among others. Tuberculosis and pneumonia, for example, are names for processes that are judged to be pathological on biological grounds: they clearly threaten to shorten or impair the life of the organism. Consequently, there is little controversy, within the field of medicine, about the fundamental concept of disease: one does not find a group of dissenters claiming that it is unfair to describe a person who is manifesting the symptoms of pneumonia as ill. Furthermore, to say that a person is physically ill is not to say that his or her mind, psyche or soul is impaired, which is a much more incriminating assertion.

But in the case of what is defined as neurosis, or psychosis, or mental illness, the dominant cultural values influence what the experts define as pathological. But are these cultural values to be accepted as absolutes? And is not the use of the term 'mental illness' a devious strategy to undermine the self-respect of those who deviate from the status quo? In the nineteenth century, masturbation was considered to be symptomatic of a disease. Homosexuality was considered a disease until 1973, when thanks to lobbying by homosexual psychiatrists within the American Psychiatric Association it was decided by a rather close vote that it was no longer a disease (as long as the homosexual likes it; homosexuality continues to be classed as a disease when the homosexual dislikes being homosexual). Internists do not vote at conventions to decide whether one should classify tuberculosis as a disease. For this reason, it's difficult to refute Szasz's and Laing's argument that the term 'mental illness' is used to stigmatize individuals who deviate from social norms. This suggests, of course, that therapists may be creating problems for individuals rather than helping to alleviate them.

Anthropology adds additional weight to the argument against the medical model. In 1934, Ruth Benedict, one of the founders of anthropology, wrote, "It is clear the culture may value and

make socially available even highly unstable human types. If it chooses to treat their peculiarities as the most valued variants in human behavior, the individuals in question will rise to the occasion and perform their social roles without reference to the ideas of the usual types who can make social adjustments and those who cannot. Those who function inadequately in any society are not those with certain fixed 'abnormal' traits, but may well be those whose responses have received no support in the institutions of their culture. The weakness of these aberrants is in great measure illusory. It springs not from the fact that they are lacking in necessary vigor, but that they are individuals whose native responses are not reaffirmed by society. They are, as Sapir phrases it, 'alienated from an impossible world'."[2]

Over 30 years later, R.D. Laing argued that indeed the person who was most likely to be labelled severely mentally ill was saner than those who were doing the labeling, that he was "alienated from an impossible world", as Ruth Benedict put it. In Laing's words, "Our society may itself have become biologically dysfunctional, and some forms of schizophrenic alienation from the alienation of society may have a socio-biological function that we have not recognized."[3]

Two aspects of Laing's argument should be noted. In the first place, he was one of the first to redirect attention to the social context in which behavior labelled 'pathological' took place. By doing this he was able to demonstrate the intelligibility of behavior which, abstracted from its social context, seems unintelligible and thus is likely to be labeled pathological by individuals ignoring its context. Laing was influenced here by the work of Bateson, Jackson, Haley, and Weakland,[4] all of whom except Bateson later became family therapists and who did the classic study of schizophrenics and their families which showed that, as Laing put it, *"No* schizophrenic has been studied whose disturbed pattern of communication has not been shown to be a reflection of, and reaction to, the disturbed and disturbing pattern characterizing his or her family of origin."[5] In other words, puzzling or dysfunctional behavior does not unfold

[2]Ruth Benedict, *Patterns of Culture* (New York: Houghton-Mifflin, 1934), 270

[3]R.D. Laing, *The Politics of Experience* (New York: Pantheon, 1968), 120

[4]G. Bateson, D. O. Jackson, J. Haley, and J. Weakland, 'Towards a Theory of Schizophrenia', *Behavioral Science,* Volume 1, November 25th, 1956

[5]Laing, *The Politics of Experience, op cit,* 114

relentlessly out of a defective system within the body. The metaphor of mental illness obscures this fundamental fact.

Secondly, Laing claimed that psychiatrically labelled people were in fact more aware, more sensitive, more spiritually inclined, and thus likely to be discriminated against by a materialistically oriented establishment. Laing's meditation on schizophrenia in his classic book, *The Politics of Experience,* was an attack on the spiritual vacuity of modern civilization.

This claim is actually lent credence by Julian Silverman's seminal article, 'Shamans and Acute Schizophrenia', published in *The American Anthropologist* in 1967. Reviewing a broad range of anthropologic material, Silverman compared the initiatory ordeal typically experienced by the novice shaman to what psychiatrists term a schizophrenic episode; he is not referring to the experiences of the veteran shaman but to the initiand. Silverman concludes, "Significant differences between acute schizophrenics and shamans are not found in the sequence of underlying psychological events that define their abnormal experiences."[6] The major difference Silverman did find was that in primitive society these abnormal experiences were valued and individuals were provided with an interpretive framework that enabled them to make sense of these experiences and to integrate them into their daily lives. This was part of the process of being initiated into the vocation of the shaman. Silverman termed shamanism a "unique resolution of a basic life crisis". In the modern world, these experiences are not valued but "invalidated", as Laing had argued, and the elders of this society do not present the individual in crisis with the option of shamanism—or anything other than chronic mental patienthood—as a means of resolving his or her suffering.

In a paper that I delivered several years ago to a conference of ex-'mental patients', I wrote, "The implications of this are staggering. Yesterday's shaman is today's chronic schizophrenic! The kind of person who, in a bygone era, would have been initiated into the vocation of shaman, medicine man, spiritual healer, is now likely to be initiated into the role of tragic-victim-of-the-most-serious-mental-illness-known-to-modern-civilization."[7]

[6]Julian Silverman, 'Shamans and Acute Schizophrenia', *American Anthropologist,* 69, 1967, 21

[7]Seth Farber, 'The Challenge of Cosmic Optimism', *Inside Out Magazine,* Vol 1., No. 2, November-December 1988, 12

Mircea Eliade, the prominent historian of religion, wrote that the shaman "has succeeded in integrating into consciousness a considerable number of experiences that, for the profane world, are reserved for dreams, madness or post-mortem states. The shamans and mystics of primitive society are considered—and rightly—to be superior beings; their magico-religious powers also find expression in an extension of their mental capacities. The shaman is the man who knows and remembers, that is, who understands the mysteries of life and death. . . ."[8]

Silverman's article and Eliade's studies, both of shamanism and puberty initiation rites in pre-modern cultures, lend weight to another one of Laing's contentions: that the 'schizophrenic breakdown', when left to run its natural course, constitutes a natural process of spiritual death and regeneration. The crisis that precedes regeneration is frequently a total crisis leading to the 'disintegration of the personality', as Eliade describes a shamanic crisis. "In no rite or myth do we find the initiatory death as something final, but always as the *condition sine qua non* of a transition to another mode of being, a trial indispensable to regeneration; that is, to the beginning of a new life."[9] The procedures of the mental health establishment abort a process whose ultimate aim is spiritual rebirth, the creation of a new being, the formation of a more mature sense of personal identity.

Sarbin corroborated this point in 'Self-Reconstitutive Processes'. He demonstrated that a death-rebirth process takes place in contexts as diverse as Alcoholics Anonymous, Christian monastic mysticism, religious conversions, shamanic initiations, brainwashing and in successful psychotherapy.[10] We have also seen that this same process took place in the survivors whose stories were told above.

The idea that individuals until recently labelled schizophrenic (now precisely the same kinds of individuals are more likely to be labelled 'manic-depressive') were somehow more spiritually inclined, in other words, possessed particular qualities that might be looked at as gifts in another context, was ridiculed by the Establishment. The idea that 'schizophrenia' was potentially regenerative was ignored. Article after article denounced Laing

[8]Mircea Eliade, *Birth and Rebirth* (New York: Harper, 1958), 102

[9]Mircea Eliade, *Myths, Dreams, and Mysteries* (New York: Harper and Row, 1975), 224

[10]T. Sarbin and N. Adler, 'Self-Reconstitutive Processes', *Psychoanalytic Review,* 1971, 56(4), 599–616

as an unrealistic romanticist who was impervious to the tremendous suffering of the 'mentally ill'.

The establishment turned a blind eye to the cogent arguments made by Laing and others that it was in fact their own very practices that greatly exacerbated and perpetuated the suffering of 'the mentally ill'. They failed to acknowledge that terms such as 'mental illness', 'damaged ego', 'deeply rooted pathology' or, more recently, 'biochemical imbalance' were merely metaphors. Other metaphors, equally or more fitting, and less degrading, could be substituted, as Sarbin and Mancuso argued. These terms are metaphors insofar as they refer not to an actual corporeal body, but to the person's incorporeal mind or psyche, which is the Greek word for soul, the core of the person's being. The ascription of such metaphors is in fact the first step in a process of degradation.

> If the label of disrespect is applied by an individual or a group empowered to apply such labels, the society goes to work to treat the individual as a non-person . . . The pejorative labels provide a means of codifying the answers to the *who are you* question, and to designate a *degraded social identity.* The pejorative label, for example, schizophrenic, is assigned by mental health workers. The label serves the same function as visible stigmata of degradation. . . . The stigmata of degradation serve the purpose of identifying non-persons. [Sarbin and Mancuso use the term 'non-persons' to describe individuals who have been deprived of all social status and of the right and privilege of being held responsible for their actions.] Even branding has been used to designate such declared non-persons as harlots, heretics, and slaves. In modern times, non-visible stigmata in the form of diagnostic labels have been employed —mental patients, psychotics, schizophrenics, lunatics, etc.[11]

A variety of sociologists and psychologists began to look at the psychological and physical processes that individuals were subjected to once they were defined as 'mentally ill'. Szasz had argued that this particular definition was a pretext for depriving individuals of their democratic rights: "How are involuntary psychiatric interventions—and the many other medical violations of individual freedom—justified or made possible? By calling people *patients,* imprisonment *hospitalization,* and torture *therapy;* and by calling uncomplaining individuals *sufferers,*

[11]Theodore Sarbin and James Mancuso, *Schizophrenia: Medical Diagnosis or Moral Verdict?* (New York: Pergamon, 1980), 217

medical and mental health personnel who infringe on their liberty and dignity *therapists,* and the things the latter do to the former *treatments.* That is why such terms as *mental health* and the *right to treatment* now so effectively conceal that psychiatry is involuntary servitude."[12]

The sociologist Erving Goffman examined the 'scientific' and 'medical' procedures that typically take place in mental hospitals, and showed that they were not scientific procedures at all, that they were "rituals of degradation" (he borrowed that phrase from the sociologist Garfinkle).

> Mental hospitals bureaucratically institutionalize this extremely wide mandate [to pronounce the final verdict on the individual's past] by formally basing their treatment of the patient on his diagnosis and hence upon the psychiatric view of his past. . . . The case record is an important expression of this mandate. The dossier is apparently not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of his past conduct. One of its purposes is to show the way in which the patient is 'sick' and the reasons why it was right to commit him and is right currently to keep him committed; and this is done by extracting from his whole life course a list of those incidents that have or might have had 'symptomatic' significance. The misadventures of his parents or siblings that might suggest a 'taint' may be cited. Early acts in which the patient appeared to have shown bad judgment or emotional disturbances will be recorded. Occasions when he acted in a way which the layman would consider immature, sexually perverted, weak-willed, childish, ill-considered, impulsive and crazy may be described. . . . In addition, the record will describe the state on arrival at the hospital—and this is not likely to be a time of tranquility and ease for him.[13]

In other words, the so-called neutral diagnosis is not a balanced picture, but is based on a selective focus on those incidents in the individual's life where he or she has failed to cope or has acted inappropriately. His or her successes are ignored. The case record, of course, is the basis upon which a 'diagnosis' and a 'prognosis' will be based. The individual and

[12]Thomas Szasz, *The Theology of Medicine* (New York: Harper and Row, 1977), xix

[13]Erving Goffman, *Asylums* (New York: Doubleday, 1961), 155–56

his or her family will be told that it has been determined scientifically that he or she suffers from a 'chronic mental illness' and that he or she must drastically lower his or her expectations about what he or she can accomplish in life.

Rosenhan's 'On Being Sane in Insane Places', published in 1973, was only the most dramatic of a number of studies demonstrating that there is in fact nothing scientific about psychiatric diagnosis. The psychiatrist or other mental worker has a tendency to see 'pathology' everywhere. Furthermore, the study demonstrates that the labelling process is irreversible: once a person is labelled schizophrenic, there is virtually no way he or she can get rid of the label. In Rosenhan's study, 'normal' people, that is to say, individuals who worked as professionals (teachers, lawyers, psychologists, and so forth) and who had no previous history of psychiatric hospitalization, pretended they were hearing sounds in order to be admitted into psychiatric wards; once in the wards they acted as they normally would. *Not a single one* of the staff of psychiatrists, psychologists, social workers, or aides suspected that these were in fact 'normal' people. Rosenhan wrote that, "having once been labelled schizophrenic there is nothing the pseudo-patient can do to overcome the tag. The tag profoundly colors others' perception of him and his behavior."[14] Indeed, Rosenhan found from an examination of the staff notes and case reports that the patients' behavior and past history were interpreted in such a way as to confirm the diagnosis of 'schizophrenia'.[15] "Many of the pseudo-patients' normal behaviors were overlooked entirely or profoundly misinterpreted to make them fit into the assumed reality."[16] When the patients were finally discharged, they were discharged with the diagnosis, "schizophrenia in remission".[17] In other words, all of these individuals were told that they were chronically mentally ill and were in perpetual danger of going crazy again. Although Rosenhan's article caused a controversy in the intellectual world, it had no impact on any of the practices and procedures in mental hospitals or in outpatient clinics.

All of these investigations and critiques demonstrated a sensitivity to environmental variables and to the *context* in

[14]D. Rosenhan, 'On Being Sane in Insane Places', in Paul Watzlawick (ed.), *The Invented Reality* (New York: Norton, 1984), 125

[15]*Ibid.,* 125–130

[16]*Ibid.,* 125

[17]*Ibid.,* 122

which behavior takes place that is completely lacking in the adherents to the medical model. It now began to appear that much of the distress or dysfunctional behavior did *not* proceed relentlessly out of a defective psychological system or a defective physiological system, as Scheff had put it.

The family therapy movement, which began to develop in the 1950s, provided a new perspective from which to view 'deviant' behavior.[18] The innovators in this field rejected the idea of mental illness. Behavior that appeared to be crazy or pathological was in actuality a response to unacknowledged and unnegotiated conflicts within the family. These conflicts ultimately evoked the fear of a splintering of the family, such as separation or divorce. Alternatively, even in the absence of potentially divisive conflicts, 'symptomatic behavior' might appear at the time of an impending transition to a new phase in the individual or family life cycle, which inevitably raises the spectre of disintegration. Leaving home, getting married, having children mark transitions that might potentially lead one member of the family to act sympomatically, in order to keep the family together, to restore stability at any price. Haley wrote, "The symptom is a signal that a family has difficulty in getting past a stage in the life cycle."[19] The task of the therapist is to facilitate these transitions.

The symptomatic behavior did not unfold relentlessly out of a defective system within the individual. Three points are relevant here. Firstly, the 'identified patient'—this was a phrase family therapists invented to express their critical stance toward the idea of mental illness—was expressing anxiety experienced by other family members as well. Secondly, the symptomatic behavior was viewed by family therapists as an indication not that there was something wrong with the psychological or physiological system of the individual, but rather that the family as a whole was relating in a dysfunctional manner. Thirdly, the symptomatic behavior was not the *result* of a pathological process, but was a goal-directed act (however unconscious or barely conscious). It was the identified patient's solution to the threat or imagined threat of the disintegration of the

[18]Lynn Hoffman, *Foundations of Family Therapy* (New York: Basic Books, 1981). Jay Haley, *Problem-Solving Therapy* (New York: Harper and Row, 1976)

[19]Jay Haley, *Uncommon Therapy; The Psychiatric Techniques of Milton H. Erickson* (New York: Norton, 1973), 42

family; it was a solution that maintained unity while warding off the threat of change.

Traditional therapy can be destructive for a number of reasons. In the first place, it confirms the identified patient's status as a mentally ill person: thus, unity is achieved at the cost of the autonomy of the individual defined as an identified patient. Family conflicts continue to be unacknowledged and everybody joins together in order to sympathize with and help the poor 'chronically mentally ill patient'. Secondly, of course, no therapy takes place insofar as the underlying family problems remain untouched. The symptomatic behavior is now sanctioned by the Mental Health Establishment, which acts as if this behavior is beyond the control of the individual. This was a powerful critique of the traditional medical model—and it worked.

Pioneers in the family therapy movement such as Minuchin,[20] Haley[21] and Watzlawick[22] were explicitly and implicitly critical of psychoanalytic theory which postulated that the individual was 'damaged' because of events in early childhood. From the family therapy perspective, the causes of the individual's dysfunctional behavior were irrelevant. Unlike the Freudians, the family therapists did not believe that the individual was pursuing irrational or illusory goals, such as trying to obtain Mommy's approval through the medium of another adult. On the contrary, their observations and interventions were consistent with the thesis that their clients were motivated by the desire to create fulfilling relationships in the present. The problem was rather that the clients had developed patterns of behavior that subverted their ability to achieve these goals. Theoretical discussions of the intricacy of the psyche provided a socially acceptable means of intellectual stimulation for mental-health professionals, and it maintained their social status as intrepid explorers of the netherworld of the mind. Unfortunately, it bypassed the more mundane task of helping their clients to achieve the goals for which they sought help in the first place.

Furthermore, the psychoanalytic dogma that individuals are programmed in the first few years of their lives and will continue to re-enact those programs again and again unless they spent years in psychotherapy did not stand up to empirical scrutiny.

[20]Salvador Minuchin, *Families and Family Therapy* (Cambridge: Harvard University Press, 1974)

[21]Jay Haley, *Leaving Home* (New York: McGraw Hill, 1980)

[22]Paul Watzlawick et al., *Change: Principles of Problem Formation and Problem Resolution* (New York: Norton, 1974)

Kenneth Gergen (1977)[23] has termed this view "the stability orientation" and points out that its quintessential feature is its premise that behavior patterns remain stable over time and that the individual is basically predictable. Both Gergen and Jerome Kagan[24] refute the psychoanalytic dogma on the overwhelming preponderance of early childhood experience for later development. The major variable the neo-psychoanalysts stress is anxiety over 'object loss' in the first few years of life. Yet Kagan (1970) noted, "The variation in degree of anxiety over loss of access to attachment figures during the first three years of life predicted no significant behavior in adolescence or adulthood."[25] Although the work of Kagan and Gergen and others supports a more optimistic interpretation of the effect of early childhood experience on later development, there has been no modification of psychoanalytic theory or practice. Nor has this research had much impact on contemporary culture, which Gergen observes has "almost fully accepted the assumption that early experience is vital in shaping adult behavior."[26]

Furthermore, Gergen summarizes the data collected by life-span development researchers which indicate that development is idiosyncratic and unpredictable: "The individual seems fundamentally flexible in most aspects of personal functioning. Significant change in the life course may occur at any time. . . . An immense panoply of developmental forms seems possible; which particular form emerges may depend on a confluence of particulars, the existence of which is fundamentally unsystematic."[27]

If development is idiosyncratic, then psychoanalysts have no justification for placing individuals within 'diagnostic' categories (based on their ostensible degree of mental pathology) and acting as if those categories reflect ontological features of the universe. They have no justification for making predictions about individuals' future development—these very predictions themselves constrain individuals' possibilities for change and action as self-fulfilling prophecies. If development depends upon 'unsystematic' factors, then conceivably a problem that seems to be very serious and intractable—for instance, a 'psychotic' breakdown—could resolve itself in the twinkling of an eye. Falling in love could conceivably completely alter the trajectory of a person's previous development.

[23]Gergen, 'Stability, Change and Chance in Understanding Human Development. In N. Datan and H. Reese (eds.), *Life Span Developmental Psychology: Dialectical Perspectives* (135–158). New York: Academic Press, 1977

[24]J. Kagan, 'Perspectives on continuity.' In O. Brim and J. Kagan (eds.), *Constancy and Change in Human Development* (26–74). Cambridge: Harvard University Press, 1970

[25]*Ibid.*

[26]Gergen, *op. cit.*, 142

[27]K. Gergen, 'The Emerging Crisis in Life-span Development Theory. In P. Baltes and O. Brim (eds.), *Life-span Development and Behavior* (31–63). New York: Academic Press, 1980, 43

In 1980, Theodore Sarbin and James Mancuso published their monumental work, *Schizophrenia: Medical Diagnosis or Moral Verdict?* Both authors were professors of psychology and Sarbin in particular was known in social psychology for his numerous contributions over many years to the development of role theory. This book is the most thorough examination and critique of the medical model in psychology. As the Michelson-Morley experiment spelled the end of traditional physics and paved the way for Einstein's theory, so ought Sarbin and Mancuso's work to have put an end to the disease model and paved the way for the kinds of alternative conceptualizations outlined in this book and elsewhere. It is a sad reflection on the mental health professions that by 1988 this book was already out of print. Sarbin and Mancuso meticulously examine in this book 20 years of research, published in the standard psychiatric and psychological journals, designed to prove that schizophrenia is a disease. As Krasner said in the introduction to the book, "Sarbin and Mancuso play fairly in that the 'schizophrenia' research is analyzed within the context of the rules of the scientific game. They demonstrate unequivocally that the research is deficient. To demonstrate with detailed scholarship and research sensitivity in the field of 'schizophrenia' that 'the Emperor has no clothes' is indeed a major accomplishment. . . . The full implications and consequences of the Sarbin-Mancuso alternative conceptualization should, could, and must be developed by the current generation of scientists, practitioners, and students."[28]

Sarbin and Mancuso write after surveying 60 years of research, and carefully scrutinizing the last 20 years, "Not one dependent measure has been identified that would allow a professional diagnostician to make a reliable diagnosis. If schizophrenia could be diagnosed like pneumonia, then 60 years of research would have identified at least one causal agent."[29]

[28]Sarbin and Mancuso, *op. cit.*, xxi

[29]*Ibid.*

Although the researchers in the journals invariably draw the conclusion that schizophrenia is a disease that destroys cognitive and perceptual abilities, the data indicate otherwise. In each experiment, the data reveal only small differences in group means between the performance of schizophrenics and the performance of the control groups on the experimental tasks. This means, as Sarbin and Mancuso note, that the majority of individuals labelled schizophrenics were performing comparably to the majority of people labelled normal. The small differences in the group means indicate that only some of the experimental group were performing less adequately. Sarbin and Mancuso easily account for this difference by examining a number of "disguised variables", such as the effects of psychotropic drugs on the performance of the experimental task.

They conclude that the resolution of a life crisis is forestalled by the mental health workers who initiate a process of transvaluing and degrading individuals' social identity. Their model takes into account what happens to the individual in the context of a mental hospital, where he or she is subjected to the variety of degradation rituals previously mentioned, and isolated and sequestered with other labeled deviants, and denied opportunities to engage in the kind of 'role enactments' that are capable of earning one esteem within the existing social order.

Sarbin and Mancuso's analysis here interfaces with that done by Jay Haley in his book, published in the same year, *Leaving Home,* although neither of them shows any awareness of the other's work. The crisis that an individual faces can only be resolved by extricating him or her from the patient role as quickly as possible and introducing him back into a natural environment where he or she would have the opportunity to engage in the kinds of role-enactments that typically earn one esteem. The mental health establishment *discourages* this process and tells individuals that they have a disease that will prevent them from leading a normal life and engaging in esteem-earning activities.

As Sarbin and Mancuso were fading into obscurity, Peter Breggin launched a new attack with his book, *Psychiatric Drugs: Hazards to the Brain.*[30] Breggin debunked the myth that psychiatric drugs were medications designed to cure specific mental diseases. He showed that the most widely prescribed psychiatric

[30]Peter Breggin, *Psychiatric Drugs: Hazards to the Brain* (New York: Springer, 1983)

drugs, the phenothiazines, were in fact drugs that did not have a specific effect on individuals with specific disorders, but had the same general effect on any individual who took such drugs. They are neurotoxic drugs that interfere with higher cortical level functioning and that in general induce a state of "psychic indifference".

The initial promoters of the drugs were quite blunt about the drugs' effects: they produced a "chemical lobotomy" and made it more easy to control the schizophrenic patient. The discoverer of chlorpromazine wrote, "Patients receiving the drug become lethargic. Manic patients often will not object to rest and patients who present management problems become tractable. . . . The patients under treatment display a lack of spontaneous interest in the environment. . . . They tend to remain silent and immobile when left alone and to reply to questions in a slow monotone. . . ."[31] Furthermore, he acknowledges, "Many patients dislike the 'empty' feeling resulting from the reduction of drive and spontaneity which is apparently one of the most characteristic effects of this substance."[32] Revealingly enough, he compares the effects of this drug to a lobotomy. "In the management of pain and terminal cancer cases, chlorpromazine may prove to be a pharmacological substitute for lobotomy."[33]

Laing had written in *The Politics of Experience* that "the condition of alienation, of being asleep, of being unconscious, of being out of one's mind is a condition of normal man."[34] It is not surprising that psychiatrists are quite enthusiastic about a drug that turns restless and discontented individuals into individuals who, like themselves, have made their peace with the *status quo.* As Noyes and Kolb wrote in the 1958 edition of *Modern Clinical Psychiatry,* "If the patient responds well to the drug, he develops an attitude of *indifference,* both to his surroundings and to his symptoms. He shows decreased interest in and response to his hallucinatory experiences and a less assertive expression of his delusional ideas. Even though not somnolent, the patient may lie quietly in bed, unoccupied and staring ahead. He may answer questions readily and to the point but offer little or no spontaneous conversation; however, questioning shows that he is fully aware of his circumstances."[35] In the 1977 edition

[31]*Ibid.,* 14

[32]*Ibid.,* 15

[33]*Ibid.,* 15

[34]Laing, *The Politics of Experience, op. cit.*

[35]Peter Breggin, *Psychiatric Drugs: Hazards to the Brain, op. cit.*

of the same book, Kolb repeated: "If the patient responds well to the drug, he develops an attitude of indifference, both to his surroundings and to his symptoms."[36] (The argument that the use of these drugs accounts for the release of many patients from state mental hospitals is questioned in Appendix 2.)

Breggin's argument that these drugs cause serious neurological damage when used for more than a brief period of time is no longer even controversial. This has become so evident that even mainstream psychiatrists cannot deny it. Massive reliance on these drugs has caused an epidemic of tardive dyskinesia. The American Psychiatric Association Task Force report –18 estimated that 60–65 percent of the individuals who take these drugs regularly develop tardive dyskinesia.[37]

Psychiatrists are increasingly relying on Lithium as the drug of choice. This drug also has deleterious effects on the body and brain when used for more than a brief period of time. Its destructive effects are less noticeable, since it does not cause uncontrollable muscular spasms and twitching. Like the phenothiazines, it also produces a feeling of 'psychic indifference'. One of the promoters of this drug described patients who were taking the drug: "It was as if their 'intensity of living' dial had been turned down a few notches. Things do not seem so very important or imperative; there is a greater acceptance of everyday life as it is rather than as one might want it to be; and their spouses report a much more peaceful existence."[38]

Breggin also devoted a book to documenting the destructive consequences of what is euphemistically termed 'electro-shock therapy'.[39] This is a more controversial treatment and its promoters have gone to great lengths to convince the public that the 'new, modified' ECT is in fact a useful therapeutic tool that causes no ill-effects. In the last few years ECT has been increasingly relied upon by psychiatrists and it was estimated in 1978 that 100,000 to 200,000 individuals per year received ECT.[40] (Vigorous promotion of ECT in the last five years leads me to surmise that its use has increased.)

[36]*Ibid.*, 17

[37]*American Psychiatric Task Force,* Report No. 18 (Washington, DC: American Psychiatric Association, 1980)

[38]Breggin, *Psychiatric Drugs: Hazards to the Brain, op. cit.,* 198

[39]Peter Breggin, *Electroshock: Its Brain-Disabling Effects* (New York: Springer, 1979)

[40]*American Psychiatric Task Force,* Report No. 14 (Washington, DC: American Psychiatric Association, 1978)

It's no wonder that so many individuals remain trapped within the mental health system. The brainwashing procedures used to convince them that they are chronically mentally ill are as potent as any of the procedures used in Chinese prisoner-of-war camps. The conditions at mental hospitals, despite the illusion of progress and humanitarian reform, have not changed much since the last century. In 1830, John Connolly, then professor of medicine at the new University College, London, and later to become one of the most famous figures in nineteenth-century English psychiatry, wrote that for two-thirds of the inmates, "confinement is the very reverse of beneficial. It fixes and renders permanent what might have passed away. . . . I have seen numerous examples . . . in which it was evident that . . . a continued residence in the asylum was gradually ruining body and mind. . . . The sanest among us would find it difficult to resist the horrible influences of the place. . . . Patients are subjected . . . to the very circumstances most likely to confuse or destroy the rational and healthy mind."[41]

Criticisms of the medical model have had no effect on public policy. This is perhaps not surprising because of the power of those groups with a vested interest in the perpetuation of the *status quo.* As Krasner noted in his introduction to Sarbin and Mancuso's book, "It would be an interesting exercise in economics and occupational sociology to show in detail how 'schizophrenia' as a disease metaphor has spawned thousands of jobs, not only for the psychiatric team (psychiatrists, clinical psychologists, and social workers), and other mental hospital employees, but also for the pharmaceutical, publishing, hospital supply, and related industries. The first task of any industry is to perpetuate itself and then to expand."[42]

Probably, a good deal less than one percent of the practicing therapists actually believe that 'schizophrenia' or 'manic-depression' do *not* refer to actual diseases but are merely labels applied by one group of human beings to another. Mainstream psychologists' and psychiatrists' response to their critics is to insist that they are, at best, well-meaning but misguided romanticists who fail to understand the plight of the chronically mentally ill. The media merely repeat the official party line on mental illness, and intellectuals in related disciplines have turned a deaf ear to the

[41]Andrew Scull, *Social Order/Mental Disorder* (Berkelely: University of California Press, 1989), 45–46

[42]Sarbin and Mancuso, *op. cit.,* x

critics of the mental health establishment and have been content either to reiterate the Freudian homilies as if they were the word of God or to give their adherence to the doctrine of the genetic defect.

Psychotherapists have ignored the data on experimenter bias which have revolutionary implications. This research shows that we are responsible for the creation and perpetuation of the behaviors that we classify as mental illnesses. Reviewing the literature on this topic, Jerome Frank writes: "To recapitulate the chief findings, an experimenter's expectations can strongly bias the performance of his subject by means of cues so subtle that neither experimenter nor subject need be aware of them." Furthermore, "a therapist cannot avoid biasing his patient's performance in accordance with his own expectations, based on his evaluation of his patient and his theory of therapy. His influence is enhanced by his role and his status, his attitude of concern, and his patient's apprehension about being evaluated."[43]

In short, the so-called epidemic of mental illness is a self-fulfilling prophecy created by the institutional mental-health system. It is an artifact of the set of uniform and limited expectations maintained about individuals who have been psychiatrically labelled—and an artifact of mental health workers' expectations about their own ability to genuinely help individuals who act in socially deviant ways.

The facts reviewed above suggest that the search for the specific genetic defect is otiose. Research demonstrates that environmental factors *cannot* be excluded: there *is* a genetic predisposition to having a breakdown or to becoming psychiatrically labelled. But as noted above, there is reason to suspect that the same kind of genotype constitutes an advantage in other cultures: the individual becomes initiated into the vocation of the shaman. What needs to be changed is not people's genetic codes, but the sensibilities of those who are in positions of power and authority in this society. "The genetic defect myth loses its persuasiveness when we ask, 'By what standard is the individual defective?' As we have seen with the case of 'schizophrenia,' the individual is defective when judged by the standard of modern Western society. But that is no absolute—is an individual to be judged defective because he or she is not predisposed to conform

[43]Jerome Frank, *Persuasion and Healing* (New York: Schocken Books, 1973), 127–28

to the current cultural norm? Certainly this individual will face greater obstacles, but this fact may give him or her the impetus to contribute to the transformation of a culture that does not encourage the expansion of the human spirit. The individual with a genetic 'defect' may actually be genetically predisposed to make a greater contribution to the process of spiritual evolution that I believe is taking place on the planet. When viewed from a broader perspective, what is termed a genetic defect may in actuality constitute a genetic opportunity."[44]

There has been one major change in the mental health field in the past 10 years. For decades, 'schizophrenia' had been what Szasz called "the sacred symbol of psychiatry". As Szasz wrote, "The symbol that most specifically characterizes psychiatrists as members of a distinct group of doctors is the concept of schizophrenia; and the ritual that does so most clearly is their diagnosing this disease in persons who do not want to be their patients. . . . Schizophrenia has become the Christ on the cross that psychiatrists worship, in whose name they march in the battle to reconquer reason from unreason, sanity from insanity; reverence toward it has become the mark of psychiatric orthodoxy, and irreverence toward it the mark of psychiatric heresy."[45] The new sacred symbol of psychiatry is 'manic-depression', also termed 'bipolar disorder'. People who have breakdowns are now most likely to be told that they suffer from manic-depression, that is to say, a defective metabolic system that has been genetically programmed to become imbalanced at regular or irregular intervals, completely independent of the circumstances in which the individual finds himself or herself.

The number of individuals diagnosed 'schizophrenic' or 'neurotic' has dwindled, whereas the number of individuals diagnosed as 'manic-depressive' has mushroomed,[46] leading the less than wholly credulous observer to the conclusion that the kinds of individuals who were previously diagnosed as 'schizophrenic' or 'neurotic' are now diagnosed as 'manic-depressive'. Manic-depressive associations are springing up everywhere and mental health workers sing reverential praises to Lithium. An individual who has a breakdown is told that he or she has a 'chronic recurrent illness, analogous to diabetes', and that he or she must

[44]Seth Farber, 'The Challenge of Cosmic Optimism', *op. cit.*, 34

[45]Thomas Szasz, *Schizophrenia: The Sacred Symbol of Psychiatry* (New York: Basic Books, 1976), xiv

[46]Lee Coleman, *The Reign of Error* (Boston: Beacon Press, 1984), 149–150

accept the ingestion of lithium carbonate for the rest of his or her life.

This prognosis becomes a self-fulfilling prophecy. As the diagnosis of 'schizophrenia' is irreversible so is the diagnosis of 'manic-depression'. Two of the major promoters of Lithium, for example, described a number of cases where individuals stopped taking Lithium and actually felt better. The pleasant feelings that these individuals experienced were described by the promoters of Lithium as "pathological". They described a writer: "She finally discontinued the lithium carbonate therapy and is now finishing her next novel which her editors state appears very favorable. She's now relaxed, comfortable, happy, and says that for the first time in a long time she's really enjoying life. She remains at present in a mild hypo-manic state."[47] Thus, to paraphrase the old adage, the bland use all their powers to persuade the unbland to come to them in order to be made bland.

After 16 years of studying psychology, after many years of working as a psychotherapist in clinics and later in private practice, after many years of listening to people's stories, I am convinced there's no such entity as mental illness and that as long as we attempt to comprehend individuals with the use of the categories provided by the mental health establishment, we will injure them. The mental health establishment has snowed the American people: it launches the most unimaginably brutal psychological and physical assault on human beings in distress, calls this 'medical treatment', and then blames the outcome on 'mental illness'.

This book argues that the mental health establishment is wrong. It will not, of course, demonstrate this to those who do not have the ears to hear. For these individuals, 'schizophrenia' is a chronic disease and I am just another naive romanticist who does not understand the complexity of the problems of the severely mentally ill.

I am indeed arguing that the majority of individuals labelled 'chronically mentally ill' would become creative individuals and responsible citizens if treated with sensitivity, compassion, and intelligence—if encouraged. I believe this on the basis both of my experience of working with people who are psychiatrically labelled and of my readings. A small group are perhaps more

[47]Quoted in Breggin, *Psychiatric Drugs: Hazards to the Brain, op. cit.*, 200

intractable. Individuals who commit violent crimes, like Charles Manson, are associated in the popular mind with the 'mentally ill'. It should be noted, however, that these individuals are criminals, not patients. Violent crimes are less common among people who have been in psychiatric hospitals than among the 'normal' population. Statistically, a person labelled 'mental patient' is *less* likely to commit a violent attack than someone not so labelled.

It is undeniable, of course, that individuals do experience problems in life and that they frequently act in ways that are not conducive to their own emotional and spiritual well-being and development. If this were not the case there would be no need for therapy at all. It is not that they are 'mentally ill' or defective; they simply do not possess the wisdom, skills, or trust in the environment that would enable them to resolve, without guidance, the particular life challenges that confront them as individuals. The role of the therapist is not to eradicate an illness but to provide guidance, direction, emotional support, and encouragement to persons who are involved in a process of learning and growth.

My hope is that the testimony recorded in this book will make it more likely for an individual to get up and walk away when the psychiatrist, psychologist or social worker he or she is consulting says, 'You have a chronic mental illness'. Walk away because this statement is an insult to your dignity as a human being, and lacks any scientific foundation. It is time to say 'No' to the mental health establishment. It is time to put an end to the horrific nightmare they have created.