Introduction

"I've always been mad you know I've been mad, like the most of us have"- Pink Floyd

If it was a "Prozac nation" when I was growing up, then I didn't really know it. No one suggested I had any disorder at school, I don't remember seeing any ads about psychiatric drugs on TV or in the literature I read, and none of the kids in my social group referred to "mental illness" or "mental health" as a subject different from their personal and interpersonal dramas. My father *was* (and is) a psychiatrist, but I knew virtually nothing about his work. My mother *was* among one of the first women her age to begin using Prozac but I wasn't even told that until I was late in high school and even then, it was never talked about.

I grew up in a middle-upper class 88% white suburban town, in central Massachusetts, and I went to a well-ranked public high school. Where we lived, it was always presented that racism, discrimination, and poverty existed, but they were either of the past or things of a faraway place. I did not truly have the privilege of learning, until after I moved away, that poverty was abundant just ten minutes away from where I grew up, that our town was amongst many suburbs in America that was inherently racist and classist in its acceptance of "white flight". Furthermore I did not realize that discrimination of those diagnosed with mental illnesses was woven into our school system and culture so consistently that we didn't even realize it was there. Like I said, I didn't think I lived in a Prozac nation, and while I do think that was partially because my privileged town seemed to send fewer people to mental hospitals and fewer of its citizens were prescribed psychiatric drugs than many other areas in the country, the other factor is that often, it simply wasn't talked about. It was only after I left high school that I learned how many of my classmates were on psychiatric drugs and simply never brought it up.

I did learn later in my life that psychiatry was actually booming during the time I was growing up. These were years that psychiatric drugs sales were multiplying, the years of the Texas Medical Algorithmic Project scandal, and years of the Columbine shootings that was linked partially to the shooters' use of psychiatric medication.

As I will describe throughout this chapter, it has been a rather long, and in some ways surprising, process that has brought me to a thesis that analyzes and questions many of the fundamental principles and practices of the modern mainstream "mental illness complex". (I will define this term below) My process involved going from knowing next to nothing about psychiatry and those diagnosed as "mental patients," to, as I soon describe, experimenting with and romanticizing the phenomenon of "psychosis" to most recently, working with psychiatric survivors and learning about the disempowering effects and the vast political implications of "mental illness."

When I decided to start using LSD, and thus voluntarily induce a drastically altered state of consciousness, the subject of insanity, and the reality of psychiatry first became an interest for me. When I first chose to use LSD, I had not yet researched the way the drug was used by the Central Intelligence Agency (CIA) and various psychiatrists as an attempt to temporarily mimic psychosis (Congressional Report 1975). I did know however, that hallucinations, hearing-voices, and rapid thoughts were all potential effects of the drug. And during my first LSD experience, I had many of these effects and more. I experienced the "out-of-body" phenomenon, synthesesia, rapid thoughts, voice-hearing, an extreme sense of euphoria, and an experience of colors constantly changing around me. As the experience continued, I noticed my judgment altered and my sense of self and the world around me was dramatically different.

Fascinated by this first experience, I took to a habit of LSD, and not dissimilar to many who use the drug, I started experiencing insomnia from it. Late nights, wide awake for hours, convinced my thoughts were epiphanies I would scribble four words a page in large text and then frantically move on to the next. During sleepovers, my friends would try to stay up with me recording my words as fast as they could while I spoke of the conclusions and ideas I came up with while "tripping". When left alone on those sleepless nights in my basement, and when done writing, I turned to the books on the bookshelves. Daughter of a psychiatrist, it is no wonder I found books such as "Going Crazy," and "Experiencing Madness". Over and over I found myself interested in anecdotes and quotes about the people who the book called "schizophrenics." These books both excited me and terrified me, for a very similar reason; the accounts inside the story presented situations and experiences similar to my own. There were examples in the book of hearing voices in one's head, of experiencing a strong presence of an "other," of walking out on the street without shoes in a snowstorm, of utter paradoxical confusion. Inevitably, I found myself facing the question: “was I too, ‘going crazy?’”

The struggle with this question was an extremely loud one in my head, but a quiet one to those around me. The extreme euphoria, the sensual uniqueness, the seeming wisdom of my thought processes, led me back to insist on using LSD over and over again despite the insomnia, the grueling “come-downs,” and the disconnection from people who once understood me.

When I went off to college, I was still using LSD and thus still struggling with intangible questions from my trips that haunted me night after night. But I also started struggling with a range of social and environmental issues. The times had become dark for me, and before I knew it I was immobilized, occasionally unable to get out of my bed, and I began cutting myself. I continued hearing voices, and I was losing my sense of purpose and passion. One night, after trying hopelessly to sleep outside in sub-degree temperatures I looked up “the early warning signs of schizophrenia” on the Internet, the diagnosis I always had foolishly romanticized. I had the majority of warning signs listed, and became convinced that I might have been on the path towards the disease, or at the very least, in need of help. I showed a few of my peers the similarities of my behavior and the list of warning signs, though, in retrospect I am glad they didn’t take those warning signs too seriously. At one point I made an “urgent” appointment with the school psychologist, this being my first and only personal run-in with the mental health professional. Also in retrospect, I am grateful she did not take my cuts or situation seriously enough to give me any sort of immediate diagnoses or referral.

In retrospect, I really didn’t fit all of DSM’s criteria for schizophrenia, though not all were necessary for the diagnoses. I considered myself to have many of the "associated features" including euphoric moods and depressive moods, an increasingly fearful and dependant personality, and an antisocial personality. However, I was not grossly disorganized (though I was pretty disorganized) I was not catatonic, and I did not have disorganized speech. I was hearing voices and having "delusions" though not consistently, and my affect was flattened, though not severely. Throughout this breakdown I remember feeling as though it was both a severe experience and really quite mild. I recall feeling it was extreme relative to anything I had gone through before, but I recall knowing it was going to end, and thinking that the "schizophrenics" are people who have such experiences that never end.

I can't be sure what snapped me out of the time period of my life I considered to be "hell." I literally remember waking up one morning, a sunny day, and walking towards my bicycle and thinking "This is it. It's over. It's going uphill from here." And within a few months I was able to live completely alone in the woods, capable of a regular sleep cycle, capable of a prolonged sense of joy, and feeling nothing more than the mere residual effects of my breakdown.

Considering we live in such a rigid economic, political, and social system it was a privilege, that I could afford to flirt with a sort of psychosis, without being forced or coerced into the interventions of the criminal justice complex or the mental illness complex. And while my struggles were tough at the time, I have also had a privilege to grow up with a loving family, a comfortable socio-economic position, and surrounded by relatively little violence, and thus I have not had to face the type of severe and consistent suffering that many have faced. However, not everyone has been granted these privileges and many people have to cope with severe suffering, or have had their extreme moods or altered states of consciousness met with forced or dangerous intervention. It is my assertion that the dominant "mental illness complex," while sometimes helpful to people, has generally robbed people of the meaning of their extreme states and has often intervened in ways that have caused more harm than good. The Freedom Center of Northampton, Massachusetts as well as the greater "mad movement" or ex-patient/survivor movement, are amongst some of the few people I know who are also making this assertion.

I learned about the Freedom Center in the beginning of my third year at Hampshire when I decided to organize a conference titled the Vision and Resistance Gathering, which aimed to address "various forms of oppression and ways in which we can transform them through resistance and collectively working towards a vision." At the time, I had not necessarily thought issues around psychiatry as falling within this conferences rubric. However, after I learned about the Freedom Center's general goals, I realized that it did.

The Freedom Center's goals were (and are) to:

> "end all force and coercion, including involuntary treatment and forced drugging; to ensure that all treatment decisions are based on true informed consent; to support effective alternatives to toxic psychiatric drugs such as nutrition, exercise, and holistic health care; to promote voluntary, non-paternalistic social supports such as peer-run programs, housing, and therapy; to expose psychiatric and the pharmaceutical industry myths, propaganda, and corruption; to make true client control and empowerment the center of all mental health services; to defend our human rights; and to end fear and misunderstanding of 'madness' and extreme states of consciousness" (freedom-center.org 2005)

Since these goals fit right in with the conference I was organizing I invited them to do a workshop. They agreed and at the conference did a workshop titled “Fighting Corporate Psychiatry,” which discussed the various mistreatments that members of the Freedom Center had gone through as well as some information about corruption of privatized mental health care and the pharmaceutical companies.

A little less than a year later, because I was intrigued by their workshop and their general goals, and because I was looking for a group to work with as part of my Division 3 project for Hampshire College I started attending weekly support group meetings. When officially deciding to work with the Freedom Center as part of my project, I chose to write in the form of an ethnography, this being the first time I have ever written a long piece using this method. It was inspired in part due to having a self-identified anthropologist as the chair of my division 3 committee and in part by my desire to learn and write about the personal stories of the fascinating individuals I was getting to know through going to support group meetings.

However, my goal is not primarily to contribute to the ‘field’ of anthropology. It is more to understand and learn about the politics, shortcomings, mythologies, and injustices of the “mental illness complex”. I am using the term “mental illness complex” instead of “mental health” because as a Freedom Center member once pointed out, the so-called “mental health” establishment rarely talks about health, and always talks about illness. I used the term “complex” because the ideas and practices I will refer to come from a complex system of ideas and practices of pharmaceutical companies, mental health professionals, and politicians who often work together and influence each other. While there is a difference between the CEO of pharmaceutical company SmithKline and a just out of graduate school practicing psychologist, and while some perspectives differ widely in the mental illness complex, I also aim to show that there is a great deal of homogeneity of ideas and practices. For example the expression of mental illnesses is primarily an understood biological disease best treated with biological interventions is common to the pharmaceutical companies and doctors alike. And while I understand and respect the fact that many mental health practitioners work hard, not just to earn a living, but also out of a genuine humanitarian care for those who become their patients, I do think they have a responsibility to understand the origin and implications of these ideas. Furthermore, while I acknowledge that some of the practices and rhetoric are different than it was seventy years ago, I argue that this mental illness complex has roots in, and still a great connection to a traumatic and abusive history where "mental patients" are exploited, granted little dignity, and few rights.

I also argue that the mental illness complex is in the context of a unique type of power and authority present in capitalism in the last century. This argument comes from looking at specific powerful institutions including Central Intelligence Agency (CIA), American Psychiatric Association (APA), pharmaceutical companies, and the United States of America's federal government and assessing their tactics such as advertising, pseudoscience, drugging, and the consolidation of power. This unique form of power is rooted in capitalism, is centralized and hierarchical. Throughout my discussion of eugenics in psychiatric history, I explain how eugenics is very much a class system, a binary philosophy that involves dividing people up into two main classes, the "eugenic" and the "cacogenic." While the dominant discourse no longer involves eugenics, I argue that the actual results of policies and practices of the mental illness complex still involves the classist treatment of mental patients as though they were second class citizens or an inferior race.

In writing about the mental illness complex and trying to assess how power plays out I have undeniably came across and been referred to philosopher and historian Michel Foucault. Michel Foucault's approach to power and the history of psychiatry has both radical difference and relevant similarities as mine. For example, In Foucault's La Volonte De Savior Paris Foucault's perception of power can be described when he states, "Power is everywhere, it arises at every moment, at every point, or rather in every relationship between one point and another" (Foucault m: La Volonte De Savior Paris, Gailmard 1976). This also can be shown in his writing Dits et Ectits in which he accepts the concept of power, but redefines it by primarily rejecting the concept of domination and binary oppression. While I agree that power has and is always manifesting in dynamic ways on a personal level I think this perception is missing the main point when it comes to many of the past and present threats and injustices of the mental illness complex. Despite living through the popular international movement, Foucault has no mention of the huge and damaging role eugenics, a binary power philosophy has played in psychiatry. Furthermore, while I acknowledge he was not living or writing in the United States, his history is only so relevant to my paper because it does not have any specific discussion of the institutions (APA, CIA, drug companies, US federal government) nor the specific tactics (pseudoscience, advertising, drugging,) that I find it have found important to approach.

Nonetheless, in Foucault's later works, such as his book Discipline and Punish: The birth of the Prison he does have some overlapping notions as I do with notions about power. In his chapter "The Correct Means of Training" have a sections titled "Hierarchical observation," "Normalizing judgment" and "The examination" are sections in which power is, like I have suggested, perceived as hierarchical, centralized, and related to capital. His discussion throughout these sections of certain tactics, such as the surveillance and homogenization will come up later in relation to my discussion of diagnosis and my discussion of the New Freedom Commission.

Some other works that I have found critical to support my thesis has includes the work and stories of psychiatric survivors themselves (mainly members of the Freedom Center though also the works of several other ex-mental patients), the official rhetoric of major mental health institutions, and the work of more critical medical professionals such as psychologist Paula Caplan, psychiatrist Peter Breggin ,and neurologist Elliot Valenstein.
Social history is told not only from psychiatric survivors but also from a journalistic perspective from journalists such as Robert Whitaker John Buchanan and Martin Lee.

While, I acknowledge madness or craziness or extreme states can be an extremely mysterious phenomenon with an ancient history, and unknown causes, I argue that while this may be the intention of some individual doctors, generally the mainstream American mental illness complex is not about healing or understanding these extreme states, but rather is about following the objective interests of the capitalist class and system. Lack of access to true information, inadequate living conditions, trauma from abusive relationships with family, jobs, schools and lack of access to adequate diet are common causes of why individuals end up in the psychiatry system and when broken down most of these causes also have roots in capitalism. Similarly corrupt drug company funded studies, psychiatrists six digit annual income, the creation of an exploited class, and Bush's new policies also have roots in capitalism. While I am not trying to say capitalism is single cause of the injustices and mythologies of modern psychiatry (surely there has been corruption and injustice in other systems) I am claiming it is a primary root cause

Rather, some primary means of supporting my thesis has included members of the Freedom Center's (their personal stories and their past work), as well the works of several other ex-mental patients. I have also evaluated the dominant ideas and practices of the mental illness complex by looking at the official rhetoric of major "mental health" institutions as well as through looking at the works of more critical medical professionals such as psychologist Paula Caplan, psychiatrist Peter Breggin ,and neurologist Elliot Valenstein Social history in my piece is approached more from a journalistic perspective from journalists such as Robert Whitaker John Buchanan and Martin Lee.

While, I acknowledge "madness" or "craziness" or extreme states can be an extremely mysterious phenomenon with an ancient history, and unknown causes, I argue that generally the current American mental illness complex is not about healing or understanding these extreme states, but rather is about following the ‘objective’ interests of the capitalist class and system. Lack of access to true information, inadequate living conditions, trauma from abusive relationships with family, jobs, schools and lack of access to adequate diet are common causes of why individuals end up in the psychiatry system and when broken down most of these causes also have roots in capitalism. Similarly corrupt drug company funded studies, psychiatrists’ six digit annual income, the creation of an exploited class, and Bush’s new policies also have roots in capitalism. While I am not trying to say capitalism is single cause of the injustices and mythologies of modern psychiatry (surely there has been corruption and injustice in other systems) I am claiming it is a primary root cause.

Nonetheless, I understand that the overthrowing or transforming of a capitalist system is an extremely large and long-term goal, and in the meantime I acknowledge there are many other short-term approaches to bringing justice and truth forward. And while I do believe and aim to show in my paper that if our living conditions were better, if our diets were more adequate, if we had a greater sense of community, and if we didn't live in an industrialized capitalist system, then perhaps we wouldn't feel as though we need mental institutions, restraints, electroshock therapy and toxic psychiatric medications; I also acknowledge that we do not live in that world now, nor, does it seem, unfortunately, that we are heading there any time too soon. I also understand that in the conditions we currently live in, there are many emotional, economic, physical or social reasons that would drive an individual into choosing, or being coerced into using, psychiatric services and psychiatric drugs. Throughout my work this year I have met several anti-capitalists/antiauthoritarians who, with full knowledge of the corruption of the drug companies, and even many of the health risks of the drugs, have made the decision to take psychiatric medications for the sake of everyday functioning or in some cases, for the sake of their lives. I have also met other people who would love nothing more than to get off their drugs, but who remain on them because they greatly fear or do not have time for the intensive withdrawal process that comes with getting off their drugs. I want to emphasize that in revealing the dangers, mythologies, and injustices in this system my goal is not to stigmatize individuals with diagnoses or those who are taking psychiatric drugs. My goal is rather to help individuals understand that it is often times *not* their fault, nor the “fault” of their “broken brain” that they end up in these situations. I know patients, x-patients and potential patients have gone through a tremendous amount of suffering and I think the least people deserve is the truth and dignity. My paper aims to be a tiny part of that process.

The Freedom Center stands in sort of a holographic relationship to my thesis. Hologram is derived from the Greek words *holo*, meaning whole and *gram* meaning to write. With a hologram, if only a small part of the plate is illuminated with laser light the whole of the original objects is seen three-dimensionally and with luminous depth and great detail from many viewpoints. In other words, many of the stories of members of the Freedom Center are complex though usually invisible to the unaided eye, and by illuminating them, I aim to give the reader a chance to look in more depth at the whole picture of what is going on with health and healing in our whole society.

My ethnographic work with the Freedom Center comes from attending Freedom Center’s organizing meetings, events, movie showings, the meditation group, and the yoga group. It also came from doing more formal work with particular individuals in the organization on political projects throughout the year, such as event organizing and public presentations. Finally, it comes from one-on-one interviews in which I used a tape-recorder and had the full permission of the interviewee to use his/her words in my paper. For confidentiality purposes, I used different names for all members of the Freedom Center with the exception of Will Hall and Oryx Cohen the founders of the organization, because so many of their quotes come from public statements to which their name is already attached. The support groups are confidential, so despite the fact that much of my participatory work, and much of what I learned about the individuals in the organization came through this setting, details about the support group will never be revealed in my project. I will refer to the support groups generally, and as a way of talking about a particular therapeutic model, but never with the specifics of what was revealed in that setting about individual's struggles,

I see myself (and believe that I am seen by the organization) on much more of the participatory end of the participant-observation spectrum of anthropology. While, unlike the vast majority of those involved with the Freedom Center, I myself have not been diagnosed with a mental illness or received unfair treatment from the psychiatric system, and this is a relevant difference, I have experienced extreme states of consciousness and some states of "madness" and do stand in solidarity with those who have had this experience and aim to achieve the Freedom Center's goals. Some members of the organization consider me an "ally." Others just consider me another member of the organization. Others consider me to have both of these roles. I consider myself both of these things: an ally and a member. Many of the individuals in the organization are now my good friends, and my commitment to them (and to the collective vision of the group) goes far beyond the scope of this paper. My friendships have not blinded me to critiscm of the tactics, strategies, or language of the organization or the members of it. Throughout this year and throughout my paper there are plenty of times in which I bring forth conceptual or tactical disagreements. Yet, in illuminating the Freedom Center's work and the work of many other scientists, journalists, and academics who seem to support the Freedom Center's general goals I aim to help the reader understand injustices, mythologies, and shortcomings of the capitalist mental illness complex .

Chapter 1: The Freedom Center

"It took a lot of courage to start the freedom center," the co-founder of the organization told me, "It still takes a lot of courage."

Will Hall, who originally came up with the idea of the Freedom Center in 2001, did so, as he explained, "really more out of anger and pain than anything else." He was looking for an outlet to express his rage, and also to find support in his struggle regarding the psychiatric abuse he knew to be present in the lives of many. Will's father was a survivor of electroshock therapy from hospitalizations in the 40's and 50's, and was tortured by psychiatry at the request of his grandfather as a form of punishment for acting out as an adolescent. Will explained this during a public speak-out,

> "My father's emotional scars from this abuse directly affected me and the rest of my family, because he never got adequate treatment and carried around severe PTSD all during my childhood. Of course, when my psychiatrists where I was locked up found out this about me, they used it to try to convince me my problems were genetic brain malfunctions correctable by medications. Not once did they ever ask me about my own childhood experiences of trauma. Only later did I learn that there is no actual basis for the genes/brain disorder claim, that it is only psychiatric dogma."

Will's own first experience with psychiatry came in 1990 when he was 24 and was volunteering with a Central American solidarity group as well as working two jobs. Some combination of time constraints in addition to his past trauma, smoking pot, and drinking a lot of coffee is, (in Will's opinion) what led him to the hands of psychiatry. He decided to try Prozac to deal with his stress. He originally described the Prozac as being like the "best cup of coffee" he had ever had, as it seemed to play a role in increasing his productivity at work, and facilitating his feeling "better than well." But then, not dissimilar to many accounts with Serotonin Reuptake Inhibitors (the type of drug Prozac is classified as), he had a manic reaction to the drug. He describes the experience:

> "I was suddenly acting very differently at work, wearing weird clothes and getting into big arguments with my co-workers. It was the first time anything like this had ever happened to me, and it was absolutely terrifying. No doctor warned me, and nobody got me off the Prozac when the manic reaction started. I ended up losing a long term job as a result of this drug side effect."

Two years later, after many other intensive experiences with psychiatrists, Will ended up in the locked unit of a public psychiatric ward in San Francisco, which he describes as being like a prison.

> "I was told I was a danger to myself and that it was for my own good, but like so many people it was really being in the wrong place at the wrong time. I begged

> them not to lock me up, because I didn't want to lose my two jobs. I kept saying ‘Please let me go so I can go to work, please, I can make a no harm contract, I don't want to miss work. But I ended up losing those jobs.”

No harm contracts have been a commonly used intervention when working with suicidal clients. This a written agreement in which the counselor attempts to engage the client in a “pact” to not attempt suicide. Important components of the contract include: specific time frame for which it is in effect, specifies a delay in attempts to harm self, specific information on what to do (and who to contact) in case of ideation or the urge to harm self. The contract also includes an agreement to dispose of and/or surrender means, times/dates scheduled for next appointment or check-in times, and contingences for violations of terms of the contract (Westefeld, Range, Rogers, et al, 2000). While research has not proven that harm contracts are a guarantee against suicidal behavior, they have proven to be helpful for the liability of the counselor. (Westefeld, Range, Rogers, et al, 2000). ,Yet despite Will’s offer to sign this contract, he remained in the locked ward.

Not only did Will feel as though he was in prison and losing two jobs, but he also had horrible experiences because of the psychiatric drugs he was put on. He was prescribed Narzane, a drug to treat schizophrenia which he reported, in retrospect, changed his personality and denied him the most basic sense of who he was: “It made me stupider, slower, fatter, and at times more desperate and suicidal.” He was increasingly socialized to believe that he had a permanent brain disease, and he witnessed multiple people around him commit suicide. However, right before he was about to get electroshock treatment a social worker came into the hospital and said there was no more funding to keep him in the hospital, so he was released immediately.

The lack of funding to keep Will in the hospital, is part of a larger trend of the mental illness complex known as “deinstitutionalization”. While the most drastic push for deinstitutionalization occurred in the late 1960s and early 1970s, and Will’s hospitalization was in the 1980s he does speculate that this is part of what was going on, as “deinstitutionalization” has been an ongoing agenda. Deinstitutionalization is the process of shutting down inpatient facilities, such as hospitals (Kamis-Gould 1997). The rhetoric around deinstitutionalization originally was that it was both more cost-effective and would allow mental patients to become more integrated into the community (Kamis-Gould 1997). Others have noted that factors such as the increasing use of psychotropic medication, (such as Haldol and Thorazine) were enabling elements of deinstitutionalization (Cohen 5 2001). While practitioners say this is because patients could now be more involved in the community many patients have framed it that this is instead providing “wards in their back yards” (Cohen 6 2001). In Will’s particular case, he seems grateful that the funding got cut off to keep him in the hospital because it prevented him from having electroshock therapy.

Will’s traumatic experience clearly played a role in the creation of the Freedom Center, which came about in 2001, just a year after Will had moved to the other side of the country. The creation of the Freedom Center was partially inspired by the organization MindFreedom, which is an international organization that connects over 100 groups fighting for the human rights of those diagnosed with mental illness. MindFreedom was founded in 1988 by Harvard alum and psychiatric abuse survivor David Oaks; and Will wrote to David initially about his idea for the Freedom Center. David Oaks wrote back telling him that he should meet up with Oryx Cohen, another psychiatric abuse survivor who had been diagnosed as bipolar and who was living in Will's area. When I asked Oryx to tell me about the birth of the organization he told me that he had been working with David Oaks on an oral history project of psychiatric survivors when David suggested that he meet Will. And though he had some doubts initially about the meeting he now points out "we just got along great and we both had a similar vision for what needed to happen."

Even though Oryx was in grad school at the time and Will was working, the two of them applied for a grant through the Department of Mental Health. The specific grant which they applied for was under the framework of, 'Consumer-Run programs' and they got the grant for $500 and thus had to decide how to prioritize the money. "We really wanted to integrate support with activism," Oryx explained to me. He went on to say,

> "A lot of groups in the movement are very gung-ho on the activism, which is great but there's not as many that provide support for people. So we really wanted to make sure that supportive relationships was the foundation of the group. So that's how it started and all the activism kind of grew out of that."

Having a foundation of supportive relationships is one unique quality that the Freedom Center has. The fact that people diagnosed with mental illnesses have the leadership roles in the organization is another unique quality of the Freedom Center.

> Will reflects on this when he points out,
> "In this area there was no group run by and for people with severe mental illness labels themselves -- everything was run by the mental health system. No one was protesting psychiatric abuse, it was as if it didn't exist. So three years ago we co-founded the Freedom Center together to break the silence."

Considering it was the first in the area of its type, the organization attracted much interest. In 2001, the organization had support group meetings once a month, with only a few people at each meeting, and informal organizing meetings at random. Within a year, due to increasing demand and desire from participants, the group started meeting twice a month. Steadily, out of people's desires and ideas, the organization began expanding and offering other activities as well. By 2003, the organization met for both a support group and had an organizing meeting once a week as well as a bi-weekly film series, a weekly yoga class, a weekly writing group, and a weekly meditation group.

The Freedom Center does not have its own space, but instead rents out an area of the local Quaker group's space for its support group and meditation group (where Freedom Center members also have a closet to keep their literature). The Freedom Center is allowed to use a church for free as part of their yoga group, and it holds various events, including big speakers and its film series.

The Freedom Center's support and advocacy meetings run for two hours each week and the meetings are "open to people labeled with mental illness, survivors of psychiatric abuse, and people struggling with extreme states of consciousness (freedom-center.org 2005)" The group has also decided that, "Allies and supporters willing to share their personal experiences are also welcome (mental health staff allies are welcome but should contact us first; please, no 'observers.')" As mentioned previously, I consider myself an ally and not an observer, and believe I have earned that role in the mind of others in the group due to my personal openness with the group, my political perspectives, and my participatory work in facilitating meetings, organizing events, and organizing an herbal medicine shelf.

The support group meetings, one of the main community building activities of the organization, begin with announcements, including Freedom Center activities and updates. After that, there is a facilitator who helps guide the time for individual's to share their feelings and experiences, talk about recovery or medications, get ideas and resources or get help with specific advocacy needs. Some members also share poetry, dreams, or their personal visions, as members can use their time in any way they feel they need to. The intention of the support group is focused on listening and mutual respect, while keeping in mind group safety.

The free yoga class meets once a week, and is open to anyone regardless of their physical or mental abilities. There is no formal commitment to the yoga class, so one can join at any time. Part of the purpose of the yoga class is to "provide a non-pharmaceutical means for individuals to cope with depression, anxiety, or any other form of physical or mental stress"(freedom-center.org 2005).

The writing group and the meditation group are also community events designed to facilitate a healing process. Hayley, the individual who started the writing group out of the Freedom Center support groups describes it as

> "for anybody at all who wants to shake up their creative juices and pour them into words. We'll engage in various writing exercises and then read them aloud to each other in the name of sharing, caring, and jumping over the hurdles of fear."

The weekly meditation group, which also came from the desire for alternative wellness tools, is also a communal, free, open to anybody group for people to

> "learn how to relax and improve your concentration using simple, easy to learn and non-religious meditation techniques in a friendly, informal and supportive environment."

The Film Series takes place at Mt Holyoke College in South Hadley, MA, and is co-sponsored by the Mt Holyoke Psychology department. The film series is also a community event, which is free and open to anyone interested. In the 2004/2005 academic year, the series has included movies on eating disorders, attention deficit disorder, a mental institution for the "criminally ill," and a movie on the experience of shifting from hospital life to non-hospital life.

One can also find online the Freedom's Center's Internet On-Line Chat Room, a once a week space for individuals to discuss various issues related to mental health, and also has a website, which has individuals' speak-out pages as well as a range of information regarding Freedom Center activities, other similar groups, and more intensive research about the psychiatric industry.

All of these activities, with the exception of the film series, which was started by a psychologist and professor ally from Mt Holyoke have been initiated by people diagnosed with mental illnesses; they are initiated either in an effort to reveal truth about the psychiatric industry or to provide alternatives to this establishment.

While the organization is united by this common vision (to reveal truth and to provide alternatives) it is essential to understand, particularly within the context of this ethnography, that the Freedom Center is in large part an elusive and amorphous organization. I use the terms elusive and amorphous not because the organization does not have a clear sense of its goals but more because "membership" varies so much. The Freedom Center has no official form of membership or registration, and no set standards of participation. There are individuals who attend one meeting and never come back, those who come once every other month, those who attend meetings regularly, those who help organize, and those who can't make meetings but consider themselves allies. Furthermore, opinions can, and do, vary widely amongst the organizers/founders of the Freedom Center and those who use its resources. While I have found myself generally most politically allied with those in leadership roles, it would be extremely limited and would not do justice to the Freedom Center if I only focus on these individuals as a means of forming the identity of the organization. I believe the identity of the organization is formed by all those who participate in it, whether that is through attending support group meetings, events, and the yoga group, or through political organizing and campaign work. I will use the term "member," to refer to any and all of these individuals. Without a doubt, by this definition I, too am a member of the organization, and play a role in defining it.

While the specific characterizations of individuals in the organization will be explored in depth throughout the piece, I will generally point out that the Freedom Center is open to people of all ages, ethnicities, class backgrounds, abilities, and genders. In my experience with the organization the Freedom Center has attracted people from a wide diversity of ages, class backgrounds, abilities, and genders. The Freedom Center is not noticeably diverse ethnically, but this is perhaps primarily having to do with the fact that it is based in a town that is 90% white (US Census 2002).

While the Freedom Center is striving towards its own non-profit status, currently it receives any funding it gets through its fiscal sponsor, an advocacy non-profit group known as "M- Power." Freedom Center does not have annual meetings, does not have any paid staff, and the organization has little to no accountability to the state or any major corporation. Most of the funding it receives comes from private foundations, with the exception of one grant that came from the Department of Mental Health to fund the yoga class. The funding the Freedom Center receives goes towards paying its yoga teacher, paying to keep the website up, paying for copies of flyers, brochures, etc. As of now, the Freedom Center is an entirely volunteer-run organization, constantly changing in its membership and resources, and thus truly qualified to receive the label of "grassroots".

The Freedom Center has rose in response to the abuses of mental illness complex and through its programs has attempted to provide both of a confrontation of where this complex fall shorts and alternatives to it. While the Freedom Center is not publicly anti-capitalist and consists of many members who do not identify as anti-capitalist both of the co-founders of the organization seem to identify themselves this way and have designed some of the programs and services accordingly. I also believe many of the Freedom Center's programs and actions are subversive to capitalism. For example, the very fact that the support group meeting, yoga group, meditation group, film series, and events are all free and available for people regardless of their capital, challenges the hierarchy of capitalist medicine. There are always ways, which I will elaborate on in Chapter 5, in which the Freedom Center seems to subtly perpetuate the individualistic ideas that capitalism depends on. Nonetheless we at the Freedom Center are a community and as a community many of our actions, ideas, and programs truly challenges both the capitalist system and the mental illness complex.

Chapter 2: Informed Consent?

"You can't heal me without my cooperation, you can't"-carol patterson, ex-patient

Each and every Freedom Center support group meeting starts off with the traditional preamble, often stated by the founder of the organization. The preamble states,

> "The Freedom Center is not necessarily for or against psychiatric medications, but instead is for true informed consent, which is something people often don't get within the psychiatric system. We respect each individuals' wellness plan and

> recognize that people have very different ways of healing, but we think people have the right to choose and deserve to do so knowing the different options and some of the benefits and risks of those choices."

Informed, meaning "to impart information or knowledge" and consent meaning, ": to give assent or approval : agree" (Merriam Webster Dictionary 2005) is an essential guiding principle, and demand, of the Freedom Center. The word true, added to the beginning of the phrase, has developed in response to mainstream psychiatry's policies and practices that many patients and ex-patients feel are still primarily dishonest, inaccurate, skewed or lacking information. Throughout this chapter I will also be arguing that there is a relationship between receiving accurate information and whether or not one consents to treatment. While there is a difference between medical procedures done brutally with no information given, and no consent asked for and those that occur "voluntarily" yet without proper warnings about the effects, I argue that both are a violation of providing true informed consent.

I also believe that in order for true informed consent to be provided there must be complete honesty about what is known and not known about the cause, diagnoses, and treatment of so-called mental illness. If, for example, Joe Schmoe is told that the cause of his diagnosis of lung cancer has come from eating eggs, and that upon switching to a liquid egg substitute, his prognosis will go from living for 6 years rather than 6 months, then he will likely accept the treatment of a liquid egg substitute. If his doctor then gives him honest and accurate information about the benefits and risks of the so-called treatment (his liquid egg substitute) but fails to show him the abundance of evidence that smoking (of which Joe has a two pack a day habit) is linked to lung cancer and furthermore the lack of evidence for egg consumption causing or treating lung cancer than simply telling him the benefits of risks of liquid egg substitute does not account for "true informed consent." Even if Joe originally heard about cutting out eggs from an advertisement or a TV show, rather than the doctor, the doctor is still complicit in essentially prescribing this diet, and withholding information about other possibilities for cause, diagnoses, prognoses and treatment.

Though often the treatment is nowhere near as benign as egg substitutes, I argue that the situation with the mental illness complex is similar in many ways. There is false information about what is known and not known about the causes of so-called mental illness that leads to false information about the diagnoses/prognoses and thus the treatment of such phenomena. As I will show with my discussion of the informed consent forms, there is certain fallibility granted with psychiatric treatments, but there is very little granted with both the causes and the diagnoses of mental illnesses.

There is indeed a connection between true information and whether one consents to medical intervention. In other words, one can choose to consent due to accurate information or be coerced into consenting through false information. False information can sometimes be as subtle as advertisements which manipulatively, though seemingly voluntarily, drive people into a system or as overt as lying to someone about where they are going and what is being put in their body. By looking at the Freedom Center's model and several other "mad movement" models I will be discussing the demands for true informed consent and more voluntary approaches to healing.

Cause

I've interviewed many members of the Freedom Center about what it is they think “caused” the extreme state of consciousness or extreme emotions they were undergoing when first being diagnosed as mentally ill. Many members have told me it was complex, and often some combination of extreme stress from school, jobs, sexual abuse, or fighting in war. Others have told me about poverty, diet, or hormonal imbalances playing huge roles. Nobody has said anything about truly feeling in retrospect that a biochemical imbalance or bad genes caused his/her experience. Yet the causes of so-called mental illnesses via the American Psychiatric Association, the National Alliance for the Mentally Ill, the Surgeon General, and many mainstream news reports, claim to be due to chemical imbalances of the brain or to genetic factors. While the brain and genetics have become two of the most common terms heard in modern medical discourse, the brain plays a particularly popular role in psychiatry. The discussion of the role in genetics causing mental illness dates back to the early 1900s eugenic movement, while the discussion about the brain and chemical imbalances is only about forty years old (Valenstein 1988).

The 1983 article in the fashion magazine Vogue displays brain scan images of the “mentally ill.” Specifically it shows three brains, with three different images, and the three different words NORMAL SCHIZO and DEPRESSED(Dumit 6 2004). These images conjure up the idea that the schizophrenic is different than me, (I’m sure I would be the “normal” brain) and that some brain problem causes schizophrenia. Many other sources also give the public reason to think this. The National Alliance for the Mentally Ill (NAMI) states in their schizophrenia fact sheet that both schizophrenia and bipolar disorder are “a disorder of the brain” (www.nami.org 2005) Xavier Amador says schizophrenia and symptoms of it are due to a “broken brain” (Amador 2003). Most other mental illnesses have also been contributed attributed to the brain. The consumer group Children and Adults with Attention Deficit Disorder (CHADD) states in their literature "AD/HD is clearly a brain-based disorder" (www.chadd.org 2005). Serotonin, the brain chemical of choice amongst those interested in depression in the mental illness complex, is widely acclaimed to be the cause and solution of many of our problems. A University of Washington psychiatrist referred to the "serotonin depleting times" we are living in as the root of his perceived "world wide epidemic of depression" (Valenstein 1-20 1988) Similarly, Pulitzer Prize winning science writer talks about the "revolutionary" finding of norepinephrine and serotonin balance in major personality and behavioral traits (Valenstein 1-20 1988).

For over three decades scientists, academics, and politicians have been using this discourse and for over three decades many scientists, doctors, and ex-patients associated with the mad movement have challenged it. Ex-patients used to march in the streets saying these theories were disempowering and damaging while demanding to see the evidence to support these claims. As described in Chapter 5, one group even did a hunger fast outside of the American Psychiatric Association demanding to see the evidence for mental illness as a biological brain disease.

The Freedom Center too, has rejected the discourse about brain imbalances and genetics in their work. They have had speakers and sold books to educate people on the lack of scientific evidence used to support this discourse. Furthermore, their pamphlet reads, "We are not genetically inferior. There is no proof that mental illnesses are biological brain diseases."

Will of the Freedom Center who was diagnosed with schizoaffective disorder, has also explained the ways in which this diagnosis, and the belief that it was caused by genetics and a chemical brain imbalance were disempowering and not helpful for him. He states:

> “By conducting research and educating myself to the facts about psychiatric diagnosis, and learning that these labels are subjective and political and not based on any solid science, I was able to see through what had become an interpretive prison. I stopped believing I should never have children because I have bad genes. I stopped believing I should never trust my emotions and thoughts because they are always corrupted by illness. I stopped believing that I had chemical imbalances that only medication could help. I stopped doubting my spirituality, my creativity, and my sensitivity. I stopped believing recovery was impossible. I started to respect myself and my differences and uniqueness, rather than seeing myself as a disease to be cured or a problem to be solved.”

In October 2004 at a Freedom Center public forum where psychologist Daniel Dorman was talking about the way in which he successfully used psychotherapy (and only psychotherapy) for a long-term, catatonic, voice-hearing, patient diagnosed with schizophrenia, a woman in the audience, who had received the Freedom Center pamphlet and listened to the talk stood up to ask the doctor a question about it. “It says here that there is no proof that mental illnesses are biological brain diseases. Is that true?” Daniel Dorman, went on to respond,

> “There are NO physical signs that are diagnostic for schizophrenia. Period. There are some ‘correlations,’ like different areas of the brain that ‘light up’ on brain imaging studies, but such findings are not exclusive to schizophrenia, thus are not diagnostic. In fact the same ‘lit up’ areas of the brain exist in people undergoing severe stress, like victims of violent crime, war survivors, etc. Anyone who says that there are diagnostic physical findings for schizophrenia, or for any other so-called mental illness, is misrepresenting correlation with cause (Dorman 2004)”

Dorman is not the only one that has pointed out the holes in claims about the brain's role in psychiatric medical science. Doctor and author Elliot Valenstein in his book, Blaming the Brain, further illustrates the problems with the hypothesis that mental illness is caused by chemical imbalances and brain disorders. He carefully spells out the story of how certain psychiatric drugs (including SSRIs) were discovered and the emergence of chemical theories proposed to explain how the drugs work. Furthermore, he shows most of the evidence and arguments used to back these theories to help the reader understand why so many people accept them. Valenstein then points out how rarely replicable these studies are when he states

> "While there are some reports of finding evidence of an excess or deficiency in the activity of a particular neurotransmitter system in the brains of decreased mental patients, these claims are controversial. As other investigators cannot find any such relationship. At best, such claims are trends that result from averaging the data from many patients. As the brain chemistry of many patients in these studies was found to be perfectly normal, it is hard to argue that their mental problems were caused by a chemical imbalance" (Valenstein 118 1988)

As Valenstein goes on to point out, serotonin is but one of hundreds of brain chemicals, and to think that it alone could cause and treat depression is extremely oversimplified. The American Psychiatric Association itself has admitted that the brain is a vastly complicated organ and science had not advanced to the point of understanding a lot of what is going on biologically and chemically (APA statement Fast For Freedom 2005). To illustrate this point, Australian psychologist Philip Owen warned:

> "The claim is continually made that the drugs repair chemical imbalances in the brain. This claim is false. It is still not possible to measure the exact levels of neurotransmitters in specific synapses within the human brain how, then, is it possible to make claims about chemical imbalances" (Owen 2003)?

Thus the chemical imbalance theory is at best, an unproven hypothesis as there is no convincing evidence that most mental patients have a bona fide disease primarily caused by genetics or a chemical imbalance (Owen 2003). There is a lack of tests available for assessing the chemical status of a living person's brain, thus there is no real way of knowing whether there is a chemical "abnormality" or if drugs will "correct" it. What there is, as of recently, are PET scans, a highly expensive technology that can track, not chemicals, but different activities of different parts of the brain. Even if a brain-chemistry technology was developed or a chemical abnormality was found to consistently correlate with a particular diagnosis, it would not be clear how such a finding should be interpreted. The chemical "abnormality" could very well be caused by stress or some behavioral peculiarity rather than being an inherent illness. Focusing strictly on the brain psychiatry is not only ignoring other vital organs of the human body but also is also ignoring all potential social, environmental, economic, and dietary factors.

One Freedom Center member illustrates this when telling me about her thoughts on brain theories. She refers specifically to the new technology that helps produce those images and how it relates to a situation she can relate to:

> "Let's say my dad just kicked the shit out of me, and I am too scared to go back to school because I don't want to tell anyone, the abuse and threats continue and three years later my body freezes up, my affect is blunt and I'm catatonic. I don't want to tell the doctors, they're scary strangers you know? At that point, I could use a safe place to stay, a nurturing environment, maybe someone to listen to me. Honestly, I could give a shit what color my brain and what spots show up. It's not what really going on."
>
> When I asked her if that meant she was "against" PET scan machines, she tells me:
>
> "Against them? I don't know…. I mean… if PET Scan machines weren't replacing the reality of looking at social causes, if they weren't spending billions of dollars on them instead of programs which really listened to the communities proposed needs, then I would see them as a potential 'advancement,' or at least just another

> diagnostic technique, but right now I see them more as more of an academic exercise or in the media, as propaganda used to move attention away from the social, the political, and onto the biological."

Furthermore, focusing primarily on genetics and chemical brain imbalance causes lack many preventive options (how can you prevent having "bad genes"), and put the expertise in the role of scientists. The ruling class of scientist, doctors and drug companies will always have power as long as genetics and brain imbalances are considered the main causes of mental illnesses, regardless of what evidence they do or do not have. In chapter 3 and 4, I will describe in more detail the history of how such bio-dominated theories came to lead psychiatry. When it comes to the cause of mental illness, informed consent means acknowledging that the lack of evidence around genetics and chemical brain imbalances and it means considering the role of past trauma, diet, and one's living conditions. Believing that the cause of mental illness is a chemical imbalance or genetic is why so many people turn to, or trust, psychiatry and meanwhile this information is distorted, and thus is not true informed consent.

Diagnosis

A primary thing the vast majority of Freedom Center members have in common is dissatisfaction with the mental illness complex and a psychiatric diagnosis. Members dissatisfaction with the mental illness complex may never have arose if it was not for this factor. Considering there are over three hundred psychiatric diagnoses, the similarities between peoples experience should be few, but considering the consequences of these diagnoses many similarities have arose.

When discussing cause, I proposed that a person's extreme state of consciousness or emotions are often traced more to social, political or economic factors than to biological. I also briefly proposed the non-medical incentives involved in having mental illnesses depend on the brain chemistry and genetics. Similarly, there are many social, economic, and/or political incentives for one to receive a diagnosis. Throughout this section I will look at who creates these diagnoses, who receives these diagnoses, who benefits from diagnoses, and the consequences of the diagnoses as a way of exploring the lack of informed consent in the diagnoses of the mental illness complex.

While the official Department of Mental Health informed consent form does state that an individual should at least be *presented* with alternatives to psychiatric medication, it does not state that individuals should even be *presented* with alternatives to their diagnoses. The informed consent policy requires that the psychiatrists give the patients "a description of the condition being treated" Rather it states, "The Authorized Prescribing Clinician will discuss the nature of the illness and the need for medication with the client, its risks and benefits, probability of side effects, alternative treatments, and the prognosis with and without any treatment (Informed Consent Policy 3 2004)" This implies that the diagnoses must be accurate and the nature of the illness understood. Yet as mentioned above there are still no clear tests, or no clear proof of most of the "disorders" in the Diagnostic Statistical Manual so without these tests**,** where do these diagnoses come from? Who creates them? And furthermore, why do so many people embrace them?

Mental illness diagnoses are subjective social/political constructs, currently developed by a voting process of members of the APA (Dorman 2004). With the other three hundred diagnoses including anything from mood disorders, to academic problems, to "Parent-Child Relational Problems" "Oppositional Defiance Disorder" to "Sexual Arousal Disorder" to "Female Orgasmic Disorder" to "Unspecified Mental Disorder," the DSM basically has just about every type of human experience. And as clinical and research psychologist, Paula Caplan explores, in detail, in her book They Say You're Crazy these diagnoses are not based on empirical data, but rather she proposes, on the desire to pathologize certain characteristics (Caplan 1995).

Paula Caplan was first motivated when she learned the Premenstrual Dysphoria Disorder (PMDD), a "supercharged" version of PMS was to become a psychiatric disorder in the DSM. A roundtable group--which included psychiatrists, psychologists and a representative from Eli Lilly Endicott and a panel of experts determined in 1999 that PMDD is a distinct clinical entity, based the fact that "normal functioning of the hypothalamic-pituitary-adrenal axis, show biologic characteristics generally related to the serotonin system, and a genetic component unrelated to major depression" (Caplan 1995). This conclusion not surprisingly quickly led to the idea that Serotonin Reuptake Inhibitors were a means of treatment for this disorder.

Yet Caplan not satisfied by this claim demanded to see the evidence that this was a known bona fide psychiatric disorder and that not just a hormonal experience that occasionally results in the symptoms of PMDD. Caplan and a team of psychologists concluded that there no compelling empirical justification for identifying any particular cluster of symptoms as PMDD, nor for considering PMDD a form of mental disorder (*Feminism & Psychology*, 2:27-44, 109). There was no link between the symptoms ascribed to PMDD and premenstrual changes in hormonal levels.

Furthermore, Caplan's claim was that the diagnosis generally was not one that helps people and that it in fact fed into negative stereotypes about woman when she states:

> "Any normal hormonal change in people of either sex can exacerbate migraines, thyroid problems, etc., but no one suggests calling...men's hormonal changes kinds of mental illness"

Caplan goes on to say:

> “It is really appalling that using PMDD for women who want recognition for discomfort is a very clear message that goes something like: 'OK, OK, we'll believe you are feeling bad if we get to call you mentally ill for feeling bad.' (Caplan 2004).

Because of this lack of evidence and potentially sexist motivations Caplan goes on to speculate about the empirical evidence to support other DSM disorders, such as autism. She, along with several of her colleagues, did searches in some of the country’s biggest medical journals. They found that there was no empirical evidence that four of the six characteristics listed as features of autistic children are in fact features of autistic children. In other words, the literature shows that in people diagnosed with autism there is no evidence that any more than two of the six DSM criteria for the category tend to appear in the same person at the same time (Caplan 120-146 1995). Yet, the DSM presents a list of six criteria that are presented as frequent features of allegedly autistic children, and one also finds that such children have to have all six of the criteria in order to receive the label. Caplan explain a difficult situation in which a family enters her office desperately trying to find a label for their infant. Caplan points out:

> If I knew that, if that little boy met all six of the criteria listed under “infantile autism” in the DSM a certain kind of medication or assistance would help him, I’d

> be delighted to stick the label on him. Or even if applying the label enabled me to tell his parents that he would probably never learn to read or speak, I would at least be glad I could give them a chance to prepare for the future of their son. But despite the fact that massive amounts of writing has been done about "infantile autism", no one has ever produced the kinds of data that would make it clear that this is a condition that can unambiguously defined, that any particular person can be shown for certain to 'have' or 'not have' it (Caplan 78 1995)"

Caplan is not suggesting there are not woman who feel as the DSM says, "feelings of guilt hopelessness and worthlessness" before they menstruate or that there are not children who are socially withdrawn or "fail to develop peer relationships " but what Caplan is posing is that perhaps the consequences of a diagnosis (often including stigma or psychiatric treatment) is not worth it when the diagnosis cannot even dependably and repeatedly offer some insight into the physical possibilities or lack there of for the patients? Perhaps if patients and families had information about the fallibility of these diagnoses, rather than trusting the "science" of the DSM they may not consent to a diagnosis.

While the APA creates the DSM diagnoses it is not always directly from this book that people "voluntarily" turn to the psychiatry. Another common reason that many people turn to psychiatric diagnoses is due to advertising. In a fall 2004 copy of Newsweek I recall seeing a full-page picture of a beautiful woman who is wearing a hat that slightly covers her face. I could barely see her eyes as she is looking down at the ground in a sweet, withdrawn sort of way. The text reads, "Is she just shy? Or it social anxiety?"

At first I wonder, "What's the difference?" Then after seeing the drug logo and the reference to pseudo-scientific studies I remember the answer to my own question: "shy" is simply a personality trait something anyone can go through, "social anxiety" rather, is a "disorder", a sort of chronic pathology that needs medical attention. This simple re-framing of how I think about the woman's withdrawn and petite look opens up a door to completely re-conceptualize her experience based on the APA's term.

Kathryn Schult's article in the New York Times, titled "Did Antidepressants Depress Japan?" outlines the ways in which the arrival of Paxil into Japan altered the way in which the Japanese thought about melancholy. While Japanese Buddhism has often perceived suffering as inevitable, and even part of a bittersweet aesthetic, much of Japan is now adopting the idea that this experience is a disease. In Japan, where direct consumer-to-patient advertisements are illegal, drug companies chose instead to advertise the *disease.* Since doing so, Paxil's sales rose by $190 million in Japan within just two years.

Campaigns such as "Anxiety Awareness Week" or "Depression Awareness Week" are other ways that diseases have been introduced into the public's mind. These campaigns, as Peter Breggin emphasizes, "gives them a seemingly benign 'educational' aura, while clearly their sponsorship emphasizes other interests" (Breggin 1991). Breggin elaborates that this "benign educational aura" can also be seen with drug-company sponsored consumer groups, such as the National Alliance for the Mentally Ill and Children and Adults with Attention Deficit Disorder. Both of these groups hold national meetings that bring together drug advocates to talk directly to consumers. These advocates make subjective and deeply provocative statements about the fact that half of America will suffer a psychiatric disorder at some point in their life.

In other words many turn to the psychiatric system because they have, with the influence of advertising and "educational campaigns" diagnosed themselves. These self-diagnoses do not always come from direct misinformation necessarily (for example, in the social anxiety ad, it never said the woman had social anxiety) but rather from a type of manipulation, or coercion of language consciously constructed by those who benefit from the diagnoses. (Those who benefit from the diagnoses include both the APA and the drug companies as both depend on the diagnoses for the existence of their institution).

So while some diagnoses are received by people who "self-diagnose" themselves or turn to the system "voluntarily," based on "information" from the DSM or from advertising, I argue that this is still not true information (as it is not based on the empirical data it claims to be) or true consent (as the information is not received and the economic benefits are not clear)

Other people have diagnoses more vehemently pushed on them. As I will explain in chapter 3, "mental patients" throughout history, were not necessarily pathologizing themselves, but being pathologized by the dominant class who saw them as threatening. This is still true today.

Poor young black males in the United States are disproportionately prescribed schizophrenia diagnoses and thus disproportionately subjected to involuntary commitment (Breggin 2003). The DSM-IV-TR even states that there is "a far higher incidence [of schizophrenia] for second generation African Caribbeans living in the United Kingdom." (DSM IV-TR 1994) In chapter 4 I will get into even more detail about specific communities receiving psychiatric diagnoses.

The consequences of these diagnoses, also vary depending on social and economic status though there is some consequences that most diagnoses seem to share. One of the most obvious, and most severe consequence of a psychiatric diagnoses is the treatment that is associated with it. Being diagnosed within the paradigm of psychiatry often results in people receiving treatment in the paradigm of psychiatry. However, another consequence of a psychiatric diagnoses, is the stigma that comes along with it. Some members have referred to "coming out" regarding their psychiatric experience in the same way homosexuals do because of the shame so commonly associated with it. As will also be discussed in the section about insight, many members have also felt a lack of agency or responsibility as a consequence of their psychiatric diagnoses.

Just a few months ago Paula Caplan wrote to the Freedom Center telling them that she was doing work about the harm caused, not just by psychiatric interventions such as drugging, electroshock, and seclusion, rather by the diagnosis itself. She asked for any insight or stories that members of the Freedom Center may have. She got a response from Will Hall, in the form of a statement. He stated:

> "In 1992 I received a diagnosis of schizoaffective disorder schizophrenia while in a locked psychiatric ward. I was certainly going through a great deal of pain and extreme states of consciousness at that time. However, my experience with the mental health system and its treatments, many of them administered to me without my consent and with no other options, was negative and harmful. My diagnosis became part of the problem, not the solution.
>
> After being in the system for years I was left worse off than when I went into it. Being diagnosed as schizophrenic was deeply humiliating, taught me to distrust my innermost feelings and thoughts, and encouraged me to surrender my autonomy and self-reliance to others. It pushed me deeper into isolation and separation from the rest of humanity. My diagnostic label promoted despair and threatened to become a self-fulfilling prophecy.
>
> It was only when I stopped believing in my schizophrenia diagnosis that I began to get better. I was shocked to learn the extent of misinformation and manipulation that surrounds psychiatric diagnosis.
>
> I certainly am not saying that my suffering was a myth or that I do not have painful experiences that are far outside the mainstream of what is considered normal. And I am not denying that others have found it helpful to believe they have

> an illness, just as some people might find it helpful to believe their alcoholism is a disease. However, when they imposed a schizophrenia diagnosis on me, they prevented me from exploring my experience for myself and learning how to understand and heal myself in ways that work best for me. Diagnosis denied me the rich possibilities of seeing the creative, spiritual, and culturally different meaning in who I am and what I go through. Diagnosis as schizophrenic denied me an understanding of the role of emotional and physical violence in my condition, let the mental health system and its mistreatment of me off the hook, and distracted me from seeing the role poverty, nutrition, and social and cultural factors played in the crisis that led me to be hospitalized. Diagnosis as schizophrenic steered me away from the complementary and holistic medicine that eventually became so central to my recovery.
>
> Psychiatric diagnoses like schizophrenia always risk harming people, always risk becoming a self-fulfilling prophecy, always deny people the right to define and understand themselves for themselves, always mislead people about the facts of what is truly known and not known about mental illness, always unfairly promote narrow drug treatments against holistic alternatives, and always impose an interpretation on others based on subservience to power. Psychiatric diagnoses perpetuate a long legacy of mistreatment of the mentally ill, who should be embraced as humans deserving of full dignity, not labeled as broken and different.
>
> I therefore believe it is an urgent necessity to clearly and unequivocally expose the true nature of psychiatric diagnostic labels and the risks associated with imposing them on people, and to stop perpetuating the myths and misinformation that have become the foundation of biomedical psychiatry. It is essential that we end the cynical and manipulative trend of psychiatric diagnosis as a vehicle for corporate marketing, a trend which far surpasses any other country in the world and which has now shamefully reached our children in growing numbers.
>
> I believe that our system of helping people in extreme states of consciousness and severe suffering can and should dispense with pseudo-scientific psychiatric diagnoses. I believe we can find ways to care for people without harming them."

Will's story about his own life shows clearly how the consequences of a diagnosis can result in feeling an unnecessary self-fulfilling prophecy and a lack of agency in the world. His demand to "dispense the pseudoscientific psychiatric diagnosis" shows the role that he believes that informed consent could have had in his own experiences. When it comes to diagnoses, rarely is true information revealed about the lack of scientific evidence or the economic or political incentives, or the consequences of a diagnosis. If such information was revealed, how many people would truly consent? Diagnoses are something that unnecessarily and unjustly falls outside of the realm of informed consent, and, as I will elaborate in the next section, people who are diagnosed to "lack insight" particularly fall outside of the realm of informed consent.

Insight, Rogers Order

While social critics and psychologists alike are consistently coming out against the obvious ambiguity of many of the so-called mental illnesses, the "severe and persistent" mental illnesses, such as schizophrenia (coined the "sacred symbol of psychiatry") and bi-polar disorder, have often fallen in a different category and are rarely questioned.

The DMH informed consent policy also describes a legal exception to receiving informed consent that is called a "Rogers Order." The Rogers Order is the "judicial review and approval required to treat individuals with anti-psychotic medications, electro-convulsive treatment or psychosurgery who are unable to give informed consent"(Informed Consent Policy 2003). In other words, the Rogers Order ensures the court the right to decide that certain people are incapable of receiving adequate information and adequately giving permission for some of the most severe and risky interventions psychiatry has to offer. In fact, despite informed consent laws in many states, the Rogers Order, or its equivalent, exists in forty-two states. These laws can enforce outpatient commitment in which citizens are court ordered to take psychiatric drugs against their will even while living peacefully in their own homes.

When a person is picked up off the street for unusual behavior it is often the *police* who make the first call about whether they go to jail or whether they go to a mental institution. After going through the judgment call of that first authority (the police) an individual often then sees a psychiatrist, or in extreme cases, the court system. How does a doctor or a judge know when a person is "not capable of giving informed consent" form medical reasons and when they simply aren't giving it because they *don't want to*? If it was in fact, primarily a medical decision about whether the person was too "sick" to be capable of this decision, then why are the initial decision often in the hands of the police and the final decision often in the hands of the court?

From talking to some medical professionals, and ex-patients, I do believe that both the courts and psychiatrists sometimes go through complex and difficult processes deciding on Rogers Order, and that in some cases the Rogers Orders have been enforced due to desperation from family members who have figuratively or literally seen their loved one "standing on the edge", and did not know what else to do to keep them from committing suicide. I do not think that it is always easy to decide what to do in these situations yet that does not necessarily justify the power laying most in the hands of the police, psychiatrist, and judge, all of whom most likely do not know the given patient's family history, socio-economic background, reasons for their decision, diet, and drug use. The Rogers Order leaves so much space for forced and coerced psychiatry that potentially undermines and damages the individual involved. Since working with the Freedom Center, I have known more than one person who has turned to the organization for support in fighting his/her Rogers Order in court. These people knew, passionately and consistently that being legally bound to psychiatry was not what they wanted. Kally shares her story with me,

> "I was in Cooley Dick and I got in there because I was angry at my abusive husband and I was yelling in the streets. Yelling in the streets? I swear if I did that in New York City no one would even look the other way. And I was in the hospital and I swear most of the women in there aren't even sick. But they tried to shoot me up with Thorazine, and they were about to and then told me to sign a form. I told them, 'no I'm not going to take your stupid drugs or sign your stupid form' and they told me 'fine, we'll just sign it for you and mark down that you're incompetent to sign this.'

The Rogers Order seems to be the legal manifestation of the "insight theory", in psychiatry, a theory that states that with several disorders (most often bi-polar disorder and schizophrenia, though "psychotic depression" has also been considered part of this) that it is really part of the illness for patients not to have insight into the fact that they have an illness. It is, often claimed to be inherent to their disorder not to acknowledge their disorder and thus inherent to their disorder to resist treatment. The book, <u>I am not sick! I don't need help!</u>, by Xavier Amador refers to this common idea about why so many people deny they are ill or deny treatment. Amador's book assumes mental illness to be biochemical diseases and specifically has his own hypothesis and his colleagues that "poor insight in people with serious mental disorders is a consequence of, to coin a phrase, a broken brain." He believes, when dealing with these diagnoses that "cultural differences" and "defensive denial" play an occasional role in the reason that patients refuse medication but that the primary reasons patients refuse is because of their "neuropsychological deficit". His hypothesis is then used to walk readers through the process of getting their loved one the "help they need." (He goes into details about the benefits of calling the police, committing someone, using neuroleptics, and restraints.)

Amador states that his hypothesis ought to be a relief to the relatives of those diagnosed with mental illness because “a broken brain is easier to ‘fix’ than personality stubbornness or defensiveness” (Amador 45). In other words, it may be easier for those unsure and uneasy about their relatives in extreme states who may be experiencing a tremendous amount of suffering, to be bio-chemically altered than it would be to confront the emotional, psychological, environmental, and interpersonal elements that contribute to the formation of the personality and behavior of this individual.

The British Psychological Society’s “Recent advances in understanding mental illness and psychotic experience” refers to this theory when it points out how highly controversial of an area of mental health this theory can be. Specifically it states:

> “insight traditionally refers to the agreement of the patient that they have a diagnosable mental illness. Since many people (including many clinical psychologists) feel that ‘diagnosable mental illnesses are A highly dubious concept, it seems odd to insist that people share one view of their problem (British psychological society”

Odd is one way to put it, but perhaps there is more of an insidious element to a theory that puts such authority in the hands of the doctor, and so little in the hands of the patient. I have read many stories and heard from many Freedom Center members who have told me about the powerlessness they have experienced because a doctor simply did not believe that they had “insight.” One example comes from one of the main organizers of the Freedom Center, Kay, who was going to a Jewish boarding school and was hospitalized when she was 15 due to, as she described it, feelings of social isolation due to her class background and sleep deprivation because of her social life and desire to overcompensate in her academic life. In a café in Northampton one day, I interviewed Kay who described the experience of what it was like to be told that she did not have insight into her disease. She points out,

> "The other message that I kept on getting was 'oh it was a disease' and I kept saying that there wasn't anything wrong with me you know? Everything was being pathologized, like the fact that I was painting my nails different colors. My sexuality, although homosexuality ceased to be a mental illness, it was seen as a lack of insight into my problems. I thought at the beginning that there was just too many people, I really began to accept what they thought of me and it didn't help that they put me on these anti-depressants and neuroleptics."

However, from being friends with her, I can certainly account for the fact that Kay is not the type to simply roll over and accept what others think of her. She continued to deal with her power-struggles with psychiatrists for the right to her own interpretation of her situation. She describes such an experience in her hospital journal that reads:

> "The psychiatrist, a chivalry wrist-watched suited symbol of the
> patriarchy, with that same velvety voice that you'd expect he would have
> respecting authority, pity, good WASPY breeding, what?
> 'Your mother said something about locking the doors behind you before you go
> into a room how long has that been going on?'
> 'a long time'
> 'why do you do that?'
> 'it's not paranoia if that's what you are thinking'
> Bushy old man eyebrows up, the girls know something
> 'what is it then?'
> 'stability and security, I like to be alone in a room and I like to be firmly
> in it, is that abnormal?'
> 'Outrageous, outrageous control issue. Off the charts'
> 'Really? I beg to differ. I only do it in my own room, and if I didn't it would
> give people a chance to come in without knocking, at least this gives me a
> chance to adjust to a visitor."

But this logic somehow didn't come through to the psychiatrist, as Kay goes on to point out with her journal:

> “He reads from my psych testing w/conviction
> ’exquisite sensitivity to the nuances of interpersonal relationships
> ineffective emotional modulation, judgment, impaired.’
> He deflects my criticism responses to him, tells me I have trouble detailing what I think and feel, being preoccupied w/other people.
> ‘Actually I’m very good at that. I just reserve it for when it’s needed.’
> ‘It’s very important here.’
> ‘But rarely understood’
> ’We need to teach you how to speak so you will be easily understood, here and elsewhere’
> ‘And thus become inaccurate’
> ’To be frank, to be concrete, to be grounded in reality?’
> He tells me they represent the world outside.
> ‘I hope you don’t’
> I tell him that he doesn’t respond to me, holds an interrogation, not a dialogue.
> He tells me that my getting out of here depends on my participation in his interrogation.
> ‘Yes, it does depend on you.’
> -Hospital journal (year?)

My interpretation of the “outrageous control issue” does not come from Kay’s desire to lock her door, so much as it comes from the doctor’s desire to label and interrogate her. Kay clearly had enough insight not only to make the decision to lock her door and use clear logic to explain why she locked her door but also to know how the doctor was going to perceive this phenomenon. Yet the doctor insisted that this behavior was still problematic and symptomatic of an illness.

Another example of this type of absurd and damaging use of diagnosing behavior comes from Freedom Center member Jane. Jane has been given diagnoses since she was seven (she initially received a diagnosis, she tells me, because her parents, who are both psychologists, assumed she would have a mental illness since they both had been diagnosed with them. Jane has received at least six different disorders and 17 different medication prescriptions since then and told the story to me of when she was seen as having a lack of insight because of the learning method she used when in the hospital,

> " I was really bored, I was really bored there. So I was reading my physics book, and I have a hard time so I was writing it down, and just to give it a little meaning I was explaining it to my Teddy Bear, because I was trying to think aloud. So the guy wrote in my chart, 'attempts to teach higher learning to inanimate objects.' (Laughter)
> So at the next meeting they were like, 'We're going to put you on Haldol, because you are psychotic and are trying to teach higher learning to inanimate objects.' And I was like 'what are you talking about?' And they were like 'do you not have any memory of it?' And I was like 'no, it's just…' and I was trying to explain it to them but they wouldn't listen… so then I flipped out again"

Was it psychosis, or a just a different style of learning? Since the doctor perceives it as psychosis, and assumes that she does not understand, he is able to have the authority to diagnose her. By simply suggesting that Jane's learning style way "abnormal" or a "disorder" the doctor, like many who diagnose construct the consistent need for conformity. As Foucault quite simply said "In a sense, the power of normalization imposes homogeneity" (Foucault 187 1977).

Oryx, who is also the co-founder openly suggests that in his experience that got diagnosed as bi-polar, was unusual he did not have all the insight necessary to prevent him from danger. Nonetheless he found meaning in the experience and did not in the doctor's judgment of it:

> "I look back now and I now realize I wasn't perceiving things as well as I could have. Progressively it got worse. The more I would stay up, the more trouble I would get into. I would preach to whoever came my way, I was a nonstop chatterbox. I would tell them what I thought about the world and all my solutions to our problems. If we could only free our minds, I told them. People were intrigued and even touched by some of the things I was saying about interconnectedness and meaning, but eventually they were scared that I was going 'crazy.' I was going to create this underground world where we would have a revolution of the mind. I started sending out memos to people in my department, and eventually they did think I was crazy. Well, this kind of freaked me out even more, and eventually I got worse and worse until I got into a bad car accident. I'm very lucky to be alive today."

However, even in his situation, in which he openly admits that he was lacking a certain insight that could have helped prevent these troubles, Oryx saw the insight of psychiatrists as, in many ways, hindering to his recovery process.

> "After the car accident (I had broken my collar bone and had a huge cut on my forehead). I was life-flighted to the hospital's trauma center. Amazingly, after only one day in the trauma center, after hearing about the way I was behaving, I was sent limping to the psychiatric ward of the hospital. Here I was looking like Frankenstein, and they sent me up to the psych ward, even though my grandfather was willing to have me recover at his house.
>
> I was told that I was mentally ill, bipolar, and would have to be on medications for the rest of my life. That was it. They didn't ask me anything about who I was before that, didn't matter. Didn't ask anything about what led up to this. I was just symptoms. The meaning from all these experiences just went out the window."

While Oryx may have lacked insight into certain elements of what happened in these times, it was primarily through a process of self-reflection in which he developed his own insight, rather than accepting the doctors insights that helped him heal from it. Furthermore, he still reflects on the experience as meaningful and does not label it is a biological disease.

I do not want to take away from the fact that certain people in extreme states of consciousness or extreme emotional states sometimes “lack insight” into their experience, or at least, struggle with things such as short-term memory loss, hearing voices, visual or auditory hallucinations, impaired judgment, or irrational behavior. These situations can be extremely difficult for the individual experiencing them or their loved one being affected by them. Furthermore, I do not want to take away from the fact that there can be biological connections and causes that relate or help create these extreme states. By refuting Amador’s “broken brain” theory that has a primary bio-chemical focus and by refuting the harmlessness and effectiveness of his suggestions for interventions, such as restraints, drugging, and hospitalization, I am not denying that nutritional-deficiencies, allergies, genetics, and particular pollutants can affect the body and mind in such a way that makes one less stable or functional. The point is that the theory of “insight” is leading to many psychiatric diagnoses and medication prescriptions which often co-opt peoples’ real emotional and social experience struggles. It also encourages family members to assume that their loved one’s extreme experience fits into limited categories which are often not based on empirical data or biological testing, and can lead to dangerous and counterproductive interventions.

Since working with the Freedom Center I have been in situations where several members of the community perceived that an individual was taking actions that were putting his/her life and thus the health of their community at more risk than they were he/she was acknowledging. We at the Freedom Center, too, have struggled with questions about how to communicate this or what actions or interventions may be necessary. Particularly in situations when people may be a physical threat to others, I know these situations can be difficult, and I don't propose the answers are always simple and straightforward. I do believe and have heard stories to this effect- that bringing somebody to a hospital can help individuals, and in some cases save lives. But as is proposed by my research above, this system is filled with economic and political incentives, and almost always risks severe harm done to the "patient" if these diagnoses and services are involuntary and the patient is not informed about what is going on.

The Freedom Center resources and their support group model *does* offer a sort of insight to others into the experiences individuals are having. After a person takes time at a support group meeting several people may respond with different thoughts, ideas, or advice as to possible causes or solutions to the issue they are dealing with. There are several main differences, however. One is that a member only gets feedback if he/she chooses to have it. Another is that multiple people are offering up ideas all coming from a range of backgrounds, often presenting a range of options.

Treatment

Often the justification for intervention including psychiatric drugs, institutionalization, electroshock therapy, and restraints are based in large part on the assumption that the cause of one's experience with extreme states of consciousness or suffering is his/her chemical imbalance. In discussing the lack of accurate information regarding cause and diagnoses it is already evident that even if the benefits and risks are honestly and accurately given about a drug the treatment can still occur due to a lack of informed consent. However, accurate information is rarely given to patients, or often even to doctors, about the risks of a given treatment. Misinformation about drugs has come through a myriad of mediums: pharmaceutically funded or influenced advertisements, studies, consumer groups, funded movies and television shows. Without recognizing the initial origin many people are "acculturated" into a sort of faith or belief in the effectiveness of psychiatric medications.

There have been thousands of lawsuits against pharmaceutical companies by patients and family members who have felt that they did not receive adequate information about some of the truly harmful side effects of the drugs. There have been an increasing number of investigative journalists who have unraveled ways in which the harmful effects of drugs are systemically ignored by drug companies, scientists, and the FDA alike. Partially in response to these legal repercussions several states have adopted the previously mentioned "informed consent policy."

Medication and electroshock therapy are the only two areas in psychiatry that have policies specific to "informed consent." Although it is unfortunately not a federal law, several states, including my home state of Massachusetts, have adopted "informed consent" policies. This is in some ways a progressive move (though perhaps as much about liability than actual patients rights) and some patients are grateful to know at least some of the benefits and risks of the drugs they are taking. However, I have heard many stories from patients and even from psychiatrists who acknowledge that many professionals fail to follow this law and furthermore that these laws have fallen short in providing “true informed consent” because of their loopholes, and due to the lack of alternatives and the misleading information which is still in them.

In Massachusetts, for those who are not on the Rogers Order, the DMH informed consent policy does require that psychiatrists give an explanation of the proposed treatment including the “type of treatment, its risks and benefits, probability of side effects, alternative treatments, and the prognosis with and without any treatment” (Informed Consent Policy 2003) Also included as part of the policy is an attached Department of Mental Health “Medication Information Form.” This lists the purpose of the medications along with the risks of various drugs. The form adequately mentions some of the most severe side effects of these drugs, including tardive dyskinesia, neuroleptic malignant syndrome, and risks in pregnancy. However, when referring to other ways to treat patient’s illness the medication information form states,

> “Other medications may be available to treat your illness. You may ask your doctor to give you more information about these other medications and their benefits and risks. Other forms of treatment have also been tried, such as individual therapy with a psychiatrist. In studies that compared medications with these other treatments, people that got medication generally did much better than people that did not. It is also known that people with schizophrenia who stop taking medication almost always have a return of their symptoms” (Medication information form, DMH informed consent policy).

To begin with, there are many other forms of therapy which are not linked to the mental health industry that people have used, such as peer-support groups, acupuncture, nutrition, changes in their social and environmental conditions. Furthermore, the statement clearly implies that medication is the most effective way of dealing with schizophrenia, a statement that is not even scientifically defended. Below I will describe how with two particular psychiatric medications, neuroleptics and amphetamines there is evidence that contradicts the informed consent policy about these being the best treatments. Later I will go on to talk about two other forms of treatment, restraints and SSRIs that are also frequently prescribed against the principles of informed consent. I am choosing these four forms of treatment because they are four of the most common, however with other forms of treatments including benzodiazapines, electroshock therapy, and psychosurgery there is also an abundance of similar evidence.

Neuroleptics

Neuroleptics, also known as "anti-psychotics," are most commonly used in the treatment for schizophrenia, are an example of a class of drugs that don't seem to support the informed consent policies statement about drugs being the most effective form of treatment. A World Health Organization study in 1968 about schizophrenics in poor countries where psychiatric drugs were less frequently used shows that patients were doing dramatically better than those in developed countries where these drugs were used (Jablensky 1-95 1992). Patients in India, Nigeria, and Colombia were much more likely to be completely recovered, faring well in society, and display, in the study's words "an exceptionally good social outcome" (Jablensky 1-95 1992). After five years, sixty four percent of the patients in poor countries were asymptomatic and functioning, compared to 18 percent in the United States (Jablensky 1-95 1992).

In another article by Robert Whitaker, titled "The Case Against Antipsychotic drugs: a 50-year record of doing more harm than good," he analyzes studies done by the National Institute of Mental Health, by MRI studies from investigators at the University of Pennsylvania, and from a range of American and Canadian investigators that all lead to similar conclusions about the ineffectiveness, over use, and side effects of these drugs. The NIMH conducted two-medication withdrawal studies that showed the rise in relapse rates in correlation with neuroleptic dosage. The researchers of the NIMH study even concluded that, "relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo— the higher the dose, the greater the possibility of relapse (Whitaker 4, 2004)" This study suggested that the use of neuroleptics actually *increased* the patient's biological vulnerability to psychosis.

In 1976 an American Journal of Psychiatry study titled, "Maintenance anti-psychotic therapy: is the cure worse than the disease?" the researchers concluded that, "Relapse during drug administration is greater in severity than when no drugs are given (Whitaker, 6 2004)." Similar to the above NIMH study, the conclusion of this research indicated that the drugs were making patients chronically ill.

The researchers from the University of Pennsylvania who used MRIS to investigate the effects of neuroleptics on the brain. These investigators found the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia, which are associated with "greater severity of both negative and positive symptoms (Whitaker 7 2004)" This information translates as the researchers noting that the use of neuroleptics caused a worsening of the very symptoms the drugs are said to alleviate.

Whitaker points out the way neuroleptics were perceived and used when they originally came out. They came shortly after lobotomy (removing an area of one's brain), and were intended to be a sort of "chemical lobotomy," which could "hinder brain function much in the same manner that lobotomy did" (Whitaker 141 2002). The very word neuroleptic, coined in 1954, translates in Greek to mean to "to take hold of the nervous system (D-Anton Stephens 543-557 1954). Of the original "anti-psychotics," Chlorpromazine was deemed successful by the medical community because it produced a "vegetative syndrome" in patients who became, "completely immobile" and "move(d) about like puppets" (D Anton-Stephons 543-557 1954). Whitaker states,

> "Researchers concluded that neuroleptics 'modified' patients in ways that made their behavior more acceptable to others . They could be used to attain a neuropharmalogic effect, not to 'cure' a disease." (Whitaker 146 2002)

In those early-mid 1900's, these effects were seen as *desirable* for psychiatrists, and thus justified; however, now that the desired effect is to 'fix the brain dysfunction' it is evidently not justified.

> One Freedom Center member, Lily describes her experience with the drug:
> As I became worse and worse they pumped me full of more and more drugs - nothing was working. I was put on a total of twenty different psychiatric medications, most of which were antipsychotics. The medications actually made me worse. It was extremely hard for me to focus on anything, including my recovery. All I could do was stare at the television for the six hours a day - the drugs made me very sleepy.

While for various reasons, some individuals may feel better, or may be less symptomatic after taking neuroleptic medication there does not seem to be the evidence to support the statement in Informed Consent Policy's Medication Information about this being the most effective form of treatment.

Amphetamines

Amphetamines have been used since the 1930's for psychiatry, though Ritalin (a psychiatric amphetamine) was first approved for behavior disorders in the 1950s (amphetamines.com). These drugs, remarkably similar to highly addictive and illegal street drugs, have been suggested by many studies to cause more harm than good (Breggin 1-38 2002). One article in the Journal of the American Medical Association, not only confirmed the similarities of cocaine and Ritalin, found that Ritalin is more potent than cocaine in its effect on the dopamine system in the brain (Breeding 2005). One Freedom Center member, Dan told me about his own experience of being put on amphetamines when he was six and later becoming a cocaine addicts, an experience which he connects to the original psychiatric amphetamine prescription.

Psychiatrist Peter Breggin who was used in the civil action shows in his "Response to Defendant Novartis Pharmaceutical Corporation's Supplemental Memorandum in Support of Summary Judgment" that despite numerous large studies, in the last forty years there has been no substantial evidence for improvement in academic, social, or psychological functioning with Ritalin consumption (Breggin 6 2003). Breggin has described in great detail the failure for amphetamines to show long-term efficacy.

One example Breggin uses is the extensive review James Swanson of the University of California Irvite did on the Attention Deficit Disorder Center. Swason's review addressed the question of Ritalin's long-term effect on behavior. The review came to the conclusion that “parents and teachers should not expect long-term improvement in academic achievement or reduced anti-social behavior” (Breggin 8 2002)

Another example is when the National Institute for Mental Health assembled review teams of Ritalin advocates that also concluded that there were not long term benefits to the use of these drugs.(Regier and Leshner, 1992),They came to the conclusion: “the long-term efficacy of stimulant medication has not been demonstrated for any domain of child functioning.” In the 1992 NIMH it even stated that that short-term effects are limited to reducing “class room disturbance” and improving “compliance and sustained attention (Breggin 6 2003)” They also confirmed that the drug seems “less reliable in bringing about associated improvements, at least of an enduring nature, in social-emotional and academic problems, such as antisocial behavior, poor peer and teacher relationships, and school failure” (Breggin 6 2003).

Another study, which was the 1998 NIH Conscensus Development Conference on the Diagnosis and Treatment of ADHD concludes that “conclusive recommendations concerning treatment for the long term cannot be made presently (Breggin 8 2002). Breggin even evaluates studies as early as in the 1970s that demonstrated that children in the long-term did worse on Ritalin than on no drug at all (Breggin 9 2002).

Many of these same large institutions and their studies have even showed the that there is evidence for cognitive impairment, social withdrawal. Breggin states:

> “Swanson, Cantwell, Learner, McBurnett, Pfiffnerr, and Kotkin (1992_ describe cognitive toxicity in detail with multiple citations to their literature. They summarize ‘The clinical procedure of using parent and teacher reports to titrate the dose of stimulant medication may result in treatment of some ADHD children with doses that produce cognitive toxicity in as many as 40% or more of typical treated cases’”

The NIH Consensus Development Conference noted that amphetamines can cause "central nervous system damage, cardiovascular damage, and hypertension"

The common effects of the drug such as nervousness, insomnia, and loss of appetite are reported by mainstream mental health groups such as CHADD, but the more severe effects such as toxic psychosis and death are very rarely if ever brought up. Several parents who have lost children to psychiatric amphetamines are now active in lawsuits and movements against these drugs (Baughman 2005).

Again the question arises, if the true information about the lack of evidence for ADHD as a bona fide disease, or for the of the lack of academic and social long-term efficacy of psychiatric amphetamines, and/or the tremendous evidence of their dangers were revealed for how many parents would truly consent to putting their child on psychiatric medication? Amphetamines and neurolpetics are thus two highly researched examples that contradict the informed consent policies statement about medication being the best form of treatment. Another psychiatric drug that, like amphetamines and neuroleptics seems to provide some *opposite* effects of that which it is trying to heal is yet has had information about them suppressed is "anti-depressants" or SSRIS.

SSRIs

SSRIs, or "Serotonin Reuptake Inhibitors" are some of the biggest claims to fame of modern science. As mentioned earlier serotonin depletion has been claimed as a "worldwide epidemic," and SSRIs as a sort of "miracle cure". Yet since I began writing this paper in Fall of 2004 the FDA has been pressured to issue a "black box" warning about the potential role of antidepressants in suicidality. Europe had had this warning for many years, and in Europe all except one SSRI is illegal for children. It is important to emphasize here that “suicidality” is not any old “side effect”; it is the exact opposite of what the drug is supposed to do, and it can cost some one his/her life. Though this is far from a newly discovered warning, for the FDA or the drug companies who have made these drugs for twenty years; this information has just become available to the public.

One Freedom Center member, May, describes her experience over 10 years ago of being put on anti-depressants:

> I immediately began to experience insomnia, for which I was given a mild sedative to help me sleep at night. I felt a horrific inner restlessness, a feeling of wanting to jump out of my skin, that I now know is called akasthisia. For about two years, my dosage of Prozac was continually being raised in hopes that it would finally start to work. From the beginning, I began to suffer from brief but regular periods of racing thoughts that I could not control. All this anxiety and restlessness was simply attributed to my worsening "illness." I began to have intense thoughts of cutting myself, killing myself. It occurred to me that I should act on my thoughts of self-mutilation, and began to slice my wrists and forearms with razors. This too, was chalked up to my advancing mental illness, and I began a long downward spiral of hospitalizations, which fed the feelings of depression and anxiety. In 1991, at age sixteen, while taking Zoloft, I made my first bona fide suicide attempt, swallowing an entire bottle of painkillers. I cannot even recall the reason for doing so. I became completely unable to control feelings of terror and rage that seemed to come out of nowhere, surpassing any teen angst or depression that I had ever heard of.

It was only later, when Leah got off the drug that she was able to link this suicide attempt as having connection to her drug use. She describes:

> In 1993, at the age of eighteen, I decided to take matters into my own hands as a legal adult, and to get off the antidepressants for good. Since stopping SSRI medications over a decade ago, I have never again self- mutilated, had suicidal thoughts, or entered the hospital. The suicidality simply vanished! For me, this is clear proof that the drugs must have played some kind of role in my suicidality and self-mutilation.
>
> I tried to forget the past and get on with my life, but I was haunted by the

> bewildering experiences I had endured. A few years ago, I started to read up on everything I could find about SSRI-induced suicidality in both children and adults. When I began to hear last year about the reports coming out of Great Britain about children and SSRI medications, I felt enormously vindicated. There was finally an explanation for my experiences. If only my doctors, my family, and I had had access to this information connecting SSRIs with self-mutilation and suicidality in some children! Perhaps my complaints and behavior might have been interpreted differently. Perhaps some of the anguish that I experienced as a child could have been prevented

In this case, (and in many others) doctors, medical students, the patients and the public alike are denied informed consent. As Peter Breggin describes in his "Anti-Depressant Fact Book," the FDA knew from the beginning that these drugs could cause suicidality. Breggin had the opportunity to review the FDA documents as a medical expert in product liability suits against the pharmaceutical company, Eli Lilly. When doing so, Breggin realized not only did Eli Lilly know about these life-threatening dangers but they were also influencing the FDA to deny this evidence. Breggin describes how chief medical officer Richard Kapit, who was in charge of evaluating Prozac's adverse effects repeatedly warned that the drug might worsen depression in some patients. Kapit stated that, "Prozac causes a set of adverse effects which resemble those caused by an amphetamine" including agitation, insomnia, anorexia, and weight loss, and put emphasis on how the drug may cause an "exacerbation" of depressive symptoms.

Nonetheless, the FDA systemically ignored those and many other warnings and did not require the company to mention any of these dangers. It was only after the demand of the public and the use of a lawsuit that the FDA was willing to acknowledge these struggles.

There is little suggestion around the addictiveness of these drugs. Regardless of the lack of warning about the-addictive quality of psychiatric medications I have heard well over 15 stories of individuals getting off these drugs and having horrific withdrawals. One member, Jane states

> "I spent the last ten days getting off Effexor [an anti-depressant] which was a really, really grueling process. I mean it was at least as bad for me as other drugs I've had to get off, like coke, dope, even neuroleptics, if not worst. I was having crying fits, horrible nightmares, fighting with everyone around me."

Another member, when asked by the press what happened when she got off medications, described:

> "I went through withdrawal when I went off of my medication. I knew that it was incredibly important to go off my medications very slowly, since the body and brain gets so accustomed to medications (I was on them for 12 years). The physical reactions I had when I went off meds were insomnia, muscle tension, headaches, fatigue and I easily caught viruses. The most intense reaction I had was on an emotional level. The medications had greatly numbed my emotions. I had to deal with huge amounts of feelings flooding my entire being that I hadn't felt in full force for 12 years."

Nonetheless, the addictive quality of these drugs was never mentioned to either of them by their psychiatrist when they were first put on them.

Restraints

Certain places and programs in the mental illness complex such as state hospitals, and crisis teams commonly use restraints, a psychiatric practice that seems to inherently defy consent. While restraints are justified by claiming it is for the safety of the patients and/or the mental health worker, these methods often perpetuate a violent cycle. Restraints often include being tied to a bed or put in shackles, rarely does would the concept of "consent" ever cross their mind. Rather it seems the very concept of restraints are created to force an individual into confinement. The 1998 Hartford Courant's five-part investigative series, "Deadly Restraint," exposed how "hundreds of the nation's most vulnerable have been killed by the system intended to care for them" (Weiss 1998) The series uncovered stories of children dying after having been shackled to beds, held in body bags, or pinned to the floor by mental health workers, until they asphyxiated (Weiss 1998).

In Freedom Center members Kay's own experience, she pointed out that she felt as though she was:

> "being treated like a toddler over and over again. Punishments, the constant threat of restraints, the whole fear, the fear that adults have of teenagers, especially lower-class or teenagers of color, they are made into these boogie men by the American media. Many people died in the years that I was there from being improperly restrained brutally, that doesn't happen so much in adult wards. I got that at the same time."

. From horizontal boards spun at great speeds to "tranquilizer chairs" to modern day police handcuffs and chokeholds, restraints are often far more violent than the violence they claim to be preventing. One Freedom Center member, Shayl, joined the Freedom Center after working as an intern at Providence hospital and witnessing horrible abuse from the patients who were put in restraints. After joining the Freedom Center, Shayl was empowered to write a letter to Providence Hospital telling her story of witnessing this abuse. Her letter ended up getting the support of the whole group, so that it became from everyone instead of just her. The letter read:

> "We at the Freedom Center believe that a culture of restraint and seclusion is not conducive to recovery in any way. Rather, restraint and seclusion practices consistently serve to exacerbate any existing effects of psychological trauma in individuals, and can lead to new trauma."

This belief in fact, is backed up by several major organizations and institutions that have seen how extreme states can be handled without restraints. Even the Substance Abuse and Mental Health Services Administration (SAMHSA) is working in conjunction with the Centers for Medicare and Medicaid Services (CMS) to reduce seclusion and restraint use. On April 11, 2005, The Department of Mental Health formally proposed new regulations with regard to seclusion and restraint, demonstrating an expanding awareness of the link between psychological trauma and their use. Nonetheless various institutions, including the growing number of crisis teams continue to use these practices with or without the consent of their patients.

After doing the research on these various treatments it became more clear to me why the Freedom Center had a goal, and statement regarding "true informed consent" After all it has become clear to me that the lack of informed consent is an adequate way to describe one of the most severe injustices of the mental illness complex. Nonetheless with the patient and ex-patient demand for true informed consent, has come the rise of alternatives to these treatments.

Healing Through Non-coercive and Informed Approaches

In additions to struggles to end forced treatment and abuse, ex-patients and allies have formed their own means of healing. “Nothing about us without us!” screamed ex-patients in addition to the common cry for “love and food and understanding, not drugs” (Chamberlain 1993). In 1971 a Harvard-trained physician, named Loren Mosher designed an experiment known as the Soteria Project that compared the outcomes between the demands of patients and ex-patients (for food, love, and understanding) with the agenda of psychiatrists (drugs). Mosher himself prescribed neuroleptics previous to the creation of the Soteria Project, though he had become skeptical that their benefits were overly hyped, and that perhaps schizophrenia rose more from trauma than it did from a “broken brain.” If that hypothesis was true, then it seemed that a humane environment would foster an even better healing mechanism than drugs. Soteria, therefore, intended to create a “homelike shelter for people in crisis” staffed “simply by people who had empathy for others, along with the social skills to cope with people who could be strange, annoying, and threatening” (Mosher 142-149 1999). The philosophy of the staff was to do things “with the residents” rather than to do things “to” them.

The house had twelve rooms and treated those with a common set of problems, such as having “visions of spiders and bugs coming from the walls, or of being the devil, or of how the CIA was after them” (Whitaker 220 2002). And though residents were often loud, aggressive, and sometimes urinated on the floor the staff never used wet packs, seclusion rooms, or drugs. Often times they listened to their stories of trauma, not arguing patients into believing that any of their beliefs were irrational. The residents were however, expected to clean up, help with chores, help with cooking, and not be violent towards each other. The staff fostered these expectations most by acting this way themselves, in an attempt to "hold up a mirror". In the ten years of the project's existence in which over 200 patients were treated there were only ten cases of violent patients' causing injuries and almost all of them were minor (Mosher 142-149 1999). Patients, contrary to the reports found from mainstream psychiatry, reported about the Soteria with extreme fondness. "I took it as my home," said one patient. Another stated

> "If it wasn't for this place I don't know where I'd be right now. I'd have to be on the run if it wasn't for Soteria. Soteria saved me from a fate worse than death. Food's good too. And there is a whole lot of love generated around this place. More so than any place I've ever been" (Whitaker 223 2002).

When the reporting outcomes data came out three years after the opening of the house, it showed that psychotic symptoms abated to the same degree as in medicated patients and that, in fact, Soteria patients were staying well longer, relapsing less, and functioning better socially. The success of Soteria threatened conventional biomedical psychiatry, particularly the use of neuroleptic drugs for schizophrenics, and thus slowly but surely watched itself lose its funding from organizations such as the National Institute for Mentally Ill (Mosher 142-149 1999). A soteria project has never been repeated in the United States since though a similar project has reemerged in Europe in 1984. Dr. Luc Ciompi, professor of social psychiatry in Bern, Switzerland, is replicated the original Soteria study findings finding that roughly two-thirds of newly diagnosed persons with schizophrenia recover with little or no drug treatment in 2 to 12 weeks (Mosher 142-149 1999).. The project in turn inspired about ten houses of a similar nature have appeared in Sweden all of which reported good outcomes (Deurr 1988).

Several members of the Freedom Center have told me in personal interviews and have announced at events that their long-term goal is to create a "safe house" similar to the Soteria House. While there has been some discussion about the possibilities of this project, there has been little actual planning to make it happen.

Another more recent project, The Hearing Voices Network in England, also aims to satisfy patients and ex-patients' search for non-pathologizing, non-forced, non-drug-oriented means of healing. One Freedom Center member, Ellen, has been to Europe and told us about the network as well as exposed Freedom Center members to literature about the network. This network consists of a number of people who hear voices, many who have been through and rejected treatment from the mainstream psychiatric model (Hearing Voices 2002). This network is dedicated to providing support for those who hear voices and consists of over 100 groups across England. Each group holds support group meetings to help people cope with their voices. In dominant psychiatry, voice-hearing is considered a symptom of an bio-chemical illness, and the goal is to suppress or get rid of the voices. In the hearing voice's network, hearing voices is considered a result of extreme stress, trauma, a mystical experience, or various other factors and the goal also varies, depending on the individual (Hearing Voices 2002). As Ellen has told us, the groups are usually facilitated by one voice-hearer and one non-voice hearer and the vast majority of those who attend the group meetings are voice hearers. Some people join groups who want to negotiate with their voices, and tell them times of the day when it is ok for them to arise and times it is not. Others, she explains, want to negotiate so that the message they state is more pleasant, and others simply want to share what it is they have been hearing. Some want to find the root of his/her voice-hearing and discuss the issues that are related to that, and others aim to get rid of them completely. It makes sense to me that when voices are not explicitly made out as something to be feared, and voice-hearers have the chance to get feedback around this experience from other people with similar experiences then often members feel more comfortable and capable of healing.

The hearing voices network has even started doing trainings of its own where the members train mental health workers, teachers, and social workers by having them attempt to do everyday tasks while listening to a tape recorder for them with various genders, tones and messages that resemble the voices that members are used to hearing in their head. This network does not deny the unique suffering of voice-hearers, yet does not pathologize or drug the experience either. Rather, voice-hearers advocate for themselves and support each other in their own experiences (Hearing Voices 2002).

The Freedom Center's own services, or recommended services, also allow for different perspectives and insights on the phenomena they experience, At the support group meetings there is an herbal tea available for members to drink and a small "medicinal herb shelf" consisting of literature as well as bulk herbs, pills, and tinctures for members to sample if interested in exploring this realm of medicine. Plant medicine and nutrition, for example, has been a means of healing for humans for several millions years and still remains the primary form of medicine for 85% of the world's population (Kilham 2003). The human body has had more time to adapt and co-evolve with these treatments than with highly concentrated and isolated synthetic chemicals, such as pharmaceutical drugs, and knowledge about plants is often folk knowledge, dating back hundreds of years.

Economically they are also more accessible, and less likely to be co-opted as most people can grows herbs, or find them in the wild, thus there is less of an incentive for the type of high corporate and government corruption regarding their benefits and risks.

The Freedom Center's yoga group offers members a chance to understand the connection between the "body" "mind," and "spirit," three things often separated in conventional psychiatry. The website also links articles on the studies done about the psychological and emotional benefits of yoga. All Freedom Center services are free, so as to be accessible to everyone and furthermore all the services are completely voluntary, with no strings attached, with the possible exception of "strings" that arise naturally from forming relationships with other individuals. Besides their own services the Freedom Center has worked with an acupuncturist/Chinese herbal medical practitioner who can cater towards low-income people (and often gives Freedom Center members a discount) as well as a naturopathic doctor who also caters towards low-income people.

Within the ancient practice of acupuncture there is a diagnostic technique that includes taking the pulse of the individual, asking him/her personal questions, learning about his/her diet and exercise habits, and looking at the color/texture of one's tongue, The diagnosis process involves a qualitative description of an individual's constitution, with an ever-changing prognosis and often recommendations that involve changes a person can make in his/her daily life, with or without regular visitations to the acupuncturist.

> Freedom Center member Lily states,
> "I strongly support and encourage the use of acupuncture. Since stopping drugs four years ago, I have received weekly acupuncture treatments. After being treated pharmacologically for depression for over forty years, I am now drug-free and depression-free. When I was still having bipolar shifts while recovering from

drugging, the acupuncture was immediately effective in reversing shifts."

The point is not that everything that is not that these other forms of treatment are always effective or that it is without risk of being authoritative or occasionally creating self-fulfilling prophecies, nor that support groups will never consist of people stating inaccurate information (though often in these settings there is less of an institutionalized power dynamic than in conventional medicine, often leaving more space for others to correct, or at least challenge this information.) But more, the point is that as these treatments are generally voluntary, and their principles and practices are inherently less monolithic. Furthermore, overall most of these treatments show to be significantly more accessible, more time-tested and safer for the human body (Kilham 1-16 2001).

Philosophy and intention have often been considered essential to the healing process. If one's primary intention is to make money or for social control, he/she will have less attention focused on being effective healers. "First do no harm" is a famous medical principle, used in several medical traditions and often proposed by ex-patients. Even some psychiatry claims to embrace this principle, but in practice it rarely seems to manifest this way. "First do no harm" implies the necessity of trying the least invasive, and least potentially harmful treatment first and then, only upon failures resorting to harsher treatments. As the MindFreedom fasters pointed out in their protest, generally dominant psychiatry does not do this, but instead almost dogmatically jumps to one of the most severe, potent, and risky potential treatments available. According to ethnobotanist Chris Kilham pharmaceutical drugs are the third leading cause of death, far surpassing deaths caused by illicit drugs, car accidents, and guns put together (Kilham 1-16 2001). While empirical data is not the basis of many healing traditions (some cultures have more qualitative or elemental understandings of sickness and health) it is the foundation of modern medicine. And yet empirical data has not proved that, according to patients, psychiatric diagnoses and psychiatric medication does more good than harm. I have assessed this throughout this chapter the ways in which cause, diagnoses/prognoses, and treatment all have false information and thus non-consenting implication involved with them. And I have acknowledged the connection between the drug companies, the FDA, APA, consumer groups, medical literature, doctors, and laws alike fail to provide the public and patients with informed consent. In my next two chapters I will get into even more detail about the current and historical complicity of high-level politicians and the criminal justice system. It is my belief that with such massive complicity of private interests there needs to be a massive systemic change demanded and manifested in order for "true informed consent" to be provided. The Freedom Center's demands and attempts to reclaim this term, is a lucid pocket of resistance and promise for such change.

Chapter 3: Paranoia? Or Real Steps Towards Mind and Behavior Control?

It is not so incredibly uncommon for members of the Freedom Center to refer to psychiatrists as “Nazis,” express extreme criticism of the APA, or bring up fear or anger they have in relation to the CIA. Opinions clearly differ between members of the organization in this area; some casually and regularly refer to psychiatrists as Nazis while others have told me they think fascism is a term ‘thrown around a little too much’; some embrace the CIA conspiracies, while others will outright identify members who describe them as ‘paranoid.’ Nonetheless, it is still a topic of frequent relevance to members of the organization and, according to my father, a psychiatrist, it is a topic of frequent relevance to many people identified as ‘mentally ill.’ When I asked him how many patients complain or express fears regarding the government or the CIA he responded with emphasis, “A LOT.”

While many people may have fear regarding operations or actions of the CIA or U.S. federal government that seem unfounded or unsupported by solid evidence, it is my argument that the CIA and the U.S. federal government are also common sources of many people’s fear or so-called “paranoia” because of the covert and insidious operations that they *are* and *have been* complicit in. Researcher and activist Lenny Lapon states, “”In fact what really scares me is not that there are some people who somewhat erroneously think that they are part of a CIA experiment, but rather that there are so many who erroneously think they are not a part of such an experiment of operation" (Lapon 5 1986). While I personally think peoples "erroneous" beliefs can sometimes be worrisome as well, I do generally agree with Lenny's point that the Central Intelligence Agency, as one of the most powerful institutions of the world has a needs to be talked about in order to adequately understand the threats that many people face. Indeed there is a truthful historical connection between the CIA and psychiatric practices and though I by no means think that all psychiatrists or mental health service workers are CIA agents or the equivalent of Nazis, I do think some are, and I do I think that dominant psychiatry historically has more of a fascist influence historically and today than most are willing to acknowledge.

This chapter will include a mix of stories as told by members of the Freedom Center about psychiatric abuse and how they connect it to a fascist eugenics agenda of. I will elaborate on the United States' history of 'treating' mental patients compared and connected with that of Nazi Germany, for I feel it is one of the most revealing ways to understand what some mental patients are up against in their struggle for human rights, empowerment, and justice.

In the informed consent chapter, I described how certain ideas (such as "mental illness is caused by a biological brain disease and drugs are the way to fix them") are largely homogonous ideas. The homogeneity of such ideas does not that "spread " so much as these ideas are intentionally are created for a given means and then pushed by powerful through a range of medias such as the DSM, advertisements, and media campaigns. In this chapter I will explain in even more detail how this power and domination can occur from a top-down model, with a relatively small group of elites leading the way. This will include an analysis of some of the dominant agendas of psychiatry since the mid 1800s. When I discuss the CIA, U.S. Government, the APA, and Nazi Germany throughout this chapter I am not trying to say each of these social bodies is exactly the same. I am however, trying to say that these are social bodies with many similarities and with deep economic, political, and social connection to each other. All groups have consistently used tactics of force, manipulation, and violence. All groups group consist of rich and powerful global elites that survive based on the exploitation of an underclass. This dependence on an underclass exists systemically within capitalism, and is not unique to psychiatry. For example, where would the coffee trade be without the military enforcing the work of underpaid farm workers? Where would the military be in a war if they had never had land and people to test their new weapons on? Similarly where would psychiatry be without hungry, confused, desperate and exploited “mental patients”?

Psychiatry is the social institution that is responsible for ideas and practices around human behavior and beliefs. In wartime an understanding of the behavior and beliefs of one’s enemy (or one’s own soldiers) can prove as extremely beneficial. For example, if one’s enemy has important information, finding ways to interrogate or break one’s defenses would be helpful or if nationalism and unity is found to be a strong component in perpetuating one’s own soldiers to continue fighting, then understanding the language and behavior that would perpetuate these ideas is essential. Similarly, in establishing and maintaining social order, it is helpful to have control over the society’s thoughts and behaviors to achieve the ends intending to be met. As I will show throughout this chapter, psychiatry has often been forced on people by these major institutions as an attempt to achieve these ends.

Their Stories Speak

Several members of the Freedom Center express that they have been directly affected by operations of the CIA, federal government, and/or the Nazis. One member told me the story about when Ray, her friend and a Freedom Center member, was telling her about a government program that involved putting computer chips in human brains. Thinking he was 'paranoid' she brought him to a mental institution. Months later, she went to purchase a dog from a local shelter. She explains:

> "I was told I couldn't get a dog without a chip in it. I mean every dog at this place had a tiny tracking chip under its skin that they said was there in case I lost the dog. I began to realize what Ray was saying may very well be true, and I was in such shock."

The anxiety and depression that arose from realizing this led to her first hospitalization in 17 years. Later, upon doing research she learned that these chips were not just designed for pets, but did in fact have intended human uses. (I too have done this research and have found evidence from sources including the LA Times article "Chips to be Implanted in Humans" (*LATimes*, May 10, 2002), the Associated Press story "Engineer looks to human brain for new technology" (Associated Press August 5th 2002); and the Cnet story "Under-the-skin ID chips move toward U.S. hospitals" (CNet; July 27, 2004). Another Freedom Center member, Faune, went on a long description to me about how she was 'experimented' on with LSD. She described the experience of having agents come in her house and put hallucinogens in her food. She told me she has seen an official analysis of her personal trips in official documents from Princeton University.

> "Yeah they were trying to learn about the transcendence of time and space and LSD's role in it. You know- all about whether it's a possibility for a sort of 'mental space travel.' And they were testing it, testing it on me, I was married to Princeton at the time, and I didn't realize what he was using me for. I saw it, I saw the documents, you can ask Gail, she has seen them too."

Although I have not seen the official documents to confirm this case (nor have I looked), as I will elaborate on later I have seen the hard evidence to support that LSD experimentation on 'psychiatric patients' or random citizens was used for such purposes and that Princeton University was a center of a lot of it (Lee 13-159 1985) .

Ray, who was an extremely religious man and regularly referred to the importance of faith in God and love in his words, continuously referred to George Bush as the devil. Ray was a Rastafarian, who regularly preached about peace and love, listened to reggae, smoked a lot of pot, and constantly shared his curiosity about herbal healing. He carried with him a daunting combination of both the love for life of excited child and the bitter sadness of loss of such joy and naiveté to a "fucked up world". In a long monologue style interview in the woods of Northampton, Ray, described to me his story and his initial suspicious about going into a mental institution he let me know that about first instinct of the doctors:

> "Yeah, I was hearing voices. And I went to a mental… to a hospital I went into a hospital, and there were people around and I stood up and said 'what we need is hope and faith' and two officers, two police officers grabbed me and strapped me down and brought me to a regular hospital, they brought me to mass health, and there I could have stayed, I didn't know what was going on, I was in a state of shock still about George Bush being advertised in Boston because I thought he was the beast and I went into that place and I saw people there, and it's tough. And I slept that night and I woke up the next morning and I went into a room where it

> seemed like there was 70% bald-headed men in the room, it looked very Germanic and I just… I was confused, or perplexed I supposed it would be… perplexed is more the essence of what my mind was in because I knew these people were probably people that would do harm to me or people I didn't want to be around in the first place. So I had a doctor, and he gave me Haldol, and when he gave me Haldol I had this dream that night, that my mom was pregnant, and I knew it was with me, and there was a knife hanging over her stomach wanting to kill me and my mom. And I knew it was the Haldol. And it was terrible."

His use of the term "Germanic" implied to me that he was linking the psychiatrists with Nazis, a reference he has made many times. When I asked if that was what he meant he replied

> "Ya, that's how I felt like I was in some sort of camp surrounded by Nazi doctors or something, that's how I feel when I see George Bush too..."

Another member of the Freedom Center, Joanne, I talked with on the same day that I had finished reading Lenny Lapon's book about the connection between the American Psychiatric Association, CIA, and Nazi Germany I had the privilege of interviewing Joanne about her personal history and research in regards to some of these topics. We talked (on record) for several hours in the Freedom Center's space before a support group meeting. She described to me in detail her experience of growing up, going through trauma and drug addiction within the mental health system.

> "I was 17. I hadn't made any plans for college; I had just turned 17. It was two months before graduation but this recruiter came to my door looking for minority students to go to this Midwestern Methodist college, and they were willing to cut me a lot of slack because I hadn't been a really terrific student, and my mom was willing to ship me anywhere so I went, Iowa… and when the winter hit… I wasn't ready for what hit me. Believe it or not they have worse winters there, I was really rundown… I didn't know how to take care of myself."

Partially due to her sickness and her dislike for the school, Joanne left and found herself in Chicago where she temporarily worked as a typist. When that didn't work out, she found herself back living with her mother. She tells me:

> "I didn't have a very good relationship, and it took many years for me to realize mom wasn't not really mature, she didn't know a whole lot about anything. She was pushing my buttons left and right, so as soon as I recovered a little of my strength… I was so exhausted I went to this stupid teacher, because I had a crush on him, I always fall for the most disgusting men. And he sent me to this psychiatrist named Jack Ward, who he sent a lot of people to apparently.

She went on to say:

> In those days, I believed what you were supposed to believe, I didn't have what you have today… I don't know how you have come to have what you have so early in your life, to extricate your mind, but I didn't have it I was colonized, I was totally colonized so I shuffled off to this shrink named Jack Ward he did do blood tests he told me I was hypothyroid and then he told me not to take the thyroid medication the only thing that I really really needed, the only drug that I needed was thyroid. That can trigger autoimmune, etc. I already had the disposition. Instead of pursuing why I was hypothyroid he dismissed it told me not to take thyroid drug and instead he diagnosed me on first meeting as schizophrenic. And even then I remember asking 'isn't that a psychosis' ? I had heard that much. And he said yes. And I said but I've never hear things that weren't there I've never seen things that weren't there even when I was drunk I didn't hear things that weren't there.

"Why did he give you that diagnosis?" I asked her.

"You gotta ask him."

Of course I can't ask Jack Ward whether Joanne's story is true, and if so why he gave her one of the most severe and stigmatizing diagnoses without her having the appropriate symptoms or without informing her of the qualities of potential consequences of such a diagnosis. However, as she continued her story with me, I began to develop a theory as to why such a thing might happen.

> "But he convinced me that I was suffering from schizophrenia. He was the authority, he was the expert he was the doctor, and it was very authoritative and I was desperate for attention I had nobody, ever. So I was very vulnerable to an adult who was willing to talk to me for 50 minutes no matter what he was saying though

> I did question it, I definitely did question I, and I asked some pretty good questions. He wanted to put me on these drugs. The first drug he wanted to put me on was LSD and I said 'doesn't that make people crazy?' I didn't want to feel nausea so I adamantly refused."

LSD does in fact make one 'crazy,' or, at least, has the potential at even a slight dose to produce nearly all of the effects that the DSM characterizes as psychosis. This includes visual and auditory hallucinations, disturbances in perception, disruption in judgment, and disassociation. Considering this, and assuming Joanne's story is true, one can't help but wonder what Jack Ward was thinking when he offered such potent hallucinogenic drug to someone who had none of the signs or symptoms of psychosis.

What Jack Ward Was Thinking: LSD, The CIA, and Psychiatry

According to official government documents, Jack Ward was just one professional amongst many who tried using LSD during this time period (1950's through 1960's). Many of these professionals were being influenced by agenda of the Central Intelligence Agency. The CIA took an interest in LSD almost immediately after it was invented. The CIA was interested in LSD as a truth serum used to interrogate enemies, as a weapon which could "produce anxiety or terror in medically unsophisticated subjects unable to distinguish drug-induced psychosis from actual insanity" (Lee 17 1985).

Under The CIA's project ARTICHOKE dated October 21, 1951 the drug was tested as mind control drug (Security Officials 1953). The CIA had considered it as a possible "truth serum" to get information out of its enemies, or even as a possible weapon used as a "crazy gas" against it's enemies (Artichoke October 1951). ARTICHOKE mentions that LSD was used during "civilian experimentation" and also amongst federal prisoners. Another CIA document mentions that LSD was administrated by a CIA psychiatrist on "at least twelve human subjects of not too high mentality" (Lee 14 1985). Despite the extremeness of the drug, these subjects were told that nothing dangerous would happen to them (Lee 38 1985).

The CIA also funded the infamous Ewen Cameron, while he was the president of the American Psychiatric Association in the 1950's to do LSD experimentation amongst other forms of experimentation, such as negative driving, electroshock, and sensory deprivation) with his patients (Wikipedia 2005). As described in horrific detail in Psychiatry and the CIA: Victims of Mind Control, a book written by Harvey Weinstein, the son of one of Cameron's patients, these experiments often broke down some of the most fundamental functions of a person, including knowledge of their own name, and how to eat. The CIA, interested in Cameron's brainwashing techniques funded him under a project code titled MKULTRA (Weinstein 32 1990.) MKULTRA was started on the order of CIA director Allen Dulles in April 1953, and the goal of MKULTRA was to produce a perfect truth drug for use in interrogating suspected Soviet spies during the Cold War and generally to explore any other possibilities of mind control (Lee 20-29 1985). In addition to wanting to use similar methods on their own captives, the CIA was also interested in being able to manipulate foreign leaders with such techniques, and would later invent several schemes to drug Fidel Castro (Congressional Report 1975). Wiki-media an online encyclopedia descrives MKULTRA:

"Experiments included dosing CIA employees, military personnel, other

> government agents, prostitutes, mental patients, and members of the general public with LSD to study their reactions, usually without the subject's knowledge."

This has been compared many times to the dosing of unwitting subjects in Nazi Germany. Martin Lee Bruce Schlain's state in their book Acid Dreams: The Complete Social History of LSD: The CIA, The Sixties, and Beyond:

> "Like the Nazi doctors at Dachua, the CIA victimized cerrtain groups of people who were unable to resis: prisoners, mental patients, foreigners, the terminally ill, sexual deviants and ethnic minorities"

Weinstein, along with nine other family members of Cameron's patients, participated in a large lawsuit against the CIA when they learned of this project and this funding connection (Weinstein 8 1990). Joanne was herself an unwitting subject, told neither of the reasons for her proposed treatment nor any information about the drug itself. Fortunately for Joanne she was in a position where she was suspect of the LSD and could resist the experimentation. Unfortunately, however, she stayed with the same psychiatrist and was subjected to many of the same problems. Later she told me,

> "As for Jack Ward, he impressed me with his uhh.. his colleagues he had all these famous colleagues and to me, once I started reading the literature many years later I realized his famous colleagues were really dangerous colleagues. These colleagues, he repeatedly name-dropped people like Humphry Osmond & Carl Pfeiffer, they're all CIA and military connected and so was Jack Ward. Jack Ward repeatedly stated that he worked with Carl Pfeiffer, that Pfeiffer and he were colleagues. I am reasonably certain that Jack Ward, along with his colleague Pfeiffer, used the teenaged boys at the Bordentown Reformatory as subjects in their experimental and/or operational protocols."

From the research I have done, Joanne was certainly right about Jack Wards' colleagues' connection to the CIA. As described in Acid Dreams, "Isbell, Pfeiffer, Cameron, West, and Hoch --- all were part of a network of scientists who gathered intelligence for the CIA (Lee 25 1985)" As one of Pfeiffer's associates put it,

> 'Princeton was crawling with agents. They came courting everyone. It was obvious. They would give us whatever we wanted...We realized we were being recruited, but at that time we were flattered that such a prestigious government agency was interested in us (Lee 45 1985)'

Furthermore, Osmond was a psychiatrist studying the use of LSD in psychiatric circles. As described earlier most of the LSD experimentation in these circles was just that, experimentation. There was very little solid research done on the actual benefits and risks of this drug yet Osmond was a respected psychiatrist for using it. Lee states that:

> "The CIA, ever intent on knowing the latest facts as early as possible, quickly sent Informants to find out what was happening at Weyburn Hospital. Unbeknownst to Osmond and his cohorts, throughout the next decade they were contacted on repeated occasions by Agency personnel. Indeed, it was impossible for an LSD researcher not to rub shoulders with the espionage establishment, for the CIA was monitoring the entire scene (Lee 56 1985)"

Joanne's decision to stay with the doctor resulted in her addiction to another drug, which presumably was prescribed to her for many of the same reasons. Joanne went on to describe what drugs she *did* end up on after refusing LSD,

> "Then he put me on these anti-depressants… he does pressure me like the fox with the honey dripping on the downside of his mouth … He used to shoot me up in my veins with sodium a___methadrene…. It's a hell of a rush… I don't remember anything after the rush… and see… I get anxiety just from remembering this stuff…"

Joanne became highly addicted to the drug to the point where she was stealing it on the street and from his office. Joanne was not informed of the addictive quality of the drug she took, nor of the long-term side effects. The doctor either didn't notice or chose not to notice the degree of her addiction, as, according to her he continued to shoot her up with the drug in his office. What Joanne once described as a sort of teenage loneliness transformed into what she instead described as the life of a "speed freak."

Joanne went on to describe to me how this experience of being 'psychiatrized' at such a young age basically ruined her whole life. Though her doctor told her that the drugs she was on were non-addictive, she described what she now realized was her "horrific withdrawal" process to me. After dealing with the physiological damages of her addiction to the prescribed psychotropic, she turned to alcoholism. Her alcoholism bore with her for many years, and she experienced many long-term side effects from the drug she was put on. Furthermore, Joanne has described the experience of having the social stigma of the 'schizophrenia' diagnosis. Finally she states,

> "I'm not a reporter, I'm not an investigator, I just want to find out what the hell happened to me and I wasn't shot up with plutonium or at least I hope not but it was something just as egregious."

The last thing Joanne said to me at the end of a long interview was, "I had nothing even remotely close to informed consent with what they were doing to me"

From The U.S. to Nazi Germany: Eugenics, Mental Hygiene, and Psychiatry

Joanne, by no means, was alone in having such an experience. LSD was by no means the only "treatment" used at the expense of the patient and for the purpose of advancing "science" and/or a political agenda. Throughout U.S and European history, psychiatrists and other authorities in positions of "treating" the "mentally ill" have used psychiatry as a means of advancing an elite class. The international eugenics movement is fundamental to understanding what led up to MKULTRA, ARTICHOKE, and psychiatrists such as Ewen Cameron.

The book Mad In America by medical journalist Robert Whitaker's was handed to me when I was first introduced to the Freedom Center. This book outlines the eugenics history particularly of the United States. This book was handed to me because the main organizers felt it was important for me to know this history in order to understand part of why they have formed an organization to stand against "abuse, fraudulent science, and dangerous treatments." In Whitaker's third chapter "Unfit to Breed" he points out the origin of the philosophy and practice of eugenics. The term "eugenics" was coined in 1833, by Francis Galton who was an extremely wealthy European influenced by Darwin's writing. The term was derived from the German word meaning 'well-born' and was defined partially by giving the 'more suitable races or strains of blood a better chance of prevailing speedily over the less suitable than they otherwise would have had" (Whitaker 38 2002).

Eugenics then came into practice in America in the mid-1800s, during the first great wave of immigration, when the ruling class ("White Anglo Saxon Protestants") became threatened by the rapid growth of the immigrant population. In 1850, the US census showed a near doubling of the "insanity rate" in America. There was a clear interconnection between the poor, the immigrants, and the "insane," as all three were often considered part of the "less suitable race" and often ended up in mental institutions (Whitaker 45-60 2002). Forty percent of those in state mental hospitals were foreign born as compared to the fourteen percent of the general population. (Grob 8 1988) "White Anglo Saxon Protestants" were facilitating the process of mental patients being locked into asylums partially based on the assumption that immigrants were the most "common carriers of this defect in germ plasm" or the "bad seed strain in humans" (Whitaker 46 2002)

In the late 1800s a book called The Rapid Multiplication of the Unfit was published, which argued for the segregation, forced sterilization, and prohibition of marriage of those deemed 'unfit.' Since this agenda clashed with democratic political principles of America at the time, it truly took off in the supposedly neutral and highly respected field of science. Andrew Carnegie, a Harvard-educated biologist, provided one of the biggest salaries to any scientist in America to Charles Davenport for this pursuit. Davenport set out to prove immigrant and societal misfits were genetically inferior (Davenport 216-219 1911). While this science has never been even close to conclusive or justified, the idea of the genetically inferior class has been used to justify coercive psychiatric "treatment," as well as segregation.

During the Post World War I/pre-World War II time period, the agenda of eugenics in the United States escalated to an even more serious level. After an international conference consisting of speakers from the most prestigious colleges in the country there was a committee to establish a national eugenics society. Most members of this society graduated from Ivy League schools and five members were at some point presidents of the American Psychiatric Association (Mehler 1968). As described by Whitaker:

> "The society focused on promoting eugenics to the American public--- getting textbooks and pamphlets into schools and conducting informational campaigns to build support for sterilization laws. One of its popular traveling exhibits, consisting of a board with blinking lights was titled 'Some people are Born to Be a Burden on the Rest.' Every fifteen seconds, a light flashed to warn onlookers that American taxpayers had just spent another $100 caring for defectives. Every thirty seconds, a

light flashed to signal that another defective had been born."

Despite the fact that by 1933 there was not a state in the United States where the 'insane' could get married, eugenicists pushed for even greater segregation, such as asylums (Eugenical News 1925). Asylums were designed to be a type of permanent segregation, where people were kept until they were sterilized or at least, past the reproduction age. By 1929, 272,527 of America's people were in asylums, four times as many as were in them fifty years previous. Sterilization was a bit more difficult of an element of eugenicists' agendas, since states deemed it unconstitutional; still, though, by the 1930s there were 2,200 sterilizations happening annually (Judge 2002). One massive sterilization experiment that was approved by major academic institutions in California and was called "The California experiment" (Whitaker 60-64 2002). In 1937 one magazine found that 66 percent of Americans favored sterilization, and editorials in New England Journal of Medicine and New York Times spoke positively of the practices. By 1945, 45,127 Americans, nearly half of who were mental patients in state hospitals, were legally sterilized. (Whitaker 78 2002).

Eugenics and discussions about stopping the procreation of the "unfit" were simultaneously becoming part of the dominant discourse in Nazi Germany in the 1950s. Similar as well as more severe practices were occurring in Germany. In 1933, when Hitler was in power he instituted the "Nazi Act for Averting Descendants Afflicted with Hereditary Diseases," a Eugenics Law which set up the Nazi Eugenics courts. The German eugenicists who drew up that legislation had gone to school in the United States, and American eugenicists boasted about this connection by stating "The leaders in the German sterilization movement state repeatedly that their legislation was formulated only after careful study of the California experiment" (Whitaker 63 2002) In the start of World War II in 1939, the Nazis were actively sterilizing "mental patients." In 1939, The Nazi Eugenics Court ordered for (and saw through) the sterilization of approximately 375,000 people, most of who were "mental patients" described publicly, or to those who challenged it, as a "mercy death to incurably insane patients (Lapon 56 1986)." The New England Journal of Medicine points out that Germany had become "perhaps the most progressive nation in restricting fecundity among the unfit" (Whitaker 64 2002) With major academics and medical journals in America were boasting about America's influence or envying the tactics of Nazi Germany, there is little hiding the connection of these movements. Research, activist, and psychiatric survivor Lenny Lapon wrote a book called Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States that I discovered on that "Mad Market" of MindFreedom internationals' catalogue. Lapon's work along with the work of many other researchers outlined the historical connections found in psychiatry in America in the last century and in Nazi Germany.

The murdered children and adults in Germany were regarded as "useless lives devoid of value" (Lapon 24 1986). Fredric Wetham's A Sign for Cain: An Exploration of Human Violence points out that gas chambers were used to kill hundreds of thousands of people during the peak of Nazi Germany, most of these chambers were operated by (directly or orders were given from) psychiatrists (Wertham 150-166 1966). These killings were justified by psychiatric professors, students, and followers based on the philosophy of eugenics that spoke about the need to eliminate those of 'inferior genetic material.'   The first gassing took place in Auschwitz and 250 of the 850 gassed that year were psychiatrist-diagnosed 'mental patients' (Auschwitz, PBS 1994). This extermination and others was first implemented under the direction of a committee Hitler set up called "Reich Committee for Scientific Research of Hereditary and Severe Constitutional Diseases (Lapon 22 1986). After this committee was set up there were two major projects, Reich Chancellery and the Ministry of the Interior each project managed the countries insane asylums' at the time (Lapon 22-23 1986). The head administrators of these projects (including Hitler's physician) called for a project known as T-4. T-4 was the project that set up six major killing institutions called Bernburh Bradenburg, Grafeneck, Hadmar, Hartheim, and Sonnestein (Dawidowicz 135 1975.). It also was the project responsible for setting up questionnaire forms (a screening process) for "experts" to figure out which inmates were "recommended" for "euthanasia" (Lapon 24 1986).

The forms (I have seen them) are hauntingly simplistic and in ways similar to the modern New Freedom Commission's "screening process" that I will outline later. These forms that were later used as evidence in the Nuremberg doctors' trials included multiple-choice or one-line fill in responses (Lapon 24 1986.). The one-line fills in questions were about their nationality, religion, and what value of work they are capable of. The form also included questions options such as "mental debility: weak____ imbecile____ idiot___. (the physician was supposed to check one) as well as yes and no questions about the patient's restlessness (Lapon 25-28 1986). There was no hard science, no patients, no study reviews, no clinical trials just the 'expert opinions' of the Nazi doctors to make these life or death decisions. After the forms were filled out, many patients were transferred to killing centers where they were murdered in gas chambers. While, as I have written about throughout this paper, there was and is no 'genetic test' performed on those diagnosed as mental patients, this is still the underlying philosophy that justified the mass exterminations.

The story of Nazi Germany and psychiatry would be horrifying enough if it ended there, and if justice were sought, and if there were no comparable practices since. However this is far from the case. The Nuremberg trials, which supposedly existed as a means of prosecuting the Nazi soldiers and Nazi doctors, actually prosecuted an extremely marginal number of these individuals (Lapon 39 1986). Horrifically enough, not only were many major doctors who participated in the mass murder of 'mental patients' allowed to continue their practice post-Nazi Germany, some did so in the United States.

Lenny Lapon presents a series of facts in his book describing the connection between psychiatrists in the American Psychiatric Association and those in Nazi Germany. Lapon looks at the 1977 version of the <u>Biographical Directory of the Fellows and Members of the American Psychiatric Association</u> and comes across approximately 400 members of the APA who had "worked and/or studied in Germany and the Nazi-occupied countries during or very close to the Nazi period" (Lapon 105-150 1986.) Lapon lays out the biographical sketch of 63 of them, many of whom were either killers themselves in Nazi Germany or who had teachers or colleagues who worked the gas chambers. (Lapon 105-150 1986**).** In his chapter "From the Third Reich to the APA" Lapon even went on to publish interviews he did with APA fellows and members who had Nazi connections. Many of the APA members thought Lapon was a medical student when he originally called them up and asked to talk to them about what they were doing during the "war time period." The response to his questions were mixed, some mentioned proudly and according to Lapon almost arrogantly that they trained under Ewen Cameron, some denied they had any connection to the Nazis despite their biographical sketch which clearly linked them, others got so nervous that they stuttered and hung up (Lapon 105-157).

After I told members of the Freedom Center about Lenny Lapon's book, another member read it and then decided to contact him to present with the Freedom Center at a "Coercive Psychiatry" event at Hampshire College. Freedom Center sponsored this event and the co-founder of the organization helped design the flyer that reads:

> "Despite a public image of benevolence, psychiatry and mental health care have intimate ties to racist eugenics, the Holocaust, human experimentation, political repression, and brutal treatments. Unless we remember and understand this disturbing legacy, we will fail to see the way it continues today"

The Freedom Center has acknowledged that understanding psychiatry's long traumatic history is essential to understanding the situations many of them have ended up in, in recent years.

Ewen Cameron: The doctor with a little bit of APA, CIA, and Nazi Germany

Dr. Ewen Cameron, who at various points of his life was president of the American Psychiatric Association, Canadian Psychiatric Association, and World Psychiatric Association was a practicing professor and psychiatrist in both Europe and the United States. Cameron had attended the Nuremberg trials as an examiner and *w*hile his initial publications after returning from Nuremberg maintained an image of being against the horrific events of Nazi Germany, his later writings and actions as a psychiatrist were hauntingly similar. As Harvey Weinstein, son of one of Cameron's tortured Jewish patients, described:

> "Over time his writings began to reflect a sense that the world was made up of the strong and the weak, the latter being those with anxieties or insecurities. The strong would need to protect others from these people; they could not be allowed to influence children. Some of the weak he called 'dangerous men and women.' Thus, the lesson that this psychiatrist took from Nuremberg was the need to protect society from those who could bring it more to chaos; these people would need to be identified and their role in society evaluated. Behavioral scientists were in an excellent position to undertake this task. This would be undertaken in his zeal for a new world order where chaos was controlled." (Weinstein 95 1990)

While claming to be against eugenics, Cameron too was talking about daunting ideas that saw the world broken into binary power, with the need to protect society's "strong" from society's "weak". Soon after, Cameron, while being president of the APA, practiced "treatments" that eventually led him to have a reputation as one of the most torturous psychiatrists in history. In the 1950's Cameron was simultaneously practicing electroshock treatment, negative driving, psychological isolation, sensory deprivation, LSD, PCP, Thorazine, Serynl, insulin, and drug-induced sleep "therapy". Electroconvulsive "therapy" was a "treatment" that consisted of an initial stimulus of 150 volts for one second followed by five shocks of 100 volts during the primary convulsion. One investigator described the function of this as "a process that involved regressing patients to the level of four year olds-wetting, soiling, and unable to care for themselves" (Weinstein 111 1990)

Negative driving is a form of "therapy" in which the patient would listen to headphones where negative messages such as "I am a bad father" or "I am a failure" would play over and over and over again in the patients ears. The effects of these "treatments" included depersonalization, complete change in personality, thought disorder, disorganization, paranoia, catatonia, and extreme anxiety. Cameron even wrote a book titled Psychic Driving that described his theory on "correcting madness", by erasing existing memories and rebuilding the psyche completely (Wikipedia 2004). His experiments were typically carried out on patients who had entered the institute for minor problems such as anxiety disorders and post-partum depression, many of whom suffered permanently from his actions (Wikipedia 2004). Patients were never told the potential danger of the drug, and rarely, if ever asked for consent. Some patients even pleaded for the "treatment" to stop but were ignored (Lapon 112 1986).

Cameron was a man in positions of extreme power and great prestige who had a tremendous influence over his colleagues. Yet he was practicing torture. And though he was on the Nuremberg Trials as an investigator himself, he was violating the Nuremberg code for medical ethics by participating in sponsors on unwitting subjects. It does not seem that Cameron could rise to such high positions of power without an understanding and support of the work he was doing by other powerful leaders in these institutions. If the president of the American Psychiatric Association and World Psychiatric Association who was supposed to be bringing justice to the psychiatric abuse in Nazi Germany, is practicing such abuses himself, while being sponsored by the CIA, then there is great reason to speculate about what the dominant 1950's agenda of "mental health" really was.

Ewen Cameron's history is relevant to the Freedom Center for the same reason Lapon's book was, because it represents not only the horrors of one man, but the high-level institutionalized psychiatric abuse that has never been truly apologized for and thus may repeating today. Furthermore, Cameron's history is particularly relevant to Freedom Center member Joanne, who see herself as nearly being part of the MKULTRA experiment, an experiment Cameron played a big role in. Cameron's ideas and practices are also an example of the institutionalized hierarchical power manifesting in an oppressive way. This international eugenics movements has left literal and emotional scars on the bodies of mental patients who today are left fearing such treatment.

Chapter 4: That Was Then This is Now: Eugenics, Dirty Money and Social Control

Perhaps mental patients and allies would have a chance of healing from this historical trauma, if at least now, it was over or ending, but again, it’s not.

America’s underclass is growing. Asylums no longer exist, and as mentioned with deinstitutionalization, even mental hospitals are being closed down, but now prisons have become “de facto” mental hospitals. In fact, prisons are rapidly expanding in the United States (home to the largest prison population in the world) and the Los Angeles County Jail currently has the largest psychiatric ward in the country (Staples 1 2004) There is a reason groups like the Freedom Center have become so popular and have such high turn-outs at their event, which is that psychiatric diagnoses and treatments are more pervasive. We are now at a place where official government documents, and thus huge public figures are stating that 50% of America is ‘mentally ill.’ (Health and Health Care in Schools 2001).

Close to 20 percent of our nation's school age children took prescription drugs in 2003, a 5,000 percent increase since 1970 (Breeding 2003). The pharmaceutical companies have more lobbyists in the white house than any other industry or given ‘cause’ or ‘issue.’ (They make up approximately 60% of the white house lobbyist) (Reinherd 2002).

Furthermore, in the highest political positions are historical de ja vu’s such as George W. Bush who has just returned for his second term of office as the president of the United States and has a personal and family history of eugenics and complicity with the various social bodies analyzed in Chapter 3. George W. Bush’s grandfather, Prescott Bush was president of the American Eugenics Society. Prescott Bush was also a trustee of Yale/ New Haven Hospital and Yale Medical School at the time that these institutions advocated for sterilization and used their laboratories for hands-on practice lobotomies (Tarpley 1 2001). Furthermore, it is widely believed that the exposure of Prescott Bush’s connection to eugenics, thus Nazi Germany and is part of the reason he lost the election in the early 1950’s (Buchanan 4-19 2003). It was not until 1951, after this extremely negative publicity that Prescott Bush even divested himself from the so-called “enemy nation” of Nazi Germany (Buchanan 4-19 2003).

George Herbert Walker Bush, the father of current president George W. Bush was the director of the Central Intelligence Agency in 1976. He also sat on the sat on the board of directors of pharmaceutical company Eli Lilly in the late 1970s and was president of the United States government of the United States from 1989-1993 (Levine 6 2001)

George W. Bush Jr. who became president of the United States in 2000 also has a well-documented alliance with the pharmaceutical companies. Prior to his presidency, George W. Bush was governor of Texas and actively helped initiated the Texas Medical Algorithm Project. Furthermore several of his plans, including the “No Child Left Behind” Plan and the to be-described New Freedom Initiative seem largely to be perpetuating a eugenics agenda.

New Freedom Initiative

George W. Bush’s newest plan, the “New Freedom Initiative” was announced on July 26, 2004, with the sub-title “Achieving the Promise: Transforming Mental Health Care in America”. The initiative has been endorsed by major organizations including National Alliance of the Mentally Ill, Children and Adults with Attention Deficit Disorder, National Institute Mental Health, many states’ Department of Mental Health and the American Psychiatric Association. While press releases of the plan claim that it will “blend the promise of modern science with the compassion of skilled professionals” critics and journalists, such as Phylis Schafley have described it as “no child left unmedicated” and claim it will “result in many thousands of children being medicated by expensive, ineffective, and dangerous drugs” (Shafely 1-9 2004).

The commission proposes that the Texas Medication Algorithm Project (TMAP) be used as the "model program" for the New Freedom Initiative because it "illustrates an evidence-based practice that results in better consumer outcomes." The goal of TMAP was said to be,

> “To ensure quality care for people with serious mental illnesses by developing, applying, and evaluating medication algorithms. An algorithm is a step-by-step procedure in the form of a flow chart to help clinicians deliver quality care through

> the best choice of medications and brief assessment of their effectiveness. The target population is people with serious mental illnesses served by public programs" (Ripley 1997).

The stated outcome of the project was:

> "The algorithm package implemented by Texas was more effective than treatment-as-usual for depression, bipolar disorder and schizophrenia. It reduced symptoms and side effects and improved functioning.166-168 The package's benefit for reducing incarceration is being studied. In addition, medication algorithms have been developed for treating children with depression or attention deficit hyperactivity disorder (AD/HD). TMAP algorithms have also been adapted to treat adult consumers who have co-occurring mental and substance use disorders" (Ripley 1997).

Dr Darrel Regier, director of research at the American Psychiatric Association (APA), approved of the president's initiative and the Texas project model saying, "What's nice about TMAP is that this is a logical plan based on efficacy data from clinical trials" (Jones 5 2003).

The rhetoric sounds great, but what exactly is the Texas Medication Algorithm Project? Allen Jones, a whistleblower who was employed as an Investigator in the Commonwealth of Pennsylvania Office of Inspector General (before being fired for revealing the details of this project) and who was studying pharmaceutical company fraud (until effectively removed from his position) describes how this project actually manifested. Jones writes about how TMAP is just one example of many that shows the "unhealthy alliance between politics and the pharmaceutical companies" (Jones 3 2004)

TMAP began in 1995 with start-up grants from several major pharmaceutical companies, including Johnson & Johnson a company that owns multiple pharmaceutical companies and allegedly funded George Bush's presidential campaign in 2000 (Kashner, Rush, Alshuler, 111-121 1999). Texas, home to the largest prison population in the United States is also infamous for an extremely "crowded" mental health system. Just prior to the implication of the plan, a large number of pharmaceutical companies heavily contributed to lobbying efforts of individual political campaigns such as governors, representatives, judges, and senators. Furthermore, they were also pouring money into universities and institutions in an attempt to validate this plan (Kashner, Rush, Alshuler, 111-121 1999)

Algorithms are flow charts that were by TMAP to track the drug menus of schizophrenia, depression, and bi-polar disorder. As I suspect the drug companies are well aware, displaying a confusing and complicated yet seemingly sophisticated formula, such as the algorithm, is a very good way to convince the public that they know what they are doing. The relatively quick conclusion of the project was that all newer, patented anti-depressants and bi-polar drugs were superior to generic drugs (Jones 32-36 2004). And how did they get to this conclusion? Jones described that:

> "TMAP essentially utilized pseudo science to create the appearance of drug safety and effectiveness. TMAP purchased scientific influence in the propagation of data to suggest that newer, patented drugs were safer and superior to generic drugs. Essentially TMAP opted to 'establish' new drugs as the best drugs for various illnesses by surveying the opinions of doctors and psychiatrists of TMAP's own choosing" (Jones 36 2004)

He states that TMAP had, "No hard science, no patients, no study reviews, and no clinical trials--- just the 'Expert Opinions' of persons TMAP elected to the survey" (Jones 40 2004). Soon after, the results were that state doctors were required to use the algorithms and if a state doctor used a generic drug in a first or second line treatment than he/she must write down a rationale for it (Jones 46 2004). With the initiation of the TMAP plan the door was more open than ever for the influence and marketing of the most expensive drugs within the prison system, juvenile justice system, and Texas state hospitals (Jones 45-52 2004).

When running for president, former Texas governor George W. Bush has referenced his support for the TMAP, as well as his recent state budget recommendation to spend an additional 67 million dollars on mental health drugs (Graham 2005). It is no surprise then, that when George W. Bush became president, that the New Freedom Commission developed wanting to use TMAP as a model. It logical to express suspicion of a similar process of pharmaceutical company and politician alliance, pseudo-science, unsafe and untested drugs, corrupt government will occur with Bush's New Initiative but it is also important to look at the Initiative itself to understand the possibilities.

Some of the main 6 goals of the initiative, as presented by the official federal document, at first sight may look strikingly similar to some of the goals of the Freedom Center. Goal #1 states "Americans understand mental health is essential to overall health" (Achieving the Promise 2004) This almost fits under the Freedom Center's goal (calling for holistic health) if only the sentence were constructed in a slightly different way, i.e. "Americans understand overall health is essential to mental health." This slight alteration shows a significant difference in meaning of the term, the first, implies that the brain (the area most associated, though perhaps inappropriately, with 'mental health') is a sort of dominant organ and its well being alone decides that of the rest of the body. The second statement, displays the interconnection of all body parts, without choosing a dominant one, and notes that "mental health" is just one factor in the treatment of the rest of the body.

Goal #2 of the plan is that “mental health care is consumer and family driven” (Achieving the Promise 2004). This goal at least *sounds* empowering and in some ways similar to the Freedom Center’s statement about voluntary treatment and self-determination. But even though it sounds as though the power rests more in the hand of the patients and their family than the drug companies and psychiatrists there is little evidence that this is actually their goal. The Bush Administration has failed, despite numerous efforts from activist groups, to appoint any qualified consumer or survivor activists, or people who have experienced first hand what it’s like to be on the receiving end of services. If consumers were to be truly involved in their own mental health care process, shouldn’t it start by being part of the process of creating the policies about them? Furthermore, as I will elaborate on in more detail later, the initiative claims to use the Texas Medical Algorithm project as a model, a plan that was anything but consumer-driven.

Goal #3 of the New Freedom Commission states “Disparities in Mental Health Services are Eliminated” referring to ethnicity, as if the entire establishment did not have deep historical roots of perpetuation these “disparities” (Achieving the Promise 2004). This goal states:

> “While bold efforts to improve services for culturally diverse populations currently are underway, significant barriers still remain in access, quality, and outcomes of care for minorities. As a result, American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans bear a disproportionately high burden of disability from mental disorders. This higher burden does not arise from a greater prevalence or severity of illnesses in these populations. Rather it stems from receiving less care and poorer quality of care’ (Achieving the Promise 2004)

Psychiatry and the Bush Administration has such a horrific history with poor people and people of color that it is next to impossible to believe that the true intentions of this goal is for the health and care of people of color. In the book Wild Indians: Native Perspectives Hiawatha Asylum for Insane Indians, written in 1995 there is a detailed account of Native Americans being "torn" from their communities and brought to insane asylums. One native states,

> "Our peoples for centuries students and philosophers of the stars and of all nature, gentle, compassionate, hard-working and courageous lived a completely Spirit-dominated life. In a very short period of time our millennia old way of life was nearly wiped out" (Yellow Bird 3 1995).

He explains, that part of this "wipe out" was putting Native Indians in insane asylums. They were often brought to these asylums for illnesses such as tuberculosis or diabetes, seemingly unrelated to "mental health" and sicknesses that natives already had treatments for. Many Native Indians were brought to these asylums and often were chained and restrained or locked in isolated rooms (Yellow Bird 1-50 1995).

When brought to the asylum the doctors would tell them they were there to "beat the Indian out of them" Another native in this account states,

> "Native peoples generally do not have a notion of 'insane' or 'mentally ill.' I have been unable to locate a native language whose indigenous language has a word for that condition. " (Yellow Bird 4 1995)

Seventy years later the President of the United States is pushing to expand "treatment" and to create "culturally competent services" that acknowledge "cultural differences, language, histories" to Native Indians. I can't help but wonder if this will include an acknowledgement of the mistreatment of Native Indians in the mental illness complex.

Similarly African Americans have been at the brute end of mental health service for many years. Once referred to in dominant discourse as genetically inferior, African Americans have received some of the harshest forms of treatment the mental health establishment has to offer (Breggin 1991). Just recently, an article in the New York Times exposed the disproportionately harsh treatments that African Americans receive in New York's mental health system.

Like most states, the state of New York has passed a law giving judges the power to force the mentally ill to comply with treatment. This law, titled Kendra's law, developed in 1999 in New York City due to a woman being pushed into the path of an approaching subway train by a man diagnosed with schizophrenia (Cooper 2005). In a recent study the New York Lawyers for the Public Interest, concluded that blacks were nearly five times as likely as whites to be the subject of court orders stemming from Kendra's Law. Examining court orders for treatment that have been issued since the law took effect, the group found that 42 percent of the 3,958 orders for treatment were invoked against blacks, who make up 16 percent of the state's population, while 34 percent of the orders applied to whites, who make up 62 percent (Cooper 2005).

African American Luishah Tes in the book In Our Own Voice: African American stories of Oppression, Survival and Recovery in Mental Health Systems states "We know that if sanity is defined by white upper-middle class standards then we are in grave danger. It is very easy at this time when Third World people are seeking are own identities, to say

‘That NIGGA’s crazy lock him up’” (Jackson 9 1995)

Until the Bush Administration says that “disparities being eliminated” means the screening of the rich, the CEOs drug companies, and the politicians, (those who truly show up in the smallest numbers in the mental health system) there is little reason to believe this rhetoric is truly about equality.

The fourth goal of the New Freedom Initiative, is where the ‘no child left unmedicated’ critique is directed. This goal is stated to be the “Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice” (Achieving the Promise 2004). The sub-goals of this plan include to “promote the mental health of young children”, to “improve and expand school mental health programs”, and to “screen for co-occurring mental and substance use disorders and link with integrated treatment strategies” (Achieving the Promise 2004). Part of the goal is also to “screen for mental disorders in primary health care, across the life span, and connect to treatment and supports” (Achieving the Promise 2004). The commission states this on childhood:

> “Early childhood is a critical period for the onset of emotional and behavioral impairments.[115] In 1997, the latest data available, nearly 120,000 preschoolers under the age of six - or 1 out of 200 - received mental health services.[116] Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.” (Achieving the Promise 2004)

Thus, according to the plan "consumers of all ages," including preschool children will be screened” (Achieving the Promise 2004). Furthermore, as part of this goal The New Freedom Commission proposes the screening of all Americans for ‘mental illness,’ with public schools, being in the “key position” of screening 52 million Americans (including children and potentially staff and faculty). Despite the extreme rise in mental illness diagnoses and drug prescriptions, the commission that designed the plan claims “despite their prevalence, mental disorders often go undiagnosed” (Achieving the Promise 2004).

The Commission states that the organization Teen Screen, a web-based corporation will be used in the school system. Yet Teen Screen has already been used, with great dissatisfaction in Illinois. A Columbia University pilot project of screening students called TeenScreen resulted in one-third being flagged as "positive" for mental health problems, and at least half of those being turned over for mental health treatment. If this is a preview of what would happen when 52 million public school students are screened, it would mean putting a label on 17 million American children. (Shafley 2004). Is “mental health” the true goal, or is it the expansion of psychiatry and the perpetuation of an underclass?

What does it do for a capitalist system to have so many children both evaluated and labeled? Here Michel Foucault has several suggestions about the “examination” that seem quite relevant to this initiative. Foucault describes:

> “The examination combines the techniques of an observing hierarchy and those of a normalizing judgment. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish. It establishes over individuals a visibility through which one differentiates them and judges them”

185 There is an early understanding, classification, and qualification of these school children that are forced to undergo mental health screenings. Furthermore, Foucault points out,

> “The examination also introduces individuality into the field of documentation. The

> examination surrounded by all its documentary techniques makes each individual a 'case.'"

Few greater friends are there to capitalism than individuality. "Bi-polar." "attention deficit," "obsessive compulsive," each child and parent and peer will know from a young age, the place of themselves and their schoolmates. While assessing the rhetoric is one valid way to get a sense of the New Freedom Commission, another valid way is to look at what similar plans have already been implemented.

A perhaps even more concrete perspective of how the agenda will manifest, can come from looking at the state of Illinois, the first state to vote in the plan. In 2003, the General Assembly passed the $10 million Illinois Children's Mental Health Act and created a Children's Mental Health Partnership. This act and partnership is expected to become a model for other states. The partnership's plan, released July 16, calls for periodic social and emotional developmental examinations to be administered to all children, and for all women to be screened for depression during pregnancy and up to a year postpartum (Schafely 2004).

As described by globalization researcher and conservative Phyllis Schafley,

> When the partnership showcased this plan with five public hearings stacked with bureaucrats and social service workers, a political tempest erupted, with state legislators saying they had no idea this was what they had voted for." (Schafely 2004)

The details of the Illinois plan includes periodic developmental exams for children age 0-18 years, a statewide data-reporting system to track information on each child, social-emotional development screens with all mandated school exams in kindergarten, fourth grade and ninth grade, and report cards on children's social-emotional development. The mental health assessment is to become added to the state's physical examination certificate, along with mandatory immunization records so unless religiously exempt, all children in Illinois, are required to have up-to-date health examinations (Schafly 2004).

Also in the state of Illinois just recently (in April 2005), National Alliance for the Mentally Ill has joined with law enforcement, medical, education and social service to launch a statewide "Campaign for the Mind of America." The name in it of itself implies a consolidation of power, as does the simple fact that so many people different institutions are launching this campaign. The plan, like all others, aims to expand psychiatric practices.

Certainly the shallow and computerized mandatory screenings that are based on pseudo-science resemble Nazi Germany, though the results of these screenings hopefully will not. Certainly, there is a difference between children being recommended for psychiatric medication and those recommended for death camps. Nonetheless, an agenda to label and as one Freedom Center member calls it “chemically control” citizens of a nation also has fascist effects. When I interviewed Lenny Lapon about why he wrote a book about psychiatry in Nazi Germany and what he sees as similarities or differences today. Lapon responds,

> “Well I think what happened in Nazi Germany was there was a whole structure of mechanism of death machines. They were architects for the final solution. The killing methods, gas chambers, all set up by psychiatrists depending on biological psychiatrists. I’ve seen weird attempts to separate fascist Nazi with the eugenics component but its all the same stuff. As for today? Well, I like the term friendly fascism. Today the propaganda machine is much more advanced. And it’s more like 1984. They are not killing people to the same degree at all, in Germany they killed 7/8 of their mental patients… and though I do think there are still many overlooked or

> denied deaths in psychiatry from things like electroshock, drugging, and restraints right now it would probably be more like 1/8. But there are many more people on the streets or in the schools who are forced or coerced into really dangerous drug use. It's more pervasive, millions and millions now. "

When I asked him if he thought there were still "fascist" intentions of psychiatry responded:

> "Intentions? Well, it depends on whom you are talking about. On a lower level I think a lot of mental health workers and parents putting their kids on drugs have really good intentions and really big hearts. But part of it is the road to hell is paved with good intentions. No matter what the intentions are we have to look at the effect. On the higher level, they know what they are doing…the power is in the hands of a few… they are dominating politically and economically. Forcing people to conform… you know its kind of subtle sometimes"

The effects of having the 17 million children receiving a psychiatric diagnoses, of having psychiatric services expand across cultures and ethnicities, of having so many institutions enforcing this agenda, of the fine line between "criminals" and "ill" are forewarnings to the public about the creation of a class of "unfit".

Yet indeed America still claims to be democratic and many of its citizens still wholeheartedly believe in democracy, so as the agenda escalates an increasing number of whistleblowers, angry parents and even children have seen through it. The Freedom Center speaks about the New Freedom Commission during its presentations and has public petitions against the plan on their website. Many newspapers articles (though very few in corporate mainstream press) have been written to criticize the New Freedom Commission. I do believe if the agenda was more understood than dissent from the general public would be greater and there would be a greater possibility of deescalating this plan. If private capitalist interests are revealed, the public will often be outraged. One Freedom Center member and parent describes a situation in which this actually succeeded:

> "Yea, it's really scaring me… what they are trying to do… and I look at my kids, and I think of my own experience and I think… that can't happen to them… but since working with the Freedom Center I've learned to ask the right questions in the school. Who is funding that screening? What are the implications of it? Does my kid have to do it? I even was communicating with someone in Florida who brought information about the pharmaceutical funding of teen-screen to the school board, and watched the school board members change their mind and reject the plan. I don't know, I think there's some hope."

It is not that power always has to go unchecked within a hierarchical fascist capitalist system claiming to be a democracy. If the Freedom Center and groups like it on a national level were to dissent to a greater degree there is hope of transforming these mythologies and injustices of the mental illness complex.

Chapter 5: The Mad Get Movin'

"In a spirit of mutual cooperation, we aim to lead a nonviolent revolution of freedom, equality, truth and human rights that unites people affected by the mental health system with movements for justice everywhere" –Mindfreedom International

In my discussion of insight theory, informed consent, the CIA's covert funding of psychiatric experimentation, eugenics, Nazi Germany, and the new freedom initiative, I have outlined specific aspects of past and current injustices within the "mental illness complex." Not surprisingly, these assaults have not gone unnoticed, and have not gone without the courage and strength of the survivors of them rising up.

Although there have been individual resistances to the assaults of psychiatry most likely throughout all of psychiatric history, and some instances of organized resistance such as Alleged Lunatic's Friends Society in 1845 and the Anti-Insane Asylum Society in 1868 the larger scale organized ex-patient movement, truly emerged in the United States in the early 1970s (Chamberlain 1 1993).

As I will discuss throughout this chapter, the Freedom Center is by no means the first organization to form with the intent of dealing with the human rights abuses within psychiatry. Nor are they the first group to try and claim their own voice and have their own definition of what has happened to them. Rather, they exist in the context, and connected to a 35-year-old movement of similar such organized resistance. The Freedom Center has joined with a larger movement, both historically and currently, organized around very similar goals and campaigns.

Throughout this chapter I will discuss the Freedom Center's political efforts in relationship to the campaigns of the mad movement through history. I will also analyze language, tactics, and complexities of this movement both historically and in the present.

Freedom Center's Political Efforts

For more than three years the Freedom Center put pressure on a local mental health service provider (ServiceNet) to give patients basic human rights and to end forced treatment. ServiceNet is a private mental health service provider funded partially by the Department of Mental Health with both residential and non-residential services. For a long time Freedom Center focused campaigning for the right to private phone use for people in ServiceNet's residential programs. Despite the fact that Chapter 123 Section 23 of the state law protects the right to confidential access to phones ServiceNet ignored this law (Disability Law Center 2000). One organizer told the press, "We kept telling them they were breaking the law, but ServiceNet was doing nothing, just nothing. They don't take us seriously (ServiceNet Campaign News December 2003) " Will Hall tells the press,

> "Think for a moment what it would be like always making phone calls from a public place, where your landlord, counselors, and people who control your resources and services can overhear what you're saying. Now imagine that you knew this was against the law -- and the law was being ignored. How would you feel? That's the message the mental health system keeps giving to clients -- the message that you are a second-class citizen and don't matter. (ServiceNet Campaign News December 2003)"

After a tireless struggle of being ignored by ServiceNet, Freedom Center members turned to the Disability Law Center, which after a fair amount of pressure eventually got their professional advocates and lawyers involved. Organizers noticed the difference in ServiceNet's reaction when lawyers became involved as is evident by the fact that in March of 2004 clients were finally granted the right to phone access (ServiceNet Campaign News March 3, 2004).

Nonetheless, Freedom Center has continued its larger campaigns against Service Net in several other areas with their ultimate goal being to end their forced treatment/ drugging and end medical neglect. They held public protests/speak-outs of their own outside of the ServiceNet building that include individuals' peoples' stories of their own experience of abuse from ServiceNet. Freedom Center members compiled letters to the organization, which have also been posted on their website and sometimes released out to the mainstream press. These letters include commonly reported themes of the injustices and shortcomings of ServiceNet's programs. These themes include

> "a general atmosphere of hopelessness and indignity, intimidation, demeaning and patronizing attitude of staff towards clients, repeated mistakes and mistreatment in administering medication and medical needs, verbal abuse, and misleading information about the nature of mental illness" (Service Net Campaign News March, 2004)

Along with the description of these problems the Freedom Center's letter outlined seventeen "steps towards positive change" that ServiceNet could take. The steps read almost like a list of demands, and amongst them Freedom Center states the need for ServiceNet to provide informed consent, stop forced treatment, hire full-time peer advocate staff for every resident, stop using police to intimidate clients, offer alternatives to medication, and to take seriously trauma described by patients. These letters and demands were sent directly to the board of ServiceNet, summarized in the form of press releases, and posted publicly on the Freedom Center's websites and discussion list.

> ServiceNet has not met most of those demands. One organizer told me:
> "I think there is a difference in the way they treat patients now that they know we are here. Since the pressure and attention they have received from us and since the lawsuit filed by one of our members who was put on thirteen medications at once and experienced an immense amount of side effects, they know we are watching and I honestly believe they are less inclined to mistreat people because of it."

The Freedom Center's political work also consists of their media attention from local newspapers, radio, and television shows, and other non-profit groups. In 2003 The Republican Union News ran an article titled "Group Opposes Forced Drugging: The Freedom Center believes patients being treated for mental illness should have the right to refuse drugs”. In September of 2004, the local paper the Hampshire Gazette had a front-page article titled “Closing the Medicine Cabinet Doors” highlighting Freedom Center members’ stories and problems with psychiatric medication. In December of 2004, The Republican Union News also had a front-page article highlighting the tension in the debate about treatment between Freedom Center, NAMI, and Service Net (a debate I will elaborate on in my discussion about co-optation). Furthermore, the Freedom Center has held several speak-outs in colleges and local areas to tell about their own experiences of abuse within the psychiatric system. They have also organized several major speakers to come and present on their behalf. Medical journalist Robert Whitaker, has three times in the past four years to speak about the eugenics history of psychiatry, and the dangers of neuroleptics. Elliot Valenstein came in 2003 to talk about the problems with the roots and shortcomings of the bio-medical model of psychiatry. Daniel Dorman came in 2004 to talk about listening as a means of therapy for people diagnosed with schizophrenia and to talk about the arbitrary notion of diagnoses.

In addition to these campaigns and big events there is the consistent day-to-day work of discussing goals and intentions, supporting one another through group meetings, the yoga group, and the informational resources on the website as well as through advocacy work for people who turn to them regarding help with their forced treatment, hospitalization, Rogers Order etc..

While the Freedom Center's exact model, and individuals involved are unique, the idea of doing activism, advocacy, and support group for those diagnosed with mental illnesses is not. As explained in the introduction, this group would most likely not exist, if not for MindFreedom Support Coalition, a group developed in 1988, which existed itself due to influence from the grassroots groups of the early 1970's.

Language of the Movement

The early 1970s was a heated time in American history. President Nixon was in office. The mass invasion of Vietnam by American troops was still going on. And Watergate was being revealed to the public. Furthermore, it was a time when so many other groups of people (such as women, African Americans, and gays/bisexuals/trans) were joining movements to demand rights, choice, and empowerment. When the "mad movement" developed in the early 1970s, like the other movements of the time it too was demanding rights, choice and empowerment. But rather than focusing primarily on white power or male domination, ex-patients/patients and allies were focusing on domination of the psychiatry establishment. As with most of these social movements, the movement consisting of those fighting the injustices of the "mental illness complex" has taken on several titles throughout history, as well a range of different ideologies and tactics.

In my research and with my work with the Freedom Center I have found people using the terms "mental patient liberation", "survivor", "ex-patient", "ex-inmate", "consumer" and the "mad" to describe the movement they consider themselves a part of. These terms can be used individually and distinctly, with specific meanings amongst those who have been mistreated by psychiatry/ their allies, while others use these terms interchangeably.

The “mental patient liberation movement” was one of the first terms used to describe the movement. Yet often feeling disempowered by the use of medical language in their description of themselves, the discourse moved on to be called ex-patients (Firestorm 1-27 1995). The problems with “ex-patient” as I see it, is that it both excludes allies and it excludes current patients. Furthermore, many found this term to have the disempowering effects of “mental patients” and pointed out that “survivor” had a meaning of its own which acknowledged the struggles of those injured by psychiatry without speaking on the mental health systems terms (Chamberlain 7 1993).

The term “consumer,” is one of the most recent terms used, and as I will analyze further in the co-optation section below, I, along with many ex-patients believe it is an extremely limited term that often compromises many of the goals of the original movement.

The term “mad” tends to be used more as a celebration of mad culture, often done through organizing mad pride marches, through writing, creativity and the arts. Like gay pride marches, mad pride marches are developing in response to the shame imposed on participants by larger society. Similar to the term “queer” or “black” used by participants in other social movements the term “mad,” which is often used in a derogatory fashion is attempting to be reclaimed by the very people who have been stigmatized by it. Mad Pride marches aim to publicly counteract discrimination and prejudice, promote positive images of mental health, and to educate the public in mental health issues. As one organization describes in its call to action for a Mad Pride march,

> “It therefore is always to be written Mad to distinguish it as a deadly serious political word - a constant reminder of how we were treated by others, how we are

> treated by others, but sending out a message that the day has now arrived when we are not going to be treated like this any more" (madpride.org 1998).

Mad pride marches consist of people walking down the street, often wearing wild costumes, sometimes singing songs against coercive psychiatry or holding signs that read expressions such as, "Force the Issue not the Patients" or "You bet your ass we're paranoid." The book Mad Pride: A Celebration of Mad Culture is a collection of stories about individuals boasting about the wild things they have done when "losing it." This book consists of anything from anti-capitalists rebelling against their jobs, to stories about drunken drug binges, to advice for dealing with mental institutions, to stories of games they call "mental ping-pong". Some stories take a bold and firm political position, while others just ramble with tales of their promiscuous lives.

To this day all of the terms are used by various organizations in the movement. Even within the Freedom Center there is no unified consensus on which term to use, and at some point or another I have heard members use all of the terms listed above, though it is perhaps most common that one refers to him/herself or the movement as "survivor" or "mad." Regardless of the terminology used (with possibly the exception of "consumer") the movement has and is generally united by their rejection of the dominant medical paradigm, and their demand for justice from the mental illness complex. I will be consciously using these terms both interchangeably and distinctly throughout this chapter, depending on how those I am referring to use them and also as sort of a poetic comment on the mixed vision of the movement.

Actions and Strategies

Three of the earliest and most active mad groups originated in New York, Boston and the San Francisco Bay Area. Boston was home to the Mental Patient's Liberation Front (a self-help group that has worked to overcome the stigma, oppression, and powerlessness experienced by patients and survivors of the mental health system); the Bay Area home to The Madness Network News (one of the prime channels for psychiatric survivors to write about their experiences) and New York to Mental Patient's Liberation Project which sponsored numerous demonstrations, boycotts, and sit-ins around the inhumane practices of mental institutions) (Satcher 2004) . The Madness Network News printed publications, gave lectures and ran education campaigns around psychiatric abuse and problems within the mainstream biomedical model. At first they were composed of radical mental health professionals and ex-inmates but conflicts between the two resulted in the group only to being led by ex-inmates (Deurr 1-27 1983). Furthermore, The Madness Network News was the catalyst for one of the most powerful ex-patient groups of the time. This group (known as "Network Against Psychiatric Assault) started in 1978, because an individual who was diagnosed as a paranoid schizophrenic. The person had spent nine months in a mental institution in which he forcibly received 85 shock treatments and 50 insulin comas because of his diagnosis. He attended a lecture by the editor of Madness Network News (Deurr 1-27 1983). The lecture moved him both personally and politically to the point where he was inspired to start a group, the Network Against Psychiatric Assault to do further political work on these issues. This group did letter writing campaigns to legislators and held protests and demonstrations outside of hospitals, offices, and public meetings as an attempt to end forced drugging and demand an end to electroshock therapy on misinformed or non-consenting patients (*Madness Network News April 1974)*. NAPA even held a month-long sleep-in demonstration in the office of a governor, as an attempt to end the forced unpaid labor as well as the forced treatment in California's psychiatric facilities (Lapon 163 1986). Since, in many instances the mentally ill had about as many rights (and in some cases fewer) than even prisoners, defending fundamental human rights, was a primary agenda of NAPA. NAPA formed a Legal Action Committee, which successfully gained the release of many people incarcerated in psychiatric facilities (Madness Network News September 1974).

Furthermore, the Mental Patient's Liberation Project of New York City formed a patient's Bill of Rights in 1972, in responses to the systemic abuses of mental institutions. The Mental Patient's Liberation Project Bill of Rights included rights to refuse treatment, to be treated with respect, to refuse work or receive a fair wage for work, to have uncensored communication via phone, letter, or personal contact and to have decent living conditions (Firestorm 2000)**.**

These groups, and many other grassroots groups that were springing up around the country were meeting at annual conferences, titled The Annual Conference on Human Rights and Psychiatric Oppression, the first of which took place in Detroit in 1973 (Lapon 167 1986). Discussions around the specific goals, tactics, and terms used in the movement were happening regularly in individual organizations and the annual conferences. One of the crucial discussions revolved around the role that non-patients/ex-patients, including "allies" and "professionals" played in the movement.

It was the belief amongst many survivors that the persons undergoing "treatment" and extreme states of consciousness, were themselves the experts on their experience. Several ex-patients and activists have described rising tension between professionals who felt they were the experts on patient's experience and ex-patients who did not think this was the case. This tension became particularly apparent by the third annual conference in San Francisco. Psychiatric survivor and activist Lenny Lapon described how the conference was dominated by professionals and academics who were "constantly exhibiting mentalist and patronizing attitudes towards ex-inmates (Lapon 173 1986)" Ex-patient and activist Judi Chamberlain, who was also a participant in this conference discusses the sort of "mentalism" and "sane chauvinism" which, while it could be found in patients or non-patients alike**,** came primarily from professionals. Chamberlain proposed that like many have said about men, heterosexuals, and whites within the woman's, gay, and black liberation movement, that this oppression was worked through best when non-patients were not present (Chamberlain 17 1986). This was because like many gays' in relationship to sexuality, many survivors have perceptions about "mental illness" that were diametrically opposed to those of the general public and thus it would be insensible to let non patients into, or to dictate the goals of organization.

Because of voices like Lapon's, Chamberlain's, and several other survivors, an ex-inmate caucus formed. The caucus initially discussed whether they were to confront the workshops they found objectionable, or ignore the rest of the conference and just meet with each other about issues they found important. After the latter was decided upon, "most of the ex-patients could be found behind a door with a very clear "Keep Out" sign intended for [who] anyone who hadn't done time in a mental institution (Lapon 182 1986)"

Lapon described all of the inherent difficulties that came along with making this separatist decision. He pointed out that while ex-inmates needed a safe space it was also an opportunity for ex-inmates to confront what he saw as the contradictions in workshops such as having staff speak about "half-way" houses (that patients had demanded more power in) or having those who prescribe psychiatric drugs (versus those who have been on them) speak on their effects. Indeed, as pointed out by Robert Desjarlis in Shelter Blues there is a sort of danger in "essentializing experience." If the patients is always the experience the sort of authority than, as Desjarlis pointed out it involves "only one rather inward looking arrangement of human action among many" (Desjarlis 14) Nonetheless, there is a sort of intimate participatory relationship (however abusive this relationship may be) that an individual has with a drug they have had to put in their body every day that non-experiencing professional does not have. Professionals can only observe the symptomatic changes of individuals on these drugs, a perspective that is blind-sighted to the whole internal experience. And furthermore, patients are not offering one, but many shared experiences of what it is like to undergo psycho-pharmaceutical treatment. Thus this is an understandable frustration of ex-inmates who saw workshops such as these in the conference. Lapon points out the struggle of having the caucus rather than the confrontation when he states:

> "Here was an opportunity for discussing real alternatives, for challenging the whole idea of professionalism, for forcing those who made money off human suffering while presenting themselves as radicals to listen to us, the real experts" (Lapon 171 1986)

But communication was not successful, and thus the third conference was the last for many years to come, in which professionals played a leading role. After that the workshops focused more on issues essential for their own organizing of political change as well as their rights and well-being. These workshops included things that appeared to be glaring omissions from the previous workshops, such as "History of the Movement, Psychiatry and the Military, Madness and Spirituality, Our Relationship to Other Movements, Civil Disobedience, Government and Mind Control, Psychiatric Drug Withdrawal (Lapon 193 1986)" These topics embraced issues more immediately relevant to survivors and to political organizing and also discussed some of the most threatening issues of the psychiatric establishment.

Especially since ex-inmates began organizing, "empowerment" and "self-determination" became main goals of the movement. "Empowerment" and "self-determination" meant that ex-patients themselves would no longer be in the role of passive recipients, but would in fact have a voice in mental health matters. Self-determination originates from the discourse of the United Nations (UN) who has defined "peoples". The UN initially referred to "self-determination" in Article 3 of their declaration of rights. Article 3 states, "Indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development" (United Nations 2001). Empowerment meant that there was an active decision-making power coming from those most directly affected by the decisions. Rogers et al (1997) has defined empowerment as "self esteem/efficacy, actual power, and community activism."

The conferences also began to include demonstrations as part of them. The next annual conference took place in 1974 in Boston and included a march to the Massachusetts Mental Health Center and demanded the rights to be informed in clear language about the dangerous effects of treatment, as well as the right to uncensored communication and an end to surveillance (Chamberlain 20 1993).

In 1978, during the sixth annual conference, ex-inmates and supporters demonstrated outside of the national headquarters of Smith, Kline, and French. SmithKline, the parent company of one of the largest drug manufacturing companies in the U.S, was also the first to put the "Thorazine" a neuroleptic and "major tranquilizer" on the market. Demands of SmithKline, came from the protests, and the demands included to stop promotion of their "mind-control chemicals," to admit the dangers of this drug, and to stop "cooperating with the rape and economic exploitation of third world peoples (Lapon 13, 1986)." It seems that this is finally bringing together many of the true traumas and forms of oppression that face psychiatric patients and peoples around the world. The conference also called for a boycott of all of SmithKline's over- the-counter products, which, while it proved to be unsuccessful on a large scale, did gain the support of many other rights organizations of the time (Madness Network News October, 1978).

Right around the time of this conference (in 1978) Judi Chamberlain wrote her popular and influential book called On Our Own: Patient Controlled Alternatives to the Mental Health System" which described different alternatives to the mental health establishment. Chamberlain outlined the importance of consciousness-raising in which people share and examine their own experiences as an attempt to understand the context in which their lives were embedded. This would help people understand that their problems are not only individual and personal, rather a part of systemic oppression. Her book outlined the existence of, and provided inspiration for, the self-help groups of survivors (Chamberlain 1973). When co-founder of the Freedom Center Oryx Cohen in 1994 did his masters thesis with former or current mental patients (most of whom were diagnosed with schizophrenia), he too found empowerment essential, noting that 94% of them said that empowerment or self-help (using the definition used above) played a role in their recovery (Cohen 1994).

When I asked Freedom Center member Kay what helped her recover from her trauma she responded:

> "Getting off medication and participating in social justice movements, realizing in contrast to what the hospital told me I was, that I was someone who could affect change who could make you know rational decisions and follow through on them and who could achieve, having an independent life free of all the people who controlled me when I was younger, psychiatrists, my parents etc"

Other Freedom Center members have found their own voice and described their own experience for themselves at the Freedom Center support group meeting, and through the Freedom Center's speak-out page, as well as through developing decision making power and community activism.

Though having an improvement of one's self-esteem after being severely disenfranchised seems like in many ways a necessary step to healing, in my opinion the goal of “empowerment” on a larger scale has many limits. For one, this term, as I will elaborate on in my discussion of co-optation, empowerment is a rather vague term that can be manipulated easily for various uses. Another limitation is that the term can often imply a sort of individuality; for example, one can be “empowered” for example to leave the country and take care of themselves on a deserted island, but this move may be ignoring the needs and responsibilities of the person’s friends and family. An individual community of ex-patients can be “empowered” to start their own peer support group, but this does not respond to the high-level corruption occurring in the country. The term implies a sort of individuality, even if it is an “individual community” which does not necessarily take into account the needs of the larger social body.

However, even as Judi Chamberlain used it, empowerment did not always have to mean being “on our own” or having autonomy. Judi Chamberlain has discussed the term in reference to current and former patients’ roles in influencing public policy, being advocates, once sitting on boards and committees that represent the interest and challenge the misinformation of those being diagnosed with mental illness (Chamberlain 30 1973).

This topic (around autonomy) came up at a recent Freedom Center workshop when a non-Freedom Center participant raised his hand to ask a question. He stated that as horrible as his hospitalization struggle was, his biggest struggle came when he got out of the hospital and had to get a job, find a house, and eat with no money and a psychiatric diagnosis. He pointed out that while support and yoga groups sounded nice, they do not respond to some of the most important issues at hand, similar to, he claimed, many “activist groups.” “With all the problems the state has,” he said, “It does seem they have more resources and are more capable at providing these fundamental services. How does your group deal with this?”

Will, co-founder of the organization, responded pointing out that the Freedom Center does not have a “wall up against state or federal services” and that the Freedom Center, as a barely funded group, tries to be very clear about their limitations. However, what the Freedom Center can provide, besides their own services and references to other low-income services is the ability to help people “navigate their way through the system”. If, for example, someone is thinking of trying to get SSI disability funding, they can come to a support group meeting and have a whole range of people who have gone through that same process tell them the pros and cons of it. In other words, empowerment is most effective, when the other goal of the movement, true informed consent and basic human rights, go along with it.

Co-option and Fragmentation

Empowerment was an extremely potent and meaningful term the way the movement used it in the early days but now it is has been taken over, or co-opted by every mental health group. Appropriation or cooperation with those who are not truly looking out for your best interests, (co-optation) is a sophisticated and manipulative tactic of repressing dissent used by elites against social movements for a long time.

When Will described to me a clubhouse that wished to have the Freedom Center present on our organization the subject of co-optation came up. “They’re big on empowerment” he said in a sort of sarcastic emphasized way.

“Aren’t we big on empowerment?” I asked

> “Well…ya… but it’s important to remember that these are just words. Words like ‘rights’, and ‘empowerment’, and ’choice’ were incredibly radical when they first started being used by the movement… but like any movement the system begins to take these words and sort of slowly co-opt them over time, to the point where they don’t have that much meaning anymore.”

What he had said I had already known to be true, as the word “empowerment” is popular with pharmaceutical-funded “consumer” groups such as NAMI and CHADD. Even the New Freedom Commission talks about “consumer run programs” implying a sort of empowerment. The struggle I discussed with ex-inmates and mental health professionals was in a sense a struggle not only semantics but about the co-optation of the true empowerment, self-determination and goals of ex-inmates. Furthermore, within the last few years co-optation has been happening most in the mad movement with the advent of “consumer” groups. The term consumer, from consume meaning “to utilize economic goods” or “to engage in fully” sees the mental patient as a type of customer of mental health, versus a person struggling. Furthermore, it implies a sense of choice, ignoring the abusive and coercive elements of psychiatry, as though the mental patient simply chooses his/her mental health service or psychiatric drug like a mother chooses groceries for their refrigerator. Often, “consumer groups” are as focused (if not more focused) on a diagnosed person’s family as they are on the patients themselves. This is because those diagnosed as mentally ill are often considered incompetent or “lacking insight” into their illness and thus professionals turn to family members. Furthermore, the term is exclusive to those who have recovered and want nothing to do with or have violently protested the mental health establishment. Rae Unzicker explains this in his article “History, Principles, And

Definitions Of Consumer-Direction And Self-Determination”

> “I saw with my own eyes the split in the movement. People who had, before this time, chained themselves to the gates of mental hospitals, were now talking about working cooperatively with the system, advocating for rights within a system in which there are no rights. Rights as we know them, are, in the mental health system, called privileges. And we earn those privileges---walking outside, being unlocked from seclusion rooms, making phone calls, and writing letters—by compliance with medical-model treatment. We take our drugs. We cooperate, we assent (Unzicker 1999)”

By Unzicker pointing out that what was once a “human right” transforms into a “privilege” is a way of him pointing out the dehumanizing process that occurs to mental patients once inside mental institutions. Unzicker’s concern about cooperating with the system was his own expression of fear regarding co-optation

His point and my point is certainly *not* that people who choose to consume psychiatric medications or use psychiatric services should be excluded from the movement. The Freedom Center works very hard to make sure that no one thinks that this is the case, and certainly many members take psychiatric medication. The point is rather that since many, many individuals have worked hard to get off their drugs, recover from the trauma caused to them by the mental health establishment, and reveal the lies of the dominant psychiatric model that to simply accept the term “consumer” as a description of the movement is, to basically accept the fundamental principles and practices of dominant psychiatry.

This struggle between so-called consumer groups and survivor groups became evident recently when NAMI and the Freedom Center clashed. The Freedom Center attempted to dialogue with the new president of the board of the Western MA chapter of the consumer group, National Alliance of the Mentally Ill. NAMI uses the terms “recovery” “empowerment” and “the involvement of users and their families” (nami.org) Will Hall, co-founder of the Freedom Center reached out to Mary Rives, the new president of the board of NAMI and a psychiatric survivor herself to see if they could work together in certain areas where they do actually have things in common. When Will reports in his public statement about the scenario he states that both of them acknowledged that NAMI’s organizational methods and some of their fundamental beliefs are different. For example, NAMI still promotes the idea that mental illness is primarily a biological brain disorder and drugs are the primary means of treating them. Nonetheless, Will and Mary “agreed to disagree” on these issues and talked about how they could collaborate on other issues such as ending disability discrimination and defending section 8 funding, a federal low-income housing assistance program. According to Will, the two were having active dialogues via phone and email for a while, with plans to meet in person. However, when the time came for them to meet in person, Mary called to tell Will she could only meet with him at the office when other NAMI board members were present. Despite his discouragement about this, Will agreed to these terms. Just a few days later however, Will received a phone call that Mary Rives had been fired without warning or cause. Will, shocked by this, asked Mary to do an interview on-the-record to talk about the firing. Mary agreed and in this interview she explained the firing:

> “When I reported back to work after a four day national NAMI conference, two NAMI-WM executive board members were at the office upon my arrival. I was told I was terminated "without cause" from the organization. When I asked them why, they said they were not at liberty to tell me, and would only confirm the board's decision. I reminded them that just recently the three of us had met and they gave me a glowing job performance evaluation. I asked them to please have the

> decency tell me what went wrong. But they only repeated themselves sternly and instructed me to pack my things and leave the premises immediately ”

Mary Rives also said in her interview that NAMI did not even let her retrieve personal information from her computer. Rather, a board member physically blocked her access to the computer then got on his hands and knees to unplug her computer, telling her she could not bring any files home with her whatsoever. While NAMI never directly told Mary exactly why she was being fired, there was plenty of reason to believe that it was simply for communicating with, and beginning to consider principles of, the Freedom Center.

Will also asked Mary in this interview “Were you ever able to find out why you were fired?” Mary responded:

> Not directly, but by putting the pieces together it became clear I was fired because of philosophical differences (this was confirmed by one board member who revealed what happened at the board meeting where I was voted out). Here is a glimpse at some history, which I believe, brought out differing philosophies: NAMI's brochure states that mental illnesses are not curable or preventable. Soon after my participation in an online community discussion about this issue, (and after my positive job performance evaluation), a meeting was called during which I was literally interrogated by Police Desk Sgt. and NAMI-WM Board President, Donald Sicard. I was told numerous times, verbatim, "We want to look deep into your eyes and see if you are telling the truth. Are you more Freedom Center or NAMI?"

Why would one have to be “more Freedom Center or NAMI” if both claim to be speaking for the same people (those diagnosed with mental illnesses)? If NAMI is concerned primarily about people diagnosed with mental illnesses then why will they not even allow contact with a group that is run by these very people? NAMI appears to be threatened by an agenda that truly challenges dominant psychiatry and offers alternatives to it. Therefore this firing, along with NAMI's connection to the APA and the fact that 18 drug firms gave NAMI a total of $11.72 million between 1996 and mid-1999 (Mother Jones 2000) has shown that "empowerment, and recovery," terms once used to challenge the dominant psychiatric model, have become terms that apply only when supporting it.

NAMI is a particular sort of example because many activists and researchers speculate that it may very well have never been a grassroots group to begin with (but rather formed to pose as one). However, co-optation has also taken form in groups that were truly political, grassroots and survivor run, who became apolitical. One member, Joanne, when referring to friends of hers who used to do activism around psychiatric injustice, stated,

> "They left the mad movement, the survivor movement because it was getting so co-opted, so willing to de-politicize itself, and they kept going in the political… saying this is really a political issue, and they were right in my opinion. It is very political this is social control writ large and everyone's convinced its medical."

Her point is illustrated partially through the mid 1980s when many groups in the mad movement, including grassroots survivor groups became primarily federal or state funded (MindFreedom.org). There are all sorts of limitations on the political role that a group can have when getting state and federal funding, and in these cases the human rights political activity was toned down after receiving this money. In these cases groups that became co-opted did not necessarily have to accept or encourage the medical model, but in accepting a sort of de-politicization, it often revealing of the fact that their initial goals and struggle has been appropriate.

Still Crazy After All These Years

While co-optation has played an increasingly large role in stifling dissent and compromising many of the original goals of the mad movement, this movement is still alive and struggling for many of the original goals, though often with new and creative tactics. The Freedom Center, belongs to several coalitions, including the MindFreedom Support Coalition International, which gathers over 100 grassroots groups with of winning campaigns for human rights of people diagnosed with psychiatric disabilities. MindFreedom is an independent organization that formed in the late 1980's. The majority of members of these groups identify themselves as survivors of human rights violations in the mental health system, but MindFreedom does state in their description that

> "membership is wide open to everyone who supports human rights including concerned mental health professionals, advocates, activists, family members and quite possibly you!" (Mindfreedom.org 2005)

In September of 2003 members of MindFreedom joined together to have a hunger strike/fast outside of the national American Psychiatric Association. The strike lasted 22 days and throughout included ongoing media campaigns and statements by both MindFreedom members and the APA. In the original statement members to the public and APA MindFreedom explained, "This fast is about human rights in mental health. The psychiatric pharmaceutical complex is heedless of its oath to 'first do no harm.'"(Mindfreedom.org 2005) Besides aiming to end forced treatment, Mindfreedom members were also challenging the APA to prove that there was a known biological origin of mental illnesses. Since this was so much of the rhetoric used to justify the use of drugs and other damaging treatments, MindFreedom members demanded to see either the scientifically valid evidence or a public statement admitting the lack of scientific evidence to the media, government officials and the general public. Specifically, amongst their demands

MindFreedom members included:

1. EVIDENCE THAT CLEARLY ESTABLISHES the validity of' schizophrenia," "depression" or other "major mental illnesses" as biologically based brain diseases.
2. EVIDENCE FOR A PHYSICAL DIAGNOSTIC EXAM -- such as a scan or test of the brain, blood, urine, genes, etc. -- that can reliably distinguish individuals with these diagnoses (prior to treatment with psychiatric drugs), from individuals without these diagnoses.
3. EVIDENCE FOR A BASE-LINE STANDARD of a neurochemically-balanced "normal" personality, against which a neurochemical "imbalance" can be measured and corrected by pharmaceutical means.
4. EVIDENCE THAT ANY PSYCHOTROPIC DRUG can correct a "chemical imbalance" attributed to a psychiatric diagnosis, and is anything more than a non-specific alteration of brain physiology.
5. EVIDENCE THAT ANY PSYCHOTROPIC DRUG can reliably decrease the likelihood of violence or suicide.
6. EVIDENCE THAT PSYCHOTROPIC DRUGS do not in fact increase the overall likelihood of violence and suicide.
7. FINALLY, that you reveal publicly evidence published in mainstream medical journals, but unreported in mainstream media, that links use of some psychiatric drugs to structural brain changes. (Fast for Freedom News September, 2004),

The fasting group, also had within them a panel of 14 scientists, mainly doctors with PhDs, who would evaluate the evidence produced by the APA.

The APA responded to the initial demands and claims by telling MindFreedom that their actions were “ill-considered,” with general reading suggestions of journal articles (though no specific studies). The group looked at the sources, pointed out that there were no specific studies, and continued on with their demands. This dialogue went on for eleven days with scientists on the panel often pointing out the loopholes and shortcomings of the APA’s suggested reading. Right at the end of the fast the APA released a statement, and several parts of it, while in a very coded language admits to MindFreedom’s claims. The

APA states:

> “B]rain science has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive biomarkers of a given mental disorder or mental disorders as a group.”
>
> “In the absence of one or more biological markers for mental disorders, these conditions are defined by a variety of concepts. ...”
>
> “the lack of a laboratory-based diagnostic test is not unique to mental and behavioral disorders. ...” (Fast For Freedom News September 2004)

In the absence of biological markers, or predictive biomarkers, or laboratory-based diagnostic test, or discernible pathological lesion or genetic abnormalities, what does the psycho-pharmaceutical industry have to point to justify such as severe interventions as psychiatric drugs? If these drugs are not fixing a chemical brain imbalance, as the dominant discourse claims what in fact, are they doing?

The Fast for Freedom received a tremendous amount of both local and national attention and showed the public the shortcomings and mythologies that lead to the injustices of the psycho-pharmaceutical industry. Furthermore, this action did something that was often a struggle in the early days of the movement, which was to combine ex-inmates, professionals, and supporters and thus have the ability to speak to a wide audience. Professionals, academics or those who highly value the scientific tradition as a way of understanding medicine, get a chance to hear from others with a similar background about the myths of mainstream psychiatric discourse. Furthermore, those who have been directly affected by the psycho-pharmaceutical complex get to hear from ex-inmates who have had this experience themselves.

The action was lead by ex-patients, with supporters providing encouragement and professionals using their status to the benefit of the goals of the ex-patients. While I believe those in extreme states and ex-patients deserve a safe space for themselves to help support each other through their unique form of oppression, I also think it is essential in order to be effective, for the movement to include other struggles. So many others fighting oppression can and do connect with issues of the mental health industry. Poverty, (poor living conditions and nutritional deficiencies) is often a catalyst for psychiatric intervention. People of color (particularly African and native Americans) generally receive the harshest diagnoses and the worst treatment in wards, women have disorders specified for them such as “PMS.” Until recently homosexuality was a disease in the DSM, and being transgendered still is. Not having access to education or nutrition, working 2 jobs 7 days a week just to survive, dealing with the trauma of war, are surely going to lead more intro extreme states that will be diagnosed as primarily medical problems. Furthermore, as explained throughout the paper the New Freedom Commission, CIA funded experiments, will also coerce those who may feel there is next to nothing wrong with them into the psychiatric system. Therefore, to be effective the movement against psychiatric oppression must focus on a larger systemic change. This means acknowledging how their oppression is connected to others and both how their actions can serve as a sort of mutual aid for one another.

The Freedom Center too has reached beyond people diagnosed with mental illnesses. Besides having open arms for allies/supporters and having selective professionals work with them Freedom Center also has a coalition with several other groups working for dignity and rights. This includes working with several mental health human rights groups, Health Care for All, the Disability Task Force, a domestic violence shelter, a low-income rights group in Springfield and a group working against prison expansion. The issues that come up with these groups come up frequently on the Freedom Center's email discussion list and are thus a part of the general consciousness of the group. Many of the groups the Freedom Center aligns itself with are also subversive to a capitalist system, which profits from private prisons and private health care.

It is through these alliances and connections across classes, across identities, across geographic locations, that the common vision of all these groups truly shows promises of manifesting. It is through the combined pressure on the system to improve, the autonomous structures of support and alternatives, and the revealing of truth, that the mad movement and movements of oppressed people all over the world offer the possibility of large-scale systemic change.

Indeed, the purpose of this piece is not to suggest that the systematized classist capitalist power structure described is fixed, or impermeable. Though historically embedded, often academically respected, and economically and politically wealthy, the tides begin to change when truth begins to surface and the public dissents. There is no doubt that the harsh rhetoric of early American eugenics history has changed to the generally more gentle diplomatic rhetoric of today partially based on the public's desires and demands. And while that rhetoric still coats a horrific agenda, such as the New Freedom Commission, the words of the public could have a similar power if the camera lens is turned around and the injustice is both seen and called out. The Freedom Center is a beautiful example of those who can lead help the way, once seen as the bottom of the class structure, this community has in ways effectively reclaimed their communities dignity and worked work together towards honesty and healing. The path is lit then, by survivors themselves, for patients and doctors, rich and poor alike to illuminate holographically the myths and manipulations of the mental illness complex as a means of providing an in depth image honesty and healing for the whole scarred society.