PSYCHIATRY AS A TOOL OF REPRESSION

by Jenny Miller

Temkin

Every year millions of people in the U.S. are incarcerated in psychiatric institutions and given brain-damaging psychiatric "treatments," usually without their consent. About one percent of the population will be inmates on a psychiatric ward in any given year, and about ten percent will be psychiatric inmates ("mental patients") at some time in their lives.[1] This does not include the additional millions of inmates of nursing homes, children's detention centers, prisons, as well as out-patients who are forcibly treated with psychiatric drugs. Primarily affected are poor people, women, the elderly, Third World people, the differently-abled, lesbians and gay men, and other groups who lack power in this society. Most psychiatrists are white men with high incomes who are trained to perceive people's feelings of rage, rebellion, despair, and apathy as symptoms of psychiatric pathology, rather than seeing them as natural and valid responses to an extremely oppressive political-economic system.

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Psychiatric inmates have historically been denigrated, experimented on, injured, and even exterminated in the name of healing. In this context it is important to examine the legal rights of psychiatric inmates today, and the most prevalent techniques used to control them: psychosurgery, electroshock, and neuroleptic drugs.

Power of Detention

Legal rights of "mental patients" are almost nonexistent. Even in California, which is considered to have some of the most progressive laws in the country, people may be locked up for an initial 72-hour period, before and during which time they do not have the right to a hearing. The police and certain designated mental health professionals have the power to commit individuals for this period if they think that such persons might

be a danger to themselves or others or are unable to provide for their own needs. In practice, possible reasons for detention are: not having a place to live; fighting with or threatening a family member; talking about or attempting suicide; dressing, eating, or living in a way that a visiting social worker finds unacceptable. Children and teenagers are often committed for running away from home or experimenting with street drugs. Women trapped in the role of "housewife" have been committed for losing interest in housework.

During the initial 72-hour hold, persons so detained are almost always forcibly drugged with powerful "tranquilizers" which make it difficult to talk, concentrate, or read. If the hospital still wishes to hold them after three days, they have a right to a court hearing, but only on request. These hearings usually take place on the grounds of a psychiatric institution. The detained persons are frequently too drugged to read or understand their legal rights and often are inadequately represented by an overworked public defender. If the judge decides they are still a possible danger to themselves or others, or are unable to provide for food, clothing, and shelter, they may be involuntarily incarcerated for an additional 14 days. After that the detained persons may be placed on an additional hold, or subject to conservatorship proceedings, under which they may be repeatedly committed for one year at a time. Almost all of the "rights" officially listed for psychiatric inmates—such as the right to wear their own clothes, the right to make and receive phone calls, the right to receive visitors—can be denied for "good cause" by the doctor in charge or the doctor's designee. During their detention inmates frequently have their hands and feet tied to a bed in leather restraints and may be confined to an isolation cell as punishment.

Even the right to refuse electroshock is not absolute. If individuals are judged by a court to be incapable of giving consent, they can be given shock against their will. Involuntary inmates (those on holds or conservatorship) do not have the right to refuse drugs. While inmates who have voluntarily admitted themselves to an institution technically have the right to sign themselves out and to refuse drugs, they can be quickly converted to involuntary status if the doctor does not agree with their decision.

Lobotomy Then and Now

The first modern lobotomy was performed in 1888 by the Swiss doctor Gustav Burckhardt who removed eighteen grams of healthy brain tissue from a woman in order to "quiet" her. Most of the interest in this century derives from experiments performed in the 1930s by Drs. John Fulton and Carlyle Jacobsen at the Yale Primate Laboratory.[2] They trained two female chimps to perform complicated activities in order to obtain food. When the chimps' attempts were repeatedly unrewarded, they became quick-tempered and confused, which the scientists termed "experimental neurosis." Sometimes the chimps kicked their cages, pulled their hair, and threw their feces at the scientists who were experimenting on them. The frontal lobes of each chimp were completely removed and replaced with sterile oil-soaked cotton. After this operation the chimps lost much of their problem-solving ability and their attempts to gain food met with little success. Since they now exhibited no emotional responses they were considered "cured" of their "neurosis."

One person who was impressed by Fulton and Jacobsen's work was the Portuguese neurosurgeon Egaz Moniz, who immediately began practicing on humans. Instead of removing the frontal lobes (a procedure called lobectomy), he and a young colleague decided to concentrate on destroying the neuronal association fibers underlying the frontal lobes (termed a leucotomy). In their first operation, they cut two one-inch holes in a woman's skull and used pure alcohol to destroy the targeted tissues. In subsequent operations a leucotome (modeled after an apple-corer) was used to remove cores of tissue from the brain. Nine more patients were operated on before the head of the institution, who had been supplying the patients, became alarmed, refused to supply more, and publicly spoke out against the operations. It soon became impossible for Moniz to continue his experiments.

However, two doctors at George Washington University, inspired by Moniz' example, began to perform operations on the human brain. They were Walter Freeman, a professor of neuropathology, and Dr. James Watts, a neurosurgeon. While only Watts was authorized to perform surgery, he allowed Freeman to perform the operations clandestinely, and Freeman strongly urged other psychiatrists who had not been trained in surgery to practice lobotomy. Freeman believed that best results were obtained with women, blacks, Jews, and people with simple occupations—the very best were obtained with black women.[3] "The operation is suitable for a woman of whom you expect nothing but that she do a minimal amount of housework...Women make better victims, they tend to submit more easily to victimization and they have less power in general."[4] Further extolling the virtues of lobotomy, Freeman wrote, "Society can accommodate itself to the most humble laborer, but justifiably distrusts the thinker...Lobotomized patients make rather good citizens."[5]

The first victim chosen by Freeman was a 63-year-old woman who came to him complaining of nervous-

ness, insomnia, and depression. Additional symptoms were that she "bitched" at her husband, was overly scrupulous in her housecleaning, and was "unable to adjust to the idea of growing old." He decided to operate the following day.

Six cores of tissue were removed from the connecting fibers of the left lobe and six from the right side. The next day the patient was unable to remember why she had been upset before coming to the hospital. Five days later she became completely disoriented and temporarily lost her ability to talk. Of the original 20 patients operated on, five were dead within five years.

A new "transorbital lobotomy" technique developed by Italian psychiatrist Amarro Fiamberti was adapted by Freeman in 1946 for use on a mass scale. His instrument was an ice pick that he found in his kitchen drawer. The victim was first rendered unconscious by the application of three electroshock treatments within two minutes. Freeman would insert the ice pick into the conjunctiva—through the orbital bone of the skull, between the eyeball and tear duct—and then swing it in a 30 degree arc. Freeman was not too concerned about sterilization, which he referred to as "that germ crap."

After the introduction of ice pick lobotomy, operations accelerated dramatically in the U.S., from 100 per year to approximately 5000 per year.[6] Between 1936 and

1955 about 50,000 lobotomies were performed in this country. The Veterans Administration's wholehearted acceptance of the technique contributed to its popularity. Lobotomy also received a tremendous boost when Moniz was awarded a Nobel Prize in 1949. (A few years after he received this prize, Moniz was beaten to death by a disgruntled patient.)

It is doubtful, however, that the technique would have achieved wide acceptance if it had not been for Walter Freeman's one-man campaign. Making countless trips to back wards throughout the U.S. he performed thousands of operations, sometimes as many as 25 in one day. (He referred to these as "head-hunting" expeditions and to his lobotomized patients as "trophies.") In recognition of his activities, Freeman was appointed head of the Medical Society of the District of Columbia in 1948, and later that year was elected president of the American Board of Psychiatry and Neurology. It was not until the mid 1950s that the ice pick technique began to fall into disrepute, partly because of the irrefutable evidence of thousands of human vegetables living in back wards, and partly due to the introduction of phenothiazines for the treatment of psychiatric inmates, which were hailed by some as a form of chemical lobotomy.

The history of lobotomy does not end with the demise of the ice pick methodology. As recently as the late 1970s a number of psychosurgeons were still practicing in the U.S., each with his own method of destroying the brain. Psychosurgeons like to claim that these procedures have nothing in common with the older, more crude lobotomy, and it is true that the amount of destruction is less severe. Stereotaxis, the most common of the new methods, destroys brain tissue using thin electrical wires. From 1965 through 1968 approximately 4000 a year were performed for such conditions as: aggression, depression, fear and anxiety, drug addiction, alcoholism, epilepsy, overweight, homosexuality, and so-called hyperactivity in children. It has also been used on prisoners, children labeled retarded, and psychiatric inmates. Hundreds of these operations were performed on black children in Mississippi during the 1970s to "quiet" them down (the same rationale used by Gustav Burckhardt in 1888).[7]

In the late 1960s and early 1970s, professors Mark, Ervin, and Sweet of Harvard University received over a million dollars in government grants to do research in psychosurgery. They had suggested in a letter to the *New England Journal of Medicine* that "ghetto violence" might be prevented by screening for potential rioters and then treating them with psychosurgery. Only a concerted public protest, led by Dr. Peter Breggin, prevented further funding of this project.[8]

One psychosurgeon who is currently active is H. Thomas Ballantine of Massachusetts General Hospital. Psychologists at MIT, operating on government grants to evaluate Ballantine's work, are enthusiastic about psychosurgery as a treatment for depression. Their enthusiasm is echoed in an article in the December 1982 issue of *The American Journal of Psychiatry* in which the authors pay tribute to Moniz and go on to recommend psychosurgery as a "safe and effective treatment for obsessional neurosis."[9]

Electroshock

The use of electroshock was originated by Ugo Cerletti and Lucio Bini in Italy in 1938, when Mussolini was in power. According to Cerletti's journals, he had observed that in slaughterhouses hogs who had been given an electric shock through the temples did not resist having their throats slit. Cerletti's first human victim was a vagrant arrested for riding a train without a ticket. After the first 80 volt shock, the vagrant, who until then had been incoherent, said clearly, "Not another one! It's deadly!" Although Cerletti's colleagues urged him to discontinue his experiment, he ignored them, applying 13 treatments in all to this original victim, at even higher voltages.[10] Even Cerletti himself came to regret his practice of this treatment.

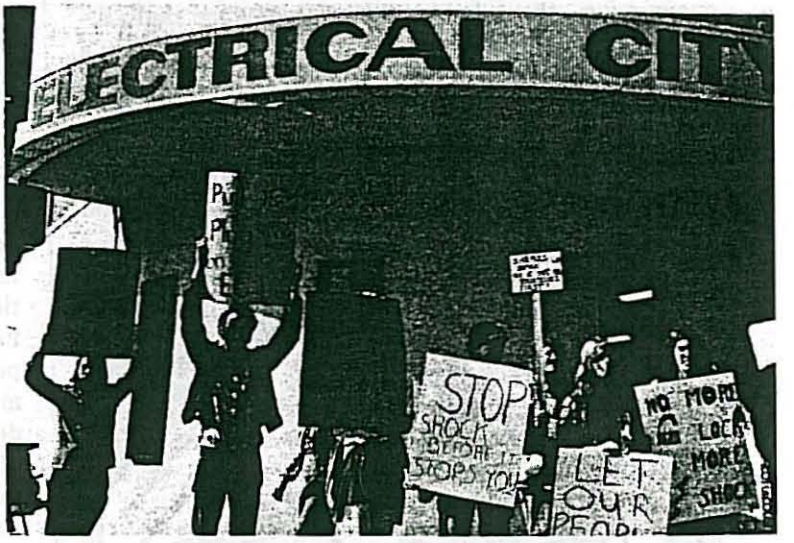
> It was not long after that I witnessed electrically produced convulsions in man...that I came to the conclusion that we must get away from the use of electroshock. When subjecting unconscious patients to such an extremely violent reaction as these convulsions, I had a sense of illicitness and felt as though I had somehow betrayed these patients.[11]

The followers of Cerletti have no such compunctions. Today, a typical shock treatment ranges from 70 to 200 volts, with a current of 500 to 900 milliamperes, about the power consumed by a 100-watt light bulb. The result is a grand mal convulsion similar to an epileptic fit. The number of treatments in a series ranges from 6 to 25 and many people have more than one series performed on them. At least 100,000 people annually receive shock treatment in the United States, and in California, two-thirds of shock recipients are over 45 and two-thirds are women. A survey taken in 1978 by the American Psychiatric Association indicated that 22% of its members used electroshock.[12]

Most psychiatrists now use a sleep-inducing barbituate and a muscle-paralyzing agent such as Anectine to suppress the outward symptoms of the convulsion. As noted by Berkeley neurologist John Friedberg, however,

> These "improvements" are like the flowers planted at Buchenwald...The muscle paralyzer can cause prolonged failure to breathe and cardiac shock. The paralysis may also intensify the horror of the patient's experience...While barbituates make for a smoother trip into unconsciousness, they also increase the chances of death by choking. Although they do produce sleep, they do not bring a complete loss of feeling...One man reported, "All you are aware of is this jolting pain going through your mind like a crowbar."[13]

Testimony before the Berkeley Human Relations and Welfare Commission in April 1982 indicates that the majority of shock recipients are devastated by the experience. Dozens of shock patients came forward to describe how their memories and lives had been severely damaged; none of the recipients testified that they had been helped by the procedure. All three people who testified in favor of electroshock were psychiatrists.



Ken Stein

Anti-electroshock demonstrators on march through downtown Berkeley, CA, 1982.

The early practitioners of electroshock in this country did not attempt to hide the fact that brain damage was the desired goal. For example, Dr. Abraham Myerson wrote: "I think it may be true that these people have, for the time being at any rate, more intelligence than they can handle and that the reduction of intelligence is an important factor in the curative process... The fact is that some of the very best cures that one gets are in those individuals whom one reduces almost to amentia [feeble-mindedness]."[14] In the 1940s there were numerous published reports indicating extensive brain

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damage from electroshock. In recent years the psychiatric profession has attempted to cover itself by ignoring those studies which exist, and by ostracizing any professional who calls for further investigations. John Friedberg, author of *Shock Treatment is Not Good for Your Brain,* was dismissed from his residency at Pacific Medical Center in San Francisco because of his research in this area.[15]

Although shock promoters like to claim that the hazards of brain damage and memory loss which have always been associated with shock are no longer a problem, another Berkeley doctor, psychiatrist Lee Coleman, points out, "Since neither the brain nor electricity has changed since the 1930s, the result is still the same—brain damage." In fact, a greater amount of current is required to produce a convulsion when the person is sedated.[16]

As with the practice of lobotomy, many victims of electroshock die as a result of the treatment. The psychiatric profession has avoided any systematic study of shock deaths, and many of these deaths are officially attributed to other causes. In one 1957 study, Dr. David Impastato, himself an advocate of the treatment, estimated that the rate of immediate death for shock recipients of all age groups was 1 in 1000, while for recipients 60 or older, it was 1 in 200.[17] (One third of the people who received shock in California in 1979 were over 65.)

Electroshock's popularity may be due in part to the fact that it is extremely lucrative. In 1975, when psychiatrists in California were billing $40 to $50 for each treatment, those who relied heavily on shock were earning $100,000 to $200,000 each year, as contrasted with less than $60,000 for psychiatrists who did not use shock. When the price of electroshock was lowered to less than $10 in Quebec, the use of the technique dropped dramatically (the current California rate is about $110 per treatment).[18] Medical insurance companies and government agencies prefer to cover the cost of electroshock over that of verbal therapies, prompting Boston psychiatrist David Viscott to note that finding that the patient has insurance seems to be the most common indication for electroshock.[19]

Psychiatric Drugs

Thorazine, the first of the "major tranquilizers," was introduced in 1954. Within a year it was being administered to an estimated 2 million patients in the U.S. Sales for the manufacturer, Smith, Kline and French (SKF), increased from $53 million in 1953 to $347 million in 1970, largely attributable to the marketing of Thorazine.[20]

Today, neuroleptic drugs such as Thorazine are given to virtually all inmates of psychiatric institutions, as well as to a large percentage of inmates in other institutions and to millions of outpatients as well. The long list of unpleasant effects of neuroleptics includes: painful and uncontrollable muscle cramps, constant writhing and jiggling, drooling, impaired vision, dizziness, lethargy, vomiting, increased depression, hallucinations, epileptic seizures, muscle rigidity, fecal impaction, extreme sensitivity to sunlight, and cerebral edema.[21]

A form of permanent brain damage from the use of neuroleptics, termed tardive dyskinesia, began to be reported in 1957. Tardive dyskinesia (TD) produces grotesque rhythmic and involuntary movements of the face and limbs; cheek-puffing; lip-smacking; chomping of the jaws; repeated tongue thrusts, difficulty speaking and swallowing; jerking of the wrists, fingers and feet.[22] For many years psychiatrists and the drug industry denied the existence of TD, until a 1972 lawsuit forced SKF and other manufacturers to release information on it.

In one study of a New York clinic, outpatients were found to have been taking neuroleptic drugs for an average of four and a half years. Forty-three percent of those studied had TD; 14% of them had been taking the drugs for less than a year.[23] Indicative of staff attitudes toward this disease, the director of one institution stated (under oath at a trial) that while a quarter to one-half of the patients at his hospital might have TD, no patient charts showed this diagnosis. Another psychiatrist testified that most patients who have TD are not aware of it and "are not troubled by it." He also testified that refusal to take these drugs is an expression of the patients' illness.[24]

It is common psychiatric practice to prescribe dosages much higher than the accepted "safe" maximum dose. A case in point is that of Lynette Miller, a 17 year old Black woman who died in 1976 after receiving massive dosages of phenothiazines (a subcategory of neuroleptics). Her mother was recently awarded up to $7.8 million in a wrongful death suit; a doctor testified that Lynette had been receiving about four times the maximum recommended dose of drugs, and that in his opinion her death was caused by the combination of electroshock treatment and phenothiazines.[25]

"Sudden death" is, in fact, a listed "side-effect" of neuroleptics. There are a variety of ways in which these drugs can be fatal: bone marrow poisoning, disturbance of the body's temperature-regulating mechanism, paralysis of the intestines, asphyxiation caused by

interference with the gag reflex, and cardiac arrest. Several years ago a New York medical examiner revealed that 30% of the deaths of psychiatric inmates in Rockland County were directly attributable to the use of psychiatric drugs which caused them to aspirate their own food and vomit. He noted that the death rate for psychiatric inmates from aspiration was twenty times higher than that of non-institutionalized patients, and emphasized: "This is not unique to Rockland County. This is going on in every institution in the state of New York and everywhere in the country. These deaths are not from overdoses. The deaths are occurring at the therapeutic dosage level."[26]

Psychiatrists continue to prescribe these deadly chemicals for several reasons. One is that the use of drugs justifies the psychiatrist's professional existence. Social workers, psychologists, and counselors of all kinds can provide "talk therapy"; only a psychiatrist (with a medical degree) is authorized to provide the somatic (body) therapies: drugs, shock, and psychosurgery. Of these therapies, drugs are the most readily available and can be used to treat an ever-expanding number of people. Secondly, the harmful effects of neuroleptics are not "side-effects" as the psychiatric profession maintains. The incapacitating and addictive qualities of neuroleptics ensures a constant supply of patients for the $15 billion "mental illness" industry. Often the bizarre effects of the drugs are interpreted by both patients and psychiatric workers as "symptoms" of emotional disorder.[27] The neuroleptics are designed to maintain staff control over a large number of potentially rebellious institutionalized people, and in that respect they are extremely effective. So effective in fact that almost the same degree of control can be exerted once the patient is released: she or he can be required to come in every two weeks for a shot of a long-acting phenothiazine such as Prolixin in order to receive a welfare check. (Since the stigma of being an ex-mental patient prevents many former inmates from finding work, especially if they are exhibiting weird drug reactions, they have no choice but to comply.)

Finally, the reason most psychiatrists continue to prescribe neuroleptics is that almost all of their information about them comes from the drug companies. Drug companies spend an estimated $1.5 billion a year in advertising and promotion for prescription drugs, or about $7500 a year for each prescribing doctor. In 1976 drug companies spent $800 million to employ 20,000 "detail men" to convince doctors, hospitals, and pharmacists to buy their product. That same year the drug industry spent $125 million on advertising in medical journals (which accounts for most of these journals' income) and $39 million in direct mail promotion of prescription drugs.[28] In recent years the drug industry has become a major force in a movement to supply "continuing education" to doctors. In addition to sponsoring classes, seminars, and conferences, drug companies pay for free trips to conference sites and provide luxury hotel accommodations.

Drug companies also fund most of the research on psychiatric drugs (as well as funding the journals where research is reported and the conferences where the research is discussed). Peter Schrag, author of *Mind Control*, sums it up this way:

> It's a cozy relationship. Most of the major figures in drug research serve as consultants to drug firms and, at the same time, to NIMH [National Institute of Mental Health] and the Food and Drug Administration, which licenses the drugs. They review each other's grant proposals, sit on the same committees, work on the same studies, write for each other's journals, attend the same meetings, and go to the same parties.[29]

With an estimated 35 million ~~North Americans~~ people in the U.S. who are regular users of some form of psychotropic drug, the industry's profits show no signs of diminishing.

A still from the film "Hurry Tomorrow." Richard Cohen and Kevin Rafferty, Hound Dog Films dist.

Eugenics, Mental Hygiene, and the Killing of Mental Patients

The eugenics movement, which advocated the purification of the human race through sterilization of people considered to be inferior, was founded by English psychologist Francis Galton in the late 1800s. Backed by a number of industrialists, the eugenics movement gained strong support in the U.S., and by 1928 the study of eugenics was standard in most U.S. colleges. Interra-

cial marriage was banned in 30 states, most states passed legislation for the sterilization of "misfits," and immigration from Eastern Europe and Mediterranean countries was limited. Between 1909 and 1934 over 15,000 psychiatric inmates were sterilized in California alone. The American Neurological Association formed a committee in 1934 which, operating on a grant from the Carnegie Institute, concluded that the U.S. should follow the example of Germany which had passed the "Law for the Prevention of Offspring with Hereditary Diseases," setting up over 200 eugenics courts to determine who should be sterilized. Approximately 400,000 people considered to be insane, feeble-minded, or epileptic were sterilized in Germany between 1933 and 1938.[30]

The eugenicists in Germany did not stop with sterilization. In 1920 psychiatrist Alfred Hoche co-authored *The Destruction of Life Devoid of Value,* advocating the "mercy killing" (or euthanasia) of people labeled mentally ill. The mass extermination of German mental patients began in the summer of 1939. Leading psychiatrists such as Max de Crinis, professor of psychiatry at the University of Berlin, and Werner Heyde, professor of psychiatry at the University of Wurzburg, administered the extermination programs. At least 270,000 mental patients were killed according to the Czech War Crimes Commission. The psychiatrists invented techniques for mass killing, and later introduced them into the concentration camps set up to destroy other kinds of "undesirables": Jews, gypsies, homosexuals, political prisoners, etc. A number of psychiatrists involved in the mass murder of mental patients continued with their medical practices after the war.[31]

Support for the elimination of "useless eaters" was expressed by leading physicians in the U.S. as well. Dr. Alexis Carrell, a French-American Nobel Prize winner at the Rockefeller Institute, published his book *Man the Unknown* in 1935, in which he recommended that so-called criminals and mentally ill be "humanely and economically disposed of in small euthanasia institutions supplied with proper gases." And in 1941, Foster Kennedy, chief of neurology at Bellevue Hospital and President of the American Neurological Association, advocated the killing of "unfit and feeble-minded children of at least five years of age" whom he described as "useless and foolish and entirely undesirable." This position was first presented at the annual meeting of the American Psychiatric Association, and later published in the *Journal of the American Psychiatric Association* in July 1942. The *Journal* printed an editorial guardedly endorsing Kennedy's views by pointing out that the only objection to his idea is the "fondness" (quotation marks theirs) of the parents for these children, and suggesting that perhaps the parents' attitudes could be overcome with exposure to the principles of mental hygiene.[32]

Resistance

In May of 1982, sixteen people calling themselves the Psychiatric Inmates Liberation Lobby were arrested while holding a silent vigil in the lobby of of the Sheraton Hotel in Toronto where they were protesting the annual meeting of the American Psychiatric Association (APA). During the protest demonstrators sat in a circle on the floor, holding signs assailing such

THE PSYCHIATRIC RESISTANCE MOVEMENT

The organized psychiatric inmates' liberation movement in North American began with the founding of the Insane Liberation Front in Portland, Oregon, in 1970. Soon thereafter, groups sprang up in New York, Boston, San Francisco, and Vancouver. The first Conference on Human Rights and Psychiatric Oppression was held in Detroit in 1973, and has been held annually ever since, organized by ex-psychiatric inmates in different parts of the U.S. and Canada. In 1972 a group of mental health professionals & ex-inmates came together to publish *Madness Network News,* an anti-psychiatry journal which has become the main source of communication for the movement in the U.S. (The editorial staff is now composed entirely of former inmates.)

The following is a listing of some of the groups active in the movement: the **Network Against Psychiatric Assault (NAPA)** has demonstrated and worked against electroshock treatment in the San Francisco area for the past eight years; the **Alliance for the Liberation of Mental Patients** has successfully organized around the issue of access for advocates to state psychiatric institutions in the Philadelphia area; the **Alternatives to Psychiatry Association** in Lake Worth, Florida, is running a refuge house as an alternative to institutionalization; the **Mental Patients Alliance** in upstate New York holds educational forums on drugs, and anti-shock demonstrations. In Boston, the **Mental Patients Liberation Front** instigated the first class action suit against forced drugging (*Mills* v. *Rogers*); in Pontiac, Michigan, the **Oakland Patients Environmental Nexus** provides legal advocacy to inmates; the **Vermont Liberation Organization** has taken over management of a rooming house to use for housing and meeting space; in Toronto, ex-inmates run a drop-in center, a second hand store, and publish an anti-psychiatry journal called *Phoenix Rising.* There are currently about seventy such groups in North America, Europe, and Australia.

psychiatric crimes as forced treatment of inmates with brain-damaging drugs, electroshock, and psychosurgery. A large crowd of supporters, police, hotel security, reporters, and smirking psychiatrists gathered around the silent group. After an hour and a half, supporters were forced to leave the lobby, and the members of the vigil were dragged and carried to waiting police vans. The demonstrators came from all parts of North America to attend the 10th International Conference on Human Rights and Psychiatric Oppression being held simultaneously with the APA convention in Toronto.

John Wood

Demonstrators protesting the annual meeting of the American Psychiatric Association (APA) conference in Toronto, Canada, 1982.

Each year during the International Conference the anti-psychiatry movement holds a demonstration at an appropriate location. In 1978 hundreds of conference participants and friends demonstrated at Smith, Kline and French headquarters in Philadelphia to protest the vast profits made from the promotion of dangerous chemicals such as Thorazine and Stelazine. Also at that conference, a national boycott was organized of all SKF products. In 1977 the Conference called for a national day of protest against psychosurgery and demonstrations were later held in eight cities.

One of the most dramatic events in the history of the movement was the month-long sit-in, organized by the Network Against Psychiatric Assault (NAPA) and Women Against Psychiatric Assault, in California Governor Jerry Brown's office in 1976 to protest forced labor without pay and forced treatment and incarceration in psychiatric institutions. During the sit-in, several demonstrators met with Brown and showed him the documentary film *Hurry Tomorrow* which depicts life on a locked psychiatric ward in Los Angeles. Not satisfied with his response to their demands, the demonstrators continued the sit-in and held a Tribunal on Psychiatric Crimes in his office, which was attended by 150 people and covered by many radio and TV stations. The immediate effect of the sit-in was to spark an investigation into inmate deaths in the California state hospital system, with a tremendous amount of publicity.

Last November's successful ballot initiative to ban electroshock in Berkeley gained national media coverage for the anti-psychiatry movement. Although NAPA had been publicizing the issue in Berkeley since 1974, and had succeeded in somewhat limiting the power of shock doctors through state legislation, it was not until the Coalition to Stop Electroshock was formed in early 1982 that shock treatment became a major issue in city politics. With 61% of the vote, electroshock became a crime in Berkeley, punishable with six months imprisonment, a fine of not more than $500, or both. The shock doctors are now trying to get a permanent injunction to overturn the ordinance.

Books and Publications by the Psychiatric Inmates' Liberation Movement

- *Madness Network News,* 2054 University Ave., Room 405, Berkeley, CA 94704. Subs are $6 for 6 issues for individuals. Sample copy is $1.
- *Inmates' Voice,* published by the Alliance for the Liberation of Mental Patients, 1427 Walnut, Philadelphia, PA 19102. $5 for 4 issues.
- *Phoenix Rising,* Box 7251, Station 'A', Toronto, Ontario, Canada, M5W 1X9. Subs are $8 in the U.S. Sample copy is $2.50.
- *Big Mama Rag* (feminist newsjournal with strong anti-psychiatry perspective), 1724 Gaylord, Denver, Colorado 80206. Subs are $7. Sample is $1.25.
- *On Our Own: Patient-Controlled Alternatives to the Mental Health System,* by Judi Chamberlin, McGraw-Hill, 1978; from On Our Own, Box 7251, Station 'A', Toronto, Ontario, Canada M5W 1X9, $8.
- *Too Much Anger, Too Many Tears: A Personal Triumph Over Psychiatry,* by Janet and Paul Gotkin, Time Books, 1975, $4.95.

Available from Network Against Psychiatric Assault (NAPA), 2054 University Ave., Room 405, Berkeley, CA 94704:

- *Madness Network News Reader,* Sherry Hirsch *et al.* (eds.), Glide Publications, 1974.
- "Psychiatry as Social Control," 13-page annotated bibliography, $1.50.
- "Psychiatric Drugs," by Dr. Caligari, $3.50.
- *The History of Shock Treatment,* Leonard Frank (ed.), $7.
- "Shock Packet," Leonard Frank and Jenny Miller (eds.), $2.

Although former psychiatric inmates have rightfully taken the lead in the anti-psychiatry movement, the existence of institutions and policies which deny all human rights to those involved, profoundly affects everyone in our society. The problems faced by current and former inmates—denial of housing and jobs, social isolation, invasion of privacy, overcrowding, bad food, exposure to harmful substances, vulnerability to rape and brutality—all are problems faced by millions of people in this country. The "mental health" system encourages us to see these problems as personal, rather than looking to the source: the multi-billion dollar corporations which create an environment and culture where profitability is the only measure of worth. The solution to "emotional problems" cannot be found by turning to experts trained in the arts of power and control. The solutions must be found by trusting ourselves and each other in fighting back against the forces which are daily mystifying, robbing and damaging us. Or as the slogan of the Mental Patients Liberation Front says: "We'd rather by mad with the truth than sane with lies!"□

REFERENCES

1. From U.S. Mental Health Services Register data, reprinted in the *Archives of General Psychiatry,* Vol. 35 (June 1978) p. 688.
2. For the early history of lobotomy see David Shutts, *Lobotomy, Resort to the Knife,* New York: Van Nostrand Reinhold, 1982.
3. Peter Breggin, "The Return of Lobotomy and Psychosurgery," *Congressional Record,* February 24, 1972, pp. E1602-E1612.
4. Joe Heath, "Genocide of the Mind," *Science for the People,* Vol. 6 No. 3 (May/June 1974) p. 10.
5. Shutts, *Lobotomy,* p. 134.
6. Alan Sheflin and Edward Opton, *The Mind Manipulators,* New York: Paddington Press, 1978, pp. 251 and 267.
7. *Ibid.,* pp. 267-269; Peter Breggin, "The Second Wave," *Madness Network News Reader,* Sherry Hirsch *et al.* (eds.), San Francisco: Glide Publications, 1974, p. 89.
8. Sheflin and Opton, *The Mind Manipulators,* pp. 288-320.
9. Elliot Valenstein (ed.), *The Psychosurgery Debate,* San Francisco: W.H. Freeman, 1980, p. 204; Jon Tippin and Fritz Henn, "Modified Leukotomy in the Treatment of Intractable Obsessional Neurosis," *American Journal of Psychiatry,* Vol. 139 (December 1982), pp. 1601-1603.
10. Sheflin and Opton, *The Mind Manipulators,* pp. 355-357.
11. Shutts, *Lobotomy,* p. 95.
12. Bruce Bower, "Berkeley Passes ECT Ban: APA Challenges Move," *Psychiatric News,* Vol. (November 19, 1982); *Annual Report to the California State Legislature on Electroconvulsive Therapy,* California Department of Mental Health, Sacramento, 1979; American Psychiatric Association Task Force Report No. 14 on Electroconvulsive Therapy, Washington, D.C., September 1978.
13. John Friedberg, "Let's Stop Blasting the Brain," *Psychology Today,* Vol. 9 (August 1975) p. 23.
14. David Rorvik, "Electroshock: The Horror Continues," *Penthouse,* Vol. (June 1982) p. 152.
15. John Friedberg, *Shock Treatment is Not Good for Your Brain,* San Francisco: Glide Publications. 1976, p. 14.
16. Lee Coleman, "Electric Shock Treatment is Increasing in Popularity," *Oakland Tribune,* April 23, 1982, p. ; Peter Breggin, "Disabling the Brain with Electroshock," in Maurice Dongier and Eric Wittkower (eds.), *Divergent Views in Psychiatry,* Hagerstown: Harper & Row, 1981, p. 252.
17. Peter Breggin, *Electroshock: Its Brain-Disabling Effects,* New York: Springer Publishing, 1979, p. 62.
18. Scheflin and Opton, *The Mind Manipulators,* p. 402; Rob Haeseler, "Startling Ballot Fight Over Shock Therapy," *San Francisco Chronicle,* October 22, 1982, p. 29.
19. Leonard Frank *et al.*, "NAPA Responds to Cosmo Fabrications," *Madness Network News,* Vol. 6 (Summer 1982) p. 34.
20. Andrew Scull, *Decarceration: Community Treatment and the Deviant, A Radical View,* New Jersey: Englewood Cliffs, 1977, pp. 79-80.
21. Dr Caligari, *Psychiatric Drugs,* Berkeley: Network Against Psychiatric Assault, 1978; for a complete list for each drug see the *Physician's Desk Reference.*
22. J. Horowitz, "The Hidden Cost of Mind Medicines," *Human Behavior,* Vol. 7 (May 1978) pp. 53-54.
23. Dr Caligari, "The Tardive Dyskinesia Epidemic," *Madness Network News,* Vol. 5 (Autumn 1978) p. 1.
24. Peter Sterling, "Psychiatry's Drug Addiction," *The New Republic,* Vol. 181 (December 1979) p. 16.
25. Jenny Miller, "It Could Have Been You," *Plexus,* Vol. 9(September 1982), p. 1.
26. Richard Hughes and Robert Brewin, *The Tranquilizing of America,* New York: Warner Books, 1979, p. 176.
27. Testimony by Judi Chamberlin to Senate Subcommittee to Investigate Juvenile Delinquency, August 18, 1975, Washington, D.C.: U.S. Government Printing Office, 1977, p. 88.
28. Hughes and Brewin, *The Tranquilizing of America,* pp. 210 and 217.
29. Shrag, *Mind Control,* pp. 123-124. Pantheon 1978
30. Lenny Lapon, "Psychiatry: Tool of Fascism," *Madness Network News,* Vol. 6 (Summer 1982), p. 1; Samuel Chavkin, *The Mind Stealers,* Boston: Houghton Mifflin, 1978, pp. 162-163; Shutts, *Lobotomy,* pp. 46-47.
31. Lenny Lapon, "Psychiatry's Final Solution," *Inmates' Voice,* Vol. 1 (Fall 1982) pp. A-2, A-7 and A-8; Peter Breggin, "The Killing of Mental Patients," in Hirsch, *Madness Network News Reader,* p. 151.
32. Bernard Schreiber, *The Men Behind Hitler,* San Francisco: Section Five Books, 1982, pp. 23-24; "Euthanasia," *American Journal of Psychiatry,* Vol. 99 (July 1942) pp. 141-143.