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**SCHISMATIC MIND: CONTROVERSIES OVER THE
CAUSE OF THE SYMPTOMS OF SCHIZOPHRENIA**

A thesis submitted in fulfilment of the
requirements for the award of the degree

DOCTOR OF PHILOSOPHY

from

UNIVERSITY OF WOLLONGONG

by

RICHARD GOSDEN, BA Honours (First Class)

Science, Technology and Society Program

2000

Certification

I hereby declare that this thesis is my own work and has not been submitted for a degree to any other university or institution.

Richard Gosden

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Abstract

Doubts about the real nature of schizophrenia are long-standing. There are no laboratory tests to confirm diagnoses and it is not certain whether there is consistency in the diagnostic process. Various models have been developed to explain the cause of the symptoms. The dominant explanatory model is based on medical assumptions that the symptoms are pathological and are caused by an illness of the mind or brain. The medical model embraces a wide variety of psychological and biological theories of aetiology but there is no scientific/medical consensus and all the evidence supporting medical theories is equivocal. This apparent confusion gives rise to questions concerning the validity of a medical interpretation. Alternative, non-medical models explain the cause of the symptoms as being either a mystical/spiritual emergency (mystical model) or as social alienation (myth-of-mental-illness model).

When a comparative analysis of the medical, mystical and myth-mental-illness models is undertaken in the light of interest group theory it is apparent that competing interest groups are promoting different explanatory models to achieve political ends. A key determinant of this political struggle involves the selection and emphasis of conflicting human rights imperatives. Human rights are central to the issue of schizophrenia because people who display the symptoms tend to be socially disruptive and, as a result, are frequently hospitalised involuntarily and forcibly treated with drugs that are mentally and physically debilitating.

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Publications in Support of the Thesis

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Richard Gosden, 'Early Psychosis', Correspondence Column, British Journal of Psychiatry, Vol. 174, May 1999, p. 461.

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1. Introduction

Objectives of the Thesis

Psychiatric researchers are currently investigating many widely divergent theories about the cause of schizophrenia. This lack of consensus about the cause has been largely hidden from the public so as not to undermine increasingly strident psychiatric claims that drug treatment is essential at the earliest signs of schizophrenic symptoms. There is an urgent need to reinform the public about the aetiological confusion surrounding schizophrenia because it points to an inherent irrationality in the psychiatric imperative to impose drug treatment.

The treatment imperative is currently being accompanied by an international lobbying campaign to alter mental health legislation and make it easier for psychiatrists to force treatment on unwilling patients. This campaign appears to be largely funded by drug companies which are seeking to expand markets for their new schizophrenia drugs. (See Chapter 10). There are two essential goals of this drug marketing strategy. The first is to extend the definition of schizophrenia into a pre-psychotic phase and thereby lay the groundwork for a drug-based preventive medicine campaign. The second is to introduce new legal devices that provide for involuntary treatment of schizophrenics while they remain living in their own homes.

Schizophrenia drugs (neuroleptics), including the newer ones, are dangerous and can cause sudden death, brain damage and a wide range of debilitating side-effects. On top of this it is hotly disputed whether these drugs have any beneficial effect for the users. Opponents of drug treatment argue they are only prescribed as ‘chemical strait-jackets’ to control people who are disruptive, or who might be disruptive.

An intention of the thesis is to cast doubt on the wisdom of extending psychiatric coercion by demonstrating that the medical model is only one of three meta-models for explaining the cause of schizophrenia. Of these three models only the medical model provides a rationale for psychiatric practice. The other two explanatory models are the mystical and myth-of-mental-illness models. Critical analyses of the medical model, making up the existing body of antipsychiatry literature, lack completeness and sophistication in not subdividing non-medical approaches into these two clearly defined alternatives.

A further objective of the thesis is to demonstrate that each of the three models give rise to different and conflicting human rights imperatives. This means that the human rights entitlements of people diagnosed with schizophrenia largely depend on the model through which the cause of the symptoms is viewed. While the medical model gives rise to the much touted ‘right to treatment’ and ‘informed consent’, the mystical model supports ‘the freedom of thought and belief’ and the myth-

of-mental-illness model favours ‘the right to liberty’ and the right not to be subjected to ‘torture, or cruel, inhuman or degrading treatment or punishment’.

Overall, the thesis sets out to demonstrate that psychiatrists have coercive powers to monopolise a subject they do not properly understand. By imposing drug treatments on unwilling patients psychiatrists routinely violate basic human rights. Most psychiatrists are unaware of these routine violations because they only view the symptoms of schizophrenia through the limited perspective of the medical model.

Methodology and Underlying Theoretical Perspective of the Thesis

The methodology used for researching the knowledge base of this thesis has involved an extensive review and analysis of the relevant literature; review and analysis of relevant internet sites; extensive participation in email and internet discussion groups comprised of psychiatric survivors, and recovering/recovered schizophrenics; extensive personal correspondence with members of these discussion groups; correspondence with mental health professionals and attendance at conferences and seminars on mental health issues and aspects of schizophrenia.

The opportunity to participate in email discussion groups with people who have first-hand experience of the symptoms of schizophrenia has been especially fruitful. The cross-section of discussion groups chosen provided daily access over a number of years to several hundred people who argued incessantly about the correct interpretation of their mental experiences. Differences of opinion about explanatory models for unusual psychological experiences were a constant feature of these debates. They also engaged in articulate, and often passionate, debate about the value of psychiatric interventions and the injustice of involuntary treatment.

Email discussion groups are a relatively new tool for social sciences research that provide distinct advantages over more traditional methods like face-to-face interviews. The most significant advantages are the informality and spontaneity of the dialogues; the positioning of the researcher as a discussant rather than an interrogator; the international reach of the research; and the easy storage and retrieval of written records of dialogues.

The theoretical perspective supporting this thesis is a combination of interest group theory and human rights law. The premise is that interest groups are driving the controversy over the cause of schizophrenia by favouring particular philosophical and scientific points of view. At the same time these interest groups are also rejecting competing knowledge claims which might damage their group interests. This process of knowledge selection with respect to schizophrenia is sometimes

conducted in a highly charged emotional atmosphere and the normal scientific simulation of objectivity is not always apparent.¹

In their efforts to win public support some of the proponents of the competing philosophical positions have adopted conflicting articles of human rights law.² These human rights have multiple uses: they are used as a focus for organising and coordinating the interest groups supporting particular positions; they are used in lobbying governments to give urgency to demands; and they also serve as moral cudgels for use against opponents in the struggle for moral ascendancy.³

This struggle for epistemological and moral ascendancy is multi-dimensional and can be analysed from a number of different perspectives. In order to give coherence to the analysis this field was narrowed down to one dimension by using, as an analytical framework, the most fundamental of the schizophrenia controversies — the controversy over aetiology. This approach allowed subsidiary controversies — like the nosological controversy, involving the psychiatric classification system which identifies the symptoms of schizophrenia as a disease in the first instance; the diagnostic controversy;⁴ the controversy over treatments; and the controversy over the coercion that is often involved in the treatment of people diagnosed with schizophrenia⁵ — to be explored and analysed as they arise in the discourse.

The controversy over aetiology is brought into focus by dividing the field of contention into a philosophical level and a scientific/psychiatric level. On the philosophical level there are three competing models which variously argue that the cause of schizophrenic symptoms is (1) pathological (Medical Model), that it is (2) natural (Mystical Model), and that it is (3) non-existent (Myth-of-Mental Illness Model).

This philosophical level has not been subjected to sophisticated analysis in the past and other analysts have been content with a simple dichotomy between the medical model and a generalised

¹ The medical model for schizophrenia includes numerous conflicting aetiological theories that sometimes have little supporting evidence. The absence of normal scientific simulation of objectivity is particularly evident when psychiatrists make statements in support of their own branch of research as if it has consensual acceptance. For example, “Schizophrenia is a brain disease, now definitely known to be such. It is a real scientific and biological entity as clearly as diabetes, multiple sclerosis, and cancer are scientific and biological entities.”, in E. Fuller Torrey, Surviving Schizophrenia: A Family Manual, Harper Colophon Books, New York, 1983, p. 2.

² See for example, Baruch A. Brody and H. Tristram Engelhardt, Jr., eds., Mental Illness: Law and Public Policy, D. Reidel, Dordrecht, 1980.

³ See for example, Support Coalition, ‘National Organisation Escalates a Chemical Crusade, Angering Human Rights Advocates’, Dendron, Nos. 37-38, Summer 1996, pp. 8-9.

⁴ See for example, Samuel I. Cohen, ‘Overdiagnosis of schizophrenia: role of alcohol and drug misuse’, The Lancet, Vol. 346, No. 8989, Dec 9, 1995, pp. 1541-1543.

⁵ See for example, Paul Kaihla, ‘A Mother’s Tragic Tale: Citizens demand changes to laws on committing schizophrenics’, Maclean’s, Vol. 108, No. 10, March 6, 1995, pp. 56-59.

non-medical model,⁶ without separating the non-medical arguments into the two clearly defined alternatives. It is necessary to separate the arguments opposed to the medical model because attached to each of the three philosophical positions are conflicting human rights imperatives which are used to focus and promote the arguments of disparate interests.

Beneath the philosophical level of the aetiological debate is another scientific/psychiatric level of controversy. This scientific/psychiatric level is an extremely rich field of controversy that is wholly subsumed within the medical model. The psychiatric controversies about the cause of schizophrenic symptoms are, in the first instance, concerned with a dichotomy between arguments for a biological cause, on the one hand, and an environmental/experiential cause on the other.⁷ There is also a position which sits mid-way between these two alternatives which combines both.⁸ This mid-way position is sometimes called a ‘biopsychosocial’ approach and argues that an underlying brain defect makes a person vulnerable to psychological and/or socially induced stress, which triggers schizophrenia.⁹

On the biological side of the dichotomy there is strong support for drug treatment and a feed-back loop reinforces the association between assumptions of a biological cause and the prescription of drugs.¹⁰ The feedback loop is propelled by observations that some drug treatments ameliorate some of the symptoms of schizophrenia.¹¹ This observation provides the argument supporting practitioners of biomedical psychiatry that effective pharmaceutical treatments indicate a biological cause.¹² The assumption of a biological cause in turn promotes the search for more effective drugs.¹³

A similar feed-back loop exists on the other side of the debate in the relationship between theories about environmental/experiential causes and talking therapies. When talking therapies are observed to ameliorate the symptoms this provides evidence that the cause of schizophrenia can be found

⁶ See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels: The Revolt Against The Mental Health System, Open Court, Chicago, 1993.

⁷ Donald W. Black, William R. Yates and Nancy C. Andreasen, ‘Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders’, in John A. Talbott, Robert E. Hales and Stuart C. Yudofsky, eds., Textbook of Psychiatry, American Psychiatric Press, Washington, 1988, pp. 378-385.

⁸ A. Furnham, and P. Bower, ‘A Comparison of Academic and Lay Theories of Schizophrenia’, British Journal of Psychiatry, No. 161, 1992, pp. 201-210.

⁹ Jon McClellan and John Werry, ‘Practice parameters for the assessment and treatment of children and adolescents with schizophrenia’, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 33, No. 5, June 1994, pp. 616-636.

¹⁰ A. A. Grace, ‘The Depolarization Block Hypothesis of Neuroleptic Action: Implications for the Etiology and Treatment of Schizophrenia’, Journal of Neural Transmission, No. 36, 1992, pp. 91-131.

¹¹ Norman Keltner, ‘Antipsychotic Drugs’, in Norman Keltner, Lee Hilyard Schwecke and Carol E. Bostrom, eds., Psychiatric Nursing, Mosby, St. Louis, 1995, pp. 227-249.

¹² Harvard College, ‘Schizophrenia Update’, The Harvard Mental Health Letter, June 1995.

¹³ Steve Carrell, ‘Coming: host of schizophrenia drugs with lesser side effects’, Drug Topics, Vol. 139, No. 14, 24 July, 1995, p35.

somewhere in the patient's past experience or environment.¹⁴ The development of theories about a variety of experiential and environmental stresses which might trigger schizophrenic symptoms¹⁵ has allowed for the emergence of a number of talking therapies which purport to ameliorate the stresses.

Although the combined biological/environmental position doesn't have the same kind of feed-back loop to reinforce its position it does have the facility of being able to support whatever treatment a therapist finds is convenient or profitable.¹⁶ Needless to say, drug treatment does not support arguments for an environmental/experiential cause, nor does talking therapy support the biological position.

The assumption of a biological cause leads to a range of different arguments about the exact nature of the biological defect that causes schizophrenic symptoms. These hypotheses range widely including theories about genetic defects,¹⁷ viral infections,¹⁸ imbalances in brain chemistry¹⁹ and defects in brain architecture.²⁰ On the environmental/experiential side of the psychiatric level of controversy there is a similarly wide ranging set of hypotheses to choose between. This range includes theories about the so-called 'schizophrenogenic mother'²¹, family stress,²² double-bind theory,²³ social structure²⁴ and traumatic past experiences,²⁵ as all being possible originating causes for schizophrenic symptoms.

¹⁴ D. A. Wasylenki, 'Psychotherapy of Schizophrenia Revisited', Hospital & Community Psychiatry, Vol. 43, No. 2, 1992, pp. 123-127.

¹⁵ I. R. Nicholson and R. W. Neufeld, 'A Dynamic Vulnerability Perspective on Stress and Schizophrenia', American Journal of Orthopsychiatry, Vol. 62, No. 1, 1992, pp. 117-130.

¹⁶ P. Weiden and L. Havens, 'Psychotherapeutic Management Techniques in the Treatment of Outpatients with Schizophrenia', Hospital & Community Psychiatry, Vol. 45, No. 6, 1994, pp. 549-555.

¹⁷ D. F. Levinson and B. J. Mowry, 'Defining the Schizophrenia Spectrum: Issues For Genetic Linkage Studies', Schizophrenia Bulletin, Vol. 17, No. 3, 1991, pp. 491-514.

¹⁸ E. F. Torrey, 'A Viral-Anatomical Explanation of Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 15-18.

¹⁹ P. Riederer, K. W. Lange, J. Kornhuber and K. Jellinger, 'Glutamate Receptor Antagonism: Neurotoxicity, Anti-Akinetic Effects, and Psychosis', Journal of Neural Transmission, No. 34, 1991, pp. 203-210.

²⁰ S. E. Arnold, B. T. Hyman, G. W. Van Hoesen and A. R. Damasio, 'Some Cytoarchitectural Abnormalities of the Entorhinal Cortex in Schizophrenia', Archives of General Psychiatry, Vol. 48, No. 7, 1991, pp. 625-632.

²¹ John Neill, 'Whatever Became of the Schizophrenogenic Mother?', American Journal of Psychotherapy, Vol. 44, No. 4, 1 October, 1990, pp. 499-506.

²² R. D. Laing and A. Esterson, Sanity, Madness and the Family, Penguin, Hammonds Worth, 1970.

²³ G. Bateson, D. D. Jackson, J. Haley and J. H. Weakland, 'Toward a Theory of Schizophrenia', Behavioral Science, No. 1, 1956, pp. 251-264.

²⁴ August B. Hollingshead and Fredrick C. Redlich, Social Class and Mental Illness: A Community Study, John Wiley & Sons, New York, 1958.

²⁵ Gavin Cape, Daniel Antebi, Penny Standen and Christine Glazebrook, 'Schizophrenia: The Views of a Sample of Psychiatrists', Journal of Mental Health, Vol. 3, No. 1, January, 1994, pp. 105-114.

It is not proposed to explore the full extent of these scientific/psychiatric theories in this thesis. They are too numerous and many of them readily divide into sub-branches of controversy. It is intended to only discuss the various controversies on this psychiatric level in sufficient detail to demonstrate that, despite the hyperbole about imminent breakthroughs, supporters of the medical model are actually in a state of great uncertainty about the cause of schizophrenia.

In the final chapter it is proposed to examine the three main competing aetiological models — the medical, mystical and myth-of-mental-illness models — by comparing the persuasiveness of their explanatory frameworks against a newly expanded concept of schizophrenia called early psychosis. Early psychosis includes a supposed pre-psychotic stage of schizophrenia. Early psychosis identification and intervention programmes are already operating in Australia as a preventive medicine campaign against schizophrenia but the symptomatology and treatment techniques are still in the experimental stage. This means the psychiatric profession has yet to reach consensual agreement on many aspects and so it is an area in which the mystical and myth-of-mental-illness models of schizophrenia aetiology can compete on a more even footing with the medical model.

The conclusion of the thesis finds that neither the medical, the mystical nor the myth-of-mental-illness models, on their own, successfully explain schizophrenia for the full range of people who receive a diagnosis. At the same time, each of these models give plausible explanations for some of the people. It is therefore apparent there are three entirely different classes of people who are wrapped up in the package of schizophrenia. One class has social problems but no mental or physical problems (myth-of-mental-illness model). Another class has some very serious mental problems but they are mystical/religious problems and are therefore well outside the province of medical expertise (mystical model). A third class has medical problems — like substance-induced disorders, infection or head injury — but members of this class should be diagnosed with, and treated for, these physical conditions, rather than schizophrenia.

A diagrammatic plan of the thesis framework appears on the following page. In relation to this diagram **Chapter 3** provides an overview of the medical model which is covered by the heading of **Pathological**. **Chapter 4** discusses the psychiatric dichotomy and the proliferation of models under the heading of **Psychiatric Level**. **Chapter 5** deals with interest groups and human rights imperatives associated with the medical model. **Chapters 6-7** discuss the mystical model and its associated interest groups and human rights imperatives which the diagram positions under the heading of **Natural**. **Chapters 8-9** discuss the myth-of-mental-illness model covered under the heading of **Non-Existent**. **Chapter 10** tests the three models by feeding them into the putative pre-psychotic phase of schizophrenia called **Early Psychosis**.

This diagrammatic plan juxtaposing the various elements of controversy over the cause of the symptoms of schizophrenia was developed for this thesis and is an original contribution to the

understanding of schizophrenia. It has provided the outline for the many unique lines of inquiry which have been pursued in researching the thesis. These original contributions include: the juxtaposing and comparative analysis of three distinct meta-models for explaining the cause of schizophrenic symptoms; the comparative analysis of conflicting human rights imperatives which are separately attached to each of the three meta-models; the description and analysis of mystical experience and its comparison with schizophrenic symptoms; and the application of Article 18 of the International Covenant of Civil and Political Rights to the problem of involuntary treatment for schizophrenia. To the best of my knowledge Article 18 has not been applied in this way before. This is probably because there has been no prior serious attempt to analyse the human rights associated with mystical experience and the violations that occur as a result of psychiatric interference. The critical analysis of pre-psychotic detection and intervention programmes for schizophrenia is also an original contribution. There will undoubtedly be a lot more critical analysis of preventive medicine campaigns against schizophrenia as psychiatric theories about pre-psychotic detection and treatment are taken up in North America and Europe.

A Brief Description of Schizophrenia

Psychosis is a psychiatric term used to describe a state of altered consciousness in which people appear to lose the ability to control their own minds and behaviour.²⁶ Traditional descriptions of this condition use words like madness, insanity and lunacy²⁷ and it is generally understood, by psychiatrists and lay people alike, that a state of psychosis is clearly distinct from other, milder forms of mental deviance like neurosis, personality disorders and substance abuse.²⁸

In psychiatric classification systems²⁹ schizophrenia is usually classified as the most serious sub-type of a spectrum of psychotic disorders. The principal symptoms of schizophrenia are hallucinations, delusions and disordered thinking. The hallucinations are usually in the form of inner voices which pass judgement on the person experiencing them. The inner voices also frequently appear to supply the person with esoteric knowledge about religious and political affairs and reveal secret meanings behind everyday events that are hidden from normal people. Delusional beliefs are formed from these internal experiences and disordered thinking often accompanies attempts to communicate the beliefs to other people.³⁰

²⁶ Frederick J. Frese, 'A Calling', Second Opinion, Vol. 19, No. 3, 1994, pp. 10-26.

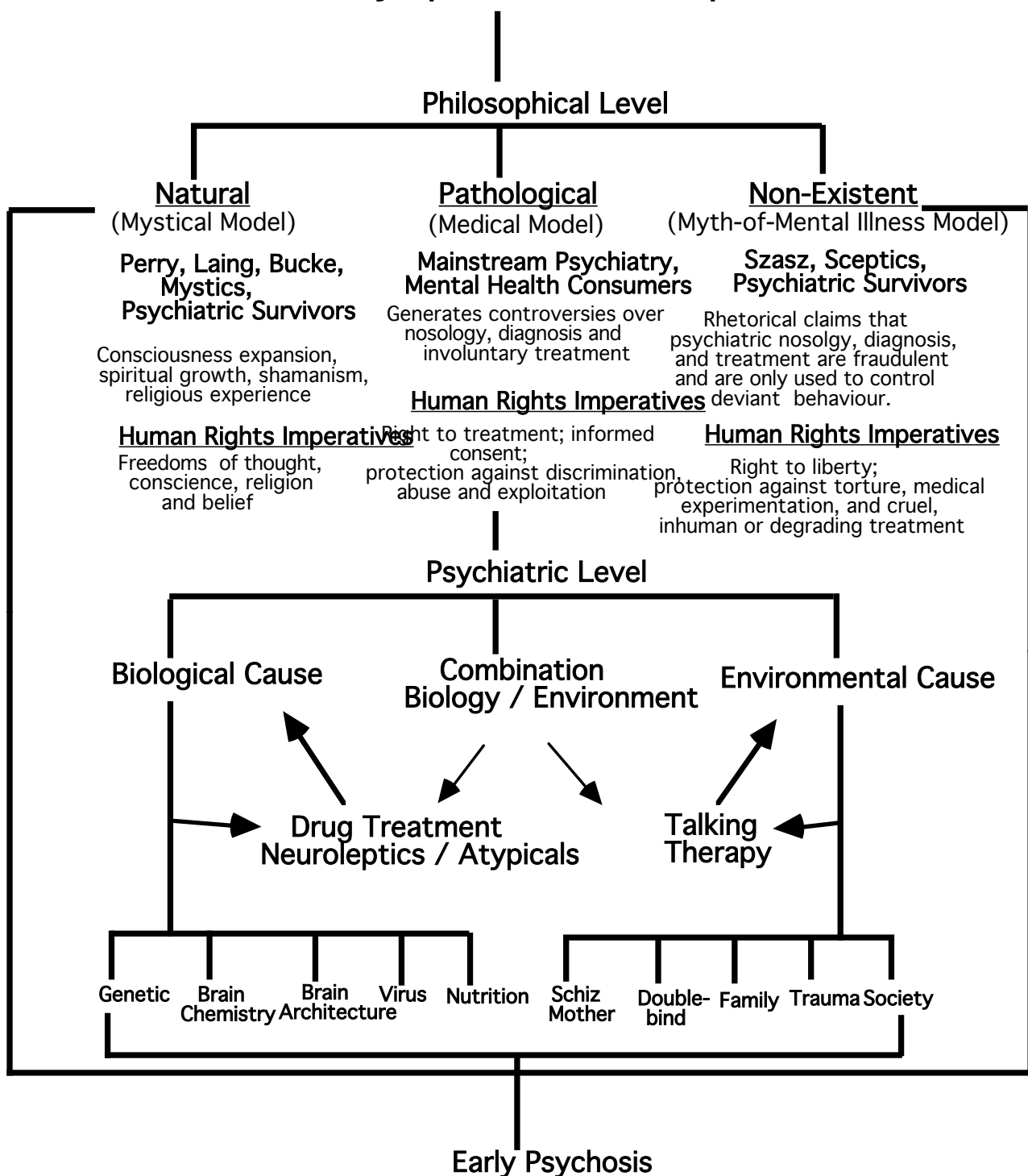
²⁷ Thomas Szasz, 'Idleness and Lawlessness in the Therapeutic State', Society, Vol. 32, No. 4, 1995, pp. 30-36.

²⁸ Samuel I. Cohen, 'Overdiagnosis of schizophrenia: role of alcohol and drug misuse', The Lancet, Vol. 346, No. 8989, 1995, pp. 1541-1543.

²⁹ See for instance, American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth ed American Psychiatric Association, Washington, 1994; and, World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines World Health Organisation, Geneva, 1992.

³⁰ Robert Taibbai, 'Schizophrenia: living in a nightmare', Current Health, Vol. 20, No. 2, 1993, pp. 30-32.

Controversies Over The Cause Of The Symptoms Of Schizophrenia



Before diagnosing schizophrenia psychiatrists must first eliminate the possibility that the symptoms have a somatic cause like infection, intoxication or head injury. There are no laboratory tests to verify the presence of schizophrenia and identification of the condition relies solely on the subjective opinions of diagnosticians. The absence of laboratory tests to confirm diagnoses gives rise to doubts about the diagnostic certainty of the symptoms, whether there is uniformity in the

recognition of symptoms, and whether the thoughts and beliefs of individuals who receive a diagnosis are necessarily pathological.

Schizophrenia Controversies

Despite almost one hundred years of recognition as a valid and distinct mental illness by mainstream psychiatry,³¹ most aspects of schizophrenia still remain controversial. There is controversy about the psychiatric nosology (classification system) that identifies a diverse range of schizophrenic signs as symptoms of a discrete mental disorder;³² there is controversy about the classification of sub-types of schizophrenia;³³ there is controversy over the diagnostic techniques and the efficacy of diagnosis for the condition;³⁴ there is controversy over treatments,³⁵ particularly when the treatment is given without informed consent;³⁶ and there is controversy over the aetiology, or cause, of schizophrenia.³⁷

Most of the schizophrenia controversies have long and frustrating histories of claim and counter claim without approaching closure.³⁸ However, a belief has developed within some sections of the psychiatric profession in recent years that most of these disagreements are now close to resolution. The line of scientific research generating a lot of this optimism is concerned with new techniques in brain imaging³⁹ which, it is claimed, promise to demonstrate once and for all that schizophrenia has a biological cause and that people who manifest the condition have brains that are structurally different from those of normal people.⁴⁰ A second line of research, generating similar levels of

³¹ See for instance, German Berrios and Roy Porter, eds. A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders New York University Press, New York, 1996.

³² Steven S. Sharfstein, (Review), 'The Selling of DSM: The Rhetoric of Science in Psychiatry, Social Problems and Social Issues', JAMA, The Journal of the American Medical Association, Vol. 270, No. 14, 1993, pp. 1749-1751.

³³ Nancy C. Andreasen, 'Symptoms, signs, and diagnosis of schizophrenia', The Lancet, Vol. 346, No. 8973, 1995, pp. 477-483.

³⁴ See for instance, Gabrielle A. Carlson, Shmuel Fenning and Evelyn J. Bromet, 'The confusion between bipolar disorder and schizophrenia in youth: where does it stand in the 1990s?', Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 33, No. 4, 1994, pp. 453-461.

³⁵ See for instance, Matthew J. Kleinerman, 'Controversy grows over monitoring system for new schizophrenia drug', JAMA, The Journal of the American Medical Association, Vol. 264, No. 19, 1990, pp. 2488-2490.

³⁶ James Willwerth, 'Madness in fine print: using mentally ill subjects for psychiatric experiments too often means extracting and relying on their ill-informed consent', Time, Vol. 144, 7 November 1994.

³⁷ Scott O. Lilienfeld, 'Pseudoscience in Biological Psychiatry: Blaming the Body', Skeptical Inquirer, Vol. 19, No. 6, 1995, p. 45.

³⁸ See for instance, Andrew Scull, Charlotte Mackenzie and Nicholas Herve, Masters of Bedlam: The Transformation of the Mad-Doctoring Trade, Princeton University Press, Princeton, 1996.

³⁹ J. M. Cleghorn, R. B. Zipursky and S. J. List, 'Structural and Functional Brain Imaging in Schizophrenia', Journal of Psychiatry & Neuroscience, Vol. 16, No. 2, 1991, pp. 53-74.

⁴⁰ S. A. Bachneff, 'Positron Emission Tomography and Magnetic Resonance Imaging: A Review and a Local Circuit Neurons Hypo(dys)Function Hypothesis of Schizophrenia', Biological Psychiatry, Vol. 30, No. 9, 1991, pp. 857-886.

optimism, concerns claims that the treatment debate will soon be closed due to pharmaceutical breakthroughs in the development of a new generation of drugs to treat schizophrenia.⁴¹

If the developments in brain imaging do lead to the identification of a biological aetiology for schizophrenia it is hoped this will also lead to the eventual closure of the controversy over diagnosis, as well. It follows that if brain imaging can detect consistent abnormalities in the brains of people with schizophrenia, and it can be further demonstrated that these abnormalities cause the schizophrenic symptoms, then it is thought that it might also become possible to use brain imaging as a front line diagnostic technique for detecting the condition.⁴²

Yet even if the aetiological, diagnostic and treatment controversies do reach closure there might still remain a controversy over the psychiatric nosology that identifies schizophrenic thinking and belief patterns as pathology. The problem here is that there are philosophical and religious aspects attached to this part of the schizophrenia debate that are deeply entrenched in the history of human experience.⁴³ It is not at all certain that closure of this aspect of the schizophrenia debate would necessarily follow a scientific demonstration of a correlation between schizophrenic symptoms and brain abnormalities.

To put it simply, there is a school of thought that is willing to argue that the experience of schizophrenia is not always harmful and that it can actually be beneficial for some people.⁴⁴ The proponents of this line, if confronted with evidence of a correlation between brain abnormalities and symptoms, might simply argue that the same type of correlations can probably be found between the heightened sensory abilities of some people and structural variations in their relevant sensory organs. What is at issue in the nosological controversy is not simply the identification of abnormalities, but whether the abnormalities associated with schizophrenia are rightly judged to be pathological.

The question about whether the symptoms of schizophrenia should be necessarily treated as pathology is part of a larger debate about the wisdom of an increasing tendency to medicalise various forms of mental and behavioural deviance that hitherto have been more closely associated with questions of character, intelligence, morals and discipline.⁴⁵ The expansion of psychiatric

⁴¹ P. M. Ryan, 'Epidemiology, Etiology, Diagnosis, and Treatment of Schizophrenia', American Journal of Hospital Pharmacy, Vol. 48, No. 6, 1991, pp. 1271-1280.

⁴² Daniel R. Weinberger, 'From neuropathology to neurodevelopment (Schizophrenia, part 2)', The Lancet, Vol. 346, No. 8974, 1995, pp. 552-558.

⁴³ See for instance, Joseph Campbell, 'Schizophrenia — the Inward Journey', in Joseph Campbell (eds), Myths To Live By, Condor Book, New York, 1970, pp. 201-232.

⁴⁴ See for instance, John Weir Perry, The Far Side of Madness, Prentice-Hall, Englewood Cliffs, New Jersey, 1974; R. D. Laing, The Politics of Experience, Penguin, Harmondsworth, 1967.

⁴⁵ See for instance, Paula J. Caplan, They Say You're Crazy, Addison-Wesley, Reading, Massachusetts, 1995.

practice into new areas appears to be associated with a commensurate increase in psychiatric coercion.

Expanding the Diagnostic Net

The significance of the trend to expand the net of psychiatric diagnosis can be brought into focus by reference to a recent survey published in The Medical Journal of Australia.⁴⁶ Using the standard DSM diagnostic system formulated by the American Psychiatric Association⁴⁷ the South Australian study found that 26.4% of 1009 ordinary rural adults had mental illnesses. 11% were found to have two or more disorders. This compared to a similar study undertaken in Christchurch NZ which found that 20.6% of the general population had mental illnesses and two studies in the United States which found rates of 20% and 29%.⁴⁸

The South Australian study found that only 4.2% of the people with mental illnesses had seen a psychiatrist or psychologist in the previous 12 months and it agreed with US researchers that “most community residents are not treated for their psychiatric problems”.⁴⁹ Blame for this was directed towards general practitioners of medicine: “the ability of GPs to identify psychiatric problems and to provide an accurate diagnosis, particularly of depression, has been questioned.”⁵⁰ These findings can be expected to encourage the medical profession in the belief they are under-diagnosing mental illness and that more effort should be put into early diagnosis and treatment.

But there is another way to interpret these findings. Of 1009 people there were 11 people (4.2% of 26.4%) who acknowledged they had mental problems and who sought specialist treatment for them. A further 255 people (26.4% minus 11) were diagnosed with mental illnesses but were not receiving treatment. From the medical point of view these 255 people should receive treatment and if they are unwilling to volunteer for it then coercion might be necessary. But most of these people apparently disagree and are prepared to cope with life in their untreated state. If they were not coping without treatment they would have already come into contact with psychiatry as either voluntary or involuntary patients.

What is apparent from this interpretation of the survey is the huge gap that exists between the psychiatric profession’s view of the community’s state of mental health and community’s own view of itself. This confirms sociological research which has found that “lay beliefs are often quite

⁴⁶ John R. Clayer, Alexander C. McFarlane, Clara L. Bookless, Tracy Air, Graham Wright and Andrew S. Czechowicz, ‘Prevalence of psychiatric disorders in rural South Australia’, The Medical Journal of Australia, Vol. 163, 7 August 1995, pp. 124-128.

⁴⁷ American Psychiatric Association, op.cit.

⁴⁸ Clayer et al, op.cit., pp. 124-128.

⁴⁹ Ibid., p. 128.

⁵⁰ Ibid.

distinctive in form and content” to clinical medicine.⁵¹ It is these “lay beliefs” that promise to obstruct any final closure to the controversies over schizophrenia, even if a biological aetiology for schizophrenic symptoms is established.

By finding about a quarter of the population to be mentally ill, when these same people seem to be willing to carry on with life as they are, the South Australian researchers have raised an interesting question: Are we living in a society that is quite literally partly mad, where a quarter of the population seem to be unaware that they have already developed mental illnesses, and where the rest of us appear unwilling to acknowledge that soon it might be our turn? Or is there something wrong with the diagnostic techniques used by the researchers? Is there something about the way psychiatry is practised that predisposes psychiatrists to find pathology where ordinary non-medical people might find foolishness, stupidity, aggression, laziness, drunkenness, boorishness, unhappiness, self doubt and numerous other character faults that affect most people at some time or another, making them unpleasant company, but which do not really distinguish people as having diseased minds.⁵²

The non-medical approach to mental and behavioural deviance is sometimes referred to as the “moral model” to distinguish it from the medical or psychiatric approach. In a discussion about the differences between the moral model and the medical model Ronald Leifer has observed:

When the moral model is used to explain human behaviour, it is assumed the person has the capacity for free choice and is responsible and accountable for his or her actions. The medical model, on the other hand, is deterministic and explains human actions in terms of antecedent causes. These causes may be biochemical, social, psychological or historical.⁵³

The DSM Diagnostic System

The Diagnostic and Statistical Manual of Mental Disorders (DSM) used in the South Australian survey was devised and published by the American Psychiatric Association (APA). The APA is the main professional organisation of psychiatrists in the United States and the APA’s diagnostic manual has become one of two international standards for psychiatric diagnosis. (The other being the World Health Organisation’s ICD-10, which will be discussed in Chapter 3). The DSM system

⁵¹ Gareth Williams and Jennie Popay, ‘Lay Knowledge and the Privilege of Experience’, in J. Gabe, D. Kelleher, and G. Williams, eds., Challenging Medicine, Routledge, London, 1994, p. 118.

⁵² For a discussion on the expansion of psychiatric services in the United States see, Sheila M. Rothman, ‘More of What Ails You: The Boom in Psychiatric Syndromes’, The Washington Post, Sunday, April 13, 1997, p. C01.

⁵³ Ronald Leifer, ‘The Medical Model as the Ideology of the Therapeutic State’, The Journal of Mind and Behavior, Vol. 11, No. 3 and 4, 1990, pp. 247-258.

is deeply entrenched in Australian medical practice and codes from the manual are required for lodging medical rebate claims for psychiatric expenses.

Early versions of the DSM had little pretence of being scientific and were largely heuristic guide-books that incorporated much of the psychiatric lore derived from Freudian psychoanalytical techniques.⁵⁴ But with the third revision in 1980, a “fateful point in the history of the American psychiatric profession was reached. The decision of the APA first to develop DSM III and then to promulgate its use represents a significant reaffirmation on the part of American psychiatry to its medical identity and its commitment to scientific medicine”.⁵⁵ Scientific pretensions have been a central feature of the hyperbole surrounding the use of subsequent revisions of the manual.⁵⁶

The recent editions of DSM attempt to classify all deviant personality types in such a way as to provide a universal reference for aspects of human expression and identity that the APA thinks require modification. The preparation of the most recent edition of the manual, DSM IV, was a “team effort” involving more than a thousand people.⁵⁷ Codes and descriptions are supplied for a total of 390 separate mental disorders. They range in scope from “Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence” like the learning disorders — 315.00 Reading Disorder and 315.1 Mathematics Disorder — and the disruptive behaviour disorder — 313.81 Oppositional Defiant Disorder — through to a whole range of adult forms of deviancy including substance abuse of various kinds, sexual dysfunctions, personality disorders and psychoses. A recent reviewer, prompted by the width of its scope, observed that, “According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (popularly known as DSM-IV), human life is a form of mental illness”.⁵⁸

There are obvious dangers to civil liberties⁵⁹ arising from the empowerment of medical practitioners to use the DSM system as a template for dividing the general population into a 75% portion of normal people and a 25% portion of people who are unfit in their present condition. But even if the alienation of a quarter of the population were acceptable in terms of civil liberties why should a conservative American professional organisation be allowed to specify the types of people that are socially unacceptable in other countries like Australia? Consider some of the features of **301.7 Antisocial Personality Disorder**, for instance:

⁵⁴ Stuart A. Kirk and Herb Kutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry* Aldine De Gruyter, New York, 1992, pp. 4-5.

⁵⁵ G. L. Klerman, ‘The Advantages of DSM III’, *American Journal of Psychiatry*, No. 141, 1984, p. 539.

⁵⁶ B. J. Gallagher, B. J. Jones and L. P. Barakat, ‘The attitudes of psychiatrists towards etiological theories of schizophrenia: 1975-1985’, *Journal of Clinical Psychology*, Vol. 43, No. 4, 1987, pp. 438-443.

⁵⁷ American Psychiatric Association, *op.cit.*, p. xiii.

⁵⁸ L. J. Davis, ‘Diagnostic and Statistical Manual of Mental Disorders, 4th ed.’, *Harper’s Magazine*, Vol. 294, No. 1761, 1997, p. 61.

⁵⁹ Civil liberties and human rights are key themes of this thesis.

Irresponsible work behaviour may be indicated by significant periods of unemployment or by the abandonment of several jobs without a realistic plan for getting another job. There may be a pattern of repeated absences from work They may have an inflated and arrogant self-appraisal (e.g. feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured or cocky.⁶⁰

This type of person may be unattractive to employers in the United States, and indeed to employers in other parts of the world as well, but do most modern people really believe that these character traits are manifestations of mental disease? Some Australian psychiatrists have argued, apparently with little success, against the respect given to the DSM system in Australia, particularly by courts of law: “When a sceptical psychiatrist points out that the DSM is no more than a distillate of the prejudices and power plays of a group of aging American academics, of no interest to most Europeans and only passing relevance to some Australasians, this carries no weight.”⁶¹

But doubts about whether a US-devised classification system for mental deviance has validity outside of the United States are further compounded by doubts about whether diagnosticians can even be consistent in their identification of the forms of deviance that the manual describes. The classification system largely deals with manifestations of mind and personality and diagnosing the mental disorders that the system specifies requires subjective value judgements that have to be made without the assistance of definitive methods of measurement or laboratory tests.⁶² What is “excessively opinionated, self-assured and cocky” to one diagnostician might be “well-informed, confident and amusing” to another.

In extensive surveys of psychiatric diagnosis, where two psychiatrists were required to interview the same patients on admission to psychiatric hospitals, it has been repeatedly found that agreement between the psychiatrists is often little better than mere chance.⁶³ Researchers concluded after assessing six studies conducted in the US and the UK that the diagnostic agreement for schizophrenia was “no better than fair”.⁶⁴

⁶⁰ American Psychiatric Association, *op.cit.*, pp. 646-647.

⁶¹ Michele T. Pathe and Paul E. Mullen, ‘The Dangerousness of the DSM-III-R’, *Journal of Law and Medicine*, Vol. 1, July 1993, p. 48.

⁶² For instructions on how this is done see, Ekkehard Othmer and Sieglinde C. Othmer, *The Clinical Interview*, American Psychiatric Press, Washington, 1989.

⁶³ Kirk and Kutchins, *op.cit.*, pp. 37-75.

⁶⁴ *Ibid.*, p. 60.

Growth of the Mental Health Industry

Despite the known shortcomings of psychiatric diagnosis the mental health industry continues to expand. This expansion is greatly assisted by the DSM diagnostic system which provides psychiatrists with a supposedly ‘scientific’ justification for “the medicalisation of deviance”.⁶⁵ In the United States between 1975 and 1990 the number of psychiatrists increased from 26,000 to 36,000, clinical psychologists from 15,000 to 42,000 and clinical social workers from 25,000 to 80,000 while the total cost of mental health care rose between 1980 and 1990 from about \$20 billion to about \$55 billion.⁶⁶

This ‘medicalisation of deviance’ is becoming particularly apparent in the socialisation of children. Social commentators are beginning to observe a growing tendency amongst parents and schoolteachers to rely on drugs like Ritalin to “suppress the passion of children”⁶⁷ and to assist in the correction of perceived behavioural problems.

Early detection of supposedly serious psychiatric problems in children is also becoming a widely discussed imperative. In New South Wales the Schizophrenia Information Centre, for instance, warns parents to be watchful for early signs of schizophrenia in their children advising that treatment should be given immediately if any symptoms are observed. One of the signs they advise parents to look for is a child who is observed to “say or do things most people find socially embarrassing — like telling someone they’re ugly or their nose is a funny shape. It is as if their brain disorder involves some damage to the internal ‘filter’ which helps people sort out what’s appropriate from what’s not.”⁶⁸

A recent paper on childhood schizophrenia in the US gives a number of examples of supposedly psychotic symptoms that have been observed in child patients. The observations include:

An 8-year-old girl reported hearing multiple voices including the voice of a dead baby brother saying — I love you sister, sister I’m going to miss you. An 11-year-old boy heard God’s voice saying, ‘Sorry D., but I can’t come now, I’m helping someone else’. An 8-year-old girl reported an angel saying things like, ‘You didn’t cry today’ and ‘You’ve been a very nice girl today’. An 8-year-old boy stated, ‘I can hear the devil talk — God interrupts him and the devil says ‘shut up God’. God and the devil are always

⁶⁵ *Ibid.*, p. 8.

⁶⁶ *Ibid.*, pp. 8-9.

⁶⁷ Peter Breggin, *Toxic Psychiatry* Fontana, London, 1993, pp. 363-390.

⁶⁸ Schizophrenia Information Centre, ‘Schizophrenia: The Early Signs’, *Schizophrenia Information Centre Bulletin*, NSW Association For Mental Health, Gladesville.

fighting’. A boy described monsters calling him ‘Stupid F....’ and saying they will hurt him.”⁶⁹

The researcher reports that the mean age of the onset of Nonpsychotic Symptoms in these children was 4.6 years; the mean age of the onset of Psychotic Symptoms was 6.9 years; and the mean age at diagnosis of schizophrenia was 9.5 years.⁷⁰

It is worth noting that this particular study was conducted in Los Angeles on 38 children, 17 of whom were black, 16 Hispanic, 4 white and 1 Asian. All the children had been screened to ensure their symptoms met strict DSM criteria for schizophrenia.⁷¹ The DSM description of schizophrenia is normally used to determine abnormality in adults and it seems extraordinary to read a paper like this, published in a prestigious journal of the US National Institute of Mental Health, reporting research that has adapted the diagnostic criteria for use on children without any explanation or equivocation. The implication is that the researcher believes that children should meet the same standards of conformity in their thoughts, beliefs and expression that are expected of adults.

Perhaps the racial background of the children can help explain why the researcher might hold such an intolerant view. Observers of psychiatric trends in the US have become concerned about a tendency to fund research into a perceived link between inner-city street crime and an assumed imbalance of brain chemistry in the perpetrators. A part of this line of research involves the development of new psychiatric drugs which it is hoped will pacify aggressive people by increasing the availability of serotonin in their brains. Young black males are seen as the prime targets for this type of therapy and the accompanying debate has inspired the headline in at least one black newspaper, “PLOT TO SEDATE BLACK YOUTH”.⁷²

Social Control, Youth and Unemployment

The use of psychiatry as a means of social control is becoming apparent in preventive medicine programmes for various mental illnesses. These programmes are designed to detect children and young people who have divergent thinking and behavioural patterns and get them into treatment before their supposed mental illnesses develop. In Australia, as part of the National Mental Health Strategy, programmes have recently been initiated which are aimed at the early detection and treatment of psychosis in young people. Clinical Guidelines for best practice in this area describe the risk factors and signs which can be used to identify young people who are in need of

⁶⁹ Andrew T. Russell, ‘The Clinical Presentation of Childhood-Onset Schizophrenia’, Schizophrenia Bulletin, Vol. 20, No. 4, 1994, pp. 631-646.

⁷⁰ Ibid., pp. 631.

⁷¹ Ibid., p. 632.

⁷² Robert Wright, ‘The Biology of Violence’, New Yorker, March 1 1995, pp. 68-77.

prophylactic treatment to prevent the development of psychotic conditions like schizophrenia. (See Chapter 10).

Unfortunately, the Australian Human Rights and Equal Opportunity Commission seems to be unaware of the harm that might be done to human rights by encouraging the early diagnosis and treatment of mental illness. In the early 1990s the Commission conducted a National Inquiry into the Human Rights of People with Mental Illness. The Inquiry's report claimed that:

Conduct disorder and other disruptive behaviours are a source of considerable morbidity in child and adolescent mental health with problems occurring in 3.2-6.9 percent of young people. Prevention of conduct disorders in childhood and adolescence, or their early and effective treatment, is of special significance given the great personal, social and economic costs produced by antisocial behaviour and other disorders.⁷³

Conduct disorder is specifically confined to children and adolescents and some psychiatrists believe it is a precursor of psychotic disturbances like schizophrenia.⁷⁴ According to DSM IV, "The essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated Children with this disorder often have a pattern of staying out late at night despite parental prohibitions."⁷⁵ The text-book recommendation for treating this kind of waywardness, as well as for treating other social imperfections in children like Tourette's Disorder, characterised by the blurting out of obscene expletives, is dosing with haloperidol,⁷⁶ a high-strength neuroleptic drug used for treating schizophrenia.

The Human Rights Inquiry's report was particularly enthusiastic about the early diagnosis and treatment of schizophrenia:

Psychiatrists working with general practitioners in an English community have been able to detect the earliest signs of schizophrenia — and with education, supportive interventions and short-term psychotropic medication — prevent the onset of an episode

⁷³ Human Rights and Equal Opportunity Commission, Report of the National Inquiry into the Human Rights of People with Mental Illness Australian Government Publishing Service, Canberra, 1993, p. 855.

⁷⁴ Kathleen McKenna, Charles T. Gordon, Marge Lenane, Debra Kaysen, Kimberly Fahey and Judith L. Rapoport, 'Looking for childhood-onset schizophrenia: the first 71 cases screened', Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 33, No. 5, 1994, pp. 636-645.

⁷⁵ American Psychiatric Association, op.cit., pp. 85-86.

⁷⁶ Harold I. Kaplan and Benjamin J. Sadock, Synopsis of Psychiatry: Behavioural Sciences, Clinical Psychology, Sixth ed Williams and Wilkins, Baltimore, 1991, pp. 798-799.

.... Obviously this research must be repeated and tested in different settings, including Australia, but these early findings are encouraging and warrant urgent attention.⁷⁷

The Human Rights Commission apparently had not considered the potential threat this line of research might pose to basic human rights — like those specified in Article 18 of the International Covenant on Civil and Political Rights concerned with the freedom of thought and belief.

The implication of the Inquiry's report is that it might be useful to screen the general population for the "earliest signs of schizophrenia". If this screening were to be carried out, and people with the "earliest signs" were then coerced into preventative mental health programmes, the effect would be to lower the community's tolerance level for individual differences in thoughts and beliefs. The current tolerance level is only crossed when a person manifests the symptoms of full-blown psychosis. But in the absence of any laboratory tests for schizophrenia the "earliest signs" are simply the supposed pre-psychotic deviations in thoughts and beliefs discerned by observing a person's speech and behaviour.⁷⁸ Children and adolescents, who are thought to be in need of discipline, and people marginalised through unemployment and homelessness, might be particularly vulnerable.

US-based antipsychiatry campaigner Thomas Szasz has focussed on youth unemployment as a major risk factor for receiving a diagnosis of schizophrenia.⁷⁹ It is not difficult to find confirmation of Szasz's argument. Sociological research has linked treatment for schizophrenia with both unemployment and lower socio-economic status. Faris and Dunham found during the Great Depression of the 1930s that the rate for treated schizophrenia was nearly three times higher in the slum areas of Chicago than in the most affluent areas.⁸⁰ Modern psychiatrists believe that "it has become so common for schizophrenics to be out of work"⁸¹ that unemployment has become one of the main indicators of the disorder.

DSM IV specifies that a mental disorder is a condition that "causes clinically significant distress or impairment in social, occupational, or other important areas of functioning".⁸² This suggests that a psychiatrist charged with making an assessment of an unemployed person might begin with the assumption that the person's 'occupational impairment' indicates the presence of a mental disorder in need of diagnosis.

⁷⁷ Human Rights and Equal Opportunity Commission, *op.cit.*, p. 857.

⁷⁸ Per Vaglum, 'Earlier Detection and Intervention in Schizophrenia: Unsolved Questions', *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, pp. 347-351.

⁷⁹ Thomas Szasz, *Cruel Compassion: Psychiatric Control of Society's Unwanted* John Wiley and Sons, New York, 1994, p. 145.

⁸⁰ Richard Warner, *Recovery From Schizophrenia* Routledge & Kegan Paul, London, 1985, p. 35.

⁸¹ *Ibid.*, p. 132.

⁸² American Psychiatric Association, *op.cit.*, p. 7.

DSM IV groups the criteria for diagnosing schizophrenia into several categories and sets them out in a box. The first group, Criterion A, is concerned with unusual thinking patterns — like delusions and hallucinations — and it is necessary to correlate a symptom from this group with one of the indicators from the second group. Criterion B is headed:

Social/occupational dysfunction.

For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic or occupational achievement).⁸³

In an effort to clarify these indicators the manual declares elsewhere that, “Many individuals [schizophrenics] are unable to hold a job for sustained periods of time and are employed at a lower level than their parents (downward drift).”⁸⁴

Another authoritative diagnostic manual, the World Health Organisation’s ICD-10, has a description of schizophrenia that might be even more threatening for unemployed people. One of the ICD-10 sub-types of schizophrenia is called ‘simple schizophrenia’ and the following diagnostic guidelines are given to identify it:

Simple schizophrenia is a difficult diagnosis to make with any confidence because it depends on establishing the slowly progressive development of the characteristic “negative” symptoms of residual schizophrenia without any history of hallucinations, delusions, or other manifestations of an earlier psychotic episode, and with significant changes in personal behaviour, manifest as a marked loss of interest, idleness, and social withdrawal over a period of a least one year.⁸⁵

It should be noted that this sub-type of schizophrenia doesn’t require the usual signs of psychosis. It is quite likely that the description of ‘simple schizophrenia’ would easily fit a great number of people who have been forced to adapt to the experience of long-term unemployment.

Unemployment is now at chronically high levels in most parts of the world and, apart from the link with schizophrenia and other mental diseases, there is also a traditional tendency to view

⁸³ *Ibid.*, p. 285.

⁸⁴ *Ibid.*, pp. 277-278.

⁸⁵ World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines World Health Organisation, Geneva, 1992, p. 95.

unemployed people as a socially destabilising force, in need of control. Youth unemployment in Australia has stabilised at a little under 30%. This means that at any given time about 30% of the youth workforce might be said to suffer from the psychiatric symptom of ‘occupational dysfunction’. When ‘unemployment’ can be psychiatrically redefined as ‘occupational dysfunction’ unemployed youth would appear to be highly vulnerable to an expansion of psychiatric coercion.

The assumed link between mental illness and unemployment is now so deeply entrenched in Australian thinking that the report of the Inquiry into Human Rights and Mental Illness has even promoted the view:

Unemployment is a particular stressor, both for the mentally ill and those who are at risk of mental illness. It may lead to, or exacerbate depression, anxiety and other mental disorders. The most recent research has indicated very adverse effects on health generally — and mental health in particular. Recent studies have indicated that more than 50% of unemployed young people suffer from depression.⁸⁶

The argument that unemployment induces stress may be self-evident, and the link between unemployment and mental illness may actually be based in a statistical reality, (although the evidence is not supplied). However, such a link can only be made by assuming the mainstream psychiatric position in nosological and diagnostic controversies. This is because any survey which seeks to establish the rate of mental illness in a particular class of people has to begin by assuming that the mental illness in question actually exists (nosological certainty) and that techniques are available to accurately identify it (diagnostic certainty).

The lack of equivocation in the statement by the Human Rights Commission above is quite alarming. It indicates that the authors are either unaware of the many psychiatric controversies associated with mental illness or else they have assumed that the position of mainstream psychiatry is correct. It is this kind of uncritical attitude on which the expansion of psychiatric coercion is feeding.⁸⁷

But the situation is complicated. Viewed from the perspective of voluntary consumers of psychiatric services, mainstream psychiatry’s position is not without some human rights merit. The merit is based on the assumption that people who are identified with mental illnesses are unfortunate victims of disease who have a right to receive treatment. From this perspective there are competing human rights involved: “The right to be treated competes with the right to be

⁸⁶ Human Rights and Equal Opportunity Commission, *op.cit.*, p. 846.

⁸⁷ Seth Farber, ‘Institutional Mental Health and Social Control: The Ravages of Epistemological Hubris’, *The Journal of Mind and Behavior*, Vol. 11, No. 3 and 4, 1990, pp. 285-299.

protected”⁸⁸ from unwanted medical attention. Special ethical problems arise when people are diagnosed with mental illness because they are often thought to be incapable of making their own decisions about the need for psychiatric treatment.⁸⁹

The problem that now seems to be overtaking mental health establishments in most industrial societies is that this “right to treatment” argument is combining with psychiatric hyperbole about breakthroughs in research, particularly in schizophrenia research, and it is having a marked affect on developments in mental health policy and legislation.

An example of the type of pressure arising from this situation can be found in the 1995 Annual Report of the New South Wales (NSW) Mental Health Review Tribunal. The Mental Health Review Tribunal is a quasi-judicial body constituted under the NSW Mental Health Act with some 29 designated responsibilities for hearing appeals and reviewing the cases of detained mental patients.⁹⁰ Scattered throughout the 1995 Report were repeated references to a perception by members of the Tribunal that involuntary commitment to mental hospitals was being unnecessarily restricted.

The Tribunal appeared to be of the opinion that civil liberties protections were being interpreted in a way that was too restrictive of psychiatric practice⁹¹ and that a much wider net should be cast for coercive use of psychiatry. One of the Tribunal’s statements even went so far as to argue that the criteria for involuntary commitment should be expanded to include people with personality disorders “who would benefit from behavioural modification, rehabilitation, or drug and alcohol programmes”.⁹²

Yet despite these repeated appeals to widen the criteria for involuntary commitment the Tribunal, in the same report, ironically also drew attention to the way the numbers of involuntary patients had been steadily increasing under the existing criteria.⁹³ The total number of involuntary hospital admissions in NSW rose from 5,499 in 1992,⁹⁴ to 7,370 in 1995,⁹⁵ a 34% increase in three years. (By 1997 this number had risen to 9,398, almost double the 1992 figure.)⁹⁶

⁸⁸ Darold A. Treffert, ‘Balancing Legal Realities: The Courts, the Legislature and Public Psychiatry’, in C. Christian Beels and Leona L. Bachrach (eds), Survival Strategies for Public Psychiatry, Jossey-Bass Inc., San Francisco, 1989, pp. 63-64.

⁸⁹ Anne M. Lovell, ‘Coercion and Social Control: A Framework For Research On Aggressive Strategies In Community Mental Health’, in Deborah L. Dennis and John Monahan (eds), Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law, Plenum Press, New York, 1996, pp. 147-166.

⁹⁰ Mental Health Review Tribunal, Executive Summary for period January 1994 to June 1995, Inside cover page.

⁹¹ Mental Health Review Tribunal, Annual Report, NSW Government, 1994, pp. 13, 17 & 20.

⁹² Ibid., p. 13.

⁹³ Ibid., p. 20.

⁹⁴ Mental Health Review Tribunal, Annual Report, NSW Government, 1992, p. 91.

This had been accompanied by an even more accelerated rise in the numbers of Community Counselling Orders (CCOs) and Community Treatment Orders (CTOs). CCOs and CTOs are legal devices which facilitate commitment of people as outpatients in NSW and allow for their compulsory treatment while they remain living in the community. A CCO achieves this under threat of arrest for non-compliance. A CTO provides for arrest and incarceration in a mental hospital for non-compliance. The combined total of CCOs and CTOs issued in NSW had risen from 510 in 1992⁹⁷ to 1901 in 1995,⁹⁸ a 270% increase in three years. (The 1997 figure was 3,018, nearly 6 times the number in 1992.)⁹⁹

Apart from drawing attention to the increase in the numbers of involuntary patients, the Tribunal also reported declining numbers of voluntary patients.¹⁰⁰ According to the Tribunal the combination indicated a developing “trend towards coercive, as opposed to consensual treatment”.¹⁰¹ But the Tribunal did not indicate any disapproval of this trend and it is difficult to avoid the conclusion that it was deliberately encouraging the trend by arguing for a widening of the criteria for involuntary commitment.

In response to lobbying by interest groups the NSW Mental Health Act was amended in 1997. The amendments specify that it is no longer necessary to establish that a person is likely to be physically dangerous to themselves or other people before involuntary treatment can be imposed on them. The maximum period for Community Treatment Orders (outpatients commitment) has also been extended from 3 months to 6 months.¹⁰²

The concept of outpatients commitment introduces a new dimension to mental health arrangements that worry some people. Soon after Community Treatment Orders were introduced into NSW, for instance, a community mental health nurse wrote a persuasive article against them arguing that “they offer too many avenues for abuse by punitive and anxious staff”.¹⁰³

⁹⁵ Mental Health Review Tribunal, Annual Report, NSW Government, 1995, p. 58.

⁹⁶ Mental Health Review Tribunal, Annual Report, NSW Government, Appendix 1, (unpublished appendix personally obtained), 1997.

⁹⁷ Mental Health Review Tribunal, Annual Report, NSW Government, 1994, p. 41.

⁹⁸ Mental Health Review Tribunal, Annual Report, NSW Government, 1995, p. 28.

⁹⁹ Mental Health Review Tribunal, Annual Report, NSW Government, 1997, p. 23.

¹⁰⁰ Ibid. p. 18.

¹⁰¹ Ibid., p. 20.

¹⁰² NSW Health, ‘Mental Health Legislation Amendment Bill 1996’, in Centre for Mental Health (eds), Caring for Health: Proposals for Reform — Mental Health Act 1990, NSW Health, Sydney, 1996, p. 7.

¹⁰³ Anthony York, ‘Community Treatment Orders, Community Counselling Orders and Moderate Police’, The Lamp, Vol. 49, No. 4, 1992, p. 27.

One of the major concerns is the lack of restriction on the number of people who might eventually be controlled by forced drugging in outpatients programmes. Before the development of outpatients commitment a person had to be incarcerated in a hospital to receive involuntary treatment.¹⁰⁴ This requirement placed finite limits, in terms of the availability of accommodation and funding, on the total number of people who could be subjected to forced treatment at any given time. But outpatients commitment removes those limitations and it remains to be seen how many people will eventually be diagnosed with mental illnesses like schizophrenia and placed into forced treatment programmes, while still living in their own homes.

One analyst of the pharmaceutical market recently argued that the \$1 billion a year US market for schizophrenia drugs could be expanded to \$4.5 billion a year if all the people who have symptoms of schizophrenia could be forced into treatment with the new, more expensive drugs:

One in 100 people is schizophrenic. That is about 2.5 million Americans, half of whom never receive treatment. Of those who do get treatment, two-thirds take haloperidol, a drug introduced in 1967 that remains the benchmark maintenance therapy and costs about 65 cents a day.¹⁰⁵

On top of the market expansion promised by outpatients commitment in developed countries a lot of attention is also currently being directed towards expanding psychiatric applications in developing countries. Researchers have predicted that schizophrenia “will afflict 24.4 million people in low-income societies by the year 2000, a 45% increase over the number afflicted in 1985”.¹⁰⁶

Given this current state of play there would seem to be a distinct potential for the scientific and economic enthusiasms about new schizophrenia research to get out of hand. By combining with a human rights imperative focussed on the 'right to treatment' large numbers of people might be treated inappropriately, perhaps to their detriment.¹⁰⁷ . On top of this there is the possibility of a declaration of premature closure of the various schizophrenia controversies which would create conditions of false certainty and cause medical scientists to waste resources on research which is founded on false assumptions.¹⁰⁸

¹⁰⁴ Virginia Aldige Hiday, 'Outpatient commitment: Official Coercion in the community', in Deborah L. Dennis and John Monahan (eds), Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law, Plenum Press, New York, 1996, pp. 29-47.

¹⁰⁵ Reuter Information Service, Drugmakers look for home-runs with schizophrenia drugs, Chicago, Nando.net, 1996, URL, http://someset.nando.net/newsroom/ntn/health/032496/health3_14068.html

¹⁰⁶ Arthur Kleinman and Alex Cohen, 'Psychiatry's Global Challenge', Scientific American, March 1997.

¹⁰⁷ For a detailed analysis of the detrimental effects of standard psychiatric treatments given under the currently held assumptions see, Peter Breggin, Toxic Psychiatry Fontana, London, 1993.

¹⁰⁸ Goran Sedvall and Lars Farde, 'Chemical brain anatomy in schizophrenia', The Lancet, Vol. 346, No. 8977, 1995, pp. 743-750.

2. Interest Groups and Human Rights

The theoretical framework of this thesis is a combination of interest group theory and human rights. This chapter begins with a discussion on the use of interest group theory as an analytical framework. Interest group theory is then examined in relation to the political aspects of controversies over schizophrenia. The general principle of using human rights as a tool of activism is discussed before relating human rights specifically to problems that arise from the practice of psychiatry.

Interest Group Theory

In her book Tainted Truth: The Manipulation of Fact in America¹ Cynthia Crossen devoted a chapter to 'Drugs and Money'. She related a series of events which took place in the late 1980s to illustrate the way in which research funding from pharmaceutical companies can sometimes influence the way in which medical researchers interpret their scientific findings.

The circumstances involved two researchers who had worked on the same biomedical project. One of the researchers became concerned when the project was expanded, with extra funding from a drug company, so that tests could be conducted on the efficacy of a drug manufactured by the donor company. At the conclusion of the project the two researchers disagreed about the interpretation of results. Conflicting articles were submitted to the New England Journal of Medicine. One article said the drug was efficient, (although it only worked in 30% of cases), the other said it was inefficient. Only the positive findings were accepted for publication and while the published author's career continued to prosper, largely with drug company funding, the dissenter's career plummeted. Reviewing the situation afterwards the dissenting scientist observed: "The ultimate goal of the pharmaceutical industry is to make money The goal of medicine is curing people. One is self-interest, one is altruism. It's an intersection of two different social systems."²

Advocates of scientific purity might argue that, providing the published material received the proper peer reviewing, the above story only indicates that better scientists receive better funding. They could also argue that proper scientific training is sufficient to overcome the bias³ or temptation to corruption that is implied in the story. However, at the same time, they might agree with the dissenting scientist's belief that medical research is primarily motivated by altruism rather than self-interest. And herein points the way to deep confusion within the scientific identity. Analysts who have researched the way in which commercial, political and social influences

¹ Cynthia Crossen, Tainted Truth: The Manipulation of Fact in America Simon and Schuster, New York, 1994.

² Ibid., p. 166.

³ Paul R. Gross and Norman Levitt, 'A higher superstition? A reply to Steve Fuller's review', History of the Human Sciences, Vol. 8, No. 2, 1995, pp. 125-130.

impinge on scientific and technological outcomes have developed a number of theoretical approaches to explain why scientific knowledge often appears to be tainted. Interest group theory is one of these approaches.

Interest group theory has its origin in political science. The study of political groupings which lobby governments and exert pressure on public policy making has been a central feature of politics discourses for the past half-century:⁴

With a long intellectual heritage, the pluralist tradition, in its extreme form, views government as a neutral identity which arbitrates group conflict by forming public policies in response to group pressure.⁵

In political activities, interest groups may have formal or informal organisational structures and are amalgamations of individuals or organisations which share a common interest or demand that can be represented before policy makers or knowledge brokers. Interest groups may campaign independently but readily join coalitions of like-minded groups when such an alliance improves the chances of success.⁶ Exclusive access to decision-makers isn't necessary for success and interest groups often find it is the securing of exclusive access to members and finances that is most essential in finding a niche in the political landscape.⁷ Despite some debate about nuances of meaning, interest groups are also commonly referred to as special interests, private interests, pressure groups, organised interests, or lobby groups.

Political scientists usually make a distinction between interest groups and social movements. Social movements are generally thought of as linking individuals across broad-ranging topics of general concern. Interest groups, on the other hand, are usually more narrowly focused and depend on drawing organised support from within a larger social movement. While interest groups usually have specific public policy goals, and focussed lobbying tactics to achieve them,⁸ social movements provide the broader background of public sentiment or discontent from which interest groups draw their significance.

⁴ Martin J. Smith, Pressure, Power and Policy Harvester Wheatsheaf, New York, 1993, p. 3.

⁵ Daniel J. B. Hofrenning, 'Into the public square: explaining the origins of religious interest groups', The Social Science Journal, Vol. 32, No. 1, 1995, pp. 35-49.

⁶ Marie Hojnacki, 'Interest groups' decisions to join alliances or work alone', American Journal of Political Science, Vol. 41, No. 1, 1997, pp. 61-88.

⁷ Virginia Gray and David Lowery, 'A niche theory of interest representation', The Journal of Politics, Vol. 58, No. 1, 1996, pp. 91-112.

⁸ Ken Kollman, 'Inviting friends to lobby: interest groups, ideological bias, and Congressional committees', American Journal of Political Science, Vol. 41, No. 2, 1997, pp. 519-545.

Unlike social movements, the dynamic focus of interest groups, and the competitive arena in which they operate, tend to make them unpredictable. So much so that public relations consultants, who are often required to manage the issues raised by interest groups, have recently been advised, apparently in all seriousness, that “[c]haos theory is particularly useful for structuring emerging social concerns and interest-group behaviour.”⁹

Although political science has developed considerable expertise in understanding the way in which interest groups function in the broad political landscape,¹⁰ it appears this discipline is less deft when it comes to understanding the “concept of the scientific estate”¹¹ and the way in which interest groups function in that more restricted territory. While discussing typical attitudes held by political scientists, science and technology studies (STS) scholars, Cozzens and Woodhouse, have observed that,

Scientific claims are generally accepted as unproblematic truth; but, when controversy arises, science policymaking is perceived as being so much like any other kind of political activity as to be unworthy of special attention. The discipline treats the politics of the sciences as if they were about as worthy of study as the politics of Albania.¹²

In an effort to fill this gap in academic research, STS scholars have adapted interest group theory to explain how scientists go about their work. According to Woolgar scientists constantly adjust their research in the light of “the potential presence or absence of interests in the work and activities both of others and themselves”.¹³ Responding to Woolgar, Callon and Law have argued that Woolgar’s “ethnomethodological preoccupation with the essential reflexivity of discourse”¹⁴ was, at the time they were writing in the early 1980s, only one of two competing “notion[s] of social interest for the social study of science.”¹⁵ The other notion was the more conciliatory “Edinburgh” approach which agrees “that interests are theoretical constructs reflexively imputed to data, but argue[s] that there is

⁹ Priscilla Murphy, ‘Chaos theory as a model for managing issues and crises’, Public Relations Review, Vol. 22, No. 5, 1996, pp. 95-114.

¹⁰ David Lowery and Virginia Gray, ‘The population ecology of Gucci Gulch, or the natural regulation of interest group numbers in the American states’, American Journal of Political Science, Vol. 39, No. 1, 1995, pp. 1-30.

¹¹ Susan E. Cozzens and Edward J. Woodhouse, ‘Science, Government and the Politics of Knowledge’, in Sheila Jasanoff, Gerald E. Markle, James C. Petersen and Trevor Pinch (eds), Handbook of Science and Technology Studies, Sage, Thousand Oaks, 1995, p. 535.

¹² Ibid.

¹³ Steve Woolgar, ‘Interests and explanation in the Social Study of Science’, Social Studies of Science, Vol. 11, 1981, p. 371.

¹⁴ Michel Callon and John Law, ‘On Interests and their Transformation: Enrolment and Counter-Enrolment’, Social Studies of Science, Vol. 12, No. 4, 1982, p. 616.

¹⁵ Ibid., p. 615.

nothing obnoxious so long as it is understood that there can be nothing final about this (and all other) explanatory attempts”.¹⁶

However, Callon and Law were dissatisfied with both these approaches and they proposed a third view which saw the interest groups surrounding scientific issues as actors who enrol one another in a networking process:

Actors great and small try to persuade by telling one another ‘it is in your interests to...’. They seek to define their own position in relation to others by noting that ‘it is in our interests to...’. Our view is that they are trying to impose order on a part of the social world. They are trying to build a version of social structure.¹⁷

This view was illustrated by a recent controversy that erupted in the United States over the future of the National Center for Injury Prevention and Control (NCIPC).¹⁸ The NCIPC, a branch of the Centers for Disease Control and Prevention (CDC), was under threat of elimination due to budget cuts. The arguments mounted for and against the budget cuts confirm the Callon/Law observation.

The NCIPC had been engaged in research on the effect of injuries from firearms and had concluded that the existence of guns in the community constituted a hazard to public health. These findings had been challenged by a coalition of interest groups including the National Rifle Association, the Heritage Foundation, and the Doctors for Integrity in Research and Public Policy, who oppose gun control. Together these organisations had publicly argued that the NCIPC’s findings were out of date and that the research had been politically motivated. This lobbying had led to the threat of budget cuts. The medical research community, acting on behalf of collective interest, responded by accusing the government of caving in to political pressure and warned that health promoting research should not be influenced by special interest groups.¹⁹

Although the influence of special interests is normally better concealed than it was in this case, STS researchers usually find it is possible to identify a variety of impinging interests when the social background of scientific research is analysed. In their description of actor networks, Callon and Law trace the history of a hypothetical research project to demonstrate how similar projects can be originally conceived and modified by such simple and perennial interests as the need to tailor research to fit publication requirements.²⁰

¹⁶ *Ibid.*, pp. 615-616.

¹⁷ *Ibid.*, p. 622.

¹⁸ Jerome P. Kassirer, ‘A partisan assault on science: the threat to the CDC. (Centers for Disease Control and Prevention)’, *The New England Journal of Medicine*, Vol. 333, No. 12, 1995, pp. 793-795.

¹⁹ *Ibid.*

²⁰ Callon and Law, *op.cit.*, pp. 616-620.

In a more recent publication Callon has updated his view and describes four models to explain the “social organisation of science”.²¹ He calls his third model “science as sociocultural practice” and discusses how

groups outside the scientific community may be mobilised in the production of knowledge. The border between insiders and outsiders fluctuates and is negotiable. But what is analytically important is to explore the mechanisms by which constraints, demands, and interests outside the circle of researchers influence scientific knowledge.²²

Interests theory appears in the STS literature as a variant that is primarily concerned with class interests. Restivo argues that the use of interests theory for analysing scientific knowledge formation “is not an innovation of modern students of STS. It is a centrepiece of Marxist thought and of the classical sociology of knowledge”.²³ He observes that proponents of the theory sometimes have to mount a defence against critics who view the application of interest arguments merely as a “process of imputation.”²⁴ Countering this Restivo argues that when interest attribution is carried out appropriately it is “an act of theory.”²⁵ Unfortunately he does not go on to detail a method of appropriate attribution.

In discussing an approach to the use of interests theory Abraham has offered some clarification of the problem Restivo was discussing:

inconsistencies in scientist’s claims are necessary, though not sufficient, to impute the operation of bias. To demonstrate bias it is necessary to show that scientific knowledge claims are not only influenced by values and interests, but that they are also non-credible.²⁶

²¹ Michel Callon, ‘Four Models for the Dynamics of Science’, in Sheila Jasanoff, Gerald E. Markle, James C. Petersen and Trevor Pinch (eds), Handbook of Science and Technology Studies, Sage, Thousand Oaks, 1995, p. 30.

²² Ibid., p. 43.

²³ Sal Restivo, ‘The Theory Landscape in Science Studies’, in Sheila Jasanoff, Gerald E. Markle, James C. Petersen and Trevor Pinch (eds), Handbook of Science and Technology Studies, Sage, Thousand Oaks, 1995, p. 106.

²⁴ Ibid.

²⁵ Ibid., p. 107.

²⁶ John Abraham, ‘Scientific Standards and Institutional Interests: Carcinogenic Risk Assessment of Benoxaprofen in the UK and US’, Social Studies of Science, Vol. 23, 1993, p. 391.

In relating interest group theory to the political aspects of controversies over schizophrenia it could be said that while the whole mental health system constitutes a broad background social movement,²⁷ the psychiatric profession,²⁸ psychiatric survivors,²⁹ relatives of people who have been diagnosed with schizophrenia,³⁰ civil libertarians,³¹ and the pharmaceutical industry³² are some of the major interest groups active within the larger mental health movement.

Similarly, when interest group theory is applied in a more restricted way by confining the analysis to scientific research associated with the aetiology of schizophrenia, it is anticipated that influences on knowledge formation caused by pressure from interest groups involved in the wider political debate will become apparent. The proliferation of conflicting scientific hypotheses, and the certainty with which a number of diverse theories are currently being promoted, indicates it is a field rich with the ingredients Abraham requires for imputing bias.

However, the plan which has been outlined for this thesis also calls for analysis of the non-scientific “philosophical” aspects of the schizophrenia controversy. This begs the question: Can interest group theory be adapted to analyse philosophical controversies? The answer to this question is simple; when philosophical positions become controversial, of necessity, they also become political. (The same could also be said about scientific controversies.) So that what is being referred to here as the “philosophical level” of the controversy could just as suitably be called the “political level”. Therefore it would seem unnecessary to make any adaptive adjustments in applying interest group theory to what is best described as a philosophical controversy.

There might seem to be some problem, however, in the proposal to apply a theory of political analysis to a situation in which the proponents of the differing philosophical positions are not equally engaged in active advocacy of their respective positions. Whereas the medical model of schizophrenia is vociferously pursued by well-organised and well-funded entities that fit any criteria for interest groups, the advocacy of the myth-of-mental illness and mystical models is largely conducted by individual authors who write for fairly vaguely defined audiences of supporters. The problem here is that those who believe in either a non-existent or natural cause for

²⁷ David Mechanic, ‘Establishing mental health priorities’, The Milbank Quarterly, Vol. 72, No. 3, 1994, pp. 501-515.

²⁸ Stephen W. White, ‘Mental illness and national policy’, National Forum, Vol. 73, No. 1, 1993, pp. 2-22.

²⁹ See for instance, Dendron News, published by psychiatric survivor organisation, Support Coalition, 1999, Available URL, [http:// www. efn.org/~dendron](http://www.efn.org/~dendron).

³⁰ For a description of the relatives' movement in the US see, Peter Breggin, Toxic Psychiatry Fontana, London, 1993, pp. 448-450.

³¹ Bruce J. Ennis and Richard D. Emery, The Rights of Mental Patients: An American Civil Liberties Handbook Avon Books, New York, 1978.

³² Steve Carrell, ‘Coming: Host of schizophrenia drugs with lesser side effects’, Drug Topics, Vol. 139, No. 14, 1995, pp. 35-36.

schizophrenia might not be consistently active enough to fit some of the more rigid definitions for interest groups.

Fortunately though, there is an interest group model available which is well suited to deal with this problem of disproportion amongst competing advocates. A. Paul Pross, a political analyst, found when he was attempting to dissect the complexities of Canadian politics that the term “interest group” was used widely to describe both politically active and non-active entities, and that this imprecision made analysis difficult. In order to clarify the situation he decided to divide “the entire spectrum of interests associated with any given public policy into three categories: formal interest groups, solidarity groups, and latent interests.”³³

These three points on the spectrum essentially represent a diminishing gradation of active advocacy and the scheme is well suited for application to the three philosophical positions on schizophrenia. In Pross’ model formal interest groups are structured organisations that are more or less constantly engaged in applying political pressure. Pross preferred to call these “pressure groups”.³⁴ Most of the interest groups engaged in advocacy of the medical view of schizophrenia easily fall into this category.

Solidarity groups, on the other hand, operate without much formal organisation but are still “made up of individuals with common characteristics who also share some sense of identity” and who have “enough group feeling to elicit a common reaction to public events, which may register in individual interventions in public debate”.³⁵ The interest groups that advocate the myth-of-mental-illness model for schizophrenia fit fairly easily into this category of solidarity groups.

According to Pross, the third point of the spectrum, latent interests, are more difficult to identify because they,

are comprised of individuals and corporations with interests in common but with no sense of solidarity with one another. They may be extremely active in protecting their individual interests, but do not feel the need to recognise their mutual interest and register a collective voice in order to promote it.³⁶

³³ A. Paul Pross, Group Politics and Public Policy Oxford University Press, Toronto, 1986, p. 15.

³⁴ Ibid.

³⁵ Ibid.

³⁶ Ibid.

The advocates of the mystical model of schizophrenia fit well into this description of latent interests. Pross has shown his spectrum of interest groups in diagrammatical form as what he calls “a funnel of mobilisation”.

Funnel of Mobilisation

Human Rights and Activism

The creation, ratification, observation and compliance monitoring of human rights law are political processes in which interest groups are usually deeply involved, and to which interest group theory can be applied as an analytical tool. Human rights advocacy is a well established tactic used for advancing the interests of both individuals and minority groups who have cause to believe they are disadvantaged by existing laws, policies and social structures.³⁷ The technique, in its simplest form, involves identifying one or more articles of human rights law and campaigning for public recognition that past or present conditions violate the rights that are guaranteed therein.³⁸

In respect to the schizophrenia controversy, a situation prevails in which the proponents of the three divergent models each require very different articles of human rights law to assist them in making their respective cases. The refinement of their respective human rights arguments — and the degree of recognition of the arguments by the United Nations (UN), national governments and the general

³⁷ Adelaide G. Farrah and Zachary Elkins, ‘Racing toward a new disability strategy’, *Americas*, Vol. 46, No. 4, 1994, pp. 56-58.

³⁸ Gail M. Gerhart, ‘Protecting Human Rights in Africa: Strategies and Roles of Nongovernmental Organizations’, *Foreign Affairs*, Vol. 76, No. 2, 1997, p. 200.

public — largely accords with the spectrum of mobilisation illustrated by Pross in the diagram above.

The formal interest groups representing the medical model are by far the most advanced. Their human rights case is now greatly assisted by the United Nations' adoption in 1991 of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.³⁹ These principles, which will be discussed more fully a little further on, have been incorporated into the UN's human rights regime. The advantages they give the proponents of the medical model are derived from the fact that they specify human rights that are dedicated solely to the issue of mental illness. As such the Principles are generally recognised as the definitive human rights statements that apply to the mental health area to which schizophrenia belongs. Although the Principles do not currently have equal legal status to articles specified in declarations and covenants, they may be upgraded to a higher status in the future.

The interest groups representing the myth-of-mental illness and mystical models gain little comfort from the human rights specified in these UN Principles. As a result they are required to adapt articles of human rights law which have been originally conceived for more general purposes and then interpret them for the specific circumstances encountered when the medical model is imposed on individual schizophrenics. This task is becoming increasingly difficult as national governments in various countries become signatories to the Principles and progressively adjust their mental health legislation and mental health systems to accommodate these Principles. The problem facing the proponents of the myth-of-mental illness and mystical models is that once this process has been completed it is likely that the controversy over conflicting human rights might be declared closed.

In order to convey the seriousness of this situation for the non-dominant interpretations of schizophrenia it is necessary to discuss some background to human rights in general, and also some background about the relationship between human rights and psychiatry.

Background to Human Rights

Human rights are the basic rights all humans hold by virtue of being human.⁴⁰ The precursor of modern human rights was known as 'natural rights'⁴¹ and arose from a belief that human nature required certain liberties in order to fully express itself. The principal determinant of this view of

³⁹ United Nations Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care', in Australian Human Rights and Equal Opportunity Commission (eds), Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993, pp. 989-1005.

⁴⁰ John Dunn, 'Rights and political conflict', in Larry Gostin (eds), Civil Liberties in Conflict, Routledge, London, 1988, pp. 24-27.

⁴¹ Paul Sieghart, The Lawful Rights of Mankind Oxford University Press, Oxford, 1985, p. 29.

human nature was an interpretation of the moral nature of humanity.⁴² These origins of modern human rights are to be found in the thinking of European political theorists of the seventeenth and eighteenth centuries, particularly the English political philosopher Locke.⁴³ At this time a surging middle class was seeking dialectical means by which to out-manoeuvre the various ancient regimes of Europe and ‘natural rights’ became the basis for the civil and political rights that the middle class claimed in order to achieve this goal.⁴⁴

These bourgeois origins have attached to human rights a somewhat confused legacy. As the largely middle class proponents of natural rights gradually moved out of opposition and into political control the claims for natural rights, particularly property rights, became associated with moves to impede further political change rather than to initiate it. In Britain, by the early 19th century, the language of natural rights had virtually become an exclusive possession of the middle class being restricted to ruling party rhetoric and a sprinkling of liberal reformers who wanted to spread the luxury of property owners’ civil and political rights to the masses: “The radical left largely abandoned the language of natural rights”.⁴⁵

Even so, as the voting franchise expanded throughout the nineteenth century, working-class politics continued to develop and increasing pressure was applied to incorporate concerns for social and economic justice into the political mainstream. This process eventually gave rise to a concept of workers’ rights. By the end of the nineteenth century, the dichotomy of capital and labour was increasingly seen as a struggle “between the rights of property and the rights of the common man — especially the worker”.⁴⁶ In modern times this struggle has eventually come to be represented as a tension between middle-class conceived civil and political rights, on the one hand, and working-class conceived economic and social rights on the other.⁴⁷

It takes little analysis to expose this development as a false dichotomy. One obvious fault is that the traditional bourgeois emphasis on the civil/political right to accumulate unlimited property clearly belongs more appropriately in the category of economic rights. But the causes of such anomalies are to be found in the long history of middle class struggle to overthrow feudal values and are not of great importance to us now. The matter is only raised here because human rights in their modern

⁴² Maria Borucka-Arctowa, ‘Historical Development of the Principles of Equality and Freedom and the Conception of Man’, in Gray Dorsey (eds), Equality and Freedom: International and Comparative Jurisprudence, Oceana Publications, New York, 1975, pp. 51-73.

⁴³ John Locke, ‘Second Treatise of Government (1689)’, in Peter Laslett (eds), Two Treatises of Government, Cambridge University Press, Cambridge, 1967.

⁴⁴ Jack Donnelly, Universal Human Rights in Theory and Practice Cornell University Press, Ithaca and London, 1989, pp. 88-106.

⁴⁵ Ibid. p. 29.

⁴⁶ Ibid.

⁴⁷ Edward S. Herman, ‘Immiseration and Human Rights’, Third World Resurgence, No. 58, June 1995, pp. 41-43.

context are sometimes viewed with unnecessary suspicion by certain sections of the left because of their long antecedent as a tool of the middle class quest for power.⁴⁸

The modern international human rights regime was established under the auspices of the United Nations (UN) in the wake of the second world war. One of the early objectives of the UN was to draw up an agreement regarding the basic rights of all human individuals which should be respected by all present and future governments. The first products of this dialogue were 1948 conventions concerned with the freedom of association and the prevention of genocide, together with the Universal Declaration of Human Rights. The Universal Declaration was intended as the basis for future international law. This did not eventuate until 1966 when two binding human rights covenants were approved by the UN General Assembly — The International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).

The Universal Declaration, together with the two Covenants, now form the core of a growing international human rights regime and the three documents together are often referred to as The International Bill of Human Rights.⁴⁹ Whereas the two Covenants are considered to be legally binding on the participating nations, the Universal Declaration is of a lesser legal order, although it too is now considered by many commentators to have gained the status of international law through its regular usage to invoke legal, moral and political legitimacy.⁵⁰ Australia, along with an overwhelming majority of the world's nations, has ratified all three documents and has inserted the ICCPR into Australian law by incorporating it in the Human Rights and Equal Opportunities Act.⁵¹

The International Bill of Human Rights has the potential to supply the world with the foundation for an international system of justice in the same way as the United States Bill of Rights has been used as the basis for US justice for the last two hundred years. The principle is that the Bill of Rights defines in law the limits of authority that can be imposed on individuals, as well as the basic necessities that are required by them, so that all individual people, in every place, and at all times, can retain their human dignity.

Human Rights, Science and Technology

Although human rights have hitherto been under-utilised as methodology for STS research their usefulness for this purpose is readily apparent. The United Nations has long held the view that

⁴⁸ Dunn, *op.cit.*, pp. 24-27.

⁴⁹ Leah Levin, *Human Rights* United Nations Educational, Scientific and Cultural Organisation, Paris, 1982, p. 17.

⁵⁰ *Ibid.* pp. 12-13.

⁵¹ Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into the Human Rights of People with Mental Illness* Australian Government Publishing Service, Canberra, 1993, p. 21.

scientific and technological developments can pose a direct threat to human rights. This view was first officially expressed at a 1968 UN conference held in Teheran to mark the twentieth anniversary of the Universal Declaration of Human Rights. The Proclamation of Teheran stated that, “While recent scientific discoveries and technological advances have opened vast prospects for economic, social and cultural progress, such developments may nevertheless endanger the rights and freedoms of individuals and will require continuing attention”.⁵²

The conference identified a number of areas for priority consideration: privacy issues arising from developments in recording techniques; the protection of physical and intellectual integrity in the light of advances in biology, medicine and biochemistry; the way in which electronics might threaten people’s rights; and “more generally, the balance which should be established between scientific and technological progress and the intellectual, cultural, and moral advancement of humanity.”⁵³

Through the 1970s concern about the effect that scientific and technological developments might be having on human rights was a constant feature of UN conferences and a number of studies were commissioned on the subject. A review of these studies in 1982 found that,

Science being itself a part of culture, the essential problem facing mankind in relation to scientific and technological progress, on the one hand, and the intellectual, spiritual, cultural and moral advancement of humanity, on the other, is to decide on the appropriate two-way relationship which should exist between them An investigation of this relationship includes an examination of the impact, both beneficial and harmful, of recent scientific and technological developments upon the rights laid down in the Universal Declaration of Human Rights.⁵⁴

The division of scientific and technological impacts on human rights into beneficial and harmful aspects has since become a standard feature of UN thinking.

There are signs that some professional organisations of scientists are becoming increasingly aware of the human rights obligations of their members. In the United States the American Association for the Advancement of Science (AAAS) conducts a forensic sciences training course designed for

⁵² United Nations, 'Proclamation of Teheran', quoted in Yo Kubota, 'The Institutional Response', in C. G. Weeramantry (eds), Human Rights and Scientific and Technological Development, United Nations University Press, Tokyo, 1990, p. 108.

⁵³ Ibid.

⁵⁴ United Nations, Human Rights and Scientific and Technological Developments, pp. 91-92, quoted in Yo Kubota, 'The Institutional Response', in C. G. Weeramantry (eds), Human Rights and Scientific and Technological Development, United Nations University Press, Tokyo, 1990, pp. 120-121.

doctors, lawyers and other professionals who are working for human rights organisations investigating the activities of repressive governments.⁵⁵

The AAAS also recognises that “[t]he pursuit of knowledge and scientific discovery are enhanced in an environment where human rights are protected.”⁵⁶ The particular rights the AAAS considers are most pertinent “include the right to education and work; the right to seek, receive, and impart information and ideas; freedom of movement and residence; and freedom of association and assembly”.⁵⁷

Japanese historian of science Shigeru Nakayama has examined the possibilities of utilising human rights in STS analysis and has devised a system for applying human rights to test scientific and technological developments. His system involves the use of a table which divides science and technology into four types: academic, industrial, defence and service. These divisions are cross-referenced with three essential features of scientific and technological development: the method by which the science is assessed, the nature of the competitive atmosphere in which it is developed, and whether expression of the science is open or classified.⁵⁸ (See table below).

Nakayama’s purpose is to identify stages of development at which different kinds of science and technology can be assessed for their human rights value. The implication is that some kind of professional self-regulation might be possible which would require scientists and technologists to evaluate their work at various stages of development in order to identify potentially harmful aspects before they actually manifest as human rights problems.

⁵⁵ Kari Hanibal, Taking Up The Challenge: The Promotion of Human Rights. A Guide for the Scientific Community American Association for the Advancement of Science, Washington, 1992, p. 11.

⁵⁶ Ibid., p. 4.

⁵⁷ Ibid., p. 5.

⁵⁸ Shigeru Nakayama, ‘Human Rights and the Structure of the Scientific Enterprise’, in Weeramantry op.cit., p. 138.

Human Rights and Psychiatry

When the international system for the protection of human rights was developed after the second world war, it was largely in response to Nazi atrocities. The Nazis had held a collective belief that the German nation was a living organism and that its well-being was threatened by “useless eaters” and “life unworthy of life”.⁵⁹ The German medical profession, 45% of whom belonged to the Nazi Party in the early 1930s, was empowered to tend to the health of the national organism. The psychiatric branch of the profession led the way by “medically killing” some 80,000-100,000 hospitalised mental patients. The expertise the Nazi psychiatrists acquired in killing off their mental patients was later applied to Jewish people.⁶⁰

Even under the legislative frameworks that are typical of most modern democratic societies, psychiatry still treads a particularly fine line between benefiting and harming the exercise of human rights. This is largely because the social objectives of psychiatry and human rights are, to some extent, opposed to one another. While the basic principle of human rights is to set limits on the degree of social authority which is allowed to be imposed on individuals, the speciality of psychiatry is to fit ‘difficult’ individuals into the social fabric. These fundamental differences sometimes threaten to turn psychiatry and human rights into antitheses, even in the most benign political conditions.

Psychiatry has little trouble in establishing its potential benefit to the exercise of human rights when ‘difficult’ individuals acknowledge that they have a mental disease and seek treatment for it. A specific article of human rights law that psychiatry can enhance in this way is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 concerns “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁶¹

The second part of this article specifies “The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness”.⁶² The human rights sentiments expressed in Article 12 are the basis for the ‘right to

⁵⁹ Robert Jay Lifton, The Nazi Doctors: Medical Killing and the Psychology of Genocide Basic Books, New York, 1986, p. 46.

⁶⁰ Ibid., pp. 34, 134-144.

⁶¹ United Nations, ‘International Covenant on Economic, Social and Cultural Rights’, Article 12 (1), reproduced in Satish Chandra, ed. International Documents on Human Rights Mittal Publications, New Delhi, 1990, p. 16.

⁶² Ibid.,

treatment’ which is often promoted by advocates of the medical model as being the most important human right in regard to psychiatry.⁶³

But the ‘right to treatment’ can have a hollow ring to it when psychiatry is practised on people against their will. Many ‘difficult’ people deny they have a mental illness or, if they are willing to acknowledge it, prefer not to have it treated. The human rights problems for psychiatry largely arise from the tendency of most modern industrial societies to have mental health laws which empower psychiatrists to make clinical judgements about the mental health of the people they encounter in their work and to impose treatment on them, without their consent, if it is thought necessary.

Involuntary mental patients often find themselves in a situation in which they are incarcerated for an indefinite period without being charged with a criminal offence, interrogated, coerced into changing their thoughts and beliefs, subjected to painful and uncomfortable treatments if they cannot or will not make the required mental changes, and denied freedom until their identity has been sufficiently modified. It is in this context that questions arise about whether certain psychiatric practices might violate other human rights.

Soviet Psychiatry

Perhaps the most blatant example of human rights abuse by psychiatry in recent times occurred in the Soviet Union. In the last couple of decades of the Soviet regime, the communist authorities viewed a growing epidemic of political dissidence as a malign social force and Soviet psychiatrists were empowered to assist in dealing with it.

As early as 1974, psychiatrists in the West had become curious about reports of the high prevalence of schizophrenia in the Soviet Union — 5-7 per 1,000 population compared to 3-4 per 1,000 in the UK.⁶⁴ In due course it was revealed that Soviet psychiatrists had discovered a unique form of mental disease to fit the profile of political dissidents. They called the condition “sluggish schizophrenia, a form of schizophrenia where the symptoms are subtle, latent or only apparent to the skilled eye of the psychiatrist”.⁶⁵ Soviet dissidents who “wanted to reform the system and claimed that they had the personal vision to do it were exhibiting the text-book symptoms of sluggish schizophrenia.”⁶⁶ Soviet psychiatrists became so deeply involved in the control of political

⁶³ See for example, John Grigor, ‘The Right To Treatment’, in Human Rights and Equal Opportunity Commission (eds), Schizophrenia: Occasional papers from the Human Rights Commissioner, Number 1, Sydney, 1989, pp. 7-14.

⁶⁴ J. K. Wing, ‘Psychiatry in the Soviet Union’, British Medical Journal, 9 March 1974, p. 435.

⁶⁵ David Cohen, Soviet Psychiatry: Politics and Mental Health in the USSR Today Paladin, London, 1989, p. 24.

⁶⁶ Ibid., p. 44.

dissidents that a whole system of special mental hospitals was established which they ran in co-operation with the KGB.⁶⁷

When the full situation became apparent to the international psychiatric community, there was widespread condemnation of the Soviet practice. In order to pre-empt inevitable expulsion from the World Psychiatric Association (WPA), the Soviet professional organisation, the All-Union Society of Neuropathologists and Psychiatrists, resigned from the WPA in 1983.⁶⁸ The WPA responded to the resignation by announcing that the Soviets would be welcome to return if they provided “evidence beforehand of amelioration of the political abuse of psychiatry in the Soviet Union”.⁶⁹ It is worth noting that the WPA considered that ‘amelioration’ was all that was necessary to bring the Soviets back into line with international standards. Perhaps what prompted this conciliatory approach was the general perception amongst western psychiatrists that, despite the abuses, “the concept of disease employed in the former USSR was similar to its counterpart in the UK and USA in being strongly scientific in nature.”⁷⁰

UN Principles on Mental Illness

The Soviet use of psychiatry for political purposes was the catalyst for a more general investigation into international psychiatric practices by the UN Commission on Human Rights. In 1977 the Commission appointed a “Sub-Commission to study, with a view to formulating guidelines, if possible, the question of the protection of those detained on the grounds of mental ill-health against treatment that might adversely affect the human personality and its physical and intellectual integrity”.⁷¹ The primary task given to the two Special Rapporteurs the Sub-Commission subsequently appointed was to “determine whether adequate grounds existed for detaining persons on the grounds of mental ill-health”.⁷²

The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care⁷³ did not emerge until more than a decade later. Unfortunately, despite the

⁶⁷ *Ibid.*, pp. 102-120.

⁶⁸ A. L. Halpern, ‘Current Dilemmas in the Aftermath of the US Delegation’s Inspection of the Soviet Psychiatric Hospitals’, Paper presented at the Emerging Issues For The 1990s In Psychiatry, Psychology And Law, Proceedings of the 10th Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law, Melbourne 1989, p.11.

⁶⁹ C. Shaw, ‘The World Psychiatric Association and Soviet Psychiatry’, in Robert Van Voren (eds), Soviet Psychiatric Abuse in the Gorbachev Era, International Association on the Political Use of Psychiatry, Amsterdam, 1992, p. 50.

⁷⁰ K. W. M. Fulford, A. Y. U. Smirnov and E. Snow, ‘Concepts of Disease and the Abuse of Psychiatry in the USSR’, British Journal of Psychiatry, Vol. 162, 1993, pp. 801-810.

⁷¹ Kubota, *op.cit.*, p. 115.

⁷² *Ibid.*

⁷³ United Nations Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, *op.cit.*, pp. 989-1005.

brave start, the final document had been so repeatedly rewritten and massaged by numerous committees dominated by psychiatrists that the original focus was lost. The primary tasks of attending to involuntary detention and the risks of treatment were largely buried by cross-referencing and other priorities.

The final version of the 'Principles' adopted by the United Nations General Assembly in 1991 is primarily designed to protect the rights of voluntary patients, not involuntary patients. Principle 1 begins with an assertion of the 'right to treatment'. This right thereafter becomes the basis for most of the other voluntary patients' concerns, like confidentiality and protection against discrimination, addressed by the document.

Where the 'Principles' do address the problems of involuntary patients, it is done in a way that tends to undermine their rights rather than protect them. Principle 11, for instance, deals with "Consent to Treatment" and specifies that "No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13, and 15." Paragraph 6, however, denies the right of informed consent to involuntary patients: ".... treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied: (a) The patient is, at the relevant time, held as an involuntary patient;"⁷⁴

Involuntary admission is not only permitted under the 'Principles' but the criteria which are specified for correct procedure were considerably less restrictive than those which were contained in the NSW Mental Health Act (MHA)⁷⁵ at the time the Principles were brought into force. Whereas the NSW MHA, at this time, required that a person must be thought likely to cause serious physical harm to themselves or other people before involuntary commitment was permitted, under the 'Principles' a person can be committed merely because "a qualified mental health practitioner" considers the person's condition is likely to deteriorate, or treatment will be prevented, without incarceration.⁷⁶ (It is worth noting that the NSW MHA has recently been amended to bring it more closely into line with the UN Principles.⁷⁷)

The weakness of the UN Principles in relation to involuntary patients invites a speculation: had the Principles been in existence in the 1970s and 1980s would they have deterred the Soviets from using psychiatry for political purposes? The answer to this question is by no means certain.

⁷⁴ *Ibid.*, Principle 11, pp. 994-995.

⁷⁵ New South Wales Parliament, NSW Mental Health Act 1990, Reprinted as in force at 17 October, NSW Government Information Service, Sydney, 1994, Section 9, p. 5.

⁷⁶ United Nations Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care', *op.cit.*, Principle 16, p. 1000.

⁷⁷ New South Wales Parliament, Mental Health Legislation Amendment Bill 1997, NSW Government Information Service, Sydney, Section 9, p. 3.

Although Principle 4 requires that diagnosis “shall be made in accordance with internationally accepted standards” and “A determination of mental illness shall never be made on the basis of political, economic or social status”⁷⁸ these requirements might have simply guided Soviet psychiatrists to be more circumspect in their definitions.

The Burdekin Inquiry

The UN Commission on Human Rights was not the only official human rights body to be galvanised into action by the Soviet example — only to end up burying psychiatry’s darker side beneath a restatement of the ‘right to treatment’. The Australian Human Rights Commissioner, Brian Burdekin, in his opening address to the Sydney hearings of the 1991/92 Inquiry into Human Rights and Mental Illness, referred to Soviet psychiatry and said that Soviet human rights abuses in this area had been the catalyst for his own Inquiry.⁷⁹

Burdekin explained that human rights circles in the Western democracies had formed the view that investigations were required into the mental health systems of democratic countries, to ensure that they were beyond reproach, before a full human rights assault could be launched on the Soviet psychiatric system. He said that his own Inquiry had been conceived as part of this project but that while preparations had been under way to commence his Inquiry the issue had gone off the boil because the Soviet Union had collapsed.⁸⁰ This change of affairs probably explains the confusion that subsequently developed in the Commission’s priorities over mental health.

The Commission’s confusion of priorities is apparent in a number of respects. One of them is the apparent lack of significance given by the Inquiry to the rights of involuntary patients when they conflict with the needs of their frustrated relatives. Under the heading of “Involuntary Detention” the Burdekin Report observed that:

Involuntary detention — for any reason and under any circumstances — is an extremely serious matter involving curtailment of several fundamental rights the most important of which is the right to liberty. The Inquiry received extensive evidence on this subject, particularly from consumers.⁸¹

⁷⁸ United Nations Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, op.cit., Principle 4, p. 992.

⁷⁹ Brian Burdekin, Federal Human Rights Commissioner, Opening Address to Sydney hearings, National Inquiry into Human Rights and Mental Illness, June 17, 1991, Personal observation.

⁸⁰ Ibid.

⁸¹ Human Rights and Equal Opportunity Commission, op.cit., p. 230.

Even so, after only one more brief sentence on the subject the report moves on to a lengthy discussion in support of denying the very same “fundamental rights” the Inquiry had just recognised:

Difficulty in Gaining Involuntary Admission — Families and other carers are faced with a dilemma when the person for whom they are responsible has lost touch with reality and has insufficient insight⁸² into his or her condition to accept the need for treatment.⁸³

The Commission’s confused priorities become further evident when the terms of reference are carefully analysed in the light of the subsequent course of the Inquiry. The first term of reference clearly listed the classes of people the Inquiry had initially intended to deal with: “To inquire into the human rights and fundamental freedoms afforded to persons who are or have been or *are alleged to be* affected by mental illness, having due regard for the rights of their families and members of the general community”.⁸⁴ [my italics]

What is meant by *alleged to be affected* by mental illness is not immediately apparent. An early usage of the term ‘alleged mental illness’ can be found in a published dialogue between US patient rights activist Leonard Roy Frank and American Civil Liberties Union attorney and mental patient advocate, Bruce Ennis. Ennis explained in the interview that he used ‘alleged mental illness’ because “I personally have seen no evidence at all that there is such a thing as mental illness”.⁸⁵

The terms of reference made no attempt to define what it meant by *alleged* but it is unlikely that it was used to question the existence of all mental illnesses in the way that Ennis used the term. What is more likely is that in the planning stage of the Inquiry it was thought necessary to distinguish between certainty in the accuracy of diagnoses of mental illness when applied to some people and uncertainty when the diagnoses are applied to other people.

There are at least two ways the Inquiry might have originally intended to utilise this distinction. The first possibility may have been an intention to examine the problem of false positive diagnosis. This is a perennial problem for psychiatry and arises from the subjective nature of psychiatric diagnostic

⁸² ‘Insight’ is a Catch-22 device used in psychiatric coercion. A person who rejects the label of mental illness is said to lack insight into their condition. Lack of insight means the condition is much worse than would otherwise be the case and it therefore requires more drastic treatment for a longer period. Critics of psychiatric coercion have likened the demand for ‘insight’ to that of a torturer’s demand for ‘confession’.

⁸³ Human Rights and Equal Opportunity Commission, *op.cit.*, p. 230.

⁸⁴ *Ibid.*, p. 5.

⁸⁵ Leonard Roy Frank, ‘An Interview with Bruce Ennis’, in Sherry Hirsch, Joe Adams, Leonard Frank, Wade Hudson and David Richman (eds), *Madness Network News Reader*, Glide, San Francisco, 1974, p. 165.

techniques and the lack of laboratory tests to confirm most diagnoses. The second possibility may have been an intention to review patients diagnosed with certain varieties of mental illness — like the Soviets' sluggish schizophrenia — which are not generally recognised by international standards but which some psychiatrists may allege to exist. Perhaps the Inquiry had originally planned to investigate both problems. There are well established concerns about Western psychiatric practice regarding both the problem of false positive diagnosis⁸⁶ and the proliferation of new varieties of mental disease.⁸⁷

Regardless of what the Inquiry's original interpretation of *alleged mental illness* might have been it certainly seems appropriate that an Inquiry into Human Rights and Mental Illness should give hearing to any person who might have suffered the discomfort and humiliation of a psychiatric diagnosis, and possibly incarceration and imposed treatment, on the basis of a mere allegation. But despite the nomination of this category in the terms of reference, as it transpired, the Inquiry completely ignored these people. They were not mentioned in the Inquiry's report at all outside of the terms of reference.

In fact the definitions that were eventually adopted by the Inquiry made it impossible to recognise people who *are alleged to be* mentally ill. The Inquiry chose to use the term "consumer"⁸⁸ to describe all of the people who are deemed to have a mental illness, thereby implying they are all willing participants in a mental health service industry. This does not necessarily pose a problem for the recognition of people who *are or have been* mentally ill but the description of "consumer" was totally inappropriate for those who *are alleged to be* mentally ill. Neither false positives nor people diagnosed with non-existent diseases could satisfactorily be described as consumers.

The inability of the Inquiry to recognise the *alleged* group is further apparent in a table published in the Inquiry's report which classifies the people who made submissions and were witnesses to the Inquiry⁸⁹ (see table overpage). If the category of "Consumers" is indeed inapplicable for those who *are alleged to be* mentally ill then the only other categories into which they might fit are "Concerned citizens" or "Others". Although these two categories made 68 and 28 written submissions respectively, not a single person from either of these two groups was called as a witness.

⁸⁶ See for example, David Pilgrim and Anne Rogers, A Sociology of Mental Health and Illness Open University Press, Buckingham, 1993, p. 55.

⁸⁷ See for example, Stuart A. Kirk and Herb Kutchins, The Selling of DSM: The Rhetoric of Science in Psychiatry Aldine De Gruyter, New York, 1992, pp. 1-16.

⁸⁸ Human Rights and Equal Opportunity Commission, op.cit., p. 13.

⁸⁹ Ibid., p. 10.

It seems apparent therefore that somewhere between the time when the terms of reference were drafted and the time when the hearings of witnesses began, a mechanism was deliberately or inadvertently put into place which blocked the people who *are alleged to be* mentally ill from influencing the outcome of the Inquiry.

Interest groups representing the mystical and the myth-of-mental-illness models for schizophrenia would have been greatly disadvantaged by the Inquiry's cold-shouldering of people who *are alleged to be* mentally ill. The breakdown of the Inquiry's participants in the table on the next page indicates a definite slant to favour some interest groups which support medical models for explaining extreme mental conditions like schizophrenia.

The favoured treatment of psychiatrists and profession psychiatric associations is particularly evident in the ratios of their written submissions to the number of their witnesses. This ratio suggests the Inquiry might have solicited psychiatrists as expert witnesses. The opposite indication is apparent for "Consumers" where the number of written submissions was more than four times the number of witnesses. The contrasting levels of influence between these two interest groups suggests they might hold different positions on Pross's funnel of mobilisation.

Burdekin Inquiry Participants

Conclusion

Various interest groups are driving the controversy over the cause of the symptoms of schizophrenia by adopting conflicting human rights imperatives to amplify their claims. It is proposed to use a combination of interest group theory and human rights law as a framework for analysing the dynamics of this controversy. Although there is a disproportion in the power and influence of the interest groups supporting each of the three models, Pross's "funnel of mobilisation" is a useful framework for dealing with this disproportion.

Psychiatric practice, in so much as it is concerned with reshaping atypical individuals and fitting them into the social fabric, has the potential to enhance some human rights while endangering others. But all human rights do not have equal significance in international law. The disproportion in the power and influence of the interest groups driving each of the models does not necessarily reflect the relative standing in international law of the conflicting human rights which are separately used to give moral credibility to each of the three models. It is possible that the medical model, by far the most widely recognised of the three models, actually relies on human rights imperatives that have lower standing in international law than the human rights supporting the other two models.

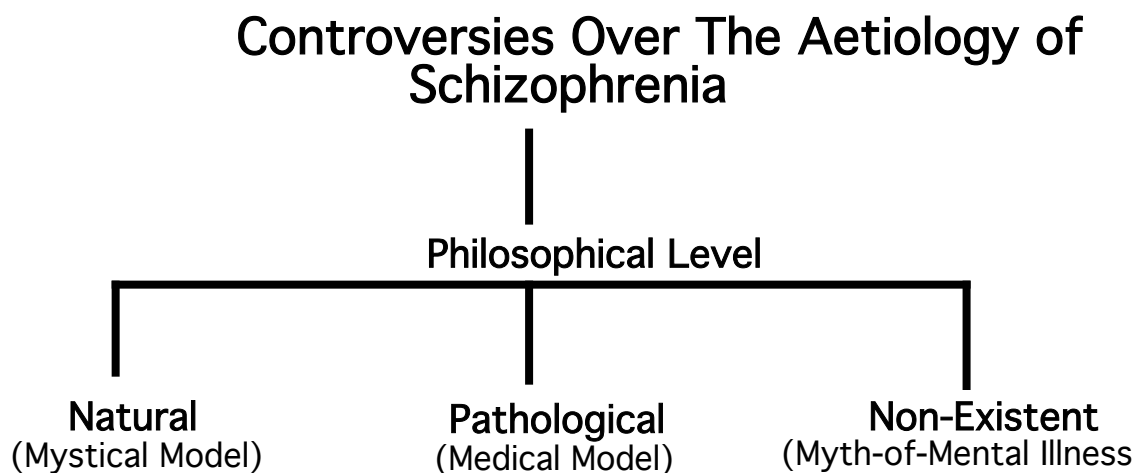
3. The Medical Model: Schizophrenic Symptoms as Pathology

This chapter begins with an introduction to the philosophical level of the debate. The concept of medical pathology is discussed, followed by a description of the current diagnostic criteria for schizophrenia. The origins of descriptive psychopathology for schizophrenia are examined and an outline is given of the work of Kraepelin and Bleuler, the first psychiatrists to define schizophrenia as a distinct disease entity.

Introduction

Controversies about the aetiology of schizophrenia first arise on a philosophical level, as distinct from the scientific/psychiatric level, largely because it is not self-evident that a condition, characterised by an unusual pattern of thoughts and beliefs, is necessarily a medical problem.

The philosophical controversies that are generated by speculation about the cause of schizophrenia can be brought into focus by assembling the main arguments into three platforms. These three platforms are: (1) the symptoms of schizophrenia have a pathological cause (medical model);¹ (2) they have a natural cause (mystical model);² (3) the cause is non-existent, i.e. the symptoms are consciously selected behaviours (myth-of-mental illness model).³



To cast light on the nature of these three platforms it is useful to briefly apply them to a couple of other conditions that also generate controversy as a result of being medicalised. Baldness might be useful as a comparative example. Does baldness have an underlying pathological cause requiring

¹ C. Tennant, 'Psychosocial factors in psychiatric illness', in Pierre J. V. Beumont and R. B. Hampshire (eds), Textbook of Psychiatry, Blackwell Scientific Publications, Melbourne, 1989, pp. 478-479.

² Seth Farber, Madness, Heresy, and the Rumor of Angels Open Court, Chicago, 1993, pp. 13-18.

³ Thomas Szasz, Schizophrenia: The Sacred Symbol of Psychiatry Syracuse University Press, Syracuse, New York, 1976.

medical attention?⁴ Is it a natural part of the aging process? Or, is it merely a stylistic affectation some people express by shaving their heads?

Homosexuality, which until fairly recent times was also classified as a mental disease,⁵ can be compared in a similar way. Is homosexuality a manifestation of mental disease requiring medical treatment? Is it one of a variety of natural forms of sexual expression? Or, is it an adaptation some people — like prisoners — choose to make when they are denied the companionship of the opposite sex?

In the cases of baldness and homosexuality, it should be fairly apparent that the third platform, the argument that they have non-existent causes and are only the result of personal choices, most certainly applies to some people who fall into these two classes, but obviously not to all. But deciding which of the other two platforms, pathological or natural, is the more generally applicable, is not so readily apparent. To make an assessment in this regard it might be useful to examine the concept of ‘disease’ and see how it differs from the idea of ‘natural’.

One approach to understanding what is a disease and what is not disease is to consider the concept of function.⁶ Function is an attractive approach because the arguments can be made to appear objective.⁷ If the function of hair on top of a man’s head, for instance, is to provide insulation for his brain against extremes of heat and cold, and the climate demands this insulation so that a bald man must take special precautions, then a lack of hair might be considered a malfunction and therefore a disease.

But if, on the other hand, the function of hair on a man’s head is to attract sexual attention, and the baldness only develops after the man is no longer sexually active, then lack of hair in an elderly man would hardly constitute a malfunction. But some human features have both function and accidental utility and it is important to distinguish between them. A nose, for instance, “has the function of heating and humidifying inspired air”⁸ but it also has the accidental utility of being able to support spectacles. So according to this line of thinking a nose that functions properly, although it is unusually shaped, might be an oddity, but it wouldn’t be diseased simply because it was unsuitable for supporting spectacles.

⁴ See for instance, Steve Dow, ‘New pill hailed as cure for baldness’, Sydney Morning Herald, June 10 1997.

⁵ Jenny J. van Drimmelen-Krabbe, T. Bedirhan Ustun, David H. Thompson, Andre L’Hours, John Orley and Norman Sartorius, ‘Homosexuality in the International Classification of Diseases: a clarification’, JAMA, The Journal of the American Medical Association, Vol. 272, No. 21, 1994, p. 1660.

⁶ R. Finlay-Jones, ‘Disease and Illness’, in Beumont and Hampshire, op.cit., p. 1

⁷ Lawrie Reznick, The Nature of Disease Routledge and Kegan Paul, London and New York, 1987, p. 98.

⁸ Ibid., p. 100.

The function test can also be applied to homosexuality, but there might be philosophical problems to solve in choosing between possible functions. Is the function of human sexuality to procreate, or is it to give pleasure? If it is to procreate then homosexual expression might be considered a malfunction. But such an argument would also render all other non-reproductive sexual expression, involving contraception and bad timing, a malfunction, and therefore diseased, as well.

But the test of functionality seems even more problematic when it is applied to schizophrenia.⁹ One of the functions of the human mind would appear to be the formulation of thoughts and beliefs. But the mere formulation of thoughts that appear to normal people to be unusual or bizarre, and beliefs (delusions) that are judged to be false, is not enough in itself to indicate malfunction. A mind could only malfunction in this regard if it had first been clearly established that functional thoughts and beliefs must necessarily conform with social norms.¹⁰

A converse problem with the functionality test occurs when it is agreed that a certain condition definitely indicates malfunction but the cause of the malfunction is in dispute. Death, for instance, is a fairly definite indication of serious malfunctioning. Yet surveys of medical students, interns and hospital resident doctors have shown that only 56-57% of them can correctly identify causes of death on death certificates.¹¹ This converse approach to malfunction can be tested on a schizophrenic symptom like hallucinations. It might be agreed that an hallucinating mind is definitely malfunctioning but theories on the cause of the hallucinations might range from something essentially non-medical like fatigue to a cause that is indisputably medical like malarial infection.

But if the functionality test for distinguishing disease is problematic there are several others to try. One involves discarding the pseudo-objectivity of functionality by adopting normativism: "Normativism is the thesis that the concept of disease is value-laden and the most plausible Normativist Theory defines diseases in terms of harm."¹² On the surface this is a simple premise: if a person is harmed in any way by having a certain condition, and is worse off than they would otherwise be, then the condition can be described as a disease.¹³

⁹ X. F. Amador, D. H. Strauss, S. A. Yale and J. M. Gorman, 'Awareness of Illness in Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 113-132.

¹⁰ James J. McDonald and Paul R. Lees-Haley, 'Personality disorders in the workplace: how they may contribute to claims of employment law violations', Employee Relations Law Journal, Vol. 22, No. 1, 1996, pp. 57-81.

¹¹ Jacqueline Messite and Steven D. Stellman, 'Accuracy of death certificate completion: the need for formalized physician training', JAMA, The Journal of the American Medical Association, Vol. 275, No. 10, 1996, pp. 794-797.

¹² Reznek, op.cit., p. 134.

¹³ Carol Ann Rinzler, 'Odd ills (new ailments)', American Health, Vol. 15, No. 7, 1996, pp. 16-18.

Many non-controversial disease descriptions, like cancer and cholera, are easily accommodated by the test of ‘harm’. But problems are soon encountered when the test of ‘harm’ is applied more widely. On the one hand there are many conditions which apparently cause harm, like ignorance and clumsiness, but which are not usually described as diseases. While on the other hand, a mild dose of what is clearly understood as a disease, in the form of a vaccination, for instance, can be good for a person, rather than harmful.

The problem with using ‘harm’ as the criterion for determining disease is further exacerbated if we return to our three test cases — baldness, homosexuality and schizophrenia. In each case there are circumstances in which a major aspect of the harm that can be caused by these conditions appears to come from cultural values, in the forms of aesthetics, prejudice and discrimination, rather than from individual incapacity. If we were to allow social harm to determine what is and is not disease we might leave the door open to claims that beautiful people are more healthy than ugly people; that light coloured skin in a predominantly black society, and vice versa, are diseases; and that personal traits that tend to give offence like vulgarity, loud voices and excitable behaviour,¹⁴ are all symptoms of disease.

A further problem with the concept of ‘harm’ is that from time to time medical scientists develop notions that certain conditions are harmful, and forcefully propagate their view. Subsequently, however, a consensus view might develop that relegates this condition back to the status of non-disease. There are a number of examples of this tendency, the more notable ones often being to do with reproductive organs: “In 1856 T. B. Curling considered that the frequent emission of sperm gave rise to ‘constitutional symptoms of a serious character’, and constituted the disease of ‘spermatorrhoea’. However, frequent ejaculation is not harmful, and so there is no such disease.”¹⁵

Another approach to the nature of disease would be to consider the question of whether diseases are invented or discovered. To argue that diseases are discovered is to assume that disease classification is an ongoing process after the fashion of biological and botanical classification systems. But there is a major problem with this assumption. The entities that we call diseases all share one essential characteristic that isn’t necessarily found amongst those entities we place in biological or botanical classes. Like ‘pests’, diseases all derive their class identity from human values and human attitudes towards them. Two bacteria might share very similar properties and be both placed in the same biological family but only the one that causes human disapproval, through causing ill-health in humans, or to domesticated animals or food crops, will be classified as a disease-causing organism.

¹⁴ See for instance, David B. Allison and Mark S. Roberts, ‘On constructing the disorder of hysteria’, *The Journal of Medicine and Philosophy*, Vol. 19, No. 3, 1994, pp. 238-259.

¹⁵ Reznek, *op.cit.*, p. 208.

When looked at this way it seems apparent that human values play an essential part in determining what is, and what is not, a disease.

Regression Theories

It is these human values that have produced a cultural consensus in modern industrial societies whereby people who manifest schizophrenic symptoms are said to be mentally diseased.¹⁶ This assumption of pathology is a way of explaining a commonly held belief that people who appear to lose control of their minds are thereby deprived of some essential aspect of their humanity. This attitude has its origins in the period of European cultural development generally referred to as the Enlightenment.¹⁷ Enlightenment thinkers bequeathed to the people of contemporary industrial societies a belief that rational, self-controlled thought is the essential function of a fully developed human being. Mental activity that lacks rationality and self-control is viewed as harmful and as being less than fully human. Throughout the Enlightenment mad people were usually treated as if they had lost their humanity and had reverted to an animalistic state.¹⁸ This Enlightenment view of madness allowed for mad inmates of institutions to be kept in chains and sometimes displayed like zoological exhibits.¹⁹

It is from this treatment-as-animals that the medical profession claims to have rescued mad people around the turn of the 19th century by medicalising their condition and redefining it as mental illness.²⁰ In doing so, however, some elements of the medical profession retained the notion, although somewhat vaguely, that irrationality and loss of mental control are expressions of less than full humanity.²¹ In relation to schizophrenic symptoms modern psychiatry has two alternative forms of ‘regression’ theory which are used for explaining the nature of this shortcoming. One explanation of regression is that schizophrenic symptoms indicate a reversion to thought patterns which are believed to have prevailed in the minds of early or primitive human types. In this context schizophrenic delusions have been referred to as ‘paleological thinking’ by some psychiatric theorists.²² This psychiatric hypothesis, however, is largely speculative and does not have a substantial following.

¹⁶ Chris L. Fleshner, ‘Insight from a Schizophrenia Patient with Depression’, Schizophrenia Bulletin, Vol. 21, No. 4, 1995.

¹⁷ Michel Foucault, Mental Illness and Psychology Harper and Row, New York, 1976, pp. 64-75.

¹⁸ Michel Foucault, Madness and Civilisation: A History of Insanity in the Age of Reason Vintage Books, New York, 1965, pp. 76-78.

¹⁹ A. Rosenblatt, ‘Concepts of the asylum in the care of the mentally ill’, Hospital and Community Psychiatry, Vol. 35, 1984, p. 244.

²⁰ Norman L. Keltner, Lee Hilyard Schwecke and Carol E. Bstrom, Psychiatric Nursing, Mosby, St. Louis, 1995, p. 5.

²¹ Phil Gunby, ‘Epidemiology indicates a disorder that assaults much of patients’ ‘humanness’ in prime of life. (schizophrenia)’, JAMA, The Journal of the American Medical Association, Vol. 264, No. 19, 1990, p. 2487.

²² See for instance, S. Arieti, Interpretation of Schizophrenia, Basic Books, New York, 1974.

A second, more commonly accepted explanation was originally provided by early psychiatric theorists like Freud. These early theorists were interested in psychotic phenomena for the light that might be shed on the development of thinking processes from childhood to adulthood: “there was an assumption that psychotic processes reflected some regression to an earlier, and more ‘primitive’ level of organisation”²³ found in children. Freud used the term “primary process” to describe a child’s first mode of thinking. He contrasted this with “secondary process” which he thought was an adult way of thinking.

Primary process thinking is, first of all, drive-directed. Its content and direction are determined by impulses rather than by considerations of external reality. Secondary process thinking is, instead, reality-oriented, having been developed to facilitate adaptation to the world outside the self.²⁴

Using this formula there are a number of ways that the inward focus of schizophrenic thinking can be likened to childish thought processes. Delusions and hallucinations can be interpreted as wish fulfilment; schizophrenics can be observed to deny reality in the pursuit of their own goals in the way that demanding children do; and demonstrably infantile forms of behaviour, like playing with faeces, can sometimes be observed in schizophrenics.

However, there is no universal pattern to these observations and the same childish thinking and behaviour can be observed in various types of non-schizophrenic people. Prisoners, for instance, will sometimes smear faeces on the walls of cells as a form of protest and many gamblers may attempt wish fulfilment by holding delusions about being in contact with forces that control the outcome of chance.

But the weaknesses of regression theories do not threaten to undermine the medical model. The security of the mainstream psychiatry position does not rest on either closely argued theory or empirical evidence. Instead it remains largely unformulated and mostly relies on affirmation provided by a widespread lay understanding, often gained directly through observation of family members, that the behaviour of people with schizophrenic symptoms is self-evidently caused by a weakness in the mind. This weakness is most easily explained by notions of illness:

²³ Fred R. Volkmar, ‘Childhood and adolescent psychosis: a review of the past 10 years’, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 35, No. 7, 1996, pp. 843-852.

²⁴ Loren J. Chapman and Jean P. Chapman, Disordered Thought in Schizophrenia Prentice-Hall, Englewood Cliffs, New Jersey, 1973, p. 208.

Literary portrayals such as the madness of Orestes in the *Oresteia* of Aeschylus and the mumblings of Poor Tom in *King Lear* make it clear that serious psychoses have been recognised even by lay people for many years.²⁵

In this situation the psychiatric profession prefers to focus most of its attention on the problem of standardising the diagnostic criteria for schizophrenia rather than going to the trouble of providing a persuasive philosophical rationale for pathology.²⁶ This is to ensure some consistency of diagnosis since it has to be done in the absence of any confirmation from laboratory tests.

Current Diagnostic Criteria

There are two internationally-recognised diagnostic systems for mental disorders which psychiatrists currently use in most countries of the world.²⁷ One is the 10th revision of the International Classification of Diseases (ICD 10),²⁸ compiled and published by the World Health Organisation. The other is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM IV),²⁹ compiled and published by the American Psychiatric Association. The respective teams of psychiatric researchers responsible for compiling successive editions of the ICD and DSM systems have cooperated closely in their work to ensure that the two systems maintain a high level of compatibility.³⁰ Whereas the DSM system is dominant in English-speaking parts of the world like North America and Australia, the ICD is the main diagnostic reference in European and developing countries.

Both manuals begin their respective descriptions of the symptoms of schizophrenia with a general outline of the disorder and then give definitive lists of diagnostic criteria that must be fulfilled in order for a diagnosis to be made. Schizophrenia is said to display psychotic symptoms but “the term psychotic has historically received a number of different definitions, none of which has received universal acceptance.”³¹ Nevertheless, the core understanding, to which most psychiatrists subscribe, is that when delusions, hallucinations, disordered thoughts or extreme moods give rise to irrational behaviour, then psychosis is likely to be present.³²

²⁵ Donald W. Black, William R. Yates and Nancy C. Andreasen, ‘Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders’, in John A. Talbott, Robert E. Hales and Stuart C. Yudofsky (eds), Textbook of Psychiatry, American Psychiatric Press, Washington, 1988, p. 358.

²⁶ Mark J. Sedler, ‘Foundations of the new nosology’, The Journal of Medicine and Philosophy, Vol. 19, No. 3, 1994, pp. 219-239.

²⁷ Nancy C. Andreasen, ‘Symptoms, signs, and diagnosis of schizophrenia’, The Lancet, Vol. 346, No. 8973, 1995, p. 478.

²⁸ World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines World Health Organisation, Geneva, 1992.

²⁹ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, American Psychiatric Association, Washington, 1994.

³⁰ Ibid., p. xxi.

³¹ Ibid., p. 273.

³² Ibid., p. 770.

Schizophrenia is defined as a sub-type of psychosis: “The essential features of schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months.”³³ In conjunction with these signs and symptoms there is also a “marked social or occupational dysfunction”.³⁴

Although clarity of consciousness and intellectual capabilities might still be present there are “characteristic distortions of thinking and perception”.³⁵ These often take the form of delusions that “supernatural forces are at work to influence the affected individual’s thoughts and actions in ways that are often bizarre”.³⁶ In these circumstances the person might believe himself/herself to be at the centre of world-shattering events that are taking place around him or her.

“Hallucinations, especially auditory, are common and may comment on the individual’s behaviour or thought.”³⁷ This leads to disturbances in thinking patterns and particularly in behaviour. To observers of a person with schizophrenia, the person’s thinking seems vague and when it is expressed in speech it is sometimes impossible to understand. There are “breaks and interpolations in the train of thought”³⁸ and the person’s mood appears to be characterised by shallowness, ambivalence and inertia.

Delusions can be of many types and cover a variety of characteristic subject matter. Delusions may be persecutory, in which case the person might believe “he or she is being tormented, followed, tricked, spied on, or subject to ridicule”.³⁹ Alternatively, delusions can be referential, meaning that the person interprets certain signs and signals in the surrounding environment, like bill-board advertisements or newspaper headlines, as being directed specifically at themselves and containing hidden messages. Or the delusions might be bizarre. Examples of bizarre delusions can include “a person’s belief that his or her thoughts have been taken away by some outside force (“thought withdrawal”), that alien thoughts have been put into his or her mind (“thought insertion”), or that his or her body or actions are being acted on or manipulated by some outside force (“delusions of control”)”.⁴⁰

³³ *Ibid.*, p. 274.

³⁴ *Ibid.*

³⁵ World Health Organisation, *op.cit.*, p. 86.

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ *Ibid.*, p. 87.

³⁹ American Psychiatric Association, *op.cit.*, p. 275.

⁴⁰ *Ibid.*

Hallucinations may be associated with any of the senses but auditory hallucinations are particularly characteristic of schizophrenia. “Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts.”⁴¹ These voices might take the form of presenting a running commentary on the person’s thoughts and behaviour or they might enter into dialogue with the person’s own thoughts.

Disorganised thinking is also one of the definitive markers of schizophrenia. In diagnostic settings psychiatrists have to rely on patterns of speech to indicate this symptom. Speech can indicate the presence of disorganised thoughts in a number of ways: “The person may ‘slip off the track’ from one topic to another (‘derailment’ or ‘loose associations’); answers to questions may be obliquely related or completely unrelated (‘tangentiality’); and, rarely, speech may be so severely disorganised that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganisation (‘incoherence’ or ‘word salad’).”⁴²

Disorganised thoughts and delusions may also affect a person’s behaviour so that it becomes irrational: “Grossly disorganised behaviour may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation.”⁴³ The person may find it difficult to carry out normal tasks necessary for day to day living concerning things like meals and personal hygiene. Dress may become eccentric and behaviour may become inappropriate to situations in the form of indecent sexual displays, shouting and unpredictable shows of anger and agitation.

One of the more extreme forms of behavioural disorder associated with schizophrenia is catatonia: “Catatonic motor behaviours include a marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures (catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement).”⁴⁴

All the symptoms discussed so far fall into the category of “positive” symptoms. Juxtaposed to the positive symptoms are a range of “negative” symptoms: “The negative symptoms account for a substantial degree of morbidity associated with the disorder”.⁴⁵ There are three principal negative symptoms — flattened mood, poverty of speech and avolition. Flattened mood “is especially common and is characterised by the person’s face appearing immobile and unresponsive, with poor

⁴¹ *Ibid.*

⁴² *Ibid.*, p. 276.

⁴³ *Ibid.*

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

eye contact and reduced body language.”⁴⁶ Poverty of speech is indicated by an inability to engage in useful communication while “avolition is characterised by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities”.⁴⁷

A major difficulty in diagnosing schizophrenia is that there are, “No laboratory findings [which] have been identified that are diagnostic for Schizophrenia.”⁴⁸ This means that a diagnosis can only be made by a psychiatrist interviewing a person and making assumptions about the person’s mental state by observing self-expression through speech and behaviour. This gives rise to a need to standardise psychiatric interpretations of observations so there is consistency in diagnoses. In order to facilitate this standardisation both the ICD-10 and DSM IV supply diagnostic guidelines which act as a ready reference to narrow down the otherwise excessive subjectivity of the diagnostic process.

ICD-10 Diagnostic Criteria for Schizophrenia

The diagnostic guidelines from the ICD-10 are as follows:

Although no strictly pathognomonic symptoms can be identified, for practical purposes it is useful to divide the above symptoms into groups that have special importance for the diagnosis and often occur together, such as:

- (a) thought echo, thought insertion or withdrawal, and thought broadcasting;
- (b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations: delusional perception;
- (c) hallucinatory voices giving a running commentary on the patient’s behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
- (d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
- (e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear effective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
- (f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*, p. 277.

⁴⁸ *Ibid.*, p. 280.

- (g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
- (h) “negative” symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;
- (i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time *during a period of 1 month or more*. Conditions meeting such symptomatic requirements but of a duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder (F23.2) and reclassified as schizophrenia if the symptoms persist for longer periods. Symptom (i) in the above list applies only to a diagnosis of simple schizophrenia (F20.6), and a duration of at least one year is required.⁴⁹

There are two more paragraphs describing prodromal symptoms, like loss of interest in work, which may have been present for an extended period of time, and instructions that the 1 month criteria is only to apply to the specific symptoms given in the list above. There is also a warning about the difficulty that is sometimes encountered in distinguishing schizophrenia from the affective disorders and that schizophrenia should not be diagnosed in the presence of known disorders that have physical causes like brain disease, drug intoxication or epilepsy.⁵⁰

The above symptoms are meant to be guidelines for identifying the presence of schizophrenia in general. Once a diagnostician decides schizophrenia is present the next task is to determine which of the various subtypes is the most appropriate label. The ICD-10 diagnostic system provides a choice from seven subtypes:

⁴⁹ World Health Organisation, *op.cit.*, pp. 87-88.

⁵⁰ *Ibid.*, pp. 88-89.

Paranoid schizophrenia. This is the most common type of schizophrenia. It is where the delusions and auditory hallucinations inspire beliefs of persecution, exalted birth, special mission or other paranoid beliefs and where the “voices” often threaten or give commands.⁵¹

Hebephrenic schizophrenia. This is a variety of schizophrenia in which the “delusions and hallucinations are fleeting and fragmentary” and which tends to be marked by a shallow mood and “giggling or self-satisfied, self-absorbed smiling, or a lofty manner, grimaces, mannerisms, pranks, hypochondriacal complaints and reiterated phrases”.⁵² Hebephrenic schizophrenia tends to have an early onset, between the ages of 15 to 25 years, hence the name, derived from the Greek goddess of youth, Hebe.

Catatonic schizophrenia. This type of schizophrenia requires one or more of the following symptoms to be a dominant clinical feature before a diagnosis can be made:

- (a) stupor (marked decrease in reactivity to the environment and in spontaneous movements and activity) or mutism;
- (b) excitement (apparently purposeless motor activity, not influenced by external stimuli);
- (c) posturing (voluntary assumption and maintenance of inappropriate or bizarre postures);
- (d) negativism (an apparently motiveless resistance to all instructions or attempts to be moved, or movement in the opposite direction);
- (e) rigidity (maintenance of a rigid posture against efforts to be moved);
- (f) waxy flexibility (maintenance of limbs and body in externally imposed positions); and
- (g) other symptoms such as command automatism (automatic compliance with instructions), and perseveration of words and phrases.⁵³

Undifferentiated schizophrenia. This diagnosis is used when the person meets the general requirements for schizophrenia but doesn’t conform to any of the other subtypes.

Post-schizophrenic depression. As the name suggests this involves depression which is experienced after a schizophrenic episode and while some symptoms of schizophrenia are still present, but which “no longer dominate the clinical picture”.⁵⁴

⁵¹ *Ibid.*, pp. 89-90.

⁵² *Ibid.*, p. 90.

⁵³ *Ibid.*, p. 92.

⁵⁴ *Ibid.*, p. 93.

Residual schizophrenia. This diagnosis is used when schizophrenia appears to have entered a chronic stage.

Simple schizophrenia. “An uncommon disorder in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance. Delusions and hallucinations are not evident, and the disorder is less obviously psychotic than the hebephrenic, paranoid, and catatonic subtypes of schizophrenia.”⁵⁵

DSM IV Diagnostic Criteria for Schizophrenia

The diagnostic guidelines in the American Psychiatric Association’s DSM IV present the symptoms of schizophrenia in the form of grouped criteria:

Diagnostic criteria for Schizophrenia

A. *Characteristic symptoms:* Two (or more) for the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- (1) delusions
- (2) hallucinations
- (3) disorganised speech (e.g. frequent derailment or incoherence)
- (4) grossly disorganised or catatonic behaviour
- (5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms

⁵⁵ *Ibid.*, p. 95.

listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are present for at least a month (or less if successfully treated).⁵⁶

The DSM IV system follows the same pattern as the ICD-10 by providing the diagnostic criteria for schizophrenia in general and then going on to define a number of subtypes for refining the diagnosis. Most of the DSM IV subtypes are the same as those in the ICD-10. The duplicated subtypes are: Paranoid Type, Disorganised Type (Hebephrenic in the ICD-10), Catatonic Type, Undifferentiated Type, and Residual Type. However there is no DSM IV equivalent of the ICD-10's Post-schizophrenic depression and, whereas the DSM IV describes Schizoaffective Disorder as a subtype of schizophrenia, in the ICD-10 it is given a coding that places it in an independent category, as a separate and distinct mental disorder, located between Schizophrenia and the Affective Disorders.

The subtype that is called Simple Schizophrenia in the ICD-10 has no exact equivalent in the DSM IV. The nearest subtype in the DSM IV is called Schizophreniform Disorder, and its description gives it a curiously different twist. Although Simple Schizophrenia (ICD-10) and Schizophreniform Disorder (DSM IV) are both largely distinguished from other forms of schizophrenia by having a reduced number and variety of symptoms, the prescribed reductions for each are very different from one another. Whereas Simple Schizophrenia is largely concerned with social malfunctioning, and doesn't require the presence of psychotic features like delusions and hallucinations, Schizophreniform Disorder is the opposite. A diagnosis of Schizophreniform Disorder requires

⁵⁶ American Psychiatric Association, *op.cit.*, pp. 285-286.

psychotic symptoms of a reduced duration (1-6 months) but social/occupational dysfunction is not necessary.

This difference might point to an interesting divergence of philosophical priorities between the cultural environments that respectively prefer to use the two different diagnostic manuals. The ICD-10 environment, mainly Europe, apparently sees social dysfunction as the main residual symptom to be concerned about in this milder subtype of schizophrenia. The North Americans, however, would seem to be more concerned with identifying abnormal mental activity as the residual symptom.

The taxonomies relating to psychosis in both the ICD-10 and the DSM IV are presented as if it is assumed there is a continuous spectrum of disorder that has to be broken up into recognisable segments. The result is that Schizophrenia, as it is described in both manuals, shades into a number of descriptions of similar, but clinically distinct, disorders. These schizophrenia spectrum disorders, as they are sometimes called,⁵⁷ are described in both manuals in pages adjacent to, and following, the descriptions of Schizophrenia. The more similar the description is to Schizophrenia, the closer it is positioned to Schizophrenia in the pages of the manuals. It is worth briefly describing this spectrum of disorders because it will help to clarify what Schizophrenia is by examining the descriptions of disorders psychiatrists think are similar, but distinct from Schizophrenia.

In the ICD-10 the description of Schizotypal Disorder follows that of Schizophrenia. This positions Schizotypal Disorder adjacent to Schizophrenia on the spectrum of schizophrenia disorders. As the name suggests this condition has characteristic features that are similar to Schizophrenia but, unlike Schizophrenia, there is an absence of any “dominant or typical disturbance”.⁵⁸ Schizotypal Disorder is followed in the ICD-10 by the Persistent Delusional Disorders, and then Acute and Transient Psychotic Disorders, and then by Induced Delusional Disorder and finally by the Schizoaffective Disorders, which are to be diagnosed when both “affective and schizophrenic symptoms are prominent within the same episode of illness”.⁵⁹ After the Schizoaffective Disorders the ICD-10 goes on to describe the Affective Disorders (mood disorders) associated with the bipolar mood extremes of mania and depression.

The DSM IV system sees the order in the spectrum a little differently. Following the subtypes of Schizophrenia is Delusional Disorder. The DSM IV gives a fairly complex description of Delusional Disorder with a number of subtypes. One of the puzzling features of this DSM IV description is an instruction that Delusional Disorder is to be distinguished from Schizophrenia by

⁵⁷ A. M. Persico, Z. W. Wang, D. W. Black, N. C. Andreasen, G. R. Uhl and R. R. Crowe, ‘Exclusion of close linkage of the dopamine transporter gene with schizophrenia spectrum disorders’, American Journal of Psychiatry, Vol. 152, No. 1, 1995, pp. 134-136.

⁵⁸ World Health Organisation, op.cit., p. 95.

⁵⁹ Ibid., p. 105.

the absence of any symptoms from Criterion A of the diagnostic guidelines for Schizophrenia.⁶⁰ However, when one refers back to Criterion A the first symptom given is “delusions”. The distinction between the two disorders apparently largely rests on an understanding that the “delusions” of Schizophrenia are “bizarre” whereas those of Delusional Disorder are non-bizarre.⁶¹ To facilitate this distinction the DSM IV defines a “bizarre” delusion as one “that involves a phenomenon that the person’s culture would regard as totally implausible.”⁶²

This problem of differentiating Schizophrenia from Delusional Disorder draws attention to a couple of interesting points that should be noted at this stage. The first concerns the contradiction between the general outline for Schizophrenia and the diagnostic instructions for Delusional Disorder in the DSM IV. Whereas a number of non-bizarre delusions — like delusions of reference and persecutory delusions — are clearly listed as symptoms of Schizophrenia, at the same time, the diagnostic instructions for Delusional Disorder claim all non-bizarre delusions for that particular disorder. Contradictions like this suggest an underlying arbitrariness in the taxonomic mapping of mental disorders and lays a basis for questioning the validity of pathologising any of the symptoms described.

Indeed, the question of pathological validity is the second point to be raised about Delusional Disorder. If DSM IV defines a bizarre delusion as one “that involves a phenomenon that the person’s culture would regard as totally implausible”, while stating that Delusional Disorder is only concerned with non-bizarre delusions, then it begs the question as to whether Delusional Disorder pathologises delusions that the person’s culture would find plausible. When the diagnostic criteria are examined in the light of this question, this does indeed seem to be the case.

Seven subtypes of Delusional Disorder are given in the DSM IV. The Erotomantic Type, for instance, pathologises unrequited love and “applies when the central theme of the delusion is that another person is in love with the individual. The delusion often concerns idealised romantic love and spiritual union rather than sexual attraction Most individuals with this subtype in clinical samples are female.”⁶³

Similarly, a Delusional Disorder of the Jealous Type is a supposedly pathological delusion which “applies when the central theme of the person’s delusion is that his or her spouse or lover is unfaithful”.⁶⁴ It could perhaps be successfully argued that unwarranted suspicion about the fidelity of a spouse or lover is a pathological condition. But how would a psychiatrist know with any

⁶⁰ American Psychiatric Association, op.cit., p. 296.

⁶¹ Ibid., p. 284.

⁶² Ibid., p. 765.

⁶³ Ibid., p. 297.

⁶⁴ Ibid.

certainty that a patient's suspicion was unwarranted? This kind of question is highly relevant when one considers the power vested in psychiatrists to impose involuntary treatment on people diagnosed with delusional symptoms.⁶⁵

Following Delusional Disorder on the DSM IV taxonomic spectrum is Brief Psychotic Disorder, which is followed by Shared Psychotic Disorder (the equivalent of the ICD-10's Induced Delusional Disorder in which one person is persuaded to share another person's delusion), Psychotic Disorder Due to a General Medical Condition and then Substance-Induced Psychotic Disorder. A final residual category, Psychotic Disorder Not Otherwise Specified, is given before the DSM IV introduces the Mood Disorders.

The significance of the implication contained in both manuals, that Schizophrenia is one section of a spectrum of psychotic disorders, can be brought into focus when one considers the conditions under which a diagnosis is made. Without any laboratory tests a diagnostician has to rely on evidence provided by the speech and behaviour of the person in question,⁶⁶ together with reports from third parties. The person's behaviour first has to be tested, in the diagnostician's own mind, against the range of normal speech and behaviours that is within the diagnostician's experience.⁶⁷ This will determine whether the person's mental state deviates too greatly from normal and is therefore pathological. Then, if it is judged to be abnormal, it has to be fitted into the correct point on the spectrum of mental disorders.

In regard to diagnosing schizophrenia this would seem to be a task fraught with possibilities for inconsistency. If, for instance, a person is expressing religious beliefs the diagnostician must first determine whether they are delusional; i.e. false beliefs not "ordinarily accepted by other members of the person's culture or subculture".⁶⁸ If they appear to be delusional the diagnostician then has to decide whether the delusions are bizarre, and therefore indicative of Schizophrenia. If they are non-bizarre the alternative diagnosis might be Delusional Disorder - Grandiose Type: "Grandiose delusions may have a religious content (e.g., the person believes that he or she has a special message from a deity)."⁶⁹

⁶⁵ "Delusions" is one of five symptoms specified in the NSW Mental Health Act which, if identified by a medical practitioner, can lead to involuntary incarceration and treatment. See Mental Health Act 1990, NSW Government Information Service, Reprinted as in force at 17 October, 1994.

⁶⁶ See for instance, Mary Hollis Johnston and Philip S. Holzman, Assessing Schizophrenic Thinking, Jossey-Bass, San Francisco, 1979.

⁶⁷ Nancy M. Docherty, 'Communication disturbances in schizophrenia and mania', JAMA, The Journal of the American Medical Association, Vol. 276, No. 1, July 3, 1996, p. 4B.

⁶⁸ American Psychiatric Association, op.cit., p. 765.

⁶⁹ Ibid., p. 297.

The risk of inconsistency is further apparent when one considers there is often a distinctly bizarre appearance to many religious beliefs that are culturally acceptable, and therefore not delusional (in the psychiatric sense, that is). Thousands of people may practise a pseudo-cannibalistic ritual together, believing the biscuits and grape juice they consume to symbolise the body and blood of a god, but if the ritual belongs to a respectable mainstream Christian church, and is therefore culturally acceptable, by necessity psychiatrists must view it as being motivated by a non-pathological cause. However, if a solitary individual were to invent and practise a similar ritual it is unlikely the same protection would be available. Such a person might easily be given a diagnosis of schizophrenia and, if so, would probably also be considered dangerous.

Origins of descriptive psychopathology for Schizophrenia

The origins of the pathological approach to schizophrenia can be traced in the history of the relevant diagnostic language. The key words and terms that are currently used to describe the symptoms — like delusions, hallucinations, thought disorder and catatonia — all have long histories of development for usage as diagnostic tools, first for madness in general, and later for specific forms of mental illness like schizophrenia.

Berrios has recently undertaken extensive research into the development of descriptive psychopathology.⁷⁰ (I mostly rely on this research for this section). Berrios found that up to the middle of the 19th century the French word *délire* meant either madness or delusion and when it was used for delusion the meaning was interchangeable with delirium.⁷¹ This means that for several centuries in France the three concepts — madness, delusion and delirium — were often indistinguishable. Influenced by religious beliefs, all three forms of *délire* were thought to be organic in nature because “the soul is always in the same state and is not susceptible to change. So the error of judgement that is *délire* cannot be attributed to the soul but to bodily organs”.⁷²

In pre-18th century Italy a similar view was expressed about the cause of delusion and delirium:

Delirium was caused by organic changes for the soul cannot become diseased: ‘How can delirium be called affection of the soul, in view of its [the soul’s] unchangeable nature?’ ‘Where is the seat of delirium?’ It is evident that true and basic errors of judgment and of reasoning, without any lesion in the organ of external senses, must be due to a physical disease of the brain.⁷³

⁷⁰ German E. Berrios, *The History of Mental Symptoms* University of Cambridge Press, Cambridge, 1996.

⁷¹ *Ibid.*, p. 85.

⁷² Arnulphe d’Aumont, 1754, quoted in Berrios, *ibid.*

⁷³ Vincenzo Chiarugi, quoted in Berrios, *ibid.*, p. 86.

British thinkers appear to have had a more circumspect view of delusions and madness, sometimes being less willing to associate delusions with brain disease. Hobbes saw delusions as being the primary indicator of madness but he was equivocal about the cause, unsure whether to adopt an ancient interpretation blaming “Daemons, or Spirits, either good, or bad, which might enter into man, possess him, and move his organs in such strange, and uncouth manner,”⁷⁴ or whether to adopt the opinion current in his time that underlying “passions” were the cause.

John Locke introduced the belief that delusions and madness were caused by associating inappropriate ideas: “some of our ideas have a natural correspondence and connection with one another: it is the office and excellency of our reason to trace these, and hold them together in that union and correspondence”.⁷⁵ However, to Locke madmen “do not appear to me to have lost the faculty of reasoning, but having joined together some ideas very wrongly, they mistake them for truths, and they err as men do that argue right from wrong principles.”⁷⁶

Locke’s view remained popular up to the middle of the 19th century after it was amplified by 18th century associationists like David Hartley. But Hartley believed, like the French, that delusions and madness could also have organic causes:

the causes of madness are of two kinds: bodily and mental. That which arises from bodily causes is nearly related to drunkenness, and to the deliriums attending distemper. That from mental causes is of the same kind with temporary alienation of the mind during violent passions, and with prejudices of opinionativeness, which much application to one set of ideas only occasions.⁷⁷

In the late 18th century French and German commentators agreed that hallucinations can be the cause of mental disorder but they didn’t agree on the extent of this disorder. The Frenchman Dufor was of the opinion that “The false impression of the external senses, then, must necessarily create disorder and confusion in a person’s conduct.”⁷⁸ Crichton, a German, responded “that the diseases of the external senses produce erroneous mental perceptions, must be allowed; but it depends on the concurrence of other causes, whether delusion follows”.⁷⁹

Disagreements like these led on to a 19th century debate about whether hallucinations could be a cause for insanity. Hallucinations were defined early in the debate: “If a man has the intimate

⁷⁴ Thomas Hobbes, quoted in Berrios, *ibid.*, pp. 86-87.

⁷⁵ John Locke, quoted in Berrios, *ibid.*, p. 88.

⁷⁶ John Locke, quoted in Berrios, *ibid.*

⁷⁷ David Hartley, quoted in Berrios, *ibid.*, pp. 88-89.

⁷⁸ Jean Francois Dufor, quoted in Berrios, *ibid.*, p. 35.

⁷⁹ German E. Berrios, *ibid.*, p. 35.

conviction of actually perceiving a sensation for which there is no external object, he is in a hallucinated state.”⁸⁰ But unfortunately the word *hallucination* was closely linked with the word *vision* and therefore produced some difficulties in dealing with false perceptions that were not concerned with the sense of sight.

Even so, a vigorous defence was mounted for the use of the word by the 19th century French psychiatrist, Esquirol. As a result *hallucination* has been inherited by modern psychiatry:

Hallucinations of vision have been called visions but this is appropriate only for one perceptual mode. Who would talk about auditory visions, taste visions, olfactory visions? However, the functional alterations, brain mechanisms and the clinical context involved in these three senses is the same as in visions. A generic term is needed. I propose the word hallucination.⁸¹

An important early debate about the nature of hallucinations was concerned with whether the fault was to be found in the external sense organs or whether it was in the “central organ of sensitivity itself”.⁸² Esquirol was of the opinion that “hallucination is a cerebral or psychological phenomenon that takes place independently from the senses. The pretended sensations of the hallucinated are images and ideas reproduced by memory, improved by the imagination, and personified by habit visionaries are dreaming whilst awake”⁸³

Baillarger took up similar arguments after Esquirol died and in 1844 presented his views to the Royal Academy of Medicine in Paris: “The most frequent and complicated hallucinations affect hearing: invisible interlocutors address the patient in the third person, so that he is a passive listener in conversation the insane deaf is more prone to hear voices.”⁸⁴ But Baillarger’s view was challenged by another of his countrymen named Michéa who posed a complicated argument that “hallucination consisted of a metamorphosis of thinking, was neither a sensation nor a perception but intermediate between perception and pure conception. It occupies the middle ground between these two facts of consciousness and participates in both.”⁸⁵

In the middle of the 19th century an important debate broke out amongst French psychiatrists about the nature of hallucinations. According to Berrios there were three main points to the debate: “could hallucinations ever be considered as ‘normal’ experiences? Did sensation, image and hallucination

⁸⁰ E. Esquirol, quoted in Berrios, *ibid.*, p. 37.

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ *Ibid.*, pp. 37-38.

⁸⁴ J. Baillarger, quoted in Berrios, *Ibid.*, p. 39.

⁸⁵ C. F. Michéa, quoted in Berrios, *ibid.*

form a continuum? Were hallucinations, dreams and ecstatic trance similar states? A fourth issue (as Henri Ey noticed) ‘haunted everyone but was not made the base of the debate’, namely, whether hallucinations had a ‘psychological’ origin.”⁸⁶

All of these issues remain unresolved today.⁸⁷ Indeed, they form much of the basis for the current controversy. It seems that although considerable progress has been made in the past century and a half in categorising, identifying and treating unusual mental phenomena, little progress has been made in understanding their underlying nature. This point is well illustrated by the example of thought disorder.

Thought disorder, as a symptom of schizophrenia, is indicated by disorganised or nonsensical speech.⁸⁸ Unlike delusions and hallucinations, of which the people experiencing them usually have some insight, the identification of disordered thoughts must usually be made by an observer.⁸⁹ For a long time this necessity caused the symptom to be considered as secondary in importance to delusions and hallucinations. As a result it wasn’t until the second half of the 19th century that psychiatrists began to form theories about the causes and nature of disordered thoughts:

Two models of ‘thinking’ vied for supremacy during the nineteenth century: the associationistic approach was the legacy of British empiricism and started with Locke’s description of simple and complex ideas The second approach was based on Faculty Psychology that the mind is a cluster of independent powers, capacities or faculties⁹⁰

Both models are now deeply embedded in modern psychiatric thinking about schizophrenia. After passing through dubious stages of development, like the 19th century phrenology movement, based on the belief that a person’s personality could be revealed by measuring and mapping the pattern of bumps on their head, faculty theory is now largely at the base of current attempts to draw maps of the brain by identifying various mental functions with parts of the brain.⁹¹ This area of research, as

⁸⁶ German E. Berrios, *ibid.*, p. 40.

⁸⁷ J. M. Cleghorn, S. Franco, B. Szechtman, R. D. Kaplan, H. Szechtman, G. M. Brown, C. Nahmias and E. S. Garnett, ‘Toward a Brain Map of Auditory Hallucinations’, *American Journal of Psychiatry*, Vol. 149, No. 8, 1992, pp. 1062-1071.

⁸⁸ T. C. Manschreck, B. Maher, M. T. Celada, M. Schneyer and R. Fernandez, ‘Object Chaining and Thought Disorder in Schizophrenic Speech’, *Psychological Medicine*, Vol. 21, No. 2, 1991, pp. 443-446.

⁸⁹ P. D. Harvey, M. F. Lenzenweger, R. S. Keefe, D. L. Pogge, M. R. Serper and R. C. Mohs, ‘Empirical Assessment of the Factorial Structure of Clinical symptoms in Schizophrenic Patients: Formal Thought Disorder’, *Psychiatry Research*, Vol. 44, No. 2, 1992, pp. 141-151.

⁹⁰ Berrios, *op.cit.*, p. 72.

⁹¹ Bruce Bower, ‘Hallucinating brains pose for first scans’, *Science News*, Vol. 148, No. 20, 1995, p. 310.

will be discussed further on, is central to current scientific endeavours to link schizophrenia with defects in brain architecture.⁹²

The associationistic approach, on the other hand, had considerable influence on both Kraepelin and Bleuler, the two psychiatric researchers who are most commonly cited as being the first pioneers, the inventors/discoverers/definers, of the disease entity called schizophrenia.⁹³ Through Kraepelin and Bleuler the associationistic approach has had an important influence on nominating the primary indications of schizophrenia that are found in modern diagnostic manuals.

Kraepelin and Bleuler

Emile Kraepelin was a German psychiatrist practising in the late 19th century. In Kraepelin's time the psychiatric nosology was still very much in flux and there was only a shifting consensus about matching particular symptoms with specific mental diseases. This situation provided scope for individual psychiatrists to "discover" new disease entities and then persuade their colleagues to recognise their new discovery. Kraepelin was the first psychiatrist to observe a certain pattern in a form of madness that had an early onset and, as he falsely thought, led finally to a deteriorating condition:⁹⁴ "To accentuate the progressive destruction of mental abilities, emotional responses and the integrity of the personality which he saw as central to this condition, Professor Kraepelin termed it dementia praecox — dementia of early life."⁹⁵

Kraepelin's argument was that three psychiatric conditions, previously recognised separately, were actually different aspects of a single disease he called dementia praecox. The three pre-existing disease entities were hebephrenia, which was characterised by "aimless, disorganised and incongruous behaviour; catatonia, in which the individual might be negativistic, motionless or even stuporous or, at other times, extremely agitated and incoherent; and finally dementia paranoides, in which delusions of persecution and grandeur were prominent."⁹⁶

Kraepelin had to overcome professional opposition to gain recognition for his new interpretation. One of its central features was a clear distinction from other forms of madness, which sometimes produced similar symptoms, but which have a demonstrable biological cause, like cerebral syphilis.

⁹² Daniel R. Weinberger, 'From neuropathology to neurodevelopment (Schizophrenia, part 2)', The Lancet, Vol. 346, No. 8974, 1995, pp. 552-558.

⁹³ Louis L. Lunskey, 'A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders', JAMA, The Journal of the American Medical Association, Vol. 276, No. 10, 1996, p. 836.

⁹⁴ For a discussion which compares Kraepelin's view to modern interpretations of schizophrenia see, R. S. Keefe, D. S. Lobel, R. C. Mohs, J. M. Silverman, P. D. Harvey, M. Davidson, M. F. Losonczy and K. L. Davis, 'Diagnostic Issues in Chronic Schizophrenia: Kraepelinian Schizophrenia, Undifferentiated Schizophrenia, and State-Independent Negative Symptoms', Schizophrenia Research, Vol. 4, No. 2, 1991, pp. 71-79.

⁹⁵ Richard Warner, Recovery From Schizophrenia Routledge & Kegan Paul, London, 1985, pp. 9-10.

⁹⁶ Ibid., p. 10.

He also sought to distinguish dementia praecox from other forms of mental illness that are clearly stress induced, and also from cyclical mood disorders. The description he gave of dementia praecox has become the foundation for the modern psychiatric description of schizophrenia.

Kraepelin worked as part of a highly successful team of psychiatric researchers that included Alzheimer, after whom Alzheimer's Disease takes its name. Kraepelin believed that dementia praecox was a "brain disease and that its neuropathological substrates would be identified by the new techniques that he and his investigative team were developing."⁹⁷ This focus on a search for a biological cause was largely based on what emerged to be a false assumption that the disease necessarily takes a deteriorating course, from which sufferers do not recover.⁹⁸

As Kraepelin's research progressed he began to find that the symptoms of a substantial percentage of the patients he had selected, according to the new diagnostic criteria, did not follow a deteriorating course, and that 12% of these patients actually made a complete recovery.⁹⁹ This potential for recovery intrigued a Swiss psychiatrist named Eugen Bleuler who realised that the new disease of dementia praecox had been misnamed: "Stimulated by the psychoanalytical theories of his assistant, Carl Jung, Dr Bleuler formulated a new unifying concept for the condition and gave it a new name."¹⁰⁰ Bleuler believed that the major identifying characteristic of the condition was not a progressive deterioration but was instead a discontinuity and fragmentation between thinking and feeling. So he reformulated the description and called the condition *schizophrenia*, meaning split mind.

In 1911 Bleuler published a monograph entitled Dementia Praecox or the Group of Schizophrenias¹⁰¹ in order to propagate his new description. Although this book was not translated into English for some 30 years it is generally recognised as the foundation for the modern psychiatric understanding of schizophrenia.

In the first few pages of the book Bleuler painstakingly explained why Kraepelin's description was unsatisfactory and why he found it necessary to rename the condition.¹⁰² His argument was that the name *dementia praecox* inappropriately limited the disease to young people who progressively

⁹⁷ Nancy C. Andreasen, Laura Flashman, Michael Flaum, Stephan Arndt, Victor Swayze II, Daniel S. O'Leary, James C. Ehrhardt and William T. C. Yuh., 'Regional brain abnormalities in schizophrenia measured with magnetic resonance imaging', JAMA, The Journal of the American Medical Association, Vol. 272, No. 22, 1994, pp. 1763-1770.

⁹⁸ For a discussion about research on recovery from schizophrenia see, Anne D. Walling, 'Residential status of schizophrenic patients', American Family Physician, Vol. 50, No. 3, 1994, pp. 688-691.

⁹⁹ Warner, op.cit., p. 15.

¹⁰⁰ Ibid., p. 14.

¹⁰¹ Eugen Bleuler, Dementia Praecox or The Group of Schizophrenias, Translated by Joseph Zinkin International Universities Press, New York, 1950.

¹⁰² Ibid., pp. 3-12.

deteriorate. He said this had caused great confusion within the psychiatric profession in a number of countries since it was readily apparent that many victims experienced the first onset later in life and not all victims progressively deteriorated.

Bleuler then went on to categorise the symptomatology of schizophrenia into two groups. The first group he called “fundamental symptoms”. These were symptoms “that are present in every case and at every period of the illness even though, as with every other disease symptom, they must have attained a certain degree of intensity before they can be recognised with any certainty”.¹⁰³ According to Bleuler the “fundamental symptoms consist of disturbances of association and affectivity, the predilection for fantasy as against reality, and the inclination to divorce oneself from reality (autism).”¹⁰⁴

The second group of symptoms he called “accessory symptoms”. These involve “manifestations such as delusions, hallucinations or catatonic symptoms. These may be completely lacking during certain periods, or even throughout the entire course of the disease; at other times they alone may permanently determine the clinical picture.”¹⁰⁵

As a “disturbance of association”, thought disorder was one of Bleuler’s “fundamental symptoms” which he described in an unusually candid fashion. He supplied numerous examples taken from conversations with his patients, as well as extracts from their letters, to demonstrate what he thought were the illogical and bizarre effects that can be produced by inappropriately associating ideas. The effect was to give an insight into psychiatric thinking that is rarely available in modern psychiatric writing.

One of Bleuler’s examples, for instance, utilises quotations from a patient’s written impression of ancient Egypt. According to Bleuler the patient’s writing demonstrates a failure to control impulses of fantasy which have opened the way for all sorts of incongruous material to be introduced. The writing refers to the habits and preferences of various national and religious groupings including Parsees, Afghans, Jews, Moors and Arabs and finishes with the assertion that “China is the Eldorado of the Pawnees”.¹⁰⁶ Much of this material clearly does not belong in a factual account of ancient Egypt. But Bleuler’s argument that the writing demonstrates clinical evidence of madness is also doubtful in a modern context. What might have been an excellent example of bizarre self-expression to a turn-of-century scientist is, to a contemporary reader, somewhat familiar as a variety of stream-of-consciousness writing.

¹⁰³ *Ibid.*, p. 13.

¹⁰⁴ *Ibid.*, p. 14.

¹⁰⁵ *Ibid.*, p. 13.

¹⁰⁶ *Ibid.*, p. 15.

Bleuler also gives examples of questions that he asks his schizophrenic patients. The answers they give are then offered as clinical evidence to demonstrate the nature of disordered thinking. But as Bleuler describes his method he seems to disregard the underlying humanity of his patients and seems to be unaware of the potential that might exist for the patients to give flippant or witty answers, or for them to be teasing or joking with him, instead of expressing their most seriously held beliefs. In his effort to appear scientific Bleuler has been careful to demonstrate objectivity as he interprets and records his interactions with patients. But what might be objectivity in other scientific research looks more like naivety — and a tendency towards the literal — in psychiatric research.

He gives an example of schizophrenic symptoms concerning, “A female patient, supposed to help in the household work, is asked why she is not working. The answer, ‘But I don’t understand any French’, is logically related neither to the question nor the situation.”¹⁰⁷ Bleuler’s assumption is that her answer indicates disordered thoughts. However, it is possible to read a sophisticated retort into the answer. If, for instance, a similar dialogue were encountered in a novel a reader might simply assume that the woman was protesting against being asked to do housework and, with tongue in cheek, was perhaps asserting that she was not a French maid.¹⁰⁸

Throughout Bleuler’s book there is an unsettling single-mindedness and inflexibility in the record of his interactions with patients. He gives the impression of having exclusively adopted the role of an investigative scientist in his personal interactions with patients, and that everything they say is firstly scientific evidence before it is human communication. In this situation it seems highly likely that distortions would be introduced into the communications and behaviour of the patients interacting with him. If one places oneself in the position of the patient in the interactions described by Bleuler it is apparent that the patients might have encountered some difficulty in responding to this scientist who was talking to them as if they were all laboratory exhibits.

This same point has been raised by R. D. Laing in relation to Kraepelin’s work. In The Politics of Experience¹⁰⁹ Laing quoted from Kraepelin’s Lectures on Clinical Psychiatry¹¹⁰ in which Kraepelin described a clinical examination of a female patient he conducted in front of a live audience of doctors to demonstrate dementia praecox. In Kraepelin’s account the woman paced back and forth on a stage while he attempted to distract her. The woman’s indifference to Kraepelin’s activities constituted the evidence of her condition. In Laing’s reproduction of the account all of Kraepelin’s actions in relation to the woman are printed in italics.

¹⁰⁷ *Ibid.*, p. 22.

¹⁰⁸ R. D. Laing has observed that when psychiatric patients are given the opportunity they will often boast about how they have deliberately used subtle language to insult or contradict a psychiatrist.

¹⁰⁹ R. D. Laing, The Politics of Experience Penguin, Harmondsworth, 1967.

¹¹⁰ E. Kraepelin, Lectures on Clinical Psychiatry Bailliere, Tindall and Cox, London, 1906.

*.... On attempting to stop her movement if I place myself in front of her with my arms outstretched if one takes firm hold of her will not allow it to be forced from her If you prick her on the forehead with a needle*¹¹¹

Laing's purpose was to separate out the psychiatrist's own actions in his account and to demonstrate how extraordinary these actions were and how bizarre was the situation with which the woman had to deal.

Both Kraepelin's and Bleuler's works raise an important question about psychiatric research work in general: Is it possible for a patient's mind to be used as a laboratory exhibit for scientific investigation, and for it still to give responses that are considered normal? Perhaps another way of examining this problem is to ask: Is it normal to behave like a normal person when the situation is clearly abnormal? There is also a variant of this question which has considerable significance for the discussion at hand: If a psychiatrist assumes a patient's mind is diseased, and the patient's mind perceives the psychiatrist's assumption, is it possible for the patient's mind to function in response to this perception in a way that is normal?¹¹²

This second question implies that patients might have choices about how to adapt to the situations they find themselves in. The possibility that schizophrenic symptoms are merely adaptive behaviour will be discussed more fully in the sections of the thesis which analyse the mystical and myth-of-mental-illness models. However, it seems apparent that the argument for a pathological cause relies heavily on the assumption that all symptomatic behaviour for schizophrenia is necessarily involuntary. The medical model tends to disregard the possibility that schizophrenic symptoms might sometimes be a deliberate strategy induced by the circumstances in which psychiatry is practised.

Conclusion

The symptoms of schizophrenia are similar to the phenomena of baldness and homosexuality in that it is impossible to make sound arguments that define them in pathological terms. It is apparent that diagnostic procedures utilised by the medical model for schizophrenia have been developed, and are applied, independently from any certain knowledge about the cause of the symptoms. The current diagnostic criteria are quite wide-ranging and include negative and positive symptoms that can affect both mental and social activity. When the history of the descriptive psychopathology for schizophrenia is examined it becomes apparent that debate over the cause and significance of these mental symptoms has been going on for hundreds of years within European intellectual circles.

¹¹¹ Laing, *op.cit.*

¹¹² For a discussion on the effects of labelling and cognitive dissonance see, Warner, *op.cit.*, pp. 181-186.

However, a determination of medical pathology was only definitively stamped on these symptoms when Kraepelin amalgamated a number of separate and distinct forms of mental pathology and called the new hybrid mental disease dementia praecox.

Bleuler's subsequent observation that people who were diagnosed with this new consolidated mental disease did not necessarily degenerate into dementia necessitated refinements to the descriptive psychopathology of the condition. Bleuler also renamed the disease schizophrenia. A major criticism of the disease explanation involves arguments that the symptoms are sometimes only behaviour that has been adapted to the extraordinary conditions caused by the practice of psychiatry itself.

4. The Psychiatric Dichotomy and the Proliferation of Models

This chapter begins by identifying the fundamental aetiological controversy within the medical model for schizophrenia — the dichotomy between theories that speculate about a biological cause for schizophrenia and theories which focus on an environmental/experiential cause. A description is given of the major biological theories and the drug treatments that support these theories. The range of enviro-experiential theories are then discussed together with the talking therapies they support.

Introduction

The wide ranging variety of scientific/psychiatric models that are currently used to explain the cause of schizophrenic symptoms¹ is indicative of the high level of confusion that persists within the medical model. These proliferating hypotheses can be readily divided into two different types: those which assume a biologically-based aetiology²; and psychodynamic theories rooted in assumptions that the cause is to be found in stresses resulting from the past experience, and/or the past/present environment of the sufferer.³ This dichotomy is an echo of the old nature/nurture debate about human psychological attributes.⁴ As with the nature/nurture debate, there is also a seemingly balanced and common sense view of schizophrenia aetiology which assumes both sides of the dichotomy will eventually be found to contribute to the answer.⁵

Associated with this dichotomy over aetiology is a fundamental difference of opinion within the psychiatric profession over the best forms of treatment for schizophrenia.⁶ Supporters of a biological aetiology normally hold a view that proper treatment requires some form of physical intervention, usually with neuroleptic medication.⁷ Subscribers to the environmental/experiential theories, on the other hand, usually prefer one of the many forms of talking therapy.⁸

¹ Donald W. Black, William R. Yates and Nancy Andreasen, 'Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders', in John A. Talbott, Robert E. Hales and Stuart Yudofsky, eds., Textbook of Psychiatry, American Psychiatric Press, Washington, 1988, pp. 378-385.

² Norman L. Keltner, 'Schizophrenia and Other Psychoses', in Norman L. Keltner, Lee Hilyard Schwecke and Carol E. Bostrom, eds., Psychiatric Nursing, Mosby, St. Louis, 1995, pp. 366-368.

³ S. Marchevsky and E. Baram, 'Is a diagnosis of occupational post-traumatic schizophrenia possible?', Medicine and Law, Vol. 11, Nos. 1 and 2, 1992, pp. 127-136.

⁴ Keltner, op.cit., p. 366.

⁵ G. O. Gabbard, 'Mind and brain in psychiatric treatment', Bulletin of the Menninger Clinic, Vol. 58, No. 4, 1994, pp. 427-446.

⁶ John M. Kane and Thomas H. McGlashan, 'Treatment of schizophrenia', The Lancet, Vol. 346, No. 8978, 23 Sept, 1995, pp. 820-826.

⁷ L. H. Lindstrom and I. M. Wieselgren, 'Schizophrenia and antipsychotic somatic treatment', International Journal of Technology Assessment and Health Care, Vol. 12, No. 4, 1996, pp. 573-584.

⁸ J. Zubin, 'Suiting therapeutic intervention to the scientific models of aetiology', British Journal of Psychiatry, No. 5, July 1989, pp. 9-14.

But the situation is not as clear cut and as logical as a simple *biological aetiology=drugs treatment* versus *enviro-experiential aetiology=talk therapy* debate. Sometimes it seems apparent that the two psychiatric factions have reached their aetiological and treatment associations in the opposite order. That is, the psychiatrists whose training has favoured drug therapies have simply assumed a biological aetiology as a convenient rationale for the forms of treatment they have been trained to apply.⁹ Similarly, psychiatrists who have undertaken training in psychoanalytic and psychotherapeutic forms of talking therapy appear to have little choice but to assume that the cause of the problem they have been trained to talk through can be found in the past experience or environment of the patient.¹⁰

But even when logic would appear to require both camps within the psychiatric community to be permanently locked into the alternatives of an *either or* situation — *either* biology plus drugs *or* enviro-experiential plus talk — the actual practice of psychiatry on schizophrenics does not follow such logical patterns. In practice most psychiatrists are prepared to supervise treatment plans that mix both drugs and talk.¹¹ However, it is probably fair to assume that when a psychiatrist supervises such a mixed plan of treatment, one form of treatment will be seen as the essential therapy while the other is just a convenient supplement.¹²

For a biopsychiatrist — i.e. a psychiatrist who favours a biological aetiology for schizophrenia and drug therapy — the supplement of talking therapy is most likely to be useful when it involves teaching a patient some kind of living skills.¹³ This can be a convenient supplement to the medication used for treating schizophrenia because the efficacy of combined treatment is largely measured by the ability of the patient to return to a position of at least partial social functioning. While the drugs supposedly re-balance a patient's brain chemistry, so that he or she *wants* to return to normal, supplementary living skills-type therapy can supposedly teach the person *how* to be normal.¹⁴ If a semblance of normality is achieved then the efficacy of the medication is confirmed and the psychiatrist can claim a successful outcome.

⁹ R. L. Martin, 'Outpatient management of schizophrenia' American Family Physician, Vol. 43, No. 3, March, 1991, pp. 921-933.

¹⁰ H. L. Provencher, J. P. Fournier and N. Dupuis, 'Schizophrenia: revisited', Journal of Psychiatry and Mental Health Nursing, Vol. 4, No. 4, August, 1997, pp. 275-285.

¹¹ G. E. Gomez and E. A. Gomez, 'Chronic schizophrenia: the major mental health problem of the century', Perspectives on Psychiatric Care, Vol. 27, No. 1, 1991, pp. 7-9.

¹² P. Weiden and L. Havens, 'Psychotherapeutic Management Techniques in the Treatment of Outpatients with Schizophrenia', Hospital & Community Psychiatry, Vol. 46, No. 6, 1994, pp. 549-555.

¹³ A. E. Farmer and P. McGuffin, 'The pathogenesis and management of schizophrenia', Drugs, Vol. 35, No. 2, February, 1988, pp. 177-185.

¹⁴ F. A. Wiesel, 'Neuroleptic Treatment of Patients with Schizophrenia. Mechanisms of Action and Clinical Significance', British Journal of Psychiatry, No. 23, 1994, pp. 65-70.

Similarly, a talking therapist might find medication a useful supplementary tool to calm a patient as a necessary prelude to achieving a therapeutic relationship:¹⁵ i.e. a relationship in which the patient submits to the dominance of the therapist. However, this type of convenience is not appreciated by all talking therapists and an argument is sometimes mounted that no useful talking therapy can be undertaken so long as the patient is under the influence of neuroleptics.¹⁶ This sort of argument is most likely to be made by therapists who are seeking the cause of the schizophrenia in the past experience of the patient, where memory and accurate recall are important, rather than by therapists who specialise in teaching adaptation skills.

Theories of a Biological Aetiology

There are so many different hypotheses speculating on a biological aetiology for schizophrenia that it is impossible to review them all. A search of the database Medline, for instance, which combined keywords ‘schizophrenia’ and ‘etiology’, just for the years 1990-1997, produced 1577 abstracts. Most of these articles describe scientific research seeking to confirm one or more of the hundreds of different variations on the biological hypothesis. This section of the thesis reviews some of the more influential hypotheses and demonstrates that there is very little consensus amongst scientific researchers.

Biochemical Hypotheses — and Associated Drug Treatments

The most influential of the biological hypotheses are biochemical theories that assume schizophrenic symptoms are caused by an imbalance in the chemistry of the sufferer, most particularly by an imbalance of brain chemistry. The reason for the influential position of biochemical theories is not because schizophrenic symptoms can be directly linked in laboratory work with a chemical imbalance. Rather, it is a convenient rationale derived from observations that neuroleptic medication appears to ameliorate some of the symptoms of schizophrenia. As a result it can be reasoned that the cause of the symptoms is a shortage of the chemicals contained in the medication.

This reasoning is not very sound and it could just as easily be argued that a person who counters shyness by drinking alcohol apparently has a shortage of alcohol in the brain. But the weakness in reasoning has not inhibited research based on this type of deduction. The ‘dopamine theory’ is the most prominent of the biochemical hypotheses and a great deal of research has been undertaken to explore the relationship between the positive symptoms of schizophrenia and the supposed hyperactivity of the dopamine system in the brains of schizophrenics.

¹⁵ J. H. Zahniser, R. D. Coursey and K. Hershberger, ‘Individual Psychotherapy with Schizophrenic Outpatients in the Public Mental Health System’, *Hospital & Community Psychiatry*, Vol. 42, No. 9, 1991, pp. 906-913.

¹⁶ Peter Breggin, *Toxic Psychiatry*, Fontana, London, 1993, pp. 481-483.

The dopamine hypothesis is principally derived from two kinds of observation. The first is that drugs which increase the supply of dopamine, like amphetamines¹⁷ and the anti-parkinson drug L-dopa,¹⁸ can cause a person to enter a psychotic state. The second is that neuroleptic drugs has been observed to block dopamine receptors in laboratory animals and thereby inhibit the supply of dopamine.¹⁹ The hypothesis derived from these observations argues that untreated schizophrenics have hyperactive dopamine systems and require neuroleptic medication to inhibit the supply of dopamine in their brains.

An often cited weakness²⁰ with this theory is that, whereas the dopamine receptors in the central nervous system are blocked within 20 minutes of neuroleptic medication, the drugs usually take days, sometimes many weeks, or even months, before they show any clinical effect.²¹ A second weakness is that,

although the correlation of dopamine blocking effects with the clinical potency has led to the dopamine hypothesis of schizophrenia, it is also true that these drugs reduce psychotic symptoms regardless of the diagnosis. The therapeutic effects of dopamine receptor blockade, therefore are not unique to the pathophysiology of schizophrenia.²²

In other words, just as alcohol affects garrulous people in much the same way as it affects shy people — and therefore makes improbable a ‘lack of alcohol’ theory to explain the cause of shyness — so neuroleptics have much the same effect on people whether they have a prior diagnosis of schizophrenia, or not. Everyone who is treated experiences “some degree of (often total) indifference and apathy”.²³ This means that although neuroleptic medication might ameliorate some of the florid features of schizophrenia, all the same, it is not a cure and therefore the dopamine hypothesis is actually quite doubtful.

On top of this the effects of neuroleptic medication on brain chemistry can be quite various, and unpredictable, depending on the type that is prescribed and the individual tolerance levels of the patient. Apart from blocking dopamine receptors various neuroleptics also blockade noradrenergic,

¹⁷ Black et al., *op.cit.*, p. 382.

¹⁸ Keltner, *op.cit.*, p. 367.

¹⁹ Black et al., *op.cit.*, p. 382.

²⁰ Harold I. Kaplan and Benjamin J. Sadock, *Synopsis of Psychiatry*, Williams and Wilkins, Baltimore, 1991, p. 639.

²¹ Keltner et al., *op.cit.*, p. 367.

²² Kaplan and Sadock, *op.cit.*, p. 639.

²³ David Richman, ‘Pursuing Psychiatric Pill Pushers’, in Sherry Hirsch, Joe Adams, Leonard Frank, Wade Hudson, and David Richman, eds., *Madness Network News Reader*, Glide, San Francisco, 1974, p. 113. (For a more extensive description of the effects of neuroleptics see Chapter 6.)

chlonergic and histaminergic receptors, and a number of adverse effects can sometimes manifest as a result.²⁴

There are many variables involved in the prescription of neuroleptics. A match has to be found for a particular patient, through a combination of heuristics and trial and error, with a particular type and brand of neuroleptic according to the individual tolerance of the patient; an appropriate dosage has to be determined for each individual patient — with the right combination of anti-side effect drugs; and the treatment has to be continued for an indefinite period to suppress psychotic symptoms that tend to fluctuate over time.

According to a number of critics,²⁵ the mainstream of the psychiatric profession was in a state of semi-denial until recently regarding the seriousness of the side effects caused by neuroleptic medication. This situation seems to have changed with a new openness about the problem being displayed in the latest version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM IV). The revised manual contains an appendix of "psychiatric subjects recommended for further study". Prominent amongst them is a detailed survey of medication-induced movement disorders. These are a group of diseases caused by the use of neuroleptics.²⁶ The list includes Neuroleptic-induced Parkinsonism which features a variety of tremors and muscle rigidity mimicking Parkinson's disease. It afflicts some 50% of patients on long-term neuroleptic treatment.²⁷ Neuroleptic Malignant Syndrome is an acute toxic reaction to the drugs and occurs in 0.07% to 1.4% of patients treated with neuroleptics. Of these 10%-20% die from it.²⁸

Neuroleptic-Induced Acute Dystonia features abnormal positioning of the head and neck in relation to the body, spasms of the jaw muscles, impaired swallowing, thickened or slurred speech, tongue protrusion, eyes deviated up, down or sideward and abnormal positioning of the limbs or trunk. Fear and anxiety are also often a symptom and it occurs most commonly in young males.²⁹ If a person looked sane before treatment they certainly would not after developing this side effect.

Neuroleptic-Induced Acute Akathisia features symptoms of compulsive restlessness like fidgety movements, walking on the spot and inability to sit still. The reported prevalence of this side effect in people receiving neuroleptics varies widely from 20%-75%.³⁰ Once again a set of physical

²⁴ Kaplan and Sadock, op.cit., p. 639.

²⁵ See for instance, Pam Goring, 'Drugs and Madness', in Erica Bates and Paul R. Wilson, eds., Mental Disorder or Madness, University of Queensland Press, St. Lucia, Qld., 1979, pp. 217-233.

²⁶ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, American Psychiatric Association, Washington, 1994, pp. 735-751.

²⁷ Ibid., p. 736.

²⁸ Ibid., p. 740.

²⁹ Ibid., p. 743.

³⁰ Ibid., p. 745.

symptoms induced by the treatment contributes dramatically to the person's appearance of being mad.

The side effect of greatest concern is Neuroleptic-Induced Tardive Dyskinesia. The indications of tardive dyskinesia are involuntary movements which might be rapid and jerky, slow and sinuous or rhythmic. They might involve the tongue, jaw, trunk or extremities. 20%-30% of people receiving neuroleptics develop tardive dyskinesia with the percentage ranging up to 50% amongst elderly people.³¹ The reason why this side effect is so serious is because there is no supplementary drug treatment with which to mask its symptoms and if the neuroleptic treatment is discontinued the tardive dyskinesia symptoms remain permanently in 50% of cases. This permanency is much higher in elderly people in whom it remains unremitted in up to 95% of cases.³²

These neuroleptic-induced movement disorders are collectively known as the central nervous system extrapyramidal side effects (EPSEs). It is perhaps incorrect to call these disorders side effects because they occur as a direct result of blocking the dopamine receptors and most of the patients receiving neuroleptics develop EPSEs. In fact it is partly through the existence of EPSEs that scientists have been able to work out how neuroleptics affect brain chemistry.

Atypical Neuroleptics

There are a number of different types of dopamine receptors and the conventional neuroleptics under discussion have been shown to be most effective in blocking D2 receptors. But a new generation of neuroleptics, called 'atypicals', have recently become available which target other types of receptors. It is claimed that the atypicals will prove to be safer than the conventional neuroleptics and will reduce the incidence of neuroleptic-induced disorders.³³ At this stage the evidence for this claim is equivocal since most of the atypicals are very new. If the new drugs do turn out to cause the same types of problems as the conventional neuroleptics it may take some years of usage before the problems become fully apparent.

However, one of the atypicals called clozapine is not a new drug and some of the major problems attached to its usage have been known for some time. Clozapine dates back to the early 1970s: "clinical trials of clozapine were begun in the United States in 1972, but they were temporarily halted in 1975 following reports of clozapine-induced agranulocytosis".³⁴ Agranulocytosis is "a life-threatening blood disorder that reduces the white blood cell count"³⁵ and it was found that some

³¹ *Ibid.*, pp. 747-749.

³² *Ibid.*, p. 748.

³³ William Harwell Wilson and Arvilla M. Clausen, '18-Month Outcome of Clozapine Treatment for 100 Patients in a State Psychiatric Hospital', *Psychiatric Services*, Vol. 46, Number 4, April 1995, p. 386.

³⁴ Moisey Wolf, Solomon Wolf and William Harwell Wilson, 'Clozapine Treatment in Russia: A Review of Clinical Research', *Psychiatric Services*, Vol. 46, No. 3, March 1995, p. 256.

³⁵ Breggin, *op.cit.*, p. 106.

1-2% of patients treated with clozapine were afflicted with this condition and of these some 35% died from it.³⁶

Clozapine earned such a bad reputation from its early usage that a Reagan-era drug deregulation campaigner even blamed it for causing some of the legal constrictions that he claimed inhibit drug research. He described clozapine as being one of a number of “major tragedies which have created public alarm and fear and which have led to the condemnation of drugs”.³⁷

By the end of the 1980s, however, as the accumulation of evidence about disorders induced by conventional neuroleptics began to overwhelm the psychiatric establishment in the United States, clozapine was still the only neuroleptic medication with an atypical profile which gave hope for a resolution to the EPSE problem. And so, in some desperation, clozapine was rehabilitated. It was approved for clinical use in the United States in 1990 after FDA-controlled trials which “lasted only six weeks”.³⁸

When it first went back on the market the manufacturer Sandoz,³⁹ as a precautionary measure, required that all the recipients undergo a weekly blood test conducted by the company’s laboratories. This procedure was very expensive and pushed up the price of treatment to about \$9000 a year. Under pressure from the consumer lobby, however, Sandoz was forced to make some concessions about the rigour of these blood tests and the cost of clozapine treatment was soon lowered to about \$4000 a year in the US.⁴⁰

The combination of agranulocytosis risk, the inconvenience of regular blood tests and excessive cost led to a situation in which clozapine was only being recommended for use with patients who did not respond to the traditional neuroleptics or who could not tolerate the adverse effects associated with these drugs. The clinical advice in the early 1990s described “a patient who has been unsuccessfully treated with three different antipsychotic drugs from different classes in sufficient doses, each for a least two months, is probably a candidate for treatment with clozapine.”⁴¹

³⁶ Keltner et al., op.cit., p. 245.

³⁷ M. Weatherall, ‘An end to the search for new drugs’, Nature, Vol. 296, April 1, 1982, p. 387.

³⁸ Breggin, op. cit., p. 447.

³⁹ Sandoz has since merged with Ciba-Geigy and the new conglomerate is named Novartis. For an analysis of the implications of the merger for the pharmaceutical industry see, Joan Harrison, ‘Gaining critical mass to stay on top: a Ciba/Sandoz combo would have the size and cash for new R&D areas’, Mergers & Acquisitions, Vol. 30, No. 6, May-June 1996, pp. 53-56.

⁴⁰ Keltner, et al., op. cit., pp. 245-246.

⁴¹ Kaplan and Sadock, op.cit., p. 648.

During the period of its banning in the US clozapine remained available in some European countries where it continued to earn a bad reputation with some psychiatrists. Peter Breggin claimed: “Clinicians I have spoken to in Europe feel that clozapine produces a particularly profound lobotomy effect, adding to concern about long-term dangers of tardive psychosis and dementia.”⁴²

This negative view, however, was not shared by all European psychiatrists with long-term experience of clozapine. Two Russian psychiatrists who emigrated to the United States claimed that the drug had been used successfully in their home country for more than 20 years where “it was not reserved for neuroleptic-resistant disorders but instead was used with some success as a first-line treatment in acute disorders”.⁴³ However, they admitted that their information was largely anecdotal and that “the Russian studies did not include controlled clinical trials, standardised diagnostic criteria, random assignment, double-blind conditions, standardised rating instruments, and other methodological approaches that we associate with scientific rigour”.⁴⁴

Clozapine survived the early scares and is now generally considered to be less dangerous than was first thought while being at least as efficacious as the conventional neuroleptics in reducing positive symptoms.⁴⁵ It is also claimed that clozapine causes less impairment of cognitive functioning than conventional neuroleptics⁴⁶ although there are apparently some severe problems with a psychotic rebound effect attached to withdrawal from clozapine.⁴⁷

Most of the evidence indicates that the incidence of EPSEs is reduced with clozapine and for some time research has been turning to explore the link between clozapine’s ability to reduce some negative symptoms of schizophrenia and the serotonin levels in the brains of schizophrenics.⁴⁸ This new line of research in schizophrenia treatment has helped to spawn a growing array of atypical neuroleptics to complement clozapine. All of these atypicals share similar features:

⁴² Breggin, *op. cit.*, p. 105.

⁴³ Wolf et al., *op. cit.*, p. 256.

⁴⁴ *Ibid.*, p. 258. The human rights record of Soviet psychiatry poses some interesting questions in regard to the reliability of anecdotal information like that supplied by the Wolfs. There are also ethical considerations about using any scientific knowledge derived from procedures and conditions that may have been in violation of human rights.

⁴⁵ Robert Kerwin, ‘Adverse Reaction Reporting and the New Antipsychotics’, *The Lancet*, Vol. 342, No. 8885, 11 December, 1993, p. 1440.

⁴⁶ D. E. Fujii, I. Ahmed, M. Jokumsen and J. M. Compton, ‘The effects of clozapine on cognitive functioning in treatment-resistant schizophrenic patients’, *Journal of Neuropsychiatry and Clinical Neuroscience*, Vol. 9, No. 2, 1997, pp. 240-245.

⁴⁷ T. M. Shiovitz, T. L. Welke, P. D. Tigel, R. Anand, R. D. Hartman, J. J. Sramek, N. M. Kurtz and N. R. Cutler, ‘Cholinergic rebound and rapid onset psychosis following abrupt clozapine withdrawal’, *Schizophrenia Bulletin*, Vol. 22, No. 4, 1996, pp. 591-595.

⁴⁸ Anon., ‘Atypical Meds Help Treatment-Refractory Patients’, *Psychopharmacology Update*, Vol. 6, No. 11, November, 1995, pp. 1-3.

While it was formerly believed that EPSEs and the antipsychotic benefits were inexorably bound, the atypical antipsychotic agents have been found to decrease EPSE liability through serotonin antagonism, reduced $[D_2]/5[HT_2]$ receptor activity ratios, intrinsic anticholinergic activity, and dopamine receptor selectivity.⁴⁹

One of the more recently launched atypicals is olanzapine (Zyprexa) made by Eli Lilly. Although quite a lot is already known about the effects of olanzapine on chemical receptors in the brain it is not understood whether any of these known effects contribute in any way to the observed reduction in schizophrenic symptoms: “The mechanism of action of olanzapine (oh lan' za peen) is unknown. The drug binds to serotonin type 2, 3 and 6, dopamine D_1 , D_2 and D_4 , histamine H_1 , adrenergic α_1 , and muscarinic (particularly M_1) receptors.”⁵⁰

The binding properties of the atypicals are giving rise to wide speculation about the aetiology of schizophrenia which extend well beyond the old dopamine theory inspired by the conventional neuroleptics.⁵¹ Some researchers think the mechanisms of the atypicals will eventually make it possible to trace the cause of schizophrenic symptoms while others believe that little aetiological evidence will emerge from atypical usage.⁵²

Despite the claimed benefits for schizophrenics from atypical usage enthusiasm for the new drugs amongst pharmaceutical researchers might be best understood in economic terms. By the end of the 1980s, as patents for the conventional neuroleptics expired and generics became available, the continued reliance on conventional neuroleptics threatened to undermine pharmaceutical profits . As a result of this situation the quest for a new generation of schizophrenia drugs was driven at least as much by a need to ensure the long-term profitability of pharmaceuticals for schizophrenia treatment as it was to discover safer drugs which targeted the cause of schizophrenia more precisely. In fact when the cost of the atypicals is compared to that of conventional neuroleptics, and the equivocal nature of some claims for atypicals is borne in mind — particularly in regard to improved safety and aetiological insights — then the significance of the economic factors is brought into perspective.

⁴⁹ Walter Alexander, ‘For schizophrenia: atypical agents offering promise’, Drug Topics, Vol. 140, No. 11, 10 June, 1996, p. 71.

⁵⁰ Anon., ‘Olanzapine For Schizophrenia’, Medical Letter on Drugs & Therapeutics, Vol. 38, No. 992, 17 January, 1997, pp. 5-7.

⁵¹ Maude Campbell, ‘New Atypical Antipsychotics Focus of International Workshop on Schizophrenia’, Psychiatric Times, May 1995, Available URL, <http://www.mhsource.com/edu/psytimes/p950523.html>

⁵² Editorial, ‘Atypical treatments for schizophrenia’ The Lancet, Vol. 339, No. 8788, 1 Feb, 1992, pp. 276-278.

The table below shows the cost to pharmacists in the United States for 30 days treatment with usual dosage based on the average wholesale price in 1996 and January 1997.⁵³

COST OF SOME DRUGS FOR SCHIZOPHRENIA

Other Biochemical Theories

Only the dopamine theory is directly linked to the array of neuroleptic medications that are routinely prescribed for schizophrenia. However, many psychiatric researchers are willing to uncouple their assumptions of cause from standard forms of treatment. Beside the theories derived from research associated with the usage of conventional and atypical neuroleptics there are also a number of other biochemical theories. But without any specific drug treatment to support them none of these other biochemical theories is as persuasive as the dopamine hypothesis.

As well as extending the aetiological search to serotonin neurotransmitters researchers have also targeted the neurotransmitters concerned with norepinephrine, glutamate, and related excitatory amino acids, and the neuropeptides cholecystokinin and neurotensin, but have only found a “fragmentary body of data which provides neither consistent nor conclusive evidence for any specific etiologic theory”.⁵⁴

⁵³ Anon., ‘Olanzapine For schizophrenia’, *op.cit.*, pp. 5-7.

⁵⁴ J. A. Lieberman and A. R. Koreen, Neurochemistry and Neuroendocrinology of Schizophrenia: A Selective Review’, *Schizophrenia Bulletin*, Vol. 19. No. 2, 1993, pp. 371-429.

It has also been argued that heightened concentrations of the neuromodulator phenylethylamine at the post-synaptic dopamine receptor could be involved in the aetiology of schizophrenia. A study carried out on Indian patients with paranoid schizophrenia has indicated a correlation⁵⁵ but the findings have not been confirmed.

Another neuromodulator theory involves a speculation that the system of nigral enkephalin peptides may be disordered in schizophrenia⁵⁶ while another speculates that the source of the problem might be found with the regulation of opioid peptides.⁵⁷ A further neuromodulator theory is based on an assumption that there are essentially two states of mind — a cognitive processing mode and an analogical mode — and that noradrenergic (NE) neurons located in the locus coeruleus switches the mind to the analogical mode while dopaminergic (DA) neurons located in the ventral tegmental area alternatively switch the mind to the cognitive mode. It is proposed that schizophrenics with positive symptoms have an excess of NE and are therefore analogically inclined while schizophrenics with negative symptoms have an excess of DA which inclines them to the cognitive mode.⁵⁸

There is a theory that a mechanism in the hippocampus might cause nicotinic stimulation of gamma-aminobutyric acid (GABA) which in turn could be the cause of the decreased responses of schizophrenics to repeated stimuli.⁵⁹ Essential fatty acids have also been linked to schizophrenia and there is indirect evidence of impaired metabolism of prostaglandin in schizophrenics.⁶⁰ It has also been suggested that prostaglandin hyposensitivity resulting from a prostaglandin deficiency is a characteristic of schizophrenics.⁶¹

⁵⁵ B. A. Davis, S. Shrikhande, V. P. Paralikar, S. R. Hirsch, D. A. Durden and A. A. Boulton, 'Phenylacetic Acid in CSF and Serum in Indian Schizophrenics', Progress in Neuro-Psychopharmacology & Biological Psychiatry, Vol. 15, No. 1, 1991, pp. 41-47.

⁵⁶ M. J. Iadarola, D. Ofri and J. E. Kleinman, 'Enkephalin, Dynorphin and Substance P in Postmortem Substantia Nigra from Normals and Schizophrenic Patients', Life Sciences, Vol. 48, No. 20, 1991, pp. 1919-1930.

⁵⁷ G. B. Stefano, B. Scharrer, T. V. Bilfinger, M. Salzet and G. L. Fricchione, 'A novel view of opiate tolerance', Advancements in Neuroimmunology, Vol. 6, No. 3, 1996, pp. 265-277.

⁵⁸ J. P. Tassin, 'NE/DA Interactions in Prefrontal Cortex and Their Possible Roles as Neuromodulators in Schizophrenia', Journal of Neural Transmission, Vol. 36, No. 1, 1992, pp. 35-62.

⁵⁹ S. Leonard, C. Adams, C. R. Breese, L. E. Adler, P. Bickford, W. Byerley, H. Coon, J. M. Griffith, C. Miller, M. Myles-Worsley, H. T. Nagamoto, Y. Rollins, K. E. Stevens, M. Waldo and R. Freedman, 'Nicotinic receptor function in schizophrenia', Schizophrenia Bulletin, Vol. 22, No. 3, 1996, pp. 431-445.

⁶⁰ D. F. Horrobin, 'The Relationship Between Schizophrenia and Essential Fatty Acid and Eicosanoid Metabolism', Prostaglandins Leukotrienes & Essential Fatty Acids, Vol. 46, No. 1, 1992, pp. 71-77.

⁶¹ H. Kaiya, 'Prostaglandin E1 Suppression of Platelet Aggregation Response in Schizophrenia', Schizophrenia Research, Vol. 5, No. 1, 1991, pp. 67-80.

There is also a theory about a possible imbalance in the relationship between dopamine and acetylcholine in the brains of schizophrenics⁶² as well as theories arguing that histamine plays a role and that an impairment of the histamine receptors might be the cause.⁶³

The possible role of norepinephrine in schizophrenia has been extensively explored. One study found a purported link in the interaction between dopamine and norepinephrine.⁶⁴ The norepinephrine hypothesis is closely linked to the dopamine hypothesis since norepinephrine is thought to regulate dopamine and an excess of norepinephrine is possibly the cause of a dopamine excess.⁶⁵ Other researchers have extended the dopamine/norepinephrine link with schizophrenia to include serotonin.⁶⁶

The dopamine metabolite homovanillic acid (HVA) has also been found at abnormal levels in schizophrenics,⁶⁷ and even in the parents of schizophrenics.⁶⁸ But HVA is mainly used as an indirect tool to assess changes in dopamine levels⁶⁹ so this area of research is also still closely linked to the dopamine hypothesis.

Uncertainties in Schizophrenia Research

The search for a definitive link between biochemistry and schizophrenia goes on. But as with all the biological hypotheses, although they can be explored using various methods of ‘hard’ science, they must always rest on swampy ground. The swamp on which schizophrenia researchers have to base their theories is two-fold. On the one hand there is the subjectivity of the diagnostic process which means that the search for a biological common denominator amongst groups of schizophrenics is founded on the dubious assumption that all the members of a schizophrenic cohort will actually have a common denominator, other than a history of neuroleptic medication, that makes them

⁶² M. Lyon, N. Lyon and M. S. Magnusson, ‘The Importance of Temporal Structure in Analysing Schizophrenic Behaviour: Some Theoretical and Diagnostic Implications’, Schizophrenia Research, Vol. 13, No. 1, 1994, pp. 45-56.

⁶³ T. Nakai, N. Kitamura, T. Hashimoto, Y. Kajimoto, N. Nishino, T. Mita and C. Tanaka, ‘Decreased Histamine H1 Receptors in the Frontal Cortex of Brains From Patients With Chronic Schizophrenia’, Biological Psychiatry, Vol. 30, No. 4, 1991, pp. 349-356.

⁶⁴ D. P. van Kammen and M. Kelley, Dopamine and Norepinephrine Activity in Schizophrenia. An Integrative Perspective’, Schizophrenia Research, Vol. 4, No. 2, 1991, pp. 173-191.

⁶⁵ D. P. van Kammen, ‘The Biochemical Basis of Relapse and Drug Response in Schizophrenia: Review and Hypothesis’, Psychological Medicine, Vol. 21, No. 4, 1991, pp. 881-895.

⁶⁶ J. N. Joyce, ‘The Dopamine Hypothesis of Schizophrenia: Limbic Interactions With Serotonin and Norepinephrine’, Psychopharmacology, Vol. 112, No. 1, pp. S16-S34.

⁶⁷ F. Amin, M. Davidson and K. L. Davis, ‘Homovanillic Acid Measurement in Clinical Research. A Review of Methodology’, Schizophrenia Bulletin, Vol. 18, No. 1, 1992, pp. 123-148.

⁶⁸ J. Wei, H. M. Xu and Hemmings, ‘Studies on Neurochemical Heterogeneity in Healthy Parents of Schizophrenic Patients’, Schizophrenia Research, Vol. 10, No. 2, 1993, pp. 173-178.

⁶⁹ M. Davidson, R. S. Kahn, R. G. Stern, J. Hirschowitz, S. Apter, P. Knott and K. L. Davis, ‘Treatment With Clozapine and Its Effect on Plasma Homovanillic Acid and Norepinephrine Concentrations in Schizophrenia’, Psychiatric Research, Vol. 46, No. 2, 1993, pp. 151-163.

different from normal people. Since there is no diagnostic certainty about schizophrenia there is also no certainty that a common aetiological factor has prior existence, which makes the quest for this common cause a tenuous enterprise.⁷⁰

The second problem is the history of neuroleptic medication which applies to practically all schizophrenics. Routine psychiatric practice normally requires that a person be medicated immediately upon diagnosis. This means that any group of schizophrenics which might be available to a scientific researcher will inevitably be comprised of people whose brain functioning has been modified by powerful chemicals. The subtle deviations from normal biochemistry and normal brain architecture that are detected by researchers can usually be better explained as artefacts of neuroleptic medication.⁷¹

This problem is readily apparent to researchers and, while most of them choose to ignore it and continue their research programmes as if it were not a factor, occasionally one researcher will add extra significance to findings by claiming to have carried out the research on schizophrenics who had no experience with neuroleptics.⁷² However, such claims consistently avoid describing how the groups of ‘never-medicated’ schizophrenics were assembled so there is some doubt about the validity of these claims. Occasionally, however, it is suggested that they were people recruited on first-admission entry to hospital.⁷³ This method of recruitment raises an interesting ethical question about a hospital admission procedure which requires people who are apparently in acute distress to undergo research testing before attention can be given to their own problems.⁷⁴ On top of this ethical problem there is also the doubt that a distressed person’s treatment history can be accurately obtained from the person at the point of entry into hospital.

Brain Imaging

There are a number of brain imaging techniques commonly used in schizophrenia research. Some of these techniques are only useful for assessing the structure of the brain while others can assess both the structure and certain functions, like blood flow.⁷⁵ The application of various forms of brain imaging to people who have been diagnosed with schizophrenia has allowed researchers to compare

⁷⁰ David E. Sternberg, ‘Schizophrenia’, in A. James Giannini, The Biological Foundations of Clinical Psychiatry, Medical Examination Publishing Company, New York, 1986, p. 148.

⁷¹ Breggin, op.cit., pp. 138-141.

⁷² Monte S. Buchsbaum, ‘Frontostriatal disorder of cerebral metabolism in never-medicated schizophrenics’, JAMA, The Journal of the American Medical Association, Vol. 269, No. 17, 5 May, 1993, p. 2204.

⁷³ Jarmo Hietala, Erkkä Syvalahti, Klaus Vuorio, Viljo Rakkolainen, Jorgen Bergman, Merja Haaparanta, Olof Solin, Mikko Kuoppamäki, Olli Kirvelä, Ulla Ruotsalainen and Raimo K. R. Salokangas, ‘Presynaptic dopamine function in striatum of neuroleptic-naïve schizophrenic patients’, The Lancet, 28 Oct, 1995, Vol. 346, No. 8983, pp. 1130-1132.

⁷⁴ For a discussion on the ethics of taking schizophrenics off medication to facilitate research see, W. T. Carpenter Jr., ‘The risk of medication-free research’, Schizophrenia Bulletin, Vol. 23, No. 1, 1997, pp. 11-18.

⁷⁵ Kaplan and Sadock, op.cit., p. 76.

the results with the brain-structure and the brain-functioning of normal people and to observe certain patterns of difference. These perceived differences have become the basis for a wide variety of hypotheses about the aetiology of schizophrenia.

Computed tomography (CT) is a method of x-raying living brains and is many times more sensitive than conventional radiography. In CT scanning x-ray photons are passed through the tissue under examination while the x-ray tube and the detector are rotated around the head as well as moved in parallel lines. The data that results from this process are entered into a computer which is programmed to provide a three dimensional reconstruction.⁷⁶ This imaging can detect lesions on the brain. Schizophrenia studies have largely focussed on a perceived enlargement of ventricles, brain atrophy and unusual brain asymmetries. Although CT does not cause physical discomfort patients are exposed to radiation by the process.⁷⁷

Magnetic resonance imaging (MRI) is not a form of x-ray and works on a different principle to that of CT. MRI applies a strong magnetic field to the brain under investigation which causes a realignment of hydrogen atoms. The realignment in turn causes an alteration to the radio frequency emitted by the hydrogen atoms and this alteration is read by a computer. The result is an image of the brain that is clearer and more complete than a CT scan but which is more expensive to produce.⁷⁸ In schizophrenia research MRI is used for the same purposes as CT. One of the advantages of MRI is that a patient is not exposed to radiation by the process.⁷⁹

Positron emission tomography (PET) is the most advanced and expensive form of brain imaging. It requires a patient to be dosed with glucose containing radioactive atoms.⁸⁰ Once the radioactive substance has reached the brain positrons are emitted which collide with electrons in the brain. The radio emission that result from this process can be detected by probes from a PET camera. The information is analysed by a computer and topographical maps of the brain are generated. It is possible to use PET to measure the number, and to assess the state, of neurotransmitters in the brain.⁸¹

Single photon emission computed tomography (SPECT) works in a similar way to PET in that a patient is required to be dosed with a radioactive substance. In the case of SPECT a single photon emitting isotope is used that generates activity in the brain which can be detected.⁸² The resulting

⁷⁶ *Ibid.*, p. 78.

⁷⁷ Keltner, *op.cit.*, p. 367.

⁷⁸ *Ibid.*, p. 367.

⁷⁹ Kaplan and Sadock, *op.cit.*, p. 79.

⁸⁰ Keltner, *op.cit.*, p. 367.

⁸¹ Kaplan and Sadock, *op.cit.*, p. 84.

⁸² *Ibid.*, p. 84.

data is processed by a computer and maps of the brain can be produced. SPECT results are not as detailed as those of PET scans but they are less expensive.⁸³

Scanning For Causes

Developments in brain imaging techniques have given rise to a growing body of speculation that the cause of schizophrenia will be found in abnormalities in the brain architecture of schizophrenics:

The kaleidoscopic images on PET scans suggest that there are structural defects in certain regions of schizophrenic brains which may lead them to process and retain information differently from healthy brains. Such alterations can produce behaviour from the extravagantly bizarre to intense withdrawal, prolonged apathy, and other emotional or affective disturbances.⁸⁴

This type of brain scanning has revealed that the ratio of blood in the frontal lobes, between the front and the back, is lower in the brains of schizophrenics than in the brains of normal people. This has led to speculation that it is frontal lobe dysfunction that causes the positive symptoms of schizophrenia. Another theory that has developed out of apparent abnormalities detected by brain scans is that the cause of schizophrenia is to be found in some kind of trauma that has been experienced in the womb. Brain scans have revealed,

increased amounts of cerebrospinal fluid (CSF) in the brain of many schizophrenics. A correspondingly slightly smaller brain volume has also been found. Since physical brain abnormalities do not progress further as the patient ages, levels of neuropathology may be present before birth.⁸⁵

Apparent evidence from CT scans of degeneration in a particular part of the brain called the cerebellar vermis has contributed to a brain atrophy hypothesis for schizophrenia.⁸⁶ MRI scans have indicated that schizophrenic brains have a smaller average volume of total brain tissue than do the brains of normal people. The smaller brain volume is also found to be offset by an increase in the volume of cerebrospinal fluid in schizophrenic brains. The frontal lobes is the area where specific decreases seem most apparent. These findings have led researchers to conclude that:

⁸³ Keltner, op.cit., p. 367.

⁸⁴ Anon., 'The anatomy of madness', Psychology Today, Vol. 25, No. 6, Nov-Dec, 1992, p. 16.

⁸⁵ Daniel R. Weinberger, 'From neuropathology to neurodevelopment', The Lancet, Vol. 346, No. 8974, 26 August, 1995, pp. 552-558.

⁸⁶ R. Sandyk, S. R. Kay and A. E. Merriam, 'Atrophy of the Cerebellar Vermis: Relevance to the Symptoms of Schizophrenia', International Journal of Neuroscience, Vol. 57, Nos. 3 and 4, 1991, pp. 205-212.

In addition to the generalised brain abnormalities observed in schizophrenia, a regional abnormality may be present in frontal regions. Since the frontal lobes integrate multimodality information and perform a variety of ‘higher’ cognitive and emotional functions that are impaired in schizophrenia, the frontal abnormality noted is consistent with the clinical presentation of the illness. Impaired frontal function and a disruption in its complex circuitry (including thalamocortical projections) may explain why patients with schizophrenia often have significant deficits in formulating concepts and organising their thinking and behaviour.⁸⁷

There is no mention, however, in the description of this research as to whether the schizophrenics had been treated with neuroleptic medication prior to the MRI scans. It therefore has to be assumed that they had been medicated and that the findings might be artefacts of the treatment.

One group of researchers used MRI to scan the brains of 15 pairs of identical twins where one twin in each pair had schizophrenia. The schizophrenic twin in 14 of the 15 pairs was found to have enlarged ventricles. To deal with the problem of prior neuroleptic treatment the degree of ventricle enlargement was cross-checked to see if it correlated with the length of time the schizophrenic twins had been on medication: “Brain abnormalities were not more severe among the schizophrenics with a long history either of the disorder or of antipsychotic drug treatment. Thus, the changes appear linked directly to schizophrenia.”⁸⁸

These findings have led to speculations that early in brain development there might be some kind of viral infection, birth injury or autoimmune disorder which underlies abnormal brain development in schizophrenics. These abnormalities could go unnoticed until late adolescence when the central nervous system undergoes maturational changes. This is the time of life when the symptoms of schizophrenia most commonly emerge.

There are, however, significant problems with this type of assumption. One problem is that the possible contribution of neuroleptic medication to the abnormalities is not properly discounted simply by finding no correlation between the duration of medication and the degree of brain structure abnormality. This approach presupposes that if neuroleptics play a role then the longer they are used the greater would be the abnormality. But no evidence is supplied to support this assumption.

⁸⁷ Nancy C. Andreasen, Laura Flashman, Michael Flaum, Stephan Arndt, Victor Swayze II, Daniel S. O’Leary, James C. Ehrhardt and William T. C. Yuh, ‘Regional brain abnormalities in schizophrenia measured with magnetic resonance imaging’, JAMA, The Journal of the American Medical Association, Vol. 272, No. 22, 14 December, 1994, pp. 1763-1770.

⁸⁸ B. Bower, ‘Brain Anatomy Yields Schizophrenia Clues’, Science News, Vol. 137, No. 12, 24 March, 1990, p. 182.

Another problem is that in most groups of schizophrenics there are some schizophrenics who do not have large ventricles. One investigation found that it was only the males in a group of schizophrenics who had large ventricles.⁸⁹ On top of this it has been found that some people with Alzheimer's disease and others with manic depression also have large ventricles so that this abnormal feature is neither necessary for schizophrenia, nor is it associated solely with schizophrenia.⁹⁰

A medical scientist who reviewed the research literature on the neuropathology of schizophrenia in the early 1990s wrote:

Neuroscientific inquiry into this most devastating of mental illnesses is, then, bearing hard won fruit. Few would now dispute that a substantial proportion of patients with schizophrenia do indeed have consistent structural and physiological brain abnormalities. The challenges for research workers are to establish the specificity of these abnormalities to schizophrenia and to clarify the relations between biological, aetiological, and diagnostic heterogeneity.⁹¹

But the above statement is riddled with complications and the sought-after heterogeneity that would positively define aetiology is still eluding the researchers. More recently the enlarged ventricles of schizophrenics have been associated with prenatal exposure to influenza,⁹² but the evidence is equivocal.

Infection Theories

The theory of an infectious organism as the cause of schizophrenia is not new. In the early decades of the 20th century between a quarter and a third of patients admitted to mental hospitals in industrialised countries were suffering from general paresis, a condition produced in the tertiary stage of syphilis.⁹³ For a long time there was considerable confusion within mental hospitals between people who manifested the symptoms of neurosyphilis and those who had schizophrenic symptoms.

The advent of penicillin in the 1940s seems to have focussed a belief amongst some psychiatric researchers that a similar infectious cause and medical remedy might be found for schizophrenia.

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ L. S. Pilowsky, 'Understanding schizophrenia: structural and functional abnormalities of the brain are present in the condition', British Medical Journal, Vol. 305, No. 6849, 8 August, 1992, pp. 327-329.

⁹² N. Takei, S. Lewis, P. Jones, I. Harvey and R. M. Murray, 'Prenatal exposure to influenza and increased cerebrospinal fluid spaces in schizophrenia', Schizophrenia Bulletin, Vol. 22, No. 3, pp. 521-534.

⁹³ Thomas Szasz, Schizophrenia: The Sacred Symbol of Psychiatry, Syracuse University Press, Syracuse, New York, 1976, p. 7.

Viral theories of aetiology are particularly attractive to some researchers because they can tie up a number of loose ends like the perceived seasonality of schizophrenic births,⁹⁴ the difficulties some schizophrenic women are said to have in childbirth, the frequency of auditory hallucinations and an assumed genetic component of the disease.⁹⁵

The viral theories are essentially of two types: those which postulate an active but undetected virus that directly affects the brain and gives rise to unusual psychological phenomena; and theories which postulate a past infection that, although no longer active, caused abnormalities in brain development. Retroviruses have been suggested as the likely culprit for the first type of possibility but researchers have been unable to find any positive link between schizophrenia and this type of virus.⁹⁶ Borna disease was recently discounted as a virus that might be active in schizophrenics.⁹⁷

One explanation for the second type of possibility is that schizophrenia is linked to viral epidemics that have occurred prenatally. It is argued that schizophrenics might be part of a sub-population with special resistance to disease. Although the resistance itself may not be a factor of schizophrenia it might result in fetal vulnerability to hormonal disturbances during prenatal viral infection. This vulnerability might in turn lead to neurodevelopmental damage. It is further argued that if this were so then schizophrenia could be seen as one of the prices a population has to pay for surviving epidemics.⁹⁸

Enthusiasm for the viral epidemic theory has recently focussed on polio. There seem to be a number of attractive features to the polio theory — a claimed decrease in numbers of schizophrenics coinciding with the advent of polio vaccine, a higher number of winter births confirming the possibility of second trimester infection in summer months, when polio is most active, and a higher incidence of schizophrenia amongst immigrants to the United Kingdom coinciding with higher incidence of polio in countries of origin. Once again it is postulated that prenatal infection with

⁹⁴ R. L. O'Reilly, 'Viruses and Schizophrenia', Australian & New Zealand Journal of Psychiatry, Vol. 28, No. 2, 1994, pp. 222-228.

⁹⁵ E. F. Torrey, 'Viral-Anatomical Explanation of Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 15-18.

⁹⁶ M. A. Coggiano, R. C. Alexander, D. G. Kirch, R. J. Wyatt and H. Kulaga, 'The Continued Search for Evidence of Retroviral Infection in Schizophrenic Patients', Schizophrenia Research, Vol. 5, No. 3, 1991, pp. 243-247.

⁹⁷ J. A. Richt, R. C. Alexander, S. Herzog, D. C. Hooper, R. Kean, S. Spitsin, K. Bechter, R. Schuttler, H. Feldmann, A. Heiske, Z. F. Fu, B. Dietzschold, R. Rott and H. Koprowski, 'Failure to detect Borna disease virus infection in peripheral blood leukocytes from humans with psychiatric disorders', Journal of Neurovirology, Vol. 3, No. 2, 3 April, 1997, pp. 174-178.

⁹⁸ G. Rubinstein, 'Schizophrenia, Infection and Temperature. An Animal Model For Investigating Their Interrelationships', Schizophrenia Research, Vol. 10, No. 2, 1993, pp. 95-102.

polio might cause developmental problems in the brain that do not emerge until sexual maturity.⁹⁹ But no significant evidence has been found yet to provide confirmation for the polio hypothesis.

Nutrition

Nutrition is an area of speculation with a substantial following. Like the viral theories nutritional theories divide into theories that postulate prenatal nutritional deficiencies, causing developmental abnormalities, and theories arguing that a deficiency in the current diet of the patient is the cause. Whereas the first group of theories generally do not have a direct remedy, the second group often does. (These are usually in the form of dietary supplements. This form of 'treatment' does not give rise to human rights problems).

A considerable amount of research has focussed on historically recorded famines and these events have been used to explore a hypothesised link between the starvation of pregnant mothers and schizophrenia in offspring.¹⁰⁰ The Dutch Winter Famine of 1944-1945 has provided Dutch researchers with the opportunity to explore this connection and one group has concluded that starvation during pregnancy can be a factor in the development of schizoid personalities in offspring.¹⁰¹

Researchers give four reasons for supporting the prenatal nutrition hypothesis: 1) the known effects of prenatal starvation are not incompatible with the observed features of schizophrenia; 2) brain abnormalities can develop as a result of these events; 3) general malnutrition has also been observed to cause abnormalities in areas of the brain that have been linked to schizophrenia; 4) it is known that proper prenatal nutrition is essential for the correct development of the fetal nervous system.¹⁰² But the circumstantial nature of this reasoning readily demonstrates that no hard evidence has yet been found to support this type of hypothesis. Indeed, it actually seems quite implausible when there appears to be no evidence of a higher incidence of schizophrenia in countries where malnutrition has been endemic for generations. Nevertheless this area seems particularly attractive to some researchers and the Dutch Winter Famine has been statistically linked to a two-fold increase in the risk of schizophrenia.¹⁰³

⁹⁹ R. F. Squires, 'How a poliovirus might cause schizophrenia: a commentary on Eagles' hypothesis', Neurochemical Research, Vol. 22, No. 5, May, 1997, pp. 647-656.

¹⁰⁰ J. O. Davis and H. S. Bracha, 'Famine and schizophrenia: first-trimester malnutrition or second-trimester beriberi', Biological Psychiatry, Vol. 40, No. 1, 1 July, 1996, pp. 1-3.

¹⁰¹ H. W. Hoek, E. Susser, K. A. Buck, . H. Lumey, S. P. Lin and J. M. Gorman, 'Schizoid personality disorder after prenatal exposure to famine', American Journal of Psychiatry, Vol. 153, No. 12, December, 1996, pp. 1637-1639.

¹⁰² A. S. Brown, E. S. Susser, P. D. Butler, R. Richardson-Andrews, C. A. Kaufmann and J. M. Gorman, 'Neurobiological plausibility of prenatal nutritional deprivation as a risk factor for schizophrenia', Journal of Nervous and Mental Disorders, Vol. 184, No. 2, February, 1996, pp. 71-85.

¹⁰³ E. Susser, R. Neugebauer, H. W. Hoek, A. S. Brown, S. Lin, D. Labovitz and J. M. Gorman, 'Schizophrenia after prenatal famine. Further evidence', Archives of General Psychiatry, Vol. 53, No. 1, January, 1996, pp. 25-31.

Amongst the second line of nutritional theories, which argue that schizophrenia is caused by deficiencies in the diets of adult schizophrenics, one theory claims that low concentrations of PGE-1, n-6 fatty acids, vitamin C and zinc have been linked to schizophrenia and can be rectified with a high wheat diet.¹⁰⁴ But the recommendation for a high wheat diet directly contradicts information publicised recently by the Schizophrenia Association of Great Britain:

The kinds of cereal grain from products customarily eaten may be a factor in the production of psychiatric symptoms. There might be a relationship between schizophrenia and coeliac disease, a disease of known sensitivity to wheat and sometimes to milk. The wheat and rye-eating areas of the world have the highest incidence of schizophrenia, with oats and barley areas next, followed by the rice-eating areas (with approximately 60% of the incidence of the wheat areas). In sorghum and maize-eating areas the incidence of schizophrenia was approximately 25% of the wheat areas and in the highlands of New Guinea a practically nil incidence is found. Here no grains are eaten. William Philpott, an American psychiatrist, found that half his sample of schizophrenic patients could not tolerate milk and 64% were wheat sensitive.¹⁰⁵

The confusion over whether wheat might have a beneficial or detrimental effect on people inclined towards psychosis is fairly typical of the many contradictions that surround schizophrenia. Perhaps this particular area of confusion might in part be explained by the well-known relationship between vitamin B12 deficiency and pellagra, a disease that effects the skin, the digestive and nervous systems, and which commonly presents with schizophrenia-like symptoms.

In 1937, Elvehjen identified niacin deficiency as the cause and niacin the cure for pellegra, after which large numbers of pellagra psychotics recovered and were found not to be schizophrenic. As a result of this discovery, niacin is now routinely added to bread.¹⁰⁶

Despite this long-known association between vitamin B12 deficiency and psychotic symptoms contemporary researchers still occasionally announce its re-discovery. One recent example from Singapore reported a case study involving an observed link between vitamin B12 deficiency,

¹⁰⁴ R. S. Smith, 'The GI T-lymphocyte theory of schizophrenia: some new observations', Medical Hypotheses, Vol. 37, No. 1, January, 1992, pp. 27-30.

¹⁰⁵ Brian Hyfryd, 'Neglect of the Body to the Detriment of the Patient: Management Notes', Journal of Nutritional & Environmental Medicine, Vol. 7, No. 1, March, 1997, pp. 47-53.

¹⁰⁶ James S. Howard, 'Requiem For Schizophrenia', Integrative Physiological & Behavioral Science, Vol. 31, No. 2, April-June 1996, pp. 148-155.

anaemia and schizophrenia and recommended supplementing neuroleptic medication with a substance to compensate.¹⁰⁷

Genetic Theories

Genetic theories underlie many of the biological theories since it is often assumed that only those people with a genetic vulnerability will manifest the neuropathological condition that causes schizophrenia, or succumb to the virus, or the malnutrition, that causes the neuropathology that in turn causes schizophrenia. Indeed, a genetic factor is fairly essential to give credibility to any biological explanation of aetiology because one of the few uncontested features of schizophrenia, to which most observers agree, is that schizophrenia tends to run in families. Without a plausible genetic argument the phenomenon of family propensity for schizophrenia might always be better explained by environmental causes.

The idea that a single dominant genetic component might be solely responsible — that there could be a ‘schizophrenia gene’ — has to be discounted by other observable phenomena. Breggin argues that when geneticists go in search of a dominant gene as the cause for a disease like Huntington’s chorea the quest makes sense because there is prior knowledge from the set pattern of family inheritance that a dominant gene is responsible.¹⁰⁸ But this is clearly not the case with schizophrenia. Although there is a family association with schizophrenia, there is no set pattern of inheritance.

The prior existence of a logical refutation of any claims to have discovered a ‘schizophrenia gene’ has not deterred some genetic researchers from embarking on the quest and occasionally announcing success. In 1988 it was announced that chromosome 5 was the site of the schizophrenia gene: “For the first time, scientists have obtained evidence that a specific chromosome mutation contains a gene predisposing its bearers to schizophrenia and closely related mental disorders”.¹⁰⁹

The announcement was made in the November 10, 1988 issue of Nature and a refutation came so swiftly it was even published in the same edition of the same journal:

Another study in the same NATURE indicates, however, that schizophrenia is too complex to result from a single gene. Psychiatrist James L. Kennedy of Yale University and his co-workers report that the same region of chromosome 5 is unrelated to schizophrenia in several generations of a large Swedish family. The researchers suggest

¹⁰⁷ S. M. Ko, and T. C. Liu, ‘Psychiatric syndromes in pernicious anaemia — a case report’, Singapore Medical Journal, Vol. 33, No. 1, February, 1992, pp. 92-94.

¹⁰⁸ Breggin, op.cit., p. 122.

¹⁰⁹ Bruce Bower, ‘Schizophrenia: genetic clues and caveats’, Science News, Vol. 134, No. 20, 12 Nov, 1988, p308.

there may be several genes, each causing a different biochemical abnormality, that together result in a 'final common pathway' to schizophrenia.¹¹⁰

More recently the search for the schizophrenia gene has concentrated on Irish families and in 1995,

a team of scientists headed by Scott Diehl of the National Institute of Health found a specific region of Chromosome 6 that appears to contain a gene for the disorder. "If our finding holds up, it means that, contrary to what a lot of researchers have thought, there is at least one major gene that predisposes a person to schizophrenia," said Diehl.¹¹¹

The equivocal statement, "If our finding holds up," was a definite warning that Diehl himself was uncertain about the claims he was making for Chromosome 6. Ten days later the reason for this uncertainty was revealed. It seems that Diehl had published the results of work he had been engaged in as a junior research scientist at the Medical College of Virginia under the direction of Dr. Kenneth Kendler. But Diehl had moved on to another research facility in 1993. A simmering dispute had continued between Diehl and Kendler between 1993 and 1995 over whether Diehl had any rights to the research he had undertaken while working for Kendler. Diehl's 1995 announcement of having discovered the schizophrenia gene turned out to be a pre-emptive strike to claim ownership of the intellectual property. But it seems that Diehl had only completed 10% of the gene mapping work envisioned in Kendler's research scheme and Diehl's article only described preliminary findings. At stake were millions of dollars of research funding to complete the project.¹¹²

Many genetic researchers were not convinced that Kendler and Diehl are even on the right track in pursuing chromosome 6. Some researchers have targeted chromosome 22 as being the most likely site for the schizophrenia gene.¹¹³ Most genetic research, however, now assumes that there is no single schizophrenia gene and that a variety of separate genetic factors are involved.¹¹⁴

¹¹⁰ Ibid.

¹¹¹ Mark Bowden, 'Study finds evidence for gene that may help cause schizophrenia,, Knight-Ridder/Tribune News Service, 1 May, 1995 p. 501.

¹¹² Mark Bowden, 'Top human geneticists argue over ownership of schizophrenia research', Knight-Ridder/Tribune News Service, 11 May, 1995, p. 511.

¹¹³ K. C. Murphy, A. G. Cardno and P. McGuffin, 'The molecular genetics of schizophrenia', Journal of Molecular Neuroscience, Vol. 7, No. 2, 1996, pp. 147-157.

¹¹⁴ Peter McGuffin, Michael J. Owen and Anne E. Farmer, 'Genetic basis of schizophrenia', The Lancet, Vol. 346, No. 8976, 9 September, 1995, pp. 678-683.

The basis for the genetic theory is a well-observed pattern of psychiatric morbidity in the families of people with schizophrenia.¹¹⁵ Psychiatric textbooks routinely present these concordance rates as being established genetic risk factors for schizophrenia.

Genetic Risk for Schizophrenia

These concordance rates, however, can also support arguments for an environmental cause. In cases, for instance, where one or both parents have schizophrenia it can be argued that it is not the transmission of genes that passes the condition on to offspring but rather bad parenting. Similarly, if one child develops schizophrenia due to an environmental cause in family life then it is likely other children in the family will also be affected in the same way.¹¹⁶

This exploitation of concordance research by advocates for an environmental cause has prompted genetic researchers to explore the concordance rates of siblings who have been reared separately. The adoption studies that are most frequently cited, however, are quite old dating back to the 1960s and 1970s. Of these the most important was published in 1975 by a team led by Seymour Kety.¹¹⁷

The Kety study was sponsored by the National Institute for Mental Health in the United States and involved locating Danish schizophrenics who had been adopted as children, before their schizophrenia had become apparent. Denmark was chosen because of the efficiency of the official system of record-keeping. The second step to the investigation required locating and psychiatrically assessing the biological relatives of the adopted schizophrenics to see if there was a higher incidence of schizophrenia amongst them than there was amongst the relatives of a control group of

¹¹⁵ S. L. Varma, A. M. Zain and S. Singh, 'Psychiatric morbidity in the first-degree relatives of schizophrenic patients', American Journal of Medical Genetics, Vol. 74, No. 1, 21 February, 1997, pp. 7-11.

¹¹⁶ P. J. Tienari and L. C. Wynne, 'Adoption studies of schizophrenia', Annals of Medicine, Vol. 26, No. 4, August, 1994, pp. 233-237.

¹¹⁷ S. S. Kety, D. Rosenthal, P. H. Wender, et al, 'Mental illness in the biologic and adoptive families of adoptive individuals who have become schizophrenic: a preliminary report based on psychiatric interviews', in R. Fieve, D. Rosenthal and H. Brill, eds, Genetic Research in Psychiatry, John Hopkins University Press, Baltimore, 1975, pp. 147-165.

non-schizophrenic adoptees. The findings showed that schizophrenia and 'schizophrenia spectrum' disorders were more prevalent amongst the relatives of the schizophrenic adoptees and this was taken to be positive evidence of a genetic link for schizophrenia.¹¹⁸

However, this study has been severely criticised. Claims have been made that there was a double sleight-of-hand involved in the presentation of the results.¹¹⁹ Whereas there was no increase in schizophrenia amongst the close relatives — mothers, fathers, sisters and brothers — there was an increase amongst paternal half-siblings. But this increased incidence was all contained within one large family.

Furthermore, the increase was largely due to the inclusion of 'schizophrenia spectrum' disorders in the comparative study. DSM II was used to define the relevant range of disorders and this edition of the manual included a category, which has since been dropped, called 'latent schizophrenia'. This was a supposed tendency towards schizophrenia without a history of psychosis. It was similar to the Soviet concept of 'sluggish schizophrenia' and almost anybody could be fitted into it. Fourteen of a total of eighteen half-siblings diagnosed with schizophrenia spectrum disorders only had this latent form.

Breggin argues that the four cases of full-blown schizophrenia within the one family could be best explained by an environmental cause, perhaps sexual abuse. He dismisses the cases of latent schizophrenia as irrelevancies.

Adoption studies have also been severely criticised because of concerns that adoption practices may have been influenced by eugenics policies in the countries where the most influential adoption studies were carried out. Jay Joseph¹²⁰ has analysed the development of eugenics policies, and their translation into laws sanctioning sterilisation of mentally ill people, in Denmark, Finland and Oregon. He argues that a number of adoption studies undertaken in Denmark in the 1960s and 1970s, others undertaken in Finland in the 1970s and 1980s, and another in Oregon in the 1960s, all used schizophrenic adoptees who were placed for adoption at a time when eugenics legislation was in force.

Jay's argument is that adoption agencies would have been influenced by eugenics policies in regard to the type of families children were placed in. If a child who was given up for adoption had a natural mother who had schizophrenia, or if there was any known mental illness in the family of the mother or father, then the child would most likely have been placed in a family of lower

¹¹⁸ Black et al., *op.cit.*, p. 379.

¹¹⁹ Breggin, *op.cit.*, pp. 118-121.

¹²⁰ Jay Joseph, 'The Genetic Theory of Schizophrenia: A Critical Overview', *Ethical Human Sciences and Services*, Vol. 1, No. 2, 1999, pp. 119- 145.

socio/economic status. This in turn would have increased the likelihood that these children would have been reared in a more stressful environment, and they would therefore have been more likely to develop schizophrenia. Jay concluded:

If all schizophrenia adoption studies are considered in the context of the social and political environments from which they obtain their participants, the following can be concluded: The great majority of adoptees under investigation by the schizophrenia adoption studies were given up for adoption at a time when the compulsory sterilisation of "schizophrenics" for eugenics purposes was permitted by law in the country or state in which their adoptions took place (Denmark, Finland, Oregon). Leaving aside all other problems, the evidence suggesting that the selective placement of adoptees occurred in these studies is reason enough to disregard their findings until evidence can be produced that such placements did not occur.¹²¹

The most persuasive evidence for a genetic link comes from the study of concordance rates in twins. The twin method is widely used to determine whether a particular trait has any connection with genetic inheritance. The method involves comparing the concordance rates of monozygotic (MZ) twins (one egg, identical) with concordance rates of dizygotic (DZ) twins (two egg, fraternal). In schizophrenia studies these comparisons are confined to twins where both members have been reared together. The object is to determine whether the 100% genetic concordance of monozygotic twins, compared to the 50% genetic concordance of dizygotic twins, reflects in similarly divergent concordance rates for schizophrenia. The results are quite impressive.

When the results are pooled of 14 twin studies conducted between 1928 and 1998 the pooled concordance rates for monozygotic twins is 44% compared to 9% for dizygotic twins.¹²² At first glance this offers convincing evidence for a genetic factor in schizophrenia. However, critics of the studies point to two major problems with this approach. The first is that the studies themselves all have methodological problems. The most serious of these methodological problems are the familiar ones concerning diagnostic criteria and subjective methods of diagnosis for schizophrenia. It is pointed out that all of these studies were undertaken by researchers who set out to confirm the genetic hypothesis and that in most cases non-blinded diagnostic procedures were used. Given the subjective nature of schizophrenia diagnosis this gives rise to concerns that diagnoses might have been inflated for one group and deflated for the other.

The other major problem concerns the possibility that concordance rates might have been confounded by environmental factors. Analysis of the studies has shown that, although there is no

¹²¹ Ibid., p. 136.

¹²² Ibid., p. 123.

sex-link to the genetic hypothesis for schizophrenia, the twin studies show a distinct pattern of sex-linked concordance: "female MZ pairs were more concordant than male MZ pairs; female DZs were more concordant than male DZs; DZ same sex-sex twins were more concordant than opposite-sexed DZs; and DZ twins were more concordant than ordinary siblings, despite sharing the same genetic relationship".¹²³

These results suggest that something other than genes is responsible for the concordance patterns. It is suggested that the most likely explanation is that family environments tend to compress the identities of twins so that they experience a phenomena called "ego-fusion".¹²⁴ This occurs as a result of families endeavouring to treat them equally which often means duplication of clothing and experience. The more similar the twins are, whether MZs or same sex, the more duplicated their experience tends to be. The result is that if one twin experiences madness the other will have a propensity to follow depending on their history of duplicated experience: "It is therefore concluded that there is no reason to accept that the twin method measures anything other than the environmental differences distinguishing identical and fraternal twins".¹²⁵

It is not only the gene sceptics who warn about excessive optimism pervading the genetic quest. Some of the leading researchers in the field also find it occasionally necessary to tone down the rhetoric in order to keep the issue in perspective:

The search for genes of major effect in schizophrenia, however, is premised not so much on hard evidence that they exist, as on the absence of evidence that they do not. Recent work suggests that such genes of major effect exist in other common disorders, but linkage studies in schizophrenia must still be regarded as acts of faith. Clearly, therefore, we must explore both avenues and continue to apply to schizophrenia a range of sophisticated techniques that do justice to the intricacies of the problem.¹²⁶

Theories of an Environmental/Experiential Aetiology

Enviro/experiential theories are very different to biological theories. They begin from an altogether different premise. Biological theories largely disregard or discount any concept of mind, preferring instead to assume that abnormalities of thought are caused by abnormalities in brain functioning. Enviro/experiential theories, on the other hand, are based on the concept that the symptoms of schizophrenia are manifestations of a person's mind, rather than their brain.¹²⁷

¹²³ Ibid., p. 126.

¹²⁴ Ibid.

¹²⁵ Ibid., pp. 136-137.

¹²⁶ Michael Owen and Peter McGuffin, 'The molecular genetics of schizophrenia: blind alleys, acts of faith, and difficult science', *British Medical Journal*, Vol. 305, No. 6855, 19 September, 1992, pp. 664-666.

¹²⁷ Silvano Arieti, 'From schizophrenia to creativity', *American Journal of Psychotherapy*, Vol. 33, No. 4, October, 1979, pp. 490-505.

A major weakness of the enviro/experiential side of the debate is the inability to adequately describe what is meant by mind.¹²⁸ Since the biological determinists have claimed as their own territory all the biological organs on which mind might depend¹²⁹ the enviro/experiential determinists are only left with a vague concept of a disembodied collection of memories and feelings which apparently malfunctions when it has been assembled, or is required to operate, under inclement conditions. Although most of the enviro/experiential theories are accessible to some form of scientific investigation they normally do not demonstrate the same kind of hard scientific edge as the biological theories.

An individual's experience within the family environment is the matrix from which many enviro/experiential theories of aetiology arise.¹³⁰ Family life, particularly family life during infancy and early childhood, is often seen as the place and time where the fundamental characteristics of a person's mind are formed. It is malformations of mental characteristics that are variously blamed by the environmental determinists as causes of schizophrenia. However, although it is usually experience gained within the family which is hypothesised as the cause of schizophrenia, because this experience is in the past, and can not be re-run to achieve a more desirable outcome, the solutions devised by talking therapists are not always directed at readjusting family relationships.¹³¹

Talking therapies can be divided into a number of different types: there are those which assume the fault is a problem of intrapsychic development: i.e. that it is in the psychological makeup of the schizophrenic, and that it can be corrected by making the affected individual more aware of the problem;¹³² there are those which assume the fault is with the schizophrenic's family, or a particular member of the family, and can be corrected by making adjustments to family structures;¹³³ and there are those which assume the fault is in a competitive/hostile social environment to which the schizophrenic is maladapted.¹³⁴

¹²⁸ Michael D. Lemonick, 'Glimpses of the Mind', Time, Vol. 146, No. 3, July 17, 1995, pp. 44-53.

¹²⁹ Judith Hooper, 'Targeting the brain: the 3-lb. organ that rules the body is finally giving up its secrets. Goodbye, Oedipus', Time, Vol. 148, No. 14, 1996, pp. 46-51.

¹³⁰ Ian R. Falloon, 'Family stress and schizophrenia: Theory and practice', Psychiatric Clinics of North America, Vol. 9, No. 1, March, 1986, pp. 165-182.

¹³¹ J. Zubin, 'Suiting therapeutic intervention to the scientific models of aetiology', British Journal of Psychiatry Supplement, July 1989, pp. 9-14.

¹³² D. B. Diamond, 'The fate of the ego in contemporary psychiatry with particular reference to etiologic theories of schizophrenia', Psychiatry, Vol. 6, No. 1, 1997, pp. 67-88.

¹³³ Matti Keinonen, Hilkka Virtanen and Anne Kaljonen, 'Structural couplings between individual development and the epigenesis of family relations in schizophrenia: An eight-year follow-up', Contemporary Family Therapy, Vol. 11, No. 2, 1989, pp. 75-88.

¹³⁴ Howard N. Garb, 'Race bias, social class bias, and gender bias in clinical judgment', Clinical Psychology Science and Practice, Vol. 4, No. 2, 1997, pp. 99-120.

Developmental Theories

The first type of therapy often assumes some kind of developmental hypothesis for the aetiology of schizophrenia. Sigmund Freud's ideas about schizophrenia form the basis for many developmental theories.¹³⁵ Freud based many of his ideas about schizophrenia on an analysis of a distinguished jurist named Daniel Paul Schreber who developed a psychosis in mid-life.¹³⁶ Schreber's psychosis involved paranoid delusions of persecution which Freud interpreted as manifestations of latent homosexual attraction to his father.

Freud theorised that because the homosexual attraction was too unbearable for Schreber to acknowledge it had instead been transformed into hatred for his father. Hatred for his father, in turn, caused Schreber to see him as a persecutor. This simple rationale became the basis for a general explanation of the paranoia which is commonly associated with schizophrenia. Similarly, the equally common phenomena of hallucinations was explained conversely as "wish fulfilment of unbearable ideas rejected by the ego".¹³⁷

Freud observed that problems with interpersonal relationships were associated with schizophrenia and he applied his libido theory to find an explanation. He speculated that a schizophrenic's inability to properly relate to other people is caused by the withdrawal of libido into the self. This withdrawal of libido is a regression to the infantilism of primary process thinking and the ensuing focus on self gives rise to delusions and hallucinations as compensation for the deficit in interpersonal relations.¹³⁸

Freud believed that schizophrenics could not be treated by psychoanalytical means because their inability to form interpersonal relationships meant they were unable to engage in transference, which is essential to the process of psychoanalysis.¹³⁹ This declaration of untreatability led to the marginalisation of Freud's theories on schizophrenia and to a quest by successive theorists for a developmental hypothesis that would support some form of therapeutic intervention.

Harry Stack Sullivan's theories extended Freud's considerably. Although Freud and Sullivan had similar approaches to schizophrenia they came from very different cultural backgrounds that led them to different conclusions. While Freud came from a Jewish, middle class, sophisticated

¹³⁵ B. B. Wolman, 'New ideas on mental disorders', American Journal of Psychotherapy, Vol. 31, No. 4, October, 1977, pp. 546-560.

¹³⁶ Sigmund Freud, 'Psycho-analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)', The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. 12, Hogarth Press, London, 1958, pp. 3-82.

¹³⁷ Black et al., op.cit., p. 380.

¹³⁸ Ibid.

¹³⁹ Laurie M. Post, 'A study of the dilemmas involved in work with schizophrenic patients', Psychotherapy Theory, Research and Practice, Vol. 19, No. 2, 1982, pp. 205-218.

Viennese background, which gave him a detached, scholarly, perspective, with an observer's status that was not so much a personal attribute as one he had inherited with his ethnic identity, Sullivan, on the other hand, had grown up as a lonely outsider in a rural area of the United States.¹⁴⁰

Sullivan's personal struggle through childhood and adolescence, with a cold rejecting mother and a shy distant father, apparently gave him a certain empathy with the schizophrenics he encountered in his adult career as a psychiatrist in the 1920s to 1940s.¹⁴¹ Although he began his career accepting many of Freud's beliefs his technique of closely observing and empathising with his patients led to many revisions.¹⁴²

Sullivan came to believe that many psychiatric problems were due to the fraud and hypocrisy which he thought were endemic to society. He believed the Oedipal complex, for instance, on which Freud's theory of schizophrenia was based, "must be recognised as a distortion, not a biological development, in the normal male child. It is a fraudulent symbol situation commonly the result of multiple vicious features of our domestic culture".¹⁴³

Sullivan's version of the developmental theory conceived by Freud was that schizophrenia is the outcome of interpersonal problems. To Sullivan personality development is dependent on a person monitoring the appraisal of significant people. When significant people are perceived to have a negative opinion, or when there are no significant people in a person's life, then there is a risk of developing a personality deficit or schizophrenia.¹⁴⁴ Sullivan's theory contributed to a change in the focus of the developmental theories so that schizophrenia was no longer seen as an intrapsychic problem but instead became an environmental problem.¹⁴⁵

Family Environment

On the non-biological side of the psychiatric dichotomy over schizophrenia the theories that have evolved about environmental causes for schizophrenia usually focus either on the family environment or the larger social environment. Those which focus on the family environment demonstrate a clear pattern of evolution.¹⁴⁶ At first mothers were the focus of research under the

¹⁴⁰ Jane Pearce, 'Harry Stack Sullivan: Theory and practice', Managed Environment Systems, Vol. 14, No. 4, July, 1984, pp. 159-166.

¹⁴¹ Clara Thompson, 'Harry Stack Sullivan, the Man', in Harry Stack Sullivan, Schizophrenia as a Human Process, W. W. Norton and Company, New York, 1962, p. xxxii.

¹⁴² Harry Stack Sullivan, Schizophrenia as a Human Process, W. W. Norton and Company, New York, 1962, p. 147.

¹⁴³ Harry Stack Sullivan, 'Erogenous Maturation', Psychoanalytical Review, Vol. 61, 1926, pp. 1-15.

¹⁴⁴ Pearce, op.cit., pp. 159-166.

¹⁴⁵ Black et al., op.cit., p. 380.

¹⁴⁶ Yrjo O. Alanen, 'An attempt to integrate the individual-psychological and interactional concepts of the origins of schizophrenia', British Journal of Psychiatry, Vol. 164, Supplement 23, April, 1994, pp. 56-61.

assumption that some fault in the mother/child bonding was the cause of schizophrenia.¹⁴⁷ Then the focus of research moved on to examine marital relationships between mothers and fathers with the assumption that some kind of distortion in these relationships might impact on children and cause schizophrenia.¹⁴⁸ Finally researchers began to take account of the family environment as a whole assuming that any member of a family, or all the members of a family together, might somehow create conditions of stress that produced schizophrenia in a family member.¹⁴⁹

The term ‘schizophrenogenic mother’ was first coined in 1948 by a psychiatrist named Frieda Fromm-Reichman: “The schizophrenic is painfully distrustful and resentful of other people due to the severe early warp and rejection he encountered in important people in his infancy and childhood, as a rule mainly the schizophrenogenic mother.”¹⁵⁰ There were two ideas embodied in the concept of the schizophrenogenic mother which made this terminology a powerful message for the times. These two ideas were the notions of maternal rejection and maternal over-protection.¹⁵¹

The post World War II period was one of rapid cultural change where attention was often focussed on the relationship between mothers and children.¹⁵² Uncertainty had developed about the quality of mother-infant bonding in industrialised countries as a result of a variety of factors like a rising divorce rate, adolescent pregnancies, and working mothers who left their babies with surrogate minders. The satisfying pre-war cultural image of a young mother successfully nurturing an infant was being eroded.¹⁵³

In these circumstances it became popular for social commentators to blame mothers for any troubles children had with social adjustment and also any problems the society might have with maladjusted or delinquent children. It was discovered that mothers could be conveniently blamed for many kinds of social stresses. As a result the stereotypical suburban housewife was often portrayed as a frustrated, repressed, disturbed, martyred, never satisfied, unhappy woman — a demanding, nagging, shrewish wife — and a rejecting, over-protecting, dominating mother.¹⁵⁴

¹⁴⁷ James S. Grotstein, ‘Deciphering the schizophrenic experience’, Psychoanalytic Inquiry, Vol. 3, No. 1, 1983, pp. 37-69.

¹⁴⁸ C. Peter Rosenbaum, The Meaning of Madness: Symptomatology, Sociology, Biology and Therapy of the Schizophrenias, Science House, New York, 1970, pp. 140-163.

¹⁴⁹ Anthony Clare, Psychiatry in Dissent: Controversial issues in thought and practice, Tavistock Publications, London, 1976, pp. 189-196.

¹⁵⁰ Frieda Fromm-Reichman, ‘Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy’, Psychiatry, Vol. 11, 1948, pp. 263-273.

¹⁵¹ Gordon Parker, ‘Re-searching the schizophrenogenic mother’, Journal of Nervous and Mental Disease, Vol. 170, No. 8, August, 1982, pp. 452-462.

¹⁵² Carol Eadie Hartwell, ‘The schizophrenogenic mother concept in American psychiatry’, Psychiatry Interpersonal and Biological Processes, Vol. 59, No. 3, August, 1996, pp. 274-297.

¹⁵³ J. Kagan, Unstable Ideas, Harvard University Press, Cambridge, 1989, p. 80.

¹⁵⁴ Betty Friedan, The Feminine Mystique, Bantam Books, New York, 1964.

This changing cultural identity of women enhanced the significance of the role of motherhood in the eyes of psychiatrists. As faith in the competence of mothers declined advice was increasingly sought from professionals on matters concerning nurturing and child care. But mothers remained powerful. Although they might be perceived as failing to produce healthy well-adjusted children they could still wreak social havoc by producing deviants.¹⁵⁵

On top of this, at the same time as women were increasingly seen as becoming dominant, masculine power was thought to be on the decline. Popular literature complained about the emasculation of men due to factors like the bureaucratisation of work, the rise of the corporate ‘man in the grey flannel suit,’ and the demise of individualism. The newly enfeebled men of the 1950s had castrating women waiting for them in every suburban home.¹⁵⁶

The significance of these cultural trends to the discovery of the idea of the schizophrenogenic mother, despite the discoverer herself being a woman, is that most of the psychiatric researchers who pursued this line of research were men. The general notion they were pursuing was of a dominating, over-protective, but basically rejecting mother who somehow induced a schizophrenic reaction in her offspring.¹⁵⁷ A considerable number of uncontrolled studies were undertaken that seemed to confirm this premise. These were usually in the form of interview studies or case-record studies without control groups.¹⁵⁸

However, by the early 1980s the concept of the schizophrenogenic mother had definitely run its course. A researcher could argue in 1982, after reviewing the literature on the subject, that “[t]he most plausible explanation is that there is no *sui generis* schizophrenogenic mother; instead, there is a parental type distinguished by hostile, critical, and intrusive style and it is not particularly over-represented in the parents of schizophrenics.”¹⁵⁹ With further shifts in cultural values over the intervening years it had become apparent that only a small percentage of women who might arguably fit the criteria of schizophrenogenic mother had actually produced schizophrenic children. Conversely, many schizophrenics were found to have mothers who did not fit the criteria.

By the early 1980s some psychiatric researchers were ready to include the schizophrenogenic mother on a list with other “dangerous psychosocial hypotheses” that supposedly had retarded the

¹⁵⁵ Stella Chess, ‘The “blame the mother” ideology’, International Journal of Mental Health, Vol. 11, Nos. 1-2, 1982, pp. 95-107.

¹⁵⁶ B. Ehrenreich, and D. English, For Her Own Good, Doubleday, New York, 1987, p. 241.

¹⁵⁷ Frank Simmers and Froma Walsh, ‘The nature of the symbiotic bond between mother and schizophrenic’, American Journal of Orthopsychiatry, Vol. 47, No. 3, July, 1977, pp. 484-494.

¹⁵⁸ See for example, A. C. W. Whal, ‘Some Antecedent Factors in the Family Histories of 392 Schizophrenics’, American Journal of Psychiatry, Vol. 110, 1954, pp. 668-676.

¹⁵⁹ Parker, op.cit., pp. 452-462.

progress of psychiatry.¹⁶⁰ Yet despite the hostility that had developed against the idea within the psychiatric profession, and despite the lack of evidence to support it, the schizophrenogenic mother was still being presented as a viable concept in psychology textbooks up to the end of the 1980s.¹⁶¹

Double Bind Theory

The schizophrenogenic mother was only one of a number of possible complications in the childhoods of schizophrenics that might account for the disorder. The search for a distortion in family experience that could be described in finite terms, measured, and positively connected with schizophrenics was something of a holy grail for psychiatrists in the decades following World War II. Perhaps the most seductive idea that arose from this quest was the ‘double bind’ theory.¹⁶²

In 1956 Gregory Bateson and his colleagues at Stanford University published a “report on a research project which has been formulating and testing a broad, systematic view of the nature, etiology, and therapy of schizophrenia”.¹⁶³ The double bind theory which arose from this research was based in communications theories. Bateson’s view was that the inner turmoil experienced by schizophrenics is associated with a habit of routinely communicating in metaphorical language without first flagging that a metaphor was being used: “The peculiarity of the schizophrenic is not that he uses metaphors, but that he uses *unlabelled* metaphors. He has special difficulty in handling signals of that class whose members assign Logical Types to other signals”.¹⁶⁴

The “Logical Types” referred to are derived from a theory of Bertram Russell which argues that there is a discontinuity between a class and its members. Bateson had adapted Russell’s theory to the realm of ideas and to the communication of ideas.¹⁶⁵ Bateson argued that there are numerous classes of ideas used in human communication which each dictate different modes of communication within their fields of influence. Examples given of these classes of ideas are play, non-play, fantasy, sacrament and metaphor.¹⁶⁶ According to the theory it is imperative that a discontinuity prevails between the class and the members: i.e. between a meta idea like ‘play’ and the communication of playful ideas:

¹⁶⁰ Humphry Osmond, ‘Dangerous psychosocial hypotheses’, Journal of Orthomolecular Psychiatry, Vol. 11, No. 3, 1982, pp. 216-218.

¹⁶¹ Otto F. Wahl, ‘Schizophrenogenic parenting in abnormal psychology textbooks’, Teaching of Psychology, Vol. 16, No. 1, February, 1989, pp. 31-33.

¹⁶² John H. Weakland, ‘The development and significance of the double-bind theory’, Japanese Journal of Family Psychology, Vol. 6, December, 1992, pp. 25-38.

¹⁶³ Gregory Bateson, Don D. Jackson, Jay Haley, and John Weakland, ‘Towards a Theory of Schizophrenia’, Behavioral Science, Vol. 1, Number 4, October 1956, reproduced in Milton M. Berger, Beyond the Double Bind, Brunner/Maze, New York, 1978, pp. 3-27.

¹⁶⁴ Ibid., p. 8.

¹⁶⁵ Leena Roy and Suby Roy, ‘Does the theory of logical types inform a theory of communication?’, Journal of Genetic Psychology, Vol. 148, No. 4, December, 1987, pp. 519-525.

¹⁶⁶ Bateson et al., op.cit., p. 6

Although in formal logic there is an attempt to maintain this discontinuity between a class and its members, we argue that in the psychology of real communications this discontinuity is continually and inevitably breached and that *a priori* we must expect a pathology to occur in the human organism when certain formal patterns of the breaching occur in the communication between mother and child. We shall argue that this pathology at its extreme will have symptoms whose formal characteristics would lead the pathology to be classified as a schizophrenia.¹⁶⁷

The reference to the mother/child relationship was only a convenient example of a relationship in which this type of breaching could occur. Communications which can give rise to pathogenic breaching are theoretically possible with any close member of a family. “The hypothesis which we offer is that the sequences of this kind of external experience of the patient are responsible for the inner conflicts of Logical Typing. For such unresolvable sequences of experiences, we use the term ‘double bind’.”¹⁶⁸

Unlike the somewhat obscure reasoning of the theoretical packaging of Logical Types, the description of the double bind situation, from which schizophrenics were assumed to contract their mental pathology, was persuasive and logical. Six ingredients were specified for a double bind situation.

- (1) The “victim”, i.e. the schizophrenic person, must have had a childhood relationship with one or more family members whose communication techniques induced inner conflict.
- (2) The double bind communications were a repeated rather than a single traumatic experience. The repetition is necessary in order to induce in the victim a habitual expectation of double bind forms of communication.
- (3) The double bind communication first takes the form of a primary negative injunction. “This may take either of two forms: (a) ‘Do not do so and so, or I will punish you’, or (b) ‘If you do not do so and so, I will punish you’.”¹⁶⁹ The punishment that is threatened might take the form of either withdrawal of love or the expression of anger.
- (4) The primary negative injunction is followed by a secondary injunction which conflicts with the first. The secondary injunction is on a more abstract level and, although like the first it is enforced by an implication of punishment, it is usually communicated in a more subtle fashion which might involve nonverbal means like posture, gesture or tone of voice.
- (5) A tertiary negative injunction prevents the victim from escaping from the situation.
- (6) When the victim has learned to anticipate double bind patterns in all communications the complete set of ingredients is no longer necessary and “almost any part of the double bind sequence

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*, p. 9.

¹⁶⁹ *Ibid.*

may then be sufficient to precipitate rage or panic. The pattern of conflicting injunctions may even be taken over by hallucinatory voices.”¹⁷⁰

Although the mother/child relationship is not the only one with double bind potential Bateson and his colleagues prefer to illustrate their theory by depicting mothers:

we hypothesise that the mother of a schizophrenic will be simultaneously expressing at least two orders of message. These orders can be roughly characterised as (a) hostile or withdrawing behaviour that is aroused whenever the child approaches her, and (b) simulated loving or approaching behaviour which is aroused when the child responds to her hostile and withdrawing behaviour, as a way of denying she is withdrawing.¹⁷¹

Bateson gave an example of the double bind situation taken from observations made during clinical practice. This example is much-cited and has been frequently used by other writers to illustrate in summary the mechanism of double bind.

A young man who had fairly well recovered from an acute schizophrenic episode was visited in the hospital by his mother. He was glad to see her and impulsively put his arm around her shoulders, whereupon she stiffened. He withdrew his arm and she asked, “Don’t you love me any more?” He then blushed, and she said, “Dear you must not be so easily embarrassed and afraid of your feelings.” The patient was able to stay with her only a few minutes and following her departure he assaulted an aide and was put in the tubs.¹⁷²

The simplicity of the double bind argument was very appealing but, while many schizophrenics appeared to have a history of some kind of double bind situation,¹⁷³ so did many non-schizophrenics. In fact, the popularity of the idea might be attributable to the fact that most people have experienced the frustration of a double bind relationship with a person of authority at some time in their lives, and can easily recognise the problem.

Perhaps it happens in many situations where one person is required to exercise authority over somebody else. In a work place, for instance, egalitarian camaraderie might be encouraged while at the same time a person in authority might need to conceal incompetence, or a disinterest in a subordinate, under a veneer of authoritarian role playing. The consequence for the subordinate

¹⁷⁰ *Ibid.*, p. 10.

¹⁷¹ *Ibid.*, p. 15.

¹⁷² *Ibid.*, p. 18.

¹⁷³ Susan L. Jones, ‘The “damned if you do and damned if you don't” concept: The double bind as a tested theoretical formulation’, *Perspectives in Psychiatric Care*, Vol. 15, No. 4, 1977, pp. 162-169.

person could be a double bind situation in which a show of camaraderie is met with an authoritarian response when the person in authority perceives that an apparent lack of discipline might expose managerial incompetence. A submissive approach by the subordinate person, on the other hand, might be met by teasing jocularity, or disdain, by the person in authority, as a response to a perceived excess of obsequiousness.

Many people can respond to the frustration of the subordinate person in this type of situation, perhaps through having past experience of it themselves. However, this only begs the question: if the double bind is a factor in the aetiology of schizophrenia, why are only some people vulnerable? The answer to this question proved to be too elusive¹⁷⁴ and by the end of the 1970s researchers had largely moved on to focus on other hypotheses.

Family Stress

Another line of research, explored over the same time period as the schizophrenogenic mother and the double bind, concerned theories that distortions in the marital relationship of a mother and father might impact adversely on a child and cause schizophrenia. Theodore Lidz¹⁷⁵ was one of the leading researchers in this field. Lidz hypothesised that there are two different kinds of distortion in parental marital relationships which alternatively selected boys and girls as candidates for schizophrenia.

The first kind of distortion Lidz called “marital skew”.¹⁷⁶ This occurs when one parent yields to the idiosyncrasies and over-bearing dominance of the other. This situation was thought to be particularly relevant to the cause of schizophrenia in male children.¹⁷⁷ In families with marital skew the dominant parent was thought to be usually the mother and in contrast to her the father was perceived as being a weak passive type of person who provided a poor role model for his son. In these families the mother was believed to turn away from her husband as a source of emotional comfort and to fixate on her son in a search for solace. The combination of a poor paternal role model and a fixated, dominant and often eccentric mother, was thought to be a frequent cause of schizophrenia in male children.¹⁷⁸

¹⁷⁴ David M. Dush and Marvin Brodsky, ‘Effects and implications of the experimental double bind’, *Psychological Reports*, Vol. 48, No. 3, June, 1981, pp. 895-900.

¹⁷⁵ Theodore Lidz, Stephen Fleck and Alice R. Cornelison, *Schizophrenia and the Family*, International Universities Press, New York, 1965.

¹⁷⁶ *Ibid.*, pp. 142-145.

¹⁷⁷ *Ibid.*, p. 249.

¹⁷⁸ Julian Leff, ‘Social and Psychological Causes of the Acute Attack’, in J. K. Wing, ed., *Schizophrenia: Towards a New Synthesis*, Academic Press, London, 1978, p. 143.

The cause of schizophrenia in female children was thought to be usually caused by a variation on this theme and due to a condition called “marital schism”.¹⁷⁹ Marital schism occurred when there was conflict between the mother and father but neither party yielded to the other.¹⁸⁰ In this situation each partner was constantly striving to satisfy their own needs while ignoring the other partner’s needs. This perpetual battle for ascendancy between parents inevitably involved the children as the parents competed for their affections and enrolled them as supporters. The schismatic family was thought to be far more selective in causing schizophrenia in females than in males.¹⁸¹

In both the skewed and schismatic types of family Lidz hypothesised that children are reared in an abnormal environment because there is an absence of parental cooperation and the normal delineation’s between generations are not observed. He believed these conditions could lead to anxieties in children involving the induction of incestuous feelings. Lidz’s basic approach to schizophrenia was similar to Bateson’s in that he believed it is the manifestation of inappropriate behaviour that has been learned in the family environment.¹⁸²

Although a considerable amount of research has been conducted over the years to test Lidz’s theories, most of the results have not supported them. Perhaps the most thorough of these studies was carried out by Sharan in the middle 1960s.¹⁸³ Sharan’s study involved 12 families with a schizophrenic son, and 12 with a schizophrenic daughter. Each of these groups of families were symmetrically balanced by dividing them into 6 families with a healthy sibling of the same sex as the schizophrenic, and six families with a healthy sibling of the opposite sex to the schizophrenic.

The core of the study required each family to complete a questionnaire. This was done under tape-recorded supervision with the family members assembled in groups of three — firstly comprising the two parents and the schizophrenic child — and secondly comprising the two parents and the healthy child. Different questionnaires were used each time and answering the questionnaires required discussion amongst each separate group. The objective was to score the individual parents for indications of dominance by assessing how often one parent’s answers became the group’s decision. Support between individuals was also scored by recording how often supportive and non-supportive remarks were directed at individual family members.

Sharan could find no clear pattern confirming Lidz’s theories about either the relationship of parental marital skew to schizophrenia in male children or the relationship of marital schism to

¹⁷⁹ Lidz et al., *op.cit.*, p. 264.

¹⁸⁰ *Ibid.*, pp. 136-142.

¹⁸¹ Leff, *op.cit.*, p. 143.

¹⁸² Theodore Lidz, ‘Patients whose children became schizophrenic’, *Journal of Nervous and Mental Disease*, Vol. 172, No. 7, July, 1984, pp. 408-411.

¹⁸³ Leff, *op.cit.*, p. 144.

female schizophrenia. Nor could he uncover any clear pattern of parental support or non-support for schizophrenic children as compared to their healthy siblings.¹⁸⁴

Another line of research assuming an environmental aetiology involved studying the families of schizophrenics as whole units to see if the aetiology of schizophrenia could be found in group deviance, rather than in the deviations of individual members.¹⁸⁵ One influential hypothesis postulated that when there are mutual expectations amongst family members of reciprocal fulfilment, which have no basis in reality, the false atmosphere in the family is often accompanied by disjointed forms of communication and irrational shifts in the focus of family attention. This situation was thought to give rise to conditions where all family communications were polarised between superficiality at one pole and fragmented, disjointed thinking at the other. These conditions in turn influenced the cognitive development of children who were subjected to them. Schizophrenia was hypothesised as one of the outcomes.¹⁸⁶

More recently deviance in the language of schizophrenic patients has been compared to similar deviations in the language of their parents in the hope that some light may be shed on aetiology by understanding how the language deviations of schizophrenia are learned.¹⁸⁷ Research is now also turning to focus on positively identifying a link between genetic vulnerability and environmental stresses in family life that might trigger schizophrenia. One recent study compared adopted children of schizophrenic mothers, who were thought to have an enhanced genetic risk, with a control group of adoptees with normal genetic risk profiles, to see whether there were any consistent patterns of thought deviation in the two groups of children that might be associated with environmental triggers. However, no clear pattern has emerged from this research yet.¹⁸⁸

Stress in the family environment has been extensively researched as both an originating cause of schizophrenia and as a factor in relapse. Two types of stresses have largely been the focus of attention: the ambient stresses of everyday life and abnormal stresses brought on by important life events like a death in the family.¹⁸⁹ Ambient stresses are often measured in the form of 'expressed emotion' (EE). Schizophrenics are thought to come from families with higher than normal levels of

¹⁸⁴ *Ibid.*, p. 145.

¹⁸⁵ Deborah J. Lieber, 'Parental focus of attention in a videotape feedback task as a function of hypothesised risk for offspring schizophrenia', *Family Process*, Vol. 16, No. 4, December, 1977, pp. 467-475.

¹⁸⁶ Leff, *op.cit.*, p. 145.

¹⁸⁷ N. M. Docherty, 'Communication deviance, attention, and schizotypy in parents of schizophrenic patients', *Journal of Nervous and Mental Disease*, Vol. 181, No. 12, December, 1993, pp. 750-756.

¹⁸⁸ K. E. Wahlberg, L. C. Wynne, H. Oja, P. Keskitalo, L. Pykalainen, I. Lahti, J. Moring, M. Naarala, A. Sorri, M. Seitamaa, K. Laksy, J. Kolassa and P. Tienari, 'Gene-environment interaction in vulnerability to schizophrenia: findings from the Finnish Adoptive Family Study of Schizophrenia', *American Journal of Psychiatry*, Vol. 154, No. 3, March, 1997, pp. 355-362.

¹⁸⁹ Ian R. Falloon, 'Family stress and schizophrenia: Theory and practice', *Psychiatric Clinics of North America*, Vol. 9, No. 1, March, 1986, pp. 165-182.

EE and some researchers claim that when there is a high level of EE between a mother and child, for instance, this deepens the emotional bond, but it also puts the child at higher risk of developing schizophrenia.¹⁹⁰ Comparisons have been drawn between the key components of EE research — critical comments and the over involvement of family members in the schizophrenic's life — with the rejection and over-protection that was formerly attributed to the schizophrenogenic mother.¹⁹¹ This suggests that EE researchers might be merely extending the schizophrenogenic concept from the mother to the whole family.

One type of important event that has attracted research attention is the death of a grandparent within two years of the birth of a schizophrenic person. Researchers found that a grandparent of 41% of a large sample of schizophrenics had died within this period. This rate was significantly higher than the rate in a control group of normal people and it was hypothesised that the additional stresses introduced into family life by two major events — a birth followed by death, or vice-versa — might confuse the parenting and mourning roles. In this situation a bereaved parent might be emotionally unavailable to an infant and a spouse or, alternatively, a child might be used as a distraction from mourning and as a result could inadvertently absorb the painful feelings of the bereaved parent.¹⁹²

Social Stress

Comparisons have been made between schizophrenics and normal people to determine whether personal experience of negative life events is a significant factor. It has been found that schizophrenics have a higher incidence of these negative experiences in the areas of work, health, family and social relationships.¹⁹³ It has also been observed that the incidence of schizophrenia is higher in urban centres but recent research has been unable to confirm that the stress of city living is implicated as a cause.¹⁹⁴

Stresses arising from social class have been a subject for research into the aetiology of schizophrenia. There has been consistent evidence of a higher incidence of schizophrenia amongst people of lower social classes. Two principal hypotheses have been presented to account for this. The first is that stresses induced by social conditions like poverty, unemployment and welfare

¹⁹⁰ William L. Cook, Angus M. Strachan, Michael J. Goldstein and David J. Miklowitz, 'Expressed emotion and reciprocal affective relationships in families of disturbed adolescents', Family Process, Vol. 28, No. 3, September, 1989, pp. 337-348.

¹⁹¹ Parker, op.cit., pp. 452-462.

¹⁹² Froma W. Walsh, 'Concurrent grandparent death and birth of schizophrenic offspring: An intriguing finding', Family Process, Vol. 17, No. 4, December, 1978, pp. 457-463.

¹⁹³ Graziano Canton and Ida G. Fraccon, 'Life events and schizophrenia: A replication', Acta Psychiatrica Scandinavica, Vol. 71, No. 3, March, 1985, pp. 211-216.

¹⁹⁴ Hugh Freeman, 'Schizophrenia and city residence', British Journal of Psychiatry, Vol. 164, Supplement 23, April, 1994, pp. 39-50.

dependency can cause schizophrenia.¹⁹⁵ The second is that the confused state of mind experienced by schizophrenics makes them socially uncompetitive which in turn leads to downward social drift.¹⁹⁶

Stresses arising from racial identity have also been explored as possibly contributing to the cause of schizophrenia. A recent study conducted in the UK compared the incidence and outcomes of schizophrenia amongst whites, Afro-Caribbeans and Asians. Afro-Caribbeans and Asian women were found to have a higher incidence of schizophrenia and Afro-Caribbeans were more disabled by the experience. The only significant variable the researchers could find to explain these results, other than racial identity, was a higher level of unemployment amongst the Afro-Caribbeans.¹⁹⁷

An increasing trend amongst psychiatric practitioners is to advocate an end to the mind/brain dichotomy¹⁹⁸ and to argue that a more sophisticated approach to schizophrenia is an assumption that the aetiology has both biological and environmental components. This is sometimes called a biopsychosocial approach and it is often vaguely endorsed by psychiatrists who are currently treating schizophrenics with a mixture of drugs and talking therapy.¹⁹⁹ However, it is not a position that appears to be particularly attractive to aetiological researchers because it tends to multiply the already vast field of variables.

Conclusion

The medical model is split into two fundamentally different approaches to the aetiology of schizophrenia — the biological approach and the environmental/experiential approach. The biological approach assumes that schizophrenic symptoms are manifestations of brain disorder. Speculations about underlying brain abnormalities are various and they in turn support a range of theories about the possible causes of the brain abnormalities. The enviro/experiential approach, on the other hand, assumes that people with schizophrenia have normal brains and that the symptoms of abnormality are manifestations of developmental problems or stressful experience. There is a wide variety of environmental hypotheses which argue for different types of stressful experience as being the universal or principal cause of schizophrenia.

¹⁹⁵ P. N. Wold and S. Soled, 'The family history of mental illness and welfare dependence', Journal of Clinical Psychiatry, Vol. 39, No. 4, April, 1978, pp. 328-31.

¹⁹⁶ Leigh Silvertown and S. Mednick, 'Class drift and schizophrenia', Acta Psychiatrica Scandinavica, Vol. 70, No. 4, October, 1984, pp. 304-309.

¹⁹⁷ D. Bhugra, J. Leff, R. Mallett, G. Der, B. Corridan and S. Rudge, 'Incidence and outcome of schizophrenia in whites, African-Caribbeans and Asians in London', Psychological Medicine, Vol. 27, No. 4, July, 1997, pp. 791-798.

¹⁹⁸ Philippe Khouri, 'Continuum versus dichotomy in theories of schizophrenia', Schizophrenia-Bulletin, Vol. 3 No. 2, 1977, pp. 262-267.

¹⁹⁹ G. O. Gabbard, 'Mind and brain in psychiatric treatment', Bulletin of the Menninger Clinic, Vol. 58, No. 4, 1994, pp. 427-446.

When the various aetiological theories are critically analysed none of them provide convincing evidence of any movement towards early closure of the aetiological controversy. Although the biological side of the dichotomy is currently in the ascendancy this has not always been the case in the past. So long as the aetiological controversy remains open it is quite possible there might be a future shift in the emphasis of research back to the enviro/experiential side.

In the early 1990s Theodore Sarbin wrote about his long career in pursuit of definitive evidence that might explain the cause of schizophrenia. He related how in the early 1970s he had analysed the various aetiological theories that had been postulated up to that time. He said that “the rise and fall of theories of schizophrenia led me to conclude that such theories have a half-life of about five years. The conclusion applied to somatic theories and psychological theories alike.”²⁰⁰ Sarbin went on to cite more recent research that came to similar conclusions but which found that biological theories have shorter life-spans than psychological theories.

The sheer number of hypotheses, both past and present, on both sides of the dichotomy, is evidence of deep confusion within the medical model on the subject. This confusion is reflected in the proliferation of therapies but it is not always evident in the confidence levels of individual psychiatrists, particularly those who are willing to impose their treatments on involuntary patients.

²⁰⁰ Theodore R. Sarbin, ‘Towards the Obsolescence of the Schizophrenia Hypothesis’, Journal of Mind and Behaviour, Vol. 11, No. 3 and 4, 1990, p. 264.

5: Medical Model: Interest Groups and Human Rights Imperatives

This chapter discusses the various interest groups that support the medical model and examines their motivation and level of influence. An analysis is made of a campaign by some of these interest groups to extend involuntary treatment in NSW. The human rights imperatives associated with the medical model are examined with particular attention to the UN Principles on mental illness, the right to treatment and the concept of informed consent.

Interest Groups

A powerful coalition of interest groups support the psychiatric profession in the belief that schizophrenic symptoms are signs of mental and/or neurological pathology. In broad terms the coalition consists of consumers of mental health services (voluntary patients and patient's relatives), the pharmaceutical industry and the State.

People who manifest schizophrenic symptoms are often viewed as being socially disruptive and potentially dangerous, both to themselves and other people.¹ This widespread perception gives rise to a State responsibility to control this type of person. In past times and in other cultures there have been a variety of ways by which the State has discharged this responsibility, usually through banishment or some form of incarceration.² The current method is for the State to provide mental health services and for mad people who are thought to be potentially disruptive or dangerous to be controlled by using psychiatric treatments. To facilitate this form of control the State enacts and enforces mental health legislation which empowers medical practitioners to identify the type of people in question and, if they are unwilling to cooperate, to incarcerate them involuntarily in mental hospitals and impose forced treatment on them.³

These arrangements have one major advantage and one major disadvantage for the State. The advantage is that the human rights complaints which inevitably arise from a situation in which a large number of non-criminal citizens are stripped of their civil liberties can be deflected by

¹ M. S. Humphreys, E. C. Johnstone, J. F. MacMillan and P. J. Taylor, 'Dangerous Behaviour Preceding First Admission for Schizophrenia', *British Journal of Psychiatry*, Vol. 161, 1992, pp. 501-505.

² Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* Vintage Books, New York, 1965.

³ For a discussion on the mental health policies practised by the governments of various countries see, Kathleen Jones, *Experience in Mental Health: Community Care and Social Policy* Sage, London, 1988.

assertions that the control is actually only care and treatment for a medical condition.⁴ The disadvantage is that the State has to underwrite the cost of most mental health expenses.⁵

The costs of schizophrenia are substantial. In the United States researchers working for the National Institute of Mental Health estimated the total cost of schizophrenia for a single year — 1991 — at \$65 billion. This estimate was based on an assumption that the lifetime prevalence of schizophrenia for adult Americans was 1.5%. The costs were broken down into direct and indirect components. Direct costs were related to expenditures on treatment for both inpatients and outpatients as well as costs incurred by the criminal justice system. These direct costs were estimated at \$19 billion dollars. Indirect costs were based on estimates of lost productivity and were broken down into \$24 billion for wage earners, about \$4 billion for homemakers, about \$4 billion for individuals in institutions, \$7 billion for people who commit suicide and \$7 billion for people who could not work because they were required to take care of schizophrenic family members.⁶

Research and training expenditures on schizophrenia involve a substantial annual outlay. In the United States for 1991 they were estimated at \$71 million. This figure was comprised of \$51,302,000 in direct grants from the National Institute of Mental Health and approximately \$20 million from state governments, private institutions and pharmaceutical companies.⁷ The size of this schizophrenia research industry has allowed psychiatric researchers to become an influential interest group supporting the medical model.

Members of the psychiatric profession, in general, are broadly trained in medicine before individuals take up psychiatry as a medical specialisation. Although the training of psychiatrists produces two branches of treatment — the talking therapies and the biomedical treatments — all students of psychiatry are taught, as a matter of course, that the symptoms of schizophrenia have a pathological cause.⁸ Most psychiatrists find that their professional interests give them little cause to question this teaching. Psychiatry continues to hold a dominant position within an increasingly competitive mental health industry.⁹ But the medical training of psychiatrists can only be expected

⁴ A. Buchanan, 'A Two-Year Prospective Study of Treatment Compliance in Patients with Schizophrenia', Psychological Medicine, Vol. 22, No. 3, 1992, pp. 787-797.

⁵ T. G. McGuire, 'Measuring the Economic Costs of Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 3, 1991, pp. 375-388.

⁶ Richard Jed Wyatt, Ioline Henter, Megan C. Leary and B. A. Edward Taylor, An Economic Evaluation of Schizophrenia — 1991, Neuroscience Research Center, Neuropsychiatry Branch, National Institute of Mental Health.

⁷ Ibid.

⁸ See for example, Donald W. Black, William R. Yates and Nancy C. Andreasen, 'Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders', in John A Talbott, Robert E. Hales and Stuart C. Yudofsky, eds., Textbook of Psychiatry, American Psychiatric Press, Washington, 1988, pp. 357-402.

⁹ Kathleen Jones, Experience in Mental Health: Community Care and Social Policy Sage, London, 1988, p. 35.

to continue to provide psychiatrists with a competitive edge over rival professionals like psychologists so long as medical explanations for abnormal psychology prevail.

Like the psychiatric profession, the pharmaceutical industry has strong commercial interests in ensuring the continued dominance of the medical model for schizophrenia. The medical model provides the rationale for drug therapy and, in turn, the pharmaceutical industry provides an extensive range of neuroleptic products from which prescribing psychiatrists can choose. In the United States the pharmaceutical industry openly funds the main psychiatric professional organisation, the American Psychiatric Association,¹⁰ which receives "30% of its total budget from drug company advertising in its many publications".¹¹

Pharmaceutical companies pay through the nose to get their message across to psychiatrists across the country. They finance major symposia at the two predominant annual psychiatric conventions, offer yummy treats and music to conventioners, and pay \$1,000-\$2,000 per speaker to hock their wares. It is estimated that, in total, drug companies spend an average of \$10,000 per physician, per year, on education.¹²

The pharmaceutical industry also selectively funds scientific research into the side effects of neuroleptic drugs as well as research and development of new products.¹³ Drug company sponsorship of clinical trials is a major source of revenue for many psychiatric researchers. This flow of money provides strong incentives for further promotion of the medical model but it also casts doubt on the quality of the findings:

This spring, the New York Post revealed that Columbia University has been cashing in. Its Office of Clinical Trials generates about \$10 million a year testing new medications- much of which is granted to the Columbia Psychiatric Institute for implementing these tests. The director of the institute was being paid \$140,000 a year by various drug companies to tour the country promoting their drugs.¹⁴

Pharmaceutical companies advertise their products¹⁵ openly in psychiatric journals often competing for space with scientific research reports in the same areas of treatment for which their own drugs

¹⁰ Peter Breggin, *Toxic Psychiatry* Fontana, London, 1993, pp. 426-429.

¹¹ Loren R. Mosher, 'Are Psychiatrists Betraying Their Patients?', *Psychology Today*, Vol. 32, Issue 5, September 1999, p. 40.

¹² *Ibid.*

¹³ Michael F. Conlan, 'Drug research advances reported by industry group', *Drug Topics*, Vol. 140, No. 5, 1996, p. 122.

¹⁴ Mosher, *op.cit.*

¹⁵ Duff McDonald, 'Smile with Prozac - and laugh to the bank with Eli Lilly', *Money*, Vol. 25, No. 4, 1996, p. 88.

are being recommended. Because their role is driven by the normal market concerns for the promotion of product sales there is often a certain amount of confusion concerning the difference between scientific findings and sales promotion.

This point can be illustrated by a recent report of research undertaken into the efficacy of an atypical neuroleptic called risperidone. Unlike conventional neuroleptics which only block dopamine receptors in the brain risperidone also blocks serotonin receptors. Risperidone was approved for use in the US in 1994. The pre-approval research used a sample of 388 people who were undergoing treatment for schizophrenia with conventional neuroleptics, but who were failing to respond to the drugs. Some were given an increased dosage of a conventional neuroleptic, some were given a placebo, and some were given risperidone. After eight weeks the researchers found that the patients given risperidone were more improved than those in the other two groups.¹⁶

However, there were two problems with this research. The first was that the criteria for judging 'improvement' was simply a matter of awarding the patients daily points on the basis of their observed willingness to cooperate and interact socially. The second problem was that one of the authors, Richard Meibach, was identified in a subsequent article as being an employee of Janssen Pharmaceutical Research Foundation, the research arm of the manufacturer of risperidone.¹⁷ The wholly subjective nature of the observations of patient improvement, together with the conflict of interest of one of the observers, must cast some doubt on the scientific validity of these findings. This type of conflict of interest is a constant feature of pharmaceutical industry involvement in discussions about schizophrenia.

The appellation of 'consumer' of mental health services has come to be used in recent years to describe a fairly diverse interest group.¹⁸ Consumers divide into primary consumers — i.e. patients or people in receipt of psychiatric treatment, and secondary consumers — usually meaning the relatives of patients. However, the patients themselves can also be divided into voluntary and involuntary patients. A major problem of identity has arisen from a tendency by supporters of the medical model to hold the group identity of involuntary patients hostage within the collective description of 'consumers'. It should therefore be understood that inclusion in the category of 'consumers' is not equally convenient for all the interests that are associated with it.¹⁹

¹⁶ Stephen R. Marder and Richard C. Meibach, 'Risperidone in the treatment of schizophrenia', American Journal of Psychiatry, Vol. 151, No. 6, 1994, p. 825.

¹⁷ Editorial, Science News, Vol. 145, No. 25, June 18, 1994, p. 398.

¹⁸ Margaret Leggatt, 'Schizophrenia: The consumer's viewpoint', in Graham D. Burrows, Trevor R. Norman and Gertrude Rubinstein (eds), Handbook of studies on Schizophrenia. Part 2: Management and research, Elsevier, Amsterdam, 1986, pp. 43-53.

¹⁹ Karen Moscovski, 'Tips for writing on mental illness. (political correctness is in order)', Writer's Digest, Vol. 76, No. 11, 1996, pp. 62-64.

Some of the most enthusiastic supporters of a pathological interpretation of schizophrenia are the relatives of patients.²⁰ Madness tends to generate intense levels of fear in both the people who experience it²¹ and the people who witness others undergoing the experience.²² This fear plays an important role in galvanising relatives into support of the medical model, and in shaping their goals. The importance of relatives as an interest group lies in their immediacy to the problems that arise when a person manifests unusual thoughts and beliefs. It is usually the relatives who are the first people to become aware when a family member begins to experience unusual mental phenomena. They are often alarmed at the sudden change in the person and frequently become confused and fearful about the situation — fearful both for themselves and for the person manifesting the symptoms. The first inclination of relatives is to seek help and advice and this is usually readily available from the medical profession.²³

Of the three meta-models for explaining the symptoms of schizophrenia — the medical, mystical and myth-of-mental-illness models — the latter two, mystical and myth-of-mental illness, are likely to seem absurd to relatives.²⁴ Relatives usually see themselves as managing a crisis situation and these two models might look as if they are designed to exacerbate madness. The medical model, on the other hand, with its ability to medicate and pacify the relative, and to supply a causal explanation that satisfies normal scrutiny, can be highly attractive.

The relatives of schizophrenics frequently belong to support groups which are growing increasingly powerful as mental health lobby groups both in the United States²⁵ and Australia. A review of some of the literature directed at members of these support groups indicates strong collective support for the medical model. A pamphlet, for instance, published by the Department of Health in New South Wales which was directed specifically at relatives of schizophrenics, lists 13 points of advice on “The Role of Relatives and Friends”. The fourth point is “Help to ensure that medication is taken as prescribed.”²⁶

²⁰ Patrick Rogers, ‘A sense of purpose. (how family dealt with child’s chronic schizophrenia)’, People Weekly, Vol. 46, No. 3, 1996, pp. 139-142.

²¹ P. Chadwick and M. Birchwood, ‘The Omnipotence of Voices. A Cognitive Approach to Auditory Hallucinations’, British Journal of Psychiatry, Vol. 164, No. 2, 1994, pp. 190-201.

²² D. Titelman, ‘Grief, Guilt, and Identification in Siblings of Schizophrenic Individuals’, Bulletin of the Menninger Clinic, Vol. 55, No. 1, 1991, pp. 72-84.

²³ National Alliance for the Mentally Ill (NAMI), Schizophrenia Pamphlet by: National Alliance for the Mentally Ill, Washington, 1990.

²⁴ Schizophrenia Society of Canada, Schizophrenia: A Handbook For Families Health Canada, 1997, Available URL, <http://www.mentalhealth.com/book/p40-sc0/.html>

²⁵ Wes Shera, ‘Managed care and people with severe mental illness: challenges and opportunities for social work’, Health and Social Work, Vol. 21, No. 3, 1996, pp. 196-202.

²⁶ NSW Health, The Puzzle of Schizophrenia, State Health Publication No. (HTS) 88-016 NSW Health, Sydney, 1992.

Similarly a leaflet published by a relatives' support group called the Schizophrenia Fellowship states categorically that "Schizophrenia is now known to be a biologically-based illness...." An accompanying newsletter from the same organisation, under the heading "Not Taking The Prescribed Medication", recommends to "find a daily routine when tablet taking can become a habit (e.g. breakfast, toothbrushing)."²⁷ Another pamphlet from the Schizophrenia Fellowship declares its intention to "develop into an effective lobby".

In Australia two of the main consumer lobbying organisations are the Schizophrenia Fellowship and ARAFMI (Association for the Relatives and Friends of the Mentally Ill). In the United States the main counterpart is the National Alliance for the Mentally Ill (NAMI) which operates nationally and has some 140,000 members.²⁸ NAMI's enthusiasm for lobbying on behalf of the medical model has come under criticism for an apparent conflict of interest arising from its acceptance of large donations from drug companies:

The National Alliance for the Mentally Ill, which is pushing to have mental health laws rewritten so that people can be involuntarily hospitalised for refusing to take their medications, received nearly \$1 million in 1995 from more than 13 drug companies.²⁹

Since 1995 NAMI's drug company funding has apparently escalated dramatically.

According to internal documents obtained by Mother Jones, 18 drug firms gave NAMI a total of \$11.72 million between 1996 and mid-1999. These include Janssen (\$2.08 million), Novartis (\$1.87 million), Pfizer (\$1.3 million), Abbott Laboratories (\$1.24 million), Wyeth-Ayerst Pharmaceuticals (\$658,000), and Bristol-Myers Squibb (\$613,505).

NAMI's leading donor is Eli Lilly and Company, maker of Prozac, which gave \$2.87 million during that period. In 1999 alone, Lilly will have delivered \$1.1 million in quarterly instalments, with the lion's share going to help fund NAMI's "Campaign to End Discrimination" against the mentally ill.

In the case of Lilly, at least, "funding" takes more than one form. Jerry Radke, a Lilly executive, is "on loan" to NAMI, working out of the organization's headquarters. Flynn explains the cozy-seeming arrangement by saying, "[Lilly] pays his salary, but he does

²⁷ Olga Piatkowska and Maria Visotina, 'Coping With Difficult Behaviour: Do's and Don'ts', Schizophrenia Fellowship News, April 1992.

²⁸ Jennifer Comiteau., 'Taking the lead', Adweek Eastern Edition, Vol. 35, No. 51, 1994, pp. 24-26.

²⁹ Keith Hoeller, 'Psychiatric Drugs Harm Children', Seattle Post-Intelligencer, April Issue, 1997.

not report to them, and he is not involved in meetings we have with [them]." She characterizes Radke's role at NAMI as "strategic planning."³⁰

In Australia an organisation called Schizophrenia Australia has been set up in recent years to lobby governments and educate the public about the medical model view of schizophrenia. The organisation also uses an alternative business name, SANE Australia. In 1998 the focus of their campaign was "Help for Families". Anne Deveson, Deputy Chair of SANE Australia, explained the intention of the campaign:

SANE Australia's Campaign provides help to families effected by mental illness, through information and referral to local services. We are also determined to put their needs firmly on the agenda with Commonwealth and State governments. It is unacceptable that of the eight states and territories, six do not yet recognise the unique needs of family and other carers in their mental health strategies.³¹

Schizophrenia Australia/SANE has a glittering array of entertainment/legal and business celebrities listed as its many patrons. However, acknowledgments in its literature make it clear that, like NAMI in the US, the Australian organisation is also largely funded by pharmaceutical companies which manufacture new schizophrenia drugs. Their 1996 "Carers Handbook" states that Schizophrenia Australia's Community Education Program is "proudly supported" by Janssen Cilag, Sandoz, ICI Pharmaceuticals and Eli Lilly. The drug company logos are all prominently displayed for emphasis.³² Successive editions of SANE News, the organisation's newsletter, carry advertisements stating the "SANE News is proudly sponsored by Janssen Cilag — Supporting care of mental illness in the community".³³ SANE even sends out correspondence on letterheads which state that it is sponsored by yet another drug company, Pfizer.

Laurie Flynn, the executive director of NAMI in the United States, summed up what she called the "synergy" between relatives' support groups and drug companies this way: "The drug companies want more and greater markets, and we want access and availability to all scientifically proven treatments. We don't think drugs are everything, but for the vast majority they are important."³⁴

Secondary consumer groups are often the most active lobbyists in campaigns to persuade governments to alter mental health legislation to make involuntary commitment easier. These

³⁰ Ken Silverstein, "Prozac.org: An influential mental health nonprofit finds its 'grassroots' watered by pharmaceutical millions", Mother Jones, November/December, 1999, Available URL, http://www.motherjones.com/mother_jones/ND99/nami.html

³¹ Anne Deveson, 'Help for Families', SANE News, Issue 8, Winter 1998, p. 5.

³² SANE Australia, Carers Handbook, SANE Australia, Melbourne, 1996, p. 26.

³³ See for example, SANE News, Issue 9, Spring 1998, p. 8.

³⁴ Silverstein, op.cit.

campaigns are sometimes overtly coordinated by members of the medical profession. A common complaint of relatives' groups is a perception that civil liberties protections, which restrict unnecessary and unfair use of involuntary hospitalisation, interfere with their preference to incarcerate mad relatives in times of crisis. A recent campaign by secondary consumers to modify the involuntary commitment procedures specified in the New South Wales (NSW) Mental Health Act might serve as a useful illustration of campaign tactics.

Campaign to Extend Involuntary Treatment in NSW³⁵

On 26 May, 1995 a letter from a Dr. Inge Southcott was published in the Sydney Morning Herald.³⁶ Dr. Southcott's letter told about her anguish as "the mother of a 20 year old schizophrenic man who now lives on the streets". The purpose of Dr. Southcott's letter was to appeal for changes to be made to the NSW Mental Health Act (MHA) so that her son, who she said was "harmless and not suicidal," could be involuntarily incarcerated in a mental hospital and given treatment. Dr. Southcott's proposal was to have a stipulation removed from the MHA which required that a person had to be thought likely to cause serious physical harm to themselves or other people before they could be committed to a hospital involuntarily.³⁷

Her letter was followed five days later by an article in the same newspaper written by Anne Deveson.³⁸ Deveson's article began with a reference to Dr. Southcott's letter and then proceeded to review her own similar experience with a schizophrenic son who she says "killed himself from an overdose of alcohol and sedatives while living on the streets, psychotic, malnourished, vulnerable". Deveson's article went on to endorse Southcott's concern about the difficulties that the requirement of 'dangerousness' causes to the relatives of mentally ill people.

Shortly afterwards two more letters appeared in the Sydney Morning Herald written by doctors. They were both supportive of Dr. Southcott's proposal to amend the MHA. The letters had both been written on the day Southcott's letter was published. One doctor argued that "the criteria for instituting compulsory treatment should be widened"³⁹ while the other, after affirming the difficulty

³⁵ A version of this section has been published as a book chapter. See, Richard Gosden, 'Coercive Psychiatry, Human Rights and Public Participation', in Brian Martin (ed.), Technology and Public Participation, University of Wollongong, 1999, pp. 143-168.

³⁶ Dr. Inge Southcott, 'Anguish over mental health Catch 22', Letters To The Editor, Sydney Morning Herald, 26 May, 1995.

³⁷ Mental Health Act 1990, Section 9.(1), NSW Government Information Service, Reprinted as in force at 17 October, 1994, p. 5.

³⁸ Anne Deveson, "Towards a better treatment of serious mental illness", Sydney Morning Herald, 31 May, 1995.

³⁹ Dr. Kathleen Bocce, 'Mental health patients' families have few rights', Letters To The Editor, Sydney Morning Herald, 2 June, 1995.

of committing involuntary patients under the existing conditions, went on to demand more mental health resources.⁴⁰

Five days later Dr. Peter Macdonald, the Independent Member of Parliament for Manly, himself a medical practitioner, made a speech in the NSW Legislative Assembly outlining his intention “to lead a crusade”⁴¹ on certain mental health issues over the next few years. He indicated that amendments to the Mental Health Act to widen the criteria for involuntary treatment would be central to his plan.

Several months later, on 26th October, 1995, Macdonald introduced into the NSW Parliament a Mental Health Amendment Bill 1995 which proposed to replace the requirement of dangerousness for involuntary hospitalisation with loosely-worded criteria that would have allowed involuntary procedures to be invoked if a person was thought to be incompetent and in need of treatment.

In his two speeches to Parliament on this subject Macdonald supported his arguments by quoting letters from the mother of a young man with schizophrenia. In this correspondence the mother said she had “last worked in psychiatry in Adelaide in the late 1970s”.⁴² She also gave an account of her son’s symptoms:

Our 20 year old son developed a psychosis about three years ago. He was a top student at his school, a promising musician, well-liked and respected by his peers. Our relationship with him was good, and we had hopes that he would be a well-adjusted adult, able to take his place in society. Today he is wandering the beaches and streets of Manly, to all intents and purposes a ‘homeless youth’.

His psychosis takes the form that he believes he has to convert all to Christianity because all are doomed to go to hell. He cannot explain why he believes this and he seems to think that the world is going to end soon. He gives away all his belongings and money to people he believes God is directing him to save, e.g. he gave away \$2000 at Christmas. This was his entire savings.

For a while he was bringing home vagrants and they would spend the night in his bed while he wandered the streets looking for more people to save. We lost various possessions to these people, some of whom were also obviously suffering from psychosis themselves. He deprives himself of sleep as he believes he has to be ‘working’ i.e. evangelising.

⁴⁰ Dr. Robert Dixon, Letter To The Editor, Sydney Morning Herald, 2 June, 1995.

⁴¹ Peter Macdonald, ‘Mental Health Support and Counselling Services’, Legislative Assembly Hansard, 7 June, 1995, pp. 46-47.

⁴² Letter to Peter Macdonald April 1994, quoted by Peter Macdonald in ‘Mental Health Bill’, Legislative Assembly Hansard, 26 October, 1995, p. 1.

He has lost all his friends and his relationship with us is under great strain as he puts his 'work' before all other considerations. But he is not a danger to himself or to others so he cannot be taken to hospital under the present Mental Health Act.

The doctors involved say he would probably benefit from medication for his psychosis and they want to put him on the clozapine programme but their hands are tied until such time as he deteriorates further and does something to actively harm himself or others. Meanwhile his family suffers, his relationships with all his mates are lost, he loses all his money, he smells, he neglects all that he formerly held dear when he was well.

I think it is a disgrace that our society can let this happen, and I know it is not just my son to whom this is happening. It involves many other youths who are also wandering the streets in the grip of mental illness.⁴³

It is clear this mother wanted her son to change back to the way he had been three years earlier. However, from her own account there was every indication that he wanted to remain the way he was. If we were to hear his side of the story it is quite possible he would argue that there was nothing wrong with his mind and he was only expressing his Christian beliefs. A detached observer might argue that it would have been more rational for the mother to change the locks on her doors and lock him out rather than attempt to change the mental health laws to have him locked up. But apparently her MP, Peter Macdonald, supported her approach and he actually used the example of her son as the primary justification for proposing his amendments to the Mental Health Act.

In human rights terms Inge Southcott's role as an anxious mother campaigning for legislative changes is a matter of some interest. This is because she appeared to be participating in a co-ordinated effort. She also informed Peter Macdonald in a letter that she was a member of a support group called the Schizophrenia Fellowship and that this organisation planned "setting up a discussion group in May to look at further amendments to the Act especially the scheduling clauses".⁴⁴ The scheduling clauses provide the legal framework for involuntary incarceration.

It should be noted that Anne Deveson, the author of the Sydney Morning Herald article which supported Dr. Southcott, helped to establish the NSW Schizophrenia Fellowship and then became the vice-chairperson of the national organisation, Schizophrenia Australia.⁴⁵ Deveson has been engaged in high-profile activity on mental health issues in NSW since the 1980s. She chaired a government-appointed committee set up in 1988 to review the Mental Health Act 1983, the findings

⁴³ Anon., Letter to Peter Macdonald April 1994, quoted by Macdonald in 'Mental Health Support and Counselling Services', Legislative Assembly Hansard, 7 June, 1995, pp. 46-47.

⁴⁴ Peter Macdonald, 'Mental Health Bill', *op. cit.*, p. 1.

⁴⁵ Anne Deveson, Tell Me I'm Here, Penguin, Ringwood Vic., 1991, Facing-cover page.

of which “were integral to the final draft”⁴⁶ of the amendments to the 1983 Act. She was also the initial chair of the Mental Health Act (1990) Implementation Monitoring Committee⁴⁷ which was set up by the NSW government to report on the efficacy of the new mental health legislation.

Deveson stands out as one of the most influential figures directing recent NSW initiatives in mental health legislation. By occupation she is a film-maker/writer and her expertise in the mental health area is largely based on her experience as the mother of a schizophrenic son. The story of her relationship with this son is poignantly told in her book Tell Me I’m Here.⁴⁸ She portrays herself in this story as a frustrated, intermittent, and sometimes reluctant, carer. Her son died in 1986.

Deveson’s subsequent zeal to reform public policy on mental health issues is outlined in the proceedings of a curious Symposium on Schizophrenia and Human Rights jointly sponsored by the Human Rights and Equal Opportunity Commission and the Schizophrenia Australia Foundation.⁴⁹ The symposium was held in Brisbane in February 1989. It was curious because at the time there were daily newspaper reports emanating from the Chelmsford Royal Commission⁵⁰ exposing psychiatric malpractices. Yet most of the speakers at the Symposium chose to focus attention on a perception that “the right to treatment” should have precedence over “patients’ rights”.⁵¹ This was despite the fact that the human rights principles summarised in the opening address by the Human Rights Commissioner, Brian Burdekin, as being the principles most closely related to mental health issues, did not include a right to treatment, nor rights for relatives to arrange for involuntary treatment, but were all concerned with the rights of the individual to avoid coercion and discrimination.⁵²

Deveson’s contribution to the Symposium largely consisted of detailed advice on how members of support groups for relatives of schizophrenic people might be able to manipulate the mass media by winning over journalists to their point of view on mental health issues.

Let’s say the Schizophrenia Fellowship here in Queensland decided that its major emphasis next year was going to be legislation. Well you can plan over a year the

⁴⁶ The Mental Health Act Implementation Monitoring Committee, Report To The Honourable R A Phillips MP, Minister For Health On The NSW Mental Act 1990, “Preface”, August 1992.

⁴⁷ Ian W. Webster, Chairman of The Mental Health Act Implementation Monitoring Committee, Letter to The Hon. Ron Phillips M. P., Minister for Health, Attached to ibid.

⁴⁸ Anne Deveson, Tell Me I’m Here, op. cit.

⁴⁹ Human Rights and Equal Opportunity Commission, Schizophrenia: Occasional papers from the Human Rights Commissioner, Number 1, Human Rights and Equal Opportunity Commission, Sydney, December, 1989.

⁵⁰ This was a judicial inquiry into psychiatric malpractice at a private hospital in Sydney called Chelmsford.

⁵¹ John Grigor, ‘The Right To Treatment’, in Human Rights and Equal Opportunity Commission, op.cit., pp. 7-14.

⁵² Brian Burdekin, ‘Human Rights Issues relating to Schizophrenia’, in ibid., p. 2.

numbers of stories that you plant, you seed, on that particular topic. It's no use just doing a one-off story. It's an ongoing campaign that you have to plan and stage there is a need for something to be done about the image of psychiatrists we can lobby governments; so we can change political awareness we need to start setting a national agenda, and State agendas.⁵³

Given the linkages in the sequence of events leading up to the tabling of Macdonald's Amendment Bill it might be fair to assume that Macdonald's 'crusade' is closely associated with Deveson's 'ongoing campaign'.

On 29 November, 1995 Macdonald arranged a meeting at Parliament House with a number of representatives from organisations with an interest in mental health issues. The purpose of the meeting was for Macdonald to consult with stake-holders in order to gauge community support for his amendments. The Bill was still lying on the parliamentary table and Macdonald had to decide whether to bring the matter on for debate during the pre-Christmas session of parliament.

During the course of this meeting Macdonald acknowledged that he had drafted his amendments in consultation with the Schizophrenia Fellowship. A representative of the Schizophrenia Fellowship was at the meeting and presented an argument in support of the amendments by claiming that the removal of the requirement for dangerousness is necessary in order to save people from suicide. He argued that people who have suicidal relatives with mental illness are consistently failing when they attempt to have them committed to mental hospitals. The urgency of his presentation was calculated to induce a belief that the requirement for dangerousness was causing a virtual epidemic of suicide.⁵⁴

On inspection, however, this argument was somewhat paradoxical. There was at the time a provision in the MHA which dealt with suicidal people and permitted involuntary hospitalisation "for the person's own protection from serious physical harm".⁵⁵ But this is the very clause which Macdonald was proposing to amend. If it was true that people were having difficulty in committing their genuinely suicidal relatives to hospital then the source of the problem was unlikely to be found in the wording of the Mental Health Act. A more plausible cause would have been the inability of the relatives to convince doctors and hospital medical superintendents that suicide was actually intended.

⁵³ Anne Deveson, 'The Social Stigma of Schizophrenia as an Obstacle to the Exercise of Human Rights', in *ibid.* pp. 48-49.

⁵⁴ Representative, Schizophrenia Fellowship of NSW, Parliament House meeting room, November 29, 1995, Personal observation.

⁵⁵ Mental Health Act 1990, Section 9.(1)(a), *op. cit.*, p. 5.

But even this possibility was not supported by statistical evidence. Normally a person is involuntarily committed to a mental hospital under the direction of a doctor's certificate. But in emergencies, when there is no doctor close at hand to make the order, there is provision in the MHA for relatives and friends to take mentally ill people directly to hospital and ask for them to be involuntarily admitted.⁵⁶ In the years 1993⁵⁷, 1994⁵⁸ and 1995⁵⁹ a total of 174 people were presented at NSW mental hospitals in this way by relatives and friends. Of this number only one person failed to be admitted for not meeting the existing criteria of being both mentally ill and dangerous.⁶⁰ It therefore seems likely that the issue of suicide was inappropriately raised in support of Macdonald's Amendment Bill to give it more urgency.

Macdonald decided not to risk putting his amendments to the vote in the busy pre-Christmas session of parliament in 1995. Instead his plan was to negotiate support for the proposal over the new year break and to bring it to a vote after he had cultivated a more certain climate for success when the NSW parliament sat again in April 1996. But in taking this course Macdonald missed his opportunity.

Under instructions from the Labor government, which had observed the lobbying of Macdonald by secondary consumer groups, the NSW Department of Health set about drawing up its own plans for reform of the Mental Health Act. In May 1996 a public discussion paper,⁶¹ including proposed amendments, was circulated and comments from stake-holders and the public were sought. When the government had determined that the tide of public opinion was behind the secondary consumer groups, and that there would be no serious opposition to the erosion of civil liberties, legislative amendments were prepared which made involuntary commitment and longer periods of forced medication in the community much easier. In 1997 a government-sponsored amendment bill was passed which allows involuntary treatment of people who are thought likely to cause "serious harm" to themselves or others. The change had been affected by simply removing the word "physical" from the prior stipulation of "serious physical harm" and then loosely defining "serious harm" to include harm to finances or reputation.⁶²

⁵⁶ *Ibid.*, Section 23.(1), p. 10.

⁵⁷ Mental Health Review Tribunal, *Annual Report, 1993*, NSW Government, Sydney, p. 76.

⁵⁸ *Ibid.*, 1994, p. 74.

⁵⁹ *Ibid.*, 1995, p. 58.

⁶⁰ *Ibid.*, 1994.

⁶¹ NSW Department of Health, *Caring for Health: Proposals for Reform — Mental Health Act 1990*, May 1996.

⁶² *Mental Health Legislation Amendment Bill 1997*, Schedule 1, 1.1 [1], NSW Government Information Service, 1997, p. 3.

Human Rights Imperatives

The human rights imperatives which support the medical model are not specific to schizophrenia but relate to mental illnesses in general. These generalised human rights imperatives have been codified in recent years and all the most relevant human rights are now specified in the United Nations (UN) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.⁶³ National governments have been encouraged by the UN to ensure their mental health systems are compatible with the UN objectives and the Australian Commonwealth government is advising state governments on any changes that might be necessary to mental health legislation.⁶⁴

Principle 1.1 sets out the right to treatment as being the primary human right on which other rights are based: “All persons have the right to the best available mental health care, which shall be part of the health and social care system.”⁶⁵ A number of “Fundamental Freedoms and Basic Rights” are then listed including the “right to be treated with humanity and respect,” “protection from exploitation and discrimination,” and “the right to exercise all civil, political, economic, social and cultural rights as recognised in” other UN human rights declarations and covenants.⁶⁶

The UN Principles then go on to list a total of 25 areas of human rights protection. These include the right for people with mental illness “to live and work, as far as possible, in the community” (Principle 3). This right gives rise to a further “right to be treated in the least restrictive environment with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others” (Principle 9).

There is a stipulation that “a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards” (Principle 4). Confidentiality is protected (Principle 6), standards of care are specified (Principle 8), “medication shall meet the best health needs of the patient” (Principle 10), and informed consent to treatment is required, although paradoxically, only from voluntary patients. The Principles specify that informed consent is not required from involuntary patients, patients who are thought to be incapable of giving their consent or patients who unreasonably withhold their consent (Principle 11).

⁶³ United Nations Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, in Australian Human Rights and Equal Opportunity Commission (eds), Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993.

⁶⁴ Fiona McDermott and Jan Carter, eds., Commonwealth Department of Human Services and Health: Issues for Research, No. 4, Mental Disorders: Prevention and Human Services Research, Australian Government Publishing Service, Canberra, 1995, p. 3.

⁶⁵ United Nations Commission on Human Rights, op.cit., p. 990.

⁶⁶ Ibid., pp. 990-991.

A list of “Rights and Conditions in Mental Health Facilities” are specified (Principle 13), along with the required “Resources for Mental Health Facilities” (Principle 14). “Admission Principles” are at first covered in a general way (Principle 15), eg. “Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness”, and then more specific conditions are given for “Involuntary Admission” (Principle 16). The need for a review body, procedural safeguards, patient access to information and a complaints procedure are also specified in various other principles.

Most of these specifications are straightforward ideas that are meant to provide a regulatory framework that minimises the social exclusion of voluntary mental patients and which ensures they receive humane treatment. But the simplicity of these ideas does not always extend to involuntary patients and the standing of the Principles is largely dependent on the willingness of practitioners and proponents of the medical model to ignore the paradoxes that are created for involuntary patients.

There are two human rights specified in the Principles — the ‘right to treatment’ and the ‘right to informed consent’ — which are worth analysing in some detail. When these rights are used to guide psychiatric practice on voluntary patients they appear to simply enforce routine procedures that have long standing in other branches of medicine. But unlike other areas of medicine, psychiatry is frequently practised on involuntary patients and these two human rights have special connotations when they are used to guide coercion in psychiatric treatment. About half the people who receive psychiatric treatment for schizophrenia are involuntary patients.

Right to Treatment

The human rights specification that people with mental illnesses have a right to treatment implies that without this specified protection people in need of psychiatric treatment might be denied access to it. The implication is that people who have developed some kind of mental illness might go in search of medical treatment but, because of some kind of obstacle like lack of money to pay, a shortage of services, professional incompetence or rejection by the service providers, perhaps because of a discriminatory policy, the person in need fails to get the necessary psychiatric attention.⁶⁷

In this respect the right to psychiatric treatment is a manifestation of the right all people are assumed to have for any kind of urgently needed medical attention. This basic human right, and its limitations, are instantly recognisable when cases of denial are given publicity. A homeless man might be left injured in the street because it is assumed he has no money to pay for hospital

⁶⁷ Richard H. Lamb and J. Mark Mills, ‘Needed changes in law and procedure for the chronically mentally ill’, *Hospital and Community Psychiatry*, Vol. 37, No. 5, May, 1986, pp. 475-480.

expenses and is unlikely to have any medical insurance. Or doctors might publicly debate the ethics of withdrawing expensive life-support from terminally ill patients. As with other human rights the right to treatment is meant to support the needs of the individual when they are threatened by the exercise of social or professional expedience.⁶⁸

In respect to ensuring the right to psychiatric treatment for mental illness the New South Wales Mental Health Act, for instance, specifies that any person may apply to be admitted to a mental hospital in New South Wales.⁶⁹ The medical superintendent of the mental hospital can only refuse the person admission if he/she “is not satisfied that the person is likely to benefit from care or treatment”.⁷⁰ If the person is refused admission, or discharged prematurely, the medical superintendent can be compelled to review the decision.⁷¹

After a person has been admitted to a mental hospital the choice of treatment is normally the responsibility of the psychiatrist to whom the patient has been assigned. This choosing of treatment can also sometimes become the basis for ‘right to treatment’ complaints by the patient. In respect to treatment for schizophrenia the choice is usually between various types and brands of neuroleptic medication, on the one hand, and, less frequently, psychotherapy on the other.

An interesting case discussed in the psychiatric literature concerns a complaint made by a patient of a mental hospital in the United States that his right to treatment had been violated because he had been given psychotherapy but not drug treatment. The patient was himself a doctor and had spent several months in hospital only receiving psychotherapy for depression. The psychotherapy was ineffectual and during this time the patient’s marriage ended and other aspects of his personal life were damaged. However, he was subsequently transferred to another hospital where he received drug treatment which he believed was effective. His complaint was that he was initially denied a right to drug treatment. The first hospital was reported to have settled the matter out of court.⁷²

However, more frequently it is not the person actually manifesting the symptoms of mental illness who is most likely to complain about a supposed violation of the right to treatment. Complaints about violations of the right to treatment are more likely to be made by the relatives of mentally ill people.⁷³ But these complaints by relatives usually do not arise from situations where a mentally ill

⁶⁸ Michael L. Perlin, Kerri K. Gould and Deborah A. Dorfman, ‘Therapeutic jurisprudence and the civil rights of institutionalized mentally disabled persons: Hopeless oxymoron or path to redemption?’, Psychology, Public Policy, and Law, Vol. 1, No. 1, March, 1995, pp. 80-119.

⁶⁹ Mental Health Act 1990, Section 12, op.cit., p. 7.

⁷⁰ Ibid., Section 17, p. 8.

⁷¹ Ibid., Section 19, p. 9.

⁷² Gerald L. Klerman, ‘The psychiatric patient’s right to effective treatment: implications of Osheroff v. Chestnut Lodge’, American Journal of Psychiatry, Vol. 147, No. 4, April, 1990, pp. 409-419.

⁷³ Anon., ‘Eleventh Circuit rules on rights of child committed by parents’, Mental Disability Law Reporter, Vol. 7, No. 3, 1983, pp. 220-221.

person has approached a mental hospital voluntarily and been refused admission. On the contrary, most frequently they concern a somewhat paradoxical situation where the person who is said to be mentally ill denies it and refuses to volunteer for treatment.⁷⁴

When a person's unusual behaviour and thinking patterns give rise to a perception that a mental illness like schizophrenia might be the cause, and the person is unwilling to volunteer for treatment, it is common for relatives and mental health professionals to argue that the person's refusal of treatment is a manifestation of the mental illness. That is, the presence of mental illness has clouded the person's thinking and prevented the person from discerning for himself/herself the urgent need for treatment.⁷⁵

In this situation the person who is said to be mentally ill is handled as if he/she were unconscious. A person who has been seriously injured in a motor accident and rendered unconscious is assumed to both want treatment and to have a right to it. Similarly, a person who has been diagnosed with schizophrenia, and who refuses treatment, is frequently assumed to be so out of touch with reality that the 'real' person has been obscured by the mental illness.⁷⁶ In this situation relatives often undertake decision-making roles on the mentally ill person's behalf and assume that if the 'real' person were present he/she, like an unconscious motor accident victim, would both want treatment and have a right to it.⁷⁷ This assumption is often made in the face of vigorous objections by the person concerned.

Although this interpretation of the 'right to treatment' generally requires some kind of endorsement by the relatives of the mentally ill person its usage as a justification for psychiatric coercion has become deeply entrenched in the ethical consensus of the whole mental health system. The strength of this consensus is illustrated by the willingness of professionals who are positioned only on the periphery of the mental health industry to also ignore the paradox inherent in the concept. It is argued by social workers in the United States, for instance, that the profession is required to advocate the right to treatment whenever they encounter a mentally ill person who is going untreated:

⁷⁴ M. A. Carroll, 'The right to treatment and involuntary commitment', *Journal of Medical Philosophy*, Vol. 5, No. 4, December, 1980, pp. 278-291.

⁷⁵ X. F. Amador, D. H. Strauss, S. A. Yale and J. M. Gorman, 'Awareness of Illness in Schizophrenia', *Schizophrenia Bulletin*, Vol. 17, No. 1, 1991, pp. 113-132.

⁷⁶ P. Lysaker and M. Bell, 'Work Rehabilitation and Improvements in Insight in Schizophrenia', *Journal of Nervous and Mental Disease*, Vol. 183, No. 2, 1995, pp. 103-106.

⁷⁷ Richard M. Sarles and Norman Alessi, 'Resolved: two-week psychiatric hospitalizations of children and adolescents are useless', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 32, No. 1, January, 1993, pp. 215-221.

if there are means (medications) to treat unrelieved psychosis, failure to use these means is opposed to social work principles. Similarly, failure to advocate for a patient's right to treatment runs counter to fundamental social work principles and the right to due process. There are legal case precedents that ensure the right to treatment for people confined in public psychiatric hospitals. In the 1966 case of *Rouse v. Cameron*, the D.C. Circuit Court ruled that confining a person in an institution for treatment and failing to provide treatment is a violation of the due process clause of the Fourteenth Amendment.⁷⁸

The lack of distinction in this ethical position between the advocacy of treatment for voluntary and involuntary patients brings the paradox of the right to treatment clearly into perspective. The practice of this ethical position apparently requires social workers to advocate psychiatric treatment for people who do not want to be treated. Even if the analogy of likening a mentally ill person to an unconscious person is acceptable there is still the matter to consider of the quality and efficacy of the psychiatric treatment that is generally on offer.⁷⁹

In the case of an accident victim who is unconscious with serious injuries it can be generally assumed that medical attention will more likely be beneficial to the person than detrimental. In fact, the imposition of medical treatment on an unconscious person, who has not given prior consent, imposes on the medical practitioner an expectation that the patient's condition will not be made worse by the treatment. A patient who recovers from such a condition could be expected to show gratitude to the doctor.

However, the limitations of the analogy which likens an involuntary psychiatric patient to an unconscious accident victim become clear when these criteria are applied to the post-crisis mental patient. Unlike the case of the voluntary patient related above, many former involuntary schizophrenic patients have complained that neuroleptic drug treatment did them far more harm than good.⁸⁰ Rather than showing gratitude to the psychiatrists involved they are inclined to argue that the coercive interpretation of their 'right to treatment' violated their more fundamental 'right to refuse treatment'.⁸¹

⁷⁸ Patricia B. Higgins, 'Clozapine and the treatment of schizophrenia', Health & Social Work, Vol. 20, No. 2, 1995, pp. 124-132.

⁷⁹ Eve C. Johnstone, 'Schizophrenia: problems in clinical practice', The Lancet, Vol. 341, No. 8844, 27 February, 1993, pp. 536-539.

⁸⁰ See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels. The Revolt Against the Mental Health System, Open Court, Chicago, 1993, pp. 164-165.

⁸¹ Simon N. Verdun-Jones, 'The right to refuse treatment: Recent developments in Canadian jurisprudence', International Journal of Law and Psychiatry, Vol. 11, No. 1, 1988, pp. 51-60.

Informed Consent

The right to refuse treatment is embodied in the standard medical procedure of obtaining a patient's informed consent before treatment.⁸² The origins of the medical concept of 'informed consent' are to be found in a complex arrangement of cultural inheritance involving moral, ethical and legal considerations. The moral element is concerned with notions of individual autonomy and a person's right to determine what is allowed to be done to his/her own body by a doctor. The ethical part involves the relationship between an individual and a professional expert who has been consulted by the individual and concerns the expectations of duty and trust that surround such a relationship. The legal aspect is concerned with the actual contractual arrangements that have been entered into by the two parties.⁸³

The binding together of these separate concepts into a formally stated principle didn't occur until after the Second World War.⁸⁴ The trials of Nazi War criminals had revealed many atrocities in the name of experimental science, most of which were performed by qualified doctors, and the Nuremberg Code was adopted by the United Nations General Assembly in 1946 as an international standard to ensure they were never repeated. The first Principle of the Code states that "[t]he voluntary consent of the human subject is absolutely essential"⁸⁵ when conducting medical experiments. Although this Code is considered by many to lack the necessary detail for enforcement it is the seminal document for international law in this area and has been subsequently used as a basis for other international agreements of a similar nature.⁸⁶

From these beginnings 'informed consent' has been developed into a fully fledged doctrine to guide the delivery of professional medical services. Although the procedures appear to be deceptively simple to apply on the surface there are hidden complexities. Most of the problems can be easily sorted into two types: those concerning the notion of 'informed', and those to do with 'consent'.

To satisfy the 'informed' half of the doctrine the medical practitioner is required to tell the patient the reason why the treatment is necessary and the expected outcome, together with a description of any possible side effects and, if failure is a possibility, the likelihood of failure and its consequences. Alternative treatments should also be canvassed.

⁸² John A. Robertson, 'Informed consent: a study of decisionmaking in psychiatry', Science, Vol. 226, 23 November, 1984, p. 960.

⁸³ V. Dharmananda, Informed Consent to Medical Treatment: Processes, Practices and Beliefs, Law Reform Commission of Western Australia, Perth, 1992, pp. 1-2.

⁸⁴ Carolyn Faulder, Whose Body Is It? The Troubling Issue of Informed Consent, Virago Press, London, 1985, p. 12.

⁸⁵ The Nuremberg Code, reproduced in Ibid. p. 132.

⁸⁶ George J. Annas, Leonard H. Glantz, and Barbara F. Katz, Informed Consent to Human Experimentation: The Subject's Dilemma, Ballinger Publishing Company, Cambridge, Mass., 1977, p. 8.

Although this might seem straightforward, doctors frequently complain about problems they face in properly implementing this procedure. From the doctor's point of view the problem is usually in deciding just exactly how much detail of information is necessary to properly satisfy a particular patient. Some patients, it seems, would rather not be told any more than is strictly necessary, preferring to trust in the wisdom of their doctor to make the decisions for them. Others, particularly those who think of themselves as being 'informed' about life in general, and who truly want to understand their situation, want all the information they can get.⁸⁷

The problem for the doctors is knowing which sort of patient they are dealing with. Doctors tend to argue that giving too much information to patients who don't want it only does harm to the patients by increasing their anxiety. Doctors also complain that they are usually too busy to waste time educating those patients who want to know everything. But neither of these arguments is a sufficient defence for doctors when it comes to protecting themselves against litigation for having failed to satisfy the procedure.

Doctors in the United States are perhaps under more pressure in this regard than doctors in most other countries. The so-called "American disease of medical litigation"⁸⁸ is largely a result of US courts having built a strong foundation of case law establishing the right of the patient to be properly informed. In the US doctors are sometimes surprised by the extent of the information that courts have decided a patient has a right to know.

A recent case involved a doctor who performed an operation on a woman without informing her in advance that he was HIV positive.⁸⁹ In a separate case a doctor failed to inform a patient about the doctor's chronically agitated emotional state which was combined, so the doctor's estranged wife testified, with a dependency on alcohol.⁹⁰ In both of these cases the courts found in favour of the patients. This is despite the fact that in both cases the patients appeared to be satisfied with the medical outcome of their respective treatments. It seems that it was the failure to disclose heightened risk that required compensation.

Clinical trials of drugs pose particular problems in regard to satisfying the requirement that participants be properly informed. A recent article warned about the widespread practice of doctors who gain consent from patients for their participation in pharmaceutical trials without informing the

⁸⁷ Faulder, *Op. Cit.*, pp. 22-31.

⁸⁸ Sheila A. M. McLean, *A patient's Right To Know: Information disclosure, the doctor, and the law*, Dartmouth, Aldershot, 1989, p. 2.

⁸⁹ Rex Julian Beaber, 'HIV Positive Surgeons Must Tell Their Patients', *Health Systems Review*, Vol. 26, No. 5, Sept/Oct. 1993, pp. 41-42.

⁹⁰ Charles F. Gay Jr., 'New Twist on Informed Consent in Medical Malpractice', *Defence Council Journal*, Vol. 60, No. 2, April 1993, pp. 311-312.

patients that the doctors are receiving remuneration from the drug companies. The author implied that patients have a right to know what is motivating the doctor.⁹¹

Clinical trials of psychiatric drugs are particularly problematic in regard to informed consent. People who have been diagnosed with serious mental disorders like schizophrenia, for whom the drugs are designed, are usually assumed to be incapable of making rational decisions. This assumption is the basis for the involuntary treatment that many of them receive. However, pharmaceutical companies are constantly developing new drugs which have to be tested by clinical trials procedures before they are released onto the market. These conditions tend to produce a paradoxical situation whereby people who are deemed by medical/legal procedures to be unfit to make decisions in regard to their need for treatment in the first instance are, all the same, sometimes assumed to be rational enough to give their informed consent to participate in medical experiments.⁹² Paradoxes like this sometimes exercise the minds of medical ethicists.⁹³

The problem of ‘consent’ is the other half of the informed consent doctrine. But the notion of ‘consent’ doesn’t seem to cause so much anxiety for the medical profession in general as does ‘informed’. Even so, ‘consent’ still has many areas of contention. The main problem area concerns certain categories of people who are considered unfit to give their consent.

The least controversial of those types considered unfit to consent is the medical patient who is unconscious and needs urgent medical attention. In this circumstance it is normal practice to assume “the notion of *presumed consent*, namely that it is a safe assumption that patients would want whatever is medically indicated to minimise or prevent injury, stop the progression of disease, sustain life, relieve pain and suffering, and so forth”.⁹⁴

There are a number of devices that can extend this kind of presumption of consent into more controversial areas. They include *proxy consent*,⁹⁵ which is the form of consent given by a third party, usually a relative on behalf of children⁹⁶ and elderly people,⁹⁷ and “the doctrine of *parens*

⁹¹ John La Puma and Jerome Kraut, ‘How much do I get paid if I volunteer? Suggested institutional policy on reward, consent, and research’, Hospital and Health Services Administration Journal, Vol. 39, No. 2, Summer 1994, pp. 193-203.

⁹² James Willwerth, ‘Madness in fine print: using mentally ill subjects for psychiatric experiments too often means extracting and relying on their ill-informed consent’, Time, Vol. 144, No. 19, 7 November, 1994, pp. 62-64.

⁹³ H. Helmchen and B. Muller-Oerlinghausen, ‘The inherent paradox of clinical trials in psychiatry’, Journal of Medical Ethics, Vol. 1, No. 4, December, 1975, pp. 168-173.

⁹⁴ Stephen Wear, Informed Consent, Kluwer Academic Publishers, Dordrecht, 1993, p. 135.

⁹⁵ Raanan Gillon, ‘Research On The Vulnerable: An Ethical Overview’, in Margaret Brazier and Mary Lobjoit, Protecting The Vulnerable: Autonomy and Consent in Health Care, Routledge, London, 1991, p. 58.

⁹⁶ Jenny Morgan, ‘Minors and Consent to Medical Treatment’, in Law Reform Commission of Victoria, Medicine, Science and the Law: Informed Consent Symposia, Globe Press, Melbourne, 1987, pp. 68-76.

patriae, which provides that the state has the duty to care for those individuals who are not able to do so themselves”.⁹⁸ The right to give involuntary treatment to mental patients, without their informed consent, is largely drawn from the doctrine of *parens patriae*.⁹⁹

Conclusion

The interest groups which support the medical model are unified by a common belief that people who manifest symptoms of schizophrenia are in need of care, treatment and control. While care and treatment are often actively sought by voluntary patients, control is usually reserved for schizophrenics who resist psychiatric intervention.

A number of human rights imperatives are used to gain leverage in meeting the objectives of care, treatment and control. The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care are the basic human rights references for the medical model of schizophrenia. The UN Principles are designed to protect a wide range of voluntary patient rights by ensuring mental patients are treated with the same level of respect and care that is given to other medical patients.

However, control of patients, in the form of involuntary treatment, is not normally found in other branches of medicine. Involuntary treatment therefore necessitates a certain amount of duplicity in the interpretation of human rights, like ‘informed consent’ and the ‘right to treatment’. The usual tactic is to justify involuntary treatment by assuming that a person who resists treatment lacks sufficient insight to comprehend the need for treatment. This assumption clears the way to assert that the person would assent to treatment if the need were properly understood and that the person’s ‘right to treatment’ would be violated without the imposition of involuntary treatment. In this way the medical model can satisfy the perceived need to control certain patients while at the same time appearing to respect their human rights.

⁹⁷ Elizabeth Ozanne, ‘Informed Consent and the Elderly: Professional Defence or Consumer Right?’, in *Ibid.*, pp. 50-67.

⁹⁸ Annas, et al, *Op Cit.*, P. 154.

⁹⁹ H. Bursztajn, T. G. Gutheil, R. M. Hamm, A. Brodsky and M. J. Mills, ‘Parens patriae considerations in the commitment process’, *Psychiatric Quarterly*, Fall, 1988, Vol. 59, No. 3, pp. 165-181.

6. The Mystical Model: Schizophrenic Symptoms as a Natural Extension of Consciousness

Introduction

The mystical model for explaining the symptoms of schizophrenia had a surge of popularity two to three decades ago.¹ This occurred at a time when political activists and protest movements were busy in a wide-ranging challenge to much of the established social policy in western democracies. As with many of the other targets of this revolutionary period confidence has since been restored in the conservative psychiatric assumptions inherent in the medical model. However, these assumptions now have to coexist with a residue of opinion that remains convinced there are better ways of understanding schizophrenic deviations in thought and belief than the explanations provided by the limited epistemology of medical science.²

The mystical/religious model actually has long antecedents. It is the pre-scientific, traditional way of understanding unusual psychological phenomena. In earlier historical times European cultures interpreted abnormal mental activity featuring visions, the hearing of voices and bizarre beliefs almost invariably from the perspective of religious knowledge.³ From this perspective a person reporting communications with a deity, or with angels, might have undergone a culturally desirable experience which could indicate the bestowal of some kind of blessing. In this way a person's reputation and social standing could be enhanced by a claim of inner voices and many religious leaders, prophets and founders of religious movements are recorded as having reported them.⁴

But at the same time this traditional religious perspective could also view inner voices negatively when they appeared to prompt the hearer into sacrilege or blasphemy. When this happened the voices were likely to be interpreted as representing the devil or evil spirits, and this might lead to a judgement that the hearer was cursed rather than blessed, and was perhaps even a heretic.⁵ For these voices to be recognised as madness, in this religious context, a person would usually be required to also manifest the further symptom of irrational and dangerous behaviour.⁶

¹ See for example, R. D. Laing, The Politics of Experience and The Bird of Paradise, Penguin, Harmondsworth, 1967.

² See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels, Open Court, Chicago, 1993.

³ George Rosen, Madness in Society, University of Chicago Press, Chicago, 1969.

⁴ Ibid., pp. 21-70.

⁵ Simon Kemp, 'Ravished of a Fiend: Demonology and Medieval Madness', in Collen A Ward, ed., Altered States of Consciousness and Mental Health, Sage, Newbury Park, 1989, pp. 67-78.

⁶ Rosen, op.cit., pp. 154-158.

For modern people, the interpretation of schizophrenic symptoms as being manifestations of mystical experience is obviously problematic. This problem manifests for both those who want to protect the reputation of mysticism from association with mental illness⁷ as well as for subscribers to the medical model of schizophrenia.⁸ Science has displaced religion as the established epistemological authority and has devised the medical model to explain the phenomena it calls schizophrenia. This situation gives rise to an obvious question: Are there justifiable grounds then for giving serious consideration to a model that has already been superseded by a scientific hypothesis, even if that hypothesis is controversial and has numerous anomalies? If the medical model is inadequate would it be better to turn to another branch of science, to physics perhaps for an energy field theory,⁹ rather than revert to the less sophisticated beliefs of the pre-scientific era?

This may well be the way of the future but as things stand the mystical model still has at least one compelling claim for attention, even in the context of the scientific age. This claim is that schizophrenia is essentially a 'religious' experience in that the abnormal thoughts and beliefs that mark the condition are largely concerned with mystical or religious issues.¹⁰ Most schizophrenics report that they have been in communication with God or some higher being and/or that they have been given some kind of special messianic mission to fulfil.¹¹

This observation begs a further obvious question as to whether all mystical/religious experience should be viewed as an indicator of mental illness¹² regardless of its level of conformity with accepted religious practices. Neither the DSM-IV nor the ICD-10 supply any differential diagnostic guidelines to distinguish mystical/religious experience from schizophrenia¹³ and it is difficult to avoid the assumption that a person who reported to a psychiatrist what he/she believed was a mystical experience, would very likely incur a diagnosis of schizophrenia.¹⁴

Mystical experience has been traditionally associated with a number of beneficial aspects of human experience like spiritual guidance, the discovery/uncovery of religious knowledge, communion with a deity, healing, the arts and prophecy.¹⁵ The symptoms of schizophrenia, on the other hand, are

⁷ Kenneth Wapnick, 'Mysticism and Schizophrenia', in Richard Woods, ed., Understanding Mysticism, The Athlone Press, London, 1981, pp. 321-337.

⁸ D. A. Sternberg, 'Schizophrenia', in A. James Giannini, The Biological Foundations of Clinical Psychiatry, Medical Examination Publishing Company, New York, 1986, pp. 147-164.

⁹ John C. Pierrakos, 'Psychiatric Implications of Energy Fields in Man and Nature', in Stanley R. Dean, ed., Psychiatry and Mysticism, Nelson Hall, Chicago, 1975, pp. 145-151.

¹⁰ See for example, John Weir Perry, The Far Side of Madness, Prentice-Hall, Englewood Cliffs, 1974.

¹¹ Ibid., pp. 63-79.

¹² K. W. M. Fulford, 'Religion and Psychiatry: Extending the limits of tolerance', in Dinesh Bhugra, ed., Psychiatry and Religion: Context, Consensus and Controversies, Routledge, London, 1996, pp. 5-6.

¹³ For a proposal to add this differential diagnosis to the DSM see, David Lukoff, 'The diagnosis of mystical experiences with psychotic features', Journal of Transpersonal Psychology, Vol. 17, No. 2, 1985, pp. 155-182.

¹⁴ M. Goldwert, 'The Messiah-Complex in Schizophrenia', Psychological Reports, Vol. 73, No. 1, 1993, pp. 331-335.

¹⁵ Christopher Bamford, 'Culture of the heart', Parabola, Vol. 20, No. 4, Winter 1995, pp. 56-63.

interpreted by modern medical scientists as indicators of pathology. The mystical model for schizophrenia therefore, in so much as it challenges the medical model, tends to imply indirectly that science, through the agency of psychiatry, is actively discouraging the extension of human experience into an area which science itself might find difficulty in accessing.¹⁶

Nevertheless, even if a convincing argument can be mounted that the symptoms of schizophrenia are indeed indicators of mystical experience, and that science therefore is actively discouraging mysticism by aborting the experience through psychiatric treatment of schizophrenics, there might still be good reasons for science to perform this social control function. People who come in contact with psychiatry, and who are subsequently diagnosed with schizophrenia, usually do so because they are undergoing acute psychological distress, and/or they are causing distress to others.¹⁷ If there is any validity in the mystical interpretation of schizophrenic symptoms then it is probably fair to say at the outset that most of the people diagnosed and treated for schizophrenia demonstrate a low level of competency in handling mystical experience.¹⁸

Viewed from this perspective perhaps a useful analogy for reviewing the mystical model might be that “our schizophrenic patient is actually experiencing inadvertently that same beatific ocean deep which the yogi and saint are ever striving to enjoy: except that, whereas they are swimming in it, he is drowning”.¹⁹ Drowners and swimmers might be both in the same water, and experience many of the same sensations, and their splashing might look the same to an untrained observer, but what is pleasurable exercise to one, could be a life or death struggle for the other. Pursuing this analogy a little further, perhaps modern psychiatric practice could be viewed as a zealous life-guard who does not distinguish between drowning and swimming and simply hauls everybody out of the water whose splashing attracts attention.

This chapter will first discuss the meaning of mysticism in order to provide a context in which to evaluate the claim that schizophrenic symptoms are manifestations of mystical experience. This will be followed by a review of the arguments that have been made by some of the major proponents of the mystical model.

¹⁶ David Bradshaw, ‘The best of companions: J. W. N. Sullivan, Aldous Huxley, and the New Physics’, The Review of English Studies, Vol. 47, No. 187, 1996, pp. 352-369.

¹⁷ P. S. Gopinath and S. K. Chaturvedi, ‘Distressing Behaviour of Schizophrenics At Home’, Acta Psychiatrica Scandinavica, Vol. 86, No. 3, 1992, pp. 185-193.

¹⁸ Wapnick, op.cit., pp. 321-337.

¹⁹ Joseph Campbell, ‘Schizophrenia — the Inward Journey’, in Myths to Live By, Viking Press, New York, 1972, p. 219-220.

Background to the Mystical Tradition

Definitions of mysticism, and descriptions of mystical experience, range widely through literature. The more reliable academic sources believe that the word itself “has its origin in the Greek mysteries” and that “mystery (mysterium) comes from the Greek verb *muo*, to shut or close the lips or eyes”.²⁰ In this original sense a mystic was a person who had been “initiated into the esoteric knowledge of Divine things, and upon whom was laid the necessity of keeping silence concerning his secret knowledge”.²¹ The priests of the ancient mystery religions however lost control of the term when philosophers began to use it to describe aspects of their own speculations. From the Greek philosophers it was passed on to “the Christian Church, which held itself to be a body of initiates into a truth not possessed by mankind at large”.²²

Modern usage of terms associated with the words ‘mystic’, ‘mystical’ and ‘mysticism’ ranges far beyond the ancient applications to pagan and Christian ritual.²³ Most of the major religions of both east and west have highly developed aspects, and recognised practices, that can be understood by the modern usage of the terms.²⁴ On top of this there are also anthropological observations which focus on traditional tribal practices, like shamanism, for which the terms can also be adapted.²⁵

Mysticism in the modern sense refers to a psychological experience involving a conscious transcendence of the normal self identity.²⁶ The person who undergoes such an experience usually forms the belief that he or she has entered into a higher state of consciousness,²⁷ has made contact with a deity,²⁸ or has entered into some form of communion with the object of devotion pertaining to the particular religious or philosophical tradition to which the mystic belongs.²⁹

There is a tendency amongst some religiously-inclined academic analysts to divide mystical experience into different types, according to the category of religious/philosophical tradition to which the mystic is allied.³⁰ In this way it is sometimes argued that monistic, theistic and nature mysticism, for instance, have qualitative differences.³¹

²⁰ F. C. Happold, *Mysticism*, Penguin, Harmondsworth, 1963, p. 18.

²¹ Margaret Smith, ‘The Nature and Meaning of Mysticism’, in Woods, *op.cit.*, p. 19.

²² *Ibid.*, p. 19.

²³ Harold G. Coward, ‘Levels of Language in Mystical Experience’, in Harold Coward and Terence Penelhum, eds., *Mystics and Scholars*, Wilfrid Laurier University Press, Waterloo, Ont., 1977, pp. 93-107.

²⁴ Terence Penelhum, ‘Unity and Diversity in the Interpretation of Mysticism’, in Coward and Penelhum, *Ibid.*, pp. 71-82.

²⁵ Joseph Epes Brown, ‘The Question of “Mysticism” Within Native American Traditions’, in Coward and Penelhum, *ibid.*, pp. 109-118.

²⁶ William Ernest Hocking, ‘The Meaning of Mysticism as Seen Through Its Psychology’, in Woods, *op.cit.*, pp. 223-239.

²⁷ Arthur J. Diekmann, ‘Deautomatization and the Mystic Experience’, in Woods, *op.cit.*, pp. 240-269.

²⁸ Julian of Norwich, ‘Revelations of Divine Love,’ reproduced in Happold, *op.cit.*, pp. 322-332.

²⁹ Philip C. Almond, *Mystical Experience and Religious Doctrine*, Mouton, New York, 1982.

³⁰ Ninian Smart, ‘Interpretation and Mystical Experience’, in Woods, *op.cit.*, pp. 78-91.

³¹ R. C. Zaehner, ‘Mysticism Sacred and Profane’, in Woods, *op.cit.*, pp. 56-77.

One leading academic theorist has divided mysticism into two broad types, extroversive and introversive: “The extroversive way looks outward and through the physical senses into the external world and finds the One there. The introversive way turns inward, introspectively, and finds the One at the bottom of the self, at the bottom of the human personality.”³² The language of mysticism is often difficult, ineffability being one of the characteristics of the experience, and ‘the One’ is usually interchangeable with ‘the Absolute’, ‘God’, ‘nirvana’ or some other transcendental objective.³³

There is hardly any soil, be it ever so barren, where Mysticism will not strike root; hardly any creed, however formal, round which it will not twine itself. It is, indeed, the eternal cry of the human soul for rest; the insatiable longing of a being wherein infinite ideals are fettered and cramped by a miserable actuality; and so long as man is less than an angel and more than a beast, this cry will not for a moment fail to make itself heard. Wonderfully uniform, too, whether it come from the Brahman sage, the Persian poet, or the Christian quietist, it is in essence an enunciation more or less clear, more or less eloquent, of the aspiration of the soul to cease altogether from self and to be at one with God.³⁴

The general consensus seems to agree that, providing psychological phenomena fit into certain broad principles, the appellation of mystical experience can be applied, and all mystical experience has validity, regardless of the particular path by which it was approached.³⁵ The exception to this general rule is that the mystical validity of drug-induced experience is sometimes disputed.³⁶

Essentially, a mystical experience involves an altered state of consciousness.³⁷ A metaphor which repeatedly appears in descriptions is of a house or structure with many rooms in which human consciousness abides. Normally these rooms have to be explored in the dark but when a person consciously enters a certain room, usually in the highest part of the house, a bright light is switched on which variously blinds, confuses or inspires a person with the inner scene that is revealed.³⁸

³²Walter T. Stace, *The Teachings of the Mystics*, Mentor, New York, 1960, pp. 15-23.

³³ Evelyn Underhill, ‘The Essentials of Mysticism’, in Woods, *op.cit.*, p. 31.

³⁴ E. G. Brown, ‘A Year Among the Persians’, quoted in Smith, *op.cit.*, p. 20.

³⁵ Louis Bouyer, ‘Mysticism/An Essay on the History of the Word’, in Woods, *op.cit.*, pp. 42-55.

³⁶ Frits Staal, ‘Superstructures’, in Woods, *op.cit.*, p. 92. For a discussion on the evolution of the art of prophecy in ancient Israel beyond trances induced by “music, dancing or intoxicating drinks” see, Rosen, *op.cit.*, pp. 53-54.

³⁷ Robert E. Ornstein, *The Psychology of Consciousness*, W. H. Freeman, San Francisco, 1972, pp. 135-140.

³⁸ John Ruysbroeck, ‘The Active, Inward and Superessential Lives’, reproduced in Happold, *op.cit.*, pp. 280-293.

Plato's simile of the cave is one of the clearest descriptions of this idea. In The Republic he has Socrates describe the normal human condition as being one in which most people live out their lives chained up at the bottom of a dark cave. The reality perceived by the inhabitants of the cave is limited to a view of distorted shadows projected on the opposite wall of the cave, which the prisoners habitually misinterpret. The exceptional person who escapes this bondage, and who climbs out of the cave, is at first dazzled by the sunlight but eventually learns to view a different, properly illuminated reality.³⁹

.... connect the ascent into the upper world and the sight of the objects there with the upward progress of the mind into the intelligible region. the final thing to be perceived in the intelligible region, and perceived only with difficulty, is the form of the good; once seen it is inferred to be responsible for whatever is right and valuable in anything, producing in the visible region light and the source of light, and being in the intelligible region itself controlling source of truth and intelligence.⁴⁰

Plato also makes a point of discussing the difficulties to be encountered by a person who returns to the cave after a sojourn in the light. Such a person has to learn once again to live in the dark and to successfully compete with other people at the bottom of the cave in an elaborate game of misinterpreting reality.

Nor will you think it strange that anyone who descends from contemplation of the divine to human life and its ills should blunder and make a fool of himself, if, while still blinded and unaccustomed to the surrounding darkness, he's forcibly put on trial in the law-courts or elsewhere about the shadows of justice or the figures of which they are shadows, and made to dispute about the notions of them held by men who have never seen justice itself.⁴¹

People who describe the mystical experiences they have undergone divide most readily into two types: those who were trained for the experience and those who were not.⁴² Training methods vary as widely as the mystical traditions that teach them, and are as various as the names of the final goal: "in all the great spiritual traditions is a relatively rare but universal and liberating experience either of self-oblivion or nirvana as in Buddhism or of a special relationship with the Deity, whether this remain unnamed or named as God, the Absolute, the Ultimate Reality, the All-Holy and Almighty, Cosmic Reality, the Ground of Being, the Transcendent or the One".⁴³

³⁹ Plato, The Republic, Desmond Lee, trans., Penguin, London, 1955, pp. 316-325.

⁴⁰ Ibid., pp. 320-321.

⁴¹ Ibid., p. 321.

⁴² Sandra Stahlman, Defining Mysticism, 1992, accessed July 1997, Available URL, http://www.well.com/user/elliots/smse_deikman.html

⁴³ Walter H. Principe, 'Mysticism: Its Meaning and Varieties', in Coward and Penelhum, op.cit., p. 4.

But this variety disguises a fairly simple common principle underlying them all. This common principle is that normal human consciousness has evolved into an awareness of individual mortality, from which there is a need to escape.⁴⁴ Somewhere in the distant ancestry of humanity a threshold of consciousness was crossed after which individual humans have had to endure the constant anxiety which accompanies the anticipation of personal death.⁴⁵ The ancients variously referred to the crossing of this threshold as a fall from grace, a descent from a Golden Age, or an eviction from a garden of easy living. Modern people are perhaps more likely to see it as an advancement or an evolutionary step, rather than a fall, which has provided the fundamental distinction between humans and other animals.⁴⁶

Dealing With the Knowledge of Mortality

Whether the development of the knowledge of personal mortality is viewed as a descent or an ascent does not matter a great deal. Either way it produces the effect of what is now generally referred to as self-consciousness. The awareness of personal mortality, combined with the understanding that the lives of others, and the physical reality in which they abide, will all continue independently after a person has died, has the effect of causing individual humans to see themselves as separate and alienated from the physical and social environments in which they live. Each person understands that at the end of their life, death has to be faced alone.⁴⁷ This realisation has the tendency to develop an aspect of consciousness from which life is also faced alone.⁴⁸ This sense of alienation focuses consciousness on the individual self, and the need to prolong its survival. In this way existence can become an uncomfortable and futile experience:

And God has so arranged this existence that it is impossible in this world to be related in truth to truth without coming to suffer — and eternity judges everyone according to whether he has been related in suffering to truth.⁴⁹

Mysticism appears to be a comparatively recent innovation for dealing with this harsh reality of mortal existence and it is normally only utilised by individuals who find the traditional strategies unsatisfactory. The traditional strategies involve reinforcing the self, rather than transcending it, through identification with the phenomena of procreation and/or social status. The utilisation of procreation as a defence of the self involves viewing this phenomenon as an opportunity for

⁴⁴ Happold, *op.cit.*, pp. 33-34.

⁴⁵ Terrance G. Walsh, 'Writing anxiety in Teresa's 'Interior Castle'', *Theological Studies*, Vol. 56, No. 2, 1995, pp. 251-276.

⁴⁶ Richard Maurice Bucke, *Cosmic Consciousness* E. P. Dutton, New York, 1969, pp. 19-22.

⁴⁷ Bede Griffiths, *Return to the Center*, Templegate, Springfield Illinois, 1976, pp. 88-97.

⁴⁸ Abraham H. Maslow, *Toward a Psychology of Being*, Second Edition, Van Nostrand Reinhold, New York, 1968, p. 14.

⁴⁹ Soren Kierkegaard, *The Last Years: Journals 1853-55*, Fontana, London, 1965, p. 132.

providing a measure of personal immortality.⁵⁰ Children are seen as extensions of the self and, since it can be anticipated that children will further extend a person's procreative chain of existence, people who have children are likely to reassure themselves with the thought that their own being is a link in a chain of immortal existence.⁵¹

But there is large scope for disappointment for those who rely on this strategy. Infertility, premature death of offspring, the failure of children themselves to marry and procreate, or simply intergenerational conflict, can all easily create conditions in which the chain of immortality appears to break. The most basic problem with this strategy for men is the uncertainty over paternity.⁵² When men are prompted by anxieties over paternity to adopt tactics designed to ensure the security of paternity, like imposing binding marriage contracts on women and restricting their freedom,⁵³ the stress is passed on from men to women.⁵⁴

To combat the anxieties caused by the knowledge of personal mortality, and also ameliorate the further stresses caused by the 'cure' of procreation, a further cultural strategy has been consciously developed which involves a competitive struggle for social status/social power.⁵⁵ The principle here is simple: people who can gain power over others can command them to provide service in the task of preserving the well-being of the person holding power. Men who pursue this strategy believe that if they can dominate male rivals, and gain ascendancy over a particular woman,⁵⁶ then exclusive sexual access will be guaranteed and procreative certainty will be assured. Surplus wealth, which can be accumulated by the exercise of power,⁵⁷ can also be used to insulate the person in power against mortality risks arising from causes like accident, disease, war, exposure and hunger.

The obvious flaw in the status strategy is that it can only work for the benefit of a minority of people at the expense of the majority.⁵⁸ Mystics are usually drawn from the ranks of the majority for whom the quest for status offers little comfort. The pursuit of mystical experience can be seen as a further attempt, beyond the more normal strategies of procreation and status, to escape from the consciousness of self and the accompanying anxiety about its mortality.⁵⁹

⁵⁰ D. W. D. Shaw, 'The undiscovered country': an exploration — 'the life everlasting', Scottish Journal of Theology, Vol. 47, No. 2, 1994, pp. 149-169.

⁵¹ Harvey Whitehouse, 'Rites of terror: emotion, metaphor and memory in Melanesian initiation cults', Journal of the Royal Anthropological Institute, Vol. 2, No. 4, 1996, pp. 703-716.

⁵² Warren Cohen, 'Kid looks like the mailman? Genetic labs boom as the nation wonders who's Daddy', US News and World Report, Vol. 122, No. 3, Jan 27, 1997, pp. 62-63.

⁵³ Anon., 'Purdah — seclusion — in Pakistan: violation of women's human rights', WIN News, Vol. 20, No. 2, 1994, pp. 33-34.

⁵⁴ Rhoda Kanaaneh, 'We'll talk later', Cultural Anthropology, Vol. 10, No. 1, 1995, pp. 125-136.

⁵⁵ See for example, Vance Packard, The Status Seekers, Penguin, Harmondsworth, 1959.

⁵⁶ Amida Amazone, 'On Male Tyranny', Journal of Women's History, Vol. 8, No. 2, 1996, pp. 139-144.

⁵⁷ See for example, S. Encel, Equality and Authority: a Study of Class, Status and Power in Australia, Cheshire, Melbourne, 1970.

⁵⁸ See for example, C. Wright Mills, The Power Elite, Oxford University Press, London, 1956.

⁵⁹ Happold, op.cit., pp. 56-57.

Attaining Mystical Experience

Mystical experience which is deliberately intended, rather than spontaneous, is usually attained through the practice of some kind of spiritual exercises.⁶⁰ These exercises can take the form of meditation and yoga, as in Buddhist⁶¹ and Hindu⁶² traditions, certain forms of Christian prayer,⁶³ dancing in Sufism,⁶⁴ and even the repetition of the mystic's own name, as the 19th century English poet, Alfred Lord Tennyson found:

I have never had any revelations through anaesthetics, but a kind of waking trance — this for lack of a better word — I have frequently had, quite up from boyhood, when I have been all alone. This has come upon me through repeating my own name to myself silently, till all at once, as it were out of the intensity of the consciousness of individuality, individuality itself seemed to dissolve and fade away into boundless being, and this not a confused state but the clearest, the surest of the surest, utterly beyond words — where death was an almost laughable impossibility — the loss of personality (if so it were) seeming no extinction, but the only true life.⁶⁵

The intuitive inventiveness Tennyson describes is not unusual amongst mystics who are independent of organised disciplines. But most descriptions of mystical technique are more likely to follow the proven formula of a tradition. These proven formulas often have common elements: i.e. the novice mystic should follow a lifestyle committed to humility⁶⁶ (transcendence of the status quest) and, following the example of celebrated mystic role models like Meister Eckhardt,⁶⁷ usually be celibate as well (detachment from fertility). Once the novice has correctly arranged his/her lifestyle, which might require residence in a monastery, convent⁶⁸ or spiritual community, some form of mental exercises are then learned and practised. These exercises are usually a combination of techniques. Variations of Tennyson's name repetition are often found as components under the name of "mantra"⁶⁹ or "prayer"⁷⁰.

⁶⁰ See for example, Lu K'uan-yu, Taoist Yoga: Alchemy and Immortality, Rider, London 1970.

⁶¹ See for example, Lama Anagarika Govinda, Foundations of Tibetan Mysticism, Rider, London, 1959.

⁶² See for example, Ernest E. Wood, Practical Yoga, Wiltshire Book Company, Hollywood, Calif., 1972.

⁶³ Anon., The Way of the Pilgrim, R. M. French, trans., S.P.C.K., London, 1930.

⁶⁴ Andrew North, 'The mysterious mould', The Middle East, No. 259, Sept. 1996, pp. 35-38.

⁶⁵ Alfred Lord Tennyson, in a letter to Mr. B. P. Blood, quoted in William James, The Varieties of Religious Experience, Fontana, London, 1960, p. 370.

⁶⁶ See for example, Steve Clorfeine, 'Journey to Enlightenment: The Life and World of Khyentse Rinpoche', Parabola, Vol. 22, No. 2, 1997, pp. 91-94.

⁶⁷ Michael Maccoby, 'The two voices of Erich Fromm: prophet and analyst', Society, Vol. 32, No. 5, 1995, p. 72-83.

⁶⁸ See for example, Jaroslav Pelikan, 'Sisters in Arms: Catholic Nuns Through Two Millennia', The New Republic, Vol. 215, No. 16, 1996, pp. 39-44.

⁶⁹ Ernest Wood, Concentration: an approach to meditation, Theosophical Publishing House, Adyar, 1949, pp. 123-129.

⁷⁰ St Teresa of Avila, 'The Degrees of Prayer', in Happold, op.cit., pp. 342-354.

Meditation, in one form or another, is usually the centre-piece of mystical practice. The essential component of all meditative practice is for the practitioner to develop an ability to observe his/her own flow of thoughts.⁷¹ This involves the establishment of an aspect of identity that looks inward, and relates to mental phenomena, and is distinguished from self-identity by being its observer.⁷² This deliberate effort to consciously observe the mental activity of the self, rather than to participate in existence through the expression of self-identity, can produce an effect in which the person's mind is split so that consciousness is catapulted in a trajectory above and beyond the existential anxieties of self consciousness.⁷³

Reports of the resulting experience of transcendence have a number of common components. The most notable of these involve emotional perceptions — the transcendence of fear and the experience of love⁷⁴ — and non-sensory communications, perceived directly in the mind as voices or visions.⁷⁵

Imaginary visions may appear with the intensity of actual sensations It is as if the images and symbols normally restricted to the unconscious are released when the mind first penetrates into the unknown depths of itself. The mystical vision structures this “unconscious” material according to its own intentionality.⁷⁶

It is not normal for mystics to refer to these communications as hallucinations though clearly this is the psychological terminology that most appropriately describes them. The term ‘hallucination’, as has already been discussed in the description of the medical model, is of 19th century coinage. Mystics are generally inclined to perceive and describe their experiences in terms of the particular discipline in which they have trained and many of these predate the 19th century by a considerable margin.⁷⁷

Academic analysts have some difficulty in finding the right terms by which to describe the voices and visions of mystics: “intellectual visions are not visions proper, since they do not consist of perceptions or images. Nor are they intellectual in the ordinary sense, since they are entirely nondiscursive and contribute nothing to the subject's ‘understanding’ of himself and his world. Nevertheless, their main impact is one of insight and even of all-surpassing insight.”⁷⁸

⁷¹ Brother David Steindl-Rast, ‘My Spiritual Discipline’, in Coward and Penelhum, *op.cit.*, pp. 19-22.

⁷² Ernest Wood, *Yoga*, Pelican, Harmondsworth, 1959, p. 43.

⁷³ See for example, Yogi Ramacharaka, *A Series of Lessons in Raja Yoga*, L. N. Fowler, London, 1960.

⁷⁴ Happold, *op.cit.*, pp. 40-42.

⁷⁵ See for example, Dante, ‘Intellectual Vision’, in *ibid.*, pp. 264-268.

⁷⁶ Louis Dupre, ‘The Mystical Experience of the Self and Its Philosophical Significance’, in Woods, *op.cit.*, p. 457.

⁷⁷ Evelyn Underhill, ‘The Mystic as Creative Artist’, in Woods, *op.cit.*, pp. 400-414.

⁷⁸ Dupre, *op.cit.*, in Woods, *op.cit.*, p. 458.

Some analysts deal with the problem by focussing on the emotional aspects of mystical experience, and the “consciousness of close communion with God” is presented as being the primary aspect of mystical experience. Seemingly hallucinatory experience is relegated to a secondary role of lesser importance:

Among these symbols we must reckon a large number of the secondary phenomena of mysticism: divine visions and voices, and other dramatisations of the self's apprehensions and desires. The best mystics have always recognised the doubtful nature of these so-called divine revelations and favours, and have tried again and again to set up tests for discerning those which really ‘come from God’ i.e. mediate a valid spiritual experience.⁷⁹

However, some of the ‘best mystics’, i.e. those whose mystical experiences have been incorporated into the lore of mainstream religions, have been unequivocal about the significance of their voices and visions. John of Ephesus, for instance, the author of the Book of Revelation in the New Testament, relates how he was on the Isle of Patmos and,

was in the Spirit on the Lord's day, and heard behind me a great voice, as of a trumpet, saying, ‘I am Alpha and Omega, the first and the last’, and ‘What thou seest, write in a book’ And I turned to see the voice that spoke to me. And being turned, I saw seven golden candlesticks; and in the midst of the seven candlesticks one like unto the Son of Man, clothed with a garment down to the foot, and girt about the paps with a golden girdle.⁸⁰

Mohammed, the founder of the Islamic religion, is reported by Moslem writers to have spent many years in contemplation before a mystical experience gave him the necessary insights to launch a major religion. The mystical experience involved a vision of the angel Gabriel who asked Mohammed to read instructions written on cloth:

He was passing the month of Ramadan in the cavern of Mount Hara, endeavouring by fasting, prayer and solitary meditation to elevate his thoughts to the contemplation of divine truth. As Mohammed lay wrapped in his mantle he heard a voice calling upon him. Uncovering his head a flood of light broke upon him in such intolerable splendour that he swooned. On regaining his senses he beheld an angel in human form, which, approaching from a distance, displayed a silken cloth covered with written characters.⁸¹

⁷⁹ Evelyn Underhill, ‘The Essentials of Mysticism’, in Woods, *op.cit.*, p. 38.

⁸⁰ ‘The Revelation of Jesus Christ’, in Ernest Sutherland Bates, ed., *The Bible Designed To Be Read As Literature*, William Heinemann, London, 1920, p. 1198.

⁸¹ Washington Irving, *Life of Mohammed*, Bell and Daldy, London 1869, quoted in Bucke, *op.cit.*, p. 126.

Moses' inspiration to lead the Hebrews out of slavery in Egypt came from a mystical encounter with God as he tended his flock of sheep in the desert:

... he came to the mountain of God, even to Horeb. And the angel of the Lord appeared unto him in a flame of fire out of the midst of a bush: and he looked, and, behold, the bush burned with fire, and the bush was not consumed. And Moses said, "I will now turn aside, and see this great sight, why the bush is not burnt." And when the Lord saw that he turned aside to see, God called to him out of the midst of the bush, and said, "Moses, Moses."⁸²

Moses' 'hallucinations' covered a considerable range in this encounter with God. He was given a messianic mission and as evidence that he would have the persuasive power necessary to fulfil the role he was led to believe he had been given a magical ability to turn his rod into a snake and to induce the symptoms of leprosy by putting "his arm into his bosom".⁸³

The New Testament provides ample evidence that the 'best mystics' are not immune to encountering visions and voices in their mystical experiences. John the Baptist had been instructed by a mystical presence to baptise people in the River Jordan and to persevere in this task until he encountered a person "upon whom thou shalt see the Spirit descending,"⁸⁴

And it came to pass in those days, that Jesus came from Nazareth of Galilee, and was baptised of John in Jordan. And straight away coming up out of the water, he saw the heavens opened, and the spirit like a dove descending upon him: and there came a voice from heaven, saying, "Thou art my beloved Son, in whom I am well pleased."⁸⁵

George Fox, the founder of the Quaker religion,⁸⁶ left a diary with many accounts of his mystical experiences, some of which involved visions and voices. He relates how, on one occasion, he separated from friends to pay a solitary visit to the city of Lichfield in England.

I was commanded by the Lord to pull off my shoes. I stood still for it was winter: but the word of the Lord was like a fire in me. So I put off my shoes and left them with the shepherds; and the poor shepherds trembled, and were astonished. Then I walked on about a mile, and as soon as I got within the city, the word of the Lord came to me again, saying: Cry, 'Wo to the bloody city of Lichfield!' So I went up and down the streets, crying with a loud voice, Wo to the bloody city of Lichfield! It being market

⁸² The Book of Exodus, in Bates, op.cit., p. 82.

⁸³ Ibid., p. 83.

⁸⁴ The Gospel According To John, in Bates, op.cit., p. 1008.

⁸⁵ The Gospel According To Mark, in Bates, op.cit., p. 902.

⁸⁶ James, op.cit., p. 30.

day, I went into the market-place, and to and fro in the several parts of it, and made stands, crying as before, Wo to the bloody city of Lichfield! And no one laid hands on me. As I went thus crying through the streets, there seemed to me to be a channel of blood running down the streets, and the market-place appeared like a pool of blood.⁸⁷

In The Varieties of Religious Experience William James shows considerable respect for George Fox's mystical accomplishments and his contribution to religious understanding. James returns repeatedly to Fox's Journal to demonstrate finer points of religious understanding. By way of explaining Fox's unusual behaviour in Lichfield James writes:

No one can pretend for a moment that in point of spiritual sagacity and capacity, Fox's mind was unsound. Everyone who confronted him personally, from Oliver Cromwell down to county magistrates and jailers, seems to have acknowledged his superior power. Yet from the point of view of his nervous constitution, Fox was a psychopath⁸⁸ or *détraqué* of the deepest dye.⁸⁹

James was a medical practitioner and a psychologist and The Varieties of Religious Experience came out of a lecture series he gave at Edinburgh University in 1901-02. His assessment that Fox had soundness of mind in regard to spiritual judgement but that his nervous constitution, as indicated by the Lichfield behaviour, was psychopathic, supports the basic contention of the mystical model which argues that mental health professionals are predisposed to label mystics as mentally ill people. In James' case this is done in spite of the recognition given to the value of Fox's mysticism. This raises the interesting question as to whether James would have offered treatment to Fox, at the possible risk of undermining his mystical capacity, had the two men lived at the same time and made contact with one another.

Mysticism and Psychiatry

James was not the only mental health professional living around the turn of the 20th century who made a link between mysticism and mental illness. Richard Maurice Bucke was a late-19th century Canadian psychiatrist who published a book in 1901 entitled Cosmic Consciousness.⁹⁰ In the book Bucke outlined a theory about the evolution of consciousness which he had developed from a mixture of sources including observations made of his patients, analyses of literature, and self-

⁸⁷ George Fox, 'Journal', quoted in *ibid.*, pp. 30-31.

⁸⁸ Psychopath has been used during the 20th century to describe a specific non-psychotic mental disorder that has since been renamed and now appears as 'antisocial personality disorder' in the DSM IV.

However, this technical usage for 'psychopath' was only adopted after the time in which James wrote the comments quoted above. It is fair to assume that James used 'psychopath' here as a generic term for mental illness and that what is now called schizophrenia can be included in this generalisation.

⁸⁹ James, *op.cit.*, p. 30.

⁹⁰ Bucke, *op.cit.*

examination of his own mental functioning. The theory not only linked mysticism and mental illness but also fitted them both into an evolutionary context.

Bucke's hypothesis was that human consciousness is engaged in an evolutionary process and is slowly moving through three distinct phases of development. The first stage he called 'simple consciousness',⁹¹ which he described as being concerned with sense perceptions. This primary level of consciousness is shared with other animals and was the only kind of consciousness available to our humanoid ancestors.

According to Bucke humans became distinguished from other animals by growing into a second level of development he called 'self consciousness'.⁹² Most modern people live on this second level of consciousness but, according to Bucke, a third possibility is also available. He argued that there is a higher level of understanding, above self consciousness, which he called 'cosmic consciousness', and that its attainment is an evolutionary step above the current human status.

Bucke believed that only a select few individuals had so far experienced cosmic consciousness but he claimed to have had his own first hand experience of it. Speaking disconcertingly of himself in the third person he wrote the following description of his own mystical experience by which he was introduced to this higher level of consciousness.

He was in a state of quiet, almost passive enjoyment. All at once, without warning of any kind, he found himself wrapped around as it were by a flame-coloured cloud. For an instant he thought of fire, some sudden conflagration in the great city; the next, he knew that the light was within himself. Directly afterwards came upon him a sense of exultation, of immense joyousness accompanied or immediately followed by an intellectual illumination quite impossible to describe. Into his brain streamed one momentary lightning-flash of the Brahmic Splendour which has ever since lightened his life; upon his heart fell one drop of Brahmic Bliss, leaving thence-forward for always an aftertaste of heaven. Among other things he did come to believe, he saw and knew that the Cosmos is not dead matter but a living Presence, that the soul of man is immortal, that the universe is so built and ordered that without any peradventure all things work together for the good of each and all, that the foundation principle of the world is what we call love and that the happiness of everyone is in the long run absolutely certain.⁹³

The above description should not be dismissed as a compromising confession of mental instability from a dweller on the fringe of the psychiatric profession. At the time Bucke wrote about his experience he was at the height of a highly successful career. Between 1876 and 1890 he held posts

⁹¹ *Ibid.*, p. 1.

⁹² *Ibid.*, p. 1.

⁹³ *Ibid.*, pp. 9-10.

as Superintendent of the Provincial Asylum for the Insane at Hamilton and Superintendent of the London (Ontario) Hospital. He was also made Professor of Mental and Nervous Diseases at Western University (London, Ontario), and elected President of the Psychological Section of the British Medical Association and President of the American Medico-Psychological Association.⁹⁴

In his time Bucke was considered “one of the foremost alienists”⁹⁵ on the North American continent. The description of his mystical experience, far from being an embarrassment to him, was written up separately as a scientific account of unusual psychological phenomena and appeared in the Proceedings and Transactions of the Royal Society of Canada.⁹⁶

Bucke’s book is divided into six parts. The first three parts lay down the foundations of his theory. Part IV is concerned with demonstrating that a number of historical figures, most of whom were poets or the founders of major religions, had experienced unusual mental phenomena, which he claimed are instances of cosmic consciousness. He largely relied on interpreting their writing, or accounts of their lives and experiences, to provide the evidence. The list includes such names as Gautama the Buddha, Jesus, Mohammed, Dante, Francis Bacon (also known as William Shakespeare according to Bucke) and William Blake.

Part V of the book is a similar examination of a longer list of “Additional—some of Them Lesser, Imperfect, and Doubtful Instances”⁹⁷ of cosmically conscious individuals. This list is also largely comprised of poets and religious figures but it also includes thirteen people who were contemporaries of Bucke and whose identities he concealed by only referring to them by their initials. Some of the accounts given of the lives and experiences of these people indicate they had sought medical advice and, although Bucke doesn’t directly say so, it is fair to assume that at least some of them might have been Bucke’s own patients.

Bucke observed that people who had undergone mystical experience often developed difficulties relating to other people and that throughout history they have been “either exalted, by the average self conscious individual, to the rank of gods, or, adopting the other extreme, are adjudged insane”.⁹⁸ Bucke believed he had found a solution to this problem by defining them as ordinary people who had simply taken an evolutionary step that all humans would inevitably take, sooner or later.

⁹⁴ George Moreby Acklom, “The Man and the Book”, introduction to ibid.

⁹⁵ Ibid.

⁹⁶ Richard Maurice Bucke, Proceedings and Transactions of the Royal Society of Canada, Series II, Vol. 12, pp. 159-196, cited in Ibid.

⁹⁷ Bucke, Cosmic Consciousness, op.cit., p. 255.

⁹⁸ Ibid., p. 3.

It may be technically incorrect to identify Bucke as the originator of the mystical model for schizophrenia. Bucke, after all, developed his theory before the modern understanding of schizophrenia had been formulated. His book on cosmic consciousness was published some ten years before Bleuler's monograph, in which the term schizophrenia was first used, and Kraepelin's earlier criteria for dementia praecox described a condition that ended in a long-term slide into dementia, which did not fit Bucke's description of cosmic consciousness. However, when Bucke's accounts of cosmic consciousness are compared with modern psychiatric descriptions of the symptoms of acute schizophrenic episodes, involving delusions and hallucinations, the similarity is inescapable.

Bucke devoted a chapter to the Apostle Paul, for instance, and reproduces numerous extracts from biblical sources which refer to Paul's mystical experiences. His vision on the road to Damascus is well known:

And it came to pass, that as I made my journey, and drew nigh unto Damascus, about noon, suddenly there shone from heaven a great light round about me. And I fell unto the ground, and heard a voice saying to me, **Saul, Saul, why persecutest thou me?** And I answered, Who art thou, Lord? And he said unto me, **I am Jesus of Nazareth whom thou persecutest:** And they that were with me beheld indeed the light, but they heard not the voice of him that spake to me. and I said, What shall I do, Lord? And the Lord said unto me, **Arise, and go into Damascus. And there it shall be told unto thee of all things which are appointed for thee to do.** And when I could not see for the glory of that light, being led by the hand of them that were with me, I came into Damascus.⁹⁹

A modern person who described to a psychiatrist such an experience, involving a vision of light and the hearing of Jesus' voice, would, almost certainly, be diagnosed as suffering from schizophrenia.

Anti-Psychiatry, Laing and the Mystical Model

The widespread interest in psychic and mystical interpretations of mental phenomena, which was apparent around the turn of the century, largely lapsed into indifference as the 20th century progressed. The mystical model for explaining the symptoms of schizophrenia didn't properly come to the surface until the 1960s with the advent of the anti-psychiatry movement. The anti-psychiatry movement was largely born out of the spirit of anti-establishment protest that characterised this era and the "furious rebellion" of antipsychiatry against conventional psychiatric models "was like a lightning rod for the key ideas of the time, combining Sartre, Jung and Gregory Bateson into a perfect model of Rousseallian humanism for the counter-culture of the 1960s".¹⁰⁰

⁹⁹ Acts of the Apostles, quoted in *ibid.*, p. 114.

¹⁰⁰ Carole Angier, 'R. D. Laing: A Divided Self', *New Statesman*, Vol. 25, No. 4294, 26 July, 1996, p. 46.

The unifying principle of the anti-psychiatry movement was a view that psychiatric practice is a form of social control. However, although there was agreement on the need to curb this aspect of psychiatry there were still a number of diverse positions taken within the antipsychiatry movement on the interpretation of schizophrenic symptoms. The mystical model was only one of these positions.

The two major figures that emerged as leading polemicists for the anti-psychiatry movement were themselves both psychiatrists: Ronald D. Laing in the UK and Thomas Szasz in the US. A mystical interpretation of schizophrenia, in so much as it confirms the reality of abnormal mental experience, is anathema to Thomas Szasz's point of view. Szasz's view of the symptoms is that they are actually non-existent. His explanations as to why these mythical symptoms are persistently reported are two-fold: sometimes they are trumped up, heresy-like accusations levelled by the state against irritating citizens,¹⁰¹ in order to control them; and at other times they are the theatrically expressed fantasies of predatory, attention-seeking individuals.¹⁰² Szasz believes that schizophrenia is a myth and his theory will be closely examined in Chapter 8.

While Szasz is the leading light of the myth-of-mental-illness model, R. D. Laing, on the other hand, became the godfather of the mystical model:

Certain *transcendental experiences* seem to me to be the original well-spring of all religions. Some psychotic people have transcendental experiences. Often (to the best of their recollection), they have never had such experiences before, and frequently they will never have them again.¹⁰³

Although Laing was not certain that schizophrenia was the best route into mystical experience¹⁰⁴ he became convinced that the mystical model was the best interpretation of the schizophrenic experience. Laing appears to have been influenced by something Gregory Bateson wrote in a "brilliant introduction to a nineteenth-century autobiographical account of schizophrenia."¹⁰⁵ Bateson likened a person experiencing schizophrenic symptoms to an explorer "embarked on a voyage of discovery which is only completed by his return to the normal world, to which he comes

¹⁰¹ Thomas Szasz, *Schizophrenia: Sacred Symbol of Psychiatry*, Basic Books, New York, 1976.

¹⁰² Thomas Szasz, *Cruel Compassion: Psychiatric Control of Society's Unwanted*, John Wiley and Sons, New York, 1994, p. 145.

¹⁰³ Laing, *op.cit.*, p. 112.

¹⁰⁴ *Ibid.*

¹⁰⁵ *Ibid.*, p. 97.

back with insights different from those of the inhabitants who never embarked on such a voyage".¹⁰⁶

Laing's own favoured metaphor begins with a dichotomy which he sees as having given rise in the human condition to "the split of our experience into what seems to be two worlds, inner and outer".¹⁰⁷ The outer world is the world of normal experience whereas the inner world is the venue for the unusual experiences encountered by schizophrenics and mystics. To Laing any separation of these two worlds is artificial and "the process of entering into the other world from this world, and returning to this world from the other world, is as natural as death and giving birth or being born."¹⁰⁸

Taking up Bateson's motif of a journey to describe the schizophrenic experience Laing himself speculated that:

The journey is experienced as going further 'in', as going back through one's personal life, in and back and through and beyond into the experience of all mankind, of the primal man, of Adam and perhaps even further into the being of animals, vegetables and minerals.

In this journey there are many occasions to lose one's way, for confusion, partial failure, even final shipwreck: many terrors, spirits, demons to be encountered, that may or may not be overcome.

We do not regard it as pathologically deviant to explore a jungle, or to climb Mount Everest. We are far more out of touch with even the nearest approaches of the infinite reaches of inner space than we now are with the reaches of outer space. We respect the voyager, the explorer, the climber, the space man. It makes far more sense to me as a valid project - indeed as a desperately urgently required project of our time, to explore the inner space and time of consciousness. Perhaps this is one of the few things that still make sense in our historical context. We are so out of touch with this realm that many people can now argue seriously that it does not exist. It is very small wonder that it is perilous indeed to explore such a lost realm.¹⁰⁹

Speaking about schizophrenics who have inadvertently lost themselves in this inner world Laing says: "This is where the person sitting in a chair labelled catatonic has often gone. He is not at all here: he is all there. He is frequently very mistaken about what he is experiencing, and probably

¹⁰⁶ Gregory Bateson, ed., Perceval's Narrative. A Patient's Account of his Psychosis, Stamford University Press, Stamford, 1961, p. xiii.

¹⁰⁷ Laing, op.cit., p. 103.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid., pp. 104-105.

does not want to experience it. There are very few of us who know the territory in which he is lost, who know how to reach him, and how to find the way back.”¹¹⁰

Laing was very concerned with the approach of normal psychiatric practice, which he called “a degradation ceremonial”.¹¹¹ He believed that a new approach, an “initiation ceremonial”, should be developed for “those who are about to go into a schizophrenic breakdown”.¹¹² Laing argued that psychiatrists and psychiatric treatment should be replaced by guides who have themselves been on the inner journey: “Psychiatrically, this would appear as ex-patients helping future patients to go mad.”¹¹³

He summarised his view of a mystical interpretation of schizophrenia in point form:

- (i) a voyage from the outer to the inner,
 - (ii) from life to a kind of death,
 - (iii) from going forward to going back,
 - (iv) from temporal movement to temporal standstill,
 - (v) from mundane time to aeonic time,
 - (vi) from the ego to the self,
 - (vii) from being outside (post-birth) back into the womb of all things (pre-birth),
- and then subsequently a return voyage from
- (1) inner to outer,
 - (2) from death to life,
 - (3) from the movement back to a movement once more forward,
 - (4) from immortality back to mortality,
 - (5) from eternity back to time,
 - (6) from self to a new ego,
 - (7) from a cosmic foetalization to an existential rebirth.¹¹⁴

Laing likened returning schizophrenics to lost explorers of the Renaissance, who eventually found their way home, and he argued that schizophrenics deserved no less respect than was accorded to these explorers.¹¹⁵ But there seems to be a pessimistic streak motivating some of Laing’s thinking and he implies that schizophrenia might play some kind of essential role of renewal for the human race: “If the human race survives, future men will, I suspect, look back on our enlightened epoch as

¹¹⁰ *Ibid.*, p. 105.

¹¹¹ *Ibid.*, p. 106.

¹¹² *Ibid.*

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*, p. 107.

a veritable age of Darkness. They will see that what we call 'schizophrenia' was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds."¹¹⁶

Laing was scathing in his criticism of psychiatric practice when it is informed by a belief in a biological cause for schizophrenia:

The ways of losing one's way are legion. Madness is certainly not the least unambiguous. The counter-madness of Kraepelinian psychiatry is the exact counterpart of 'official' psychosis. Literally, and absolutely seriously, it is as *mad*, if by madness we mean any radical estrangement from the totality of what is the case.¹¹⁷

Laing himself was not very popular amongst his psychiatric peers and most of his following came from the anti-establishment new left of politics, which was surging at this time:¹¹⁸ "We may see the growth of his ideas as a progressive and serial challenging of the whole catalogue of schizoid 'symptoms' that is customarily presented in psychiatric textbooks."¹¹⁹ This challenging, it was observed, began to show evidence that Laing was not only viewing his schizophrenic patients as mystical voyagers but that he was, himself, personally engaged in mystical pursuit. Appended to the Penguin edition of his 1967 book, The Politics of Experience, was a short autobiographical fragment entitled The Bird of Paradise. This piece was written in the first person and described an inner journey. Commentators have speculated that it may have been either an experimental attempt to describe the schizophrenic experience of one of his patients or, alternatively, it could have been an account of a brief psychotic experience that Laing had actually undergone himself.¹²⁰

In 1971 Laing surprised both his psychiatric colleagues and his new left followers by withdrawing from psychiatric practice and departing for Sri Lanka. In Sri Lanka he set about devoting himself entirely to the mystical pursuit of Buddhist meditation. An academic from the Anthropology Department of Syracuse University, who encountered him there towards the end of 1971, wrote that Laing,

has virtually broken his bridges with things British and psychiatric. He is not only doing Theravada Buddhist meditation there — he does it seventeen hours a day, for the past five months. He spent six weeks in a training monastery in Kandubodda, in central

¹¹⁶ Ibid.

¹¹⁷ Ibid., p. 117.

¹¹⁸ Peter Sedgwick, 'R. D. Laing: self, symptom and society', in Robert Boyers and Robert Orrill, eds., Laing and Anti-Psychiatry, Penguin, Harmondsworth, 1972, pp. 17-22.

¹¹⁹ Ibid., p. 41.

¹²⁰ Ibid., p. 39.

Ceylon, and the senior monk there told me that Laing has been doing better, much better, than long-time meditation experts, Singhalese Buddhist as well as foreign.¹²¹

But Laing was back on the lecture circuit in the United States and Europe in less than a year. In his meditations he had been visited by a vision of a new solution to the problem of the human condition. Adults, he claimed, are haunted throughout their lives by fragmented memories of their own conception, fetal life and birth experiences. He preached a new panacea in the therapeutic 'rebirthing experience'. Of his own birth he said:

I can remember it happening to me as a body blow, a searing pain, a complete total organismic reflex ... which took my breath away before I got my breath, and produced a triple red light . . . quite suddenly the only status quo I knew was, within seconds--the time it took for the scissors and clamp to sever that connection--abruptly ended . . . being born was an experience I certainly wouldn't like to repeat.¹²²

Psychiatric theories are subject to changing fashions in social thought and Laing's approaches to psychiatric issues have now become decidedly unfashionable. One observer of psychiatric trends, writing in the mid-1990s, even had difficulty in understanding why anybody had taken Laing seriously in the first place:

But how, how could intelligent and literate college students, professors, and physicians take such nonsense seriously? It had to be the times. Large public mental hospitals were an abomination. Vietnamese were being bombed into smithereens to 'free' them from oppression. Heads of government lied to their peoples cavalierly. Reason had not worked in an age of unreason; perhaps mysticism, raw emotion, transcendental experiences, primal screams, or rebirthing would.¹²³

Jung

Laing's latter career-move to mystical self-immersion, however, is not the rule amongst advocates of the mystical model for schizophrenia. Some of the more significant psychiatric advocates of the mystical model have been fairly sober-minded Jungians. One of these, John Weir Perry, is perhaps the most articulate mystical advocate of all. However, before describing Perry's approach it might be wise to briefly discuss Jung's own interpretation of schizophrenic symptoms. The reason for this is that although some Jungians, like Perry, have theoretical approaches that clearly fall within the mystical model, Jung's own theories can not be so easily placed.

¹²¹ Ageha Bharati, 'Letter to Peter Sedgwick', November, 1971, reproduced in, *Ibid.*, p. 46.

¹²² Leon Eisenberg, 'R. D. Laing: A Biography', *The Lancet*, Vol. 344, No. 8927, 1 October, 1994, p. 939.

¹²³ *Ibid.*

Jung spent most of his long career wavering within the medical model, first favouring the biological interpretation, and then the experiential/environmental interpretation. Finally, towards the end of his career, he found a way to integrate both, along with the essential mythological components of the mystical model. The full complexity of his theory is often not adhered to by modern Jungians and, through selecting only certain parts of his theory, Jungians find they can accommodate themselves to both the mystical and medical models.

In a volume entitled The Psychogenesis of Mental Disease¹²⁴ a collection of Jung's scientific papers is to be found which span more than half a century of publication. The collection includes a number of papers which, when read in the sequence of their publication, provide a guide to the evolution of Jung's thinking on the aetiology of schizophrenia.

As a young man Jung studied under Professor Bleuler at the Burgholzli hospital in Zurich, where he was an assistant physician. Under Bleuler's guidance Jung chose for his doctoral dissertation to "investigate experimentally the disintegration of ideas in schizophrenia".¹²⁵ In 1907 he published a paper entitled The Psychology of Dementia Praecox¹²⁶ in which he set forth the knowledge he had accumulated on the subject. (This was shortly before Bleuler gave the condition its modern name of schizophrenia.) The publication of Jung's paper had a considerable impact and firmly established his reputation as a psychiatric researcher. It also brought Jung to the attention of Freud and led to their first meeting.¹²⁷

In this paper Jung continued Kraepelin's work of delineating the boundaries of the mental disease which was soon to become known as schizophrenia, and which was then generally assumed to have a biological cause. Some of Jung's most interesting assertions are concerned with a symptom he called "affectations". He argued that affectations involved phenomena like "mannerism, eccentricity, and mania for originality"¹²⁸ and were often encountered in people who were out of their social element.

A very common form of this affectation is the pretentious and artificial behaviour of women of a lower social position — dressmakers, nurses, maids, etc. — who mix with those socially above them, and also of men who are dissatisfied with their social status and try to give themselves at least the appearance of a better education or a more imposing position.¹²⁹

¹²⁴ C. G. Jung, The Psychogenesis of Mental Disease, R. F. C. Hull, trans., Routledge and Kegan Paul, London, 1960.

¹²⁵ C. G. Jung, 'Schizophrenia', in Ibid., p. 256.

¹²⁶ C. G. Jung, 'The Psychology of Dementia Praecox', in Jung, op.cit., pp. 1-153.

¹²⁷ Ibid., p. v.

¹²⁸ Ibid., p. 75.

¹²⁹ Ibid.

What is noteworthy here is that it apparently was not so much the affectations, in themselves, that Jung believed gave indication of a dysfunctional brain. He apparently found no symptoms of pathology when people of elevated social status demonstrated affectations. The brain dysfunction was only indicated when lower class people used affectations that were inappropriate for the class to which they belonged.

Jung's cavalier attitude towards power relationships, and his belief that a reluctance to adopt submissive postures was indicative of dementia praecox pathology, is evident elsewhere in this paper. At one stage he discusses "the characteristic lack of *emotional rapport* in dementia praecox",¹³⁰ which he compares to that which is found in hysteria, and explains that it is only through having this emotional rapport that an analyst can penetrate the mind of the patient and gain moral power over them. He likens this process of gaining moral power over a patient to that of "ordinary confessions".¹³¹ But he goes on to lament that dementia praecox "patients cannot feel their way into the mind of the doctor, they stick to their delusional assertions, they attribute hostile motives to the analyst, they are and remain, in a word, uninfluenceable."¹³² Quite possibly it was Jung's inability to influence this type of person that contributed to his belief at this time in a biological cause for the condition.

By 1914 Jung's thinking had advanced beyond his original class-oriented view. In a paper entitled The Content of the Psychoses¹³³ he observed that "psychiatry is a stepchild of medicine" and that unlike other branches of medicine it did not have ready access to the scientific method.¹³⁴ This was because psychiatry had to deal with problems that lie beyond the brain in the "psyche, as indefinable as ever, still eluding explanation, no matter how ingenious".¹³⁵ Jung was now ready to scoff at the "dogma which you will find repeated in every text-book of psychiatry: 'Mental diseases are diseases of the brain'".¹³⁶ This critique was reiterated in a 1919 paper entitled On the Problem of Psychogenesis in which he called the brain disease interpretation "materialistic dogma".¹³⁷

In a 1928 paper, Mental Disease and the Psyche, Jung was able to state firmly that "schizophrenia has a 'psychology', i.e. a psychic causality and finality, just as normal mental life has".¹³⁸ But by 1939 he was beginning to waver in his certainty that there was no biological component in

¹³⁰ Ibid., p. 74.

¹³¹ Ibid.

¹³² Ibid.

¹³³ C. G. Jung, 'The Content of the Psychoses', in Jung, op.cit., 153-178.

¹³⁴ Ibid., p. 158.

¹³⁵ Ibid.

¹³⁶ Ibid., p. 159.

¹³⁷ C. G. Jung, 'On the Problem of Psychogenesis', in Jung, op.cit., p. 211.

¹³⁸ C. G. Jung, 'Mental Disease and the Psyche', in Jung, op.cit., p. 227.

schizophrenia. In a paper entitled On the Psychogenesis of Schizophrenia Jung began by agreeing with his former mentor, Bleuler, that there are primary and secondary symptoms for schizophrenia. Jung argued that while the secondary symptoms “are due chiefly to psychic causes”¹³⁹ he was less certain about the cause of the primary symptom, which Bleuler had nominated as being “a peculiar disturbance of the association-process.”¹⁴⁰

Musing over the lessons of his youth Jung wrote: “My teacher, Eugen Bleuler, used to say that a psychological cause can produce only the symptoms of the disease, but not the disease itself.”¹⁴¹ Jung summed up his equivocation at this time by arguing that “it is well-nigh impossible to prove, even approximately, that schizophrenia is an organic disease to begin with. It is equally impossible to make its exclusively psychological origin evident”.¹⁴²

It was not until 1956 that equivocation between a biological and a psychological origin produced a synthesis, which could also take into account mystical considerations. In Recent Thoughts on Schizophrenia¹⁴³ Jung categorically asserted that “this condition has two aspects of paramount importance, biochemical and psychological”.¹⁴⁴ He added that he had proved fifty years ago that it could be treated by psychotherapy. He argued that the contents of schizophrenic experience were like those of a significant dream, what he called a “big dream”.

Unlike ordinary dreams, such a dream is highly impressive, numinous, and its imagery frequently makes use of motifs analogous to or even identical with those of mythology. I call these structures *archetypes* because they function in a way similar to instinctual patterns of behaviour.¹⁴⁵

Jung believed that the archetypes are probably “the psychic expressions or manifestations of instinct”¹⁴⁶ and that schizophrenia is caused when they are released into consciousness by the effect of an unknown toxin in the brain. He further argued that future research into schizophrenia will require a two-pronged effort:

Whereas the problem of a specific toxin presents a task for clinical psychiatry on account of its formal aspects, the question of the *contents* of schizophrenia and their meaning presents an equally important task for the psychopathologist as well as the psychologist of the future.¹⁴⁷

¹³⁹ C. G. Jung, ‘On the Psychogenesis of Schizophrenia’, in Jung, op.cit., p. 234.

¹⁴⁰ Ibid.

¹⁴¹ Ibid., p. 246.

¹⁴² Ibid., p. 245.

¹⁴³ C. G. Jung, ‘Recent Thoughts on Schizophrenia’, in Jung, op.cit., pp. 250-255.

¹⁴⁴ Ibid., p. 254.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid., p. 255.

¹⁴⁷ Ibid., p. 254.

Jung's view, which he further elaborated in another paper presented the following year, entitled Schizophrenia,¹⁴⁸ was essentially that stress triggered the release of a toxin, which he described as "a kind of mistaken biological defence-reaction".¹⁴⁹ When this happened the toxin could act in a way similar to hallucinogenic drugs like mescaline and, by penetrating a biological storage area in the brain, unlock the person's instincts and flood the conscious mind with archetypal images.

Jung's final theory is comprehensive, to say the least. It bridges both the medical and mystical models, and within the medical model it bridges the two main branches of biological and environmental explanations. It says that in the first instance the symptoms of stress are caused by environmental/experiential pressures and that when these are not addressed a toxin is released which switches the condition into a biological mode.

But it goes on to recognise a pattern of mythical archetypes in the phenomenological content of schizophrenic experience, whereas the medical model generally prefers to see them as random delusions and hallucinations produced by a malfunctioning brain. This recognition of mythological material might have placed Jung's theory within the mystical model except that he argues these archetypes are actually the raw material of instincts which, in normal circumstances, are locked away from conscious access in an unconscious biological storage area of the brain.

Although Jung's recognition of the mythical validity of schizophrenic images places him within the mystical model, the belief that they are accessed through the agency of a toxic brain chemical, rather than by transcendence of self-identity through mystical practice (or perhaps spontaneous collapse of self identity in the case of schizophrenics), simultaneously places Jung far outside the mystical model. Jung's is a kind of theory of everything in regard to schizophrenia and is a composite model. As a result Jungians are to be found practising therapies based on assumptions drawn from both the medical and the mystical models. One interesting Jungian theorist, who clearly practised within the mystical model, was John Weir Perry.

John Weir Perry — a Jungian

Perry trained at the C. G. Jung Institute in Zurich and, in the early 1970s, he was engaged in a US National Institute of Mental Health-sponsored programme looking at innovative methods of handling schizophrenia. Under this programme Perry established a treatment centre in San Francisco called Diabasis at which he had the opportunity to test his theories.

¹⁴⁸ C. G. Jung, 'Schizophrenia', in Jung, op.cit., pp. 256-271.

¹⁴⁹ Ibid., p. 271.

In a 1974 book entitled The Far Side of Madness¹⁵⁰ Perry gave an unequivocal account of schizophrenia as a mystical experience. In the Introduction he criticised conventional psychiatric approaches for their “interdiction against listening to the ‘patients’ nonrational concerns”.¹⁵¹ Perry recounts how a relative with personal experience of psychosis had told him early in his career that the most essential requirement of somebody experiencing schizophrenic symptoms was to have another person listen to a description of the internal experience. Perry appears to have listened to his patients much more closely than other psychiatrists and as a result he has found consistent patterns of mythological material in the symptoms.

But he hints at also having had the advantage of some first-hand experience of his own. He recounts some details of a conversation with a patient in which the woman described her descent into madness as being “a little like dying”. Perry recounts how he:

leapt at this statement to assure her that dying was just the point, that it is what has to happen when there is an urgent need for change. She responded, “Have you been through all this yourself? I’ve never met anyone as wise as you about these things.” I answered her question. I said, Yes, in a fashion I’d been through this, too; but my way was not in the involuntary experience of being overwhelmed by it as she was, but in intentionally dipping down into this same inner life to explore it; the inner experiences in that process were much the same, though.¹⁵²

It is not clear from that statement whether Perry is saying that he had once induced a significant mystical experience or whether, perhaps, he had experimented with LSD. But certainly it seems evident he believed that the symptoms of schizophrenia can be experienced voluntarily and that in these circumstances they can be beneficial to the person who experiences them.

Perry’s fundamental belief is that the human condition requires people to simultaneously live in two different dimensions. One is the familiar territory of the ego which deals in the mundane affairs of everyday life. The other is a reservoir containing “the great basic metaphors of the human experience” through which a person’s emotions can engage with worldly matters that are not yet fully conscious.¹⁵³

The latter is the mind into which one plummets when seized with madness. As Plato told us, it might be the divine frenzy of the seer or the revelation of the founder of religious forms, the inspiration of the artist or possession by a great love. And it might be a “schizophrenic” episode.¹⁵⁴

¹⁵⁰ Perry, op.cit.

¹⁵¹ Ibid., p. 2.

¹⁵² Ibid., p. 19.

¹⁵³ Ibid., p. 8.

¹⁵⁴ Ibid.

Perry theorised that schizophrenia manifests as a combination of the unconscious activating and the ego collapsing. This assessment fits closely with mystical practice in which the mystical aspirant deliberately activates the unconscious through techniques like word repetition and visualisations, while denying expression to the self-identity through ascetic practices like seclusion, celibacy and fasting.

The Far Side of Madness documents Perry's findings after analysing in depth the psychic experiences of twelve patients over a twelve year period between 1949-1961. The book identifies consistent patterns of myth, ritual, messianism and mysticism in the schizophrenic experiences of his patients. According to Perry the origins of these patterns are to be found in the kingship rituals of ancient Mesopotamia: "the ceremonial death and renewal of the year and of the sacral king and his kingdom, out of which other religious forms have differentiated and evolved in the centuries since".¹⁵⁵

The essence of Perry's theory is that civilisation, which began in ancient Mesopotamia, required the invention of specific rituals and myths in order to give collective guidance and continuity to the project. These rituals and myths became buried in the collective unconscious of the original city-dwellers. After the project was successfully launched in Mesopotamia the people of other civilisations, learning from the Mesopotamian model, absorbed in some osmotic manner, along with the urban way of life, the original Mesopotamian collective unconscious.

These rituals and myths now lie buried in the collective unconscious of all modern people where they act as a common denominator to give coherence to social organisation based around life in cities. When the individual ego of a person collapses, often through not being properly integrated into civic society, these archetypal myths and rituals flood into consciousness in an attempt to reinform the person. When this process is successful the effect is to reinvent the person's individual ego so that it can find a role that is better adjusted to the requirements of civic society.

The centrepiece of Perry's book is a table which he drew up to demonstrate the consistency of his twelve patients' inner experiences. This consistency indicates a pattern of conformity with one another as well as a uniformity of inspiration from the supposed Mesopotamian origins of the material.

¹⁵⁵ Ibid., p. 10.

Perry explains that the first commonality refers to the quality of a person's **Self-image** while the second indicates a perception by the schizophrenic person of a requirement to take part in some kind of **Drama or Ritual**. **World Center** relates to a belief that a certain location is the centre of the world or some kind of cosmic axis. **Death** is concerned with a perception of having died and of now existing in an after life. **Return to Beginning** is a regression back to evolutionary beginnings as well as the individual's own infancy. **Cosmic Conflict** involves taking part in a struggle between cosmic opposites variously represented by the forces of good and evil, light and darkness etc. **Threat of Opposite** is a perception that the opposite sex is somehow going to overwhelm the person. **Apotheosis** involves a belief in being transformed into a deity, royalty, hero, saint or messiah. **Sacred Marriage** is the psychic experience of marriage to a God or a Goddess, or a mythological, ritual or religious figure of significance. **New Birth** concerns the rebirth of the individual or the promised birth of a world redeemer. **New Society** is the vision of a new social order — the New Age, New Jerusalem, a Utopia. **Quadrated World** is “a fourfold structure of the world or cosmos, usually represented in the form of a quadrated circle (four continents or quarters; four political factions, governments, or nations; four races or religions; four persons of the godhead; four elements or states of being)”.¹⁵⁶

A lot of Perry's book is concerned with explaining the relationships between these common schizophrenic experiences and the mythology of ancient Mesopotamia. A curious aspect that should be noted, considering Perry's suggestion that he has had his own personal experience of mysticism, is the repetition of the number twelve in his analysis. He says that he conducted an in-depth study on twelve patients between 1949-1961 (twelve years), and his table reveals he uncovered twelve common symptoms amongst these patients.

¹⁵⁶ *Ibid.*, pp. 29-30.

Numerical patterns, and the quest for numerical patterns, are common themes of mystical experience. A prime example of this tendency can be found in Plato's The Republic in the form of what academic analysts call the *nuptial number*.¹⁵⁷ (Plato's number mysticism here is concerned with observing cycles of time so as to ensure the maintenance of an ideal society). Although he does not discuss the nuptial number Perry makes a number of references to Plato throughout his book, sometimes quoting him at length. It would seem fair to assume that Perry was aware during the period of his research of the frequent appearance of numerical patterns in mystically oriented writing. It is therefore perhaps significant that he does not mention having observed this tendency in his patients.

There are at least two points to consider here. One is the question of whether Perry's failure to observe numerical obsessions in schizophrenic patients indicates any differential between schizophrenic symptoms and mystical experience. To properly answer this question would require specialised research far beyond the scope of this thesis and the issue has only arisen because of the presence of the more relevant second question.

The second question concerns the nature of psychiatric researchers of the mystical model and whether the pattern of twelves in Perry's research is any more than coincidence. If it were found to be deliberate, and the pattern of twelves turned out to be the result of a mystical insight of Perry's, then this might cast Perry in an interesting light as a psychiatric researcher. Most number mysticism is concerned with a search for patterns of time and usually involves, either directly or indirectly, the transmission of secret, sacred or ritualistic calendars. The number twelve often figures prominently in these affairs since it is usually a part of the basic formula for harmonising lunar and solar cycles, there being twelve and a fraction lunations in a solar year. But if Perry was indeed making a mystical point of his own any further clues he might have left are difficult to find. (Except, perhaps, that the book is written in twelve chapters.)

In a more recent interview¹⁵⁸ Perry made clear his approach to the treatment of schizophrenia. He said that he agreed with Jung's belief that schizophrenia is not really amenable to psychiatric control, (although Jung clearly believed it could be treated with psychotherapy), and that for therapeutic purposes the best interpretation of the condition is that it is itself a spontaneous healing process. In his opinion the term sickness could only be applied to the pre-psychotic personality, which can be seen as standing in need of reorganisation.

¹⁵⁷ Plato, op.cit., p. 360.

¹⁵⁸ John Weir Perry, interview with Michael O'Callaghan, reproduced in Global Vision, 1992-1995, accessed 14 September 1997, Available URL, <http://www.ige.apc.org/glencree/dreamch2.html>

The way “schizophrenia” unfolds is that, in a situation of personal crisis, all the psyche’s energy is sucked back out of the personal conscious area, into what we call the archetypal area. Mythic contents thus emerge from the deepest level of the psyche, in order to re-organise the Self. In so doing, the person feels himself withdrawing from the ordinary surroundings, and becomes quite isolated in this dream state. The whole schizophrenic turmoil is really a self-organising, healing experience. It's like a molten state. Everything seems to be made of free energy, an inner free play of imagery through which the alienated psyche spontaneously re-organises itself - in such a way that the conscious ego is brought back into communication with the unconscious again.¹⁵⁹

Perry claimed that, in the absence of psychiatric intervention, the acute phase of the schizophrenic experience normally only lasted six weeks. He argued this was confirmed by the biblical tradition of forty days in the wilderness. He said that in his experience this pattern was so universal that he had formed the opinion that chronic schizophrenia, in which a person has recurring crises over a lifetime, was socially constructed by intolerance encountered during the first acute phase.¹⁶⁰

The great surprise to Perry was to discover that people experiencing these symptoms were largely more concerned about cultural and social issues than with their own personal affairs. He says that his Freudian training in medical school had not prepared him for this and that when Jung had informed him about it he had at first been sceptical. But after he observed the phenomenon for himself he says it became the primary reason for developing his alternative methods of handling people in acute crisis:

Our new understanding shows that the process of re-connection to the unconscious, which these millions of people go through in a way that's usually so very hazardous, isolated and uncreative, is nonetheless made up of the same stuff as seers, visionaries, cultural reformers and prophets go through.¹⁶¹

When traditional societies are overtaken by a crisis of confidence in their established cultural patterns, according to Perry, they are likely to produce messiahs, seers and prophets who have caught a glimpse of a new myth-form and who endeavour to transmit it to the people at large. If the new myth-form is successful it will give new direction and purpose to the society.¹⁶² Most modern societies are constantly changing and are therefore in constant crisis, at least in mythological terms.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² Ibid.

To Perry people in modern societies who manifest schizophrenic symptoms are struggling to fulfil the same function as the seers in traditional societies. As evidence he cites the observation that the specific nature of the opposing forces of good and evil, and the messianic function perceived by schizophrenic individuals, has been changing from one decade to another in accordance with the shifting cultural crisis of modern America. In the 1950s, for instance, the primary schizophrenic concern was with the preservation of democracy in the face of a challenge from communism. In the 1960s it was the preservation of peace against the constant threat of an enlargement of war. By the 1970s the focus had shifted dramatically to a concern about environmental issues and the need to defend the global ecology against destructive forces.¹⁶³

The therapeutic approach practised by Perry at Diabasis was to give emotional support while encouraging the person to plumb the depths of the experience. This is basically the opposite of the conventional psychiatric approach which seeks to abort the experience, usually by the application of drug treatment, as soon as possible. Perry says that in the fully supportive environment of Diabasis it was not uncommon for a person to emerge from the schizophrenic crisis prematurely. When this happened, he says, it was necessary to actually encourage the person to re-enter psychosis so as to complete the process.¹⁶⁴ In regard to the success of his method, and indeed of the healing properties of schizophrenia itself, Perry claimed of his former patients that “the outcome of their stay at Diabasis was that their life after the episode was substantially more satisfying and fulfilling to them than it had been before!”¹⁶⁵

Perry claimed that Jung had shared his belief that “schizophrenia is a self-healing process”.¹⁶⁶ However Jung did not argue this in his writings on schizophrenia and his hypothesis of a toxic brain chemical as being the initiator of schizophrenic symptoms suggests that he might have had a very different view. Why would Jung call the initiator a toxin if he believed that schizophrenia was a healing process and that the outcome could be beneficial? The incompatibility of Jung’s negative attitude towards schizophrenia, implied by his belief that it was initiated by a ‘toxin’, and Perry’s positive attitude indicated by his description of the condition as a ‘self-healing’ process, is perhaps a useful indicator of flexibility amongst psychiatric theorists and the easy manner with which they can adopt fragments of each others’ theories and adapt their own to changing requirements.

Mythological Heroes and Schizophrenia

It is not only psychiatrists who demonstrate flexibility by adapting their frames of reference to accommodate aspects of schizophrenia. Joseph Campbell, who has written extensively on the subject of mythology, has recounted how he was asked to give a series of lectures on schizophrenia

¹⁶³ Ibid.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid.

¹⁶⁶ Ibid.

at the Esalen Institute in 1968.¹⁶⁷ When he told the organiser that he knew nothing about schizophrenia he was put in contact with Perry in order to learn. Perry sent him a paper he had published in 1962 and upon reading it Campbell said he discovered “that the imagery of schizophrenic fantasy perfectly matches that of the mythological hero journey, which I had outlined and elucidated, back in 1949 in the *Hero with a Thousand Faces*”.^{168 169}

Campbell was then engaged in a vast mythological project involving cross-cultural comparative studies of mythologies on a human-wide scale.¹⁷⁰ He had paid no attention in researching this project to specific problems of psychopathology or personalised mystical visions and was mainly concerned with analysing ideas he found to be common to all mythologies:

According to my thinking, they were the universal, archetypal, psychologically based symbolic themes and motifs of all traditional mythologies; and now from this paper of Dr. Perry I was learning that the same symbolic figures arise spontaneously from the broken-off, tortured state of mind of modern individuals suffering from a complete schizophrenic breakdown.¹⁷¹

The usual pattern of the mythological hero journey uncovered by Campbell in his own research involved three stages: separation, initiation and return. An individual separates from the established social order and goes on a long inward and backward journey, deep into the psyche, and is confronted there by chaotic and terrifying forces. If the person is fortunate a centre of harmony is found, and new courage discovered, before a return journey of new birth is completed:

A hero ventures forth from the world of common day into a region of supernatural wonder; fabulous forces are there encountered and a decisive victory is won: the hero comes back from this mysterious adventure with the power to bestow boons on his fellow men.¹⁷²

Campbell drew an analogy between schizophrenia and the mythological mystical journey which he had been researching by comparing the fortunes of two divers — one who can swim, and one who cannot: “The mystic, endowed by native talents for this sort of thing and following, stage by stage, the instructions of a master, enters the waters and finds he can swim; whereas the schizophrenic, unprepared, unguided, and ungifted, has fallen or has intentionally plunged, and is drowning.”¹⁷³

¹⁶⁷ Campbell, *op.cit.*, p. 201.

¹⁶⁸ *Ibid.*, p. 202.

¹⁶⁹ Joseph Campbell, *The Hero With a Thousand Faces*, Princeton University Press, Princeton N.J., 1968.

¹⁷⁰ Joseph Campbell, *The Masks of God*, (4 volumes), Souvenir Press, London, 1973-1974.

¹⁷¹ Campbell, ‘Schizophrenia — the Inward Journey’, *op.cit.*, p. 202.

¹⁷² *Ibid.*, pp. 202-203.

¹⁷³ *Ibid.*, p. 209.

It is not uncommon for psychiatric researchers within the mystical model to position their hypotheses in the context of evolutionary theories of one kind or another. As has been discussed above, Bucke had a theory about an evolutionary potential he called cosmic consciousness, which he apparently associated with the experiences of some of his patients. Perry also developed an evolutionary theory, of sorts. In a book entitled Roots of Renewal in Myth and Madness¹⁷⁴ Perry elaborated on the themes he had developed in his earlier works and articulated a theory about the evolution of the Semitic/Judeo/Christian religious ideas in which he found most of his patients to be drowning.

Perry argued that there is indeed an evolutionary process underway involving the faculties of consciousness of individual participants. His view is that this process was initiated by a breakthrough in the development of human consciousness which occurred with the establishment of the first city states in ancient Mesopotamia. The specialised social roles that were required of people to live in cities required new forms of social organisation that fundamentally altered the way in which individual people related to one another and also the way they related to life in general. Life in cities required clearly defined structures of social authority, hierarchies of power, which in turn led to individual identity being largely vested in the position on the social hierarchy allotted to the individual concerned.

The collective and individual focus on status at first removed ordinary people from the possibility of finding a solution to the problem of personal mortality. All power was at first transferred upwards to the King and, in the initial centuries of these early city-states, the King was thought to be the only person capable of fulfilling the evolutionary potential by transcending the problem of death. The King was so powerful he was given divine status so that he could achieve this goal.

However, as time progressed the evolutionary potential slowly percolated down through the layers of class, eventually passing through the aristocracy and down to the mass of people, in what Perry refers to as a “democratisation work of messianic visions”.¹⁷⁵ Whereas the image containing the evolutionary message had at first been confined to the personification of a divine King, remote and aloof from ordinary people, the concept of a messiah, which eventually evolved as the symbol of transcendence, was a model for everyman to emulate.

Perry’s theory is that the course of acute schizophrenic imagery sequentially follows the developments of the Semitic/Judeo/Christian religious traditions. These developments have been laid down, layer upon layer, in the collective unconscious so that the schizophrenic individual, who is working through this storehouse, encounters them in the order in which they were filed:

¹⁷⁴ John Weir Perry, Roots of Renewal in Myth and Madness: The Meaning of Psychotic Episodes, Jossey-Bass, San Francisco, 1976.

¹⁷⁵ Ibid., p. 195.

It is my thesis that the visionary states we call psychosis recapitulate this entire history, as another instance of ontogeny repeating phylogeny. The renewal process attempts to evolve a new level of consciousness in the individual, and to accomplish this, induces an identification first with the mythology of sacral kingship, then with that of messianic democratisation, and finally reaches a vision of the potential spiritual consciousness for life in the world society of today.¹⁷⁶

If both mystics and schizophrenics are indeed immersed in the same stuff — i.e. an evolutionary quest to expand consciousness — then the difference between them could be simply explained by an expectation that there is a high failure rate in such an endeavour — a many-are-called-but-few-are-chosen scenario. Both of them, mystics and schizophrenics alike, regardless of the route by which they have approached the task, and whether it was voluntary or not, have become involved in an attempt to expand their consciousness by allowing the archetypes of the collective unconscious to flush through their individual conscious minds. Those we call mystics succeed, and are no longer subject to instinctual compulsions from this area of consciousness. Those we call schizophrenics, on the other hand, fail to complete the task and, as a result, fall into confusion.

Summary of the Mystical Model

The description of the mystical model given in this chapter has been limited to analyses of the works of only a few psychiatric researchers who have thought most deeply on the matter, and who have been most influential. The reason is to be able to make a coherent summary of this model. The boom in New Ageism in recent years has to some extent blurred the meaning of mysticism and I have wanted to avoid a lengthy discussion on what is, and what is not, a mystical approach to schizophrenia. The theories that have been discussed above are all easily recognisable as falling well within the boundaries of a mystical model for schizophrenia.

Putting together a coherent synthesis of the mystical model from these sources is not a difficult task. It begins with the existential proposition that the consciousness of self presents all individual humans with a paradox. This paradox concerns the self's knowledge that because personal extinction is a foreseeable inevitability, and is unavoidable, the fear of it is therefore irrational. Yet despite the knowledge of this irrationality, the fear of death remains the foundation stone in the architecture of self identity. The existential dilemma that confronts people who grow into an awareness of this problem concerns the difficulty in finding a purposeful form of self-expression in these circumstances.

The mystical quest is an attempt to break the nexus between self-consciousness and reality by transcending the self and uncovering a separate reality that is connected to a higher, deeper or

¹⁷⁶ Ibid.

expanded level, of consciousness. This improved level of consciousness is a potential that is latent in all people and involves the replacement of the self's emotional dichotomy of fear-of-death/desire-for-life with a love/courage polarity focussed on transpersonal objectives. Mystical traditions, some of which have been in existence for more than two thousand years, teach their adherents a variety of techniques which are designed to induce this transition.

Some psychiatrists researching in this area have argued that the transition of consciousness facilitated by the mystical experience can be best understood in the context of an evolutionary step. Some of them have also observed that the symptoms of schizophrenia are quite evidently the same kind of mental phenomena reported by people who have undergone mystical experiences. This leads to a conclusion that is somewhat difficult for modern people to assimilate: i.e. that individuals who are diagnosed with schizophrenia are actually engaged in an evolutionary bid involving a metamorphosis of consciousness.

According to the Jungian branch of theorists, the area into which consciousness can expand is normally occupied by an inherited assembly of symbolic representations of the evolutionary potential. These symbolic representations, or archetypes, are normally in an unconscious state but they have a force of attraction for the conscious self identity. This force of attraction is a form of instinct — an instinct to participate in the evolutionary process — and it is so strong that some people (mystics) deliberately embark on a mission of union with the archetypes by intentionally collapsing their self-identity and thereby flooding their conscious mind with the archetypal imagery. This experience apparently gives rise to an opportunity for the conscious mind to occupy this hitherto unconscious/instinctual space and apply rational thought to the themes of consciousness that lie dormant there.

However, there are other people (schizophrenics), who are perhaps the vast majority of those with first-hand experience of this phenomena, whose conscious minds succumb to the attraction of the archetypes involuntarily. These involuntary mystics are often overwhelmed with confusion by the experience of archetypes flooding through their conscious minds. When this happens they are likely to attract the attention of psychiatric practitioners who diagnose their condition as schizophrenia.

A serious concern in regard to this situation is whether psychiatrists are being over-zealous when they use drugs to forcibly abort all mystical experience they encounter. It is quite possible that many of their involuntary patients are people who have the psychological skills to survive the mystical experience. Indeed, Perry is insistent that people with acute schizophrenic symptoms can re-emerge from psychosis after six weeks, without drug intervention, if they have the right kind of supportive attention: "The persons who are frightened, overwhelmed with imagery, and engrossed in their preoccupations are the ones most likely to have a favourable inner experience, from which they

emerge with significant change."¹⁷⁷ But he makes it clear that all people who enter the mystic waters are not equally good swimmers: "I am not suggesting that all persons in the 'psychotic' form of visionary state should be considered prophets, but rather that the program of the visionary experience and its imagery is the same in well-known 'prophets' as in our little-known 'patients' ".¹⁷⁸

Perry is of the opinion that all mystical experience can be brought to a successful outcome with benefits not only for the individual concerned but also for the society at large. But he warns that these benefits might be endangered by current psychaitric practices: "If this way of viewing psychic turmoils is on target, then there is a grave danger in psychiatry's zeal to suppress them, and instead there is an urgent need to safeguard visionary experience for the benefit of the culture".¹⁷⁹

¹⁷⁷ John Weir Perry, Trials of the Visionary Mind: Spiritual Emergency and the Renewal Process, State University of New York Press, Albany, 1999, p. 14.

¹⁷⁸ Ibid., pp. 58-59.

¹⁷⁹ Ibid., p. 139

7. Mystical Model: Interest Groups and Human Rights Imperatives

Interest Groups

The interest groups which identify with the mystical model are best described as ‘latent interests’ (see Chapter 2). Latent interests related to the mystical model are mostly comprised of a very small fraction of the psychiatric/psychological professions, a significant proportion of people who have recovered from schizophrenia, but who have no discernible organisation, and a few individual authors who have published books on the subject. As things stand there is no collective voice promoting the mystical model.

The few psychiatric therapists who recognise the mystical model are largely marginalised and although they keep up a running commentary on the inappropriateness of the medical model¹ they rarely become involved in human rights advocacy on behalf of the mystical model.

However, since “schizophrenia is the condition most associated with religious delusion and disturbance”² it is worth considering whether there are any religious/mystical influences on psychiatric attitudes towards the mystical model. It is evident in the discussion provided in Chapter 6 that the most significant psychiatric advocates of the mystical model, Laing and Perry, were themselves both involved in personal quests for mystical experience. This observation suggests that some kind of religious/mystical affiliation might play a role in prompting psychiatric practitioners to adopt the mystical model for schizophrenia.³ However, the effect of religious beliefs on the practice of psychiatry is not easy to determine and there are a number of theories to choose between.

On the one hand there is evidence that psychiatrists are influenced in their professional choices by the religious instruction they have received in childhood⁴ (see later in this chapter). This means that it might be possible to tell what kind of religious affiliation is likely to influence psychiatrists to accept or reject the mystical model. On the other hand there is a theory that certain kinds of psychiatrists are vulnerable to adopting the religious ‘delusions’ of their schizophrenic patients.

¹ See for example, Selene Vega, Spiritual Emergence or Psychosis?, accessed July, 1997, Available URL, <http://www.well.com/user/selene/SENarticles/SpiritPsychosis.html>

² Mark Sutherland, ‘Mental illness or life crisis? A Christian pastoral counselling contribution’, in Dinesh Bhugra, ed., Psychiatry and Religion: Context, Consensus and Controversies, Routledge, London, 1996, p. 218.

³ See for example, Catherine Racine, ‘Mystical experience of a counsellor: an autobiographical journey’, Women & Therapy, Vol. 20, No. 1, 1997, pp. 61-69.

⁴ Gillian Fulcher and Gary D. Bouma, ‘Appendix A: The Religious Factor and Modes of Psychiatric Treatment’, in Gary D. Bouma, The Research Process, Oxford University Press, Oxford, 1996, pp. 221-231.

This theory suggests that some psychiatrists might only adopt the mystical model after they have been in contact with schizophrenics and therefore any mystical affiliation might be derived indirectly from schizophrenia itself. This theory will be discussed first.

In an essay first published in 1962 a psychoanalyst named Leslie H. Farber wrote about the special hazards that he thought attend therapeutic work with schizophrenics. Farber's insights might help to cast some light on Laing's retreat from psychiatric practice into Buddhist meditation. Farber divided therapists who work with schizophrenics into three groups: "the young, the old and the vagabonds".⁵

The vagabonds are a special class of therapist who have charismatic qualities, very little theory, and who don't last very long. Farber did not find the vagabonds very interesting and instead concentrated his attention on the other two groups — the young and the old. What interested him about these two groups was that he found they both shared the same common denominator of despair at the futility of their efforts to return schizophrenic patients to normal. He argued that there is a special danger that arises for both young and old therapists when this despair goes unacknowledged. When it is unacknowledged subtle changes are wrought on the personality of the therapist.

For the young therapist the despair-induced changes are likely to take the form of a kind of burnout in which the therapist moves on into private practice and arranges his or her professional life so as to avoid further contact with schizophrenics. For the older therapist a more subtle danger lurks when the therapist tries to deal with his or her despair by turning the patient into a kind of oracle. When this happens the patient/therapist roles may subtly reverse.

Should the therapist forget the degree to which he has supplied meaning to a patient unable to provide any for himself, he may come to regard the schizophrenic as a sort of oracle with whom he sits each day — a truly ragged oracle, untutored, unverbally and naturally unappreciated, who has the rare power to cut through the usual hypocrisies and pretensions of ordinary life, thereby arriving at some purely human meaning. His illness now appears as an appropriate response to the impurities in the therapist's heart, even to the deceptions and contradictions of the world in which he lives.⁶

Farber was not in sympathy with the mystical model for schizophrenia, nor was he writing with Laing in mind, since he first wrote about the problem of therapist-despair almost a decade before Laing retired from psychiatry. Nevertheless, he provides a convenient explanation for the process of

⁵ Leslie H. Farber, 'Schizophrenia and the mad psychotherapist', in Robert Boyers and Robert Orrill, eds., *Laing and Anti-Psychiatry*, Penguin, Harmondsworth, 1972, p. 79.

⁶ *Ibid.*, p. 92.

transformation which overtook Laing. Putting aside for this discussion the possibility that Laing may have been best suited to the category of “vagabond”, using Farber’s description of the at-risk older therapist, it is possible to speculate that Laing’s earlier research into family stress as the cause of schizophrenia led to him despairing over finding therapies that would lead to a cure. The despair went unacknowledged and, in order to deal with it, he began to view the schizophrenic experience in a positive light, as being a mystical journey. This in turn caused Laing to convert his patients into oracles, which reversed the patient/therapist roles. At this point Laing became a mystical novice and, after a suitable period of instruction, he embarked upon his own mystical journey into Buddhism.

However, the mystical experience of the patient is not the only religious element that can influence the relationship between the patient and the therapist. There is also scope for considering the religious upbringing of the therapist and whether it influences the explanatory model and treatment a psychiatrist chooses to apply to schizophrenia. A connection between religious affiliation and choice of treatment was apparent amongst psychiatric practitioners as far back as the early 19th century. The ‘moral treatment’ devised by

the Englishman Tuke’s orientation to psychiatry was very much shaped by his Quaker origins. His asylum would be a religious community: The Retreat would serve as a moral and religious segregation which sought to reconstruct around madness a milieu as much as possible like that of the Community of Quakers.⁷

Fulcher and Bouma argue that even in the late 20th century religion, still plays a significant role in the attitudes psychiatrists have towards their patients. A survey they conducted amongst Melbourne psychiatrists provides strong confirmation of this position. Their survey covered 74% of all the psychiatrists who practised in the city. They hypothesised beforehand that the differing theological perspectives of the Catholic, Protestant and Jewish faiths would differently condition the psychiatrists who were raised in these religions and that this would be reflected in their choice of treatments.

The essential differences they were looking for in psychiatric practice were concerned with somatic versus talking forms of therapy. All of the somatic therapies, and most of the talking therapies, used for schizophrenia fall within the medical model. Any psychiatrist who handles schizophrenia from within the mystical model will, of necessity, be found amongst the talking therapists.

⁷ M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, Tavistock Publications, London, 1971, p. 243, quoted in Fulcher and Bouma, *op.cit.*, p. 221.

Fulcher and Bouma's hypothesis argued that when psychiatrists were conditioned by religious upbringing to believe in a locus of control for human experience which is external to the individuals concerned then these psychiatrists would be disinclined to encourage patients to take personal responsibility for their mental state by using talking therapy. These psychiatrists would be religiously conditioned to use somatic therapies instead. The opposite was hypothesised for psychiatrists who had been conditioned to believe in an internal locus of control relying on personal responsibility.

After examining theological perspectives the researchers argued, in relation to the external/internal dichotomy, "that both Protestantism and Judaism are paradoxical here, whereas Roman Catholicism much more clearly places the locus of responsibility as external to the individual".⁸ This observation led to a prediction that Catholic psychiatrists would favour somatic forms of treatment while Jewish and Protestant psychiatrists would prove to be statistically ambivalent in their choices of treatment. The result of the survey was that 100% of Catholic psychiatrists, 53.3% of Jewish psychiatrists and 55.5% of Protestant psychiatrists practised somatic forms of treatment.

The researchers concluded that their "study of Melbourne psychiatrists has demonstrated the influence of religious upbringing on practitioners' choice of work style".⁹ Since the application of somatic treatments, like drug therapies, are anathema to the mystical model of schizophrenia the results of this survey indicate that certain types of religious upbringing, most especially Catholicism, are likely to predispose psychiatrists against using therapies that might be conducive with the mystical model.

Apart from the few professional therapists and authors who identify with the mystical model the main body of support is from people who have recovered from psychosis.¹⁰ These psychiatric survivors, however, are confronted with a number of disadvantages when they try to become proponents of the mystical model. The most important of these obstacles is that, as diagnosed schizophrenics, individual survivors have very little credibility in public forums as interpreters of abnormal mental phenomena.¹¹ This is particularly true when the interpretation involves something as culturally marginalised as mystical experience. Advocacy of the mystical model by a person who bears the stigma of a mental illness label is easily dismissed as delusions and may simply provide further evidence of the person's madness.¹²

⁸ Fulcher and Bouma, *op.cit.*, p. 226.

⁹ *Ibid.*, p. 229.

¹⁰ See for example, Seth Farber, *Madness, Heresy, and the Rumor of Angels*, Open Court, Chicago, 1993.

¹¹ Louis A. Sass, 'Heidegger, Schizophrenia and the Ontological Difference', *Philosophical Psychology*, 1992, Vol. 5, No. 2, 1992, pp. 109-133.

¹² Michael A. Thalbourne and Peter S. Delin, 'A common thread underlying belief in the paranormal, creative personality, mystical experience and psychopathology', *The Journal of Parapsychology*, Vol. 58, No. 1, March, 1994, pp. 3-39.

In Perry's description of Diabasis, the centre in San Francisco where he applied the mystical model to treatment, he emphasised the importance for a person experiencing schizophrenic symptoms not to emerge from the altered state of consciousness before the psychosis had run its natural course.¹³ He claimed a near perfect success rate for his method and said that when people had their schizophrenia handled as a mystical experience their lives afterwards became richer and more meaningful than they had been before. Considering that the drug treatment used in response to the medical model is intended to abort the psychotic experience as quickly as possible it is little wonder that a frequent complaint of psychiatric survivors, who have received involuntary treatment, is that a mystical experience of great importance to them, which they believed they could have handled if they had been left alone, was rudely interrupted.¹⁴

Strangely, given the widespread acceptance of the idea of mysticism as a legitimate practice,¹⁵ together with the equally widespread intolerance of schizophrenia,¹⁶ there are still no articulated guidelines, whether in psychiatric, religious or lay terms, for distinguishing one from the other.¹⁷ This lack of definition is particularly pertinent when psychiatric survivors claim to be mystics.

There are a number of simple responses to this situation. One response is to assume that mysticism is the theory, and schizophrenia the practice, of the same experience. And that although the idea of mysticism might have legitimacy, the experience does not.¹⁸ Another response is to assume that mystics are so different they are never mistaken for schizophrenics and that when psychiatric survivors claim to be mystics they are demonstrating a lack of insight into their madness.¹⁹

More extreme responses can be hypothesised from the perspectives of mysticism and authoritative 'scientism'²⁰. A mystic who has successfully negotiated the inner journey might argue that psychiatric practice is an obstacle course positioned to test the nimbleness of mystical aspirants and to catch incompetents. Those people who get caught in the mental health net, and who are labelled

¹³ John Weir Perry, interview with Michael O'Callaghan, Global Vision, 1992-1995, Available URL, <http://www.ige.apc.org/glencree/dreamch2.html>

¹⁴ Seth Farber, op.cit., pp. 99-109.

¹⁵ Sharon M. Van Sluijs, 'Archiving Backwards: The Mystical Initiation of a Contemporary Woman', Parabola, Vol. 21, No. 1, 1996, pp. 119-122.

¹⁶ Garland E. Allen, 'Science misapplied: the eugenics age revisited' Technology Review, Vol. 99, No. 6, August-September, 1996, pp. 22-32.

¹⁷ Sandra Stahlman, Defining Mysticism — Commentary on David Lukoff's "The Diagnosis of Mystical Experience With Psychotic Features", 1992, Available URL, http://www.well.com/user/elliotts/smse_lukoff.html

¹⁸ B. A. Fallon and E. Horwath, 'Asceticism: Creative Spiritual Practice or Pathological Pursuit?', Psychiatry, Vol. 56, No. 3, 1993, pp. 310-316.

¹⁹ X. F. Amador, D. H. Strauss, S. A. Yale and J. M. Gorman, 'Awareness of Illness in Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 113-132.

²⁰ Barry Barnes, About Science, Blackwell, Oxford and New York, 1985, pp. 90-98.

as schizophrenics, are simply failed mystics. A converse, scientific/psychiatric approach might argue that mysticism is just a euphemism for mental illness and therefore so-called mystics are simply untreated schizophrenics.²¹

Human Rights Imperatives²²

Only a very small fraction of practising psychiatrists are supporters of the mystical model. This means that most of the people who encounter psychiatry, after experiencing what they believe is a mystical or religious experience, will be diagnosed and treated by psychiatrists who are guided by the medical model. One of the few psychiatrists in private practice who works from the perspective of the mystical model has written despairingly of such encounters with his medical model colleagues:

I am quite convinced that a most certain way for a person to acquire a label of schizophrenia is to come before a clinician and talk about certain kinds of topics, these include the occult, ESP, religion, God, and the general range of metaphysical phenomena. I do not really think that *how* one talks about these things has much to do with whether or not he is given the diagnosis. He can be quite coherent and ordered in his speech, follow the rules of grammar and logic, and yet if he expresses serious concern with, or some kind of excitement in, these topics, he is on his way to winning the label.²³

Even though many people diagnosed in this way might have entered into what they perceive to be mystical experience unintentionally, and suffered considerably from confusion and anxiety as a consequence, a large fraction of them still prefer not to be treated with medications. This preference raises the question of whether their human rights are violated when drug treatments are forced on them involuntarily.

The specific intention of medical treatment for a person diagnosed with schizophrenia is to modify certain supposed malfunctions of the mind which have been psychiatrically identified as delusions, hallucinations and disordered thoughts. However, if the experiencer of these unusual psychological phenomena interprets the flow of thoughts and ideas as valid personal experience then from the

²¹ Lucy H. Labson, 'Zeroing in on schizophrenia', *Patient Care*, Vol. 18, January 15, 1984, pp. 66-84.

²² Research for this section was initially undertaken for, Richard Gosden, *Psychiatry and Human Rights*, Honours Thesis, Department of Science and Technology Studies, University of Wollongong, 1996. Parts have also been subsequently published as, Richard Gosden, 'Neuroleptics and the Freedom of Thought: How Involuntary Psychiatric Treatment Violates Basic Human Rights', *Monitors: Journal of Human Rights and Technology*, Vol. 1, No. 1, University of Texas, 26 February, 1997, Available URL, <http://www.cwrl.utexas.edu/~monitors1.1/index.html>

²³ Kenneth E. Lux, 'A Mystical-Occult Approach to Psychosis', in Peter A. Magaro, *The Construction of Madness*, Pergamon Press, Oxford, 1976, p. 95.

mystical perspective the unwanted interference of a psychiatrist is a very serious violation of human rights. The right of individuals to have their own thoughts, and to hold whatever beliefs they choose, is protected under international law. Article 18 of the International Covenant on Civil and Political Rights (ICCPR) states:

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.²⁴

The Article 18 rights most relevant to people who have undergone a mystical experience and who are consequentially alleged to have schizophrenia are the freedoms of thought, conscience and belief; the freedom to manifest belief; and the protection against coercion which would impair freedom of belief. The only limitations that are allowed to be placed on these rights are in respect to the manifestation of beliefs. The protection of thoughts and beliefs is particularly relevant to people who have undergone mystical experience because it is unusual varieties of thought and belief that characterise the residual phenomena of mystical experience.

Article 2 of the ICCPR specifies that the Covenant protects the rights of all individuals “without distinction of any kind”.²⁵ This means there is no scope for making exceptions for supposedly ‘mentally ill’ people. This point is pivotal for an Article 18 defence of the mystical model because such a defence only becomes necessary after a person has been labelled mentally ill by the medical model.

Further confirmation of this point can be found in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care: “Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and

²⁴ United Nations, ‘International Covenant on Civil and Political Rights’, Article 18, reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, pp. 32-33.

²⁵ Article 2, Ibid., p. 25.

Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments”²⁶

The rights protected in Article 18 of the ICCPR are so fundamental to the human experience that they have been restated as Article 1 of the more recently formulated UN Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief.²⁷ Article 18 of the ICCPR and Article 1 of the Declaration are almost identical.

The Spirit of Article 18

The ideas behind the freedoms of thought, conscience and belief, and the right to express beliefs, are as old as human society. Social organisation is inevitable for people who live in groups and this organisation generally requires group members to conform to prescribed behavioural patterns and subscribe to commonly held beliefs. But these same people also have to face life as mortal individuals and in this respect the knowledge of personal mortality imposes on individuals a consciousness that the self is unique and separate from the rest of the social group and that it is often necessary to ignore the collective good in order to pursue personal needs.

John Stuart Mill sought to resolve the conflict between the good of the society and the good of the individual with a simple formula:

The principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.²⁸

²⁶ United Nations Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, Principle 1.5, in Australian Human Rights and Equal Opportunity Commission (eds), Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993, pp. 990-991.

²⁷ United Nations, ‘Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief’, UN Resolution 36/55, 25 November, 1981, reproduced in Human Rights and Equal Opportunity Commission, Free to Believe? The Right to Freedom of Religion and Belief in Australia, Human Rights and Equal Opportunity Commission, Sydney, 1997, pp. 35-36.

²⁸ John S. Mill, ‘On Liberty’, in Mary Warnock, ed., Mill: Utilitarianism and Other Writings, World Publishing, New York, 1962, p. 135.

Mill's utilitarian approach is based on the underlying moral principle that a person's action should be judged by evaluating the consequences of the action for all those who will be affected by it.²⁹ Starting with the assumption that a fundamental benefit will accrue to the individual as a result of him or her exercising the individual right to act, the only justification for stopping that action is if a greater concentration of harm can be expected to accrue to other people. The question of whether or not the performer of the action actually makes a net gain should be no concern of the society.

The right of individuals to think freely and discover their own beliefs is an area which the European cultural tradition has defended against imposed conformity with particular ferocity since the Reformation. The words 'freethinking' and 'freethinker' did not begin to appear in English literature until the end of the 17th century but there were movements of people who described themselves as freethinkers as far back as the 13th century in Italy.³⁰ In the European Christian tradition heretics have usually been severely punished³¹ but at the same time there has also been a retrospective tendency to applaud heretics as "heroes who were badgered by ignorant and vicious men"³² and who often overcame great obstacles to bring new 'light' into the world.

One advocate of freedom in thought has argued that it is superstition that inhibits freethinking and that "the mission of freethought is to relieve spiritual misery".³³ The conquest of superstition is a widespread ideal in modern society and the recognition of the role played by freethinking individuals in this quest is undoubtedly one of the reasons why the freedoms of thought, conscience and belief have been enshrined in Article 18 as inviolable human rights.

The Technical Requirements of Article 18

The UN Centre for Human Rights compiles an annual report on action the UN has taken in regard to human rights. In a section that discusses resolutions formulated by the Commission on Human Rights there is a cumulative record of how the Commission has interpreted various human rights articles since its inception. Under the heading of "Freedom of thought, conscience and religion or belief",³⁴ there is a record of the occasions when the Commission has been called upon to interpret Article 18 and what it has resolved.

²⁹ Rolf E. Sartorius, 'Paternalistic Grounds For Involuntary Civil Commitment: A Utilitarian Perspective', in Baruch A. Brody and H. Tristram Englehardt Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing Company, Dordrecht, Holland, 1980, p. 140.

³⁰ J. M. Robertson, A History of Freethought, Watts and Co., London, 1936, p. 2.

³¹ See for instance, R. I. Moore, The Origins of European Dissent, Basil Blackwell, Oxford, 1985, pp. 23-45.

³² Barrows Dunham, The Heretics, Eyre and Spottiswoode, London, 1963, p. 2.

³³ Karl Pearson, The Ethic of Freethought, T. Fisher Unwin, London, 1888, p. 21.

³⁴ United Nations Centre for Human Rights, United Nations Action in the Field of Human Rights, United Nations, Geneva, 1994, p. 110.

The discussions and resolutions recorded to date only concern matters of conscience and religion. There is a record of repeated discussions on the subject of conscientious objection to military service, particularly when the military service involves enforcement of apartheid, and also on the religious rights of minorities. But there has been no discussion regarding specific infringements of the freedoms of thought or belief. Nor has the Commission been called upon to make a ruling under Article 18 in regard to either mental health or psychiatric practice.

The key terms in Article 18 are fairly straightforward and unequivocal. The meaning of words like ‘thought’, ‘conscience’ and ‘belief’ are not dependent on specific circumstances for interpretation as are value-laden words like ‘cruel’, ‘inhuman’ or ‘degrading’ which can be found in other articles of the ICCPR. The specification is simply that individuals should be free to think their own thoughts and to hold whatever beliefs they choose without interference. One human rights analyst has argued that this right is inviolable because “[t]here are some aspects of person’s lives that are so deeply personal and intrinsic, such as the right to freedom of thought that they are not subject to explicit balancing because there is no cumulative or collective interest that can justify an intrusion.”³⁵

One interpretation by the Human Rights Committee of the United Nations seems particularly relevant for use in defence of the mystical model:

Article 18 protects theistic, non-theistic and atheistic beliefs, as well as the right not to profess any religion or beliefs. The terms belief and religion are to be broadly construed. Article 18 is not limited in its application to traditional religions or to religions and beliefs with institutional characteristics or practices analogous to those of traditional religions.³⁶

A generalised UN interpretation of Article 18 emphasises the implied dichotomy of inner and outer and says that “no restriction of any kind may be imposed upon man’s inner thoughts or moral conscience” but goes on to point out that external manifestations “may be subject to legitimate limitations.”³⁷

³⁵ Margaret G. Wachenfeld, The Human Rights of the Mentally Ill in Europe Under the European Convention on Human Rights, Nordic Journal of International Law and The Danish Center For Human Rights, Copenhagen, 1992, p. 277.

³⁶ Human Rights Committee, United Nations, CCPR/C/21/Rev.1/Add.4. p.1. quoted in Human Rights and Equal Opportunity Commission, Free to Believe? The Right to Freedom of Religion and Belief in Australia, op.cit., p. 21.

³⁷ United Nations Centre for Human Rights, op. cit., p. 110.

A conference of international jurists in 1984 made a detailed examination of the limitations allowed for in the ICCPR. The outcome of the conference was the Siracusa Principles³⁸ which severely restrict the way in which limitations can be imposed. In relation to Article 18, for instance, the provision to limit the manifestation of beliefs could not be extended to limit the holding of beliefs. Nor would it be possible to place any limitations at all on a person's thoughts or conscience.

Article 18 only allows for limitations to be placed on the manifestation of belief when it is "necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." According to the Siracusa Principles "necessary" means that it has to be "in response to a pressing public need".³⁹ The definitions of 'public safety' and 'public health' would probably allow them to be used as justifications for limiting the kinds of manifestations of belief likely to be made by a person who was thought to be mentally ill. So would protection of the 'rights and freedoms of others'. But limitations on the grounds of public 'order' and 'morals' would probably not be allowed. For 'public order' to be invoked "the rules which ensure the functioning of society"⁴⁰ have to be endangered and 'public morals' are generally recognised as being outside of the province of psychiatric practice.

So, according to the Siracusa Principles, mental health legislation does not violate human rights guaranteed under Article 18 when it empowers psychiatrists to limit a person's manifestations of belief when those manifestations cause "danger to the safety of persons, to their life or physical integrity, or serious damage to their property".⁴¹ Similarly, limitations are permitted to protect the rights of others. But other people's rights only have precedence if they are 'more fundamental' than the right to manifest a belief. Being more fundamental is indicated when a conflicting right is also specified in the ICCPR and has no limitations attached to it.⁴² The limitation allowed on the grounds of protecting public health generally overlaps with public safety but public health extends a little further and would probably include "preventing disease or injury"⁴³ to the person who is actually manifesting the belief.

Despite the severe restrictions on the application of these limitations their existence still generates some uncertainty about the level of protection Article 18 can offer against involuntary psychiatric treatment for schizophrenia. Since Article 18 requires any limitations to be specified in law it is

³⁸ International Commission of Jurists, Siracusa Principles on the Limitations and Derogation Provisions in the International Covenant on Civil and Political Rights, American Association for the International Commission of Jurists, Washington, 1985.

³⁹ Ibid., p. 6

⁴⁰ Ibid., p. 7.

⁴¹ Ibid., p. 9

⁴² Ibid.

⁴³ Ibid., p. 8.

proposed to analyse the way in which a typical piece of mental health legislation actually functions in regard to schizophrenics and their Article 18 rights.

Involuntary Treatment Provisions in New South Wales (NSW), Australia

The NSW Mental Health Act 1990 (MHA) will be used for this analysis but the NSW legislation is only meant to be a demonstration and any other modern mental health law could probably be adapted in a similar way.

The framing of the 1990 Act was the second major overhaul of mental health law in NSW since 1958⁴⁴ and it has a number of new features. Unlike earlier versions it contains a detailed definition of ‘mental illness’. It also reflects recent developments in community attitudes towards mental illness by insisting on the least restrictive environment for treatment.⁴⁵

To facilitate the least restrictive environment the MHA provides for Community Counselling Orders (CCOs) and Community Treatment Orders (CTOs) which allow people to be treated involuntarily outside of an institutional setting. Care and treatment of mentally ill people must be performed so that “any interference with their rights, dignity and self-respect are kept to a minimum necessary in the circumstances”.⁴⁶ If the psychiatry practised under the sanctions of the NSW MHA cannot satisfy the requirements of Article 18 then it is likely that psychiatric practice in many other modern democratic legal jurisdictions would also fail.

The objects of the MHA are to provide for “the care, treatment and control of persons who are mentally ill or mentally disordered while protecting the civil liberties of those persons”⁴⁷ The contrary legislative impulses — to control people, while simultaneously protecting their civil liberties — illustrates the difficulties in providing a legal framework for psychiatric coercion.

The main thrust of the MHA is to identify the types of people who are thought to require care, treatment and control and to regulate the way in which the services and the restraint are delivered to them. The principal mechanism to achieve this goal is to divide mental patients into those who are voluntary, which it calls informal patients,⁴⁸ and those who are involuntary. Anyone can seek treatment as a voluntary patient and people who seek treatment should only be refused admittance

⁴⁴ The Mental Health Act Implementation Monitoring Committee, Report to the Honourable R. A. Phillips MP Minister For Health on the NSW Mental Health Act 1990, August 1992, Preface.

⁴⁵ Mental Health Act 1990, Section 4.(2) (a), NSW Government Information Service, Reprinted as in force at 17 October, 1994, p. 3.

⁴⁶ Ibid., Section 4.(2) (b), p. 3.

⁴⁷ Ibid., Section 4 (1), pp. 2-3.

⁴⁸ Ibid., Chapter 4, Part 1.

to a mental hospital if the medical superintendent “is not satisfied the person is likely to benefit from care or treatment”.⁴⁹

Involuntary patients, by definition, do not seek treatment and so, if treatment is to be given to them, it must be imposed on them. The imposition of care and treatment can be facilitated by incarceration in a hospital or by placing the person under the direction of a CCO or CTO. Incarceration and imposed care and treatment are the means by which the MHA achieves the objective of ‘control’. For a person to be controlled as an involuntary patient a diagnosis must be made of either mental illness or mental disorder. The person must also be manifesting the complaint in a manner that gives rise to alarm.

People who are made involuntary patients because they are alleged to have schizophrenia are usually diagnosed under the MHA’s definition of mental illness:

a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

- (a) delusions;
- (b) hallucinations;
- (c) serious disorder of thought form;
- (d) a severe disturbance of mood;
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).⁵⁰

However, people who are diagnosed with mental illness, and who are unwilling to volunteer for treatment, can only be made involuntary patients if they also fit a definition of ‘dangerousness’:

owing to that illness, there are reasonable grounds for believing that care, treatment and control of the person is necessary:

- (a) for the person’s own protection from serious harm; or
- (b) for the protection of others from serious harm.⁵¹

This cross-referencing to ensure that a mentally ill person is also ‘dangerous’ is meant to be a safeguard to ensure that people are not treated involuntarily unless it is absolutely necessary. But the definition of ‘dangerousness’ in the MHA has been recently watered down. In its present form there

⁴⁹ *Ibid.*, Section 17, p. 8.

⁵⁰ *Ibid.*, Schedule 1, pp. 115-116..

⁵¹ *Mental Health Legislation Amendment Bill 1997*, Section 9, Assented to by the NSW Parliament 26th June, 1997, p. 3.

is only a requirement of “serious harm” whereas in the original legislation ‘dangerousness’ was defined as a risk of “serious physical harm”.

The deletion of ‘physical’ in the recent amendments was deliberately intended to widen the net of psychiatric coercion. An explanatory note appended to the amending legislation clarifies the definition by saying that “serious harm” extends beyond “serious physical harm” to include “other kinds of harm, such as financial harm or harm to reputation....”.⁵² A further new addition also instructs that “the continuing condition of the person, including any likely deterioration in the person’s condition and the likely effects of such deterioration, are to be taken into account.”⁵³

Four of the five symptoms specified for mental illness — delusions, hallucinations, disordered thoughts and mood disturbance — are phenomena that occur inside a person’s mind. The other one — irrational behaviour — is an outward manifestation indicating the presence of one or more of the inner phenomena. For a person to be made an involuntary patient under the MHA at least one of the inner phenomena must be present together with an outward manifestation, or the possibility of an outward manifestation, that might cause “serious harm”.

The people who are alleged to have schizophrenia are a sub-set of the total number of people who are incarcerated under these legal provisions. So, in order to apply a test of Article 18 rights for people who have had their mystically-derived thoughts and beliefs diagnosed as symptoms of schizophrenia, it will be necessary to distinguish which of the MHA symptoms apply to schizophrenia.

Incarceration of Alleged Schizophrenics

The symptoms of mental illness specified in the Mental Health Act (MHA) relate to the two main branches of psychosis — the schizophrenias and the affective disorders of mania and depression. The first three of the four inner symptoms — delusions, hallucinations, disordered thoughts — are generally associated with schizophrenia while the fourth, mood disturbance, is a symptom of the affective disorders.

Under the MHA therefore a person who is incarcerated because of alleged schizophrenia will normally be required to have at least one of the first three inner symptoms, as well as behaviour that might cause harm to self or others. Incarceration on these grounds could possibly accord with the Article 18 provision that allows for the limitation of a manifestation of belief in order to protect public safety (of others) or public health (the patient from injury).

⁵² Ibid.

⁵³ Ibid.

But such an incarceration would only accord with Article 18 in very specific circumstances. These circumstances are considerably narrower than the scope provided for in the legislation. In the first instance, since Article 18 only allows for limitations to be placed on manifestations of belief, then ‘delusions’ is the only MHA-specified inner symptom which fits the criteria for possible limitation. This is because a delusion is a form of belief: i.e. a false belief. There is no provision in Article 18 for limitations to be placed on manifestations of ‘thoughts’ even though they may be in the distorted/deceptive form of ‘hallucinations’, or ‘seriously disordered’. In the second instance, the expansion of the definition of ‘harm’, to include such considerations as “financial harm and harm to reputation” goes far beyond the circumstances for which Article 18 allows limitations. The Siracusa Principles restrict such limitations to the protection of public safety and public health.

A further related problem with the MHA provisions is that to accord with Article 18 more certainty of the person’s threat to public safety or public health would be needed than is required by the MHA. The MHA stipulation of “Reasonable grounds for believing” would not satisfy the Siracusa Principle that “All limitation clauses shall be interpreted strictly in favour of the rights at issue”.⁵⁴

By not restricting the criteria for involuntary hospitalisation to delusions (false beliefs), and allowing for people to be incarcerated for having ‘hallucinations’ and ‘disordered thoughts’; and by having a definition of ‘harm’ that is considerably broader than that of public safety and public health; and also by not requiring more positive evidence for the risk of that ‘harm’; the MHA clearly provides a legal framework that does not strictly accord with Article 18. Even so, it is not an easy matter to determine whether, in practice, any of the people who are incarcerated under the provisions of the MHA actually have their Article 18 rights violated. The lack of publicly available details about the exact reasons why people get incarcerated means that it is impossible to resolve this doubt.

About 80% of all involuntary admissions under the MHA take place in response to a doctor’s certificate.⁵⁵ This certificate only requires the doctor to state in the most equivocal language that:

I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness/or a mentally disordered person and that there are reasonable grounds for believing the person’s behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment, or control of the person is necessary :

⁵⁴ International Commission of Jurists, *op. cit.*, p. 6. It should be noted that although there is provision in both Article 18 and the Siracusa Principles to limit a manifestation of belief to protect the rights and freedoms of other people this can only be done if it is specified by law. Since the MHA doesn’t specify this area of limitation it can’t be used and it is therefore not relevant to the test.

⁵⁵ Mental Health Review Tribunal, *Annual Report 1995*, NSW Government, p. 58.

- (a) in the case of mentally ill person:
 - (i) for the person's own protection from serious harm, or
 - (ii) for the protection of others from serious harm.⁵⁶

No record is required of the particular symptom of mental illness identified by the doctor nor the exact nature of the “reasonable grounds” for believing that the person might cause serious harm. After a person has been involuntarily admitted to a hospital the MHA requires that the person be further examined by the medical superintendent⁵⁷ of the hospital as well as a second hospital doctor⁵⁸ in order to confirm the certifying doctor's diagnosis. Published statistics indicate that confirmation is given in over 99% of cases⁵⁹ but there is no public record of the precise symptoms found by the hospital doctors nor is there any indication of the quality of the evidence they use to determine that the person might cause serious harm.

The MHA also requires that the person be brought “before a Magistrate as soon as practicable”⁶⁰ for the purpose of making a judicial determination “on the balance of probabilities”⁶¹ as to whether the person is a mentally ill person. This usually happens within about a week. (It should be noted that during this period the person can be given treatment without informed consent.)⁶²

In 1996 about 44% of the people admitted involuntarily were either released or had their status changed to voluntary patients before the Magistrate's hearing could be arranged.⁶³ Of those people who were brought before a Magistrate in 1996 about 59%⁶⁴ had their medical diagnosis of mental illness confirmed by a legal determination and temporary patient orders were made on them. This amounted to a total of 1,971 people.⁶⁵

There is no published information indicating whether any of these 1,971 people were found to be mentally ill by Magistrates because they had hallucinations or disordered thoughts. It is not even possible to accurately determine what fraction of them were alleged to have schizophrenia, though anecdotal information indicates about half of all involuntary patients are diagnosed with schizophrenia spectrum disorders. Nor is there any readily available assessment of the quality of the evidence used by the Magistrates to determine that these 1,971 people were dangerous. But the minimum level of evidence of dangerousness required by the Magistrate under the MHA — “on the

⁵⁶ Mental Health Legislation Amendment Bill 1997, Schedule 2, op.cit., p. 5.

⁵⁷ Mental Health Act 1990, Section 29.(1), op. cit., p. 12.

⁵⁸ Ibid., Section 32.(1), p. 14.

⁵⁹ Mental Health Review Tribunal, Annual Report 1996, NSW Government, p. 57.

⁶⁰ Mental Health Act 1990, Section 38.(1), op. cit., p. 18.

⁶¹ Ibid., Section 51.(1), p. 23.

⁶² Ibid., Section 31.(2), p. 13.

⁶³ Mental Health Review Tribunal, Annual Report 1996, op. cit., p. 20.

⁶⁴ Ibid.

⁶⁵ Ibid.

balance of probabilities” — once again would not satisfy the Siracusa Principle that “All limitation clauses shall be interpreted strictly in favour of the rights at issue”.⁶⁶ Needless to say, no statistics are available on how many of these involuntary patients would claim to be mystics, if the opportunity were available to them.

So far then all that can be said about the Article 18 rights of people who are alleged to have schizophrenia and who are involuntarily committed in NSW, is that the MHA provides a legal framework that allows for their rights to be violated. But it is impossible to determine in a generalised way, without exploring minute details of individual cases, whether the rights of this class of people are actually violated by the incarceration process.

To by-pass this obstacle let us assume that all of the people who are alleged to have schizophrenia, and who are incarcerated as a result, are only treated in this way after they have manifested beliefs (i.e. delusions/false beliefs) in ways that are irrefutably threatening to public safety or public health. Making this assumption clears the way for a close examination of the psychiatric treatments that are forced on them after incarceration and whether these treatments violate their rights.

Even though it might sometimes be legitimate to lock people up who manifest beliefs in a dangerous manner, once they have been restrained they still retain inviolable rights to the freedoms of thought and conscience, and to hold whatever beliefs they like. If psychiatric practice on involuntary patients interferes with these rights it unequivocally violates Article 18.

Hypothetical Mental Patient

Let us try to get a feeling for the human side of this problem by sketching the profile of a hypothetical mental patient. We'll call the patient Kerry. Kerry is a young person who has always felt a little bit different from other people, perhaps because of a heightened feeling of vulnerability or self-consciousness. Kerry has long held a passion for poetry and eastern religions and recently he/she began to find new meaning in favourite writings. After sitting up all one night reading he/she slipped into an altered state of consciousness involving visions and voices. When Kerry began to express unusual beliefs to the family over the next few days, together with fragmented quotations of poetry referring to “slings and arrows of outrageous fortune” and taking “arms against a sea of troubles”, the family doctor was called in to make an examination. The doctor identified delusions and found reasonable grounds for concluding that Kerry might cause serious harm to self or others and was therefore in need of care, treatment and control. This led to Kerry being involuntarily admitted to a mental hospital.

⁶⁶ International Commission of Jurists, *op. cit.*, p. 6.

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV) delusions are a primary symptom of schizophrenia.⁶⁷ The manual defines delusions as false beliefs that are not "ordinarily accepted by other members of the person's culture or subculture".⁶⁸ This suggests that Kerry's family doctor, by virtue of being a medical practitioner, is presumed under the sanctions of the MHA to be a competent judge of ordinary beliefs, and is legally designated to certify anyone who appears to hold beliefs that he/she thinks are culturally unacceptable.⁶⁹ This might appear to be a fairly dubious provision in human rights terms but since we are conceding that Kerry manifested his/her beliefs in a manner threatening to public safety then his/her Article 18 rights have not been violated by the incarceration process.

However, even after Kerry's incarceration in a hospital there are still no laboratory tests available to confirm the delusions identified by Kerry's family doctor. As things stand no biological back-up tests exist which can either identify or verify the presence of schizophrenia. In fact a key to the controversy over the aetiology of schizophrenia is the question of whether there is anything more to the condition than simply the symptoms themselves.⁷⁰

The absence of any laboratory tests allows for a simple deduction to be made in respect to the fate of Kerry's Article 18 rights after incarceration. If Kerry was hospitalised in order to receive treatment for a mental illness indicated by delusions, and if there are no laboratory tests that can trace the subsequent course of Kerry's illness, then it is fair to assume that the hospital psychiatrists would have to rely on monitoring Kerry's thoughts and beliefs, and their outward manifestations, to know whether his/her condition is improving or deteriorating. This means that treatment that is intended to 'improve' Kerry's condition will also be intended to coerce him/her to give up or change the 'false' beliefs that were the original symptoms of the illness. So long as Kerry's delusions remain in an unremitted state it is highly likely that the treatment/coercion will continue.

This simple deduction allows us to establish a *prima facie* case that any involuntary psychiatric treatment given to a person alleged to have schizophrenia would most likely violate Article 18 by subjecting the person "to coercion which would impair his freedom to have or to adopt a religion or belief of his choice".⁷¹ The further case to be made is that the standard neuroleptic drug treatment that is given to people who are alleged to have schizophrenia does not merely select delusions for

⁶⁷ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington DC, 1994, p. 285.

⁶⁸ Ibid., p. 765.

⁶⁹ The MHA stipulates that people should not be found mentally ill "merely because" they hold a political, religious or philosophical belief. See Mental Health Act 1990, Section 11.(1), *op. cit.*, p. 6.

⁷⁰ Bruce J. Ennis and Richard D. Emery, The Rights of Mental Patients: An American Civil Liberties Union Handbook, Avon Books, New York, 1978, pp. 15-29.

⁷¹ United Nations, 'International Covenant on Civil and Political Rights', Article 18.2, reproduced in Satish Chandra, ed., *op. cit.*, p. 32.

modification but also interferes with the person's freedom of thought by blocking the higher thinking centres of the brain.

Neuroleptic Treatment

Neuroleptic drugs are the treatment of first choice for schizophrenia: "Over 90% of hospitalised patients with a diagnosis of schizophrenia are prescribed neuroleptic drugs".⁷² Neuroleptics are alternatively known as major tranquillisers and antipsychotics and are used to moderate the irrational behaviour associated with schizophrenia.

The advent of neuroleptics is often identified as a turning point in mental health. These drugs not only normalised psychiatric practice, so that it clearly fell within the medical model for the first time, but the further claim is frequently made that neuroleptics also emptied out the mental hospitals by making the treatment of schizophrenia possible outside of an institutional setting.⁷³ This latter claim is often hotly contested by arguments that it was actually the development of welfare structures, most particularly disability pensions, which contributed far more to reducing the number of patients in mental hospitals than the use of neuroleptics.⁷⁴

The first commercially developed neuroleptic, chlorpromazine, was synthesised by French scientists in 1950 while they were attempting to develop an antihistamine.⁷⁵ Chlorpromazine was first tried as an anaesthetic potentiator but proved to be ineffectual. It was then used as an antiemetic but once again it was found to be not commercially useful until an experiment was carried out in 1953 on "about 100 psychiatric patients and it was declared to be an effective antipsychotic".⁷⁶ Thereafter it proved to be one of the most profitable drugs in pharmaceutical history. (Myth-of-mental-illness advocate Thomas Szasz has observed that this proves treating non-diseases can be even more lucrative than treating real ones.)⁷⁷

This new drug was found to be highly sedating. One of the early French pioneers of its usage, a physician named Laborit, found it was very useful in calming anxious surgery patients. He noted of

⁷² David Cohen and Michael McCubbin, 'The Political Economy of Tardive Dyskinesia: Asymmetries in Power and Responsibility', The Journal of Mind and Behaviour, Vol. 11, Numbers 3 and 4, Summer and Autumn 1990, p. 472.

⁷³ T. J. Steadman and H. A. Whiteford, "Medication 2: In Adults", in Robert Kosky, Hadi Salimi Eshkevari, and Vaughan Carr, eds., Mental Health and Illness: A Textbook for Students of Health Sciences, Butterworth-Heinemann, Sydney, 1991, p. 395.

⁷⁴ Peter Breggin, Toxic Psychiatry, Fontana, London, 1993, p. 80.

⁷⁵ Norman L Keltner, Hilyard Lee, and Carol E. Bostrom, Psychiatric Nursing, Mosby, St Louis, 1995, p. 227.

⁷⁶ Thomas Szasz, Cruel Compassion: Psychiatric Control of Society's Unwanted, John Wiley and Sons, New York, 1994, p. 167.

⁷⁷ Ibid.

his patients that “There is not any loss of consciousness, not any change in the patient’s mentality, but a slight tendency to sleep and above all a disinterest in what goes on around him.”⁷⁸

By targeting the dopamine neurotransmitter system of the brain neuroleptics reduce the circulation of dopamine. Along with this reduction of dopamine certain kinds of brain functions, that depend on dopamine, are also reduced. Some parts of the brain learn to compensate: “Following neuroleptic blockade of A9 neurons, post-synaptic dopamine receptor targets in the striatum undergo a compensatory increase in both numbers of dopamine receptors and their sensitivity. This dopamine supersensitivity or hyper-reactivity in the striatum causes tardive dyskinesia.”⁷⁹

Tardive dyskinesia is one of a number of serious side effects characterised by movement disorders which are associated with the use of neuroleptics. Once the dopamine supersensitivity has been established in this part of the brain the movement disorders sometimes continue to get worse, and often remain permanently, even if the dopamine blockade is lifted by discontinuing treatment. But it seems that other centres of the brain, which are also dependent on dopamine for proper functioning, and which regulate many of the higher emotional and mental activities, fail to make a similar compensatory adjustment by becoming supersensitive to dopamine. The result is that these higher mental centres close down and this is why neuroleptic treatment has been referred to as a “chemical lobotomy”.

Neuroleptics have their main impact by blunting the highest functions of the brain in the frontal lobes and the closely connected basal ganglia. They can also impair the reticular activating or 'energising' system of the brain. These impairments result in relative degrees of apathy, indifference, emotional blandness, conformity, and submissiveness, as well as a reduction in all verbalisations, including complaints and protests. It is no exaggeration to call this effect a chemical lobotomy.⁸⁰

In relation to the question of Article 18 rights it is apparent that psychiatrists have prior knowledge that the thoughts and beliefs of their patients might be disrupted by neuroleptic treatment. However, there seems to be considerable divergence of opinion as to whether this disruption of thoughts will be beneficial to patients.

⁷⁸ F. J. Ayds, ‘The Early history of modern psychopharmacology’, quoted in Keltner, et al., *op. cit.*, p. 227.

⁷⁹ Peter Breggin, ‘Brain Damage, Dementia and Persistent Cognitive Dysfunction Associated With Neuroleptic Drugs: Evidence, Aetiology, Implications’, *The Journal of Mind and Behaviour*, Vol. 11, Numbers 3 and 4, Summer and Autumn 1990, p. 445.

⁸⁰ Peter Breggin and David Cohen, *Your Drug May Be Your Problem*, Perseus Books Reading Massachusetts, 1999, p. 77.

A recent text describes the psychiatric intention as benefiting the patient through “Alterations in thought. Antipsychotic drugs improve reasoning, decrease ambivalence, and decrease delusions Antipsychotic drugs are effective in decreasing confusion and clouding hallucinations and illusions are reduced”⁸¹

Some of these intended effects, like the claim that the drugs “improve reasoning”, have to be treated with a certain amount of scepticism. Improvement to reasoning in this context might have at least two different meanings. The first is that a person’s ability to solve problems might be improved by the drugs. But if this were true one could expect there would be widespread use of the drugs by non-psychotic people — like students, scientists and competitive chess players — who might have cause to improve their problem-solving abilities. Since there is no indication that neuroleptics are ever used in this way, and are not ever likely to be, the second interpretation is more likely. This is where ‘improved reasoning’ is understood as a euphemism meaning that the patient’s thinking has fallen more into line with the will of the psychiatrist administering the treatment.

But even if submission to the will of psychiatrists can be seen as leading to a beneficial outcome for the patient, neuroleptic treatment does not always go according to plan. The small print in an advertisement for the frequently prescribed neuroleptic Haldol, for instance, warns of possible adverse reactions that are the opposite of those intended. Some of the possible effects are, “insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations and catatonic-like behaviour states which may be responsive to drug withdrawal.”⁸² In addition to these possible reactions recognised by the manufacturer researchers have also “found in a controlled study that some patients have a marked increase in violence when treated with moderately high-dose haloperidol”⁸³ (Haldol).⁸⁴

This paradoxical admission by a manufacturer that neuroleptics might actually exacerbate psychotic symptoms, rather than ameliorate them, does not weaken an Article 18 case against the drugs. On the contrary, regardless of whether a treatment diminishes or distorts a person’s thinking processes it still interferes with the person’s right to freedom in thought and belief.

In a recent book a British psychiatrist related how he had participated in an experiment that required him to take a 5 mg dose of haloperidol. This is about half the normal daily dose prescribed for

⁸¹ Keltner, et al., *op. cit.*, p. 233.

⁸² Haldol Decanoate advertisement, *Archives of General Psychiatry*, August 1995.

⁸³ J. N. Herrera, John J. Sramek, Jerome F. Costa, Swati Roy, Chris W. Heh and Bich N. Nguyen, ‘High Potency Neuroleptics and Violence in Schizophrenics’, *Journal of Nervous and Mental Disorders*, Vol. 176, Number 9, 1988, pp. 558-561.

⁸⁴ Haloperidol is the generic name while Haldol is a brand name for the same drug.

adults with schizophrenia. The experiment was intended to test the affect of the drug on attention and concentration and required him to sit in front of a computer screen and perform simple tasks.

After an hour I felt terrible. The last thing I wanted to be doing was to be seated in front of that computer. Although I did not feel suicidal, I felt restless inside, as if I could not settle. On several occasions I had to get up and walk around. If I had not done so I don't know what would have happened. On two or three occasions I came close to putting my fist through the screen, because I was so intensely frustrated and bored with what was going on. This sensation was a real physical sensation located somewhere in the pit of my stomach. I felt irritated by everything that was going on at the time. The feeling persisted well into the next day, to the extent that I found it difficult to concentrate at work.⁸⁵

Another psychiatrist who deliberately took a small dose of a commonly prescribed neuroleptic called Thorazine (chlorpromazine), in order to find out what it was like, wrote a description of the experience: "I felt overwhelmed by the blahs. I felt tired and lethargic, motivated to do nothing. My thinking was turned down from 78 to 16 rpms, my mouth got dry and I just didn't care all that much about anything". He went on to describe the effects he had witnessed of neuroleptics on mental patients in hospitals:

Thinking is slowed down — and at high enough doses "dissolved" — so that so-called "crazy" or "delusional" thinking is prevented (along with other kinds of thinking — including creative thinking). Emotions are blunted, pushed down. The result is some degree of (often total) indifference and apathy. Sterile, zombie-like personalities result when indifference is combined with the drug's sedating effects. The sparkle, vitality and exuberance of an alive human being are cut off by these drugs.⁸⁶

Surveys of patient attitudes towards neuroleptics have found that the drugs are almost universally disliked by the people who take them.⁸⁷ Confirmation of this is to be found in the fact that unlike most other mind-altering drugs there is no black market for neuroleptics.⁸⁸ One patient described the experience of enforced treatment with neuroleptics as: "They knock you out. They cause aches and pains all through your body. They make you apathetic. They stop the whole spiritual

⁸⁵ Phillip Thomas, *The Dialectics of Schizophrenia*, Free Association Books, London, 1997, pp. 111-112.

⁸⁶ David Richman, 'Pursuing Psychiatric Pill Pushers', Sherry Hirsch, Joe Adams, Leonard Frank, Wade Hudson, and David Richman, eds., *Madness Network News Reader*, Glide, San Francisco, 1974, p. 113.

⁸⁷ Seth Farber, *op.cit.*, pp. 164-165.

⁸⁸ *Ibid.*, p. 166.

transformation process. Its like putting molasses in your brain. You can't even concentrate enough to read."⁸⁹

Another patient treated involuntarily with Thorazine said:

The drugs caused me all kinds of problems. I couldn't see. I couldn't read my music or see across the room. I thought my eyes were going bad. The subjective feeling is actually one of disturbance. Its important for people to know that it's not a tranquillising effect at all. What you feel is a sense of inner turmoil. Viewed from the outside you might look less agitated because you're not going to make much noise or show your spirit. I had difficulty thinking. I remember once trying to make a list of books I needed from class and not being able to finish the list. I had difficulty moving my tongue which I really resent because I still have residual effects today.⁹⁰

Testimonies like those above indicate that people who are alleged to have schizophrenia and who are given involuntary treatment with neuroleptic medication will have their rights to the freedom of thought, conscience and belief violated. When the possibility of permanent brain damage from neuroleptic treatment is also taken into consideration it seems apparent that these violations do far greater harm to Article 18 rights than any benefit that might accrue to the Article 12 (ICESCR) right "to the enjoyment of the highest attainable standard of physical and mental health."⁹¹ (In fact, it could be easily argued that neuroleptic treatment does more harm than good to a person's Article 12 rights as well.)

This argument, however, might be countered from the perspective of the medical model with the claim that the new generation of 'atypical' neuroleptics appear to cause less of the extrapyramidal side effects, the group to which tardive dyskinesia belongs, than the traditional neuroleptics. However, regardless of whether 'atypicals' cause less brain damage than traditional neuroleptics, they are still used to deliberately interfere with the thoughts and beliefs of patients. This means that an Article 18 case works equally well against both traditional and 'atypical' neuroleptics.

Human Rights Report on Freedom of Religion and Belief

In February 1997 the Australian Human Rights and Equal Opportunities Commission issued a discussion paper⁹² on the right to freedom of religion and belief in Australia. The purpose of the

⁸⁹ *Ibid.*, p. 90.

⁹⁰ *Ibid.*, p. 105.

⁹¹ United Nations, 'International Covenant on Economic, Social and Cultural Rights', Article 12 (1), reproduced in Satish Chandra, ed., *op. cit.*, p. 16.

⁹² Human Rights and Equal Opportunity Commission, *Free to Believe? The Right to Freedom of Religion and Belief in Australia*, *op.cit.*

discussion paper was to seek responses from interested parties prior to submitting a report and recommendations to the Commonwealth Government of Australia about the need for specific legal protection in this area. The foregoing Article 18 argument against psychiatric coercion is new and has not been tested so I made a submission to this inquiry to test the Commission's response to it. I have since been informed that my submission was the only one that questioned psychiatric practices in relation to Article 18.

In July 1998 the Commission submitted their report, Article 18: Freedom of religion and belief,⁹³ to the Commonwealth Attorney General with recommendations for legislative protection. Shortly afterwards the report was released to the public. The issue I had raised concerning routine violations of Article 18 by coercive psychiatric practices had been ignored as a topic of discussion in the report. However, where the report makes specific legislative recommendations a definition of 'belief' is given as a guide for drafting legislation. This definition specifically excludes from protection "beliefs which are caused by mental illness".⁹⁴

In a subsequent telephone conversation with the Director of the Human Rights Unit,⁹⁵ who oversaw the writing of the report, I questioned whether this advice accords with Article 2 of the ICCPR which requires protection for all individuals without discrimination. I also pointed out that Principle 1.5 of the Principles for the Protection of Person's with Mental Illness guarantees that every person with mental illness will be able to exercise all the rights specified in the various UN Declarations and Covenants.

The response was that the Human Rights Commission; (a) believed in the existence of mental illness; and (b) believed that mentally ill people have two kinds of belief — those beliefs which are manifestations of mental illness, and which are not protected by Article 18 — and those beliefs which are not manifestations of mental illness, and which are protected by Article 18.

When I asked the Director of the Human Rights Unit the obvious questions about whether she thought medical diagnosticians could be trusted to accurately distinguish between these two kinds of belief, and whether psychiatric treatments only target beliefs that are manifestations of mental illnesses, leaving the others intact, she had no answer. She also had no answer as to why the report was only concerned with making recommendations for legislative protection of religion and belief and completely omitted to address the freedoms of thought and conscience. In fact, at first she

⁹³ Human Rights and Equal Opportunity Commission, Article 18: Freedom of religion and belief, Human Rights and Equal Opportunity Commission, Sydney, July 1998.

⁹⁴ *Ibid.*, p. 27.

⁹⁵ Meredith Wilkie, Director, Human Rights Unit, Human Rights and Equal Opportunity Commission, Sydney, Telephone Conversation, 7 December, 1998.

claimed that thought and conscience were not covered in Article 18. This misconception was quickly corrected by reference to the relevant Article.

Towards the end of the conversation I found I had little confidence in her understanding of the process for which she had been responsible. By way of a test I asked her how many involuntary hospitalisations and community treatment orders are made each year in the state of New South Wales. The reason was to test whether her perception that there was not a human rights problem in this area was based on an informed overview of the situation. She was reluctant to answer at first but under pressure guessed it might be in the hundreds. The actual number for 1997 was almost twelve and a half thousand. This was about 20% more than 1996, and more than double the number in 1992.

Following this telephone conversation I received a letter from the Human Rights Commissioner which sought to clarify some of the issues that had been discussed and to bring the matters to closure. The Commissioner said he agreed “with a great deal of the argument”⁹⁶ contained in my submission. However, he went on to say that the Human Rights Commission had already investigated the human rights problems associated with mental illness in a specific inquiry into these matters in the early 1990s. “Having dealt with the issues in such depth in that inquiry I did not consider it necessary or justifiable to deal with them again in our much more limited inquiry into religious freedom. Religious freedom in most respects raises other human rights issues”.⁹⁷

But according to the mystical model for schizophrenia the Commissioner might be wrong to uncouple the problems of religious freedom from the threat of psychiatric coercion. On top of this the report of the earlier inquiry into human rights and mental illness, which the Commissioner refers to, does not deal with the issues raised by the Article 18 argument. In fact there was a fundamental unsoundness about this inquiry in that it failed to fulfil one of its key Terms of Reference: i.e. to inquire into the human rights and fundamental freedoms of people who are alleged to be mentally ill. This failure has already been discussed in detail in Chapter 2.

It would seem, therefore, that the Article 18 argument against psychiatric coercion still remains untested.

⁹⁶ Chris Sidoti, Human Rights Commissioner, Human Rights and Equal Opportunity Commission, Sydney, Personal Correspondence, 23 December, 1998.

⁹⁷ Ibid.

Conclusion

Article 18 evidently provides a powerful human rights defence against forced psychiatric intervention for people who are undergoing a mystical/schizophrenic experience. This defence needs to be adapted to the specific provisions of each legal jurisdiction but the case study based on NSW legislation indicates that proper observance of Article 18 would severely restrict the range of people who could be involuntarily hospitalised.

In addition to the restriction on involuntary hospitalisation, neuroleptic drug treatment, without informed consent, would appear to be a straight-forward violation of Article 18. The unrestricted protection of the freedom of thought and the freedom to hold beliefs provided in Article 18 makes it impossible to apply involuntary treatment, using either conventional or ‘atypical’ neuroleptics, without violating the person’s human rights.

This apparent obstacle to forced drug treatment conflicts with provisions allowing treatment without informed consent in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.⁹⁸ However, Article 18, in principle, over-rides the Principles. This is because Article 18 is contained in a UN Covenant and Covenants have higher status in international law than UN Principles.

⁹⁸ United Nations, Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, Principle 11, *op.cit.*, pp. 990-991.

8. The Myth-Of-Mental-Illness Model: Schizophrenic Symptoms as Manufactured Artefacts

Introduction

The myth-of-mental-illness (M-M-I) model for schizophrenia should not be dismissed on the assumption that adherents to this interpretation are either few in number or socially insignificant. Recent research undertaken by Professor Robert Spillane, a lecturer in management at Macquarie University in Sydney, has found that one third of middle and senior level business managers in Sydney and Melbourne believe that "mental illnesses such as schizophrenia and manic depression are myths dreamed up by lazy workers" as excuses "used to escape work or gain personal rewards".¹

The basic premise of the M-M-I model is simply that there cannot be any disease of the mind because the mind is an abstract concept without any physical reality.² The M-M-I model argues that the use of the term 'mental disease' to describe unusual patterns of thought and behaviour was originally clearly understood as being metaphorical.³ The subsequent application of a medical model to this metaphor, and the modern literal understanding of it, is therefore unsound.⁴ A 'sick' mind, like a 'sick' joke, or a 'sick' society, cannot be treated medically and would only be literally understood as a medical problem by a fool.

From the M-M-I perspective the only way that the symptoms of schizophrenia can be indicative of disease is if they are manifestations of a brain disease, not a mental disease.⁵ However, despite the many hypotheses which try to link schizophrenia with brain abnormalities, no firm pattern of schizophrenia-typical lesions has yet been detected in the brains of deceased schizophrenics so there is no evidence that the diagnostic indicators of schizophrenia are symptoms of brain disease.⁶ Therefore, there is no such thing as a brain disease, let alone a mental disease, called schizophrenia: "Schizophrenia is a moral verdict masquerading as a medical diagnosis".⁷

¹ 'Mental illness myth: bosses', Sunday Telegraph (Sydney), 19 September, 1999.

² Thomas Szasz, The Myth of Mental Illness, Revised Edition, Harper and Row, New York, 1974, pp. vii-xii.

³ Thomas Szasz, 'Diagnoses are not diseases', The Lancet, Vol. 338, No. 8782, December 21, 1991, pp. 1574-1577

⁴ William J. Gannon, 'The formulated fix: The role of reification in the diagnostic process', Psychology, Vol 21, Nos. 3 and 4, 1984, pp. 43-48.

⁵ Thomas Szasz, Schizophrenia: The Sacred Symbol of Psychiatry, Syracuse University Press, Syracuse New York, 1976, pp. 34-35.

⁶ Theodore R. Sarbin, 'Towards the Obsolescence of the Schizophrenia Hypothesis,' The Journal of Mind and Behaviour, Vol. 11, Nos. 3 and 4, 1990, pp. 259-283.

⁷ Theodore R. Sarbin and James C. Mancuso, Schizophrenia: Medical Diagnosis or Moral Verdict?, Pergamon Press, New York, 1980, p. 220.

The common incidence of people supposedly displaying schizophrenic indicators does not threaten the M-M-I argument. On the one hand it can be argued that schizophrenic indicators fall within the range of natural psychological and behavioural experience and they have only been defined in pathological terms because they fall outside the boundaries of cultural tolerance.⁸ As such there are social expectations that ‘good citizens’ will avoid these patterns of thought and behaviour. People who do not avoid them are subsequently identified as deviants because, in a metaphorical sense, they have ‘sick’ minds.⁹

On the other hand it can also be argued that a provision by the medical profession of an otherwise non-existent category of human types called schizophrenics has required that individuals of this type be manufactured to fill it. To describe how this manufacturing process takes place analogies are drawn between modern schizophrenics and medieval witches.¹⁰ Just as it is now thought to be unlikely that people with magical powers of communication, and a compulsive desire to corrupt Christian citizens, actually existed in late-medieval Europe, so it is also thought unlikely that people actually manifest the extraordinary mental contortions, and compulsive forms of dangerous behaviour, attributed to modern schizophrenics.¹¹

What brings these types of people into existence is the human imagination. Belief in their existence is a kind of shared collective delusion, which fulfils transitory cultural needs, and which can be initiated when the holders of epistemological authority categorically assert that such things are true.¹² In other words, these culturally-based delusions are initiated when transmission of the false belief is from the top down.

In the case of late-medieval witches this occurred with the publication of the *Malleus Maleficarum* in 1486. The *Malleus Maleficarum* was a precise diagnostic manual for witch-hunters¹³ and it was published specifically to implement a papal bull empowering Inquisitors “to proceed to the just correction, imprisonment, and punishment”¹⁴ of heretics who corrupted the Catholic faith by

⁸ Seth Farber, *Madness, Heresy, and the Rumor of Angels: Revolt Against the Mental Health System*, Open Court, Chicago, 1993, pp. 1-3.

⁹ Ariel Stravynski and Kieron O'Connor, ‘Understanding and managing abnormal behaviour: the need for a new clinical science’, *The Journal of Psychology*, Vol. 129, No. 6, pp. 605-621.

¹⁰ Thomas Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, Paladin, St Albans, 1973.

¹¹ D. L. Penn, K. Guynan, T. Daily, W. D. Spaulding, C. P. Garbin, M. Sullivan, ‘Dispelling the Stigma of Schizophrenia: What Sort of Information is Best?’, *Schizophrenia Bulletin*, Vol. 20, No. 3, 1994, pp. 567-78.

¹² Stravynski and O'Connor, *op.cit.*, pp. 605-621.

¹³ G. Zilboorg, *A History of Medical Psychology*, Norton, New York, 1967, pp. 144-174.

¹⁴ *Malleus Maleficarum*, quoted in Szasz, *The Manufacture of Madness*, *op.cit.*, p. 35.

conversing with devils. After its publication “there soon followed an epidemic of Witchcraft”¹⁵ and people manifesting the malignant signs were discovered everywhere.

In the case of modern schizophrenics the official declaration of their imagined existence can not be so easily dated to a single publication. Kraepelin’s and Bleuler’s seminal works were part of an evolving definition of pathology to which many other researchers had contributed before them.¹⁶ The evolution of the medical model for schizophrenia has already been discussed and, as befits a scientific enterprise, the exact details of the definition of schizophrenia shift as new knowledge is negotiated into existence.¹⁷ To be valuable as scientific knowledge the belief in schizophrenia must support on-going scientific research. Ongoing scientific research inevitably keeps the definition moving. This movement gives rise to the illusion that progress is being made in the discovery of knowledge about the subject and that break-throughs are imminent.¹⁸

From the M-M-I perspective schizophrenia research is highly doubtful since it can only be founded on false assumptions. If the indicators of schizophrenia are actually quite natural forms of human expression, which are only made abnormal by cultural restrictions, nothing more can be discovered about schizophrenics beyond what is already self-apparent: i.e. that they are people who do not conform with unwritten codes of behaviour. On the other hand, if the supposed signs and symptoms are truly extraordinary, like the ones that were supposed to identify witches, then they actually exist in the minds of the observers of schizophrenia, not in the minds of the schizophrenics. If this is the case then we are confronted with the paradox that the minds which are routinely distorting reality are, in response to these distortions, researching into a non-existent disease by examining and deliberately modifying minds which would otherwise be quite normal. Once again the persecution of witches by the Inquisition is a useful analogy.

Some of the M-M-I case-studies of schizophrenics demonstrate the persuasive power of both these points of view.¹⁹ That is, although some people might have a perfectly rational explanation for being the way they are, they might be diagnosed with schizophrenia when they antagonise other

¹⁵ Szasz, ibid.

¹⁶ Anthony Clare, Psychiatry in Dissent: Controversial issues in thought and practice, Second Edition, Tavistock, London, 1980, pp. 120-168.

¹⁷ For a discussion on the way in which scientific knowledge is negotiated into existence see, H. Tristram Engelhardt, Jr., and Arthur L. Caplan, ‘Patterns of controversy and closure: the interplay of knowledge, values, and political forces’, in H. Tristram Engelhardt, Jr., and Arthur L. Caplan, eds., Scientific Controversies: Case studies in the resolution and closure of disputes in science and technology, Cambridge University Press, Cambridge, 1987, pp. 1-23.

¹⁸ Daniel R. Weinberger, ‘From neuropathology to neurodevelopment: Schizophrenia, Part 2’, The Lancet, Vol. 346, No. 8974, August 26, 1995, pp. 552-558.

¹⁹ See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels: Revolt Against the Mental Health System, Open Court, Chicago, 1993.

people by being deliberately and defiantly different.²⁰ As well as this, seemingly ordinary people, who demonstrably want to be normal and well-liked by others, can also be diagnosed.²¹ This might happen when too much stress builds up in a group, particularly a family,²² and it is necessary to nominate a convenient scape-goat. When this happens these otherwise ordinary individuals become the target for group disdain or group condescension.²³ By sacrificing one member to the mental health system the group might be able to relieve its collective stress and preserve its unity.

These kinds of M-M-I arguments are not particularly threatening to mainstream psychiatry. The medical model of schizophrenia has widespread community support²⁴ and, as a consequence, consensus within the profession is strong.²⁵ The few mental health professionals who question it have been easily marginalised.²⁶ But perhaps, paradoxically, the strength of this professional/community solidarity can be attributed to the fact that schizophrenia is indeed a myth. If the M-M-I argument is actually correct, and the process of diagnosis and treatment for schizophrenia is no more than a system for disposing of unwanted scapegoats and social deviants, then a vital social function is still being performed and one could expect it would meet with little opposition beyond the victims themselves. This could well be the reason why the M-M-I argument now appears to have very little appeal to either psychiatric professionals or ordinary people.²⁷

Nor can the M-M-I argument make any headway by demonstrating the inappropriateness of the schizophrenia label in individual cases. Where it can be convincingly demonstrated that a particular schizophrenic had a perfectly well-ordered mind at the time of diagnosis,²⁸ the psychiatric defence is simply to argue that here is an example of false-positive diagnosis, and that although medicine is not a perfect science, even so, the precision of psychiatric diagnosis is improving all the time.²⁹

²⁰ Kathleen Smith, Muriel W. Pumphrey, and Julian C. Hall, 'The "Last Straw": The Decisive Incident Resulting in the Request for Hospitalisation in 100 Schizophrenic Patients', in Richard H. Price and Bruce Denner, eds., The Making of a Mental Patient, Holt, Rinehart and Winston, New York, 1973, pp. 70-78.

²¹ See for example, Harvey Currell, Peter Bruton, and Sidney Katz, 'Psychiatric Justice in Canada', in Thomas S. Szasz, ed., The Age of Madness, Routledge and Kegan Paul, London, 1973, pp. 216-230.

²² R. D. Laing and A. Esterson, Sanity, Madness and the Family, Penguin, Harmondsworth, 1964.

²³ Irit Shimrat, 'Psychiatry: not all it's cracked up to be', Canadian Dimension, Vol. 29, No. 5, October-November 1995, pp. 10-12.

²⁴ See for example, National Association for the Mentally Ill (NAMI), Schizophrenia, Information Pamphlet, June 1990.

²⁵ Melvin Sabshin, Prepared Statement for the American Psychiatric Association, before the House Appropriations Committee Labor, Health and Human Services and Education Subcommittee, Wednesday, April 16, 1997, Federal News Service - Congressional Hearing Testimonies.

²⁶ Genevieve Stuttaford, 'Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill (Book Review)', Publishers Weekly, Vol. 237, No. 28, July 13, 1990, p48.

²⁷ E. Fuller Torrey, 'The mental-health mess', National Review, Vol. 44, No. 25, Dec 28, 1992, pp. 22-26.

²⁸ Seth Farber, 'From Victim to Revolutionary: An Interview with Leonard Frank', in Seth Farber, op.cit., pp. 190-240.

²⁹ Samuel I Cohen, 'Overdiagnosis of schizophrenia: role of alcohol and drug misuse', The Lancet, Vol. 346, No. 8989, Dec 9, 1995, pp. 1541-1543.

An often-cited weakness in M-M-I argument is that a large fraction of the people designated as schizophrenics are willing to accept the label.³⁰ If schizophrenia is a myth why are so many of the supposed social deviants and scape-goats willing to identify themselves as schizophrenics, thereby endorsing their own alienation? The M-M-I response is to argue that these apparently willing schizophrenics are involved in a type of role-playing.³¹

In order to explore the soundness of the M-M-I model it is proposed in this chapter to divide the model into three sub-types. The first sub-type is the **schizophrenic-as-cultural-outsider** and is concerned with whether the signs and symptoms of schizophrenia are anything more than a transgression of the boundaries of culturally acceptable thinking and behaviour. Schizophrenics of this type are, by definition, different from normal people, but only marginally so. Sometimes they might be aware of their difference, and deliberately cultivate it,³² and sometimes they might be surprised to discover that other people perceive them as abnormal.³³ The invention of schizophrenia, and the application of its diagnoses, are seen from this angle as a method of dealing with people who have wandered outside the cultural envelope.³⁴ To test this theory the DSM-IV diagnostic criteria for schizophrenia will be examined as if they are designed to represent boundary markers of cultural tolerance.

The second sub-type will deal with the **schizophrenic-as-scapegoat**. Here the person designated as schizophrenic is himself or herself quite normal, and would otherwise be content to live within the cultural boundaries, but has the misfortune to belong to a group that is under stress. The group might be a company, a neighbourhood, or even a nation, but most frequently it is a nuclear family.

The third sub-type involves **schizophrenia-as-role-play**. This is where the symptoms of schizophrenia are simulated. The simulation might be initiated by either the patient or the diagnostician. When it is initiated by the patient it could be motivated by the desire to adopt the schizophrenic role as a career. When the role-playing is initiated by the diagnostician it might involve the maintenance of professional norms. Either way the result can be that the person who receives the diagnosis also receives a detailed script describing how to think and behave like a

³⁰ See for example, Jim Read and Jill Reynolds, eds., Speaking Our Minds: An Anthology of Personal Experiences of Mental Distress and its Consequences, The Open University, London, 1996.

³¹ Thomas Szasz, 'Idleness and Lawlessness in the Therapeutic State', Society, Vol. 32, No. 4, 1995, p. 30-36.

³² See for example, Vaslav Nijinsky, 'The Doctors Don't Believe Me', in James Fadiman and Donald Kewman, eds., Exploring Madness: Experience, Theory, and Research, Brooks/Cole, Monterey, Calif., 1973, pp. 54-60.

³³ Sue Williams, 'Whistleblowers sacked as 'mad'', Sun-Herald, Sydney, 21 September, 1997, p. 23.

³⁴ Benjamin M. Braginsky, Dorothea D. Braginsky and Kenneth Ring, 'The Search for a New Paradigm', in James Fadiman and Donald Kewman, eds., Exploring Madness: Experience, Theory, and Research, Brooks/Cole, Monterey, Calif., 1973, pp. 69-76.

schizophrenic. A person who receives this script is thenceforth compelled by social expectations to rigidly adhere to it. This scripting of the schizophrenic role by diagnosis is often referred to as ‘labelling’.³⁵

Sub-Type 1: Schizophrenic-as-Cultural-Outsider

In considering the question of whether schizophrenics are actually normal in terms of their intrinsic humanity, and are only outsiders because they are abnormal in relation to cultural standards, it might be useful to look again at some of the main indicators of the condition in the light of the M-M-I arguments. DSM-IV specifies these indicators as being positive symptoms like delusions, hallucinations, disorganised speech, and disorganised or catatonic behaviour;³⁶ and/or negative symptoms like affective flattening, alogia and avolition.³⁷ These are the Criterion A symptoms³⁸ and if any one ‘bizarre’ example of these symptoms, or any two examples if they are non-bizarre, correlate with a Criterion B symptom³⁹ — i.e. a social/occupational dysfunction concerning matters like work, interpersonal relations or self-care — then a diagnosis of schizophrenia can be made. It should be pointed out once again that there are no laboratory tests available to confirm a diagnosis and nothing more needs to be done to make a definitive diagnosis than to follow the DSM-IV (or ICD-10)⁴⁰ guidelines.

Let us begin with delusions. In its Glossary of Technical Terms DSM-IV describes a delusion as:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (e.g., it is not an article of religious faith).⁴¹

A delusion is said to have the additional pathology of ‘bizarre’ attached to it when it “involves a phenomenon that the person’s culture would regard as totally implausible”.⁴²

The first thing that is evident here is that there is no substantial difference between bizarre and non-bizarre delusions and what seems to differentiate a delusion from a false belief is simply a matter of

³⁵ See for example, Thomas Scheff, Labelling Madness, Prentice-Hall, Englewood Cliffs, N.J., 1975.

³⁶ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), American Psychiatric Association, Washington, 1994, p. 274-277.

³⁷ Ibid., p. 277.

³⁸ Ibid., p. 285.

³⁹ Ibid.

⁴⁰ World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines, World Health Organisation, Geneva, 1992.

⁴¹ American Psychiatric Association, op.cit., p. 765.

⁴² Ibid.

cultural acceptance. This distinction between a false belief and a delusion, by cross-checking for cultural acceptance, is a special psychiatric interpretation of the word ‘delusion’.⁴³ In normal lay usage a ‘delusion’ can be any kind of false belief whether it is accepted by the person’s culture or not.⁴⁴

There are two interesting implications that can be drawn from this DSM-IV definition of delusion. Both concern the beliefs of the psychiatrists who have compiled the manual. The first is that culturally-based beliefs can be false. The second is that, although the compilers believe that religious beliefs can be false beliefs, religious beliefs are not delusions so long as they are culturally-based.

If normal people and schizophrenics both have false beliefs, with the only difference between them being that the normal peoples’ beliefs are culturally acceptable, while those of schizophrenics are culturally unacceptable, then it is hard to avoid the conclusion that the use of delusions as a symptom supports the argument that schizophrenics are no more than cultural outsiders. The requirement to correlate delusions with a disturbance in social functioning (Criterion B) only strengthens this line of thinking.

The DSM-IV Glossary of Technical Terms also defines hallucinations, which is the second Criterion A symptom.

hallucination A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from *illusions*, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognise that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (*hypnagogic*), or when awakening (*hypnopompic*). Transient hallucinatory experiences may occur in people without a mental disorder.

Types of hallucinations include

auditory A hallucination involving the perception of sound, most commonly of voices. Some clinicians and investigators would not include those experiences perceived as

⁴³ R. W. Butler and D. L. Braff, ‘Delusions: A Review and Integration’, *Schizophrenia Bulletin*, Vol. 17, No. 4, 1991, 633-647.

⁴⁴ See for example, Virginia S. Thatcher, ed., *The New Webster Encyclopedic Dictionary of The English Language*, Consolidated Book Publishers, Chicago, 1970, p. 227.

coming from inside that head and would instead limit the concept of true auditory hallucinations to those sounds whose source is perceived as being external. However, as used in DSM-IV, no distinction is made as to whether the source of the voices is perceived as being inside or outside the head.

gustatory A hallucination involving the perception of taste (usually unpleasant).⁴⁵

The list of hallucination sub-types further extends to include; mood-congruent, mood incongruent, olfactory, somatic, tactile, and visual hallucination. It is significant that the above definition of ‘hallucination’ specifies that “[t]ransient hallucinatory experiences may occur in people without a mental disorder”. This means that hallucinations, in themselves, are not necessarily indicative of abnormality.

To be an indicator of schizophrenia a hallucinatory experience must be beyond the range of normal experience.⁴⁶ Certainly it must be more unusual than the common experience where a person who is distracted, or who is in a noisy environment, imagines the voice of an accompanying person and asks, “did you say something?” When this happens there is usually no suspicion that it might be a symptom of mental disorder.

Exactly how different and unusual a hallucinatory experience has to be to qualify as a symptom of schizophrenia is not specified.⁴⁷ But it is implied by the diagnostic criteria that the “did you say something?” type of hallucination, although seemingly harmless to lay people, might be close to a schizophrenic marker. The observation in the DSM-IV quotation above that some clinicians are only interested in hallucinations of external voices, and ignore those perceived as being inside the head, clearly suggests that the “did you say something?” kind of hallucination, being concerned with an imagined external source, is of the more serious kind.

In its diagnostic overview of schizophrenia DSM-IV specifies that of all the types of hallucination possible, auditory hallucinations experienced as voices “are by far the most common and characteristic of Schizophrenia”⁴⁸. This is repeatedly confirmed in the psychiatric literature.⁴⁹ So it seems that imagined external voices are the most positive of the hallucinatory indicators for schizophrenia, even though these are demonstrably common experiences.

⁴⁵ American Psychiatric Association, *op.cit.*, p. 767.

⁴⁶ N. A. Rector and M. V. Seeman, ‘Auditory Hallucinations in Women and Men’, *Schizophrenia Research*, Vol. 7, No. 3, 1992, pp. 233-236.

⁴⁷ For a discussion on the use of a scale of assessment for evaluating hallucinations see, J. de Leon, M. J. Cuesta and V. Peralta, ‘Delusions and Hallucinations in Schizophrenic Patients’, *Psychopathology*, Vol. 26, Nos. 5 and 6, 1993, pp. 286-291.

⁴⁸ American Psychiatric Association, *op.cit.*, p. 275.

⁴⁹ See for example, P. Chadwick and M. Birchwood, ‘The Omnipotence of Voices: A Cognitive Approach to Auditory Hallucination’, *British Journal of Psychiatry*, Vol. 164, No. 2, 1994, pp. 190-201.

This lack of positive distinction between the normal and the pathological tends to shift the diagnostic emphasis in regard to hallucinations onto the cross-referencing criterion of social/occupational dysfunction. In other words hallucinations alone might not properly distinguish a schizophrenic from a normal person⁵⁰ but if a person is observed to hallucinate, and also to have a disturbance in their social functioning,⁵¹ then the hallucination might indicate schizophrenia. When the diagnostic criteria are interpreted this way it would seem that social functioning is exposed as a key determinant of schizophrenia⁵² and so there is some evidence supporting the schizophrenia-as-outsider argument.

The third symptom in the DSM-IV Criterion A for schizophrenia is disorganised speech. Examples of disorganised speech are given as being ‘derailment’ or ‘incoherence’.⁵³ In the discussion about these symptoms the manual makes it clear that disorganised speech is used as an indicator for an underlying disorganisation in the person’s thinking “because in a clinical setting inferences about thought are based primarily on the individual’s speech.”⁵⁴ This means that for diagnostic purposes the level of organisation apparent in a person’s speech is assumed to represent their level of mental organisation as well.⁵⁵

However, having specified that speech is only meant to be an indicator of a person’s mental state, in a further discussion about varieties of disorganised speech to watch out for, the manual goes on to advise that “[b]ecause mildly disorganised speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication”.⁵⁶ This means that the compilers of the manual recognise that normal people can have mildly disorganised thoughts, as is sometimes indicated by their speech, and that, in relation to this symptom, the threshold of mental illness is only crossed when a person’s mind is so disorganised that the ability to communicate through speech is impaired.

⁵⁰ N. M. Docherty, W. H. Sledge and B. E. Wexler, ‘Affective Reactivity of Language in Stable Schizophrenic Outpatients and Their Parents’, *Journal of Nervous and Mental Disease*, Vol. 182, No. 6, 1994, pp. 313-318.

⁵¹ L. A. Opler, C. L. Caton, P. Shrout, B. Dominguez and F. I. Kass, ‘Symptom Profiles and Homelessness in Schizophrenia’, *Journal of Nervous and Mental Disease*, Vol. 182, No. 3, 1994, pp. 174-178.

⁵² G. Thornicroft, G. Bisoffi, D. De Salvia and M. Tansella, ‘Urban-Rural Differences in the Associations Between Social Deprivation and Psychiatric Service, Utilisation in Schizophrenia and all Diagnoses: A Case-Register Study in Northern Italy’, *Psychological Medicine*, Vol. 23, No. 2, 1993, pp. 487-496.

⁵³ For a discussion on a method of assessing deviant verbalisations characteristic of schizophrenia see, F. Leichsenring, ‘Discriminating Schizophrenics from Borderline Patients: Study with the Holtzman Inkblot Technique’, *Psychopathology*, Vol. 24, No. 4, 1991, pp. 225-231.

⁵⁴ American Psychiatric Association, *op.cit.*, p. 276.

⁵⁵ H. A. Allen, P. F. Liddle and C. D. Frith, ‘Negative Features, Retrieval Processes and Verbal Fluency in Schizophrenia’, *British Journal of Psychiatry*, Vol. 163, 1993, 769-775.

⁵⁶ American Psychiatric Association, *op.cit.*, p. 276.

In using this particular indicator to identify schizophrenia it is the inability to communicate effectively with other people that is the key.⁵⁷ Yet if a person can be diagnosed with schizophrenia simply because his or her speech has been judged in a diagnostic situation to be too disorganised to communicate effectively,⁵⁸ and this has been combined with a perception that the person is also socially or occupationally dysfunctional (Criterion B) — which may be for the same or perhaps some other reason — then this would seem to provide particularly strong evidence that schizophrenia can be culturally determined.

A person who is diagnosed with schizophrenia in this way might simply lack sufficient interest in other people, or perhaps lack the social skills, to easily make themselves understood by others, and as a result has social/occupational difficulties. It is conceivable that the mental functioning of this person might otherwise be quite normal.

Nor does it follow that an impairment in communication necessarily indicates a short-coming in the person who is doing the speaking. In a clinical setting the inability of the diagnostician to understand the patient should perhaps be also taken into account. The essential feature of this particular diagnostic tool is one where the ability of the diagnostician to comprehend the speech of the patient is assumed to be a standard test of sanity. But this begs the question as to whether diagnosticians' minds are calibrated to make standard measurements in this regard. And, if they are, whether that standard is concerned with the measurement of mind or with cultural adaptation. If the latter is indeed the case then it offers strong support to the view of schizophrenic-as-outsider.

The fourth group of Criterion A symptoms is “grossly disorganised or catatonic behaviour”. The DSM-IV guidelines for recognising these symptoms are the following:

Grossly disorganised behaviour (Criterion A4) may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behaviour, leading to difficulties in performing activities of daily living such as organising meals or maintaining hygiene. The person may appear markedly dishevelled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), or may display clearly inappropriate sexual behaviour (e.g., public masturbation) or unpredictable and untriggered agitation (e.g., shouting or swearing). Care should be taken not to apply this criterion too broadly. Grossly disorganised behaviour must be distinguished from behaviour that is merely

⁵⁷ Nancy M. Docherty, ‘Communication disturbances in schizophrenia and mania’, Journal of the American Medical Association, Vol. 276, No. 1, July 3, 1996, p. 4B.

⁵⁸ For an analysis of why schizophrenic speech is unpredictable see, T. C. Manschreck, B. Maher, M. T. Celada, M. Schneyer, and R. Fernandez, ‘Object Chaining and Thought Disorder in Schizophrenic Speech’, Psychological Medicine, 1991; Vol. 21, No. 2, 1991, pp. 443-446.

aimless or generally unpurposeful and from organised behaviour that is motivated by delusional beliefs. Similarly, a few instances of restless, angry, or agitated behaviour should not be considered to be evidence of Schizophrenia, especially if the motivation is understandable.⁵⁹

Whereas the instructions regarding the previously discussed symptom, disorganised speech, specifically make the point that this symptom is only an external indicator of internal mental disorganisation, there is no similar instruction concerning “grossly disorganised behaviour”. This may be an omission on the part of the manual⁶⁰ or it might mean that disorganised behaviour is not meant to be read as an indicator of a corresponding level of inner mental disorganisation. If the latter is the case then the types of disorganised behaviours listed above are merely some of the things schizophrenics have been observed doing and the behaviours do not directly reflect inner mental activity.⁶¹ This would mean then that the wearing of multiple overcoats, or public masturbation, would have the same kind of relationship to schizophrenia as the wearing of a woollen beanie might have to baldness. Both bald and hirsute people might wear beanies. But when a bald person wears one, baldness can serve as a convenient, though not necessarily correct, explanation for why the beanie is worn.

Similarly, schizophrenia might serve as a convenient explanation for why a person might “dress in an unusual manner”, providing the observer has already been informed that a person is indeed schizophrenic.⁶² But to use unusual dress as a diagnostic indicator of mental disorder seems as doubtful as assuming that any person wearing a beanie is bald.

This symptom seems to be so transparently loaded with cultural bias that it does not really require any argument to prove the schizophrenic-as-outsider case. Even so, it is worth noting that although private masturbation is no longer considered to be either a cause or a symptom of madness, as it once was,⁶³ public masturbation is clearly listed as an indicator of schizophrenia. What makes the difference here, apparently, is whether the setting of the behaviour, rather than the behaviour itself, is culturally acceptable.

⁵⁹ American Psychiatric Association, *op.cit.*, p. 276.

⁶⁰ For a discussion on chaos theory as a method of analysing disorganisation in schizophrenics see, G. B. Schmid, ‘Chaos Theory and Schizophrenia: Elementary Aspects’, *Psychopathology*, Vol. 24, No. 4, 1991, pp. 185-198.

⁶¹ It is interesting to note that some of the examples given in the DSM-IV description, like wearing multiple overcoats in hot weather and public masturbation, only appear in the psychiatric literature as anecdotes and do not appear to have been subjected to any kind of extensive scientific investigation. It is possible that these forms of behaviour might have more to do with homelessness than with schizophrenia.

⁶² Richard E. Gallagher and John Nazarian, ‘A Comprehensive Cognitive-Behavioural/Educational Program for Schizophrenic Patients’, *Bulletin of the Menninger Clinic*, Vol. 59, No. 3, 1995, pp. 357-372.

⁶³ Szasz, *The Manufacture of Madness*, *op.cit.*, p. 213.

Negative Symptoms

The fifth and final group of symptoms in Criterion A are the negative symptoms like affective flattening,⁶⁴ alogia,⁶⁵ and avolition.⁶⁶ As the name suggests the negative symptoms are the opposite of the positive symptoms. Positive symptoms are indicated by forms of deviant behavioural activity and they are meant to disclose a commensurate level of inner mental deviance. Negative symptoms, on the other hand, are descriptions of behavioural inactivity,⁶⁷ or lack of activity, and they are supposed to indicate a commensurate level of inner mental inactivity.⁶⁸ If a person does not speak, or speaks as little as possible, (alogia) it is assumed it is because there is insufficient thinking going on to generate communication.

The observed presence of both positive and negative symptoms for schizophrenia indicates that it is a mental disorder with an extraordinary variety of complications.⁶⁹ A schizophrenic might be a person in a highly active delusional state, conversing incoherently with inner voices, wearing multiple overcoats and masturbating in public or, alternatively, it could also be a person who says, and feels, and does, and presumably thinks, next to nothing. It is important to note at this point that the negative symptoms have equal status as diagnostic criteria to the positive symptoms. This means that a person manifesting negative symptoms⁷⁰ is not thought to be in remission, or in an inactive phase of the disease, but is at the time a full-blown schizophrenic and diagnosable.

This range of symptoms is one of the elements that makes schizophrenia so enigmatic, and which makes scientific research into the condition so problematic. Medical model researchers have so far been unable to uncover an underlying common denominator amongst schizophrenics.⁷¹ This is not surprising when the types of people presented to them as subjects are so variable because of the range from negative to positive in the diagnostic criteria. Indeed, much doubt abounds amongst

⁶⁴ R. H. Dworkin, B. A. Cornblatt, R. Friedmann, L. M. Kaplansky, J. A. Lewis, A. Rinaldi, C. Shilliday, and L. Erlenmeyer-Kimling, 'Childhood Precursors of Affective Versus Social Deficits in Adolescents at Risk for Schizophrenia', *Schizophrenia Bulletin*, Vol. 19, No. 3, 1993, pp. 563-577.

⁶⁵ D. D. Miller, S. Arndt, and N. C. Andreasen, 'Alogia, Attentional Impairment, and Inappropriate Affect: Their Status in the Dimensions of Schizophrenia', *Comprehensive Psychiatry*, Vol. 34, No. 4, 1993, pp. 221-226.

⁶⁶ S. Oke, R. Saatchi, E. Allen, N. R. Hudson, and B. W. Jervis, 'The Contingent Negative Variation in Positive and Negative Types of Schizophrenia', *American Journal of Psychiatry*, Vol. 151, No. 3, 1994, pp. 432-433.

⁶⁷ K. T. Mueser, M. S. Douglas, A. S. Bellack, and R. L. Morrison, 'Assessment of Enduring Deficit and Negative Symptoms Subtypes in Schizophrenia', *Schizophrenia Bulletin*, Vol. 17, No. 4, 1991, pp. 565-582.

⁶⁸ W. S. Fenton, and T. H. McGlashan, 'Natural History of Schizophrenia Subtypes: Positive and Negative Symptoms and Long-Term Course', *Archives of General Psychiatry*, Vol. 48, No. 11, 1991, pp. 978-986.

⁶⁹ R. C. Bell, L. H. Low, H. J. Jackson, P. L. Dudgeon, D. L. Copolov, and B. S. Singh, 'Latent Trait Modelling of Symptoms of Schizophrenia', *Psychological Medicine*, Vol. 24, No. 2, 1994, pp. 335-345.

⁷⁰ J. P. Selten, N. E. Sijben, R. J. van den Bosch, J. Omluo-Visser, and H. Warmerdam, 'The Subjective Experience of Negative Symptoms: A Self-Rating Scale', *Comprehensive Psychiatry*, Vol. 34, No. 3, 1993, pp. 192-197.

⁷¹ Anon., 'Imaging clues to schizophrenia', *Science News*, Vol. 146, No. 18, Oct 29, 1994, p. 284.

psychiatric researchers as to whether schizophrenics are in fact all of a single type: “Although the symptoms resemble various neurological disorders in various ways, its organic basis remains uncertain. There might be a single underlying process or several processes leading to similar results; some experts prefer to speak of ‘the schizophrenias’ instead of ‘schizophrenia’.”⁷² These doubts, however, do not arise with the schizophrenic-as-cultural-outsider perspective and the use of negative symptoms for diagnosis only makes this argument easier.

Bearing in mind the diagnostic setting, which from the schizophrenic-as-cultural-outsider point of view is a kind of interrogation session in which all power is transferred to the diagnostician,⁷³ it is worth considering the DSM-IV definition of alogia, which is one of the principle negative symptoms:

alogia An impoverishment in thinking that is inferred from observing speech and language behaviour. There may be brief and concrete replies to questions and restrictions in the amount of spontaneous speech (poverty of speech). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, over-abstract, repetitive, or stereotyped (poverty of content).⁷⁴

“Concrete” is a key term and it is used here to describe “poverty” in both the quantity and quality of speech. In psychiatric literature concrete is used variously to describe the opposite of metaphorical thinking and speech,⁷⁵ as well as to describe the opposite of abstract thinking and speech.⁷⁶ The inclusion of both extremes, overconcrete and over-abstract, in the above definition, indicates that mentally healthy people stick to the middle ground.

Yet even though concreteness is viewed by psychiatric diagnosticians as indicative of schizophrenia in their patients, strangely, it is also viewed as being a quality that therapists should develop in themselves, for working with schizophrenics:

The development of a therapeutic relationship is critically important in work with persons with schizophrenia (Frank & Gunderson, 1990; Lamb, 1982). Core skills of

⁷² Anon., ‘Schizophrenia update’, Harvard Mental Health Letter, Vol. 11, No. 12, June 1995, pp. 1-5.

⁷³ Thomas Szasz, ‘Psychiatric diagnosis, psychiatric power and psychiatric abuse’, Journal of Medical Ethics, Vol. 20, No. 3, 1994, pp. 135-138,

⁷⁴ American Psychiatric Association, op.cit., p. 764.

⁷⁵ M. Spitze, M. Lukas, S. Maier and L. Hermle, ‘Comprehension of metaphoric speech by healthy probands and schizophrenic patients: An experimental psychopathologic contribution to concretism’, Nervenarzt, Vol. 65, No. 5, May 1994, pp. 282-92.

⁷⁶ P. W. Corrigan, R. Silverman, J. Stephenson, J. Nugent-Hirschbeck and B. J. Buican, ‘Situational familiarity and feature recognition in schizophrenia’, Schizophrenia Bulletin, Vol. 22, No. 1, 1996, pp. 153-161.

empathic attunement, warmth, genuineness, and concreteness were used to establish a supportive relationship (Anthony, 1980; Elson, 1986; Hepworth & Larsen, 1993).⁷⁷

What can this contrariness mean? Why is concreteness associated with qualities like “empathic attunement, warmth, genuineness” when it is found in the therapists of schizophrenics, and with a pathological impoverishment of thinking when it is found in the schizophrenics themselves? Can there be anything wrong with concreteness if it is actually recommended as a therapeutic tool? Or, does a therapist who deliberately develops concreteness in speech for therapeutic purposes also run the risk of being diagnosed with schizophrenia?

Perhaps it could be seen as a demonstration of overconcrete thinking to question, in this way, the words used to describe schizophrenic symptoms. But within the M-M-I model there is assumed to be nothing more to schizophrenia than the supposed symptoms themselves.⁷⁸ This means that the words which describe the symptoms are all important because from this perspective it is only a linguistic consensus⁷⁹ amongst psychiatrists that brings schizophrenia into existence. If that linguistic consensus fails, then the current epidemic of schizophrenia could conceivably dissipate.

Quite frequently people are involuntary participants in the clinical procedures that lead to a diagnosis of schizophrenia.⁸⁰ When considered from this perspective psychiatrists can be seen as interrogators who have been retained by a third party to ask probing questions about the person's private thoughts and beliefs, for the transparent purpose of acquiring damaging evidence.⁸¹ Under these circumstances it might not be surprising if a perceptive and wary person seems concrete in their responses, and gives other evidence of DSM-IV negative symptoms like “brief, laconic, empty replies”.⁸² In fact, when schizophrenia diagnosis is viewed from the schizophrenic-as-outsider angle, the specification of negative symptoms like these appear to be no more than a ‘Catch-22’ — anything the person says about themselves can be used against them, and if nothing of substance is said, that can be used too.

Avolition is another of the negative symptoms:

⁷⁷ William Bradshaw, ‘Evaluating Cognitive-Behavioural Treatment of Schizophrenia: Four Single-Case Studies’, Research on Social Work Practice, Vol. 7, No. 4, October, 1997, p. 419.

⁷⁸ For a discussion on the practice of interpreting signs as pathological indicators in the absence of diseases see, Thomas Szasz, ‘Diagnoses are not diseases’, op.cit., pp. 1574-1577.

⁷⁹ N. C. Andreasen, and W. T. Carpenter Jr, ‘Diagnosis and Classification of Schizophrenia’, Schizophrenia Bulletin, Vol. 19, No. 2, 1993, pp. 199-214.

⁸⁰ Thomas Szasz, ‘The Case Against Psychiatric Coercion’, The Independent Review, Vol. I, No. 4, Spring 1997, pp. 1086-1653.

⁸¹ Lara Jefferson, ‘I Have Kept a Lone Death Watch with Madness When Reason Was Dying’, in James Fadiman and Donald Kewman, eds., Exploring Madness: Experience, Theory, and Research, Brooks/Cole, Monterey, Calif., 1973, pp. 14-23.

⁸² American Psychiatric Association, op.cit., p. 276.

avolition An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self care).⁸³

Consider a person who does not share with other people an appropriate level of culturally-acquired goal-direction for specific activities like formal education and career.⁸⁴ This kind of person is often referred to as a loser, a drop-out, a bum, a hopeless case, or a never-do-well. The specification of avolition as a symptom makes it apparent that 'schizophrenic' can also be added to this list of pejoratives.

In discussing the negative symptoms DSM-IV warns: “Although quite ubiquitous in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a continuum with normality”. But this “continuum with normality” is exactly what the schizophrenic-as-outsider model argues. Alogia might be no more than a disinclination for conversation in situations where such a disinclination is culturally unacceptable.⁸⁵ Similarly, avolition might be no more than a disinclination to participate in normal social intercourse.⁸⁶ If these disinclinations are indeed on a continuum with normality, then in relation to the negative symptoms at least, the schizophrenic-as-outsider case is very strong.

Criterion B is the second group of diagnostic indicators which are concerned with social or occupational dysfunction in the areas of interpersonal relations, work or education, or self-care. If Criterion A symptoms have been identified the diagnostician cross-checks to see whether there is any evidence of social or occupational dysfunction:

Typically, functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may

⁸³ *Ibid.*, p. 764.

⁸⁴ For a discussion on establishment concerns about a perceived general decline of the work ethic in the United States see, Chuck Colson and Jack Eckerd, *Why America Doesn't Work*, Word Publishing, Dallas, 1991.

⁸⁵ For an insight into the way rating scales are used to identify this symptom see, R. H. Dworkin, G. Bernstein, L. M. Kaplansky, J. D. Lipsitz, A. Rinaldi, S. L. Slater, B. A. Cornblatt, and L. Erlenmeyer-Kimling, 'Social Competence and Positive and Negative Symptoms: A Longitudinal Study of Children and Adolescents at Risk for Schizophrenia and Affective Disorder', *American Journal of Psychiatry*, Vol. 148, No. 9, 1991, pp. 1182-1188.

⁸⁶ For a demonstration of how psychiatrists deal with patients who dispute with them on this matter, by claiming they lack insight, see, J. P. McEvoy, N. R. Schooler, E. Friedman, S. Steingard, and M. Allen, 'Use of Psychopathology Vignettes by Patients with Schizophrenia or Schizoaffective Disorder and by Mental Health Professionals to Judge Patient's Insight', *American Journal of Psychiatry*, Vol. 150, No. 11, 1993, pp. 1649-1653.

be failure to achieve what would have been expected for the individual rather than a deterioration in functioning. Comparing the individual with unaffected siblings may be helpful in making this determination. Educational progress is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents (“downward drift”). The majority (60%-70%) of individuals with schizophrenia do not marry, and most have relatively limited social contacts.⁸⁷

There seems to be some overlap here with avolition. A loss of interest in activities of social value, or a loss of interest in climbing the ladder of social status, or even failure to satisfy the status expectations of others, are all deemed to be indications of mental pathology. Ostensibly Criterion B indicators are used as a cross-reference to evaluate the level of disability a person incurs from the presence of one or more Criterion A symptoms. As such it might not be expected they would be used as symptoms themselves. That is, occupational dysfunction, as it relates to Criterion B, is only significant as a measure of the detrimental effect of a Criteria A symptom like delusions. A delusional person is not schizophrenic if a cross-check finds there is no interference with his or her social or occupational functioning.

If the corollary is true, i.e. that, for instance, an occupationally dysfunctional (unemployed) person is not schizophrenic in the absence of Criterion A symptoms, then there is not much of a case to make for the schizophrenic-as-cultural-outsider out of Criterion B indicators. This is despite the fact that these indicators are concerned with failure in normal social activities — and to interpret such failure as a sign of pathology would be clear evidence of the schizophrenic-as-cultural-outsider.

However, although Criterion B indicators are supposedly only intended to give secondary confirmation of pathology, by way of a cross-check for social and occupational incompetence, references can be found in the literature of mental health professionals arguing that “[i]mpairment in the ability to work is a defining characteristic of schizophrenia”.⁸⁸ Thomas Szasz has written emphatically about the way occupational dysfunction in young people can lead to a diagnosis of schizophrenia.⁸⁹

Further DSM-IV diagnostic instructions in Criterion C give advice that confirms Criterion B symptoms might sometimes be used as primary indicators of schizophrenia. Criterion C defines schizophrenia by the length of time that Criterion A and B indicators have been present:

⁸⁷ American Psychiatric Association, *op.cit.*, p. 278.

⁸⁸ Paul Lysaker and Morris Bell, ‘Work Performance Over Time for People With Schizophrenia’, *Psychosocial Rehabilitation Journal*, Vol. 18, No. 3, 1995, pp. 141-146.

⁸⁹ Thomas Szasz, *Cruel Compassion: Psychiatric Control of Society’s Unwanted* John Wiley and Sons, New York, 1994, p. 145.

C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).⁹⁰

What is apparent here is that Criterion B indicators can be used as the primary symptoms while Criterion A indicators can be used as the secondary symptoms. If, for instance, a person has been occupationally dysfunctional i.e. unemployed (Criterion B) for six months prior to a diagnostic encounter, and over that period had stopped looking for work for at least a month (Criterion A5, avolition), then all that is required to fix the person with a label of schizophrenia is one other Criterion A indicator that was also present for one month out of the previous six months. An obvious example that might confirm the schizophrenic-as-cultural-outsider picture, given the financial circumstances of unemployment, would be a dishevelled appearance, or unusual dress (Criterion A4).

It is clear from an examination of these three sets of DSM-IV diagnostic criteria that it is not necessary for a person to have an abnormally functioning mind in order to be diagnosed with schizophrenia. Theoretically, it is quite obvious that people can be diagnosed, even though their thinking and behaviour might be on a continuum with that of normal people, simply because a psychiatrist observes personal attributes that are outside the boundary of cultural acceptance.⁹¹

Outsider Case Studies

There are numerous case studies in the literature of psychiatric survivors that confirm this contention. A particularly compelling story of this kind about personal diagnosis and treatment for schizophrenia is told by Leonard Roy Frank in an interview with Seth Farber. Frank is the author of a number of articles⁹² and books⁹³ which argue against coercive psychiatry and particular psychiatric practices.

⁹⁰ American Psychiatric Association, *op.cit.*, p. 285.

⁹¹ For an example of how some psychiatrists are campaigning to link homelessness with schizophrenia see, E. Fuller Torrey, 'Stop the Madness', *The Wall Street Journal*, 18 July, 1997.

⁹² Leonard Roy Frank, 'Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing', *The Journal of Mind and Behavior*, Vol. 11, Nos. 3 and 4, 1990, pp. 489-512.

⁹³ Leonard Roy Frank, ed., *The History of Shock Treatment*, Leonard Roy Frank, San Francisco, 1978.

In the interview with Farber, Frank recounts how he began a promising career in real estate sales in Florida and San Francisco. At a certain point, however, he decided to quit his job and take some time off to read books and follow an interest in philosophy. When his parents heard about his new life-style they went to visit him and, dismayed at his lack of interest in continuing his career in real estate, they advised him to see a psychiatrist. When he refused they signed the necessary papers to have him involuntarily committed to a mental hospital. He was diagnosed with paranoid schizophrenia and given 85 shock treatments. When he finally obtained his psychiatric records 12 years later he discovered the symptoms that had been identified to justify the diagnosis and treatment included: “not working, withdrawal, growing a beard, becoming a vegetarian, ‘bizarre behaviour’, ‘negativism’, ‘strong beliefs’, ‘piecing eyes’, and ‘religious preoccupations’. The medical examiner’s initial report said that I was living the ‘life of a beatnik — to a certain extent’.”⁹⁴

But testimonials about personal experience like this from people who have been diagnosed with schizophrenia, and who say there was actually nothing wrong with them, do not carry much weight with either the psychiatric profession⁹⁵ or the public in general. This is because any person who has ever been diagnosed with schizophrenia is generally assumed to only have, at best, a tenuous grip on reality. This means that anything such a person says about themselves or their experiences can easily be, and often is, dismissed as delusions.

In the long run the case for the schizophrenic-as-outsider largely rests on evidence supplied by sources which support mainstream psychiatry. The schizophrenic-as-outsider argument is best made as a re-interpretation of the many descriptions of schizophrenia and schizophrenics that appear in the mainstream psychiatric literature.⁹⁶ A good example of the sort of description that can be subjected to this type of re-interpretation can be found in the 1996 Annual Report of the NSW Mental Health Review Tribunal.

The Mental Health Review Tribunal is constituted under the NSW Mental Health Act to make determinations in individual cases about psychiatric treatment, the continuation of prolonged commitment and the issuing of community treatment orders. The Tribunal appears to be conducting a campaign to extend the net of psychiatric coercion by using an assortment of arguments. One argument is that the criteria of mental illness for involuntary treatment should be expanded beyond psychosis to include DSM-IV prescribed Personality Disorders “because mental illnesses and

⁹⁴ Leonard Roy Frank, Interview, in Seth Farber, Madness Heresy, and the Rumor of Angels: The Revolt Against the Mental Health System, op.cit., p. 193.

⁹⁵ M. J. Cuesta, and V. Peralta, ‘Lack of Insight in Schizophrenia’, Schizophrenia Bulletin, Vol. 20, No. 2, 1994, pp. 359-366.

⁹⁶ See for example, J. M. Eagles, ‘The Relationship Between Schizophrenia and Immigration. Are There Alternatives to the Psychosocial Hypotheses?’, British Journal of Psychiatry, Vol. 159, 1991, pp. 783-789.

personality disorders both probably have a genetic component”.⁹⁷ Another of the Tribunal’s arguments is that homeless people, who are thought to be diagnosable with schizophrenia, should be forced into treatment. A fictitious case study is given of a generic homeless man called Max who illustrates the type of person the Tribunal wants to incarcerate:

Max is a homeless middle-aged resident of the streets of Central Sydney. He drops in daily to an inner city hostel, for a meal, and very occasionally, a wash. Max never showers. He never changes his clothes. He is dressed permanently in an incongruous outfit, far too hot for the summer months, loaded up, in its numerous pockets and cavities, with pens, and scraps of writing paper. Max has, for as long as the hostel workers have known him, suffered from the delusion that he is a high-powered corporate lawyer, working with the banks to protect corporate Australia from incursions of the Mafia. If the Mental Health Act 1990 could be brought to bear in Max’s case, he could be hospitalised for a period and his delusion addressed through psychotropic medication. A protected estates order could be obtained, so that an application could be made on Max’s behalf for a social security benefit. He could be required under a community treatment order, to live in public housing, with the rent being paid on his behalf, out of the Social Security Benefit, which could be sought on his behalf, by the protective Commissioner. Max’s life could, in other words, be taken over by a group of public officials, and mental health professionals, and he could, with the assistance of medication, be re-made. But Max literally runs very quickly in the other direction if anyone, particularly a lawyer, approaches him with an offer of help.

The Tribunal goes on:

The current definition of “mentally ill person” for the purposes of civil commitment under the Mental Health Act 1990 could conceivably be interpreted to cover Max. But, if recent media publicity is true, threatened cutbacks in services for the homeless inner city mentally ill might mean that there would be no bed for Max even if the police could be persuaded to pick him up off the street take him to a psychiatric unit for assessment.⁹⁸

In describing Max in this way, as an example of the type of supposedly schizophrenic person who is currently slipping through the net of coercive psychiatry, the Tribunal is apparently targeting homelessness as an area in need of attention. Homeless people are certainly cultural outsiders, and a

⁹⁷ Mental Health Review Tribunal, Annual Report 1996, NSW Government, p. 15.

⁹⁸ Ibid., p. 55.

close association is claimed in psychiatric literature between homelessness and schizophrenia: “an estimated 33%-50% of homeless Americans are schizophrenic”.⁹⁹

However, it is not always easy to establish whether homeless people are thought to be schizophrenic because of their homelessness, or alternatively, whether schizophrenics are thought to become homeless because of their mental disorganisation:

They generally refuse to have contact with the authorities or those who can provide treatment. They experience delusions, deep anxiety and considerable suffering. And even though there are exceptions, they are usually homeless - at least to the extent that they do not feel that they belong to the community in which they live. They have a miserable life, as social outcasts.¹⁰⁰

Certainly the Tribunal seems to be as much concerned about getting treatment for Max's Criteria B symptom of homelessness, by arranging accommodation for him, as it is to get his Criteria A delusions treated with medication.

Sub-type 2: Schizophrenic-as-Scapegoat

Acting as scapegoat for a group appears to be a role some schizophrenics are repeatedly forced to play. In psychotherapeutic situations, where schizophrenics are placed into heterogeneous groups containing patients who are not schizophrenic, it has been observed that the schizophrenics readily become the scapegoats for the group:

the schizophrenic being the prime candidate in the group for the role of the scapegoat other members can deny their fears of intimacy and project them on to the scapegoat. The scapegoat acts as a safety valve that protects the group from the imagined dangers of closeness. Shifting attention away from the scapegoat can reduce his or her anxiety.¹⁰¹

From the schizophrenic-as-scapegoat angle, if a schizophrenic is observed, after diagnosis, to fill the role of scapegoat in a psychotherapeutic group of non-schizophrenics, it is only because, prior to diagnosis, the schizophrenic had already learned to play that role in another over-stressed group

⁹⁹ Anon., 'Schizophrenia and the D2, 5-HT2 receptors: maximizing drug efficacy', Medical Sciences Bulletin, Vol. 19., No. 3, 1996, p. 8.

¹⁰⁰ Phillip W. Long, 'Schizophrenia and Homelessness: Our demand for efficiency will turn the hardest hit into outcasts', Prelapse Magazine, No. 2, September 1995.

¹⁰¹ Alan R. Beeber, 'Psychotherapy with Schizophrenics in Team Groups: A Systems Model', American Journal of Psychotherapy, Vol. 45, No. 1, 1991, pp. 78-87.

with similar problems.¹⁰² From the schizophrenic-as-scapegoat perspective, the ability to fill the role of scapegoat for a therapeutic group demonstrates the single essential feature of schizophrenia. The diagnostic criteria discussed in the previous section are largely irrelevant from this perspective and any alleged distinguishing indicators, like delusions and hallucinations, are only artefacts of imagination manufactured by members of the over-stressed group and/or the diagnostician.¹⁰³

The over-stressed group from which the schizophrenic/scapegoat has come before diagnosis is most commonly a nuclear family, but groups and organisations of other types also sometimes need scapegoats too: “the scape-goat selector — whether inquisitor or psychiatrist — does not work in a social vacuum. The persecution of a minority group is not imposed on a resistant population, but, on the contrary, grows out of bitter social conflicts.”¹⁰⁴

In the Manufacture of Madness Thomas Szasz undertakes the definitive analysis of the schizophrenic-as-scapegoat. Psychiatric historians normally assert that witches who fell victim to the Inquisition were mentally ill people who were victimised on account of their mental illness.¹⁰⁵ Szasz turns this conventional historical understanding on its head. He asserts that modern people diagnosed with mental illness are made scapegoats, in the same way as witches were in earlier times, by falsely labelling them with an imaginary form of deviance:

the basic function of the medical theory of witchcraft — and, in my opinion, its basic immorality as well — lies in distracting from the persecutory practices of the institutional psychiatrists, and focussing it instead on the alleged disorders of the institutionalised mental patients.¹⁰⁶

Szasz argues that the tendency for humans to be social and to always live in groups has a strong influence on shaping human nature.¹⁰⁷ Membership of a group has a price and sometimes members are required to attack non-members as a means of further integrating themselves into the group, and also as a way of adding cohesion to the group itself. Group dynamics can also require that a member be selected for conversion into a non-member for the purpose of being sacrificed. When this happens any members who do not participate in the scapegoating might themselves risk alienation and sacrifice.

¹⁰² See for example, John Modrow, How To Become A Schizophrenic: The Case Against Biological Psychiatry, Appollyon Press, Seattle, 1992.

¹⁰³ Szasz, Schizophrenia: The Sacred Symbol of Psychiatry, op.cit., p. 87.

¹⁰⁴ Szasz, The Manufacture of Madness, op.cit., p. 136.

¹⁰⁵ H. P. Greenberg, ‘Historical Perspectives’, in Pierre J. Beumont and R. B. Hampshire, Textbook of Psychiatry, Blackwell, Melbourne, 1989, p. 19.

¹⁰⁶ Szasz, The Manufacture of Madness, op.cit., pp. 127-128.

¹⁰⁷ Ibid., p. 316.

The explanation for why this happens concerns the need for self-validation. By declaring an enemy, either internal or external, as invalid, and therefore bad, a person by implication declares themselves to be valid and good: “Typically, we confirm our loyalty to our group by asserting the disloyalty of others (in or outside the group) to it; we thus purchase membership in the community by excluding others from it.”¹⁰⁸

Modern people have acquired a habit of attributing sub-human status to classes of people who are selected for scapegoating. This attitude was applied to witches during the Inquisition, Jews in Nazi Germany and regularly happens to people who are ethnically affiliated with the enemy in times of war. Similarly, when family groups find the need to sacrifice a member, a convenient modern method is to declare that the person has a dysfunctional brain.

In European folklore a changeling was a stupid or deformed child who was said to have been secretly changed for another, true child of the family, by fairies. The identification of a changeling was a way of disowning a child by declaring it a non-member of the family. Szasz utilises a powerful changeling-like metaphor by citing a novel written by Jerzy Kosinski called The Painted Bird.¹⁰⁹ In the novel a Polish peasant makes a practice of painting captured birds brilliant colours and then releasing them. After they are released the birds attempt to join others of their own kind but are invariably attacked and killed for being different.

The painted bird is the perfect symbol of the Other, the Stranger, The Scapegoat. With inimitable skill, Kosinski shows us both faces of this phenomenon; if the other is unlike the members of the herd, he is cast out of the group and destroyed: if he is like them, man intervenes and makes him appear different, so that he may be cast out of the group and destroyed. As Lekh paints his raven, so psychiatrists discolour their patients, and society as a whole taints its citizens.¹¹⁰

The schizophrenic-as-scapegoat model is sometimes most readily recognised by people who have themselves been declared schizophrenics. Indeed, the dynamics of selecting and out-casting a scapegoat usually mean that only the victims, or other outsiders of the group, are in a position to consciously observe the process. There are a number of personal accounts of schizophrenia told by people who see themselves as scapegoats. A particularly lucid story is told by John Modrow in How To Become A Schizophrenic.¹¹¹

¹⁰⁸ Ibid.

¹⁰⁹ Jerzy Kosinski, The Painted Bird, Houghton Mifflin, Boston, 1965.

¹¹⁰ Szasz, The Manufacture of Madness, op.cit., p. 321.

¹¹¹ Modrow, op.cit.

Modrow recounts growing up in a family riddled with stress fractures inherited from previous generations. His mother was the daughter of Norwegian immigrants to the United States and, after her father died, had been forced to play the role of surrogate mother to her siblings, while her own mother worked sixteen hours a day.¹¹²

On Modrow's father's side of the family his great-grand mother had died in an insane asylum providing grounds for whispered expectations of a family curse that would surface once again.¹¹³ A story told to Modrow by his sister, who in turn had heard it from his mother shortly before she died, is critical to his story of selection as the family scapegoat. When he was very young his mother and paternal grand mother were chatting in the kitchen while he was sitting outside in the sun, rocking back and forth, absorbed in thought. His mother, seeing him through the door, and thinking he looked cute, smiled and drew her mother-in-law's attention to him. The mother-in-law, however, misunderstood his mother's meaning and angrily jumped to the defence of the child, accusing his mother of mocking him. The result, deduced by Modrow as an adult, was a life-long accusation levelled at Modrow by his mother that he would never let her love him.¹¹⁴

After this incident, when Modrow was six, his mother decided he was in need of a psychiatric examination.¹¹⁵ There was apparently a minor incident involving Modrow and a man in a wheelchair which triggered this unusual course of action but the first psychiatrist he was taken to was so unconcerned about it that he declined to make the examination. When Modrow asked his mother many years later why she thought he needed to be examined she told him it was because, "You would never let me love you" and "Other people made you ill."¹¹⁶ These were two accusations Modrow had been hearing all his life and although the first could be traced to a plausible genesis in the misunderstanding between his mother and grand-mother, the second never made any sense to him and seemed to be something his mother might have made up.¹¹⁷

Six weeks after the first attempt to put a psychiatric label on him Modrow's mother took him to be examined by a psychiatric team at the University of Washington. According to his mother the psychiatrists told her: "We don't know exactly what is wrong with your son, but whatever it is, it is

¹¹² *Ibid.*, p. 31.

¹¹³ *Ibid.*, p. 2.

¹¹⁴ *Ibid.*, p. 34.

¹¹⁵ *Ibid.*, p. 38.

¹¹⁶ *Ibid.*, p. 33.

¹¹⁷ It is possible that "social withdrawal" was a symptom his mother had been warned by psychiatrists to look out for. For a discussion on the symptoms of childhood schizophrenia see, Kenneth E. Towbin, Elisabeth M. Dykens, Geraldine S. Pearson, and Donald J. Cohen, 'Conceptualizing "borderline syndrome of childhood" and "childhood schizophrenia" as a developmental disorder', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 32, No. 4, July 1993, pp. 775-783.

very serious. We recommend that you have him committed immediately or else he will be completely psychotic within less than a year”.¹¹⁸

His mother did not follow the advice to have him committed at that time but the assumption that he had a serious mental illness became incorporated into his family identity. Although by his own estimation there was nothing wrong with him, he was by degrees schooled into playing the role of the mad member of the family. Modrow’s description is of a family with unusual levels of stress and his supposed difference within this group allowed the other members of the family to contrast themselves with him and thereby assume normal roles. In this way the family maintained outward signs of normality until Modrow was finally hospitalised for schizophrenia as an adolescent.

His stay in hospital was only a short one but it took him another three decades of introspection and family analysis to properly understand what had happened to him. Modrow says he wrote his book because he believes “it is a fact beyond reasonable dispute that I had been victimised by a series of events — not by a disease. And I believe this can be demonstrated to be true of all people who have been labelled schizophrenic.”¹¹⁹

Families are not the only groups in need of scapegoats. Work-places also seem to produce a number of schizophrenics. A story describing the ease with which a person can be involuntarily hospitalised on the report of an employer is told in a volume of personal recollections of patients entitled Inside the Cuckoo’s Nest: Madness in Australia.¹²⁰ The story concerns John Thomas who tells how he went to his place of employment on Christmas eve for the specific purpose of attending a Christmas party. Not long after he arrived,

the Administration Manager approached me and complained of my noisy behaviour — I had shouted hurrah, once, in the board room. A few moments later, the General Manager called me into his office and also began to abuse me about the supposed noise I was making. He told me he would arrange for me to be taken home, because I was sick.¹²¹

Thomas decided to leave the party and to make his own way home. He began to walk but found he was being followed by two of his fellow workers who tried to coax him into taking a lift with them. He refused and took a short-cut through a park, hoping to lose them. When he reached the park exit three police cars suddenly appeared with sirens blaring. He was seized by two officers, held over the boot of a police car, and searched.

¹¹⁸ Modrow, op.cit., p. 1.

¹¹⁹ Ibid., p. 3.

¹²⁰ Jim Gardner, Inside the Cuckoo’s Nest: Madness in Australia, Planet Press, Sydney, 1976.

¹²¹ Ibid., p. 23.

Within a few minutes the General Manager arrived at the scene and spoke to the police officers. A cavalcade of cars then returned to the company offices and one of the policemen went into the building with the General Manager. After ten minutes the policeman re-emerged and, against his protests, Thomas was then transported in the back of a police car to the psychiatric ward of a nearby hospital. He was then involuntarily admitted to the hospital, treated against his will with the neuroleptic drugs Melleril and Largactil, used in front-line treatment for schizophrenia, and for several days was not allowed to make contact with his wife or lawyer. When he finally made contact he was quickly released. This appears to have been the only occasion on which Thomas has been involved in the mental health system and he said of the experience: "This frightening incident has caused me and my family great distress and embarrassment, and I feel it should be brought to public notice and fully investigated."¹²²

The use of psychiatry in the scapegoating of Thomas by his employers seems to be so blatant that it might not be representative of how other people become schizophrenic scapegoats at places of employment. However, the story has been briefly retold because it demonstrates in a simple way that the psychiatric label of schizophrenia can be used to scapegoat people in the work-place.

A more consistent pattern of scapegoating by using schizophrenia, and other psychiatric labels, is found in cases of whistleblowing.¹²³ A whistleblower is a person who speaks out in the public interest, typically about corruption or some other kind of wrongful practice at a place of work. Whistleblowing is the act of reporting this wrong-doing to the appropriate authority and/or publicly revealing it through the mass media.¹²⁴ There may be numerous reasons for an organisation to avoid acknowledgment of a whistleblower's message — not the least common being that, unbeknown to the whistleblower, people at upper-levels of the organisation may have given tacit or covert approval for the wrong-doing. Another common reason for resisting a whistleblower is fear that the organisation might be damaged by exposure.

Whistleblowing, therefore, can be a hazardous activity and whistleblowers themselves are usually a little bit out of the ordinary in that they are likely to have elevated levels of personal integrity and courage,¹²⁵ combining with a naive faith in the prevalence of justice. If the organisation chooses to

¹²² *Ibid.*, p. 23.

¹²³ Whistleblowers Australia, Abuse of Medical Assessments to Dismiss Whistleblowers, accessed December 1997, Available URL, <http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/psychiatry.html>

¹²⁴ For a number of stories about whistleblowing activities see, Gerald Vinten, ed., Whistleblowing: subversion or corporate citizenship?, Paul Chapman, London, 1994.

¹²⁵ For the story of a whistleblower who was inappropriately incarcerated in a psychiatric facility and subsequently awarded the Cavallo Prize for Moral Courage in 1995 see, The Cavallo Foundation, Navy Lieutenant Speaks Out Against Sexual Harassment in the Military, CitySource, accessed January 1998, Available URL, <http://www.cavallo.org/simmons.html>

ignore the whistleblower's complaint this combination of personality traits can easily lead the whistleblower into a situation of being forced to doggedly repeat assertions that something is wrong in the organisation. The whistleblower is then perfectly positioned to be a scapegoat for the organisation, to relieve the stress that might have been generated by the attempted revelation.¹²⁶ A favoured tactic is to refer the whistleblower for a psychiatric examination to be carried out by a psychiatrist retained by the organisation.¹²⁷ Even psychiatrists themselves are not immune from this treatment and in one recent case a psychiatrist who blew the whistle on improper activities in mental hospitals in the United States was "fired and labelled impaired".¹²⁸

An example of the use of psychiatry to scapegoat whistleblowers has been documented in a recently-released report by the Commonwealth (Australia) Ombudsman's office. An investigation by the Ombudsman into the harassment of whistleblowers in the Australian Federal Police (AFP) found "four relevant instances since 1992 where the AFP has arranged for officers to undergo inappropriate psychiatric assessments, either under duress, or without their knowledge or consent".¹²⁹

Whistleblowers Australia is currently conducting a survey of their members to discover how many have been treated in this way. The number discovered so far in NSW alone is about thirty.¹³⁰ Most of these people have received psychiatric diagnoses ranging from non-specific conditions like cognitive dysfunction, to personality disorders and schizophrenia.¹³¹ There is a strong conviction amongst the members of Whistleblowers that their referrals for psychiatric assessment are a form of harassment and that an allegation of mental disorder is a tactic used to discredit them and also, frequently, to terminate their employment.¹³²

At least one member of Whistleblowers Australia has lodged a complaint about her harassment with the World Psychiatric Association's Committee to Review the Abuse of Psychiatry. Interestingly, shortly after receiving acknowledgment of the complaint from the Secretary of the Committee in

¹²⁶ For an analysis of various forms of retaliation taken against whistleblowers by a government instrumentality in the United States see, National Academy of Public Administration, Department of Energy Retaliation Complaint Study, accessed January 1998, Available URL, <http://www.accessone.com/gap/www/napa.htm>

¹²⁷ Anon., Whistleblower Protection: Continuing Impediments to Protection of Military Members, Letter Report, 02/02/95, GAO/NSIAD-95-23, accessed January 1998, Available URL, <http://www.natcavoice.org/natca/f/nsiad95-23.htm>

¹²⁸ Fred A. Baughman Jr, 'The future of mental health: radical changes ahead', USA Today, Vol. 125, No. 2622, March 1997, pp. 60-63.

¹²⁹ Commonwealth Ombudsman, AFP professional reporting & internal witnesses, November 1997, p. 53.

¹³⁰ Val Kerrison, Principle organiser of the survey, Personal communication, September, 1998.

¹³¹ Louise Roy, Psychiatry and the Suppression of Dissent, unpublished report on the use of psychiatric labels to intimidate whistleblowers, December 1997.

¹³² Whistleblowers Australia, Healthquest — Unethical, Immoral and Unjust: Misuse of "Psychiatric Findings" to Aid and Abet Employers in Workplace Dismissals, Press Release, 11 December, 1997.

Denmark¹³³ the complainant was asked by her employer to attend another psychiatric examination. The result of this subsequent examination was that she was found to be in perfect mental health.

Sub-Type 3: Schizophrenia-as-Role-Play

Schizophrenia-as-role-play is a branch of the myth-of-mental-illness model which interprets the symptoms of schizophrenia as being simulations of the prescribed patterns of schizophrenic thought and behaviour. These simulations are required of a person in order to fulfil a role that may have been either chosen by the schizophrenic, or imposed by other people. Analysts who argue that such roles are normally chosen by the schizophrenics themselves are inclined to see schizophrenics as predatory, exploitative types of people.¹³⁴ Conversely, those who prefer to see the schizophrenic role as an imposition tend to argue that schizophrenics are victims of labelling who, once diagnosed, are compelled by other people's expectations to behave in the prescribed manner of a schizophrenic.¹³⁵

The evolution of Thomas Szasz's myth-of-mental-illness views has involved a passage through both the schizophrenic-as-cultural-outsider and the schizophrenic-as-scapegoat sub-types. But more recently his attachment to libertarian philosophy¹³⁶ has swung him into the schizophrenia-as-role-play model where he shows a distinct lack of sympathy for people who willingly adopt the role of schizophrenic. In a recent article, descriptively entitled 'Idleness and Lawlessness in the Therapeutic State',¹³⁷ he refers to schizophrenics as parasites. After establishing that modern society is divided between producers and parasites he goes on to argue that people with 'real' illnesses who adopt the sick role are not idle and therefore not parasites. However, "in contrast, most chronic mental patients — especially schizophrenics — are idle, economically dependent, and inclined (allegedly because of their illness) to lawlessness."¹³⁸

Szasz's view is that failure to make the necessary transitions in the process of maturation, from childhood to adolescence to adulthood, is what determines whether a person will become identified as a schizophrenic. If a person successfully passes through the three stages and establishes an adult identity by "being useful to other people",¹³⁹ i.e. having a productive occupation, then the society will accept the person as being in mental health. But "[i]f this process of maturation goes awry, the adolescent begins to envy his peers and to feel inferior to them".¹⁴⁰

¹³³ Hanne Meyn, Secretary to the Committee to Review the Abuse of Psychiatry, World Psychiatric Association, Letter to Louise Roy, 9 January, 1998.

¹³⁴ Szasz, 'Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse', op.cit., pp. 135-139.

¹³⁵ Thomas Scheff, 'Schizophrenia as Ideology', in Scheff, ed., Labelling Madness, op.cit., pp. 5-12.

¹³⁶ Roger Neustadter, 'Szasz, Lasch, and Illich on the Problem of the Therapeutic State', Quarterly Journal of Ideology, Vol. 15, Nos. 3-4, 1991-1992, pp. 29-49.

¹³⁷ Szasz, Idleness and Lawlessness in the Therapeutic State, op.cit.

¹³⁸ Ibid., pp. 30-36.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

When this happens, in order to compensate, the person might intentionally develop delusions of self-importance and perhaps begin to express unusual beliefs and mannerisms, as marks of assumed distinguishment. According to Szasz, as such a person slides further away from a normal productive adult identity, family members, teachers and friends tend to indulge the person and offer more leeway. The process of differentiation continues until the person gives some suggestion of potential violence, which might give warning of self-harm, or harm to somebody else.¹⁴¹ At this point the person is likely to be brought into contact with a psychiatrist who will give a diagnosis of schizophrenia.¹⁴² Henceforth the well-known symptoms of schizophrenia provide an easily followed identity-script to guide the person in his or her future social role.

If one begins an analysis from Szasz's viewpoint — i.e. that even before diagnosis a schizophrenic will have developed parasitic tendencies — then the key to the cause of schizophrenic symptoms will most likely be found in the perquisites of mental patient-hood. From this angle it is assumed that some people simulate the symptoms in order to get the family attention,¹⁴³ social welfare payments and special human rights considerations that are usually offered to schizophrenics. Indeed, so great has the cost of supporting people with mental illnesses become in the United States that the myth-of-mental-illness is now even being raised in an economic context:

Not well known is the fact that as of 1994, 57 percent of adults receiving SSI disability payments did so based on a diagnosis of a mental disorder and that federal spending on SSI exceeded federal spending on Aid to Families with Dependent Children by some \$7 billion.¹⁴⁴

The simulation of madness for personal advantage or disguise is not a new idea. It must have been well understood in 16th century England, for instance, because in a number of Shakespeare's plays characters feign madness in order to disguise either their identities or their intentions. Hamlet feigns madness to put his enemies off guard. In King Lear, Edgar adopts the persona of the madman, Poor Tom, when he falls out of favour with a shifting power structure. When Edgar fears for his life he flees into the countryside, but before he goes he tells the audience about the disguise he will adopt, to avoid detection — and also to help him earn a living.

¹⁴¹ For a demonstration of the way in which mass murder is linked with schizophrenia in sensational magazine articles see, Eugene H. Methvin, 'Bloody murderers', National Review, Vol. 48, No. 10, 3 June 1996, pp. 40-44.

¹⁴² M. S. Humphreys, E. C. Johnstone, J. F. MacMillan, and P. J. Taylor, 'Dangerous Behavior Preceding First Admissions for Schizophrenia', British Journal of Psychiatry, No. 161, 1992, pp. 501-506.

¹⁴³ Anon., 'Families in the Treatment of Schizophrenia', The Harvard Medical School Mental Health Letter, June /July 1989.

¹⁴⁴ Phillip D. Arben, 'Are Mental Illnesses Biological Diseases? Some Public Policy Implications', Health & Social Work, Vol. 21, No. 1, February 1996, pp. 66-70.

My face I'll grime with filth,
 Blanket my loins, elf all my hair in knots,
 And with the presented nakedness outface
 The winds and persecutions of the sky.
 The country gives me proof and precedent
 Of Bedlam beggars, who with roaring voices,
 Strike in their numb'd and mortified bare arms
 Pins, wooden pricks, nails, sprigs of rosemary;
 And with this horrible object, from low farms,
 Poor pelting villages, sheep-cotes, and mills,
 Sometime with lunatic bans, sometime with prayers,
 Enforce their charity. Poor Turlygood! poor Tom!
 That's something yet: Edgar I nothing am.¹⁴⁵

Curiously, DSM-IV now has a diagnostic label for people who fabricate madness in the way that Edgar does. In fact there are two different disorders to choose between. If Edgar were detected in the act of feigning madness by a modern psychiatrist he might be diagnosed with Malingering — but only if the diagnostician thought that ‘enforcement of charity’ was Edgar’s motivation. Malingering is only used when a person is perceived to intentionally produce false or exaggerated psychological or physical symptoms because he or she is apparently “motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.”¹⁴⁶

The alternative diagnosis for feigners of madness is Factitious Disorder — With Predominantly Psychological Signs and Symptoms. This label is used when there is the same intentional feigning “of psychological (often psychotic) symptoms that are suggestive of a mental disorder”¹⁴⁷ and “the motivation for the behaviour is to assume the sick role”.¹⁴⁸ But unlike Malingering, people with Factitious Disorder are not motivated by external incentives like economic gain. Factitious Disorder is also known by the name of Munchausen Syndrome.¹⁴⁹

The existence of these disease categories in DSM-IV points to a somewhat bizarre divergence of opinion between Szasz and mainstream psychiatry. Whereas the existence of Malingering and Factitious Disorder might appear on the one hand to give mainstream confirmation of Szasz’s

¹⁴⁵ William Shakespeare, *King Lear*, Act II, Scene III, in W. J. Craig, ed., *Shakespeare Complete Works*, Oxford University Press, London, 1969, p. 920.

¹⁴⁶ American Psychiatric Association, *op.cit.*, p. 683.

¹⁴⁷ *Ibid.*, p. 472.

¹⁴⁸ *Ibid.*, p. 474.

¹⁴⁹ John B. Murray, ‘Munchausen Syndrome/Munchausen Syndrome by Proxy’, *The Journal of Psychology*, Vol. 131, No. 3, 1997, pp. 343-353.

argument — i.e. that schizophrenia can be simulated — the pathological interpretation of this simulation, by claiming that the production of false symptoms is itself a mental disease, is very different to Szasz's position. What DSM-IV is claiming is that healthy people who pretend to be sick are in fact sick — that the pretence is itself a sickness. Szasz would ridicule this idea.¹⁵⁰

The paradoxical situation that arises from the medicalisation of play-acting is further compounded by the inclusion of a variant of Factitious Disorder, called Factitious Disorder By Proxy (FDBP), in an appendix of DSM-IV.¹⁵¹ FDBP is one of a number of mental disorders that are already recognised by large sections of the psychiatric profession but which have yet to achieve consensual endorsement. In DSM-IV's Appendix B descriptions are given of these disorders and further research into them is recommended.

The essential feature of FDBP:

is the deliberate production of physical or psychological signs or symptoms in another person who is under the individual's care. The motivation for the perpetrator's behaviour is presumed to be a psychological need to assume the sick role by proxy. The perpetrator induces or simulates the illness or disease process in the victim and then presents the victim for medical care while disclaiming any knowledge of the actual etiology of the problem.¹⁵²

If one takes the myth-of-mental-illness model seriously then perhaps FDBP provides the simplest of all explanations for the origins of apparent symptoms of schizophrenia — i.e. they are fabricated by relatives and psychiatrists who are suffering from FDBP and who are adopting the sick role by proxy. But, of course, this point of view presents yet another paradox — if mental illness is indeed a myth, then so is FDBP.

But even if Malingering and the Factitious Disorders present problems of usage within the context of the myth-of-mental-illness model their inclusion in DSM-IV still provides strong confirmation that mainstream psychiatry recognises the possibility that the symptoms of schizophrenia might sometimes only be role-playing. The question to be answered then concerns whether a significant fraction of people diagnosed with schizophrenia are either role-playing themselves, or are the victims of role-playing by relatives and psychiatrists.

Tests have shown fairly conclusively that people without a diagnosis of schizophrenia can fabricate the symptoms on request so well that psychiatrists are willing to diagnose them with schizophrenia.

¹⁵⁰ Szasz, 'Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse', *op.cit.*, pp. 135-139.

¹⁵¹ American Psychiatric Association, *op.cit.*, pp. 725-727.

¹⁵² *Ibid.*, p. 725.

The authors of one of these studies using the Rorschach test concluded that all that is required for normal people to successfully simulate schizophrenia is that they have some prior knowledge of the symptoms.¹⁵³ Another survey found that when normal people were coached in the methods of detecting schizophrenic simulation, before undertaking psychometric tests like the Minnesota Multiphasic Personality Inventory, a third of them could feign schizophrenia without detection.¹⁵⁴

However, an accurate knowledge of either the symptoms of schizophrenia, or methods for detecting simulators, might not be necessary for pretenders in real-life situations outside of the laboratory. The much-cited Rosenhan experiment¹⁵⁵ found that a high level of accuracy is not required in the simulation of symptoms, and that practising mental health professionals are unlikely to expose pretenders. Rosenhan enlisted 8 volunteers to act as pseudo-patients. Over a period of time the pseudo-patients presented themselves at 12 psychiatric hospitals and complained of hearing voices saying the words “empty”, “hollow” and “thud”. These words had been chosen because of their existential connotations suggesting the emptiness of life and because they had never appeared in psychiatric literature as being symptoms of mental illness.

No other symptoms were fabricated and on each occasion the pseudo-patients were admitted to the hospitals, and on all but one occasion they were diagnosed as having schizophrenia. After the initial interview the volunteers did not mention the voices again and acted their normal sane selves. The agreement they had made with the co-ordinator of the experiment was that they would each have to gain their own release without any outside assistance. This had to be done by convincing the hospital staff they were sane. The length of hospitalisation ranged from 7 to 52 days with an average of 19 days. All those originally diagnosed as having schizophrenia were released with the diagnosis of “schizophrenia in remission”. One conclusion made by the co-ordinator of the experiment was that, “Psychiatric diagnoses are in the minds of the observers and are not valid summaries of the characteristics displayed by the observed”.¹⁵⁶ Rosenhan’s principal contention was that mental hospitals could not tell the sane from the insane.

Rosenhan was a psychologist and when his study was first published in the journal Science there was widespread protest from members of the psychiatric profession. The next issue of the journal had 15 letters in response, only one of which was favourable.¹⁵⁷ A symposium discussing his experiment was subsequently published in the Journal of Abnormal Psychology. All of the 5

¹⁵³ B. E. Netter and D. J. Viglione Jr, ‘An empirical study of malingering schizophrenia on the Rorschach’, Journal of Personal Assessment, Vol. 62, No. 1, 1994, pp. 45-57.

¹⁵⁴ R. Rogers, R. M. Bagby, D. Chakraborty, ‘Feigning Schizophrenic Disorders on the MMPI-2: Detection of Coached Simulators’, Journal of Personality Assessment, Vol. 60, No. 2, 1993, pp. 215-226.

¹⁵⁵ David L. Rosenhan, ‘On being Sane in Insane Places’, Science, Vol. 179, 19 January 1973, pp. 250-258.

¹⁵⁶ Ibid, p. 251.

¹⁵⁷ Thomas J. Scheff, Being Mentally Ill, Aldine, New York, 1984, p. 190.

psychologists who contributed articles to the symposium were critical of Rosenhan.¹⁵⁸ Most of the criticism was concerned with either the ethics of the experiment or the methodology. The ethical problems mostly focussed on the deliberate intention of deceiving hospital staff which was inherent in the design of the experiment. Only one commentator, Thomas Scheff, writing at a later date, seems to have raised a further ethical question concerning the considerable risks that were taken by the pseudo-patients in subjecting themselves to an average 19 days of incarceration and psychiatric treatments.¹⁵⁹

One of the major criticisms about Rosenhan's methodology was the lack of controls. It was argued by one of the contributors to the symposium that the experiment was of little value because no controls had been used. It was proposed that if there had been a control group which was unaware of the purpose of the experiment then the members of this control group might have tried a lot harder to get out of hospital than did Rosenhan's pseudo-patients.¹⁶⁰

Despite these criticisms Rosenhan's findings still had a considerable impact on the psychiatric profession in the United States by temporarily undermining confidence in the validity of psychiatric diagnoses. Kirk and Kutchins relate how Rosenhan's work particularly affected Robert Spitzer,¹⁶¹ who was one of the principal architects of the DSM revision that became DSM-III: "He obviously took Rosenhan's work very seriously; it constituted a frontal assault on psychiatric diagnosis."¹⁶²

Spitzer challenged Rosenhan in a blustering article entitled "On pseudoscience in science, logic in remission, and psychiatric diagnosis: A critique of Rosenhan's 'On being sane in insane places'".¹⁶³ In this article he offered the simplistic argument that, "A correct interpretation of [Rosenhan's] own data contradicts his own conclusions. In the setting of a psychiatric hospital psychiatrists are remarkably able to distinguish the 'sane' from the 'insane'".¹⁶⁴ Spitzer argued that being released from hospital with "schizophrenia in remission" was tantamount to being found sane.

Although Spitzer claimed a successful refutation, Rosenhan's study is still "often discussed in introductory college courses in psychology and sociology"¹⁶⁵ to illustrate problems with psychiatric

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ T. Millon, 'Reflections on Rosenhan's On being sane in insane places', Journal of Abnormal Psychology, Vol. 81, 1975, pp. 456-461.

¹⁶¹ Stuart A. Kirk and Herb Kutchins, The Selling of DSM: The Rhetoric of Science in Psychiatry, Aldine De Gruyter, New York, 1992, pp. 90-97.

¹⁶² Ibid., p. 94.

¹⁶³ R. L. Spitzer, 'On pseudoscience in science, logic in remission, and psychiatric diagnosis: A critique of Rosenhan's "On being sane in insane places"', Journal of Abnormal Psychology, Vol. 84, 1975, pp. 442-452.

¹⁶⁴ Ibid.

¹⁶⁵ Kirk and Kutchins, op.cit., p. 93.

diagnosis. It has also recently been recommended in legal literature for use as a courtroom reference to refute the certainty of psychiatric assessments: “Plaintiffs’ experts should be asked to admit that psychiatrists can be fooled and that malingering is difficult to detect. In this connection, defence counsel should use the famous Rosenhan study,”¹⁶⁶ Despite the many criticisms Rosenhan’s experiment has survived as a landmark demonstration of how easy it is to simulate symptoms that lead to a diagnosis of schizophrenia.

Another elaborate experiment has demonstrated the converse of Rosenhan’s findings. That is, in order to comply with falsely conceived professional standards, psychiatric and psychological diagnosticians sometimes imagine the symptoms of mental illness in people who are behaving normally. Maurice Temberlin¹⁶⁷ of the University of Oklahoma demonstrated this when he presented a man in perfect mental health for diagnosis by various groups of psychiatrists, psychologists and psychology students. Before these diagnosticians were allowed to observe the man they were supplied with a fabricated suggestion by an expert in the field that the man was mentally disordered.

To set up his experiment Temberlin had a professional actor trained to portray a mentally healthy man using the following criteria:

he was happy and effective in his work; he established a warm, gracious and satisfying relationship with the interviewer; he was self-confident and secure, but without being arrogant, competitive, or grandiose. He was identified with the parent of the same sex, was happily married and in love with his wife, and consistently enjoyed sexual intercourse. He felt that sex was fun, unrelated to anxiety, social-role conflict, or status striving. This was built into his role because mental patients allegedly are sexually anhedonic.¹⁶⁸

The actor’s role also required him to be agnostic and disinterested in extrasensory perception or occult phenomena. This was to avoid the associations with religion and mysticism that are frequently attached to mental patients. He also had a gentle self-mocking sense of humour to combat the normal perception that mental patients are humourless people who have no insight into themselves. The actor’s script required him to deny that he had ever experienced hallucinations, delusions or any other phenomena associated with psychosis.

¹⁶⁶ James T. Brown, ‘Compensation neurosis rides again: a practitioner’s guide to defending PTSD claims. (post traumatic stress disorder)’, Defence Counsel Journal, Vol. 63, No. 4, 1996, pp. 467-482.

¹⁶⁷ Maurice K. Temerlin, ‘Suggestion Effects in Psychiatric Diagnosis’, in Scheff, Labelling Madness, op.cit., pp. 46-54.

¹⁶⁸ Ibid., p. 47.

To cap it off a happy childhood was created for him together with mild anxieties about current political affairs, to demonstrate social concern and the absence of self-obsession. His domestic life was happy and only punctuated by occasional disagreements with his wife about church-going, and infrequent musings about whether he was raising his children correctly.

The experiment required a recording to be made of Temerlin interviewing the actor as if he were a prospective patient. In order to account for the clinical setting, so that sickness would not automatically be assumed by the audience, the script described the actor as “a successful and productive physical scientist and mathematician (a profession as far away from psychiatry as possible) who had read a book on psychotherapy and wanted to talk about it”.¹⁶⁹

The actor himself was not told the purpose of the experiment. After the recording was made three clinical psychologists evaluated the interview to ensure that the actor had indeed portrayed a man in perfect mental health. Temerlin then recruited 25 practising psychologists, 25 psychiatrists and 45 graduate students enrolled in doctoral programs in clinical psychology.

The purpose of the experiment was to test whether diagnosticians could be influenced in their clinical judgement by a false statement given by a ‘prestige confederate’. Before the psychologists and psychology students heard the interview they were told by a well-known psychologist who had gained many professional honours that the patient on the taped interview they were about to listen to was “a very interesting man because he looks neurotic, but actually is quite psychotic”.¹⁷⁰ Similarly, the 25 psychiatrists were told that “two board-certified psychiatrists, one also a psychoanalyst, had found the recording interesting because the patient looked neurotic but actually was quite psychotic.”¹⁷¹

Control groups were also tested. One control group was asked to diagnose the actor without any prior prestige suggestion at all. Another group made diagnoses after hearing a prestige suggestion that the actor was mentally healthy. The results were quite extraordinary. As can be seen in the following table the psychiatrists were particularly vulnerable to being misled by the ‘prestige suggestion’.

¹⁶⁹ *Ibid.*, pp. 47-48.

¹⁷⁰ *Ibid.*, p. 48.

¹⁷¹ *Ibid.*

Diagnoses with Suggestion of Psychosis

Schizophrenia was the most common form of psychosis diagnosed and the results in many ways speak for themselves. Unfortunately Temerlin did not break down the control group results into psychiatrists, psychologists, and students. However he did indicate that the second control group was comprised of all three types: “when the prestige confederate of control group 2 said, ‘You know, I think this is a very rare person, a perfectly healthy man’, psychologists, psychiatrists, and graduate students agreed unanimously”.¹⁷²

After analysing the data Temerlin concluded that professional identity was the relevant variable and that there was no relationship in diagnostic outcomes with either length of training or experience. What is apparent is that the psychiatrists in particular were inclined to adopt a professional role-play after the appropriate script was supplied to them by a prestige confederate, whose opinion could be assumed to represent professional standards.

In attempting to explain why the psychiatrists were more easily led into diagnosing a healthy person as psychotic Temerlin observed that: “Psychiatrists are, first and foremost, physicians. It is characteristic of physicians in diagnostically uncertain situations to follow the implicit rule ‘when in doubt, diagnose illness’, because it is a less dangerous error than diagnosing health when illness is in fact present.”¹⁷³ This point was punctuated by a statement from one psychiatrist who, after learning about his error, defended a diagnosis of psychosis by arguing: “Of course he looked

¹⁷² *Ibid.*, p. 51.

¹⁷³ *Ibid.*, p. 52.

healthy, but hell, most people are a little neurotic, and who can accept appearance at face value anyway?”¹⁷⁴

One is tempted to speculate about the role of patient fees in this apparent willingness to diagnose mental illness in healthy people. DSM-IV identifies Malingering as a diagnosis for use when patients fabricate symptoms for personal gain. But, unlike Factitious Disorder, the manual does not supply a proxy complement of Malingering which could be used when mental health professionals fabricate symptoms for their personal gain. It is not surprising that Malingering By Proxy fails to even make it into Appendix B, as an area recommended for further research. But this omission leaves the way open for cynics to argue that the compilers of DSM-IV might have insufficient insight into the real cause of at least some supposed mental illness.

Conclusion

The medical and mystical models both accept the defining characteristic of schizophrenia as self-evidently being concerned with abnormal psychological experience. On this point the myth-of-mental-illness (M-M-I) model deviates from both of them and instead argues that there is no significant psychological abnormality involved and that the abnormality that distinguishes schizophrenics from normal people actually concerns their social relationships, not their minds. When abnormal mental experiences are claimed by schizophrenics, the M-M-I model explains them as being fabrications.

In order to analyse these premises this chapter divided the M-M-I model into three sub-types. Each of these sub-types was found to have plausible arguments and supporting evidence. But this division into three sub-types was only devised as a convenient tool of analysis and it is unlikely that any single one of these sub-types, by itself, could stand up against the medical model. However, when they are combined the M-M-I model provides a powerful alternative explanation.

The wide range of symptoms for schizophrenia, without any certain common denominator, combined with the subjective diagnostic methods, that have no laboratory support, ensure that some cases of schizophrenia will always be best explained by one or another of the M-M-I sub-types. However, there are other cases, particularly those where an unusual inner experience is convincingly described personally by the schizophrenic, for which the M-M-I explanations seem thoroughly inadequate.

All this points to a plurality of types of people who receive diagnoses of schizophrenia. Practitioners of the medical model themselves frequently refer to schizophrenia in the plural when they are prepared to acknowledge the ‘grab-bag’ nature of their diagnostic criteria:

¹⁷⁴ Ibid.

The ‘group of schizophrenias,’ normally referred to with a single nominative, is phenomenologically heterogeneous. Its symptoms represent multiple psychological domains, including perception, inferential thinking, language, attention, social interaction, emotion expression, and volition.¹⁷⁵

There is current movement within the psychiatric profession to further widen the diagnostic criteria for schizophrenia to include prodromal symptoms.¹⁷⁶ These are the supposed early, pre-psychotic signs and people who are identified as having them are said to have early psychosis.¹⁷⁷ If the M-M-I model is a useful tool for explaining many supposed cases of full-blown schizophrenia it is likely to be even more valuable for explaining this growth area of schizophrenia. It is proposed to test each of the three models — the medical, mystical and M-M-I models — for applicability to early psychosis in Chapter 10.

¹⁷⁵ N. C. Andreasen, S. Arndt, R. Alliger, D. Miller and M. Flaum, ‘Symptoms of schizophrenia: methods, meanings, and mechanisms’, Archives of General Psychiatry, Vol. 52, No. 5, May, 1995, pp. 341-351.

¹⁷⁶ A. K. Malla, and R. M. Norman, ‘Prodromal Symptoms in Schizophrenia’, British Journal of Psychiatry, Vol. 164, No. 4, 1994, pp. 487-493.

¹⁷⁷ Thomas H. McGlashan, ‘Early Detection in Schizophrenia: Editor’s Introduction’, Schizophrenia Bulletin, Vol. 22, No. 2, 1996, pp. 197-199.

9. Myth-of-Mental-Illness Model: Interest Groups and Human Rights Imperatives

Interest Groups

A discussion on the interest groups that support the myth-of-mental-illness (M-M-I) model is made problematic by the confusion of demarcation that generally exists between the mystical and M-M-I models. The type of analysis undertaken by this thesis has not been carried out before and, although analysis reveals these two models to be very different, most interest group activity in relation to schizophrenia is simply polarised between positions that are for and against the medical model. This means that the interest groups that are opposed to the medical model usually contain a confused mixture of positions.¹ Sometimes when the medical model is narrowly confined to biological theories these non-medical positions even include environmental theories of pathology, like problems in the family. But mostly the interest groups opposed to the medical model will simply mix the M-M-I and mystical models together² so that it is largely only the preferences of individual members that differentiates between them.

In this situation the public campaigning of interest groups opposing the medical model is more likely to be coloured by the M-M-I model than by the mystical model. Most of the activists who campaign for interest groups opposing the medical model are themselves former involuntary mental patients.³ A frequently found common denominator amongst these former patients is that they have reached a point of maturity, or self-understanding, which largely removes them from the risk of further involuntary treatment. Rather than call themselves ex-patients they often prefer to be called 'psychiatric survivors'.⁴ They tend to display a certain amount of pride in having survived a past ordeal and, when they are closely observed, it is apparent that the common ordeal they prefer to see themselves as having survived is abuse at the hands of the psychiatric profession, rather than a psychiatric illness.⁵

With these attitudes the logic of the M-M-I model is usually more accessible than that of the mystical model. Activists who oppose the medical model find that many medical beliefs and psychiatric treatments are easy targets on which to focus public scepticism and disapproval. When

¹ See for example, National Mental Health Consumers' Self-Help Clearinghouse, Available URL, http://www.libertynet.org/~mha/cl_house.html

² See for example, Duncan Double, Antipsychiatry, 1999, Available URL, http://ourworld.compuserve.com/homepages/Duncan_Double/

³ See for example, Act-Mad Mental Activism Discussion List, 1999, Available URL, <http://www.rainier-web.com/actmad/index.html>

⁴ See for example, Psychiatric Survivor's Guide, 1999, Available URL, <http://www.harborside.com/home/e/equinox/>

⁵ See for example, Victorian Advocates for Survivors of Therapists (VAST), 1999, Available URL, <http://www.cs.utk.edu/~bartley/other/vast.html>

the opportunity arises for publicity therefore it is usually not wise for an activist to risk an attempt at explaining schizophrenia in mystical terms. An M-M-I focussed attack on psychiatry can usually serve the anti-medical model cause more effectively, with far less attendant risk to the activist of appearing delusional or mentally disordered.

A further reason for the dominance of the M-M-I model amongst activist groups is that these groups are usually comprised of people with a mixture of psychiatric labels and therefore the groups are not structured for campaigning exclusively on the subject of schizophrenia.⁶ Whereas other diagnostic categories, like depression and obsessive-compulsive disorder, do not lend themselves very well to a mystical interpretation, all opponents of the medical model can usually adapt to the M-M-I model. On top of this many activists claim not to have experienced any unusual psychological phenomenal prior to their forced treatment and can therefore only relate to the M-M-I model.

The interest groups associated with the M-M-I model are best described as solidarity groups and fall in the middle of Pross' "funnel of mobilisation",⁷ between latent interests and formal interests, which were discussed in Chapter 2. These solidarity groups can be ranged along a spectrum of 'respectability' from a sub-grouping of the Church of Scientology, called the Citizens Commission on Human Rights (CCHR),⁸ at one end of the spectrum; through Support Coalition,⁹ an international network of psychiatric survivor groups; to research groups of dissident mental health professionals, like the Peter Breggin led Center for the Study of Psychiatry and Psychology;¹⁰ through to groups of civil liberties and human rights oriented legal professionals, like the US based National Association of Protection and Advocacy Systems,¹¹ at the other end of the spectrum.

Support Coalition is perhaps the most diverse and ambitious of these groups and warrants a detailed description. Support Coalition is a co-ordinated network of 60 psychiatric survivor groups, called sponsoring groups, ranging through eight different countries; Australia, Canada, France, Israel, New Zealand, Pakistan, the United Kingdom and the United States.¹² The majority are located in the United States. The head office of Support Coalition is in Eugene, Oregon (US) and some of the 60 affiliated groups are branches of Support Coalition while others are independent organisations which take advantage of the international reach of Support Coalition to amplify their voices.

⁶ See for example, Psychiatric Survivors Advocacy/Liberation Movement, 1999, Available URL, <http://www.az.com/~bipolar/PSALMS.html>

⁷ P. A. Pross, Group Politics and Public Policy, Oxford Uni. Press, Toronto, 1986, p. 16.

⁸ Citizens Commission on Human Rights, 1999, Available URL, <http://www.cchr.org/cchrhome.htm>

⁹ Support Coalition, 1999, Available URL, <http://www.efn.org/~dendron/>

¹⁰ Center for the Study of Psychiatry and Psychology, 1999, Available URL, <http://www.breggin.com/>

¹¹ National Association for Rights Protection and Advocacy, 1999, Available URL, <http://www.connix.com/~narpa/>

¹² Support Coalition International, 'List of S.C.I. Sponsor Groups and Spokes', Dendron, Nos. 39 and 40, Winter 1997- 98, pp. 46-47.

Support Coalition primarily relies on two separate methods to build solidarity amongst the groups and to focus campaigns on specific issues. The first is a journal called *Dendron* which is published several times a year and which carries articles written by members of the network about campaign issues.

The second method is more innovative and utilises the internet. There is a website¹³ with extensive material about current campaigns focussed on issues like involuntary treatment, outpatients commitment and ECT. There are also four email lists run from the website.

The first of these email lists is not a discussion list but is used for human rights alerts when cases of particularly blatant human rights abuse come to the attention of the co-ordinator.¹⁴ When this happens a ‘Dendrite’ is dispatched by email to over 1000 activists in various countries with instructions on how and where to lodge a protest by post or email. There are a number of instances where Support Coalition claims to have had resounding successes using this method by forcing mental health authorities to release individuals from involuntary hospitalisation or to cease forced treatment. The campaign technique seems to be most effective when it targets small-town mental health authorities who are easily embarrassed by international attention.¹⁵

The second email list which has about 150 international subscribers is called SCI — Support Coalition International. SCI is for members of Support Coalition’s international network to exchange campaign news and to plan strategies. Most of the subscribers to SCI have past diagnoses of serious mental illnesses which do not appear to interfere in any way with their ability to articulate complex legal, scientific and political issues in clear simple prose. This, combined with the apparent technical mastery of internet methods of communication, provides significant evidence supporting aspects of the M-M-I model. The Support Coalition lists, in fact, are fairly remarkable for their total absence of the irrational outbursts that are characteristic of many email discussion lists. There is very little in the way Support Coalition members conduct their dialogues that gives any confirmation to the medical assumptions of mental incompetence inherent in the psychiatric labels they have received.

The other two Support Coalition lists are NOFORCE “for discussion about fighting forced psychiatry”. And ZAPBACK “which is a fairly new email list for SCI members to discuss fighting electroshock human rights violations”.¹⁶

¹³ *Support Coalition*, Available URL, op.cit.

¹⁴ David Oaks, Co-Coordinator, *Support Coalition International*, P.O. Box 11284, Eugene, Oregon, 97440-3484, USA., email: dendron@efn.org

¹⁵ Drug Free!, *Dendron*, Nos. 39 and 40, Winter 1997- 98, p. 5.

¹⁶ David Oaks, SCI List (sci@efn.org), *Support Coalition*, 30 September, 1998.

Human Rights Imperatives

From the perspective of the myth-of-mental-illness (M-M-I) model the medical treatment for schizophrenia, particularly when it is given involuntarily, is quite unreasonable.¹⁷ The neuroleptic drugs used as frontline treatment have powerful effects on the minds and bodies of the patients who are treated with them.¹⁸ Some side effects of neuroleptic medication, like tardive dyskinesia, are probably the result of permanent brain damage.¹⁹ If the symptoms of schizophrenia are in fact incorrectly classified as a medical problem then, even when recipients of treatment are volunteers, it is apparent that the medical practitioner offering the treatment has gained the patient's consent by supplying false information. This is bad enough. But when the treatment is given involuntarily, without consent, some very serious violations of basic human rights take place.

A person who is not committed to the M-M-I model might find this proposition thoroughly implausible. It is one thing, as an intellectual exercise perhaps, to assimilate and even acquiesce to the simple logic of the arguments given in the foregoing chapter. But it is altogether another proposition to acknowledge the corollary of these arguments: i.e. that the medical model for schizophrenia is causing human rights violations on a massive scale. In order to make the human rights arguments attached to the M-M-I model at least plausible it might be useful to lay some groundwork by offering a reasonable explanation for why this systematic injustice has developed.

According to the M-M-I perspective the explanation for why the medical model for schizophrenia is dominant, and so blatantly used for social control, in the face of common sense to the contrary, is a matter of long-standing legal necessity. This legal necessity concerns the availability of an insanity plea which can be used to escape criminal responsibility for breaches of the law.²⁰ The insanity plea has been deeply entrenched in legal custom from ancient times²¹ and, so long as it continues to be available — and so long as the symptoms of schizophrenia are thought to be indications of madness — people who manifest these symptoms cannot be held criminally responsible for their actions. The underlying logic of the M-M-I model is that in this situation it is necessary to have an alternative to the criminal justice system to control people who manifest the signs of madness/insanity in order to protect the public from their actions.

¹⁷ Peter Breggin, *Toxic Psychiatry*, Fontana, London, 1983, pp. 57-83.

¹⁸ Alan I. Green and Jayendra K. Patel, 'The new pharmacology of schizophrenia', *Harvard Mental Health Letter*, Vol. 13, No. 6, Dec 1996, pp. 5-8.

¹⁹ B. Bower, 'Rat model of tardive dyskinesia gets boost', *Science News*, Vol. 136, No. 20, 11 Nov, 1989, p. 308.

²⁰ Thomas Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*, Routledge and Kegan Paul, London, 1974, pp. 126-127.

²¹ Chester R. Burns, 'American Medico-Legal Traditions and Concepts of Mental Health: The Nineteenth Century', in H. Tristram Engelhardt, Jr., ed., *Mental Health: Philosophical Perspectives*, D. Reidel, Dordrecht, Holland, 1976, pp. 3-14.

It should be noted that this explanation of the situation implies that even in the absence of a medical system for identifying, treating and controlling people who manifest the symptoms of schizophrenia there would still need to be another system of socially alienating mad people. And in their alienation these people would still most likely be labelled in non-medical terms as child-like, mad and insane. They would also still have a chance of escaping criminal responsibility for their actions. This indeed was the case before the development of the medical model.²² Acceptance of the M-M-I model does not necessarily preclude a belief in a lay understanding of madness/insanity, but only that the medical interpretation of this understanding is inappropriate.

Background to the Insanity Plea

There is a long-standing tradition in most legal systems that allows two kinds of excuses as a justification for breaking the law.²³ The first is the argument that the illegal act was committed in ignorance.²⁴ Here one person might shoot another. But the shooter can try to claim it was an accident because he or she did not know the gun was loaded. Or, one person might admit to poisoning another after cooking a meal. But the poisoner might claim that he or she did not know that rat poison was kept in the jar marked ‘food colouring’. The excusing of children from legal culpability is derived from this area and when a child is found to have committed a serious offence it is assumed that he or she did not know any better.

The second kind of excuse occurs when the perpetrator can claim that he or she was compelled to act in a particular way. Self-defence and extreme provocation are included in this area. Acts committed under duress of threats, as well as behaviour that is motivated by extremes of emotion, might also be excused on the grounds of compulsion.²⁵

There is a long history of excusing people who are deemed to be insane at the time of committing a crime, on one or the other, or both, of these grounds. Roman law of the latter Empire period excused insane people because an analogy was drawn between them and children.²⁶ Ancient Hebraic law “recognised that deaf-mutes, idiots and minors were not responsible for their actions”²⁷ and “[a]ncient Mohammedan law applied punishment only to individuals who have attained their majority, and who are in full possession of their faculties”.²⁸

²² Michael S. Moore, ‘Legal Conceptions of Mental Illness’, in Baruch A. Brody and H. Tristram Engelhardt, Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing, Dordrecht/Boston, 1980, p. 27.

²³ Ibid., p. 27-33.

²⁴ Jerome Neu, ‘Minds on Trial’, in B. A. Brody and H. T. Engelhardt, Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing, Dordrecht/Boston, 1980, p. 82.

²⁵ Ibid., pp. 90-100.

²⁶ Moore, op.cit., p. 27.

²⁷ Ibid.

²⁸ Ibid.

In modern times countries with legal systems derived from English law have developed a test for insanity which excuses legal culpability when the person, at the time of committing the crime, is believed to be unaware of the difference between good and evil. The legal precedent which establishes this test is known as the M’Naghten case.²⁹

In England in 1843 Daniel M’Naghten assassinated Edward Drummond, who at the time was the private secretary of the Prime Minister. M’Naghten claimed to believe that a number of people, including the Prime Minister, were persecuting him in various ways. At his trial M’Naghten successfully defended his actions on the grounds of insanity but after the trial many people still believed he might only have been feigning his madness. As a result the judges in the case were asked to appear before the House of Lords and explain the test of insanity they had applied to M’Naghten. The answer supplied by the judges has since become the basis for a test of criminal insanity:

To establish a defence on the grounds of insanity, it must be conclusively proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from the disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong. (*Regina v. M’Naghten*, 10 Clark and F. 200, 8 Eng. Rep. 718 (1843)).³⁰

The so-called M’Naghten test soon became established in English-speaking countries as the principle test of legal insanity but it also came under persistent criticism because it was thought to be too narrow in its definition. This was because it only covered the traditional defence of ignorance and did not provide a defence for a person who was aware of the nature of the act, and aware that it is wrong, but all the same was compelled by mad impulses to act contrary to the law.

In the United States this controversy finally produced a definition by the American Law Institute which incorporated both defences:

- (1) a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.
- (2) the terms ‘mental disease or defect’ do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.³¹

²⁹ Neu, *op.cit.*, pp. 81-82.

³⁰ Moore, *op.cit.*, p. 28.

³¹ *Ibid.*, p. 30.

The clarification of the meaning of mental disease by excluding “abnormality manifested only by repeated criminal or otherwise antisocial conduct” points to a simmering demarcation dispute over the boundaries of professional territory which has been going on between the legal and the medical professions ever since the medical profession secured its tenure over the madness industry. Some elements of the medical profession would be only too happy to medicalise all transgressions of the law³² and the above exclusion is to ensure that the bulk of criminal offenders remain accountable to the legal process.

More recently, under the New South Wales Mental Health (Criminal Procedure) Act 1990,³³ the related problems of ‘ignorance’, ‘compulsion’ and ‘professional demarcation’, as they relate to the insanity plea, have been handled differently. The trend now is to define ‘mental illness’ in the legislation so that the interpretation of the condition is a legal matter as well as a medical matter. Then, the terminology of criminal insanity is omitted and replaced with ‘mental illness’. This creates conditions whereby a person, who at the time an offence was committed is deemed to have been mentally ill, according to the legal definition of mental illness, is not to be held responsible for criminal acts.

The definition of mental illness given in the NSW Mental Health Act 1990 is a very simple one involving five symptoms.³⁴ The presence of any single symptom indicates that a person is mentally ill. In respect to legal action, normally only medical practitioners are authorised to identify the symptoms. As has been discussed in an earlier chapter four of the five symptoms are also listed as DSM-IV Criterion A positive symptoms for schizophrenia.

This means that a contemporary medical practitioner in NSW, who encounters a person manifesting positive symptoms for schizophrenia, and who thinks the person might also be at risk of causing serious harm, is legally authorised to have the person incarcerated, involuntarily if necessary, in a mental hospital.³⁵ Now this is where the existence of the insanity plea is important as a background motivator for the medical impositions that are placed on the person.

Ostensibly the doctor is free to choose, or not to choose, to have the person incarcerated, according to the best interests of the patient. But in reality, from the M-M-I perspective, a doctor involved in psychiatric matters is simply an agent of social control. As such the doctor is required to consider the consequences of allowing the person with schizophrenic symptoms to remain free. Having

³² Jane Ellen Stevens, ‘The biology of violence’, *BioScience*, Vol. 44, No. 5, May, 1994, pp. 291-295.

³³ *Mental Health (Criminal Procedure) Act 1990*, NSW Government Information Service, Reprinted as in force at 17 October, 1994.

³⁴ *Mental Health Act 1990*, Schedule 1, NSW Government Information Service, Reprinted as in force at 17 October, 1994, pp. 115-116.

³⁵ *Mental Health Legislation Amendment Bill 1997*, Section 9, Assented to by the NSW Parliament 26th June, 1997, p. 3.

diagnosed the person as schizophrenic, and therefore as being mentally ill in a legal sense, the doctor has in effect provided the person with a legal excuse to get away with murder, or any other crime, in the future.

From the criminal justice perspective, therefore, a diagnosis of serious mental illness, without a subsequent imposition of control, has to be seen as a sign of professional irresponsibility. The precautionary control of people who could possibly invoke an insanity plea is a necessary task that goes with the job of doctor.

Occasionally it is necessary to give the medical profession an oblique reminder of their social control duties in this area. A recent case in the United States is a good illustration. The October 10, 1998 edition of the New York Times reported a front page story with a headline that tells it all — “Killer Sues His Therapist and Wins \$500,000”.³⁶

Wendell Williamson was a law student at the University of North Carolina when he was first directed to attend a consultation with Myron B. Liptzin, the head of student psychiatric services, after he disrupted a class by claiming he had telepathic powers. Liptzin diagnosed Williamson with delusional disorder grandiose and prescribed neuroleptic medication. After eight consultations Liptzin informed Williamson that since he was soon to retire Williamson should find another psychiatrist. Williamson did not follow Liptzin’s advice and instead of finding another psychiatrist he simply stopped taking the medication.

Eight months after the last contact with Liptzin, Williamson shot two men in the street without provocation. He was diagnosed with paranoid schizophrenia and at his trial was found innocent on the grounds of insanity. At a subsequent trial he was awarded \$500,000 in damages against Liptzin, his former psychiatrist. The damages were awarded because a jury believed that Liptzin had not correctly perceived the seriousness of Williamson’s disorder and had not imposed the necessary control measures. A newspaper report said Williamson claimed that,

the verdict in the civil case showed that he and the people he killed were all victims of Dr. Liptzin's failure. “The murders would not have happened if Dr. Liptzin had done his job properly.” Williamson testified at trial of his suit last month, telling the jurors that Dr. Liptzin “had more control over the situation than I did.”³⁷

Williamson’s success with this unlikely argument is an unequivocal message to psychiatrists that the justice system expects them to impose precautionary control measures on anyone they encounter

³⁶ William Glaberson, ‘Killer Sues His Therapist and Wins \$500,000’, New York Times, 10 October, 1998, p. 1.

³⁷ Ibid., p. 1.

who might be violent, and who is likely to escape criminal liability with an insanity plea. This type of message is particularly disturbing to those who subscribe to the M-M-I perspective because it tends to reinforce the expectation of an authoritarian imposition of the medical model. Thomas Szasz and Jeffrey Schaler are leading advocates of the M-M-I model and they both responded within a few days of the Williamson story with letters to the editor.

To the Editor:

That killers can successfully blame their therapists for their actions (front page, Oct. 10) is the consequence of the fiction of mental illness and the junk science of psychiatry that it supports. Although lawyers, psychiatrists and society conspire in the twin charades of civil commitment and the insanity defence, the main culprits are the mental health professionals. If they believed in personal responsibility rather than in mental illness — and rejected the practices of depriving innocent people of liberty and excusing guilty people of crimes — we would be spared the spectacle of criminals' being acquitted of crimes and collecting damages as if they were the victims of untreated diseases.

THOMAS SZASZ, M.D., Syracuse, Oct. 10, 1998

The writer is professor emeritus of psychiatry at SUNY Health Science Center.³⁸

To the Editor:

Why did a jury hold a psychiatrist, Myron B. Liptzin, accountable for Wendell Williamson's murderous acts (front page, Oct. 10)? Because psychiatrists invented and perpetuate the myth of mental illness. As long as people believe in mental illness as a cause for behaviour, those who receive such a "diagnosis" will be exculpated — and someone else will be culpable.

Since psychiatrists removed the blame, it is only fitting that they should be saddled with it.

JEFFREY A. SCHALER, Silver Spring, Md., Oct. 10, 1998

The writer is an adjunct professor of justice, law and society at American University.³⁹

Despite these M-M-I arguments, and numerous doubtful applications of the insanity plea like Williamson's, it is still apparent that most people agree that an insanity plea should be available. Without it, undoubtedly, some people would be unjustly punished for crimes they were incapable of understanding. If an insanity plea is an inevitable component of a modern criminal justice system then for it to exist it is apparent that the definition of insanity must be couched in some kind of socially comprehensible framework. The range of possibilities in this respect seem to be limited to

³⁸ Thomas Szasz, Letter to the Editor, New York Times, 14 October, 1998.

³⁹ Jeffrey A. Schaler, Letter to the Editor, New York Times, 14 October, 1998.

analysing mental and/or moral incompetence in terms of either a religious, philosophical or medical framework.

Szasz's solution is for all accused people to be tried and a verdict reached. A court would then consider pleas of mitigating circumstances as part of the sentencing procedure. In the meantime the essential problem from the M-M-I perspective is that any positive effect on human rights gained by the application of a medically-defined insanity plea is disproportionately counter-balanced by a negative effect.⁴⁰ The negative effect is caused by the large number of innocent people who become victims of precautionary control measures.

Some comparative figures might be useful to illustrate this point. In NSW in 1996, for instance, there were 10 people who were tried for criminal offences and who were found not guilty by reason of mental illness.⁴¹ A further 3 people were found mentally unfit for trial.⁴² These 13 people who escaped criminal liability in that year can be compared to 7,601 involuntary admissions to mental hospitals,⁴³ 2,095 Community Treatment Orders⁴⁴ and 167 Community Counselling Orders,⁴⁵ totalling 9,863 involuntary impositions, in the same legal jurisdiction in the same year.

All of these involuntary impositions required a medical opinion that the people involved were at risk of causing serious physical harm to themselves or other people. But what was the real risk? For every case where a person did successfully evade criminal liability on the grounds of mental illness there were some 760 occasions on which innocent people had their human rights violated as a precautionary measure.

Relevant Human Rights

When viewed from the M-M-I angle it can be argued that people who are involuntarily hospitalised as a precautionary measure routinely have their human rights violated by the deprivation of liberty and the imposition of forced treatment. Article 9 of the International Covenant on Civil and Political Rights (ICCPR) guarantees:

⁴⁰ Thomas Szasz, Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices, op.cit., pp. 228-230.

⁴¹ Mental Health Review Tribunal, Annual Report, NSW Government, 1996, p. 50.

⁴² Ibid., p. 50.

⁴³ Ibid., p. 57.

⁴⁴ Ibid., p. 39.

⁴⁵ Ibid., p. 37.

Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with procedure as are established by law.⁴⁶

The key word here is ‘arbitrary’. If correct procedures are followed and there is good reason to arrest a person, because he or she has broken a law, then the person no longer has a right to liberty. But on most occasions when schizophrenics are involuntarily hospitalised it is not in response to a breach of the law but is only a precautionary measure. Is this arbitrary? If, as the M-M-I model asserts, there is no disease underlying the symptoms, the answer to this question revolves around whether the psychiatric diagnostic processes, even though they arbitrarily attribute the symptoms to a non-existent disease, can still accurately select people who are in need of control because they are dangerous to themselves or other people.

A great deal of research has been undertaken to determine whether people with the symptoms of schizophrenia, and other mental disorders, are more dangerous than other people.⁴⁷ The results of this research vary from marginally more dangerous⁴⁸ to being no more violent than the general population.⁴⁹ In the context of this research it is frequently observed that there are some other classes of people, like young men between the ages of 15-25, and men consuming alcohol, who are statistically far more dangerous to other people than schizophrenics.⁵⁰ Since it would be considered a blatant transgression of human rights to incarcerate all young men, and/or all alcohol drinkers, the rhetorical question is sometimes posed as to why it is thought just to incarcerate a statistically less dangerous group on the grounds of their supposed dangerousness.

Nor is there scope for the simple retort that schizophrenics are also incarcerated in order to protect them from themselves because of their supposedly high suicide rate.⁵¹ A far higher suicide rate prevails amongst people who have already attempted to kill themselves, particularly when there is a background of childhood sexual abuse.⁵² This is a group on whom no precautionary incarceration is

⁴⁶ United Nations, ‘International Covenant on Civil and Political Rights’, Article 9, reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, p. 29.

⁴⁷ See for example, Dan Hurley, ‘Imminent danger’, Psychology Today, Vol. 27, No. 4, July-August 1994, p. 54-63.

⁴⁸ G. D. Glancy, C. Regehr, ‘The Forensic Psychiatric Aspects of Schizophrenia’, Psychiatric Clinics of North America, Vol. 15, No. 3, 1992, pp. 575-589.

⁴⁹ David Shore, Schizophrenia: Questions And Answers, Schizophrenia Research Branch, National Institute of Mental Health, 1995.

⁵⁰ Bruce Bower, ‘Law and Disorders: Studies explore legally sensitive judgments in treating mental illness’, Science News, Vol. 147, No. 1, 7 January, 1995, pp. 8-11.

⁵¹ E. Nieto, E. Vieta, C. Gasto, J. Vallejo, and E. Cirera, ‘Suicide Attempts of High Medical Seriousness in Schizophrenic Patients’, Comprehensive Psychiatry, Vol. 33, No. 6, 1992, pp. 384-387.

⁵² A. L. Beautrais, Peter R. Joyce and Roger T. Mulder, ‘Risk factors for serious suicide attempts among youths aged 13 through 24 years’, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 35, No. 9, Sept, 1996, pp. 1174-1183.

imposed. Nor is there any institutionalised intervention in the lives of people who pursue life-threatening dangerous sports, like mountain climbing and car racing. On the contrary, such people are encouraged because they inspire normal people with their willingness to take risks.

In the context of this debate about the need to take schizophrenics into custody in order to protect them from themselves there is an interesting statistic. It seems that schizophrenics undergo a particularly high risk of suicide shortly after they are released from hospital.⁵³ This can be interpreted in a number of different ways. On the one hand it could be argued that hospitalisation protects a person from suicidal impulses and those who suicide after release should have been kept in longer. But on the other hand it can also be argued that it is the treatment, or the humiliation of the incarceration experience itself, that causes people to suicide as soon they get a chance.

The possibility that neuroleptic treatment might induce suicidal or violent reactions is very disturbing. Neuroleptic-induced akathisia is a side-effect of standard drug treatment for schizophrenia: "The individual is virtually tortured from inside his or her own body as feelings of irritability and anxiety compel the person into constant motion, sometimes to the point of continuous suffering".⁵⁴ DSM IV is unequivocal about the risks of suicide and violence associated with neuroleptic medication:

Akathisia may be associated with dysphoria, irritability, aggression, or suicide attempts. Worsening of psychotic symptoms or behavioural dysfunction may lead to an increase in neuroleptic medication dose, which may exacerbate the problem. Akathisia can develop very rapidly after initiating or increasing neuroleptic medication. The development of akathisia appears to be dose dependent and to be more frequently associated with particular neuroleptic medications. Acute akathisia tends to persist for as long as neuroleptic medications are continued, although the intensity may fluctuate over time. The reported prevalence of akathisia among individuals receiving neuroleptic medication has varied widely (20%-75%).⁵⁵

If mainstream psychiatric manuals observe that up to 75% of the people who are treated for schizophrenia are put at increased risk of suicide as a result of a side effect, then it would seem somewhat paradoxical to argue that the same schizophrenics need to be locked up to ensure they are given treatment to *protect* them from suicide.

⁵³ B. J. Carone, M. Harrow, and J. F. Westermeyer, Posthospital Course and Outcome in Schizophrenia, Archives of General Psychiatry, Vol. 48, No. 3, 1991, pp. 247-253.

⁵⁴ Peter Breggin and David Cohen, Your Drug May Be Your Problem, Perseus Books Reading Massachusetts, 1999, p. 78.

⁵⁵ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM IV), Fourth Edition, American Psychiatric Association, Washington, 1994, p. 745.

Torture and Cruel Treatment

Another article of human rights law that is of particular interest to proponents of the M-M-I model is Article 7 of the ICCPR:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.⁵⁶

The linkage in Article 7 between torture and unreasonable forms of punishment, on the one hand, and medical experimentation on the other, is noteworthy. From the M-M-I angle all medical treatment for mental illnesses is, and can only be, experimental.⁵⁷ And further, since there is thought to be no illness underlying the supposed symptoms of schizophrenia the rationale for applying medical treatment can only be explained in terms of punishment. That is, punishment for having allowed thoughts, beliefs and behaviour to have crossed a threshold of social tolerance.

Concerns about torture and unreasonable forms of punishment are so fundamental to human rights that a special United Nations convention is dedicated to their elimination, which is supplementary to Article 7. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment conveniently supplies a definition of torture as:

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.⁵⁸

The exclusion described in the last sentence is concerned with the application of prescribed punishments for specific breaches of the law. In some countries, for instance, whipping is still used as a punishment for certain criminal offences and the intention of the Convention is to exclude such “lawful sanctions” from the definition of torture. However, if medical treatment for schizophrenia

⁵⁶ United Nations, ‘International Covenant on Civil and Political Rights’, Article 7, *op.cit.*, p. 29.

⁵⁷ Scott O. Lilienfeld, ‘Pseudoscience in Biological Psychiatry: Blaming the Body’, *Skeptical Inquirer*, Vol. 19, No. 6, Nov-Dec 1995, pp. 45-48.

⁵⁸ United Nations, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G. A. res. 39/46, annex, 39 U. N. GAOR Supp. (No. 51) at 197, U. N. Doc. A/39/51 (1984), entered into force June 26, 1987, Available URL, <http://www.umn.edu/humanarts/instreet/h2catoc.htm>

can be shown to fit the former part of the definition of torture then it is unlikely that it would be excluded merely because it has lawful sanction under mental health legislation. It can be assumed that the lawful sanction for the application of medical treatment for schizophrenia is only given on the assumption that it will benefit the patient, not that it will deliberately cause pain and suffering.

An M-M-I argument can be made that medical treatment for schizophrenia fits the above definition of torture because it causes: *severe physical and mental suffering; it is intentionally inflicted on a person for the purpose of obtaining a confession in the form of a demonstration of 'insight'; it intimidates and coerces the person to change his or her pattern of thinking and belief; and, in the case of involuntary treatment, the mental suffering is inflicted by a government employed psychiatrist acting in an official capacity.*

The assertion that schizophrenia treatment causes physical and mental suffering in those who receive it is not difficult to establish. Medical treatments for madness, from the 15th century onwards, have almost always done so. Some noteworthy examples are “stone operations — that is, pretending to remove stones from incisions made in the heads of patients thought to be mad”.⁵⁹ This European practice, which flourished between the 15th and 17th centuries, is thought to be the origin of the description of a mad people as having ‘rocks in their heads’.⁶⁰

A 17th century English medical text-book on madness relates “that the observations that sword wounds penetrating the skull sometimes produced a cure for insanity led to operations to let out the ‘fuliginous humours’ by boring the skull”.⁶¹ The 19th century saw the widespread use of treatments such as prolonged exposure in cold water, shock therapy by the sudden dunking in cold water on the opening of a trap-door, and a rotating swing device in which the patient’s head was strapped into a position in which the centrifugal force pushed more blood into the brain.⁶²

There have also been various kinds of infection therapies whereby pustules and running sores have been deliberately induced on the scalp so that they could be incised to let “the black vapours escape”.⁶³ Early in the 20th century fever therapies were used by infecting psychiatric patients with tuberculin, typhoid and malaria.⁶⁴ The exponents of all these improbable treatments claimed success at the time they were applying them and, if it is true that such applications can indeed eliminate the symptoms of schizophrenia then, from the M-M-I perspective, it is simply a demonstration that torture and punishment can persuade people to change their minds.

⁵⁹ Elliot S. Valenstein, ‘Historical Perspective’, in Elliot S. Valenstein, ed., *The Psychosurgery Debate*, W. H. Freeman, San Francisco, 1980, p. 15.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² *Ibid.*, p. 22.

⁶³ *Ibid.*, p. 17.

⁶⁴ *Ibid.*

It was not until well into the 20th century, with the advent of more sophisticated medical treatments like insulin coma treatment in the late 1920s,⁶⁵ and in the 1930s metrazol convulsive treatment,⁶⁶ psychosurgery⁶⁷ and electro convulsive treatment (ECT),⁶⁸ that schizophrenic patients were properly introduced to modern medical practices. Insulin and metrazol have long ago been phased out as schizophrenia treatments but the record of their usage is quite relevant to the current discussion on torture. Early psychiatric pioneers of these treatments were often candid in their opinions about the usefulness of insulin and metrazol in ‘fear therapy’:

No reasonable explanation of the action of hypoglycaemic (insulin) shock or of epileptic fits in the cure of schizophrenia is forthcoming, and I would suggest as a possibility that as with the surprise bath and the swinging bed, the ‘modus operandi’ may be the bringing of the patient into touch with reality through the strong stimulation of the emotion of fear, (and) that the intense apprehension felt by the patient after an injection of cardiazol (metrazol), and so feared by the patient, may be akin to the apprehension of the patient threatened with the swinging bed. The exponents of the latter pointed out that fear of repetition was an important element in success.⁶⁹

During insulin treatment a person experienced a range of symptoms beginning with clouding of consciousness and progressing to wild excitement, involuntary gasping and sucking, protrusion of the tongue, snarling, grimacing, twitching, convulsions, spasms and deep coma.⁷⁰ It is reported to be a very unpleasant experience.⁷¹ One line from the quotation above worth repeating concerns the “bringing of the patient into touch with reality through the strong stimulation of the emotion of fear”. The reality presumably presented to the patient was that if he or she was not prepared to cease manifesting schizophrenic symptoms, and make the required adjustments of thinking and belief, then the patient would be made to suffer more insulin or metrazol treatments. This is a fairly concise description of torture, and the objective of torture — i.e. compliance.

The patient is mentally sick, his behaviour is irrational; this “displeases” the physician and, therefore, the patient is treated with injections of insulin which make him quite sick. In this extremely miserable condition he seeks help from anyone who can give it.

⁶⁵ Leonard Roy Frank, The History of Shock Treatment, Leonard Roy Frank, San Francisco, 1978, p. 5.

⁶⁶ Ibid.

⁶⁷ Valenstein, op.cit., pp. 20-23.

⁶⁸ Frank, op.cit., p. 8.

⁶⁹ P. K. McCowan, 98th Annual Report for 1937 of the Crichton Royal Institution, Dumfries (Scotland).

Quoted in L. C. Cook, ‘Has fear any therapeutic significance in convulsion therapy?’, Journal of Mental Science, Vol. 86, No. 484, 1940. Quoted in Frank, op.cit., p. 6.

⁷⁰ Frank, op.cit., p. 7.

⁷¹ Ibid., pp. 5-7.

Who can give help to a sick person, if not the physician who is constantly on the ward, near the patient, and watches over him as over a sick child?⁷²

Don Weitz is a psychiatric survivor and an antipsychiatry activist based in Toronto, Canada. He produces an antipsychiatry radio programme called Shrinkrap and is the co-founder of a Toronto-based organisation called People Against Coercive Treatment (P.A.C.T.). A perception that the forced insulin treatment he received as a young man was a deliberate form of torture motivates his ongoing campaign against psychiatric coercion.

I was once tortured for six weeks 46 years ago — it happened in December 1951 and January 1952. I was forcibly subjected to a series of over 50 sub-coma insulin shocks which psychiatrist Douglas Sharpe prescribed as a treatment for “schizophrenia”. I never believed I was “schizophrenic” or “mentally ill” — just a very confused college student struggling to find himself, a common identity crisis. I was an involuntary psychiatric patient in McLean Hospital (a teaching-research facility affiliated with Harvard Medical School and Massachusetts General Hospital).

Psychiatrist Douglass Sharpe prescribed a series of insulin shock treatments for me because I was openly angry and defiant. Here's a telling excerpt by Dr. Sharpe in my medical records: “The patient was finally placed on sub-coma insulin and after a month of sub-coma insulin three times a day he showed tremendous improvement...There was no longer the outbursts of anger...He spends most of his time trying to figure out what the effect of insulin has on him...”

The shock treatments terrorised and debilitated me. I once went into a coma and thought I was dying — a “side effect” Dr. Sharpe and other psychiatrists never warned me about. When I frequently complained to Dr. Sharpe about the maddening hunger, profuse sweating and convulsions I was forced to experience everyday on insulin-shock and that it was torture, he dismissed my complaints and calmly replied, “I'm not torturing you. These complaints are just part of your problem.” The usual blame-the-victim game. I was finally released in 1953 only after I promised to conform to the psychiatrists' stereotype of a middle-class young student — study and go back to college.

It took me almost 20 years to understand my forced psychiatric incarceration and forced treatment in political terms, 20 years to realise that I was a political prisoner of

⁷² Marcus Schatner, ‘Some observations in the treatment of dementia praecox with hypoglycemia: part 2, psychological implication’, *Psychiatric Quarterly*, Vol. 12, No. 1, 1938, pp. 22-26. Quoted in Frank, *Ibid.*, pp. 6-7.

psychiatry — locked up against my will, tortured, no right to a hearing or trial before losing my freedom, no right to appeal.⁷³

Like insulin treatment, ECT has also earned a reputation as a ‘fear therapy’.⁷⁴ Sylvia Plath described a personal experience of ECT in The Bell Jar.

“Don’t worry,” the nurse grinned down at me. “Their first time everybody’s scared to death.”

I tried to smile, but my skin had gone stiff, like parchment.

Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite.

I shut my eyes.

There was a brief silence, like an indrawn breath. Then something bent down, and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. I wondered what terrible thing it was that I had done.⁷⁵

Unlike insulin and metrazol, ECT is still widely used as a psychiatric treatment although, unlike Sylvia Plath’s experience, patients are now anaesthetised first. Even so, fear of the experience has been well documented. One group of researchers exploring the role of fear in ECT elicited comments from patients who had undergone it:

Reaction ranged from strong denial of fear, such as “I’m glad to take it,” to fear of total mental destruction or death, such as “Shock will destroy my mind,” “My heart will stop,” “I will die.” Many subjects expressed fears of being electrocuted, such as one who said, “It’s like being burned to a crisp.” Often the subject revealed under questioning a high degree of fear after first denying any fear, such as a depressed subject who admitted “I’m scared to death every time. I never know if I’m going to come out of it or not.” A very psychotic subject described ECT as “like crossing a river.”⁷⁶

⁷³ Don Weitz, ‘Cruel and Usual — A Human Rights Violation’, unpublished article, posted on, Support Coalition SCI list (internet discussion list), 4 December, 1998.

⁷⁴ Evelyn Crumpton, Norman Q. Brill, Samuel Eiduson and Edward Geller, ‘The role of fear in electroconvulsive treatment’, Journal of Nervous and Mental Disorders, Vol. 136, 1963, pp. 29-33.

⁷⁵ Sylvia Plath, The Bell Jar, Bantam, New York, 1972, pp. 117-118.

⁷⁶ Crumpton et al, op.cit., pp. 29-33.

In the past ECT was, for a time, the main treatment for schizophrenia.⁷⁷ More recently it has been largely reserved for so-called drug resistant cases of severe depression.⁷⁸ However, ECT is still recommended in treating acute symptoms of schizophrenia “in certain patients who are in severe states of withdrawal (catatonia) or who present with significant affective symptoms such as uncontrolled mania”.⁷⁹

The medical profession often seem to have a blind spot in their collective conscience concerning the difference between treatment and torture when electric shocks are involved. When electric shock is applied to the genitals it is unequivocally torture. This point is illustrated by an article in Australian Doctor which reports on evidence gathered by the London-based Medical Foundation for Victims of Torture. It relates how a Sudanese political prisoner was subjected to “burns with cigarettes and a hot metal bar, electric shock treatment to his genitals and scalding with boiling water”.⁸⁰ However, when a person is imprisoned in a mental hospital, subjected to toxic chemicals and electric shocks to the head, it is called treatment.

Psychosurgery is another psychiatric treatment that was widely used for schizophrenia in the past, but which contemporary psychiatrists now reserve for other mental illnesses, like depression and obsessive-compulsive disorder.⁸¹ Psychosurgery is a form of psychiatric treatment which ordinary people have little trouble understanding. Its conception is not much more sophisticated than an operation to cut a rotten spot out of an apple. It relies on crudely conceived brain-mapping which purports to locate specific forms of deviant mental activity in certain areas of the brain.⁸² The basic principle is that unwanted mental activity can be surgically removed. The effects of psychosurgery are irreversible.

Psychosurgery has been “practiced in most countries with the necessary technical skills”⁸³ but it particularly boomed in the United States in the late 1940s and early 1950s, shortly before the widespread adoption of antipsychotic drugs. In Britain, between 1942 and 1954, 10,365 people were given leucotomy operations, two-thirds of them being performed on schizophrenics.⁸⁴ At this

⁷⁷ Marin Fine and Michael A. Jenike, ‘Electroshock: exploding the myths’, RN, Vol. 48, Sept 1985, pp. 58-64.

⁷⁸ Egon Weck, ‘Electro 'shock' therapy; controversy without end?’, FDA Consumer, Vol. 20, March 1986, pp. 8-12.

⁷⁹ Deborah Dauphinais, Medications for the treatment of schizophrenia: questions and answers, Pamphlet produced by U.S. Department of Health and Human Services, Washington, 1992.

⁸⁰ Lynda Griffiths, ‘BMA condemns torture cases’, Australian Doctor, 25 September 1998, p. 82.

⁸¹ Neuropsychiatric Institute, General Information, Neuropsychiatric Institute (NPI), Prince Henry Hospital, Sydney, Australia, 1999, Available URL, <http://acsun.acsu.unsw.edu.au/~s8700122/npiphh.html/#NPS>

⁸² Thomas H. Lewis, ‘Psychosurgery: Damaging the Brain to Save the Mind’, JAMA, The Journal of the American Medical Association, Vol. 269, No. 8, 24 Feb, 1993, p1051-1053.

⁸³ F. A. Whitlock, ‘Psychosurgery’, in Erica M. Bates and Paul R. Wilson, eds., Mental Disorder or Madness, University of Queensland Press, St Lucia, 1979, p. 182.

⁸⁴ Ibid.

time insulin and metrazol were passing out of favour for schizophrenia treatment and mental hospitals were over-crowded with war veterans from World War II.

The popularisation of psychosurgery in the United States was largely attributable to Walter Freeman and James Watts, who jointly developed new techniques. Freeman was a neuropsychiatrist, and Watts a neurosurgeon, and in 1946 they performed the first operation using a new all-purpose technique called transorbital lobotomy: “The only instrument needed was a simple penetrating and cutting tool, which was forced through the bony orbit over the eye to enter the region of the frontal lobes”.⁸⁵

This instrument, which Freeman referred to as resembling “an ice-pick”,⁸⁶ was called a leucotome and, being a blunt instrument in both literal and metaphorical senses, was driven into the frontal lobe area with the aid of a mallet. Once in place it was rotated “so that the cutting edge would destroy fibres at the base of the frontal lobes”.⁸⁷ Estimates for the number of first wave lobotomy operations performed in the United States using this method range up to 50,000.⁸⁸ One of the main reasons for this popularisation was that:

transorbital lobotomies were relatively easy to perform and electroconvulsive shock was frequently used in place of anaesthesia, the surgery was commonly performed by psychiatrists without the involvement of neurosurgeons, anaesthetists, and surgical amphitheatres. In some instances, the operation was performed as an office procedure and the patient was taken home by the family a few hours after the operation.⁸⁹

What the family took home, however, was a very different person to the one they had taken in.

Typically the patient tends to become more inert, and shows less zest and intensity of emotion. His spontaneous activity tends to be reduced, and he becomes less capable of creative productivity, which is independent of the intelligence level With these changes in initiative and control of behaviour, our patients resemble those with frontal lobe lesions.⁹⁰

⁸⁵ Valenstein, *op.cit.*, p. 26.

⁸⁶ *Ibid.*

⁸⁷ Elliot S. Valenstein, ‘Rationale and Surgical Procedures’, Valenstein, ed., *op.cit.*, p. 69.

⁸⁸ Valenstein, ‘Historical Perspective’, *op.cit.*, p. 27.

⁸⁹ *Ibid.*, p. 26.

⁹⁰ R. Anderson, ‘Differences in the course of learning as measured by various memory tasks after amygdectomy in man’, in E. Hitchcock, L. Laitinen and K. Vaernet, eds., *Psychosurgery*, Charles C. Thomas, Springfield Ill., 1972, pp. 177-183. Quoted in Peter R. Breggin, ‘Brain-Disabling Therapies’, in Valenstein, ed., *op.cit.*, p. 491.

An extensive study undertaken by P. MacDonald Tow in 1955 of Personality Changes Following Frontal Leucotomy found very significant changes in intellectual functions including “impairment of the powers of abstraction and synthesis; of perception of relations and differences; of the ability to deal with complex situations, planning and thinking out of the next action and its consequences; and appreciation of one’s own mistakes. There is also impairment of the power of sustained attention and of the capacity for fine discrimination; and a dulled appreciation of the subject’s own level of success or failure”.⁹¹

Tow also examined journals written by patients before and after their psychosurgery. The post-surgery journals were particularly good indicators of the effects of the operation and showed that patients had deeply felt concerns about loss of creativity and self awareness and in particular they frequently had “a terrible fear of being harmed and controlled by scientific and psychiatric technology.”⁹² Breggin describes having made similar observations in post-psychosurgery patients: “I have observed a florid paranoid schizophrenic with terror of being controlled by psychiatric technology following amygdalotomy”.⁹³

There is little doubt that psychosurgery — when it was performed on involuntary schizophrenic patients, and viewed from the M-M-I perspective as a punishment — could be neatly fitted into the United Nations definition of torture. But the psychiatric profession claims to have discontinued the use of psychosurgery to treat involuntary schizophrenic patients and so to properly examine the M-M-I based human rights imperatives it will be necessary to discuss the treatments that are currently in usage. The reason for discussing past treatment methods is to clearly demonstrate that there is a long tradition in psychiatric practice of applying torturous treatments to people who manifest the symptoms of schizophrenia.

Neuroleptics, the M-M-I Model and Human Rights

As already discussed in previous chapters, a group of drugs called neuroleptics, or antipsychotics, is the contemporary psychiatric treatment of first choice for schizophrenia.⁹⁴ To complete the examination of human rights imperatives attached to the M-M-I model it will be necessary to determine whether the practice of involuntarily treating schizophrenics with neuroleptics violates human rights such as the right to liberty and the right to protection from torture.

⁹¹ P. MacDonald Tow, Personality Changes Following Frontal Leucotomy, Oxford University Press, London, 1955. Quoted in Breggin, in Valenstein, ed., op.cit., p. 489.

⁹² Breggin, in Valenstein, ed., op.cit., p. 489.

⁹³ Ibid.

⁹⁴ William Glazer, ‘Depot neuroleptics: cost-effective and underutilized’, JAMA, The Journal of the American Medical Association, Vol. 272, No. 22, Dec 14, 1994, p. 1722.

The issue of liberty will be dealt with first. When a person is diagnosed with schizophrenia, and subsequently made an involuntary patient, the person usually undergoes a loss of liberty in two different ways. In the first instance there is the incarceration process which physically removes the person from the community.⁹⁵ In the second instance there is the forced treatment with neuroleptic drugs which effectively restrict brain activity and thereby restrain the person's ability to be physically and mentally active.⁹⁶ Neuroleptic drugging is so efficient in this task that earlier methods of physical restraint once commonly used in institutions, like straitjackets, are now rarely needed. In fact, neuroleptic treatment itself is sometimes referred to as a 'chemical straitjacket'.⁹⁷

So efficient is this chemical straitjacket that incarcerated people, although they may be considered still in need of control, are now often released into the community under, what in NSW is called, a Community Treatment Order. In the United States this process is called outpatients' commitment and states are progressively passing legislation to enable it.⁹⁸ This type of legislation subjects people to a legally binding order under which mobile treatment teams have access to peoples' homes in order to inject them with long-acting neuroleptics at the required intervals. There is usually a prescribed maximum period for which an order is effective — in NSW this has recently been extended from three months to six months⁹⁹ — but successive orders can be made for an indefinite period.

From the M-M-I perspective neuroleptic treatment applied in this way can not possibly have a therapeutic benefit because there is no underlying illness on which to apply the therapy. The only possible reason for using a system like this is for social control. As such the people who are controlled have their right to liberty violated because the medical assessment process that identifies them for forced drugging is fraudulent and arbitrary. There is a simple way to verify this argument. Neuroleptics, or antipsychotics, are supposedly given to schizophrenics as therapy to rebalance their brain chemistry. However, the same drugs are also used in many different institutional settings purely as restraining devices to control the behaviour of non-psychotic people. When they are used on non-psychotic people there is no pretence of a therapeutic purpose. This suggests that the only effective use of neuroleptics may be as chemical restraints.

⁹⁵ P. Munk-Jorgensen, P. B. Mortensen and R. A. Machon, 'Hospitalisation Patterns in Schizophrenia. A 13-Year Follow-Up', *Schizophrenia Research*, Vol. 4, No. 1, 1991, pp. 1-9.

⁹⁶ Kevin Gopal, 'Battling the mind: An old story', *Pharmaceutical Executive*, Vol. 16, No. 10, October 1996, pp. 32-35.

⁹⁷ Lawrence Stevens, *Psychiatric Drugs: Cure or Quackery?*, accessed March 1998, Available URL, http://www.cjnetworks.com/~cgrandy/stevens/psychiatric_drugs.html

⁹⁸ Shay Totten, 'Legislative Madness', *Vermont Times*, Vol. 8, No. 10, 4 March, 1998, pp. 16-17.

⁹⁹ *Mental Health Legislation Amendment Bill 1997*, Schedule 1, Assented to by the NSW Parliament 26th June, 1997, p.9.

A review of psychiatric literature reveals widespread neuroleptic use for treating agitation in elderly people. But there are also varying opinions within the psychiatric profession about the correctness of this procedure. While one text protests that “the use of antipsychotic drugs to control disturbed behaviour in elderly patients with dementia is a widespread practice that should be deplored” and that “antipsychotic drugs should not be used in the routine treatment of non-psychotic patients”¹⁰⁰ other texts and professional papers canvass a very different point of view.

The influential Synopsis of Psychiatry recommends that “[i]n addition to treating overt signs of psychosis, such as hallucinations and delusions, antipsychotics have also been used to deal effectively with violent, agitated, and abusive geriatric patients”.¹⁰¹ This view is supported by another text which says that neuroleptics are in “widespread use for the control of behavioural complications” in nursing homes and hostel settings where 20-70 per cent of institutionalised patients with dementia are receiving the drugs.¹⁰² (Dementia is not regarded as a psychosis but is a symptom of brain damage/brain atrophy arising from a variety of causes like stroke, accident and suspected problems like aluminium concentrations).

Studies of neuroleptic use in nursing homes have found that informed consent is often not sought in advance but is usually ‘presumed’ and that treatment continues unless it becomes apparent that the patient no longer acquiesces.¹⁰³ Studies have also found that the neuroleptic drugging also has an unequivocally detrimental effect and hastens the decline of elderly people. One recent study found that the intellectual capabilities of elderly people receiving neuroleptics were only half those of untreated elderly people.¹⁰⁴ Another study implicated neuroleptics in an increased incidence of injurious falls in nursing homes.¹⁰⁵

In its Federal Budget Submission for 1995, the Council on the Ageing (Australia) recommended that Commonwealth funds be allocated to specifically address a number of matters raised by the Inquiry into Human Rights and Mental Illness. One of these matters is referred to as “the use of

¹⁰⁰ G. Johnson, ‘The Biological Therapies’ in Pierre J. V. Beumont, Ed-in-Chief, Textbook of Psychiatry, Blackwell Scientific Publications, Melbourne, Oxford, 1989, p. 330.

¹⁰¹ Harold I. Kaplan and Benjamin J. Sadock, Synopsis of Psychiatry, Sixth Edition, Williams and Wilkins, Baltimore, 1991, p. 816.

¹⁰² S. Tichurst, ‘Dementia’, in Robert Kosky, Hadi Salimi Eshkevari, and Vaughan Carr, eds., Mental Health and Illness: A Textbook for Students of Health Sciences, Butterworth-Heinemann, Sydney, 1991, pp. 269-270.

¹⁰³ B. S. Gurian, E. H. Baker, S. Jacobson, B. Lagerbom and P. Watts, ‘Informed Consent for Neuroleptics with Elderly Patients in Two Settings’, Journal of the American Geriatric Society, Vol. 38, No. 1, January 1990, pp. 37-44.

¹⁰⁴ Alison Motluk, ‘Dementia drugs hasten mental decline’, New Scientist, Vol. 153, No. 2067, Feb 1, 1997, p. 9.

¹⁰⁵ James W. Cooper, ‘Drugs that cause falls in the nursing home’, Nursing Homes, Vol. 42, No. 4, May 1993, pp. 45-47.

chemical restraint in residential care for older people”.¹⁰⁶ The Human Rights Inquiry had been told that old people with dementia “get zonked out with medication or tied to their chairs”¹⁰⁷ in some nursing homes as a matter of course. And that “elderly patients are routinely sedated as a management technique — rather than for therapeutic purposes”.¹⁰⁸

But if the psychiatric text-books tend to disagree about the correctness of using neuroleptics to treat agitation and aggression in elderly people there is no such equivocation when it comes to dealing with the mentally retarded: “Treatment of behavioural disturbances in the mentally retarded has tended to rely heavily on medication resulting in up to 50% of retarded people in institutions and community residences being on psychotropic drugs”.¹⁰⁹ (Neuroleptics are a sub-set of the psychotropic group). A second text-book confirms the 50% figure as being normal and enthusiastically recommends the neuroleptics Mellaril and Haldol as being “useful in reducing unwanted behaviour, such as self-stimulation, aggression, and motor activity”.¹¹⁰

Neuroleptics are also routinely used by psychiatrists to treat children and adolescents who have had complaints laid against them for being disruptive. High strength neuroleptics like Haldol, for instance, are routinely prescribed for conduct disorder.¹¹¹ Conduct disorder is specific to children and adolescents and is essentially a tendency towards disobedience. Conduct disorder is a non-psychotic condition and so, unlike the dopamine hypothesis for schizophrenia, there is no underlying therapeutic rationale for using neuroleptic medication to control it. This has left drug treatment for conduct disorder open to severe criticism: “neuroleptics are still being prescribed for childhood disorders, such as conduct disorder, for which they have no legitimate medical use.”¹¹² A recent study of children and adolescents receiving neuroleptics in New York found that one third of them had developed symptoms of parkinsonism, and one eighth had developed tardive dyskinesia, as a result.¹¹³

When neuroleptic drugs are openly used in these ways to control troublesome behavioural patterns, without any pretence of a therapeutic purpose, serious doubt is cast on the claims that these drugs are only administered to people diagnosed with schizophrenia in order to rectify supposed medical

¹⁰⁶ Council on the Ageing (Australia), Federal Budget Submission For 1995, Melbourne, December 1994, p. 9.

¹⁰⁷ Human Rights and Equal Opportunity Commission, Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993, p. 517.

¹⁰⁸ Ibid. p. 245.

¹⁰⁹ H. Molony, ‘Mental retardation’, in Beumont ed, op. cit., pp. 277-278.

¹¹⁰ Kaplan and Sadock, op. cit., p. 799.

¹¹¹ B. Bowers, ‘Antipsychotics Evoke Youthful Concerns’, Science News, Vol. 140, No. 18, 2 November, 1991, p. 276.

¹¹² Ibid.

¹¹³ Ibid.

problems, like an imbalance in brain chemistry. It seems much more likely that the drugs are administered to schizophrenics for the same reason as they are given to disruptive non-psychotic people in institutions — primarily to control their behaviour. From the M-M-I perspective then involuntary dosing with these drugs could be viewed as a restriction of liberty and therefore as a violation of Article 9.

Treatment or Torture

The other major category of human rights imperative associated with the M-M-I model concerns whether forced treatment with neuroleptics is a form of torture or cruel, inhuman or degrading punishment. Modern psychiatry has been implicated on numerous occasions in recent times for assisting police interrogators extract false confessions from political prisoners of repressive regimes.¹¹⁴ In an attempt to control these activities the World Psychiatric Association (WPA), which is the international umbrella organisation for psychiatric professional bodies, and which claims 140,000 psychiatrist members, has a sub-committee called the Committee to Review of the Abuse of Psychiatry.

When an Australian whistleblower was falsely labelled with a psychiatric disorder in 1997, so as to facilitate dismissal from employment on medical grounds, she complained to the WPA and her complaint was passed on to the Committee. The Committee responded quickly advising the whistleblower that it would investigate her complaint.

The Secretary of the Committee, Marianne Kastrup, wrote under the letter-head of a Danish human rights organisation called the Rehabilitation and Research Centre for Torture Victims/International Rehabilitation Council for Torture Victims (RCT/IRCT).¹¹⁵ RCT/IRCT is partly funded by the Danish government and is largely dedicated to the investigation of torture and international adherence to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. It is interesting to note that the Secretary of a WPA committee is located in the offices of RCT/IRCT thereby indicating that the highest levels of the international psychiatric community have unequivocally linked certain psychiatric practices with torture.

There are indications that the American Psychiatric Association has made the same kind of linkage. The APA has two standing committees which have been set up to investigate claims that psychiatric diagnosis and treatment are used for punitive purposes. The Committee on International Abuse of Psychiatry and the Committee on Abuse and Misuse of Psychiatry in the U.S. recently advertised a symposium for North American psychiatrists in order to discuss specific instances of abuse.

¹¹⁴ Editorial, 'Guilty innocents: the road to false confessions', *The Lancet*, Vol. 344, No. 8935, Nov 26, 1994, p1447-1451.

¹¹⁵ Marianne Kastrup, *Letter to Louise Roy*, 9 January, 1998.

In the U.S. there are instances of psychiatrists cooperating with big business or government agencies to deny individuals fundamental human rights. One example is of a company which referred to a psychiatrist a nuclear power plant safety inspector who exposed unsafe procedures or conditions and subsequently fired the person on 'health grounds.' Another example is of a forensic psychiatrist who treated a psychotic prisoner to render him fit for execution. Internationally, evidence strongly suggests that the Cuban government is forcing political dissidents to undergo psychiatric treatment, much as that government's former Soviet patrons once did.¹¹⁶

Soviet psychiatry is one area where the international psychiatric establishment readily admits psychiatric treatment was used as a form of punishment and torture. This is despite some claims that the approach of Soviet psychiatrists to mental illness was almost identical to that of western psychiatrists. An investigator of Soviet psychiatry in the early 1990s found that:

The dopamine hypothesis of schizophrenia and amine hypothesis of depression are widely quoted. There is a more intense approach to treatment in the early stages of an illness, and the range of drugs used is similar to that in the West. Interestingly, clozapine [an atypical neuroleptic] was used in the Soviet Union long before it became available in Western countries.¹¹⁷

The WPA was very prominent in the early 1980s in a campaign of condemnation of Soviet psychiatric abuse and there was a widespread perception in the West that Soviet psychiatrists were using neuroleptics as a form of torture on dissidents who had been diagnosed with schizophrenia.

Leonid Plyushch, a Russian scientist and political dissident of the 1970s who eventually fled to the United States, was widely reported in the US media after he told how he had been drugged in a Soviet psychoprison on small doses of the neuroleptic Haldol: "I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day. My interest in political problems quickly disappeared, then my interest in scientific problems, and then my interest in my wife and children."¹¹⁸ Haldol is not a Soviet invention. It is manufactured in the United States by McNeil Pharmaceuticals, a subsidiary of the transnational pharmaceutical giant Johnson and Johnson. In 1995 Haldol had 24% of the neuroleptic market in the United States.¹¹⁹

¹¹⁶ D. Ray Freebury, 'Abuse of Psychiatry', Psychiatric News, accessed December 1997, Available URL, <http://www.appi.org/pnews/march7/freebury.html>

¹¹⁷ Francis I. Dunne, 'Soviet and Western Psychology: A Comprehensive Study', British Medical Journal, Vol. 305, No. 6849, 8 August, 1992, p. 374.

¹¹⁸ Breggin, Toxic Psychiatry, op. cit., pp. 71-72.

¹¹⁹ Norman L. Keltner, 'Antipsychotic Drugs', in Norman Keltner, Lee Hilyard Schwecke and Carol E. Bostrom, eds., Psychiatric Nursing, Mosby, St. Louis, 1995, pp. 230-231.

Soviet psychiatry's professional body resigned from the WPA under pressure in 1983 and in 1989 a Time article warned about the dangers of allowing Soviet psychiatrists to rejoin the WPA. The article canvassed the opinion that psychiatric methods remained essentially unchanged in the Soviet Union and reviewed some of the abuses of the past. At its supposed worst, Soviet psychiatry was dominated by Dr. Andrei Snezhnevsky, the director of the Institute of Psychiatry of the U.S.S.R. Academy of Medical Sciences. Snezhnevsky had died in 1987 but he had been the leading figure in Soviet psychiatry since the early 1950s and his influence was still felt. It was Snezhnevsky who,

broadened the definition of schizophrenia by adding the category 'sluggish schizophrenia.' He defined the disorder as a slow-developing illness without the hallucinations that are a classic element in the Western definition of many schizophrenias. Instead, the 'symptoms' could be nearly all forms of behaviour — unsociability, mild pessimism, stubbornness — that deviated from the social or political ideal.¹²⁰

But this description of schizophrenia could easily be derived from the current DSM-IV diagnostic criteria where 'hallucinations' are only one of five Criterion A symptoms and are not an essential feature of schizophrenia. 'Unsociability' and 'mild pessimism' that deviate from the social ideal could be interpreted as falling into Criterion A (4) — grossly disorganised behaviour, Criterion A (5) — negative symptoms like affective flattening, and Criterion B — social dysfunction. If a person was troublesome to their family, or a social nuisance, in a Western country there is little doubt that the same criteria could be used for at least a tentative schizophrenia label like schizophreniform disorder (DSM-IV) or simple schizophrenia (ICD-10).

The same article describes the torture/punishment imposed on Soviet dissidents as being "hospitalised for years under prison-like conditions and put on powerful drugs that turned them into zombies".¹²¹ But the powerful drugs that violated human rights by turning Soviet dissidents into zombies are the same neuroleptics used on similar types of people by Western psychiatrists.

Another indignant description of Soviet psychiatry describes sluggish schizophrenia again: "One manifestation of this novel ailment was 'stubbornness and inflexibility of convictions'; the usual treatment consisted of megadoses of powerful tranquillisers like Thorazine for 'prophylactic' purposes".¹²² Once again, "inflexibility of convictions" is perhaps just another way of describing

¹²⁰ John Langone, 'A profession under stress; long ostracised by colleagues around the world, Soviet psychiatrists try to show that they are not instruments of oppression', Time, Vol. 133, No. 15, 10 April, 1989, pp. 94-96.

¹²¹ Ibid.

¹²² Victoria Pope, 'Mad Russians: Victims of Soviet 'punitive psychiatry' continue to pay a heavy price', U.S. News & World Report, 16 December, 1996, pp. 38-43.

‘delusions with lack of insight’, which is a common feature of schizophrenia diagnosis in the West. ‘Prophylactic purposes’ is called ‘maintenance treatment’ by Western psychiatrists and, as with Haldol in the earlier description, the drug used to supposedly ‘punish’ Soviet dissidents, Thorazine, is one that is routinely applied to schizophrenics by Western psychiatrists. Thorazine is the brand, and chlorpromazine the generic name,¹²³ of a commonly used neuroleptic that had 12% of the market for neuroleptics in the United States in 1995.¹²⁴ In Britain this drug is known as Largactil.¹²⁵

Thomas Szasz argues that the spectacle of the Western psychiatric profession loudly condemning Soviet psychiatrists for their abuse of professional standards is largely an exercise in hypocrisy. Szasz maintains that it is psychiatric power that is the problem from which psychiatric abuse arises and that psychiatric power is just as prevalent in democratic societies as it was in the Soviet Union: “Psychiatric abuse, such as we usually associate with practices in the former Soviet Union, is related not to the misuse of psychiatric diagnoses, but to the political power intrinsic to the social role of the psychiatrist in totalitarian and democratic societies alike”.¹²⁶ If one accepts the argument that neuroleptic treatment was a form of torture when it was used by Soviet psychiatrists then there is little reason to have a different opinion about its current usage by Western psychiatrists.

Lawrence Stevens, a lawyer in the United States who represents victims of psychiatric injustice, goes beyond the punishment/torture model for forced treatment with neuroleptics and compares the practice to rape:

In both cases, the victim's pants are pulled down. In both cases, a tube is inserted into the victim's body against her (or his) will. In the case of sexual rape, the tube is a penis. In the case of what could be called psychiatric rape, the tube is a hypodermic needle. In both cases, a fluid is injected into the victim's body against her or his will.¹²⁷

Descriptions given by patients of the treatment they have received sometimes gives confirmation of Stevens’ assertion, despite his apparent hyperbole. One woman patient, who had read a number of books about psychiatric theories of schizophrenia before her incarceration, had the temerity to demand of the hospital staff that they test her dopamine levels before giving her neuroleptic medication, in order to confirm that she did indeed have a chemical imbalance in her brain.

¹²³ Breggin, *Toxic Psychiatry*, op. cit., p. 560.

¹²⁴ Keltner, *op.cit.*, pp. 230-231.

¹²⁵ Breggin, *Toxic Psychiatry*, op. cit., p. 560.

¹²⁶ Thomas Szasz, ‘Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse’, *Journal of Medical Ethics*, Vol. 20, No. 3, September, 1994, pp. 135-139.

¹²⁷ Lawrence Stevens, *op.cit.*

When I was demanding testing at Shellharbour [a psychiatric hospital in NSW, Australia], I refused to lay on the bed for an injection unless they tested my levels first. The hospital brought in the hospital security men who forced me around to the TV room via a back corridor. They held me down and forced the injection on me.¹²⁸

This same former patient goes on to describe how neuroleptics effect patient behaviour by the same ‘fear therapy’ principle as earlier forms of treatment:

When the side effects of the drugs started taking effect I told staff that the side effects were totally unacceptable and that the drugs were toxic. Worse, they were forcing untested drugs on untested patients. The psychiatrist ‘treating’ me was furious. She said in response that I wasn’t allowed to leave the ward with the other patients. I was therefore effectively put in isolation on the ward. I had to endure the side effects etc in silence because there is always ECT down the corridor. Staff then naively believed that I had calmed down because of the drugs. One psychiatric nurse said ‘Look how much better you are now’. This woman honestly believed that I had calmed down because of biological intervention. I hadn’t changed my attitudes or feelings one skerrick. It was just that I was too terrified to say anything because this woman ‘treating’ me was vicious. She meant business. I gave up the fight out of fear of an increased risk of brain damage from increased doses over a longer period of time.¹²⁹

The fear of “ECT down the corridor” is a particularly noteworthy element in the fear therapy that was applied to this patient. She further clarified the therapeutic principle: “Because biopsychiatrists dehumanise and depersonalise schizophrenics they can’t comprehend the fact that we respond rapidly to abuse like anyone else. If someone puts the fear of God into you, you shut up. Because of the silence they think the patient has calmed down and recovered because of biological intervention”.¹³⁰

Conclusion

The human rights problems associated with the M-M-I model are mostly concerned with the loss of liberty involved in involuntary hospitalisation and the cruel nature of psychiatric treatment, which the M-M-I model argues is a form of torture/punishment. According to the M-M-I model the underlying reason why a system has been allowed to develop, which treats a non-existent disease with torture, is to be found in the continued existence of the insanity plea as a means of escaping criminal liability. The insanity plea is deeply entrenched in cultural tradition and so long as it

¹²⁸ Heather Nolan, Former psychiatric patient treated involuntarily for schizophrenia, Personal Communication (letter to Richard Gosden), 26 February, 1998.

¹²⁹ *Ibid.*

¹³⁰ *Ibid.*

remains there will be a need for the preventative control of people who manifest indicators that fit its legal criteria.

An analysis of the history of treatment for schizophrenia shows a long tradition of applying torture and cruel punishment as a form of ‘fear therapy’. In the past psychiatrists have sometimes been quite candid in their descriptions of the principle of fear therapy as being simply a matter of giving patients a choice of either adopting more acceptable behavioural patterns or suffering more pain and discomfort. Contemporary treatment in the form of neuroleptic medication, while still retaining the same fear therapy principle of earlier forms of treatment, also restricts a person’s liberty by acting as a chemical straitjacket.¹³¹ In this way neuroleptic medication appears to have the dual ability to violate human rights which protect against the loss of liberty as well as human rights which protect against torture and cruel punishment.

¹³¹ David Cohen, Testimony to a Vermont Judiciary Committee considering a new bill entitled, An Act Relating to Involuntary Medication of Mental Health Patients, reproduced in, ‘In the trenches: Resisting the spread of involuntary psychiatric drugging’, *Dendron*, Nos. 39 and 40, Winter 1997- 98, p. 33.

10. Early Psychosis: Preventive Medicine, Scientific Assault on Mystical Tendencies, or an Extension of Social Control?

Introduction

In recent years psychiatric researchers have extended the definition of schizophrenia to include a pre-psychotic phase. Detection and intervention programmes have been implemented and neuroleptic medication is used as prophylactic treatment in the belief that it can prevent the development of psychosis in people who are thought to be at-risk.¹ The pre-psychotic signs of schizophrenia are usually referred to as ‘early psychosis’² or as ‘prodromal’ symptoms of schizophrenia.³ Australia has become a particularly active site for this type of research and a National Early Psychosis Project has been launched as “a collaborative endeavour between the Commonwealth, State and Territory governments of Australia to develop and promote a national model of best practice for early intervention in psychosis”.⁴

Promoters of the concept see pre-psychosis detection and intervention as a form of preventive medicine. Their basic argument is that if the incidence of schizophrenia can be reduced by early identification and treatment, as has been the case with prevention programmes for other diseases, then numerous community benefits will follow in the form of cost savings and in the avoidance of personal trauma and family disruption.⁵

However, people who are already sceptical about bio-medical approaches to schizophrenia are likely to interpret drug-based preventive medicine campaigns differently. Apart from the risks involved in the prophylactic use of neuroleptic drugs, so-called preventive medicine might be variously seen as an unnecessary expansion of social control, a threat to human diversity through the enforcement of hyper-normality, a violation of human rights, a campaign against mystical tendencies in young people, and a marketing ploy for the new generation of atypical neuroleptic drugs.

¹ Alison R. Yung, Patrick D. McGorry, Colleen A. McFarlane, Henry J. Jackson, George C. Patton and Arun Rakkar, ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, p. 300.

² Early psychosis is currently used in three different ways. It describes psychosis in young people, first-episode psychosis, and a supposed pre-psychotic phase of schizophrenia.

³ Tor K. Larsen and Stein Opjordsmoen, ‘Early identification and treatment of schizophrenia: conceptual and ethical considerations’, *Psychiatry: Interpersonal and Biological Processes*, Vol. 59, No. 4, 1996, pp. 371-381.

⁴ *National Early Psychosis Project*, Australian Commonwealth Government, 1999, Available URL, <http://yarra.vicnet.net.au/-eppic/nepp.html>

⁵ Chris Jackson and Max Birchwood, ‘Early intervention in psychosis: Opportunities for secondary prevention’, *British Journal of Clinical Psychology*, Vol. 35, No. 4, November, 1996, pp. 487-502.

Early psychosis identification and treatment is a recent extension of the medical model for schizophrenia and the mystical and myth-of-mental-illness models have not yet been analysed in relation to it. It is proposed in this chapter to see whether a focus on the supposed prodromal symptoms can bring the three aetiological models for schizophrenia into clearer focus.

Early Psychosis as Preventive Medicine

Medical historians have identified an epidemiological transition which occurred around 1940 involving a shift of medical emphasis from the control of infectious diseases to the control of chronic diseases like cancer and heart disease.⁶ The medical emphasis that has been applied to chronic diseases in the second part of the twentieth century has largely involved various programmes of health promotion and disease prevention. Where lifestyle has been found to be a major contributor to the development of chronic diseases publicity campaigns have been put into place to guide people away from self-damaging habits and behaviours, to adopt healthy diets, and to take precautions and avoidance measures.⁷

Similarly, where early or prodromal signs and symptoms can be identified, and where early treatment can effectively prevent or cure, or make the management of a chronic disease easier, screening programmes have frequently been inaugurated and publicity campaigns launched to alert the public about dangerous signs.⁸ An on-going campaign against skin cancer in Australia, which alerts people to the dangers of exposure to ultraviolet light and encourages them to seek early treatment for suspicious skin lesions, is a typical example of this kind of preventive medicine.

Various preventive campaigns against mental diseases also fit into this pattern:

Mental health prevention has three primary aims: (1) decreasing the occurrence of new cases, (2) delaying onset, and (3) decreasing the duration of early symptoms or halting the progression of severity. The first aim is known as primary prevention or reducing the incidence of disorder; the second aim, secondary prevention or reducing the prevalence of disorder; the third aim, tertiary prevention or reducing the morbidity of disorder.⁹

⁶ Kenneth R. McLeroy and Carolyn E. Crump, 'Health promotion and disease prevention: a historical perspective', Generations, Vol. 18, No. 1, 1994, pp. 9-18.

⁷ Mary T. Shannon, 'Health promotion and illness prevention: a biopsychosocial perspective', Health and Social Work, Vol. 14, No. 1, February, 1989, pp. 32-41.

⁸ F. Douglas Scutchfield, Karma T. Hartman, 'Physicians and preventive medicine', JAMA, The Journal of the American Medical Association, Vol. 273, No. 14, April 12, 1995, pp. 1150-1152.

⁹ Thomas H. McGlashan, 'Early Detection and Intervention in Schizophrenia: Research', Schizophrenia Bulletin, Vol. 22, No. 2, 1996, p. 328.

Whereas primary prevention often only involves strategies to avoid the risk of disease, secondary and tertiary prevention enlist both preventive strategies and active treatment.

In the United States there is a long history of strategies to prevent mental illness which go back to the turn of the century.¹⁰ A recent large scale project was initiated in 1992 when the Senate Appropriations Committee of the US Congress “mandated the National Institute of Mental Health to enter into an agreement with the Institute of Medicine (IOM) to prepare an integrated report of current research with policy-oriented and detailed long-term recommendations for a prevention research agenda.”¹¹

The 1994 report that emerged from this investigation divided mental health intervention into a spectrum of stages.¹² The over-arching stages were Prevention, Treatment and Maintenance. Prevention was divided into three sub-groups: Universal, which is aimed at the general public or entire populations; Selective, which involves individuals or groups with above average risk factors; and Indicated, which targets “high risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental illness”.¹³

The investigators reviewed the various theories about the aetiology of schizophrenia and the evidence for certain risk factors and indicators. They concluded that there was not sufficient aetiological evidence at this stage to warrant preventive intervention for schizophrenia at either the Universal or Selective stages. However, they did support

indicated preventive interventions targeted at individuals manifesting precursor signs and symptoms who have not yet met full criteria for diagnosis. The identification of individuals at this early stage, coupled with the introduction of pharmacological and psychosocial interventions, may prevent the development of full-blown disorder.¹⁴

For the purpose of developing indicated prevention strategies for schizophrenia, researchers have divided the condition into three stages of development: premorbid, prodromal and onset.¹⁵ Early psychosis detection and intervention programmes generally aim at reducing the duration of untreated psychosis (DUP). The DUP is the period preceding first treatment for schizophrenia during which symptoms and signs of an impending psychological crisis are present. It is argued by

¹⁰ Patricia J. Mrazek and Robert J. Haggerty, Reducing Risks For Mental Disorders: Frontiers For Preventive Intervention Research, National Academy Press, Washington, 1994, pp. 8-11.

¹¹ Ibid., p. xi.

¹² Ibid., p. 23.

¹³ Ibid., p. 25.

¹⁴ Ibid., p. 154.

¹⁵ Tor K. Larsen, Thomas McGlashan, and Lars Conrad Moe, ‘First-Episode Schizophrenia: 1. Early Course Parameters’, Schizophrenia Bulletin, Vol. 22, No. 2, 1996, p. 241.

bio-medical psychiatrists that the DUP for most people who develop psychosis is much longer than it should be and can often be measured in years.¹⁶ There are on-going debates about the relevance of the length of the DUP to the intensity of the subsequent psychotic experience, to the response of the patient to medication, and to the course of post-psychotic morbidity.¹⁷

It has been claimed that “the cost of treatment for patients with a DUP greater than 6 months is twice the cost of those with a DUP less than 6 months”.¹⁸ Some psychiatric researchers argue that brain damage is occurring during the DUP and that the longer it continues the less chance a person has of ultimate recovery: “most of the neurobiological damage is already accomplished by the time it is possible to make a valid DSM-IV diagnosis”¹⁹ and “applying existing schizophrenia treatment as soon as possible in the course of the disorder may slow or stop deterioration”.²⁰ But apart from the equivocal evidence of unconfirmed pilot studies (see below)²¹ there is nothing much of substance to support these bio-medical contentions.

Nevertheless, despite the weak theoretical base, claims have been forcefully made that when a programme of early detection is put into place the incidence of full-blown psychosis in the community can be reduced. This is supposedly achieved by applying combined psycho-social and neuroleptic treatment to people deemed to be at risk and thereby diverting the progression of their developing psychological crisis.

Early Psychosis Programmes

Falloon has reported on a pilot project which commenced in 1984 in Buckingham, UK.²² The Buckingham Project enlisted the participation of 18 family doctors to screen a population of 35,000 people over a four year period. The screening process involved ten questions which the doctors were required to ask their patients and an eight point checklist of prodromal signs for schizophrenia, which the doctors would look for. The eight prodromal signs were derived from a list of prodromal

¹⁶ *Ibid.*, pp. 243-244.

¹⁷ John Cocks, ‘The use of very-low-dose antipsychotic medication in the treatment of first-episode psychosis’, *Early Psychosis News*, No. 9, June 1998, p. 5.

¹⁸ Thomas H. McGlashan and Jan Olav Johannessen, ‘Early Detection and Intervention With Schizophrenia: Rationale’, *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, p. 212.

¹⁹ *Ibid.*, p. 209.

²⁰ *Ibid.*, p. 201.

²¹ Jay W. Pettegrew, Matcheri S. Keshavan, Kanagasabai Panchalingam, Sandra Strychor, David B. Kaplan, Marjorie G. Tretta, and Maureen Allen, ‘Alterations in Brain High-Energy Phosphate and Membrane Phospholipid Metabolism in First-Episode, Drug-Naive Schizophrenics: A Pilot Study of the Dorsal Prefrontal Cortex by In Vivo Phosphorus 31 Nuclear Magnetic Resonance Spectroscopy’, *Archives of General Psychiatry*, Vol. 48, June 1991, pp. 563-568.

²² Ian R. H. Falloon, Robert R. Kyd, John H. Coverdale and Tannis M. Laidlaw, ‘Early Detection and Intervention for Initial Episodes of Schizophrenia’, *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, pp. 271-282.

indicators outlined in DSM-III. The doctors were assured that any person they referred would receive specialised psychiatric assessment without delay.

The screening questionnaire and prodromal checklist were as follows:

10-question screening

1. How have you been sleeping in the past week? Any difficulties getting to sleep? Wake early?
2. Have you lost your appetite recently? Weight loss of two or more kilograms?
3. Have you experienced loss of energy or interests recently?
4. Have you been worrying a lot about everyday problems?
5. Have you had difficulty concentrating on reading or watching television? Have you been more forgetful than usual?
6. How do you see the future? Do you feel that life is not worth living Have you ever felt you would like to end it all?
7. Have you any odd habits, like checking or cleaning more than other people?
8. Do you ever have attacks of palpitations, sweating, shaking, or dizziness accompanied by feelings of intense fear?
9. Has anybody commented that your speech has become odd or difficult to understand?
10. Have you ever had the experience of hearing people's voices speaking when nobody seems to be around?

Prodromal signs checklist

Onset of one of the following without explanation:

- * Marked peculiar behaviour
- * Inappropriate, or loss of, expression of feelings
- * Speech that is difficult to follow
- * Marked lack of speech and thoughts
- * Marked preoccupation with odd ideas
- * Ideas of reference — things have special meanings
- * Persistent feelings of unreality
- * Changes in the way things appear, sound, or smell²³

People who failed the screening test with the family doctor were referred on for a more formal psychiatric assessment. This involved completing another questionnaire in the company of a

²³ *Ibid.*, p. 274.

relative or household member. This psychiatric assessment was designed to “identify prodromal symptoms, particularly those of a subtle nature, such as interpersonal withdrawal.”²⁴

When a person was suspected of experiencing an early phase of schizophrenia, an integrated crisis management program was initiated without delay. Each component of this program, which included education, stress management, and neuroleptic medication, was tailored to individual needs within a clinical management protocol.²⁵

It was claimed for the Buckingham Project that the incidence of schizophrenia in the 35,000 person catchment area was lowered during the four years of the pilot scheme from an expected annual rate under normal conditions of 7.4 new cases of schizophrenia per 100,000 population to an annual rate of 0.75 new cases per 100,000 population.²⁶ But the researchers admit that “during the 4-year period, 15 other cases with symptom patterns suggesting an early phase of a florid schizophrenic episode were observed; however, these cases failed to reach the diagnostic thresholds for functional psychotic disorders”.²⁷ Since all of these 15 people were treated for schizophrenia it seems likely that the interpretation of the “diagnostic threshold” was intended to be flexible enough to provide statistical evidence to support claims of a successful pilot project.

However, this arbitrariness in the definition of psychosis was overlooked and the apparent success of the Buckingham Project was well received by schizophrenia researchers in various parts of the world. A considerable literature is building as early psychosis projects are commenced in a number of countries. Falloon has since moved to Auckland, New Zealand, where he has another early psychosis project operating.²⁸ In 1995 a symposium was organised in Norway to bring together early psychosis researchers from the United States, Australia, New Zealand and Scandinavia. The symposium stimulated numerous research papers and the following year an edition of the Schizophrenia Bulletin²⁹ was devoted to papers on the subject.

Some of the early psychosis research projects currently operating in various parts of the world include: the Clarke Institute of Psychiatry in Toronto, Canada; Hillside Hospital in Glen Oaks, New York; the Schizophrenia Research Program at the London Health Sciences Center in London, Ontario, Canada; Nova Scotia Hospital in Dartmouth, Nova Scotia, Canada; Rogaland Psychiatric Services in Stavanger, Norway; the National Early Psychosis Project, University of Melbourne, Royal Park Hospital Department of Psychiatry, Parkville, Victoria, Australia; Mental Health

²⁴ Ibid., p. 276.

²⁵ Ibid., p. 277.

²⁶ Ibid., p. 278.

²⁷ Ibid., p. 279.

²⁸ Thomas H. McGlashan, ‘Early Detection and Intervention in Schizophrenia: Editor’s Introduction’, Schizophrenia Bulletin, Vol. 22, No. 2, 1996, p. 198.

²⁹ See, Schizophrenia Bulletin, Vol. 22, No. 2, 1996.

Clinical Research Centre, University of North Carolina, NC Neurosciences Hospital, Chapel Hill, North Carolina; University of Pittsburgh Medical Center/Western Psychiatric Institute and Clinic, Psychosis Research Program, Pittsburgh, Pennsylvania; West Birmingham Mental Health Services, The Archer Centre, All Saints Hospital, Birmingham, UK.³⁰

Developing a consensus about vulnerability markers for schizophrenia is one of the first priorities: “so many markers have emerged that it seems reasonable to begin thinking about using them in ‘normal’ populations to identify groups that are at heightened risk for psychoses”.³¹ It is argued that current treatment for schizophrenia is only applied palliatively but that if an ‘at-risk’ population could be identified then vulnerability could be treated directly. It is further argued that whereas the incidence of schizophrenia in the general population is about 1-2% it would be much higher in a hypothetical population of people who all carried the vulnerability markers.³² The assembly of such a hypothetical group would therefore make surveillance of potential schizophrenics much easier.³³

Researchers believe that the use of vulnerability markers as an initial means of screening the population would reduce the incidence of false positives.³⁴ But a comprehensive list of vulnerability markers compiled for initial discussion involves many controversial aetiological and diagnostic hypotheses and it is unlikely to win the consensus support necessary for this type of screening to begin.

Vulnerability markers

Clinical

- Cluster A personality disorders
- Schizotypy in subjects, families
- Psychosis proneness

Behavioural

- Early neurointegrative deficits in temperament, arousal, development (pandysmaturation)
- Premorbid behavioural problems: perceptual-cognitive, emotional, neuromotor, social, scholastic, functional patterns

Environmental

- Perinatal factors: winter births, influenza, starvation, RH incompatibility, pregnancy and birth complications

³⁰ Neuropsychiatry Branch, National Institute of Mental Health, accessed July 1998, Available URL, <http://silk.nih.gov/silk/NPB/treat.html>

³¹ McGlashan and Johannessen, *op.cit.*, pp. 204-205.

³² *Ibid.*, p. 205.

³³ Steven Adlard, ‘Early Warning: The Early Detection of Psychosis’, Early Psychosis News, No. 7, September 1997, pp. 1-2.

³⁴ McGlashan and Johannessen, *op.cit.*, p. 205.

Psychosocial stress: low socioeconomic status, unstable rearing environment,
negative affective climate

Anatomy/neuroanatomy

Minor physical anomalies

Fluctuating anatomical asymmetries

Structural brain abnormalities

Chemistry

HVA in plasma and CSF of SPD

MAO in platelets of SPD

Motor processes

Smooth-pursuit eye movements

Visual scanning/fixation

Grip-induced muscle tension

Perceptual processes

Arousal: psychophysiology

Sustained attention: Continuous Performance Task

Selective attention: Span of Apprehension Task

Discrimination: sensory saltation

Processing: cognitive inhibition, sensory motor gating, startle, prepulse inhibition,
backward masking, negative priming, event-related potentials, mismatch negativity,
P300 latency

Contextual set: semantic priming, Stroop Test

Hemispheric integration/asymmetry: dichotic listening, covert visual attention

Perceptual-motor speed

Neuropsychology

Intelligence

Abstraction

Mental control/encoding

Verbal, spatial, story memory

Language

Dyslexia ³⁵

Apart from the vulnerability markers which are listed above under the headings of “Clinical” and “Behavioural”, and perhaps some under the heading of “Neuropsychology”, most of the others on this list are highly controversial, even within the confines of the medical model. They represent a variety of observations that have been made about some schizophrenics after diagnosis. But mostly these signs are not thought to be reliable enough for use as diagnostic indicators. The authors of this

³⁵ *Ibid.*, pp. 204-205.

list do not mount any discussion about how many, and in what combinations, these indicators would be useful for identifying at-risk individuals in a screening programme and it is unlikely that the full inventory of vulnerability markers will be adopted by early psychosis researchers in the near future.

In the meantime it is usually proposed to rely mostly on clinical and behavioural markers. In follow-up and follow-back studies it has been found that “social dysfunction and behavioural deviance reported by teachers are reliable predictors of later schizophrenia”.³⁶ School reports have indicated that in childhood and adolescence, before the development of psychosis, schizophrenics tend to be shy, passive and withdrawn, with few friends and with low academic grades.³⁷ But it is generally believed that the predictive indicators are too uncertain in childhood for diagnosis and it is only with the onset of adolescence that it becomes possible to more positively identify them: “Deviant behaviours tend to become more prominent in adolescence, a time of life that may present more socially challenging situations. Sex differences in social adjustment have also been noted with males showing more antisocial behaviours and females showing more passivity and withdrawal”.³⁸

It has been proposed that schizophrenic-type people can be identified by a combination of a psychiatric interview and reference to school teachers' reports. A six-point screening device has been suggested:

Composition of the six indicators of schizotypy

Item _____

³⁶ Su-chin Serene Olin and Sarnoff A. Mednick, ‘Risk Factors of Psychosis: Identifying Vulnerable Populations Premorbidly’, *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, p. 229.

³⁷ *Ibid.*, pp. 229-230.

³⁸ *Ibid.*, p. 230.

Researchers argue that the frequent correlations that can be found between psychiatric indicators uncovered in clinical interviews, and observations already recorded in existing teachers' reports, confirm that “schizophrenia does not appear suddenly in early adulthood”.³⁹ But school teaching is only one of many possible observations points in the community that could be utilised to filter adolescents and separate those who have the supposed early signs of psychosis. Other observation points that have been suggested include family doctors, parents and other family members, neighbours, youth workers, unemployment case managers, sports coaches, college counsellors, homeless agencies and police.⁴⁰

A programme of detection and intervention operated by researchers from the Rogaland Psychiatric Hospital in Stavenger, Norway has set up a particularly ambitious system of detection. Their Early Treatment and Intervention in Psychosis (TIPS) project,

features an educational campaign about the early signs of psychosis. This campaign is aimed at health care professionals, treatment centers, teachers, school nurses, and the public, using radio, newspaper, movies, and television advertisements, as well as brochures mailed to every household in Rogaland County. The study also features a

³⁹ *Ibid.*, p. 233.

⁴⁰ Max Birchwood, Pat McGorry and Henry Jackson, ‘Early Intervention in Schizophrenia’, *British Journal of Psychiatry*, Vol. 170, No. 1, January 1997, pp. 2-11.

special early detection team on-call 7 days a week, ready to respond within hours to calls about possible cases of first-episode psychosis or prepsychotic symptoms.⁴¹

The essential task for the promoters of early psychosis identification and intervention is to reach consensus on three points: (1) an inventory of easily recognisable symptoms; (2) the design of a community-based catchment system that funnels at-risk people into a clinical setting; and (3) an appropriate pre-psychosis treatment programme.

Case Study – The EPPIC Programme

Perhaps the most advanced programme at this stage, and one that is consistently cited as a model, is run by the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Victoria, Australia.⁴² EPPIC was established by the Victorian government Department of Health and Community Services to provide a statewide specialised service in first episode psychosis.

The researchers at EPPIC use the term ‘early psychosis’ variously to describe first episode psychosis, psychosis in young people, and the prodromal stage of psychosis. As a way of illustrating what they mean by prodromal symptoms analogies are drawn between measles and schizophrenia.⁴³ People infected with measles display a prodrome of cough and coryza which usually precedes the measles rash by 3 to 4 days. These early signs are not specific to measles and so it is not until the characteristic rash appears that it is possible to diagnose measles with certainty. The relationship of angina to an increased risk of heart attack is also used to illustrate the concept of early psychosis and further analogies are drawn between indicator signs of latent schizophrenia, like overvalued ideas and delusional mood, with symptoms indicating a developing heart disease.⁴⁴

The EPPIC researchers acknowledge that “the onset and course of psychotic disorders is more complex than in measles, which is an ‘all or nothing’ phenomenon; that is, either the full disorder develops or it does not. In psychosis, defining the onset of disorder involves a degree of judgment.”⁴⁵ One of the problems with defining psychosis is deciding whether or not psychotic disorders, of necessity, have to represent a break from normal psychological experience. Prodromal symptoms for schizophrenia are, by definition, indicators that precede, and are less significant than, a break with normal perceptions of reality. This suggests that it may not be correct to refer to a prodromal phase as early ‘psychosis’.

⁴¹ Joan Stephenson, 'Schizophrenia Researchers Striving for Early Detection and Intervention', JAMA, The Journal of the American Medical Association, Vol. 281, No. 20, May 26, 1999, p. 1877.

⁴² Patrick D. McGorry, Jane Edwards, Cathrine Mihalopoulos, Susan M. Harrigan, and Henry J. Jackson, 'EPPIC: An Evolving System of Early Detection and Optimal Management', Schizophrenia Bulletin, Vol. 22, No. 2, 1996, pp. 305-326.

⁴³ Yung et al., 'Monitoring and Care of Young People at Incipient Risk of Psychosis', op.cit., p. 284.

⁴⁴ Ibid.

⁴⁵ Ibid., p. 286.

The EPPIC researchers sometimes refer to the prodromal phase as being ‘putative’.⁴⁶ They argue that it is important to reach a consensus about whether schizophrenia can be said to begin in the prodromal phase or whether the actual onset is not until the point is reached of a full-blown psychotic break.

If the prodromal period is considered to be part of the disorder itself, then intervention at this stage would be seen as secondary — albeit early secondary — prevention. If, however, the prodrome is viewed as a separate syndrome conferring heightened but not inevitable risk for psychosis, then intervention would be viewed as primary prevention.⁴⁷

Retrospective studies of schizophrenic people, which have sought to clarify the indications and symptoms of impending psychosis, demonstrate that the most common symptoms are, “in descending order of frequency, reduced concentration and attention, reduced drive and motivation, anergia, depressed mood, sleep disturbance, anxiety, social withdrawal, suspiciousness, deterioration in role functioning, and irritability.”⁴⁸

The EPPIC researchers, however, found these to be too nonspecific for clinical work and instead looked to the list of prodromal symptoms for schizophrenia supplied in DSM-III-R. This definition of the prodrome requires:

at least two of the symptoms listed below:

- (1) marked social isolation or withdrawal
- (2) marked impairment in role functioning as wage-earner, student, or home-maker
- (3) markedly peculiar behaviour (e.g., collecting garbage, talking to self in public, hoarding food)
- (4) marked impairment in personal hygiene and grooming
- (5) blunted or inappropriate affect
- (6) digressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
- (7) odd beliefs or magical thinking, influencing behaviour and inconsistent with cultural norms, e.g., superstitiousness, belief in clairvoyance, telepathy, “sixth sense,” “other can feel my feelings,” overvalued ideas, ideas of reference

⁴⁶ Alison R. Yung and Patrick D. McGorry, ‘The Prodromal Phase of First-Episode Psychosis: Past and Current Conceptualisations’, *Schizophrenia Bulletin*, Vol. 22, No. 2, 1996, pp. 353-370.

⁴⁷ Yung et al., ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, *op.cit.*, p. 287.

⁴⁸ *Ibid.*

- (8) unusual perceptual experiences, e.g. recurrent illusions, sensing the presence of a force or person not actually present
- (9) marked lack of initiative, interests, or energy⁴⁹

Although the above prodromal symptoms for schizophrenia were included in the diagnostic criteria of the 1987 DSM-III-R they have been omitted from the more recent DSM-IV in order to simplify the definition of schizophrenia.⁵⁰ One of the problems was that the same list was used in DSM-III-R to describe both prodromal symptoms, which precede psychotic onset, and residual symptoms, which follow remission from psychosis. The same list was used presumably because the residual phase of one psychotic break was thought to also be the prodromal phase of the next. This duplication of residual and prodromal symptoms points to a earlier problem researchers had with not being sure whether the prodromal symptoms of first break psychosis were the same as the more familiar prodromal symptoms found in the intervals between recurring bouts of psychosis.

But the EPPIC researchers were mainly concerned with identifying and classifying the symptoms which precede the first psychotic break and while the DSM-III-R list was attractive because it gave a seal of professional consensus to the concept of prodromal symptoms they were uncertain about its accuracy as a screening device for adolescents: “no one knows how common these symptoms are in similarly aged persons with no disorder”.⁵¹

The problem of false positive diagnosis was very apparent to them and they hypothesised that there might be two groups of adolescents who would show the DSM-III-R vulnerability markers, but who would not go on to develop schizophrenia: (1) those who would eventually develop a different mental disorder, who were referred to as true-false positives, and (2) those who would avoid or prevent psychotic onset by learning some kind of adaptation or coping skills, who they called false-false positives. The false-false positives were thought of as people who had somehow made a “recovery before the frank psychosis develops”.⁵²

However, when the EPPIC researchers conducted a community survey of Australian high school students to determine the prevalence of the nine DSM-III-R prodromal symptoms in the general population of adolescents they found that “nearly half the sample (49.2%) had two or more symptoms and hence met the criteria for DSM-III-R schizophrenia prodrome”.⁵³ This figure was unrealistically high for their purposes so they adjusted the threshold for diagnosis by reducing the

⁴⁹ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Third Edition — Revised, (DSM-III-R), American Psychiatric Association, Washington, 1987, pp. 194-195.

⁵⁰ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), American Psychiatric Association, Washington, 1994, p. 779.

⁵¹ Yung et al., ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, op.cit., p. 288.

⁵² Ibid., p. 288.

⁵³ Ibid., p. 289.

number of symptoms. They further restricted the threshold by requiring that the symptoms needed to have been present for at least a week but less than 5 years. The 5 year limit was specified to exclude features that might have been incorporated as personality traits. When the new restricted criteria were tested on ordinary high school students it was found that only “10 to 15 percent of the sample met the criteria for schizophrenia prodrome.”⁵⁴

The usually accepted rate for schizophrenia in the general population is about 1 percent⁵⁵ and the discrepancy between that figure and the 10-15 percent for the prodrome was explained as being due to the inclusion of large fractions of both false-positives — i.e. “students [who] were undergoing ‘outpost syndromes’, that is, syndromes that resemble schizophrenia prodromes but that resolve spontaneously”⁵⁶ — and true-false positives — i.e. students who will go on to develop a mental disorder other than schizophrenia.

Satisfied that the modified DSM-III-R prodromal criteria could be used to correctly identify their target group the EPPIC researchers went on to implement “a specialised outpatient service to monitor and care for young people thought to be at high risk for psychosis”.⁵⁷ Demonstrating a skill for coining catchy acronyms they called their new clinic PACE — Personal Assistance and Crisis Evaluation. Although PACE was to be a subsidiary programme of EPPIC it was decided it should not be located with EPPIC. The reason given was to protect the at-risk group of clients from the stigma that might attach to them if they were known to be visiting a clinic which was clearly dedicated to the treatment of serious mental illness. To further avoid this association the PACE clinic was located at a generalised outpatient service and health promotion centre called the Centre for Adolescent Health.⁵⁸

This deception was motivated by more than a simple concern for protecting the clients from stigma. The EPPIC researchers did not want anything to impede the flow of clients into their clinic. It was thought that if a frank association with mental illness were declared up front it might “affect referrals, as primary caregivers may be afraid of the perception that they are labelling young people detrimentally. Stigma can also lead to attendance problems”.⁵⁹

⁵⁴ *Ibid.*

⁵⁵ Eadhard O’Callaghan, Tessa Gibson, Hubert A. Colohan, Peter Buckley, David G. Walshe, Conall Larkin and John L. Waddington, ‘Risk of schizophrenia in adults born after obstetric complications and their association with early onset of illness: a controlled study’, *British Medical Journal*, Vol. 305, No. 6864, 21 November, 1992, pp. 1256-1260.

⁵⁶ Yung et al., ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, *op.cit.*, p. 289.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*, p. 291.

⁵⁹ *Ibid.*

On top of the deception in the naming and location of PACE it also appears as if the clients themselves were not properly informed about the real purpose of the programme into which they were inducted. Instead of informing the clients that they had been diagnosed for being at-risk of developing psychosis, and were therefore being treated for early psychosis, “the need for intervention was explained in relation to the patient’s presenting problems. For example, the focus might be on helping a young person with social skills and coping at school.”⁶⁰ In other words, the clients were led to believe that their self-evident symptoms were all that was wrong with them and they were not told that these minor deviations were thought to be early indicators of serious mental disease.

The initial programme of the PACE clinic targeted young people between 16 and 30 years of age. These people were divided into three groups by categorising their symptoms. Group 1 were people who met the DSM-III-R criteria for schizophrenia prodrome and who also had a first or second degree relative with a history of a DSM-III-R psychotic disorder or schizotypal personality disorder. Group 2 were people who had one or more of the DSM-III-R positive-only criteria for schizophrenia prodrome — i.e. (1) markedly peculiar behaviour; (2) digressive, vague, overelaborate, or metaphorical speech; (3) odd or bizarre ideation or magical thinking; (4) unusual perceptual experiences. Group 3 were “young people with a history of fleeting psychotic experiences that spontaneously resolved (called brief limited intermittent psychotic symptoms, or BLIPS) within 1 week”.⁶¹

To detect these types of people in the community, and channel them into the PACE clinic, a public education campaign was launched aimed particularly at general practitioners and other specialised professionals who are frequently in contact with young people — like school counsellors, teachers and youth workers. The Early Psychosis Prevention and Intervention Centre itself, which specialises in assessing and managing young people who are deemed to have already crossed over into psychosis, proved useful in channelling a number of people who had failed to meet the threshold criteria for actual psychosis, but who appeared to be on the way.

EPPIC’s “mobile Early Psychosis Assessment Team, which, through extensive community networking, comes into contact with not only young people experiencing psychosis but also some ‘doubtful’ cases who may be in the prodromal phase”,⁶² was also a useful source of referrals.

The initial PACE programme involved 52 patients; 22 were students, 6 were in employment and 24 were unemployed. Their “most frequently occurring DSM-III-R prodromal symptoms were magical thinking, perceptual disturbance, and impaired role function, present in 67.7, 54.8, and 54.8 percent

⁶⁰ *Ibid.*, p. 292.

⁶¹ *Ibid.*

⁶² *Ibid.*, p. 290.

of the subjects, respectively”.⁶³ The researchers were aware that many of these patients could have been false positives and so they “carefully weighed the benefits of receiving treatment during the at-risk mental state versus the risks involved, if such treatment was unnecessary.”⁶⁴

Treatment involved either psychosocial talking therapy or neuroleptic medication — and sometimes a combination of the two. It was thought that:

psychosocial interventions may be justified when nonspecific symptoms only are present. But prescribing neuroleptic medication may not be justified, because of the risk of side effects including tardive dyskinesia, until more specific signs occur. Using neuroleptic medication at this early stage may be highly effective, however; hence, the duration of neuroleptic treatment may only need to be brief, thereby reducing the likelihood of short- and long-term side effects.⁶⁵

By 1996 the EPPIC researchers were ready to claim success for the initial PACE programme which, they say, proved “that it is possible to identify and follow possibly prodromal individuals in the community”.⁶⁶ But they were concerned with the fact that many of the patients monitored during the course of the programme did not make the transition to full psychosis. The transition rate to psychosis of people who have been identified with prodromal symptoms presents an interesting problem of interpretation. On the one hand, if most of the people treated for prodromal symptoms fail to cross the threshold into psychosis it can be claimed that the preventive treatment was successful. But on the other hand, it might also indicate that the prodromal indicators were not accurate and that a substantial fraction of false positives were included amongst the patients.

One way to resolve the interpretative problem would have been to follow the lead of the Buckingham Project and attempt to calculate whether the overall incidence of psychosis was reduced in the catchment area. But the PACE sample was apparently too small, and the catchment area too large, to make this approach practical. Instead the researchers decided to interpret the low transition rate of their patients as indicating that a substantial fraction were actually false/positives.⁶⁷

Notwithstanding this lack of confidence in their diagnostic and treatment procedures the researchers began a new prospective study of at-risk individuals using up-dated diagnostic criteria. The same 16 to 30 years age group was targeted and there was the same division of the clients into three study

⁶³ *Ibid.*, p. 293.

⁶⁴ *Ibid.*, p. 291.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*, p. 299.

⁶⁷ *Ibid.*

groups. But this time Group 1 was defined by a combination of having a first degree relative with a history of DSM-IV psychotic disorder or schizotypal personality disorder together with “any change in mental state or functioning resulting in a loss of 30 points or more on the Global Assessment of Functioning (GAF; American Psychiatric Association 1987) scale, including nonspecific ‘neurotic’-type presentations such as anxiety and depressive syndromes”.⁶⁸

The GAF scale assumes that the level of an individual’s psychological, social and occupational functioning can be plotted on a continuum which extends from prime mental health to serious mental illness. The continuum consists of nine paragraphs, each representing 10 points on the scale, which describe levels of functioning which progress from very high functioning to almost complete dysfunctionality. The task of measuring a person on the GAF involves choosing the paragraph that best describes the subject’s level of functioning at the time of an interview and allotting a score between 1 and 90 according to the relative position of the chosen paragraph on the continuum.⁶⁹

The revised Group 2 required the presence of one DSM-IV symptom for schizotypal personality disorder. Schizotypal personality disorder is a non-psychotic disorder of personality that has a number of schizophrenia-like symptoms: “The essential feature of Schizotypal Personality Disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour.”⁷⁰ There are nine symptoms listed for this condition and a diagnosis usually requires the presence of five or more.

- (1) ideas of reference (excluding delusions of reference)
- (2) odd beliefs or magical thinking that influence behaviour and is inconsistent with subcultural norms (e.g., suspiciousness, belief in clairvoyance, telepathy, or “sixth sense”, in children and adolescents, bizarre fantasies or preoccupations)
- (3) unusual perceptual experiences, including bodily illusions
- (4) odd thinking and speech (e.g. vague, circumstantial, metaphorical, overelaborate, or stereotyped)
- (5) suspiciousness or paranoid ideation
- (6) inappropriate or constricted affect
- (7) behaviour or appearance that is odd, eccentric or peculiar
- (8) lack of close friends or confidants other than first-degree relatives

⁶⁸ *Ibid.*

⁶⁹ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised, (DSM-III-R), op.cit., p. 12.

⁷⁰ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), op.cit., p. 641.

- (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self⁷¹

To be included in Group 2 of the new PACE programme the person's schizotypal symptom needed to occur several times a week and have been present for at least one week. The symptom should also "deviate significantly from normal as defined by a score of 2 or more on the unusual thought content scale of the BPRS or be held with a reasonable degree of conviction as defined by a score of 2 on the CASH rating scale for delusions".⁷²

(The BPRS is a system of psychiatric assessment devised in the early 1960s called the Brief Psychiatric Rating Scale. The CASH is a more recently invented assessment tool and stands for the Comprehensive Assessment of Symptoms and History. These rating systems will be discussed a little further on.)

The revised criteria for Group 3 required that a person have a history of transient psychotic symptoms like delusions, hallucinations or unusual thoughts.

This revised PACE study was also aimed at testing the "predictive power of a number of putative trait markers of schizophrenia".⁷³ As well as the various "attenuated psychotic symptoms" listed above, the putative trait markers being examined included "neurobiological markers such as increased ventricular brain ratio and ventricular enlargement, neurochemical markers such as reduced dopamine uptake by platelets, and neuropsychological markers such as information processing deficits".⁷⁴

The project was divided into two stages. In the first stage the young people thought to be at-risk of developing schizophrenia were to be divided into two streams: (1) those not receiving any treatment at all, and (2) those receiving a combination of psychosocial therapy and neuroleptic medication. The object of the first stage was to compare the transition rates to full psychosis for these two streams. The second stage divided another intake of patients into a further two comparative streams: (1) those who only receive psychosocial therapy, and (2) those who only receive neuroleptic medication. The purpose of this second stage was to similarly observe the comparative rates of progression on to full psychosis.⁷⁵

⁷¹ *Ibid.*, p. 645.

⁷² Yung et al., 'Monitoring and Care of Young People at Incipient Risk of Psychosis', *op.cit.*, p. 299.

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*, p. 300.

In a recent publication the EPPIC researchers discuss progress they have made in their project and they disclose some of their findings.⁷⁶ The critical issues which they set out to explore were whether the revised prodromal symptoms could accurately identify a group of people who were at-risk of psychosis and whether some kind of prophylactic treatment might help to protect them from psychosis. However, the researchers apparently encountered a major obstacle with these lines of inquiry.

Their problem lay in the imprecision of the existing psychiatric understanding of psychosis. All the individuals in the study had been chosen because they had psychotic-like tendencies. But at the time of selection they were deemed to be not yet psychotic. The purpose of the research was to make precise observations of their individual progression in relation to the threshold of psychosis. What the researchers discovered was that this threshold had no precise definition: “The main outcome measure in this study was the development of psychosis. The point of onset is difficult to define prospectively and has to be defined arbitrarily.”⁷⁷

When the point of psychotic onset is determined retrospectively, which is the usual way of making a determination, it can be simply pegged to the point at which a person was first thought to be in need of psychiatric care, treatment and control. But psychiatric treatment and care had been already given to the people in the PACE study while they were still in an acknowledged pre-psychotic state, so their situation raised the issue of psychotic onset as something that required more precise definition.

This was not a new problem for some members of the EPPIC team. In earlier research, as part of a satellite study to the DSM-IV field trial for schizophrenia, the National Health and Medical Research Council Schizophrenia Research Unit's Early Psychosis Prevention and Intervention Centre had conducted a programme which assessed people with first-episode psychosis. Patrick McGorry, the Director of EPPIC, had participated in this work. In the research independent raters used four different procedures to determine a diagnosis for psychosis. They found there was a high level of misclassification which arose from variations in the methods of assigning criteria which determine the onset of psychosis. They warned that this lack of consensus would impede future research in the area of early psychosis.⁷⁸

⁷⁶ Alison R. Yung, Lisa J. Phillips, Patrick D. McGorry, Mats A Halgren, Colleen A. McFarlane, Henry J. Jackson, Shona Francey and George C. Patton, ‘Can we predict the onset of first-episode psychosis in a high-risk group?’, *International Clinical Psychopharmacology*, Vol. 13 (suppl 1), 1998, pp. s23-s30.

⁷⁷ *Ibid.*, p. s26.

⁷⁸ Patrick D. McGorry, Cathy Mihalopoulos, Lisa Henry, Jenepher Dakis, Henry J. Jackson, Michael Flaum, Susan Harrigan, Dean McKenzie, Jayashri Kulkarni and Robert Karoly, ‘Spurious precision: procedural validity of diagnostic assessment in psychotic disorders’, *American Journal of Psychiatry*, Vol. 152, No. 2, February 1995, pp. 220-224.

The ‘arbitrary’ method of definition that was settled upon for the PACE study involved the specification of supposedly precise levels of a variety of psychotic indicators — like hallucinations, delusions, thought disorder and suspiciousness — on the BPRS and CASH rating scales. The EPPIC researchers reassured themselves that this definition of onset is similar to one used by other researchers in the field “and is in line with common clinical practice for instigation of neuroleptic treatment”.⁷⁹

Accordingly they found that 48% of the people inducted into the research programme became psychotic within the first 12 months. The transition rate at 6 months was 40%.⁸⁰ Satisfied that they were on the right track with the revised symptomatology the researchers pointed to their next hurdle: “The ultimate question is, having identified precursor features with good positive predictive power, can the onset of psychosis be prevented by early intervention?”⁸¹

This question points to a serious gap in the material published about the PACE programme. The research programme using the schizotypal symptoms, as it was outlined in the Schizophrenia Bulletin⁸² in 1996, had specifically intended to compare the transition to psychosis of patients who were given no treatment at all against those who received a combination of psychosocial therapy and neuroleptic treatment. It had also intended to compare the efficacy of psychosocial therapy against neuroleptic treatment.⁸³ Unfortunately the results of this research have not been published yet. What is required are precise details about whether a particular kind of prophylactic treatment might help to prevent psychosis. Or whether, on the other hand, another kind of treatment might actually help to induce psychosis. In a recent interview with a journalist McGorry claimed that:

Some preliminary results of a study comparing a small group of high-risk patients who received low doses of one of the newer antipsychotic medications (risperidone) with a control group of patients who were offered supportive treatment and monitoring found that in the 6-month treatment phase of the study, only 9.5% of the patients receiving drug therapy progressed to psychosis vs 36% of the control group.⁸⁴

The problem with this anecdote is that the control group is not identified so it is not clear whether the two groups McGorry describes involve the drugs plus psychosocial treatment vs no treatment comparisons or the drug treatment vs psychosocial treatment comparisons. Whichever is the case it

⁷⁹ Yung et al., ‘Can we predict the onset of first-episode psychosis in a high-risk group?’, op.cit., p. s26.

⁸⁰ Ibid., p. 28.

⁸¹ Ibid., p. s29.

⁸² Yung et al, ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, op. cit., pp. 283-303.

⁸³ Ibid., p. 300.

⁸⁴ Stephenson, op.cit.

seems apparent that McGorry is preparing the ground for the promotion of drug-based treatment for prepsychotic symptoms.

Perhaps a reason for the delay in publishing full details of this research stems from an unresolved ethical dilemma concerning the treatment of non-psychotic people with neuroleptic medication. If only about half of people with prodromal symptoms progressed on to psychosis it could mean that the remaining half are false/positives: “because over 50% of cases do not develop psychosis within twelve months routine treatment of this group would result in many young people being subject to unnecessary treatment and labelling.”⁸⁵

But unnecessary treatment of false/positives is not the only ethical question exercising the minds of the PACE researchers. In 1997 they published an article that gave some insight into other types of ethical matters that also worried them. Under the heading of “Ethical Issues” they rhetorically asked: “is our belief that someone is at high likelihood of imminent deterioration into psychosis enough to invoke involuntary status under the Mental Health Act?”⁸⁶ Involuntary treatment is a key issue with these psychiatrists since two-thirds of their patients at EPPIC’s first-episode psychosis clinic are involuntary patients.⁸⁷ In the same article they also went on to discuss the cost/benefit ratios of psychosocial and neuroleptic treatments and foreshadowed that “with the advent of newer antipsychotic medications with fewer side-effects especially at low doses, one could argue that a shift downwards in the cost/benefit ratio is occurring.”⁸⁸

Despite the apparently unresolved ethical dilemmas, and the delayed publication of treatment results, the EPPIC researchers are clearly using their PACE research programmes to establish a degree of hegemony in the theory of diagnosing and treating early psychosis. In conjunction with the University of Melbourne’s Department of Psychiatry they have recently initiated a Graduate Diploma in Mental Health Sciences: “EPPIC Statewide has become sensitised to a growing demand amongst clinicians for a program of study with a focus on maximising the preventive opportunities during the onset phase of serious mental illness in young people”.⁸⁹ The course is offered via distance education and is designed for health care professionals who are already qualified in the

⁸⁵ Yung et al., ‘Can we predict the onset of first-episode psychosis in a high-risk group?’, *op.cit.*, p. s28.

⁸⁶ Alison R. Yung and Patrick D. McGorry, ‘Is pre-psychotic intervention realistic in schizophrenia and related disorder?’, *Australian and New Zealand Journal of Psychiatry*, No. 31, 1997, p. 802.

⁸⁷ Paddy Power, Early Psychosis Prevention and Intervention Centre, in answer to a question after presentation of paper entitled, *An Analysis of the Initial Treatment Phase and Follow-Up of First Episode Psychosis Patients*, Second National Conference on Early Psychosis, Hobart Tasmania, 4-5 September, 1998.

⁸⁸ Yung and McGorry, ‘Is pre-psychotic intervention realistic in schizophrenia and related disorder?’, *op.cit.*, p. 803.

⁸⁹ Early Psychosis Prevention and Intervention Centre, *Graduate Diploma in Mental Health Sciences (Young People’s Mental Health) 1998 Course Handbook*, University of Melbourne, 1998, p. 3.

areas of psychiatry, medicine, psychology, nursing, occupational therapy, social work and other related disciplines.⁹⁰

The EPPIC researchers have also been active in developing national standards of best practice for early psychosis intervention and treatment in Australia. In early 1996 EPPIC won a tender to undertake the National Early Psychosis Project (NEPP).⁹¹ The EPPIC clinic in Melbourne was made the location of the National Manager of NEPP. NEPP was jointly funded by the commonwealth and state governments of Australia to fulfil a number of aims:

- * To facilitate the development and promotion of best practice in the identification and optimal early intervention in psychosis
- * To progress mental health policy to ensure that services adopt and incorporate best practice principles in early psychosis delivery.
- * To enhance the capacity of mental health professionals around Australia to meet the needs of young people with emerging psychosis.
- * To develop a network through which mental health professionals, consumers, other key stake holders can share information and ideas about early psychosis.
- * The emphasis of the project is on the development of collaborative and cooperative endeavours which can foster national agreement on best practice in this area of work whilst achieving a sustainable legacy of enhancements within the field of early psychosis.⁹²

To facilitate this project a national office of NEPP was located with EPPIC in Melbourne, as well as the Victorian office of NEPP, while other state offices were located in the capital cities of each Australian state. NEPP was conceived as an 18 month project and was set-up to run until January 1998. Throughout the life of the project EPPIC was clearly its major driving force and its principal centre for research and policy development. It can therefore be assumed that PACE research projects have been influential in devising the national best practice model that has emerged from NEPP.

This best practice model is embodied in the recently published Australian Clinical Guidelines for Early Psychosis.⁹³ These guidelines have been developed to guide best practice in the diagnosis and

⁹⁰ Ibid.

⁹¹ Early Psychosis Prevention and Intervention Centre, Newsletter of the Early Psychosis Prevention and Intervention Centre, Number 4, April, 1996, p. 8.

⁹² National Early Psychosis Project, The Development and Promotion of a National Best Practice Model in Early Intervention in Psychosis, National Early Psychosis Project, accessed September 1997, Available URL, <http://yarra.vicnet.net.au/-eppic/nepp.html>

⁹³ National Early Psychosis Project, Australian Clinical Guidelines for Early Psychosis, National Early Psychosis Project, Melbourne, 1998.

treatment of early psychosis in Australia. The guidelines extend the definition of early psychosis to include “the period described as the prodrome and also to include the critical period up to five years from entry into treatment for the first episode”.⁹⁴ Intervention during the prodromal phase is considered to be prevention and a chart supplied in the guidelines divides preventive strategies into the three levels of application described earlier: universal, selective and indicated.⁹⁵

Critical Analysis of Early Psychosis

To those who are sceptical about the medical model for schizophrenia, and who prefer one of the alternative models, the extension of the pathological definition of schizophrenia to include a prodromal phase should be disturbing. Without a prodromal phase a person is safe from unwanted psychiatric attention so long as a threshold of eccentricity is not crossed. This boundary of social tolerance, which psychiatrists refer to as a psychotic break, allows supporters of the mystical and myth-of-mental-illness (M-M-I) models to console themselves with the understanding that it is only people who can not control overt displays of mental deviance that are at risk of coercive psychiatric intervention in their lives.

In these circumstances supporters of the mystical model can argue that it is only unlucky or incompetent mystics who get labelled as schizophrenics. Similarly, advocates of the M-M-I model can believe that it is only careless or indifferent social deviants that allow themselves to become vulnerable to psychiatric scape-goating and out-casting. The existence of a commonly understood threshold which separates normal people and normal behaviour from mad people and mad behaviour gives a measure of reassurance to non-conformists and their supporters that psychiatric detection and intervention can be avoided so long as care is taken.

But the concept of early psychosis classifies mere tendencies towards mental deviance as indications of serious mental illness. The identification of a prodrome means that it is no longer required of a person to dive into the mystical waters to be branded as mentally disordered. Where there is a community screening programme for early psychosis it likely that a young person will be diagnosed with mental illness merely for showing and interest in the idea of mysticism.

Similarly, from the M-M-I perspective, it becomes no longer necessary to be recognisable as a social outcast, or to be used as a scapegoat, before the schizophrenia label is applied — now all that is necessary is to have a shortage of friends or to admit to minor difficulties in social functioning. A screening programme which purports to prevent schizophrenia, from the perspectives of these other models, can also be seen as preventing interest in the mystical experience and/or preventing individual difference.

⁹⁴ *Ibid.*, p. 11.

⁹⁵ *Ibid.*, p. 15.

At this stage of development the medical model's definition of a prodrome for schizophrenia seems highly vulnerable to accusations of arbitrariness. The EPPIC research, which experimented with various lists of prodromal symptoms, making adjustments when the fraction of school children caught in the net was too high, clearly demonstrates arbitrariness. A similar level of arbitrariness in relation to the definition of the point of entry into psychosis has been admitted by the researchers. This arbitrariness seems so transparent and pervasive that it raises questions whether the extension of the concept of schizophrenia into a prodromal phase could possibly threaten the plausibility of the whole medical model of schizophrenia.

It does not require much scepticism, for instance, to find the early psychosis screening system used in the Buckingham Project somewhat doubtful. Doctors were required to question their patients about such matters as sleeping patterns, appetite, level of interest in things, everyday worries, ability to concentrate on television, level of optimism, odd habits, panic, speech difficulties and hearing voices. A screening device like this is so broad-ranging that almost everybody would be able to give a positive answer to at least one of the symptoms at any given time.

What does it mean, for instance, when a person admits to a raft of everyday money and family worries if there is an economic recession in progress and the source of the problem is anxiety about losing employment? Or what does it mean if a person's sleeping patterns are disrupted when a spouse is doing shift work? There are so many different reasons why a person might manifest some of those symptoms, and they are such common experiences, (except for hearing voices which is normally specified as a symptom of psychosis, not the supposed prodrome), that it is hard to escape the conclusion that the Buckingham Project's criteria make the experience of minor hardships in life a sign of pathology.

In the above account of the PACE research programmes it is interesting to note that in the initial programme the most frequently occurring symptom, for which nearly 70% of the young people were treated, was magical thinking. But the standard psychiatric definition of magical thinking does not describe a particularly debilitating symptom. Many non-scientific approaches to dealing with 'problems of living', like prayer for instance, can easily fit the definition. Indeed, even some established phenomena of medical practice, like the placebo effect, could also fit. The Glossary of Technical Terms in DSM-IV defines it as:

magical thinking The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be part of normal child development.⁹⁶

It is not immediately apparent whether the programme by early psychosis researchers to eliminate magical thinking in young people supplies more evidence in support of the mystical model or the M-M-I model. But it does not supply good evidence to support the medical model. If magical thinking is indeed a normal part of child development, as DSM-IV suggests it might be, what conclusions are to be drawn about adolescents who still experience it? Are they deliberately contravening social conventions by persisting in patterns of thought that defy “commonly understood laws of cause and effect”? If so they would be better understood from the angle of the M-M-I model as social deviants. On the other hand they might be resisting conformity of thought in a way that will later lead them into the unusual psychological phenomena of mystical experience. Should we then consider magical thinking as a part of a prodrome for mystical experience?

In fact there is something quite extraordinary in the fact that the EPPIC researchers have been psychiatrically treating people for magical thinking. Patrick McGorry, the Director of EPPIC, is the one of the principal authors of a 1997 publication called the Early Psychosis Training Pack. In this document earlier research of McGorry's is cited which found that 51% of Australian 16-year-olds experience magical ideation.⁹⁷ If an outright majority of young people are known to have magical ideas should this type of mental activity be considered normal, and therefore not an indication of impending psychosis? Or, alternatively, is it an indication of the deplorable mental health of young Australians since a clear majority are shown to have a symptom of the schizophrenia prodrome? The EPPIC researchers do not mount any discussion about these choices of interpretation and their use of magical thinking as a prodromal symptom would appear to require some explanation.

The PACE research programmes also appear to raise some serious problems in regard to informed consent that might make them somewhat doubtful models for the development of national best practice standards for Australia. In their Schizophrenia Bulletin⁹⁸ article the EPPIC researchers Yung et al were surprisingly candid about the deliberate deception in the choice of the name and location of PACE. They even suggest they might have deliberately misled general practitioners about the real purpose of PACE so as not to risk losing referrals. The patients themselves were not informed about the true nature of their clinical diagnoses and a pretence was maintained that

⁹⁶ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), op.cit., p. 768.

⁹⁷ Patrick D. McGorry and Jane Edwards, Early Psychosis Training Pack, Module 1, Gardiner-Caldwell Communications, Macclesfield, Cheshire, 1997, p. 17, cited in table adapted from, McGorry et al., ‘The prevalence of prodromal features of schizophrenia in adolescence: a preliminary survey’, Acta Psychiatrica Scandinavica, 92, 1995, pp. 241-249.

⁹⁸ Yung et al., ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, op.cit., pp. 283-303.

treatment was being given to correct minor social problems. These deliberate deceptions on the part of the EPPIC researchers suggest that even the researchers themselves might lack confidence in the validity of a medical model for the prodrome of schizophrenia.

Although it is not clearly stated, this lack of an appropriate level of informed consent appears to also extend to the more recent PACE prospective research project.⁹⁹ In the first stage of this project, for which the subjects were divided into two groups, it seems likely that at least the people in the untreated group were not properly informed about the true nature of the research. There would seem to be little reason for people to remain in the programme, after being told they had the early symptoms of serious mental illness, if they had been properly informed that they had been assigned to a group for observation and would not receive any treatment.

The revised criteria for inclusion in this prospective study also require some comment in light of the alternative models for schizophrenia. The criteria for Group 1 suggest that if a person has a first degree relative with a history of psychosis or schizotypal personality disorder then any kind of temporary set-back in personal relationships or social functioning is psychiatric evidence of impending psychosis.

The GAF scale on which a set back in social functioning is to be measured does not provide any opportunity for evaluating the reason why such a set back might occur. Although the scale provides an instruction to exclude “impairment in functioning due to physical (or environmental) limitations”¹⁰⁰ there is no provision to take into account other common factors like loss of employment, exam failure, residential disruption or disruption in personal relationships.

The significance of a 30 point difference on the GAF scale can be illustrated by comparing two descriptions from the scale published in DSM-IV. At the top of the scale on 100 points a person can be described as having:

Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.¹⁰¹

While 30 points down a person might have:

⁹⁹ *Ibid.*, pp. 299-300.

¹⁰⁰ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), op.cit., p. 32.

¹⁰¹ *Ibid.*

Some mild symptoms (e.g. depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.¹⁰²

An underlying assumption of the PACE researchers apparently is that when a person has a first degree relative with a history of mental illness, although the person might only have a “few mild symptoms” and be “generally functioning pretty well”, if this level of functioning is still considerably lower than a previous level, then this set back is to be read as part of a slide towards psychosis. Given this criteria it would seem wise for any adolescent in the EPPIC catchment area of Melbourne, who has a mentally ill relative, to always put on a cheerful face in the company of medical practitioners.

Group 2 patients for this prospective study were identified by the presence of any single symptom on the DSM-IV diagnostic criteria for schizotypal personality disorder. It was required that the degree of abnormality of this symptom should be sufficient to meet a specified level of deviation on two independent rating scales — the BPRS (Brief Psychiatric Rating Scale) and the CASH (Comprehensive Assessment of Symptoms and History). Any of the schizotypal personality disorder symptoms used to identify a psychotic prodrome had to be scored at two or more on the BPRS or two or more on the CASH rating scale for delusions.

Both the BPRS and the CASH are similar to the GAF in that an interviewer is required to subjectively estimate a person’s level of mental function by observing specified characteristics and choosing an appropriate level of dysfunction according to a scale. In the case of the BPRS there are 16 specified symptoms of dysfunction that have to each be rated for intensity on a 7 level scale — i.e. not present, very mild, mild, moderate, moderate severe, severe, extremely severe.¹⁰³

If level 1 is a determination that the symptom is “not present” and level 2 only describes a symptom as being “very mild” then this means that a specification that a symptom rate at 2 or more on the BPRS actually means that only the slightest trace of the symptom needs to be found. Similarly, the CASH rating scale for delusions is a five level scale — questionable, mild, moderate, marked, severe — and a rating of 2 (mild) therefore only requires a degree more certainty than that of “questionable”.¹⁰⁴

¹⁰² *Ibid.*

¹⁰³ John E. Overall and Donald R. Gorham, ‘The Brief Psychiatric Rating Scale’, *Psychological Reports*, Vol. 10, 1962, p. 803.

¹⁰⁴ Nancy C. Andreasen, Michael Flaum and Stephan Arndt, ‘The Comprehensive Assessment of Symptoms and History (CASH)’, *Archives of General Psychiatry*, Vol. 49, August 1992, p. 618.

The purpose of specifying a minimum rating for schizotypal symptoms is apparently to ensure that the diagnostic threshold is set high enough to exclude people who only have mild symptoms. However, the above analysis clearly demonstrates that a threshold of 2 on the BPRS and CASH scales still allows a person with the slightest trace of a symptom to be included. This begs the question: why specify a diagnostic threshold if the setting is too low to be exclusive?

There is also another curious aspect about these threshold specifications. Ostensibly the idea is that a diagnostician should measure the severity of a schizotypal symptom by matching it to scaled severity descriptions on the BPRS and CASH scales. To do this there needs to be a close correlation between the description of schizotypal symptoms and the symptoms that are rated for severity on the BPRS and CASH — otherwise a match cannot be made. But when these comparisons are made it is evident there is only a partial and fragmentary correlation between the 9 schizotypal symptoms and the 16 BPRS symptoms. On top of this there is no correlation at all between the CASH rating symptom for delusions and the schizotypal symptoms because delusions have been specifically excluded from the schizotypal diagnostic criteria.¹⁰⁵

Added together these anomalies concerning the BPRS and CASH rating specifications suggest that they actually have no significance at all for distinguishing people who have the psychotic prodrome. It is difficult to escape the conclusion that these rating specifications have only been introduced to give a superficial semblance of scientific precision to the research.

Perhaps there was a reason why this was thought to be necessary. The PACE prospective study, by utilising the symptoms of schizotypal personality disorder, appropriates, without explanation, diagnostic criteria for a mental disorder that is not normally considered to be a prodrome for psychosis. In fact the DSM-IV description of the condition specifically states that, “Schizotypal Personality Disorder has a relatively stable course, with only a small proportion of individuals going on to develop Schizophrenia or another Psychotic Disorder”.¹⁰⁶ If this is true about people who meet the normal diagnostic criteria for the disorder, by having five or more of the symptoms, what is to be assumed about the real risk of psychosis for people who meet the PACE diagnostic criteria for ‘putative’ psychotic prodrome by only having one symptom, and that single symptom perhaps only in very mild form?

Indeed, the Australian Clinical Guidelines for Early Psychosis do not recommend the use of the schizotypal symptoms. Instead a 16 item list of “Prodromal Symptoms and Signs” of psychosis is provided:

¹⁰⁵ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), op.cit., p. 641.

¹⁰⁶ Ibid., p. 643.

Suspiciousness; Depression; Anxiety; Tension; Irritability; Mood swings; Anger; Sleep disturbances.

Appetite changes; Loss of energy or motivation; Memory or concentration difficulties; Perception that things around them have changed; Belief that thoughts have speeded up or slowed down; Deterioration in work or study; Withdrawal and loss of interest in socialising; Emerging unusual beliefs.¹⁰⁷

But even these officially endorsed indicators of the prodrome are supplied with a qualification. In order to cover themselves the authors of the Clinical Guidelines acknowledge that “these signs and symptoms are not usually indicative of a developing psychosis.”¹⁰⁸ This is apparently said to prevent over-zealous usage and to minimise the alarm that might arise in normal people who encounter this list and reflect on themselves. The guidelines advise that these signs are only meant to be used as symptoms of impending psychosis when “they occur in individuals who have been identified as ‘*at-risk*’ of psychosis”.¹⁰⁹

There is a separate table with a list that can be used to identify the people who are ‘*at-risk*’. The idea is to first narrow down the field before using the prodromal symptoms and signs. The narrowed field focuses on adolescents and young people. There is a fairly extraordinary mixture of further risk factors that range from the quite specific “Family history of psychotic disorder” to the equivocal “Season of birth” to the thoroughly non-specific “Life events” and “Subjective/functional change in the person”.¹¹⁰ Essentially the risk factors seem to be tailored to fit almost any young person who is a bit worrisome to parents, school teachers or other authority figures.

Apart from supplying its own lists of symptoms and risk factors the Clinical Guidelines also advise that “[i]nformation currently available to promote awareness and identification of symptoms is captured in the pamphlet ‘Something is Not Quite Right’ (SANE Australia)”.¹¹¹ SANE Australia is a business name of Schizophrenia Australia Foundation which generally purports to represent the interests of relatives of schizophrenic people. The pamphlet is distributed on request with a note on letter-head which announces that the pharmaceutical company Pfizer is one of the organisation’s sponsors. (Pfizer make a new atypical neuroleptic called ziprasidone).

The SANE pamphlet is directed at parents, teachers, employers and workmates of “difficult” people. Two checklists of symptoms are supplied to assist in recognising the severity of the

¹⁰⁷ National Early Psychosis Project, Australian Clinical Guidelines for Early Psychosis, op.cit., p. 13.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ Ibid., p. 12.

¹¹¹ Ibid., p. 19.

underlying mental illness that might be giving rise to the difficulties. Boxes are provided beside each symptom so that observers can tick off a person's faults. Checklist 1 is:

Behaviour which is considered **normal** although difficult. *Difficult behaviour at home, school or in the workplace.* People may be —

rude	irritable	over-sensitive
lazy	rebellious	weepy
argumentative	over-emotional	withdrawn
thoughtless	shy ¹¹²	

Observers are warned that these behaviours may not be cause for alarm but if they persist or are too disruptive then advice should be sought from a GP, school or workplace counsellor, Citizens Advice Bureau or Mental Health Centre.

Checklist 2 is a list of 18 behaviours which are said to be definitely abnormal and which require medical assessment as soon as possible.

- * withdraw completely from family, friends and workmates.
- * be afraid to leave the house (particularly in daylight hours).
- * sleep or eat poorly. Sleep by day and stay awake at night, often pacing around.
- * be extremely preoccupied with a particular theme, for example, death, politics, or religion.
- * uncharacteristically neglect household or personal or parental responsibilities, or personal hygiene or appearance.
- * deteriorate in performance at school or work, or leave jobs.
- * have difficulty concentrating, following conversation or remembering things.
- * talk about or write things which do not really make sense.
- * panic, be extremely anxious or markedly depressed, or suicidal.
- * lose variation in mood, be *flat*. Lack emotional expression, for example, humour, friendliness.
- * have marked changes in mood, for example from quiet to excited or agitated.
- * have inappropriate emotional responses, for example, giggling on hearing sad news.
- * hear voices that no-one else can hear.
- * believe, without reason, that others are plotting against, spying on, or following them and have extreme fear of, or anger at, those people.

¹¹² SANE Australia, Something is not quite right, pamphlet produced by SANE Australia, Melbourne, 1998.

- * believe they are being harmed, or influenced to do things against their will — by television, radio, aliens or the devil, for example.
- * believe they have special powers, for example — that they are important religious leaders, politicians or scientists when this is not the case.
- * believe their thoughts are being interfered with or that they can influence the thoughts of others.
- * spend extravagant and unrealistic sums of money.¹¹³

The SANE pamphlet advises that if the person demonstrates “outright resistance to the idea of visiting the doctor, consult with the doctor yourself to work out a plan over time. It may be possible and appropriate for the doctor to assess the person at home”.¹¹⁴ When a person is reluctant to submit to a medical assessment it is likely that the doctor will see the friends or relatives as his/her client rather than the person to be assessed. This introduces a great deal of scope for bias in the assessment particularly since the symptomatology is largely a matter of opinion. Summary detention in a mental hospital or coercion to participate in a pre-psychosis treatment programme are likely outcomes.

The SANE checklists of symptoms have been reproduced in full because their official endorsement by the Clinical Guidelines has given them special significance. They are not simply the opinions of an interest group but have been integrated into the official definition of pre-psychotic schizophrenia. This special significance should be considered in the context of a discussion about competing explanatory models for schizophrenia. The SANE programme of using non-medical people as front-line diagnosticians and encouraging them to identify and report people who are irritating/offensive/disturbing must give some credence to the myth-of-mental-illness model. The potential of using psychiatric coercion for social control is particularly evident in the fourth symptom of the above list: “be extremely preoccupied with a particular theme, for example, death, politics, or religion”.

Drug Company Influence

Some of the risk factors for psychosis specified in the Clinical Guidelines are based on hypotheses of aetiology for schizophrenia that remain unconfirmed. “Season of birth”, for instance, is a hypothesis of doubtful merit. Research undertaken in Scotland found that 13,661 schizophrenics born between 1914 and 1960 had fluctuations in the numbers born in the months of February, March, April and May. The fluctuations appeared to be tied to the temperature pattern six months earlier — the colder the autumn, the higher the incidence of schizophrenic births the following

¹¹³ Ibid.

¹¹⁴ Ibid.

spring.¹¹⁵ However, these findings are not confirmed by research in other countries. Korean researchers, for instance, who attempted to replicate the Scottish findings in their own country found no statistical link to season of birth at all.¹¹⁶

It has been claimed that statistical research undertaken in Queensland, Australia confirms the season of birth hypothesis by indicating that schizophrenics born in the Southern Hemisphere have a seasonal pattern of birth which mirrors those born in the Northern Hemisphere.¹¹⁷ But any bias towards season of birth in either hemisphere, if it exists at all, is obviously only a minor factor. Even the proponents of the season of birth hypothesis only claim that there is rise in the number of schizophrenic births at certain times of the year, not that all, or even most, schizophrenic births are tied to a seasonal calendar. The hypothesis might be a useful adjunct to aetiological research but to use season of birth as a diagnostic indicator, as the Clinical Guidelines do, is quite ludicrous. The majority of people who develop schizophrenic symptoms are still born outside the ‘risk season’ while the vast majority of people who are born within the ‘risk season’ are obviously not at any risk of developing schizophrenia.

So why does season of birth appear as a ‘risk factor’ in the Clinical Guidelines? Perhaps it is because the list of ‘risk factors’ and the list of ‘symptoms and signs’ were not originally devised for the Clinical Guidelines but were adopted without comment from a publication called the Early Psychosis Training Pack.¹¹⁸ Although the principal authors of this Training Pack are the Director and Assistant Director of EPPIC the document was produced by a British public relations company which specialises in pharmaceutical marketing called Gardiner-Caldwell Communications.¹¹⁹ The Training Pack was funded by an ‘educational grant’ from the pharmaceutical company Janssen-Cilag.¹²⁰ Janssen-Cilag manufacture a new atypical neuroleptic used for treating schizophrenia called Risperdal (risperidone).

It is perhaps worth noting that Gardiner-Caldwell also publishes a web-based journal entitled Influenza Bulletin¹²¹ for an organisation called the European Scientific Working-Group on Influenza (ESWI). ESWI receives funding from a number of pharmaceutical companies — two of which are Solvay Pharma and SmithKline Beecham. Both Solvay and SmithKline Beecham

¹¹⁵ R. E. Kendell, and W. Adams, ‘Unexplained Fluctuations in the Risk for Schizophrenia By Month and Year of Birth’, British Journal of Psychiatry, Vol. 158, 1991, pp. 758-763.

¹¹⁶ C. E. Kim, Y. S. Lee, Y. H. Lim, I. Y. Noh, and S. H. Park, ‘Month of Birth and Schizophrenia in Korea. Sex, Family History and Handedness’, British Journal of Psychiatry, Vol. 164, No. 6, 1994, pp. 829-831.

¹¹⁷ E. Fuller Torrey, ‘Theories of Causation of Schizophrenia’, The Jim Brownlie Memorial Lecture, 20th Anniversary Conference of the Schizophrenia Fellowship of New Zealand, 6-7 September, 1997.

¹¹⁸ McGorry and Edwards, Early Psychosis Training Pack, op.cit., 1997.

¹¹⁹ Ibid., Module 1, p. 30.

¹²⁰ Ibid., p. 31.

¹²¹ Gardiner-Caldwell Communications, Influenza Bulletin, accessed July 1998, Available URL, <http://www.eswi.com/bull/5/home.htm>

manufacture influenza vaccines. It seems Gardiner-Caldwell have developed a public relations speciality whereby they provide promotional assistance for medical researchers which, at the same time, helps to expand the potential markets for their pharmaceutical sponsors. The Early Psychosis Training Pack should be considered in this light. But in making this consideration questions arise as to why the clinical guidelines for early psychosis ‘best practice’ in Australia have utilised vital material from a public relations Training Pack without explanation.

A popular hypothesis amongst schizophrenia researchers about the season of birth postulates a link between influenza infection of mothers in the second trimester of pregnancy and schizophrenia in offspring. Although this theory is quite widespread a review of the evidence shows it to be doubtful.¹²² Despite the flimsy evidence some psychiatric researchers have called for an influenza vaccination programme for all women of child-bearing age as a preventive measure against mental illness.¹²³

It is an interesting speculation to consider whether Gardiner-Caldwell’s public relations work to expand the market for influenza vaccines might have some linkage to the specification in the Training Pack and the Clinical Guidelines of season of birth as a risk factor for early psychosis. Is it possible Gardiner-Caldwell might be using their influence with early psychosis researchers to position the season of birth hypothesis so that a perceived need for influenza vaccination of child-bearing age women can be made a part of future ‘best practice’ in preventive medicine for schizophrenia?

This type of public relations activity on behalf of drug companies does indeed seem to play a role in other early psychosis research. Most often, though, the public relations work is on behalf of companies that manufacture new schizophrenia drugs.

A community education programme supporting a new two-step program for early intervention in first episode psychosis at the London Health Sciences Centre, London, Ontario, is being sponsored by Zeneca.¹²⁴ The community education involves teaching doctors, parents, school teachers, college teachers and guidance counsellors how to identify the signs and symptoms of early psychosis in young people and where to direct young people for psychiatric intervention. Zeneca manufacture a new atypical neuroleptic called Seroquel (quetiapine).

¹²² Daniel R. Weinberger, ‘From neuropathology to neurodevelopment’, The Lancet, Vol. 346, No. 8974, 26 August, 1995, pp. 552-558.

¹²³ R. Livingston, B. S. Adams and H. S. Bracha, ‘Season of birth and neurodevelopmental disorders: summer birth is associated with dyslexia’, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 32, No. 3, May, 1993, pp. 612-616.

¹²⁴ Anonymous, ‘Young Adults Experiencing Psychosis Remain Undiagnosed’, Mental Health Net, accessed August, 1996, Available URL, [http:// www. cmhc.com/articles/young.htm](http://www.cmhc.com/articles/young.htm)

The Western Psychiatric Institute and Clinic (WPIC) in Pittsburg, Pennsylvania is running a Program for Assessment and Care in Early Schizophrenia (PACES).¹²⁵ To facilitate this research WPIC educates primary health care suppliers and educational professionals in their catchment area about the early signs of psychosis. A part of the research in conjunction with this programme is to test the efficacy of three new atypical neuroleptics. One is a study of the long-term effects of Janssen-Cilag's drug Risperdal (risperidone). This study is funded by Janssen-Cilag. Another looks at the therapeutic efficacy and safety of Eli Lilly's new drug Ziprexa (olanzapine). This study is funded by Eli Lilly. A third study examines the outcome of switching schizophrenia treatment from conventional neuroleptics to Pfizer's new atypical ziprasidone. This study is funded by Pfizer.¹²⁶

A recently established programme in the United States called SOS aims to increase the awareness of schizophrenia by emphasising the importance of early intervention and detection. "The SOS programme — known in full as 'SOS - Signs of Schizophrenia: What To Look For, What To Do' — was set up by the National Mental Health Association in conjunction with Janssen Pharmaceutica in the USA."¹²⁷

EPPIC's preventive treatment centre for young people, PACE, also receives drug company funding from Janssen-Cilag.¹²⁸ This may well have paid off handsomely for the company. The EPPIC researchers have established a leadership role in early psychosis research and treatment in Australia and this was apparent in the organisation of the National Early Psychosis Project and the Clinical Guidelines that emerged from the Project. It may not be coincidental that a half page of the Clinical Guidelines is dedicated to dosage recommendations for using risperidone in first-episode psychosis.¹²⁹ The Clinical Guidelines do not extend these dosage recommendations to include other schizophrenia drugs and the recommendations for risperidone give the appearance of an official endorsement of the drug.

A further indication of the influence gained by Janssen-Cilag through sponsoring EPPIC initiatives can be found in a Resource Kit for General Practitioners which has been assembled to assist doctors "in dealing with young people at risk of Serious Mental Illness".¹³⁰ The Resource Kit outlines a plan for integrating general practitioners into the ongoing out-patient services for young people who have been given psychiatric treatment for early psychosis. The plan is modelled on the existing

¹²⁵ Western Psychiatric Institute and Clinic (WPIC), accessed July 1998, Available URL, <http://brains2.wpic.pitt.edu/paces.html>

¹²⁶ Ibid.

¹²⁷ Anonymous, 'Early Detection and Intervention in Schizophrenia: The Patient's Perspective', Schizophrenia Review, Vol. 6, No. 1, January 1998, p. 4.

¹²⁸ Early Psychosis Prevention and Intervention Centre, PACE Background, Early Psychosis Prevention and Intervention Centre, accessed July 1998, Available URL, <http://brains2.wpic.pitt.edu/paces.html>

¹²⁹ National Early Psychosis Project, Australian Clinical Guidelines for Early Psychosis, op.cit., p. 28.

¹³⁰ Early Psychosis Prevention and Intervention Centre, Resource Kit for General Practitioners, Clyde Consulting, Yarraville, Victoria, 1998, cover page.

practice at EPPIC and involves an 18 month schedule during which responsibility for the patient's supervision is progressively transferred from psychiatric specialists to a local GP. The Resource Kit is designed to be kept as a reference book by GPs. To ensure GPs are encouraged to prescribe the sponsor's products a prominently displayed banner across the cover bears the Janssen-Cilag name and logo.

As well as this, the Second National Conference on Early Psychosis — “Realising the Potential” — organised and hosted by EPPIC at Hobart Tasmania in early September 1998, was principally sponsored by Pfizer, with additional sponsorship coming from Janssen-Cilag, Eli Lilly and Novartis (manufacturer of clozapine).¹³¹ The conference was attended by psychiatrists and mental health workers, most of whom were either involved in already-operating early psychosis programmes, or were in the process of setting one up.

The conference was held at the Hobart casino and the foyer of the conference venue was given a carnival atmosphere by the presence of stalls set up by the four drug companies. During intervals between conference sessions barkers from the drug company stalls competed with one another for the attention of conference delegates, with public relations teams distributing literature, coffee, and numerous gifts including pens, tea-towels, writing pads and rubber balls all prominently stamped with company and product logos. A popular gift was a soft, sponge rubber brain replica from Eli Lilly. The brain is designed to be held in the hand so the ridges and crevices can be contemplatively probed and squeezed by psychiatric therapists. Eli Lilly's new atypical neuroleptic brand name, Ziprexa, is prominently stamped on each side of the brain as a reminder of the preferred form of therapy.

In the final plenary session of this conference I managed to ask a question of the assembled delegates: “Why are early psychosis programmes taking off now — and why is it happening in Australia — when there does not seem to have been a breakthrough in knowledge about the aetiology of schizophrenia and Australia does not normally lead the world in mental health initiatives?”¹³²

The reaction to this question was very interesting. The delegates became animated as they questioned one another for the answer. But strangely, nobody seemed to have one. In the end my working hypothesis was left intact: i.e. early psychosis research and intervention programmes were being driven by funding and lobbying from the pharmaceutical companies that have recently launched new atypical neuroleptics onto the market.

¹³¹ Early Psychosis Prevention and Intervention Centre, Registration Brochure, Second National Conference on Early Psychosis, Early Psychosis Prevention and Intervention Centre, 1998.

¹³² Richard Gosden, question from the floor, final Plenary Session, Second National Conference on Early Psychosis, Hobart Tasmania, 4-5 September, 1998.

The objective of these pharmaceutical companies is to expand the market for the new drugs. The size of the market for palliative treatment of the psychotic and post-psychotic stages of schizophrenia is limited by the diagnostic conventions that have been established for schizophrenia. This is the market they are entering with their new drugs. But the size of the market for prophylactic treatment of pre-psychotic schizophrenia is potentially much larger. This is the expanded market they are seeking to create. Australia is figuring prominently in this strategy because it is being used as a proving ground for the idea of preventive medicine for schizophrenia. This is in preparation for the introduction of full-scale preventive medicine campaigns in the much larger drug markets of North America and Europe.

But prophylactic treatment with neuroleptic medication, of people who have not manifested a psychological crisis, and who are currently coping, carries an enormous burden of ethical responsibility. This is because of the severe risks of drug induced diseases that are incurred by taking the new drugs. The manufacturers of atypicals are currently warning prescribing psychiatrists about these risks by including long lists of adverse drug reactions in advertisements published in psychiatric journals. There is an extraordinary range of these drug-induced diseases and sometimes the warnings are so extensive they run to two pages of extremely small type.

The more serious adverse reactions identified in the warnings, like agranulocytosis¹³³ and neuroleptic malignant syndrome,¹³⁴ cause sudden death. The advertisements also warn about laboratory evidence which indicates the new drugs are carcinogens¹³⁵ and mutagens.¹³⁶ Despite the claims from some quarters that tardive dyskinesia is not a problem with atypicals most of the advertisements warn that these drugs do cause the disease. An advertisement for Risperdal (risperidone) spells it out clearly under the heading of WARNINGS: “**Tardive Dyskinesia.** A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.”¹³⁷

Paradoxically, the manufacturers also warn about the possibility of adverse mental and behavioural reactions. Many of these psychiatric reactions are the very disorders that prophylactic treatment

¹³³ Novartis (Sandoz Pharmaceuticals Corporation), Clozaril (clozapine) advertisement, Archives of General Psychiatry, Vol. 55, No. 1, January, 1998, p. 8.

¹³⁴ Janssen Pharmaceutica, Risperdal (risperidone) advertisement, Psychiatric Services, Vol. 49, No. 9, September, 1998, p. 1124.

¹³⁵ Eli Lilly and Company, Zyprexa (olanzapine) advertisement, Psychiatric Services, Vol 49, No. 3, March, 1998, p. 310.

¹³⁶ Zeneca Pharmaceuticals, Seroquel (quetiapine) advertisement, Psychiatric Services, Vol. 49, No. 3, March, 1998, p. 284.

¹³⁷ Risperdal (risperidone) advertisement, op.cit.

with the drugs is intended to prevent. In other words, instead of preventing psychosis the advertisements are warning that the new atypicals are likely to induce the condition. An advertisement published by Zeneca Pharmaceuticals, for instance, after warning about an extraordinary variety of ways their new atypical can induce ill-health, identifies “Other Adverse Events Observed During the Pre-Marketing Evaluation of SEROQUEL”.¹³⁸ These include:

abnormal dreams, dyskinesia, thinking abnormal, tardive dyskinesia, vertigo, involuntary movements, confusion, amnesia, psychosis, hallucinations, hyperkinesia, libido increased, urinary retention, incoordination, paranoid reaction, abnormal gait, myoclonus, delusions, manic reaction, apathy, ataxia, depersonalisation, stupor, bruxism, catatonic reaction, hemiplegia.¹³⁹

A Clozaril (clozapine) advertisement also warns about the risk of a variety of drug-induced negative and positive symptoms like loss of speech, amentia, delusions/hallucinations and paranoia.¹⁴⁰ If treatment with atypical neuroleptics can induce psychosis, hallucinations and delusions, as is frankly being admitted in advertisements for the drugs, questions most definitely arise about the application of these drugs as prophylactics against psychosis. In the long term, will prophylactic treatment actually increase the incidence of psychosis rather than reduce it? This is a question that does not seem to have been considered in the literature.

Another obvious question to be addressed concerns how to interpret the significance of transition to psychosis by a person who has been receiving prophylactic treatment. Does such an event indicate accuracy in the diagnosis of prodromal symptoms, and ineffectiveness in the prophylactic treatment to prevent the psychosis? If so then perhaps it might encourage the prescription of increased doses of prophylactic drug treatment for other patients.

But on the other hand such an event could simply indicate an adverse drug reaction by a person with a false/positive diagnosis. If this were the correct interpretation then it would be better to take other patients off their prophylactic medication altogether, rather than increase the dosage. Once again these lines of discussion are not arising in the literature.

Perhaps the most insidious of the ethical burdens for the promoters of the prophylactic use of atypicals comes from the growing body of evidence that withdrawal from some of these drugs can sometimes cause a psychotic reaction. It seems that the brain chemistry of some people treated with atypicals is changed in a way that makes them dependent on continued treatment. When atypical

¹³⁸ Seroquel (quetiapine) advertisement, [op.cit.](#)

¹³⁹ [Ibid.](#)

¹⁴⁰ Clozaril (clozapine) advertisement, [op.cit.](#)

neuroleptic treatment is withdrawn from them they experience an immediate psychotic reaction that can only be rectified by recommencement of treatment.¹⁴¹

The ethical burden for psychiatrists treating the supposed prodrome of schizophrenia will include resisting the temptation to interpret psychosis induced by atypical neuroleptic withdrawal as merely being evidence that the person was correctly diagnosed in the first place. Unethical psychiatrists may be tempted to argue that it was the prophylactic treatment which, up to the point of withdrawal, prevented the person from entering psychosis. In this way the original diagnosis and prophylactic treatment could easily be vindicated, when in fact they might both be at fault.

Conclusion

There are at least two methods by which advocates of the medical model could convincingly demonstrate the existence of an identifiable pre-psychotic phase of schizophrenia. The first would be to undertake diagnostic interviews with a large sample of adolescents and predict who would later become psychotic, and who would not. This could be done without informing the people involved of the particular prediction that had been made for them and without offering treatment to those people who were thought to be heading for psychosis. Using such facilities as electoral rolls and admission records to mental hospitals and psychiatric units the predictions could then be tested over extended time periods. But there is no indication that this relatively simple and obvious method of testing theories about pre-psychotic symptoms has been utilised anywhere in the world.

The second approach would be to detect and treat all the people in a given catchment area who manifested the pre-psychotic signs. This approach would seek to demonstrate, through early treatment, a significant reduction in the number of people who become psychotic in that area. Falloon's Buckingham Project claimed to have done this but the flexibility of his definition of psychosis cast doubt on the outcome.

As things stand the early psychosis projects that have been put into operation are largely of the same type as the Buckingham Project. They involve both detection and treatment and thereby attempt to reduce the incidence of psychosis in the catchment areas in which they operate. However, there is no certain evidence that this objective has been achieved anywhere, or indeed, is achievable. The efficacy of detection and treatment methods for pre-psychosis remains largely hypothetical at this stage. This means that the various programmes that have been put into effect are largely experimental.

¹⁴¹ J. K. Stanilla, J. de-Leon and G. M. Simpson, 'Clozapine withdrawal resulting in delirium with psychosis: a report of three cases', *Journal of Clinical Psychiatry*, Vol. 58, No. 6, June 1997, pp. 252-255.

This raises concerns about human rights, specifically in relation to informed consent. Coercion is readily apparent in the area of early psychosis intervention and two-thirds of the patients being treated by EPPIC's first-episode psychosis clinic are involuntary patients.¹⁴² Although at this time it is not apparent that people are being treated involuntarily for prodromal symptoms, the possibility is already being discussed in the literature¹⁴³ and it is likely to happen in selected cases in the future.¹⁴⁴

Problems with symptomatology and treatment make it unlikely that pre-psychosis detection and intervention programmes will ever deliver the kind of unequivocal social and community health advantages that are generally expected from preventive medicine campaigns. This means that the extension of the definition of schizophrenia into a prodromal phase is unlikely to provide further support for the medical model of schizophrenia.

However, whereas programmes of early detection and intervention might not give further support to the medical model for schizophrenia, at the same time, it is entirely possible that over time they might actually enhance the plausibility of the two competing models — perhaps the myth-of-mental-illness model more than the mystical model. When psychiatrists openly refer to pre-psychotic indicators as being 'putative', and then proceed to intervene in the lives of people who are thought to manifest them, treating them with the same potent neuroleptics that are used on supposedly full-blown schizophrenia, then the argument that schizophrenia is just a psychiatric myth seems more persuasive.

This point is emphasised by considering the commercial advantages that are likely to accrue to pharmaceutical companies from an expansion of the definition of schizophrenia to include a pre-psychotic phase. A preventive medicine campaign based on the type of prodromal symptoms and risk factors specified in the Australian Clinical Guidelines for Early Psychosis potentially defines the whole generation of young people as being at-risk and in need of treatment. If proponents of the M-M-I model can demonstrate that pharmaceutical marketing strategies are indeed the primary motivating force behind the campaign for prevention of schizophrenia then it will make it easier to argue that the whole medical model for schizophrenia is a myth that has been invented to serve special interests.

¹⁴² Paddy Power, Early Psychosis Prevention and Intervention Centre, in answer to a question after presentation of paper entitled, An Analysis of the Initial Treatment Phase and Follow-Up of First Episode Psychosis Patients, Second National Conference on Early Psychosis, Hobart Tasmania, 4-5 September, 1998.

¹⁴³ Yung and McGorry, 'Is pre-psychotic intervention realistic in schizophrenia and related disorder?', op.cit., p. 802.

¹⁴⁴ Patrick McGorry, Director of the Early Psychosis Prevention and Intervention Centre, Personal Communication, at the Second National Conference on Early Psychosis, Hobart Tasmania, 4-5 September, 1998.

Similarly, when magical thinking is found to be the most common prodromal symptom that leading researchers in the field are treating then the link between schizophrenia and mystical inclinations would also appear to strengthen. But the use of magical thinking as the pre-eminent symptom can also lend support to the myth-of-mental-illness model. This is because the EPPIC psychiatrists who are treating patients for this symptom have prior knowledge from their surveys that magical thinking is also experienced by the majority of normal young people. They seem to be ignoring evidence they have themselves collected and published that magical thinking is not necessarily a sign of mental pathology at all.

Indeed, the pseudo-authoritativeness characterising much of the literature regularly demonstrates a lack of reflection on the part of early psychosis researchers about the superficial nature of their claims. A good example of this can be found in the Early Psychosis Training Pack. Under the heading of “How to achieve early recognition — Triggers for considering psychosis or pre-psychosis”¹⁴⁵ the Training Pack advises doctors dealing with adolescents and young people to be sure of “[m]aintaining a high index of suspicion - signs to look out for.”¹⁴⁶ This advice is followed by the 16 item list of “Signs and Symptoms”, the first of which is “suspiciousness”. This juxtapositioning of the idea of suspicion, first as an efficiency measure for diagnosticians and then as a sign of pathology in patients, begs the question: Is it credible for psychiatrists to claim that “suspiciousness” in young people is a sign of serious mental illness when the same psychiatrists argue that clinicians should cultivate an attitude of suspicion in themselves as an efficiency measure?

There is a certain degree of irony here, where suspicion is encouraged to combat suspicion, which apparently escapes the authors of the Training Pack. But the contrariness raises an important question as to whether suspiciousness and the other putative signs and symptoms are correctly judged to be indicators of mental pathology. From the M-M-I perspective the duplicitous use of suspicion could easily be interpreted as evidence of using psychiatry for social control. That is, suspicion is a worthy quality when it is used as a tool of efficiency by a person with authority but it becomes a sign of pathology when it is found in a person of low status or in a person who is challenging authority.

The EPPIC researchers have cited a 1938 article by D. Ewen Cameron as their original authority for believing that “suspiciousness may predict subsequent psychosis”.¹⁴⁷ This is itself a rather suspicious source. Cameron is the Canadian psychiatrist who gained notoriety in the 1980s after it

¹⁴⁵ McGorry and Edwards, Early Psychosis Training Pack, op.cit., P.9.

¹⁴⁶ Ibid.

¹⁴⁷ Yung et al., ‘Monitoring and Care of Young People at Incipient Risk of Psychosis’, op.cit., p. 286.

was revealed he had undertaken cruel and unethical experiments on his patients during the 1950s and 1960s with funding from the CIA.¹⁴⁸

Using a deep sleep technique combined with multiple daily assaults of ECT Cameron attempted to cure schizophrenia by erasing all memory of self from his patients' minds. The CIA was apparently interested in utilising these techniques in espionage work. In 1988 the CIA acknowledged complicity in Cameron's work when they arranged to pay \$750,000 in compensation to some of the victims.¹⁴⁹ Cameron's exploits were the subject of a 1979 book by John Marks entitled The Search for the Manchurian Candidate.¹⁵⁰

Cameron is perhaps the most widely discredited psychiatrist of all time and contemporary psychiatric researchers who cite him as a source of authority for their own ideas demonstrate, at the very least, a deficiency of judgement. Nevertheless, the Cameron-inspired symptomatology has been incorporated into the Australian Clinical Guidelines for Early Psychosis where suspiciousness is given as the leading symptom of pre-psychotic schizophrenia.¹⁵¹

The deficiency of judgement regarding Cameron extends beyond merely adopting his suggestion about the use of suspiciousness as a symptom. Proponents of early psychosis repeatedly cite Cameron as the originator of the whole concept for early detection and intervention programmes for schizophrenia.¹⁵² Patrick McGorry, the Director of EPPIC, even quoted Cameron to lead his introductory essay to a June 1998 early psychosis supplement he edited of the British Journal of Psychiatry:

“Very early schizophrenia still constitutes a relatively unexplored territory. Entry into this territory calls for new ideas on the social problems involved in bringing the early schizophrenic promptly under treatment, or where the treatment should be carried out and in what it should consist.” D. Ewen Cameron (1938)¹⁵³

¹⁴⁸ Report of the Royal Commission Into Deep Sleep Therapy, Justice J. P. Slattery, Royal Commissioner, New South Wales Government, Sydney, Volume 2, 1990, pp. 48-58.

¹⁴⁹ Peter Breggin, Toxic Psychiatry, Fontana, London, 1993, p. 250.

¹⁵⁰ John Marks, The Search for the Manchurian Candidate, W. W. Norton and Company, New York, 1979.

¹⁵¹ National Early Psychosis Project, Australian Clinical Guidelines for Early Psychosis, op.cit., p. 13.

¹⁵² See for example, Alison R. Yung et al., ‘Prediction of psychosis: A step towards indicated prevention of schizophrenia’, British Journal of Psychiatry, Vol. 172, Supplement, June 1998, pp. 14-20. and Richard Jed Wyatt et al., ‘First-episode schizophrenia: Early intervention and medication discontinuation in the context of course and treatment’, British Journal of Psychiatry, Vol. 172, Supplement, June 1998, pp. 77-83.

¹⁵³ D. E. Cameron, ‘Early schizophrenia’, American Journal of Psychiatry, 95, 1938, pp. 567-578. Quoted in Patrick McGorry, ‘Preventive strategies in early psychosis’, British Journal of Psychiatry, Vol. 172, Supplement, June 1998, pp. 1-2.

Referring to the origins of the idea of pre-psychotic treatment McGorry went on to say that “[t]his form of preventive intervention, [was] originally fore-shadowed by Cameron.”¹⁵⁴ In the 1938 article Cameron writes enthusiastically about the effectiveness of “the newer therapeutic techniques used in schizophrenia”. Cameron’s 1938 article is followed by a commentary from the leading authority on schizophrenia at the time, Harry Stack Sullivan. Unlike McGorry, and without foreknowledge of Cameron’s future notoriety, Sullivan demonstrated disgust with Cameron’s proposal and issued a strong rebuttal.

I would be very deeply disturbed if, as is implied by the last speaker [Cameron], people who show signs of personality disorders, early mental disorder of an indeterminate kind, were to be rushed through treatment with insulin, metrazol and camphor on the chance that they might otherwise have developed schizophrenia. I privately have a suspicion that might have a distinctly unfavourable effect on the general intelligence level and so on of the community.

What does it mean that a person will have schizophrenia which can be detected by the intelligent layman months to years before the schizophrenia appears? In seven and half years of exclusive preoccupation with the schizophrenia problem I was unable to put my finger on anything sufficiently simple and obvious to service this purpose.¹⁵⁵

Although in the text of his article Cameron did not specify the treatments he had in mind for early psychosis some of the references he gave clearly confirm Sullivan’s suspicion that insulin shock was intended. In closing the Discussion of his article, following Sullivan’s rebuttal of his ideas, Cameron buckled and lamely reversed his former position: “I don’t think that it is any way feasible to consider at the present time treatment of persons suffering from early non-specific symptoms by means of pharmacological shock treatment.”¹⁵⁶

This exchange between Sullivan and Cameron indicates that it was Sullivan’s strong rebuttal that made pharmacological shock unfeasible as treatment in the late 1930s. If it is now feasible to use the latest form of pharmacological shock — atypical neuroleptics — on the same symptoms, then perhaps it is only because there is no figure in the psychiatric profession, like Sullivan, with sufficient stature and a commensurate level of social conscience, to mount the necessary protest.

¹⁵⁴ McGorry, *Ibid.*

¹⁵⁵ Harry Stack Sullivan, ‘Discussion’, in D. Ewen Cameron, ‘Early schizophrenia’, *American Journal of Psychiatry*, 95, 1938, p. 579.

¹⁵⁶ D. Ewen Cameron, ‘Discussion’, in ‘Early schizophrenia’, *American Journal of Psychiatry*, 95, 1938, p. 581-582.

It is not clear whether McGorry and other early psychosis proponents use Cameron as an authority out of ignorance, indifference or admiration of his unsavoury reputation.¹⁵⁷ But it is certain that their source of inspiration, and their judgement in revealing it, are both unsound. The linking of Cameron's name with a government sponsored preventive medicine campaign for schizophrenia can only strengthen arguments for the myth-of-mental-illness model in the long run.

¹⁵⁷ The question of whether they are ignorant, indifferent or in admiration of Cameron warrants further investigation as it provides a simple method of evaluating the professional integrity of the psychiatrists who are promoting preventive medicine strategies for schizophrenia. When McGorry quoted Cameron to lead his British Journal of Psychiatry article he cited D. Ewen Cameron beneath the quotation, as I have reproduced it above. The end-note reference, however, only identified D. E. Cameron, as his name appeared on his original 1938 article. D. Ewen Cameron is the distinctive form of his name by which Cameron's post World War II career was identified, first as an eminent psychiatrist and then as an unethical CIA-sponsored experimenter. McGorry's unnecessary use of the distinctive D. Ewen indicates that he knew about the post World War II prominence of the author and wanted to associate his own ideas with a psychiatric predecessor who had a sufficient reputation to lend them authority. Before his fall from grace Cameron was one of the most eminent psychiatrists of his time having served as President of the American Psychiatric Association and as first President of the World Psychiatric Association. But it is not clear to which aspect of Cameron's prominence McGorry wished to associate himself. In Toxic Psychiatry (p. 251) Breggin observed that the adverse publicity about Cameron "focussed mostly on the CIA funding rather than on the most scandalous fact of all - that Cameron and his brutalities, although well known throughout the profession, were never criticised by mainstream psychiatry". A similar criticism of the psychiatric profession for acquiescing to Cameron's work was made by Canadian QC George Cooper (quoted in Royal Commission Report, Op. Cit., p. 56.). The NSW Royal Commission into Deep Sleep Therapy devoted ten pages to examining Cameron's work and his link with the CIA (pp. 48-58, Vol. 2). This was done in order to determine whether Dr. Harry Bailey, the main subject of the Royal Commission Inquiry, was also linked to the CIA through association with Cameron. No significant connection was found but it is interesting to note that references to Cameron persistently misidentified him by the name, Dr. Ewan Cameron, throughout the entire twelve volume report. This is not consistent with any of the names by which he was normally known: i.e. D. E. Cameron; D. Ewen Cameron; or Donald Ewen Cameron. The misidentification of Cameron could simply be a typographical error in the final report. Even so, it seems to have led to confusion in the historical record whereby the CIA-sponsored, human rights abusing Cameron now appears to be a different Cameron to the former eminent leader of international psychiatric organisations. This confusion was perpetuated in a 1991 book, (Brian Bromberger and Janet Fife-Yeomans, Deep Sleep: Harry Bailey and the Scandal of Chelmsford, Simon and Schuster, Sydney, 1991, pp. 10-11.) which drew heavily on the Royal Commission report as a source and repeated the misidentification of Cameron as Dr. Ewan Cameron.

Conclusion

There is growing pressure in North America and Australia from interest groups supporting the medical model to bring the various schizophrenia controversies to closure. The mental health industry is currently undergoing an expansive phase and new mental disorders are being progressively added to psychiatric diagnostic manuals. In conjunction with this general expansion there is also a growing tendency to use coercion in psychiatric practice. These trends give rise to concerns about an exacerbation of human rights problems that arise from routine psychiatric practices.

A principal objective of this thesis is to demonstrate the depth of confusion that prevails within the psychiatric profession about the cause of the symptoms of schizophrenia. Chapter 3 laid the foundation for achieving this objective with a discussion about the philosophical problems of medicalising a condition that has no apparent physical cause. Various tests were applied to determine whether the symptoms of schizophrenia conform with generally conceived notions of disease. It was concluded that these symptoms are similar to the phenomena of baldness and homosexuality in that it is impossible to make sound arguments supporting a pathological interpretation. The descriptive psychopathology for schizophrenia was found to have a long and confused history and the contemporary psychiatric consensus about symptomatology, founded on the work of Kraepelin and Bleuler, was shown to be largely contrived.

Chapter 4 probed the aetiological confusion by examining the dichotomy between psychiatric theories postulating biological causes and theories which argue for environmental/experiential causes. The proliferation of sub-models attached to each side of this dichotomy was described and analysed. The wide variation of these aetiological theories was tendered as primary evidence that the psychiatric consensus about diagnostic and treatment techniques for schizophrenia is not supported by scientific knowledge about the underlying cause of the condition.

Another objective of the thesis is to cast doubt on the wisdom of extending psychiatric coercion so that more people can be treated involuntarily with neuroleptic drugs. This objective was achieved by demonstrating that the medical model is only one of three meta-models for explaining the symptoms. Chapters 6 and 8 described and analysed competing explanatory models — a mystical model and a myth-of-mental-illness model — which were both shown to be at least as rational and plausible as the medical model. Of the three models only the medical model supports arguments for drug treatment. The normal neuroleptic drug treatment is only a crude management tool, not a cure, and frequently does more harm than good. Treatment often results in a variety of seriously debilitating neuroleptic-induced diseases. An underlying argument of the thesis is that there is no

medical justification for treating people with these drugs against their will and that to do so violates a number of basic human rights.

Chapters 5, 7 and 9 demonstrated that each of the three meta-models is supported by competing interest groups. Partisan interest groups were found to be driving the aetiological controversy by raising conflicting human rights imperatives associated with their separate perspectives. An objective of the thesis is to demonstrate that the human rights entitlements of people diagnosed with schizophrenia largely depend on the model through which the cause of the symptoms is viewed. Most psychiatrists seem unaware they are routinely violating human rights imperatives that arise from non-medical perspectives. It seems inconceivable to psychiatrists that normal medical treatment, given in good faith, could be rationally construed as torture or a violation of the freedom of thought and belief. Yet the thesis clearly demonstrates this to be the case.

Chapter 10 on early psychosis demonstrates that psychiatrists are expanding the diagnostic net for schizophrenia into areas that appear to be outside the boundaries of their medical expertise. This chapter described and analysed current psychiatric research which is extending the definition of schizophrenia to include a pre-psychotic phase. When this research was analysed it became apparent that it is largely founded on false premises and utilises arbitrary criteria to provide a superficial appearance of scientific rigour.

Ostensibly the psychiatric intention of early psychosis research is to provide the basis for a preventive medicine campaign against schizophrenia. However, it is apparent that research funding from drug companies is helping to drive this extension of schizophrenia and it seems likely an underlying motivation is to expand the market for the new generation of schizophrenia drugs. The implementation of a preventive medicine campaign, involving pre-psychotic detection and treatment, will further exacerbate the many human rights problems surrounding the treatment of people diagnosed with schizophrenia.

The tentative status of pre-psychotic symptomatology, and the large number of seemingly normal people who fit the criteria, could quite conceivably bring the whole medical model for schizophrenia into disrepute. A preventive medicine campaign based on the current pre-psychotic diagnostic criteria may prove to be one of the many watersheds that psychiatric practice passes through from time to time.

In a 1977 article published in the journal Science George Engel, a US based professor of psychiatry and medicine, observed that psychiatric practice had then reached one of these watersheds:

At a recent conference on psychiatric education, many psychiatrists seemed to be saying to medicine, "Please take us back and we will never again deviate from the medical

model.” For, as one critical psychiatrist put it, “Psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and ‘schools of thought’, mixed metaphors, role diffusion, propaganda, and politicking for ‘mental health’ and other esoteric goals”. In contrast the rest of medicine appears neat and tidy. It has a firm base in the biological sciences, enormous technological resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments. It would seem that psychiatry would do well to emulate its sister medical disciplines by finally embracing once and for all the medical model of disease.¹

Engel himself, however, did not agree with this position and he went on in the article to analyse the crisis that psychiatry was then undergoing. He began by observing that the essential characteristic of the crisis was a split within the profession about its future direction. One camp was advocating a return to strict observance of the medical model based on assumptions of brain dysfunction as the cause of behavioural deviations. The other, “exemplified in the writings of Thomas Szasz and others who advance the position that ‘mental illness is a myth’,”² was urging the foundation of a new discipline based on the behavioural sciences which would supersede psychiatry and “be concerned with the reeducation of people with problems of living”.³

The purpose of Engel’s article was to caution psychiatrists not to be too impatient for a resolution because the crisis that was then afflicting psychiatry could also be found in other branches of medicine. He believed that the root cause of the problem lay with the over-extended usage of the biomedical model, which underpinned all of medicine. The biomedical model, he argued, was originally conceived for scientific research purposes. Although it served well in this role Engel claimed it had been extended too far into popular culture:

The historical fact we have to face is that in modern Western society biomedicine not only has provided a basis for the scientific study of disease, it has also become our own culturally specific perspective about disease, that is, our folk model. Indeed the biomedical model is now the dominant folk model of disease in the Western world.⁴

According to Engel the unsuitability of biomedicine as a folk model lies with its inability to integrate psychological and social factors into the understanding and treatment of disease.⁵

¹ George L. Engel, ‘The Need for a New Medical Model: A Challenge for Biomedicine’, Science, Vol. 196, No. 4286, 8 April, 1977, p. 129.

² Ibid.

³ Ibid.

⁴ Ibid., p. 130.

⁵ Ibid., pp. 129-136.

Engel proposed a new model to replace the biomedical model. He called the new model a biopsychosocial model and he thought it would be particularly well-suited for psychiatry: “Medicine’s unrest derives from a growing awareness among many physicians of the contradiction between the excellence of their biomedical background on the one hand and the weakness of their qualifications in certain attributes essential for good patient care on the other”.⁶ The “attributes” Engel was referring to involved recognising the psychological and social needs of patients, and the contributions these needs can make to the presentation of disease. They also involved a knowledge of how and where to refer a patient on for non-medical expert advice when the application of biomedical expertise was inappropriate. Engel recommended this biopsychosocial approach to disease be included in the educational curricula of physicians and psychiatrists.

However, as psychiatric practice has unfolded since the late 1970s it is apparent the psychiatric profession has not followed Engel’s advice. Although the terminology of ‘biopsychosocial’ is now widely used, it is usually only as a rhetorical device. Mainstream psychiatric practice has clearly followed the course that Engel warned against. From the early 1980s onward there has been an ever-strengthening commitment by psychiatrists to a strategy which positions their profession firmly within the scientific community. An important part of this strategy has been to give precedence to biomedical approaches in aetiological research and treatment techniques.

This renewed commitment to the biomedical approach is particularly evident in research into the aetiology of schizophrenia. There is very little contemporary research in this area that is founded on psychological or social premises. Interestingly though, the rhetoric, if not the substance, of a biopsychosocial approach is sometimes used to support biomedical theories about the aetiology of schizophrenia. This is apparently done to make the renewed commitment to biomedical assumptions more acceptable to non-medical mental health professionals.

Examples of this rhetorical use can be found where individuals with a hypothetical biological indicator for schizophrenia are tested for their psychological and social adaptation skills. This psychosocial testing is done to test the validity of the biological theory. The combination of a biological theory and psychosocial testing is then called a ‘biopsychosocial’ approach to aetiology.

In one recent study, for instance, 42 schizophrenics were divided into two groups on the basis of their brain ventricle size.⁷ One group had enlarged ventricles while the other group had normal ventricles. The psychological and social functioning of the two groups were compared by testing

⁶ *Ibid.*, p. 134.

⁷ Rosemary L. Farmer and Anand K. Pandurangi, ‘Diversity in Schizophrenia: Toward a Richer Biopsychosocial Understanding For Social Work Practice’, *Health & Social Work*, Vol. 22, No. 2, May, 1997, pp. 109-117.

them with a battery of measurement techniques. The objective was to determine whether ventricle size had any bearing on psychosocial functioning levels.

On this occasion enlarged ventricles were found to have no bearing on the psychosocial functioning levels of schizophrenics. However, the researchers did make an incidental discovery. It appears that the gender and race of schizophrenics does affect their level of their psychosocial functioning — women and Afro-Americans faring better than males and whites.⁸

Closure of the controversy over the cause of the symptoms of schizophrenia appears to be remote at this stage. This is despite the confident assertions by many proponents of the medical model that a breakthrough in the biological area is imminent. When the various lines of biological research are closely examined it is not difficult to discern that all of them are returning equivocal results. But it is not only the quality of the results that makes an early closure unlikely. The sheer quantity of conflicting psychiatric theories also has to be considered. There are so many divergent threads currently being pursued that it is quite evident that psychiatric researchers are a long way from reaching consensus.

Nevertheless, powerful interest groups supporting the medical model are ignoring the poor quality and scattered variety of this biological evidence. They are also tending to ignore the severity of adverse effects produced by schizophrenia drug treatments. These interest groups are currently demonstrating considerable political skills in campaigns to extend both the definition of schizophrenia into a pre-psychotic phase and also to extend the reach of psychiatric coercion.

The high confidence levels expressed by psychiatrists in their professional, philosophical and ethical capacity to deliver a just outcome from this situation often seems to be misplaced. The history of medical treatment for schizophrenia over the past century features a succession of cruel and ineffective therapies that appear to have been devised more to inspire fear and aversion in patients than to provide comfort and amelioration of the symptoms. There is a clear pattern of one cruel and ineffective treatment being replaced by another as public disclosure catches up with psychiatric practice. This pattern is currently being repeated as atypical neuroleptic medications are phased in to replace conventional neuroleptics. The new atypicals only appeared on the scene after there was extensive public disclosure about the epidemic of tardive dyskinesia and other severe negative effects which conventional neuroleptics have routinely caused in patients over the past 40 years.

A central question arising from this situation is whether the extension of the definition of schizophrenia, and the extension of coercive powers to apply psychiatric treatments, should be

⁸ Ibid.

allowed to proceed without first properly reconsidering the basic premises on which the medical model for schizophrenia is founded.

The mystical model and the myth-of-mental-illness model both provide plausible alternative explanations for schizophrenia. These alternative models are often more attractive to people who have themselves been labelled with schizophrenia. This is particularly true of people who have been made involuntary psychiatric patients. When preventive medicine campaigns using prodromal symptoms for schizophrenia are analysed in relation to the three different models it is apparent that the medical model is in many ways the least plausible of the three.

Perhaps the reason why three divergent models can all be shown to provide reasonable explanations for schizophrenia is because the various categories of symptoms for schizophrenia are themselves so divergent. A range of positive mental symptoms — like delusions and hallucinations — are said to be reflected in outward forms of irrational behaviour. But at the same time there is also a range of negative mental symptoms that can manifest as behavioural inactivity. On top of these positive/negative and mental/behavioural dichotomies there are also various forms of social and occupational dysfunction that are used as symptoms for schizophrenia.

If three entirely different models can suitably explain the cause of schizophrenia then it is not entirely implausible to assume that the diagnostic net might be so wide that it is ensnaring three entirely different and unrelated classes of people. That is, while the three models might all serve to give reasonable explanations for schizophrenia in general, if the models were to be tested separately on individual cases, it might be found that each separate case of schizophrenia is only plausibly explained by one particular model. Perhaps this is what is happening when recovered schizophrenics review their own personal experience and select for themselves the explanatory model they think is most appropriate.

It is not a difficult task to develop a hypothesis which refines the explanation of schizophrenic symptoms by separating schizophrenics into three classes of people and attaching individuals to the particular model that is most appropriate. Such a distribution would appear to be most rational along the lines of the bio/psycho/social framework. However, in order to make this adjustment it is necessary to make a correction to a long-standing anomaly in the medical model.

Although the enviro/experiential theories have been traditionally incorporated within the medical model they are increasingly ignored by practising psychiatrists. Many psychiatrists have found that it is illogical for them to assume a psychological cause for the symptoms of schizophrenia when their medical training does not properly prepare them to either understand psychological problems, or to treat them. The medical training of psychiatrists logically inclines them to prefer assumptions of a biological aetiology and the application of drug-based treatments.

This anomaly, whereby psychological theories have been falsely associated with medical expertise, can be easily corrected by combining the enviro/experiential theories with the mystical/religious theories under the heading of Psycho/Mystical Model. This adjustment leaves the biological theories under a revised heading of Biomedical Model. In this way three alternative explanatory models can still be used — Biomedical, Psycho/Mystical and Myth-of Mental Illness (i.e. social problems) — which conform with the bio/psycho/social framework.

Model	Biomedical	Psycho/Mystical	Myth-of-Mental-Illness
Type of Symptom	bio	psycho	social
Focus of Research	brain	mind	behaviour
Treatment	medical	psychotherapy meditation	social skills living skills
Human Rights	right to treatment informed consent	freedom of thought and belief	right to liberty protection against torture

Using this plan people who are diagnosed with schizophrenia could be attached to one of the three models in the following way:

(1) People who manifest any of the positive or negative mental symptoms, which can be traced to a physical cause — like substance taking, infection, brain damage or adverse reaction to neuroleptic treatment — would belong with the Biomedical Model.

(2) People who manifest mental symptoms, like delusions and hallucinations, which have no discernible evidence of a physical cause, would belong with the Psycho/Mystical Model.

(3) People who have experienced some kind of social or occupational dysfunction, without any positive mental symptoms, would belong with the Myth-of-Mental-Illness Model. (Although diagnosticians may claim to have observed mental symptoms in people belonging to this class these may simply be manifestations of role-play, rebellion, disappointment or social rejection).

Of course, this sort of pattern is already partly incorporated in normal psychiatric perceptions. People who would be directed to the myth-of-mental-illness model in the above plan, because mental symptoms have been mistakenly attributed to them, are now called false/positives by psychiatrists. That is, these people are said to have been falsely given a positive diagnosis of

schizophrenia. Psychiatrists already recognise that such people theoretically exist and that in their particular cases the mental illness attributed to them is indeed a myth. But very little psychiatric research has been conducted in this area. Rosenhan's experiment with pseudo patients, discussed in Chapter 8, indicated that the incidence of false positive diagnosis for people presenting at hospital emergency rooms may be very high.

The problem for people who fall into this category is that once a label of schizophrenia has been attached to them it is virtually impossible to have the diagnosis removed. This is because there are no laboratory tests that will overturn a diagnosis and there is no way for a person to refute a diagnosis by demonstrating sanity. Indeed, the more a diagnosed person denies the illness the more convinced psychiatrists are likely to become of the severity of their disorder. This is because psychiatrists argue that such people lack insight, or self-recognition of their mental disease, and therefore have less self-control and are more vulnerable to irrational impulses.

While psychiatrists are willing to concede that false/positives theoretically exist they seem incapable of taking any steps to identify them and to rectify the impossible situation in which false/positives find themselves. This causes many psychiatric survivors with false/positive diagnoses to adopt the myth-of-mental-illness model as a way of explaining their situation. They come to believe that not only is mental illness a myth in their own particular cases but that the whole mental health structure, and the psychiatric profession in particular, is built on fraudulence.

But if psychiatrists currently give only twisted recognition to a class of schizophrenics that fit the myth-of-mental-illness model, the irony caused by that twist is overshadowed by an even greater irony in the psychiatric convolutions over the significance of physical causes for schizophrenic symptoms. It is the identification of physical causes that would separate the people belonging to the psycho/mystical model from those belonging to the biomedical model in the above plan.

In current psychiatric practice DSM-IV requires a diagnostician to differentiate between people who have identifiable physical causes for their schizophrenic symptoms, and those who do not. Only those people with no physical causes for the symptoms are supposed to be diagnosed with schizophrenia. Under the heading of Differential Diagnosis DSM-IV offers the following advice to diagnosticians:

A wide variety of general medical conditions can present with psychotic symptoms. **Psychotic Disorder Due to a General Medical Condition, delirium, or dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests that indicates that the delusions or hallucinations are the direct physiological consequence of a general medical condition (e.g., Cushing's syndrome, brain tumor). **Substance-Induced Psychotic Disorder, Substance-Induced Delirium, and**

Substance-Induced Persisting Dementia are distinguished from Schizophrenia by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the delusions or hallucinations. Many different types of **Substance-Related Disorders** may produce symptoms similar to those of Schizophrenia (e.g., sustained amphetamine or cocaine use may produce delusions or hallucinations; phencyclidine may produce a mixture of positive and negative symptoms). Based on a variety of features that characterise the course of Schizophrenia and Substance-Related Disorders, the clinician must determine whether the psychotic symptoms have been initiated and maintained by the substance use. Ideally, the clinician should attempt to observe the individual during a sustained period (e.g., 4 weeks) of abstinence. However, because such long periods of abstinence are often difficult to achieve, the clinician may need to consider other evidence, such as whether the psychotic symptoms appear to be exacerbated by the substance and diminish when it has been discontinued, the relative severity of psychotic symptoms in relation to the amount and duration of substance use, and knowledge of the characteristic symptoms produced by a particular substance (e.g., amphetamines typically produce delusions and stereotypies, but not affective blunting or prominent negative symptoms).⁹

The intention is obviously to exclude anyone from a diagnosis of schizophrenia who has symptoms that can be traced to a physical cause. If a specific physical cause can be blamed for schizophrenic symptoms then there will be a more appropriate medical diagnosis that is associated with that physical cause. So, according to correct psychiatric practice only people who have no detectable physical cause for their symptoms are to be given a diagnosis of schizophrenia.

However, after first determining that a person with schizophrenic symptoms has no known medical (i.e. physical) cause for the symptoms the convoluted practice most psychiatrists then follow is to still proceed with medical treatment as if there were a physical cause. After first taking care to eliminate all possible physical causes by ensuring the store of knowledge about medical conditions which give rise to distorted mental states has been thoroughly sifted, strangely, they not only assume there must still be a physical cause, despite the lack of evidence, but they proceed with treatment as if they fully comprehend its exact nature. This assumption of a physical cause is made in the absence of any evidence whatsoever. We can be certain of this absence of evidence because if there were any evidence then a diagnosis other than schizophrenia should be given.

All of the current psychiatric rationale for the diagnosis and treatment of schizophrenia would seem to hinge on this practice of first eliminating known physical causes of distorted mental states and

⁹ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, American Psychiatric Association, Washington, 1994, p. 283.

then assuming an unknown physical cause. If a biomedical theory like the dopamine hypothesis were ever to be proven correct then schizophrenia would probably cease to exist as a ‘mental’ disease. Henceforth it would be a dopamine-associated brain disease, and perhaps a medical speciality other than psychiatry would be given responsibility for treating it. It would seem that the current psychiatric monopoly of treatment for schizophrenia relies very strongly on the maintenance of ignorance about the true aetiology of the symptoms and an unsubstantiated belief in an unknown physical cause.

If it is generally agreed that medically-trained professionals should not extend their range beyond the proven area of their expertise then a serious re-evaluation of the concept of schizophrenia might now be appropriate. It seems apparent that there might be three entirely different classes of people who are wrapped up in the package of schizophrenia. One of these classes comprises people who have nothing either mentally or physically wrong with them. Another class has serious psychological/mystical problems but these problems have no biological basis and their treatment therefore is well outside the province of medical expertise. A third class might have physical problems that give rise to mental distortions and are therefore clearly within the range of medical expertise but, if this is the case, then a diagnosis of schizophrenia for these people would be either incorrect or inappropriate.¹⁰

An approach to the aetiology of schizophrenic symptoms which divides the people who experience them into three types could be truly called a ‘biopsychosocial’ approach: ‘bio’ to represent those whose symptoms have a physical cause, and who should be re-diagnosed with the disease that is correctly associated with that physical cause; ‘psycho’ for those in the midst of a psycho/mystical crisis, for whom the application of a medical diagnosis and treatment is inappropriate; and ‘social’ to represent those who only have social/occupational problems, whose supposed mental illness is a myth.

If the medically-trained psychiatric profession were to adopt a truly biopsychosocial approach to the aetiology of schizophrenia they would be free to make a radical shift in the perception of their professional role in regard to this condition. People they henceforth encountered with schizophrenic symptoms would be divided into the three types. Only those with an identifiable physical cause would be given medical treatment. Individuals belonging to the other two groups would be referred on to appropriately trained non-medical experts. There is already a wide range of experts who deal with problems associated with psychological, social and occupational dysfunctions.

¹⁰ Gwynneth Hemmings, ‘Calamitous Systems of Diagnosis For Schizophrenia’, Journal of Nutritional Medicine, Vol. 4, No. 2, 1994, pp. 251-259.

It is perhaps true that there are no existing professional services available to provide guidance for people undergoing a mystical crisis. However, if this is the case the reason might simply be a lack of demand caused by the current biomedically-dominated mental health system forcibly aborting all detectable mystical experience by imposing drug treatment on involuntary patients.

Perhaps one reason why psychiatrists continue to believe that people diagnosed with schizophrenia are a homogeneous class, despite the implausibility of this position, is due to the effect of neuroleptic drugs. Prescription of neuroleptic medication normally swiftly follows a diagnosis of schizophrenia. The effect of these drugs is to suppress the schizophrenic symptoms, for which the person was diagnosed, and supplant them with the relatively homogeneous symptoms of neuroleptic intoxication and neuroleptic-induced movement disorders. These drug-induced disorders not only provide the common denominators of pathology, which apparently help to reassure psychiatrists they are treating a discrete disease entity, but they also induce many of the bizarre forms of behaviour and mannerisms that convince relatives and friends that the person is indeed seriously mad. A person who enters into psychiatric care with only a psycho/mystical or social problem will soon develop serious medical problems once neuroleptic treatment has commenced.

This point brings us finally to the question of the human rights of people who are diagnosed and treated for schizophrenia: Do these diagnostic and treatment procedures violate basic human rights? The unequivocal answer is that they most certainly do. It is clear that members of the psychiatric profession are not properly trained to understand the underlying nature of either social/occupational problems or psycho/mystical problems. Medical treatment for these problems is simply inappropriate. When people accept medical treatment for these problems voluntarily it is likely that they do so without the appropriate level of informed consent. When treatment is forced on them against their will various basic human rights — like the freedom of thought and belief, the right to liberty and the right to protection against torture and cruel treatment — are violated.

The central human rights defence that is routinely mounted to support current psychiatric practices argues that people who are in the midst of a psychotic crisis are incapable of understanding their urgent need for treatment. The psychiatric logic is that, since they have a human right to be treated, the decision to treat has to be made for them. But this human right is an imperative to treat people with medical problems. If the underlying nature of the condition is not a medical problem then this human right does not apply. For instance, there is obviously no human rights imperative to treat a transparently non-medical problem like illiteracy with medication. To argue that there is would be quite bizarre. Yet this is the type of argument that is routinely mounted in defence of current psychiatric practices.

Even when a person's schizophrenic symptoms are caused by a physical problem, and the person therefore has a right to medical treatment, a diagnosis of schizophrenia, and neuroleptic drug

treatment, are clearly inappropriate. So even this class of people seem to have their human rights abused as well.

But these observations merely beg a question: If all the many millions of people in the world who have been diagnosed and treated for schizophrenia are victims of human rights abuse, why are the victims not complaining? The answer is that they do complain, but that few people hear them. In a powerful critique of the mental health system McCubbin and Cohen have detailed some of the reasons why this happens. They argue that a range of factors come into play including systematic power disadvantages, stigma, distress, and "treatment-induced intellectual and social dysfunctions".¹¹

But the essential problem is that it is almost impossible for victims to raise the issue of psychiatric abuse without expressing the social identity of being a 'schizophrenic'. And people who have been labelled as 'schizophrenics' are rarely taken seriously. Once a person has been diagnosed with mental illness by a medical expert there is little hope for them of publicly (or even privately) challenging that determination. Any attempted challenge of this kind is generally viewed as a laughable manifestation of the person's madness.

It is largely because of this lack of public credibility of people who have actually experienced schizophrenic symptoms that interest group activity remains disproportionately weighted in favour of the existing medical model. So long as this situation prevails it is likely the human rights violations, that are intrinsic to the current psychiatric diagnostic and treatment practices for schizophrenia, will go unrecognised.

¹¹ Michael McCubbin and David Cohen, 'Extremely Unbalanced: Interest Divergence and Power Disparities Between Clients and Psychiatry', International Journal of Law and Psychiatry, Vol. 19, No. 1, 1996, pp. 1-25.

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