THE MOVEMENT

WE'RE MAD AS HELL!
AND WE'RE NOT GOING TO
TAKE IT ANY MORE!

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by *Mel Starkman*

An important new movement is sweeping through the western world. The "mad", the oppressed, the ex-inmates of society's asylums are coming together and speaking for themselves. The map of the world is dotted with newly formed groups, struggling to identify themselves, define their struggle, and decide whether the "system" is reformable or whether they need to create an alternative community.

The great majority of groups in the Mental Patients' Liberation Movement (or Psychiatric Inmates' Liberation Movement) use self-help tactics, educating themselves and a fearful public in the tactics of confrontation and co-operation, and learning what is possible and what is not. So far, there has been only minimal co-ordination among groups, but in spite of this, different groups in different cultures have arrived at a virtual identity of purpose.

The roots of the problem faced by psychiatric inmates can be traced back to the fifteenth century, and the death of the Age of Faith, replaced by the Age of Reason. Until that time, "madness" was seen as an inexplicable, divine visitation, to be tolerated, pitied and sometimes even honoured. But with the growth of reason, it needed to be *explained*--and could not be. Madness and the madman stubbornly refused to yield to reason and to science; five hundred years later, they still have not yielded, and the efforts of our society to label, categorize and "treat" fruitlessly continue. Psychiatric inmates are victims, not of their "madness", but of these (no doubt well-intentioned) efforts to pigeonhole them and solve their problems in a "scientific" way.

The Mental Patients' Liberation Movement can trace its beginnings to several sources. Much of its emphasis on consciousness-raising derives from the feminist movement, particularly from that movement's realization of the folly of medical treatment for so-called "neurotic" symptoms. For example, in Canada in the 1890s a Dr. R.M. Bucke, Medical Superintendent of London Psychiatric Hospital, performed gynecological operations to relieve "hysterical" symptoms in women. He saw a close connection between gynecological deformities and psychiatric conditions, and he was far from alone in this belief. (Consider the meaning of "hysterical"--it derives from *hysteron*, the Greek word for "uterus".) In the sixties, women began to reject such treatment, seeing it as harmful, oppressive and sexist.

A second source was the movement among radical professionals in the early seventies, inspired by R.D. Laing among others. These professionals tried to interpret schizophrenia as an altered mode of consciousness rather than as a pathological condition. They developed critiques of society--Marxist, existentialist, and so on--that de-medicalized "mental illness". However, they still tended to invalidate the inmate experience, and approach the problem in ideological terms.

The Gay Liberation Movement also had its impact. For a long time, homosexuality had been considered to be a psychiatric illness, and the rebellion of gays against that definition did much to force people with other psychiatric labels to question the validity of the terms applied to them.

The idea of self-help, as practised in other settings, was a further stimulus. Until the middle of the nineteenth century, self-help was a common way of life. Individuals, small groups, and entire communities looked to their own resources, and constructed lifestyles to match those resources. (Even today, communities such as the Mennonites practise self-help in the old way.) But around 1850, a culture of professionalism de-

veloped. Teachers, lawyers and doctors began to be seen as experts; they developed mystifying languages which the average person could not understand. They became leaders of society, deferred to by everyone, and answerable only to each other. Their claims to "science" were not questioned by a population who did not know what they were talking about.

Since the clients could not understand what the professionals were doing, they were thrown back on faith; they still are. For example, a 1979 Position Paper of the Canadian Psychiatric Association states:

> *The essence and very existence of the healing professions depends on the element of trust in the relationship between the person (hereinafter referred to as "patient") requiring treatment and the professional consulted.*[1]

The faith, however, works only in one direction; professionals routinely ignore the perceptions of their clients. For example, consider the studies of psychologist Larry Squire on ECT. *Virtually every subject* reported memory loss; Dr. Squire states, nonetheless, that memory loss does not occur. Or consider psychiatrist Vivian Rakoff's review of Blue Jolts (a compelling collection of inmate experiences, also reviewed in Phoenix Rising, *vol. 2, no. 1)*:

> *We require more sobering examination of our errors and at this stage something more helpful is needed in our approach to the sick than the notion that "sanity is a trick of agreement".*
>
> *The book's only effect may be to alarm some people who could benefit from our imperfect services.*[2]

Attitudes such as Dr. Rakoff's explain why the Ninth Annual International Conference on Human Rights and Psychiatric Oppression expressed itself as it did in its press release:

> *We demand ... an end to a way of thinking which calls our anger "psychosis", our joy "mania", our fear "paranoia", and our grief "depression".*

In other fields, people began to take power back from the professionals. Credit unions, run by members, took control of money away from bankers. Tenants' associations sprang up, as did organizations of people on public assistance, and of other groups persuaded that the "professionals" did not always know what was best. Vietnam protesters took war out of the hands of professional soldiers. Antinuclear protesters stated loudly that the scientists were not always right. And this philosophy affected the infant psychiatric inmates' liberation movement; in fact, many of its founders came from these other groups.

The last source was the Mental Hygiene Movement, started in North America in the thirties by Clifford Beers. The movement took upon itself the task of speaking for "patients", but eventually became an institutionalized structure, trying to educate people to adjust to our society. Beers, himself considered to be "manic depressive", refused to work with self-help pioneers, possibly, according to his biographer, because he wanted to maintain his own position as the "advocate of the insane."[4]

Workbook

Beginnings

The radical therapists made their move at the beginning of the seventies. Their perspective is illustrated by a quotation from a 1973 issue of *Rough Times* (originally titled *Radical Therapist*):

> *Psychological oppression is a pervasive aspect of modern capitalism. The choices of bourgeois existence are madness, total apathy and conformity.*[5]

At about this time, interaction began between the radical therapists and ex-inmates. Active collaboration lasted until the mid-seventies, when the ex-inmates came to feel that their own experience was being invalidated by these therapists as much as by the more conservative professionals. The uneasy marriage fell apart. Its demise was hastened by the new fad of middle-class people seeing psychiatrists for "life enhancement" and "personal growth", and

by the springing up of trendy therapies such as EST and primal therapy. At the same time, cult groups such as Scientology, who criticized psychiatry in the hope of supplanting it with their own quasi-religion, were causing ex-inmates to wonder if perhaps their so-called enemies--the psychiatrists--were less harmful than their so-called friends.

One of the earliest spokespersons for the Mental Patients' Liberation Movement, and still an activist in that movement, was Judi Chamberlin. Her book, On Our Own: Patient-Controlled Alternatives to the Mental Health System, is based on her own experience. In her introduction she sums up the concerns of the movement:

> *For too long, mental patients have been faceless, voiceless people. We have been thought of, at worst, as subhuman monsters, or, at best, as pathetic cripples, who might be able to hold down menial jobs and eke out meager existences, given constant professional support. Not only have others thought of us in this stereotyped way, we have believed it of ourselves. It is only in this decade, with the emergence and growth of the mental patients' liberation movement, that we ex-patients have begun to shake off this distorted image and to see ourselves for what we are--a diverse group of people, with strengths and weaknesses, abilities and needs, and ideas of our own. Our ideas about our "care" and "treatment" at the hands of psychiatry, about the nature of "mental illness", and about new and better ways to deal with (and truly to help) people undergoing emotional crises differ drastically from those of mental health professionals.*[6]

Europe

The Mental Patients' Liberation Movement sprang up at roughly the same time in Europe and North America. One of the earlier European groups was a Dutch group, Clientenbond in de Weizijnzorg. Clientenbond is now providing alternative options of care (not "treatment") and adjustment to society, and advocating strongly on behalf of inmates and ex-inmates. Their areas of effort are wide, and have created something close to an alternative community within a society they see as unredeemable. As well as providing direct services of a support and educational nature, Clientenbond is applying grass-roots pressure to the whole society, trying to change policies and attitudes. In particular,

> *they are trying to change traditional attitudes and opinions held by psychiatrists, psychologists and social workers--attitudes which Clientenbond members believe impede the course of treatment for many members.*[7]

Clientenbond is only one example of a thriving European movement, which includes groups in England, France, Italy, Belgium, West Germany, Great Britain and other countries. The British groups are loosely organized in the Federation of Mental Patients Unions, which is organized mainly around the issue of inmates' rights. The entire continent is involved in the European Network for Alternatives to Psychiatry, founded in Brussels in 1974. The network functions primarily as an information exchange, and involves ex-inmates, radical professionals, and lawyers working in the field.

North America

Clientenbond and other European organizations tend to be national in nature. In Canada and the United States, probably because of the much greater size of the countries, regional activity is more common; groups tend to exist on a local, state or provincial basis. As well, North America has developed, along with organized groups, individual charismatic personalities operating on their own with a small group of devoted followers. The effectiveness of these individuals (such as Toronto's Pat Capponi) is mixed; they are very effective at commanding media attention, but often represent a highly individualized perspective rather than a democratically arrived at collective viewpoint.

In Canada, and to some extent in the United States, the Mental Patients' Liberation Movement has developed ties with other self-help groups (such as Toronto's BOOST--Blind Organization of Ontario with Self-Help Tactics--or Boston's Disabled People's Liberation Front). These organizations share a common goal: to demonstrate that exist-

ing power structures must adjust to the realities of "consumers'" rights to make decisions about programs and structures that directly affect their lives. The strength of such coalitions has been dramatically demonstrated; for example, the Ontario Coalition on Human Rights for the Handicapped has profoundly affected the scope of human rights legislation in Ontario through the co-operation of the mentally, physically and emotionally handicapped.

The Mental Patients' Liberation Movement in North America has passed through a number of phases. The first was that of working with radical therapists, who were virtually the only people providing a perspective different to that advanced by the main body of psychiatrists.

THOMAS S. SZASZ — Ward Roberts

However, as already mentioned, this was an uneasy alliance, and many inmates and former inmates moved on to the second phase--withdrawal into self-directed groups. They practised self-education and total democracy, in an effort to avoid the kind of hierarchy of power that they had experienced as inmates. There was an almost total lack of structure, and an emphasis on collective decision-making and action. Priorities at this stage were consciousness-raising and politicization. At the same time, many groups were attempting to provide the kind of support to people that was lacking within the psychiatric system. Experiments were launched in alternative housing, alternative crisis assistance, and alternative social support. Houses were rented, storefronts were opened, and rights issues were addressed.

Much of the North American movement is still--through necessity or choice--in this second stage. The third phase began when some groups began to attract substantial funding. The groups getting grants went, in some respects, in different directions from the grantless. Total democracy and lack of structure came up against the hard reality of managing sizeable amounts of money. Funded groups were, on the one hand, in a better position to address such concerns as housing and employment and, on the other hand, less inclined to be purely political in nature, and to make a priority of radical protest against the psychiatric establishment.

Consequently, certain issues arose within the movement. Was it possible to collaborate in some efforts with professionals and established voluntary agencies, or would the movement of necessity continue to be isolated and totally anti-professional? These questions have not yet received a decisive answer.

As an illustration of the development of the Mental Patients' Liberation Movement, it may be helpful to look at the development of movement groups in several North American cities.

New York

In 1948, a group of people in New York started WANA (We Are Not Alone). It was formed by inmates of Rockland State Hospital. Volunteers in the community found the group a place to meet, but in the process "transformed the group from a self-help project to a new kind of psychiatric facility."[8] Professionals were hired, and by the early fifties "most of the original founding group of ex-patients quit in disgust."[9] WANA became Fountain House. One of WANA's members commented on the change:

> *There was a feeling of solidarity and companionship in WANA that deteriorated when the professionals got involved. For awhile, the ex-patients continued to run the club. We raised our own money [by holding bazaars, for example], and we voted in new members. But eventually the administrators decided to take that power*

> *away from us. Instead of the members deciding who could join, when new people came in they were interviewed by the staff, who decided if they were "suitable cases." WANA was unique because patients ran it--that was abolished when it became Fountain House.*[10]

Soon afterward, a group of New York ex-inmates formed Mental Patients' Liberation Project (MPLP). A storefront was opened on West 4th Street, "a really funky neighborhood".[11] By the mid-seventies the storefront had disappeared. However, before MPLP died it issued a Manifesto of Mental Patients' Rights, one of the first in existence. Another, more radical, group also formed, calling itself the Mental Patients' Political Action Committee. This group attended a conference on lobotomy, and also disrupted an orthopsychiatric conference.

When Project Release appeared on the scene, it was an example of what Judi Chamberlin calls the separatist model--a real rather than a false alternative to the discredited "mental health" system -- run totally by ex-psychiatric inmates. Project Release sees itself, not as providing services, but rather as a supportive community.

> *It is an important distinction, because the concept of a service implies the existence of two roles, the server and the served. No matter how much a group may attempt to break down such roles, some residue of them always remains when a group is delivering "services." The concept of community, on the other hand, implies interaction ... .*
> *The separatist model is by far the most radical of alternative services, but it is also the model that promotes the greatest degree of ex-patient confidence and competence.*[12]

Project Release was formed around the issue of single-room occupancy hotels in Manhattan's Upper West Side. Many ex-inmates and others on welfare were housed "in totally inadequate and unsafe conditions."[13] At first, Project Release got office space from a tenants' organizing committee; later it got a room in a neighbourhood Universalist Church. Its activities spread to publishing A Consumer's Guide to Psychiatric Medication and working on a patients' rights manual.

In late 1976, Project Release obtained a $10,000 foundation grant, with which they rented an apartment and opened a community centre. The centre is busy from late in the morning until late in the evening, seven days a week, with a communal meal in the evening. No one is designated as "staff". Passive participation is discouraged, and each member is required to serve on one or more of the committees responsible for activity areas. As Project Release's Statement of Purpose says:

> *Professional supervision creates a dependency pattern which is a cause of recidivism. In the informal programs of Project Release, members seek to extend acceptance and co-operation, letting each individual set his/her own pace in tasks and responsibilities. Project Release feels that this form of self-help is a strong antidote to the anxiety of isolation and helplessness induced by society and psychiatry.*[14]

Project Release avoids structuring as much as possible, "preferring occasional confusion to impersonal efficiency."[15] Staff/client relationships are nonexistent. No one receives a salary. Rather, the concept is one of community, of people caring about people and helping each other.

Today Project Release has a mailing list of over 2,000, and all the social service agencies in New York call on the group for representation on "mental health" questions.

Suzanne Dahlquist

drawing from "In Woman's Soul" 1972 Peace Calendar

Kansas

The Kansas City story really begins in New Haven, Connecticut. In 1968, Sue Budd had helped start a social club on a psychiatric ward. The club was very anti-psychiatry in tone. There was some help from professionals at first, but basically Sue ran the club. Sue's husband, Dennis, tells it this way:

> *[The social club] was loosely supervised by a social worker, who saw Sue and me every week. And Sue ran the club. It was most successful. It had a membership of ten to twelve. We shunned the help from the mental health association that was offered to us. A lot of people who were sent to our club were dismissed as hopeless by the staff. A lot of them improved while they were with us.*
>
> *Then Sue's boss moved to Kansas City and we decided to move with her. After she left, the Connecticut Mental Health Association laid down some rules and regulations for structuring such social clubs. Among these rules and regulations was a stipulation that no current or former mental patient should be a director of the club, because it was a hindrance to their returning to normal society. Sue attempted from long distance to fight this, but there was no way, and the club was too weak and it died. Sue was in a rage, a total rage, over this, and that was what provoked her to get politically involved.*[16]

Meanwhile, in 1972, a group of students and faculty at Kansas University's School of Social Work formed the Kansas Council for Institutional Reform, in response to the commitment of a white student by her mother because she had been dating a black man. She was released after an organized legal effort. The Council started a monitoring process, and produced a model commitment law which was introduced into the legislature in the spring of 1973.

Sue and Dennis started a Kansas chapter of a group which had been active in Connecticut--the Medical Committee for Human Rights. It produced a Mental Health Task Force, which lasted two years. The task force became involved with a group of ex-inmate nursing and boarding home residents, and undertook what was called a Resocialization Project. Although the project was formed to resocialize the residents, it ended up empowering them by raising their consciousness of their oppression.

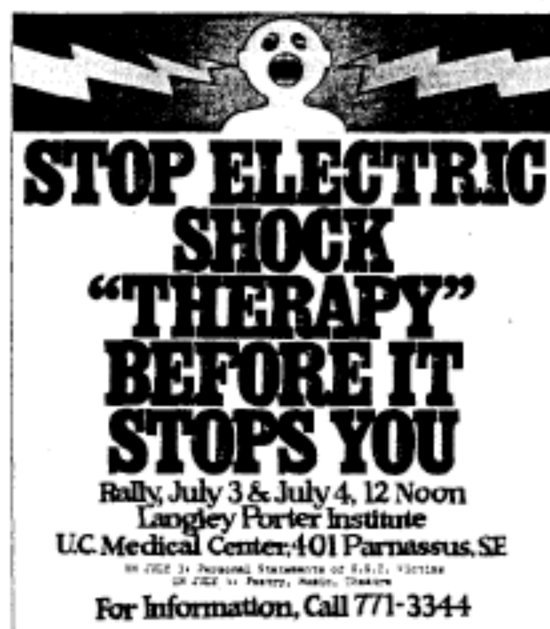
One of the residents was informed that the operator of one of the homes had been confiscating residents' support cheques. Protesters and reporters from the local TV station sneaked into the home and exposed the conditions; the house was shut down as a consequence. But shortly afterward funding for the Resocialization Project was cut off. Ironically, Dennis says, this happened one day after the project had been nominated for an award by the director of the local community mental health centre.

These events caused a fight between the radical professionals and the ex-inmates in the Medical Committee for Human Rights. The radical professionals won, and a number of the ex-inmates split away from the Committee. These ex-inmates were approached by the university group, the Kansas Council for Institutional Reform, and joined forces with them; the name was later changed to Advocates for Freedom in Mental Health.

California

Events in California began with the founding of *Madness Network News*, which began as a newsletter and developed into the main publication of the movement in the United States. Some of the staff founded NAPA (Network Against Psychiatric Assault) as a political arm of the paper, and gradually the two groups became separate.

The first meeting of NAPA in 1974 was attended by more than 250 people, in spite of a city-wide bus strike. It got underway with a vengeance. Several committees were struck and went into action, including a Drug Action Committee, which in less than a month was confronting the American Orthopsychiatric Association. Immediately afterward, NAPA held a public forum to present an anti-psychiatry play. The Legal Action Committee began working with a senator and an assemblyman to introduce legal amendments providing for the right to refuse chemotherapy, shock treatment and psychosurgery. An anti-shock campaign got underway, along with a wide-ranging variety of seminars. NAPA, through Howie the Harp, organized a Coalition of Social Support Income Recipients.



By 1976, NAPA had also moved into attacking "slave labour"[17] in hospitals, and was helping organize courses in alternative perspectives on psychiatry. By 1979, NAPA was part of the Coalition Against Forced Treatment.

At the same time, California filmmaker Richard Cohen produced "Hurry Tomorrow", a powerful documentary about conditions on a so-called "progressive" psychiatric ward at Norfolk State Hospital.

More recently on the California scene is BACAP (Bay Area Coalition for Alternatives to Psychiatry), bringing together NAPA and other California groups.

Annual conferences

As groups sprang up around the United States and began to find one another, they looked for ways to get together, share information, and support one another. The result was the First National Conference on Human Rights and Psychiatric Oppression, held in Detroit in 1973. (The name has since been changed twice--first to "North American Conference" and then to "International Conference"--to reflect widening geographic participation.)

At that first conference, some important things happened. Resistance developed among the ex-inmate participants to the idea of a structure being advanced by professional attendees, and the resulting dynamics produced a very unstructured, free-floating conference; the pattern has largely held ever since. There were no plans made to hold a second conference, but during the intervening year a Kansas group (Advocates for Freedom in Mental Health) and a New York group (Mental Patients' Liberation Project) decided to organize one in Topeka, which advertised itself as "Psychiatric Capital of the World".

The Topeka Conference began the tradition of organizing a demonstration as part of each conference, as well as continuing the idea of lack of pre-planned structure. Movement veterans tend to remember Topeka as a high point in the organization of the movement, as a "beautiful"[18] conference.

In 1975, the conference moved to San Francisco and a much more structured format. Reactions were so strong that the conference formulated an exclusionary rule to keep out professionals, who had been largely responsible for the structuring.

The 1976 Boston Conference was therefore totally unattended by professionals. This was the conference that produced the movement's first and only Position Paper--the first unified statement by the American movement as a whole, which emphatically condemned commitment and forced treatment. The conference also decided to relax the exclusionary rule, allowing professionals to attend the second half of the next conference.

Consequently the 1977 conference,

in Los Angeles, was split into two with ex-inmates only for the first half and professionals included in the second half. Again the experience was considered unsatisfactory, and the rule was altered to once again exclude professionals, unless they were sponsored by a legitimate anti-psychiatry group. The rule has been basically unchanged since then.

The 1978 Conference in Philadelphia, 1979 in Florida, 1980 in San Francisco (see Phoenix Rising, *vol. 1, no. 2*), and 1981 in Cleveland (see elsewhere in this issue) have continued to serve as a unifying force, not only to the North American movement, but to groups around the world. The participation of groups outside this continent is still limited, unfortunately, by the cost of crossing the ocean, but at least a little European representation happens, and there are hopes for the future.

Next year, the conference will be held in Toronto, Canada--physically not far from the United States, but symbolically a large step. It heralds even more progress toward a truly international movement.

Footnotes

[1] "Consent in Psychiatry: The Position of the Canadian Psychiatric Association," approved September 1979. *Canadian Journal of Psychiatry* 25:1 (Feb. 1980), p. 78.

[2] *Canadian Journal of Psychiatry* 24:5 (Aug. 1979), p. 494. Dr. Rakoff is Chairman of the Department of Psychiatry, director, and psychiatrist-in-chief of the Clarke Institute in Toronto.

[3] August 31, 1981.

[4] Norman Dain, Clifford W. Beers: Advocate for the Insane. Toronto: University of Toronto Press, 1980, p. 304.

[5] The Rough Times Staff. Rough Times. New York: Ballantyne Books, 1973, p. vii.

[6] New York: McGraw-Hill, 1978, p. xi.

[7] Andrew W. Hepburn and Anton F. DeMan. "Patient Rights and the Dutch Clientenbond," in *Canada's Mental Health* (Sept. 1980), p. 17.

[8] Jordan Hess. Quoted in Judi Chamberlin, On Our Own: Patient-Controlled Alternatives to the Mental Health System. New York: McGraw-Hill, 1978, p. 87.

[9] *Ibid.*

[10] *Ibid.*, p. 88.

[11] Allan Markman, in workshop on Movement History at Ninth Annual Conference on Human Rights and Psychiatric Oppression, August 29, 1981.

[12] Chamberlin, *op. cit.*, p. 95.

[13] *Ibid.*

[14] Quoted in Chamberlin, *op. cit.*, p. 96.

[15] Chamberlin, *op. cit.*, p. 97.

[16] Dennis Budd, in workshop on Movement History at Ninth Annual Conference on Human Rights and Psychiatric Oppression, August 29, 1981.

[17] *Madness Network News* 3:6 (June 1976), p. 7.

[18] Dennis Budd, in workshop on Movement History at Ninth Annual Conference on Human Rights and Psychiatric Oppression, August 29, 1981.