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Psychiatry and Anti-Psychiatry in the United States

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The growth of anti-psychiatric ideas and activism in the United States during the past thirty years is only the most recent and most extensive upsurge of religious and secular viewpoints largely formulated in the late nineteenth century and played out in different forms thereafter. The nature of anti-psychiatry and its periodic resurgence and decline is the subject of this essay.

Just as there is no widely accepted definition of mental illness and therefore of psychiatry so there is no commonly accepted definition of anti-psychiatry. Anti-psychiatry is an amorphous concept that has never had any fixed meaning. It has changed over time and in connection with religious, legal, political, and social concerns as well as changes in psychiatry and the mental hospital, psychiatry's major venue before the mid-twentieth century. Nor has there ever existed a real anti-psychiatry movement, disagreements among opponents of psychiatry having precluded an attempt to create organized activism with a coherent outlook and recognized leaders. Virtually the only common characteristic exhibited by those one might call anti-psychiatry has been hostility to psychiatry, the medical specialty dealing with mental disorders. (For convenience the terms *psychiatry* and *psychiatrist* will be used for the entire period, from the beginning of the speciality in the eighteenth century to our own time, although the terms first came into use during the late decades of the nineteenth century.) Anti-psychiatry can therefore be defined only as sets of attitudes, opinions, and activities antagonistic to psychiatry, ranging from sharp, serious criticism of psychiatry to absolute denial of its validity and questioning of the concept of mental disorder as a medical entity.

The distinction between anti-psychiatry and criticism of psychiatry is often a distinction without a difference, but anti-psychiatry advocates characteristically differ from critics in their more hostile attitude toward psychiatry. Therefore, although the term *anti-psychiatry* is imprecise and often more confusing than revealing, it remains at present the best term available, for it catches the emotional quality evident among opponents of psychiatry, who were not necessarily skilled logicians, philosophers, or scientists, and whose arguments contained contradictions. The arguments were, however, not thereby pointless or ineffective.

Anti-psychiatry can perhaps best be understood as a variety of groups and individ-

uals who believed that psychiatry was either a vehicle for or an obstacle to attaining certain goals that they valued, goals that often went beyond concern about the plight of mental patients or the faults of psychiatry. Much anti-psychiatry has been primarily interested in the power and influence wielded by the psychiatric profession, not only over the mentally ill but over society as a whole. Opposition to psychiatry has often been part of a larger agenda in which mental patients are of incidental concern.

Both psychiatry and its antithesis, anti-psychiatry, have also been much affected by the singular nature of mental illness as a supposed disorder of the mind, whose "loss" has been seen as a catastrophe, a descent into a nonhuman, even damnable state that can, in its violent or anti-social forms, threaten society. Psychiatry could gain sympathy for the "insane" and status for itself by claiming to restore sick minds, but it could also not help being stigmatized by the common horror and fear of insanity and of institutionalization. And certain of the religious could not help seeing psychiatry as competing with priestly ministration to the insane. Furthermore, psychiatry, concerned as it was with "unhealthy" or pathological human behavior, thought, and feeling, took on to itself a certain authority about what constituted correct—or healthy—behavior, thought, and feeling. Such authority, secular and often nonjudgmental, moved beyond the mental hospital to virtually every aspect of living; as such it could be seen as threatening traditional morality and encroaching upon the realms of religion, law, and social life. Psychiatry dealt with the mind, whose essential nature was a matter of philosophical and religious dispute and whose relation to the body was not scientifically established. Hence psychiatry would be subject to scrutiny—and self-doubt—deeper and sharper than that experienced by other, more unequivocally somatic medical specialties, especially when it failed to make the scientific and therapeutic progress exhibited by those specialties. Psychiatry had many vulnerabilities; anti-psychiatry played upon them and off them.

The so-called mental illnesses have a long history but only relatively recently have physicians played a prominent role in the care and treatment of the mentally ill. In the late eighteenth and early nineteenth centuries Western European and North American physicians first sought to monopolize the care of the insane, through superintending the new asylums built to succor and control them. But in the United States by this time, even before the formal organization of the American psychiatric profession in 1844 into the American Association of Medical Superintendents of Asylums for the Insane (predecessor of the American Psychiatric Association), there was already criticism of the medical profession's role in treating and caring for those called insane, especially among clergymen, jurists, and former mental patients.

For the religious the problem of insanity was of long standing. The tendency of medicine to naturalism had long bedeviled Christian thinkers, most of whom nevertheless made a legitimate place for physicians in the treatment of bodily ills. Insanity or madness, however, was more problematical than the so-called physical illnesses. In traditional Christian thought the mind was closely associated with the soul and assumed to be, like the soul, immortal and impervious to disease. If, on the other hand, insanity was a physical disorder of the brain, as eighteenth-century physicians usually insisted, and the mind simply the brain functioning, as some materialists maintained, then the brain, the mind, and the soul as well were subject to disease and death; therefore the Christian concept of the immortal soul was invalid. Christian religion was hence thought

by some theologians to be endangered by the materialism of the developing profession of psychiatry.[1]

For Christians only a miracle could bridge the gap between brain and mind, or soul. But in practical terms Christianity allowed medicine a role in the treatment of insanity by attributing insanity, like illness in general, to punishment for sin for which the sufferers might win God's forgiveness through confession and prayer; only then would medical treatment prove effective. But if the devil or his minions were thought to have invaded an individual, medical ministrations were disallowed. Possession, even if its symptoms resembled or resulted in madness, was a problem for the Church: Its ministry, not physicians, would ultimately decide the nature and disposition of the case. Apparently madness as punishment for sin differed from demonic possession in that in the former case God directly imposed madness while in the latter he gave the devil permission to send evil spirits to possess the sinner. In the first case one sought God's forgiveness after which medicine might be effective. In the latter case religious healers called upon Christ to counteract or expel the devil or his minions as if the cause of the disorder was primarily the devil's independent action; medicine was here inappropriate and ineffective, a view West European and American physicians increasingly contested from the eighteenth century onward.

In practice, mainstream conservative Calvinist ministers such as the eminent Cotton Mather or Jonathan Edwards in seventeenth- and eighteenth-century New England had an ambivalent attitude toward the physician's role in the treatment of insanity. Although in theory sin was commonly considered the cause of insanity, sympathetic individuals who became insane, especially among the clergy, were in Mather's and Edwards's view freed of guilt for their disorder. Mather wondered whether his wife's madness might be caused, if not by sin, by heredity. Edwards saw a charitable clergyman ministering to Native Americans as being attacked by the devil for his good works albeit the clergyman was often melancholic and thereby vulnerable to the evil one, and, one might add, not wholly free from responsibility for his eventual madness because melancholia was often thought to be the consequence of sin.[2] This equivocal position that illness resulted from sin but that nevertheless one might not be condemnable opened the gates for the use of medicine but still allowed some of the religious to denounce the use of medicine as irreligious. At the same time, both Mather and Edwards were attracted to Newtonian science, and near the end of his life Mather wrote a manuscript, "The Angel of Bethesda," in which he gave medicine a major role in the treatment of insanity.[3]

The late seventeenth-century trend among the British upper classes to deprecate religious enthusiasm as dangerous to public order was observable in North America as well. Especially important was the reaction to the Salem witchcraft trials, which contributed toward putting in doubt supernatural explanations for all sorts of phenomena, including insanity. By the mid-eighteenth century medical views of mental disorders, increasingly influential in Britain, won widespread support among the upper classes in several of the North American colonies. The association among the religious of illness with sin as evidence for the existence of the devil and therefore of God was successfully challenged or at least bypassed by an assertive medical profession, some of whose members were now specializing in the study and treatment of insanity.

Most of the mainstream religious leaders about whom we have information accommodated to the new psychiatry, though not always without conflict or cost. This accommodation represented a growing loss of authority over not only the insane but, more

importantly, over the interpretation of human nature and the nature of sin and crime, and over modes of rearing and educating children. The secularization of American life strengthened medicine and weakened religious authority, to the point where some psychiatrists in the late eighteenth and early nineteenth centuries were sufficiently sure of themselves to criticize the evangelical preachers whose revival meetings periodically swept the Northeast. Their hellfire sermons, the physicians charged, terrorized people and drove some of them mad. The revivalist leadership denied the charge and insisted that religion and especially revivals protected most persons' mental health, but that in any event the saving of souls was more important than saving mental health. The revivalists viewed secular medical values as secondary; health was not the primary concern of religion nor should it be of society. In effect, revivalists, and indeed most Christian (Protestant) churches before the Civil War, had largely surrendered their healing role to medicine, animal magnetism, and a host of popular nostrums.[4] Increasingly, physicians no longer needed to appeal to the great physician Christ as a precondition for success. Perhaps equally significant, but little noticed, was the admission of revivalist leaders, such as Jonathan Edwards and his nineteenth-century successor Charles Grandison Finney, that saving one's soul might in rare cases endanger one's mental health. The breach between religion's role of saving souls and that of curing human ills meant that a growing medical profession could step in.

Although revivalists continued to preach about damnation for sins, psychiatrists could and sometimes did exclude such preachers from mental hospitals because their sermons terrified patients and undermined physicians' authority. Nevertheless, explicit anti-psychiatry was not a theme in the revivalist movement nor in most established religions; indeed, Quakers played a major role in initiating private mental hospitals. Many clergymen saw psychiatry as a humanitarian movement; they were also intimidated by the successful developments in science and believed, as did Finney, that there was no inherent conflict between science and religion. In contrast to the turmoil in medicine that threatened the authority of the general practitioner in the first half of the nineteenth century, the new profession of psychiatry enjoyed much public prestige. The new mental hospitals, both private and state sponsored, which increasingly came under the direction of medical superintendents, reflected acceptance by laypeople of the importance of establishing asylums to cure madness and to protect society from the insane and the insane from themselves. These institutions advocated and some actually practiced a new, hopeful form of therapy called moral treatment that sought to create a therapeutic, familial environment in which the insane, considered sick rather than sinful, would be treated as much like sane people as possible. Elite religious and secular groups alike initially considered moral treatment highly successful and worthy of public support.

There were condemnations of psychiatry as anti-religious, as materialist, and as a threat to morality, but such charges did not win widespread support until after the Civil War, and then more among nonestablishment churchgoers and ministries than the old, mainstream religions. Anti-psychiatry views gained coherence and energy when new churches were founded with the express purpose of replacing secular medicine with religiously oriented therapy. Such challenges coincided with psychiatry's loss of optimism. By the closing decades of the nineteenth century, mental hospitals, especially the crowded, underfunded state institutions, had become less therapeutic than custodial; moral treatment had not proved to be a panacea, especially for chronic patients, and

anyway it was too expensive for state hospitals to maintain; and medicine and psychiatry, influenced by the new science, were becoming more materialist and deterministic.

In part in reaction to the growing influence of science and secularism in American society and to the mainstream churches' accommodation to the new trends, new Christian religions commonly known as the Metaphysical movement arose and gathered force in the late nineteenth century.[5] This occurred at the same time that spiritualism, which sought to create a science dealing with nonmaterial phenomena, was still popular. The Metaphysical movement was, and remains, not an isolated phenomenon but very much in tune with all sorts of popular religious and spiritualist movements that did not necessarily consider themselves anti-medical or anti-science but that dwelled on the so-called nonmaterial aspects of life and tended to be anti-establishment.

The Metaphysical movement differed from most Christian denominations in that, in effect, its adherents believed that the millennium was not to be found in some distant future but had always existed as a creation of God's mind. It offered people everlasting life free of disease if they only accepted and practiced its teachings. Where other Christian religions held medicine in awe and could not but praise or at least respect its efforts on behalf of suffering humanity even while physicians deprecated Christian biblical teachings about miraculous cures, the members of the Metaphysical movement took a definite stand denying the validity of medicine. Of course, even Christians who did not dispute the reality of the material world accepted a higher nonmaterial power: God could work outside the material laws of nature. Philosophically, Christians generally believed that the world was a product of God's thought, as Christian Scientists and other members of the Metaphysical movement claimed. Where they differed was in the Metaphysicalists' belief that human beings could create reality as God did, by thought.

Most visible and authoritarian in organization among the new healing churches was Christian Science, whose founder, Mary Baker Eddy, denied the independent reality of the material world, which, she insisted, was the product of thought. The illnesses that medicine described and treated were of its own creation. Only thought, which created the world, could eliminate illness and death. Eddy's religion aimed to replace traditional medicine with healers who would educate people in right thinking and thus free humankind of disease, suffering, and death.[6] Obviously there was no place for psychiatry and mental hospitals in Christian Science. In fact, however, the matter was not so simple. Eddy believed in malicious animal magnetism, which she greatly feared personally—the idea that one could create an illness or even commit murder by projecting harmful thoughts. This was a conclusion one could draw from Metaphysical religions that stressed mind over matter. Eddy gathered together a number of her supporters, who would, by thought, ward off the evil thoughts of her enemies, that is, those who did not agree with her and whom she feared contested her authority. The power and safety that Eddy and fellow members of the Metaphysical movement believed their religions provided had a dark—and nontherapeutic or anti-therapeutic—side not obvious to most of their supporters or detractors. Furthermore, mind did not always prove itself the master of matter; Christian Scientists and members of the Metaphysical movement did become ill, and some remained immune to Metaphysical healing.

Significant though it was, Christian Science and, for that matter, the Metaphysical movement as a whole did not have as devastating an impact upon psychiatry as the profession feared it might. Even though psychiatrists eventually turned pessimistic about their ability to cure insanity, mental hospitals provided the only extensive system

of care and custody for the mentally ill. Discrediting psychiatry's therapeutic effectiveness still left society without an acceptable alternative means of dealing with the insane, whose numbers would increase as the population grew. The movement to build more hospitals to transfer the insane from jails, almshouses, and the community continued. Neither Christian Science nor any other religious movement, with very rare exceptions like the Society of Friends, made provision for those whom they treated but who nevertheless did not recover.

The failures of religious therapy more often than not made their way into public mental hospitals, jails, or the streets and countryside. As long as this situation prevailed, psychiatry had a role to play that provided it with protection from all manner of criticism and rejection. What in part "saved" psychiatry as a medical discipline was its practitioners' insistence that effective treatment and the safety, economy, and convenience of society required confinement of the insane in a mental hospital directed by psychiatrists. Psychiatry offered a way to deal with a real social, economic, and personal problem. Furthermore, the new mind cure sects, although they attracted masses of people, tended in the nineteenth century and through most of the twentieth to be marginal, out of the religious mainstream, and not very powerful in the major institutions of American society. And not all the new Christian movements devoted to mental healing were anti-psychiatry. The Emmanuel movement of the early twentieth century sought the support of the psychiatric profession and adopted a policy of sending those they considered psychotic to psychiatrists for treatment.

Psychiatrists themselves were inconsistent in their approach to conditions treated by the religious mind cure practitioners. For example, psychiatrists derisively called persons who had allegedly been cured by the lay healers "hysterics" and termed them not truly mentally ill. Their "cure," psychiatrists asserted, was merely consequent to the mental influence of popular or charismatic healers; the truly mentally ill who supposedly suffered from a physical disorder would not respond, except temporarily, to such methods. But when medical men—psychiatrists and the practitioners of the new medical specialty of neurology—did turn their attention to such patients their symptoms were legitimated. The leading American neurologist Weir Mitchell dubbed their affliction *neurasthenia* and subjected neurasthenics to his famous rest cure; Charcot hypnotized them; Freud renamed them neurotics. Once psychiatrists started to treat hysteria, they came to consider it a true mental illness, not just a symptom of the normal state of many weak-willed women.

Even the claim, so derided by psychiatrists, of Eddy and her Metaphysical opponent W. F. Evans that medical means were unnecessary and harmful[7] was in the twentieth century repeated by American psychoanalysts, some of whom preached a secular mind cure. The psychiatric profession had long been conflicted or at least ambivalent in its views about the etiology and proper therapy for the mentally ill and united only in opposition to competitors. Much of anti-psychiatry involved interpreting negatively or from a different perspective ideas and practices that were in dispute or even accepted within psychiatry. The key difference was that the religious view was based on a largely Christian view of humankind: Etiology and cure were ultimately supernatural and in the final analysis not under the unaided control of human beings. Yet a century later an undoubted materialist such as psychiatrist Thomas Szasz, who rejected almost all the assumptions and premises of Christian Scientists and the Metaphysical movement, came to comparable conclusions respecting psychiatry: that mental illness is largely a

product of the psychiatric profession's self-interest, that there is really little or no valid role for institutional psychiatry, that psychiatry and mental hospitals are the problem not the solution, and that a change in the public's views on the subject would largely eliminate the so-called problem of insanity. How to account for the similarities? Psychiatry could not establish the etiology of most forms of mental disorder, and psychiatrists could not agree on a unified theory of brain and mind. Consequently, whether opponents started from an immaterialist, dualist, or materialist point of view, they could dismiss the idea of mind as a functioning brain, with no independent existence, and hence deny to psychiatry an unequivocal role as a medical specialty treating what was basically brain pathology.

Psychiatry itself had trouble with this concept of mind-brain unity. The diversity of opinion within the psychiatric profession over the role of medicine as opposed to psychological and social factors in etiology and therapy raised many of the issues dealt with by the religious. From the late eighteenth century to the decline of moral treatment after the Civil War, psychiatrists were ambivalent about the value or relevance of psychiatry as a medical specialty. The initial introduction of moral treatment in England, a system of care that the Society of Friends in Frankford, Pennsylvania (now in Philadelphia) advocated early in the nineteenth century, stressed religious, social, and psychological factors to the neglect and even exclusion of medicine. The psychiatrists who soon came to dominate the new asylums established on principles of moral treatment denied the validity and value of evangelical preaching, in part because of its emotionalism, but were themselves practitioners of a therapy that emphasized moral suasion, that is, they relied largely on the positive effects of emotion and a favorable psychological as well as physical environment. Even the often strict somaticists of a succeeding generation of psychiatrists appealed to patients' emotions through the use of restraint, punishment, and rewards, which were considered essential in disciplining patients and therefore to restoring their sanity. What then separated the emotionalism of revivalism and that of psychiatry? Revivalism gave free rein to open expression of strong emotions and to such extraordinary behavior as swooning, barking, ranting, and the like, in the service of religious conversion. Psychiatrists tried to train patients consciously to subdue, even repress, but above all control emotional expression in the service of mental soundness: Unbridled emotionalism led to illness, self-control, to health.

Dr. Samuel Woodward, for example, the first medical director of the Worcester State Hospital in Massachusetts, established in 1833, considered moral treatment useful but insisted on the necessity for medical therapy since he regarded insanity as a somatic disorder. By the 1840s, however, other medical superintendents accepted moral treatment as the best therapy and deprecated the value of medication. But how then to justify psychiatry as a medical discipline? Where was the somatic disorder that medicine alone was supposedly capable of treating? This was a special problem, since pathological studies in the 1840s failed to reveal a consistent pathology in the brains of those who died while insane.

A compromise was reached that psychiatrists generally found palatable. Before insanity became firmly established in a patient, that is, before somatic pathology took hold and while the disorder was presumably only functional in nature, practices stressing the environment and psychological condition of the patient could restore the individual to health without the use of medicine. Subsequently, when physical pathology was present in the brain or nerves, only medicine, if anything, could work therapeuti-

cally. What helped make this compromise and thereby also moral treatment acceptable was the perceived therapeutic success of moral treatment and the view that it could only be applied in medically administered mental hospitals. With the decline in the rates of recovery in mental hospitals after the Civil War, moral treatment's nonmedical aspect resurfaced as a major issue within psychiatry. Influenced by lower recovery rates and ideas of social Darwinism, especially theories of degeneration, psychiatrists increasingly abandoned their theoretical commitment to moral treatment in favor of a more exclusively somatic approach.

The other powerful profession of the nineteenth century, the law, also found psychiatry a significant challenge to its authority on a range of issues over which lawyers and judges had long held largely undisputed sway. By 1843 the British courts had adopted the M'Naghten rule, which was widely accepted as law by state courts in the United States. In essence, under this rule, a defendant could be freed from responsibility for an act if it was proved that he or she could not distinguish right from wrong at the time of the alleged crime or misdemeanor. Psychiatrists, who by this time were being recognized as experts on insanity and called upon as expert witnesses, often objected that the M'Naghten rule relied too exclusively on intellectual understanding. In the psychiatrists' experience, many patients in mental hospitals knew right from wrong but could not control their behavior because their intractable emotions overrode all other considerations. Since there was actually no consistent judicial policy, in some cases the courts, especially juries, did accept psychiatric views not consistent with the usual judicial interpretation of the M'Naghten rule. Nevertheless, jurists usually insisted that in principle psychiatrists did not have the authority to substitute psychiatric criteria for legal criteria as to criminal responsibility.

The most extreme expression of dissatisfaction with psychiatry came in disputes over the so-called moral insanity defense, later called the psychopathic personality defense. In the 1840s Dr. Isaac Ray, author of a classic work on medical jurisprudence, insisted that since science did not know the precise relationship between insanity and a person's failure to abide by the law or act morally, all those declared insane should be freed from responsibility for their behavior. Although other psychiatrists hesitated to advocate this position, many of them did join Ray in advancing the theory that there was a form of insanity evidenced by immoral and illegal acts committed by an essentially rational person. To jurists, along with clergymen, among others, this theory of moral insanity converted all crime to mental disorder: It medicalized crime and hence threatened to undermine the criminal justice system.

As early as the 1840s, one lawyer, John Van Buren, son of President Martin Van Buren, voiced the fears of many lawyers and judges of his day and since about the danger to society of the growing power of psychiatry. If psychiatrists rather than juries were granted the authority to determine sanity or insanity in legal proceedings, then psychiatry would come to dominate society. For example, Van Buren argued, no economic transaction is valid if the individual engaging in it is mentally incompetent, so that allowing psychiatrists to decide such an issue would potentially place in their hands enormous economic power. Another objection was that society had the right and indeed the duty to determine the degree of mental disorder that justified freeing an individual from responsibility. Some prominent psychiatrists argued in effect that human actions were determined and that therefore personal responsibility, as traditionally understood

in law, was irrelevant, since where there is no choice there is no freedom and therefore no blame. The English legal system had long held that in criminal cases where there was no evil intent, there could be no blame and therefore no crime or punishment. Critics perceived the criminal justice system to be endangered by such theories as moral insanity and Ray's views about responsibility of the insane. All criminal acts, some jurists, along with clergymen, argued, could be considered the acts of irrational persons. Indeed, in traditional Christian thought, with the fall of Adam all humankind inherited a somewhat defective brain, which could explain why so many people were willing to endanger their immoral souls by disobeying Christ's commandments for some paltry gains during their short stay here on earth. In brief, all people were somewhat mad and innately evil, but that did not absolve them from guilt and sin, as psychiatric deterministic standards would have it.

Psychiatrists insisted that the law accept their "scientific" findings, which must supersede tradition, while jurists held that no scientific findings could replace society's right to protect itself by setting standards for human conduct. New discoveries about human nature or how disease affected responsibility, or questions on whether humans could be considered responsible in the light of deterministic science, were ultimately beside the point. Jurists, in effect, insisted that they must protect society, and they usually saw their professional mission as synonymous with society's interests, which required fixed standards by which to judge human actions. Psychiatry sought to protect the interests of the insane in accord with the uncertain or conditional findings of medicine about human nature, and the needs of psychiatry as a profession. It should be remembered, too, that the insanity defense sometimes involved defendants charged with capital crimes, so that the death sentence was a real option. Psychiatrists, in their view, were saving innocent lives by attempting to prevent the courts from executing madmen.[8]

Since the law did recognize an insanity defense, jurists most commonly demanded from psychiatrists an unambiguous definition of insanity that could be used in determining individual responsibility according to legal criteria; the courts also sought prediction of future behavior to aid judges in sentencing. Instead, psychiatrists gave conflicting definitions of insanity, ambiguous and sometimes contradictory prognostications about future conduct, and contrary opinions on the mental states of defendants. Jurists as a result often objected to granting psychiatrists expert status in court because the discipline of psychiatry had no standard criteria. Any opinion, no matter how outlandish, jurists complained, could find some psychiatrist to support it. None of these issues has been resolved to the present day.

Nineteenth-century psychiatrists believed that they should be able to do much of what jurists asked of them. All would be well if jurists would call as expert witnesses only superintendents of mental hospitals, that is, experienced psychiatrists, and preferably in a nonadversarial setting, rather than physicians who did not specialize in treating the insane. The outcome would be consistent testimony. But prominent psychiatrists also wanted the courts to abandon the M'Naghten rule for one that more closely resembled medical concepts of insanity—rather than knowledge of right from wrong. Psychiatry no less than the law was in a quandary. After all, psychiatrists themselves assumed that their patients had some control over their behavior; otherwise how could moral treatment, which involved reeducation, work? How then could psychiatrists logically ask the courts to accept the view that insane persons who knew right

from wrong were nevertheless incapable of controlling their behavior or to abandon the view that punishment or its threat were appropriate deterrents and means of reform? Neither a totally free will view of human conduct nor a determinist position was adequate to the situation that the law and psychiatry faced. What gave passion to the dispute was the fear of jurists that psychiatry was irresponsible, endangering society and the very existence of the criminal justice system, by denying the moral, philosophical, social, and, indeed, Christian values and beliefs.

No anti-psychiatry advocates were more passionate than those who considered themselves the victims of psychiatry—those who were or had been patients in mental hospitals. Until the late twentieth century, only a very minute self-selected group of ex-patients published or in other ways made their dissatisfactions public, and even fewer openly expressed positive feelings about their experiences. The stigma associated with insanity inclined discharged patients either to avoid the subject, except sometimes in personal letters, or to publish their protests with the objective of proving that they were unjustifiably institutionalized or badly treated by hospital personnel, or both. Those who recognized their own madness and believed they had benefited from institutionalization seldom publicized their sentiments except in a very few instances where they sought some sort of reform in the mental hospital system or saw their experience as of potential value to society.

Ex-patients who could express themselves coherently and cogently were, despite the stigma of insanity, very effective critics of psychiatry. The decades before the Civil War witnessed the rise of all sorts of reform movements designed to improve society and right wrongs, including calls for less abusive and more therapeutic care for the insane in the new hospitals constructed for them. When former patients made public complaints that seemed reasonable about being railroaded into mental hospitals and described their mistreatment there, they could win public sympathy. This might happen if the newspapers picked up their cause, which would be likely if the complainants were of "respectable" social and class origins and character, were nonviolent, and had the support of relatives and friends. This public support was for reform, not abolition, of mental hospitals. The ex-patients who argued that they were not insane when institutionalized and that there were many sane people unjustly held in mental hospitals did not deny that some were mad or that mental hospitals, if reformed, could provide helpful care and treatment. Even the famous Elizabeth Packard, institutionalized in 1860 for several years and subsequently able to win legislative support for her demand that a husband no longer be legally able to commit his wife on his unsupported claim that she was insane, never denied the existence of insanity and the need for mental hospitals. The founder of the modern mental health movement, ex-mental patient Clifford Beers, though initially hostile to psychiatrists and playing heavily on mistreatment in mental hospitals, did not question the validity of psychiatry or of mental hospitals per se. Through his famous autobiography, *A Mind That Found Itself*, published in 1908, and his National Committee for Mental Hygiene, formed in 1909 in close collaboration with psychiatrists, Beers campaigned for hospital reform and for public education about mental illness. In the 1920s and 1930s the National Committee was instrumental in the training of psychiatrists and in expanding their role in American society.[9]

The significance for anti-psychiatry of ex-patients' complaints during the late nineteenth and early twentieth centuries involved the ability of such allegations to discredit

psychiatry as a helping profession and depict it as bureaucratic, self-serving, and insensitive to patients' needs to the point of permitting and even sometimes participating in mistreating them. Such accusations, and the tendency of public mental hospitals to restrict public access, made psychiatry increasingly suspect, so that over the years the automatic assumption of humane intent and selflessness that initially protected psychiatry and mental hospitals was vitiated.

In the courts, however, suits against medical superintendents (and sometimes also patients' relatives) for false incarceration, as well as for brutality, generally failed, and state legislatures passed laws protecting hospital medical personnel from personal liability. Besides, neither the courts nor legislatures much less the general public were willing to support the closing of mental hospitals or the replacement of psychiatrists with lay people. The only alternative to the mental hospital system being built in nineteenth-century United States was practiced in Gheel, Belgium, where mentally disordered individuals were integrated into an agricultural community that for many years had no hospital facilities or psychiatrists. "Patients" lived in the homes of farmers and performed whatever duties they could and had the freedom to move about the community. A few American medical superintendents—most notably John Minson Galt of the Eastern State Hospital of Williamsburg, Virginia, and Merrick Bemis of Worcester State Hospital—suggested this approach as a supplement to the American hospital system, and reformer Dr. Samuel Gridley Howe proposed it as an alternative, but it never was attempted in the United States. Most psychiatrists, protecting their turf, opposed it, though aspects of the system worked reasonably well in a few communities in Massachusetts, where mental hospital patients were employed on local farms.[10]

More damaging to psychiatrists was the growing perception in the late nineteenth century that psychiatry had lost its primary commitment to the patient and violated the Hippocratic directive to do no harm. This erosion of esteem was abetted by the psychiatric profession's inability to resist state legislative pressures to reduce costs by expanding the size of hospitals, which originally, under moral treatment, were by 1850 to be limited to no more than 150 patients in private institutions and 250 in public institutions. The example of industry's profitable use of efficiencies of scale was now to be applied to mental hospitals, with the widespread result that patients suffered from the anomie encouraged by bigness. Psychiatrists found it difficult if not impossible to counter the argument of efficiency of scale because they were losing their belief in the curability of insanity. Equally important, psychiatrists' class views led to their recommending that hospitals for the nonpaying lower-class patients be permitted to have inferior facilities and to house about twice the patient population as in hospitals housing paying patients, to the point where virtually no limits were applied, and state institutions with many hundreds of patients and, by the twentieth century, even thousands, were established. If custody was the inevitable fate of most mental patients, custodialism at least cost seemed, to state legislatures, the only logical way to go.

Americans have traditionally rejected the tragic view of life: There are no insoluble problems. When psychiatry in the last decades of the nineteenth century accepted the opinion of Luther V. Bell, founding member of the American Association of Medical Superintendents of Asylums for the Insane, who was quoted approvingly by another founder, Pliny Earle, that "when once a man becomes insane, he is about used up for this world,"[11] public attitudes toward psychiatry itself would turn sour and support for therapeutically effective medical hospitals continued to erode. Mental hospitals

remained necessary to protect society and patients, but they were no longer the solution to the problem of insanity.

There were attempts in the late nineteenth century to redirect psychiatry by reorienting its growing negative view of the curability of insanity. This was a tall order. Mental hospitals had become overcrowded with chronic patients at the same time as science seemed to justify a hopeless view of human potential in its support for racist and class theories about the inferiority of blacks, Catholics, Jews, the poor, and immigrant working classes. Darwin's theory of evolution was used to justify theories of degeneration that explained all manner of undesirable human activities and characteristics—crime, alcoholism, mental defects, and insanity, to name a few—as the inevitable consequences of undesirable life styles leading to biological degeneration. Darwinian natural selection was converted into a form of the old Lamarckian inheritance of acquired characteristics. From the very beginning, psychiatrists assumed that mode of life significantly influenced the tendency to fall victim to madness.[12] Therefore, they advised the public how to live to maintain good mental health, advice that often far exceeded their knowledge and also reflected their political, religious, and social prejudices. When pessimism about recovery predominated late in the nineteenth century, many leading psychiatrists shifted their attention to advice about eugenics and restricting immigration to protect the fit. This stance not only perpetuated hopelessness about mental illness but vitiated mass public support for psychiatry.

What might be called the first secular anti-psychiatry organization was created by the joint action of members of two new professions, neurology and social work, who formed in New York City in 1880 the National Association for the Protection of the Insane and the Prevention of Insanity. To some extent the issues involved matters of both class and jurisdiction. Neurologists engaged in private office practice condemned medical superintendents and mental hospitals as therapeutically ineffective and even harmful to mental patients. Some prominent neurologists exhibited contempt for state mental hospitals because of the lower-class patients they treated: As Weir Mitchell commented, only poverty and necessity justified entering a state mental hospital, which could never provide the kind of care appropriate to upper-class patients.[13] Hospital leadership, in the hands of medical superintendents, the psychiatrists of their day, excluded the neurologists, who insisted that they were the real scientists, capable of turning mental hospitals into therapeutic institutions devoted to patients' needs and to scientific research that could unravel the mysteries of mental illness. American psychiatrists, they charged, had become so bureaucratized and rigid that they could not adopt new procedures such as nonrestraint, as developed in England; they did not do scientific research; and they relied upon force as their mainstay in custodial care, to the virtual exclusion of therapy. The National Association requested the state legislature of New York to investigate state mental hospitals with a view to replacing their existing leadership—most notably Dr. John P. Gray, head of Utica State Hospital—with real scientists, the neurologists, who would quickly transform these hospitals into true therapeutic institutions.

The social workers in the National Association, including prominent members of elite society, went further to question the value of all medical treatment. The ensuing split between social workers and neurologists combined with a loss of leadership, led to the demise of the reform effort. And when the neurologists failed to win the support of the state legislature, they abandoned their fight to win control of mental hospitals.

A few did eventually achieve medical directorships, especially of private asylums, and joined Clifford Beers's reform effort through work with the National Committee for Mental Hygiene. Despite their bitter and often personal condemnation of psychiatrists, neurologists did not oppose a medical view of insanity. The most critical of them held a marginally anti-psychiatry position in the sense that they regarded psychiatry less as a valid medical or scientific discipline than as a specialized administrative profession. Psychiatry could become genuinely medical and scientific only by accepting the leadership of neurologists, who alone had the requisite scientific knowledge and research training, usually obtained in Germany. This was the first, but not the last, instance in which psychiatrists met opposition from a competing medical discipline or helping profession.

The psychiatrists were in an inherently difficult position, one that could expose them to criticism no matter how hard they worked in behalf of their patients or whatever their theories. State mental hospitals, which came to house the large majority of the insane, characteristically admitted seriously mentally disordered people, who might live on for years and sometimes decades. This problem increased in the late nineteenth century when state mental hospitals also became the institution of last resort for aged ill people with reduced mental capacity, not only the insane. These hospitals served as long-term homes for the chronically ill aged and therefore faced the difficult and expensive task of providing for all the needs of their diverse population. Such institutions were viewed medically as a sign of the therapeutic failure of psychiatry, and state legislatures often begrudged providing adequately for poor and marginal people, especially Irish immigrants, who some medical superintendents believed were unlikely to recover. Almost no provision for mentally ill blacks existed in the North, and segregation into inferior institutions prevailed in the South. Under these circumstances, psychiatrists often uncritically accepted new therapies and, in the hope of winning sufficient financial support, tended to promise more than they could deliver. They were therefore vulnerable to criticism when their promises of effectiveness went unfulfilled. This problem persisted into the twentieth century, despite efforts at reform and especially under the fiscal constraints of the Great Depression and the Second World War. During the 1930s new somatic treatments originating in Europe—insulin therapy, electroshock, and lobotomy—raised hopes among hospital psychiatrists, but the depression and the war placed innovations on hold. It was only much later that fierce protest arose among critics concerned about side effects and the abuse of shock treatments and lobotomies. Meanwhile mental hospitals continued to deteriorate, hospital psychiatry lost professional status, and prominent psychiatrists gravitated toward private practice and the new psychiatric clinics founded in the early twentieth century that focused on short-term care and scientific research.

A new and eventually powerful element in the debates about the nature of psychiatry and in the decline of hospital psychiatry was Freudian theory and psychoanalytical practice, which became influential in the United States in the 1920s and 1930s and most spectacularly after World War II. Although Freud did not deal with psychosis but rather with what he termed the neuroses, some of his American supporters soon claimed his theories applicable to all mental illnesses. A small but growing number of psychiatrists came to believe that in psychoanalysis, psychiatry had finally found an explanation for mental disorders and, contrary to Freud's early view, a therapy for all mental illness, not just the neuroses. The enthusiasm for Freudian ideas among the artistic and

literary community helped create a popular view, at least among the sophisticated, that psychoanalysis explained human nature. In a sense, Freud made the public aware of the pervasiveness of emotional disorders and thereby, so to speak, put psychiatry on the map. But among the preponderance of medical practitioners and psychiatrists, the latter before the war still working predominantly in mental hospitals, Freudian ideas met hostility out of all proportion to the limited range of mental disorders that psychoanalysts treated. Neurologists, virtually by definition somatically oriented, were equally antagonistic: Even in the reformist National Committee for Mental Hygiene the neurologists were for a number of years able to prevent any official expression of approval of Freud or psychoanalysis.

The primary complaint centered around the "unscientific" or nonmedical nature of Freud's system,[14] but animosity toward Freud, whose theories were quickly Americanized and not always to his liking, arose around other issues than his supposedly nonscientific stress on historical, social, and cultural forces rather than somatic factors in etiology and therapy. Freud's emphasis on the sexual nature of the neuroses, including hysteria, as key to understanding all human actions seemed unverified by evidence and was interpreted as a challenge to a somatic view of mental disorders. To some hospital psychiatrists Freud's theories not only directed psychiatrists away from the central issue of psychoses, they contributed to reorienting granting agencies toward support of preventive psychiatry and neglect of the psychoses. Private-office practice, characteristic of psychoanalysis, and the apparent success of psychoanalysis as therapy also diminished, among the educated public, the significance of psychoses and hospital-based psychiatry and helped thereby to discredit mental hospitals and deny them economic and professional sustenance. At the same time, growing numbers of clinical psychologists, including lay psychoanalysts, battled psychoanalysis and traditional psychiatry to claim their own authority and their right to practice psychotherapy. If the new Freudian talk therapy (and its various offshoots) was the answer, why confine it to members of the medical fraternity? Indeed, the psychologists claimed that their training, which concentrated on the psychological, was more thoroughgoing and more sophisticated than that of psychiatrists, who were burdened with irrelevant medical knowledge and ignorant of psychological theory. And social workers, even clergymen, and a variety of other persons, some with rigorous training, some not, hung out their shingles as "therapists." The old mind-body dichotomy reappeared in modern guise, again to challenge or undermine psychiatry as a medical specialty.

One could argue that Freudianism, as interpreted by Americans, encouraged an already existing tendency, derived from disappointing therapeutic results in mental hospitals, whereby psychiatry progressively moved away from interest in psychoses to dealing with the neuroses, and finally from neurosis to the "normal" public. After World War II, psychoanalysts, who had achieved great prestige within psychiatry, showed increasing concern with the emotional problems of the "normal," with the pathology of everyday life. All humankind being more or less emotionally disturbed, a truly effective psychiatry would deal with prevention among the entire population. If in traditional Christianity all humankind was somewhat irrational after Adam's fall, with Freud emotional disorder was the price paid for the repressions that civilization necessitated.[15] Just as conversion to Christ promised salvation, so psychoanalysis, through unlocking the secrets of human nature, could enable humankind to mitigate the emotional damage imposed by civilization. Some American psychoanalysts preached

that prevention of mental disorder was a step toward "positive" mental health, the elimination of all emotional disorders. An Americanized version of psychoanalysis—totally secular, liberal, and sexually candid—could replace religion as the ultimate explanation and treatment for all human emotional problems.

Freud himself was an atheist who believed that religion deprived people of their ability to understand the material, social, and cultural sources of their emotional problems and inhibited them from accepting psychoanalysis as a means to gain insight and thereby solve or alleviate such problems. Such views brought psychiatry, or, more accurately, psychoanalysis, new enemies among religious groups such as Roman Catholics, who had not been traditionally anti-psychiatry. For all its disagreements with psychiatry's view of possession and exorcism and of sin as the cause of insanity, the Roman Catholic church did not in the nineteenth century oppose psychiatry as a discipline, in part because the public mental hospitals were havens for poor Catholic immigrants who became mentally ill and for whom the church had no facilities. Furthermore, actual cases of demonic possession were considered to be rare, so that insanity could be acknowledged as the province of psychiatry. But psychoanalysis, which was equated with psychiatry, was different—atheistic, anti-religious, immoral. By the 1950s, however, the Roman Catholic Church reached an accommodation with psychoanalysis; the pope made it clear that he did not oppose the practice of psychoanalysis, much less psychiatry, where it did not contradict the tenets of Catholicism, and agreements among the Catholic clergy and sympathetic psychotherapists to cooperate in the treatment of parishioners reflected a shift in both groups' attitudes.[16]

The postwar rise in prestige and power of the psychoanalysts who came to dominate departments of psychiatry in many general teaching hospitals and psychiatric institutes paved the way for unprecedented and eventually successful assaults against the old, traditional institutional power base of psychiatry—mental hospitals. In the process, in which deteriorated hospital conditions, economic considerations, new somatic therapies, ideological and cultural trends, and political activism all played a part, the idea of the mental hospital or asylum, to which psychiatry owed its origins and for so long its influence, was effectively challenged.

During World War II, army psychiatrists, rediscovering what had been learned in World War I, that "battle fatigued" or "shell shocked" soldiers did best when not institutionalized, assumed that the mentally ill among the civilian population at home would benefit equally by being deinstitutionalized. Upon this analogy, and a newfound confidence, was built the view that it was possible to do without mental hospitals. Thus was born a campaign to substitute community mental health centers for mental hospitals.[17] The postwar years witnessed the growth of a psychiatrically led reform movement to reinvest in the decaying mental hospitals, to create therein therapeutic communities, and to supplement the hospitals with community mental health facilities. In this struggle, from about 1945 to the mid-1960s, between those who sought reform and those, led by psychoanalyst Karl Menninger, who wanted to eliminate state mental hospitals in favor of community mental health centers, the latter group, with the help of the National Institute for Mental Health, won the day, although of course only some twenty-five percent of the full 2,000 community mental health centers were ever built. As sociologist Erving Goffman asserted in his influential book, *Asylums*,[18] state-funded mental hospitals were part of the problem rather than its solution: Institutions were by definition

vehicles for social control, oppressive and inimical to real therapeutics, and certainly real abuses were rampant there. Economics figured in the situation as well: In response to the pleas of state governments that they could not afford the cost of caring for the mentally ill, federal legislation in the 1960s and early 1970s made it financially advantageous for states to mandate discharge of patients, whom the federal government would support at a higher rate outside than inside public mental hospitals. And the barrage of criticism directed at state hospitals by strongly anti-institutional social activists—charges of patient abuse and neglect, failure to provide adequate treatment, and mistreatment with inappropriate drugs and other misguided therapies—set an ideological climate antithetical to psychiatry. At the same time, advances in psychopharmacology—the new psychotropic drugs like chlorpromazine—would, the public was told, enable patients to control their symptoms sufficiently to allow them to live out in the community.

The advent of these drugs, together with new research into the possible biochemical basis of mental disease, also contributed to the decline of psychoanalysis, whose practitioners had been so active in dismantling mental hospitals. Not only did psychoanalysts have little success in treating hospitalized, psychotic patients, but by the 1960s psychoanalysis became exposed to increasing criticism when its therapeutic claims even in regard to its small select clientele could not be verified. Thus when the new chemical therapies were seen as evidence that mental illness was indeed a somatic disorder, psychoanalysis had no effective response. But the promise of neurobiology was not immediately realized, and the new drugs, along with electroshock and lobotomy—all of which could have quite damaging side effects—raised a storm of protest among a vocal group of patients and ex-patients who won support from various anti-authoritarian liberation movements in the late 1960s and early 1970s. Anti-psychiatry became part of a protest against racism, the Vietnam War, professional authority, and hierarchical distinctions common to "establishment" organizations of all kinds, including state mental hospitals, some of which were "snake pits." The activism included ex-patients organized as never before, to fight against involuntary institutionalization and involuntary treatments and for the empowerment of patients and their civil rights. Also for the first time anti-psychiatry took on a national and international character. Although American psychiatry was always influenced by European developments, earlier outbreaks of anti-psychiatry had remained local phenomena. All this changed in the 1960s and 1970s. Ex-patient anti-psychiatry organizations made contact with like-minded people abroad, and in both the United States and Western Europe persons belonging to prestigious professional organizations—in law, psychiatry, psychology, sociology, and philosophy—and having access to the mass media participated in anti-psychiatry and helped to develop its ideology.[19]

The most influential ideologist of the "new" anti-psychiatry of the 1960s and 1970s was himself a medical psychoanalyst, Thomas Szasz, whose position was a replay of issues raised by moral treatment in the early nineteenth century. Szasz was so attractive to many critics of psychiatry because he rejected the right of psychiatrists forcibly to institutionalize and treat people who he said were as a rule not really mentally ill. Szasz assumed that if mental illness qualified as a medical entity it must be shown to have some sort of somatic etiology, probably in the brain and nervous system. Since such findings were lacking in all but a few forms of insanity such as paresis, Szasz concluded that so-called mental illness was in most cases not a medical disorder; rather, mentally

disturbed people had problems in living. He clearly presumed that since medicine had not yet found a somatic basis for many forms of mental illness it never would do so.

In his heyday Szasz proclaimed that psychiatry, having no biological basis, had no moral much less medical justification for forcing treatment upon those it labeled mentally ill. If society eliminated involuntary hospitalization it would remove the primary obstacle to the proper care of the mentally troubled who were, in Szasz's view, merely lazy and irresponsible. This position begged the question of what to do with people who had problems so severe as to make them dysfunctional in society, no matter what their condition is called. To Szasz it was up to the individual to seek and pay for whatever help he or she needed; society had little if any obligation in the matter. Unfortunately for Szasz he put forward his arguments just when medical and biological research was finding evidence for the somatic nature of mental illnesses. His influence was much greater among the lay public, ex-mental patients, and the politically radical Left (whom he disdained and who wanted public funding for mental health facilities) than within the psychiatric community, which for the most part regarded him with disdain.[20]

Another radical critic of psychiatry from within, a counterculture hero of the 1960s, was British psychiatrist R. D. Laing. Initially Laing attributed the origins of schizophrenia, the subject of his primary concern, to the nuclear family, which victimized one of its members and literally drove him or her mad. Then, unable to discover the symptoms characteristic of schizophrenia among mental patients so labeled by psychiatrists, he saw such "patients" as people who were responding sensibly to a genuinely irrational or schizophrenic society. They could even be seen as potentially supernormal, superior beings—the old popular belief in the kinship of madness and genius or madness and divinity. Schizophrenia for Laing became a desirable alternative to sanity, a means of entering a deep inner world from which one would emerge emotionally cleansed and full of keen insights. This radical reversal of the attitude toward psychosis was based on a mystical view antithetical to psychiatry as a medical discipline. Laing took a path that might remove the stigma of psychosis: He viewed schizophrenia not as a clinical category and a disabling condition, but as a normal stage in the growth of some sensitive people, who could be helped by living in a benevolent, supportive group home, not a hospital.[21]

Also contributing to the denial of the so-called medical model of mental illness as well as to the anti-institution mood of the 1960s was Goffman's study of asylums, in which he attributed mental patients' "schizophrenic" characteristics to the hospital rather than the nature of mental illness. The French polymath Michel Foucault, whose ideas became so influential among American intellectuals, postulated that mental illness was a cultural artifact. Asserting, without convincing historical evidence, that the "insane" had once been integrated into society, he suggested reintegrating them but proposed nothing specific to help this supposedly more humane social relationship become established. Then there was labeling theory, championed most prominently by sociologist Thomas Scheff,[22] who, along with certain influential historical writers,[23] saw mental hospitals and psychiatry as forms of social control, as if social control was an all-or-nothing phenomenon and psychiatrists could not also seek the patient's good.

There were also psychiatrists, psychologists, and sociologists who saw learned behavior as an explanation for mental illness; they rejected the relevance of a medical

view, that is, a focus on disease, but accepted the concept of mental disorder. Prominent psychologist Hans Eysenck opposed psychoanalysis and psychiatry, arguing that the suffering of the neurotic was a learned response; in such cases there were no "lesions . . . no infection [and] nothing whatever that suggests . . . 'disease.' "[24] In cases where organicity existed, neurologists were the proper therapists; where mere neurosis existed, it had been acquired through some form of learning and was therefore the province of psychologists. Psychiatrists therefore really had no role to play.[25] And psychologist Peter Sedgwick, seeing disease as a social construct, because "*there are no illnesses or diseases in nature*," also thereby deprecated psychiatry.[26]

These various ideas were taken up by the liberal and leftist anti-psychiatry activists of the 1960s and 1970s, especially the newly vocal and influential organized ex-patients, albeit still a rather small, amorphous group of individualists. The inability of previous anti-psychiatry advocates to offer an acceptable alternative to psychiatry and mental hospitals had always been their Achilles' heel, and the anti-psychiatry religious sects had little influence in urban centers or with most state legislatures. What helped make modern anti-psychiatry much more effective was the existence of an apparent alternative to the mental hospital, the community mental health center, which had originated largely within the psychiatric profession. The new activists, many of them well educated and articulate, operating in urban areas, and supported by an environment of social and cultural change, were impressive witnesses and advocates for reform by state governments of the status and treatment of the mentally ill. Although they did not consider the community mental health centers to be true alternatives to mental hospitals, much less to psychiatry, the idea of such centers could be transformed into new forms of independently established self-help collectives or drop-in centers.[27] To the extent that such patient-run centers succeeded—and most of them eventually died out for lack of money—they tended to serve persons who could function fairly well outside the hospital. As for the mass of newly released patients, there were never enough government-sponsored, "establishment" community mental health centers and outreach workers to take care of them, and such centers never had enough money, especially in the fiscally austere 1980s and 1990s. These centers were in any case not required to make provision for the chronic and seriously mentally ill patients that the hospitals were discharging. The result was that masses of discharged seriously chronically ill but not dangerous persons were transinstitutionalized to old-age homes. Others in that category were left very much on their own, roaming the streets or exploited by boarding house or hotel owners, and, more recently, confined in local jails. The remaining mental hospitals continued to house a declining population of highly deranged, chronic patients and to serve as a short-term last resort for acutely disturbed persons.[28]

Three decades of anti-psychiatry produced a large literature critical of psychiatry but little discussion of the deteriorating condition of the mentally troubled in American society. If anti-psychiatry is not primarily responsible for this situation it is also not blameless. Indeed the lack of centrality of the mental patient is not an oversight but characteristic of and even essential to much anti-psychiatry, past and present, but especially so in the late twentieth century. Many anti-psychiatry advocates were guilty of what they charged psychiatrists—ignoring the needs of seriously ill patients, especially the aged. The long-term commitment of the American public to care for such persons in specialized institutions was being reversed.

Why would ex-patients take such a position? Why not establish facilities that included this class of patients? An obvious answer is that the ex-patients lacked the resources to do so. But more important was the ideological commitment to anti-psychiatry. Psychiatry could not be depicted as so completely evil, irrelevant, and destructive if it dealt with a real social problem with a medical component, no matter how ineffectively. The goal of activist ex-patients was to disallow any valid role to psychiatry by disallowing the existence of insanity as a medical disorder. They could then justify the establishment of self-run nonmedical facilities; ex-patients could and should control their own lives without the interference of psychiatrists or even sympathetic "sane" people. The title of ex-patient leader Judi Chamberlin's influential book put it succinctly: *On Our Own*. Such a separation proved to be impractical, and Chamberlin abandoned this position. But for others the issue became not as at first in the 1970s, capitalism, class, economic status, and gender, but the ex-mental patient versus the "sane" world.

From the beginning of the new ex-patient activism the conceptual justification came from both a Szaszian laissez-faire denial of the existence of insanity and a "Marxist" view of psychiatry as serving the interests of a capitalist, exploitative, ruling class that drove people mad or defined revolutionaries as mad in order to discredit them and confine them in mental hospitals. Both views, which incorporated well-founded claims of abuse of mental patients in hospitals and valid charges of bad side effects of indiscriminate drug prescription, found psychiatry irreconcilable with the needs of the so-called mentally disordered. For the Marxists the only solution was social revolution not reform. At the same time, a growing group of ex-patients sought to gain control over their lives before the victory of socialism. These "reformist" types were more influenced by conservative, libertarian, individualistic Szaszian social views.

Other dilemmas surfaced. Until the 1980s the spokespersons for the organized ex-patients were white, middle class, and largely politically Left in orientation. They sought to run their own facilities and thereby provide for the true needs of the mentally troubled. These facilities, however, needed the assistance of mental hospitals, which acted as an informal backup system to take in clients unable to control themselves sufficiently to function in ex-patient housing. To be on their own, ex-patients also needed substantial financial support from the very society that allegedly produced the conditions that drove people mad or at least labeled them mad and then oppressed them in hospitals and used them as a source of cheap labor. Leftist ex-patients sought the resources to become self-regulating from a government it wished to destroy and then complained when the resources were inadequate or not forthcoming. Other politically Left-oriented ex-patients believed that capitalism of necessity must oppress the "insane" who were in fact, as Laing had taught, often merely sensitive, rebellious individuals. The class struggle was the only way of liberating the "mentally ill," and the struggle against psychiatry was a means of accomplishing that broader goal, the liberation of all the oppressed classes, not just the "mentally ill." But as the more radical Marxists insisted, the only effective way of stopping the exploitation of the masses that produced insanity was to introduce socialism, so that it was a waste of time to fight psychiatry and wrong to accept government funding; the anti-government anarchists agreed.

The radicals tended to reject alliances with their natural allies, such as the National Alliance for the Mentally Ill, an organization of parents with mentally ill children. The ex-patients objected not so much to these parents' opposition to the popular psychiatric

view, heavily promoted in the 1970s by Laing and his followers, that schizophrenia was the consequence of dysfunctional family relations—strong mothers and weak fathers. Offensive to the ex-patients was the Alliance's position that insanity existed as a medical entity and that its etiology was somatic, a position that gained strength with the growth of neurobiological psychiatry.[29]

In the mid-1980s the anti-psychiatry ex-patient activism, never a well-organized, unified effort, split into several factions. At issue were its growing middle-class reformist leadership; the need to fund mental health centers by the only agencies having sufficient resources—government and private philanthropies; and the failure of radical politics significantly to empower the ex-patient activists. There were also theoretical differences. Among the leadership a critical view of psychiatry still prevailed, but some had come not absolutely to disclaim the reality of mental disorders or reject possible cooperation with psychiatry. Even before then, anti-psychiatry advocates among left-wing intellectuals, psychiatrists, and political activists had admitted that their expectations about the destruction of psychiatry and the support its destruction would give to revolutionary movements, a position popular in post-1968 France, had not materialized. Much less had conditions for the mass of mental patients notably improved.

The very patient organizations, always few in number, established to empower, house, and treat patients have themselves not been free of the internal struggles over goals, means, and power so common to all other organizations. The utopian view that ex-patients and patients would avoid forming hierarchical structures in the institutions they controlled is not being borne out, and ex-patient leaders have become connected with the "establishment" through funding arrangements and consultation with various mental health agencies, private and public. The American genius for absorbing at least the leadership among dissidents is under way.

Radical Left anti-psychiatry in a sense shared the views of psychiatrist-reformers of the early and midtwentieth century in seeing the problems surrounding the treatment of mental illness as the fault of the mental hospital as an institution. The break came when the anti-psychiatry critics attributed the failure of the mental hospital to the psychiatric profession and went farther in questioning the existence of mental illness. Another wing of recent anti-psychiatry, the radical Right, never made common cause with psychiatrists but instead categorically opposed psychiatry as a liberal, left-wing, subversive, anti-American plot. Unaffected by the anti-psychiatry among avant-garde intellectuals and unconventional psychiatrists, these activists incorporated their hatred and fear of psychiatry into a predominantly anti-Communist, nationalist world view.

In 1965 writer Donald Robison published in *Look Magazine* "The Far Right's Fight Against Mental Health,"[30] in which he captured the hostility toward psychiatry among those in the political far Right. A member of the John Birch Society is quoted as saying, "Mental health is alien and Communist-inspired," and a Wyoming chapter of the Daughters of the American Revolution "passed a resolution in 1960 charging that some psychiatrists use 'drugs, shock and lobotomy' on persons with 'certain ideological beliefs.' " Rightist Matt Cvetic charged that there was a " 'phony' concern about our so-called declining 'mental health' " planted by "Communist agents, fronters and sympathizers for the purpose of demoralizing the American people and spreading defeatism." Another rightist charged that "a substantial percentage" of mental patients are kidnapped sane people: "Will YOU sit idly by and allow them to be TORTURED and

MURDERED?'' The chief target of such extremists was the highly respectable National Association for Mental Health, successor to Beers's National Committee for Mental Hygiene, a supposed part of a Russian-run apparatus to brainwash the United States, an ''ultimate instrument of communism for taking over the free world.'' Racism, anti-Semitism, anti-Catholicism, and anti-internationalism were significant components of this attack: The nefarious plot was not only Communist but was run by Jews, Catholics, and Negroes. In the Southwest and California the extremists, who besides the DAR and Birchers included members of neo-Nazi groups and White Citizens Councils, intimidated and smeared supporters of mental health associations and vehemently opposed, often successfully, the establishment of mental health clinics.[31]

Although there were obvious differences between the anti-psychiatry radical Right of the 1950s and 1960s and the anti-psychiatry radical Left of the 1960s and 1970s, some common tendencies deserve mention. Both groups saw psychiatry as part of a conspiracy to subvert the rights and well-being of the mass of the people in the interests of the few. The leftists believed that the ''few'' were the capitalists; the rightists, that the ''few'' were the advocates of Godless communism, the tool of Satan. Both rejected compromise or reform and argued for the destruction of psychiatry in order to insure the happiness of the masses or at least the God-fearing among them. The radical leftists, or at least some of them, were interested in the plight of the mental patient, though, and they were not ethnic or religious hatemongers. The radical rightists, among whom it is not always possible to distinguish between those concerned with politics or with religion, showed little concern with the actual mental patients or ex-patients. Interest was centered mainly on mental health advocates, who were the agents of the Communists or the devil or both.[32]

Among the rightist anti-psychiatry crusaders could be found fundamentalist Christian believers, who added anti-communism to the traditional anti-modernism that had distinguished them from mainstream, modernist Protestants earlier in the twentieth century. In the 1960s fundamentalism began to make significant inroads into the broader society beyond the Southern ''Bible Belt,'' to the point where it was no longer a fringe movement. By the late 1970s and 1980s, with the rise of fundamentalism to national importance and to political influence in the Republican party, in part through the popularity of the televangelists, newly respectable fundamentalist leaders were softening their views of the medical profession in general and psychiatry in particular. Some of the ''new'' fundamentalists tended to ignore in their preaching the phenomenon of demonic possession, and some of the new charismatic religious groups were becoming involved in treating all sorts of mental disorders, sometimes in their own hospitals, and in cooperation with psychiatrists. The focus of these groups was on Christ as healer and their inheritance of his supernatural healing powers. Psychiatrists were also revising their approach to the charismatic, self-help programs of the religious sects and cults that had traditionally opposed psychiatry for spiritual reasons: Zealous groups such as the Unification Church and the Divine Light Mission, writes one psychiatrist, could ''serve as adjuncts, even collaborators, in psychiatric care'' and could ''yield relief in psychopathology.''[33]

From the early 1960s to the late 1970s, and with consequences still with us, psychiatry also became the focus of discontent among Americans who were not extremists. Much of this discontent revolved around legal issues, especially as the courts became more

activist in implementing social policy. The scenario drawn by some midnineteenth-century jurists about the effect on American society if psychiatrists' claims to be the judges of human mentality were accepted were, in the opinion of some Americans, being realized a hundred years later. A number of books, some written by liberal psychiatrists, discussed the threat to individual rights and society posed by the growing powers of psychiatry, by psychiatrists' assertion of unjustified authority in many areas of American life. The courts, for example, sought the opinion of psychiatrists about the dangerousness of convicted criminals in order to guide judges and juries in sentencing, although psychiatrists were notoriously unsuccessful in making such predictions. Psychiatrists also played an increasingly important role in the disposition of cases involving juveniles in trouble with the law. Similarly psychiatrists were given, it was said, an unwarranted role in custody fights over children and in divorce cases, in settlements of claims for injury, and, during the Vietnam War, in determining who should be exempted from the draft or who might break down in military combat.

There was evidence supporting at least some of these criticisms. Some psychiatrists did, and still do, argue that criminality was an example of mental disorder. In the twentieth century psychoanalysts added their voices to those who thought punishment ineffective in controlling undesirable human behavior.[34] Psychoanalysis, moreover, found the origin of much behavior outside of consciousness: People did not know why they acted as they did and often could not control their actions. Then some psychiatrists expanded the concept of who could legitimately be considered mentally ill far beyond the limits of schizophrenia, manic-depressive disorders, and other chronic mental illnesses or psychoses to include virtually all troubled people, all driven by unconscious forces. These ideas inspired anxiety that no one could be held responsible for anything. Courts would be abandoned in favor of hospitals and doctors. And, indeed, in the twentieth century all sorts of people were withdrawn from the criminal justice system, especially youthful offenders. Traditional beliefs about good and evil or right and wrong were converted into medical questions: Society, it was feared, was abandoning religious morality and tradition.[35] A further issue surfaced in the Hinckley case, where the psychiatrist treating the troubled young man who shot President Reagan came under scrutiny for allegedly not preventing Hinckley from acting out his fantasies. As in the past, finding a defendant not guilty by reason of insanity still creates strong public distrust of psychiatry.

Another area of dispute arose when members of the legal profession inspired by the civil rights movement joined the anti-psychiatry "movement" to insist, as never before and with success, that the courts must protect and expand the individual rights of hospitalized mental patients. Allowing patients' rights not heretofore recognized—for example, the right to obtain appropriate treatment, the right to refuse treatment, and the abolition of involuntary commitment (except in cases of demonstrated dangerousness)—seriously diminished the authority of psychiatrists in mental hospitals. By the new rules, individual rights superseded the right of society to force upon adults unwanted hospitalization or treatment, except in a medical emergency or imminent danger posed by a supposedly deranged person. Although in practice the standard of dangerousness turned out to be elastic, it did significantly reduce the numbers of patients admitted to mental hospitals, and state courts held that hospitals must provide treatment or else discharge involuntary patients; some judges tried to insure improved care by mandating minimum standards of treatment.[36]

There is no doubt that the legal challenges of the 1960s and thereafter to the authority of psychiatry were in part stimulated by the perceived failure of psychiatry to provide humane and effective therapy in mental hospitals. The new legal rights granted to mental patients could be seen as reforms or outright anti-psychiatry. Psychiatrists tended to see them as anti-psychiatry in effect and sometimes in intent: The effect was certainly to deny to psychiatrists in mental hospitals the traditional authority that they claimed was essential to successful treatment and management of patients. Another effect was the discharge of many patients because the legal mandate to offer adequate therapy and decent living conditions was too costly to be carried out; whether such persons lived under better conditions "freed" from the control of psychiatrists, in the streets or in old-age homes, is debatable. The state legislatures' protection of the personal liberty of prospective patients by requiring a finding of dangerousness as a condition for admission to the mental hospital also effectively denied hospitalization to some who could get no treatment elsewhere. By the 1970s and especially the 1980s, hospitals, with the approval of most state legislatures, sought to admit as few patients as possible in an effort to cut costs. The result was a reduced hospital population and shorter duration of average residence of patients within the hospital. That this new system was an improvement over the old is not clear. No doubt some former hospitalized patients benefited, but others were harmed by the new activism of the courts. The problem was that the courts were not an effective means of forcing psychiatrists, mental hospitals, or state legislatures to do the right thing. The almost exclusive emphasis in many court decisions on the adversarial relationship between psychiatrists and patients protected patients' rights on the apparent assumption that the primary obstacles to their recovery were the hospital and the psychiatrists, and, as usual, no one thought much about the fate of the chronic, aging inmate. As one psychiatrist put it in 1974, patients were as a consequence "dying with [their] rights on."[37] By 1992, in the majority of American communities the new legal regime had broken down: A survey sponsored by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill, supported by the American Psychiatric Association and the American Jail Association, found that, through lack of treatment programs, local jails have become, the Jail Association said, "the substitute institution of our neglect."[38]

Although psychiatrists' power was reduced, the public still viewed the psychiatric profession as a major player in the care of mentally disturbed patients, and the legal profession by the 1980s increasingly recognized that the basic assumptions of some of the legal critics of psychiatry were wanting. That mental disorders were the product of psychiatric mismanagement or venality, that the "insane" would disappear with the destruction of the psychiatric profession or mental hospitals, or that mental patients would be able to take advantage of their newly recognized rights seemed increasingly open to question.

The courts, moreover, still needed psychiatrists. After over a hundred years of complaints by lawyers that psychiatrists erroneously claimed to have knowledge about mental patients, in the late twentieth century the Supreme Court refused to accept psychiatrists' disclaimer of their ability reliably to predict dangerousness. The Court insisted that psychiatrists predict whether a particular defendant will be dangerous in the future and thus enable the judge to dispose of the defendant accordingly. Admittedly the newfound modesty of psychiatrists derives from their fear of being sued in cases where they did not warn of the danger that a patient under treatment posed.[39]

Jurists continue to dispute with psychiatrists over the nature of crime, over the legal responsibility of those found suffering from mental illness, and over the legitimate authority of psychiatry in the criminal justice system. Nor is it likely that these issues will have a definitive resolution, for they are ultimately not scientific questions. Science and medicine have influenced the way society decides these issues, but so do moral, religious, and social values and economic conditions, all of which are in constant change and which have often figured more significantly in anti-psychiatry attitudes and crusades than the condition and plight of the mentally ill.

Psychiatry itself has been reoriented, although how much is due to anti-psychiatry and economic stringency and how much to medical developments is difficult to say. Hospital psychiatry has become an endangered profession, and psychiatry has lost some of its previous status and power. Although probably many individual psychiatric practitioners had little awareness of the anti-psychiatry activism, the organized psychiatric profession, in the form of the American Psychiatric Association, did acknowledge the existence of the organized ex-patients and tried to work with them to redress their complaints. Psychoanalysis has declined; psychotherapy in general has given way to drug therapy, or combinations of both; and research into the biochemistry of behavior and the biology of the brain has come to the fore in the investigation of the etiology and treatment of mental disorder. Such research is leading to new support for psychiatry. As psychiatrist Melvin Sabshin noted in 1990, "Decision makers on Senate and House appropriation committees have commented frequently that they are now more willing to support the . . . Mental Health Administration because they can understand the palpable outcomes of the new generation of research."[40] Even Szasz's confidence that mental illness has no significant biological component has been shaken, as revealed in his 1987 book *Insanity: The Idea and Its Consequences.*[41]

In response to the new trends we have two recent books by American psychiatrists, from two opposing viewpoints, both critical of psychiatry, with arguments hotly propounded but not always substantiated or well thought out. Psychiatrist E. Fuller Torrey, a longtime critic of psychotherapy and of the medical model of psychiatry, who had written in 1974 on *The Death of Psychiatry,*[42] has become a strong advocate of the somatic approach to mental illness. In *Freudian Fraud,* published in 1992, he attributes the failures of post–World War II psychiatry to the influence of psychoanalysis.[43] Those psychoanalysts, he says, who designed the legislation creating the National Institute of Mental Health—Karl Menninger, Francis Braceland, and Robert Felix—were all Freudian and therefore imperialist in their thinking. They assumed that psychiatry or rather Freud had given them the means to solve social problems, not just those related to mental illness.[44] Torrey does not seem to be aware that an all-embracing view of the relevance of psychiatry to all human social problems did not originate with Freud and his followers but was apparent when mental hospitals and the profession of psychiatry appeared in the late eighteenth century. Freud developed a particular way of understanding human nature, which was used by some psychiatrists to comment on all manner of human activity, but the tendency of psychiatrists to do so long predated the twentieth century. And, of course, Freud the physician and scientist never abandoned somaticism; his interest and emphasis lay elsewhere.

Peter Breggin, in *Toxic Psychiatry,* which appeared in 1991, argues against the new "biopsychiatry," wherein "the brain-disabling principle applies to all of the most potent psychiatric treatments—neuroleptics, antidepressants, lithium, electroshock and

psychosurgery. The principle states that all of the major psychiatric treatments exert their primary or intended effect by disabling normal brain function." Only in psychiatry did the physician damage the brain in order to gain control over the patient. "If psychosurgery, electroshock or the more potent psychiatric drugs were refined to the point of harmlessness, they would approach uselessness. In biopsychiatry, unfortunately, it's the damage that does the trick." (That there might be a similar "principle" operating in the potent chemotherapy applied to various cancers Breggin does not acknowledge.) Even if some mental patients are discovered to have brain disease, he says, it would not "change the fact" that current psychiatric treatments further damage the brain.[45] Only a "psychosocial" approach could prove helpful to the mental patient, who is suffering primarily from pernicious family relations and a self-serving and misguided psychiatry. But once Breggin concedes the possibility that brain dysfunction may be the origin of some psychoses, then he cannot logically deny the possibility of successful treatment by biological means.

Breggin's argument against somatically oriented psychiatry is actually less theoretical than practical. Psychiatry, he contends, is more than an academic or a therapeutic discipline. "Psychiatry is the political center of a multibillion-dollar psycho-pharmaceutical complex that pushes biological and genetic theories, as well as drugs, on the society. It is a political institution licensed by the state, financed by government, and empowered by the courts." Like others disturbed by the power of psychiatry, Breggin supports denying psychiatry the legal right to enforce hospitalization and treatment. He wants a free market, with no legal licensing requirements, where psychiatry would compete with psychotherapy and psychosocial alternatives and the right of people to practice mental healing with no let or hindrance.[46] Under such conditions many clients would not, he believes, choose the harmful psychosurgery, electroshock, or chemicals that are the present mainstay of psychiatry.

The perennial mind-body arguments continue. In recent years general systems theory has been most influential, and of late there have appeared a number of writings by philosophers, neurologists, psychiatrists, and psychologists arguing for a mind-brain identity approach.[47] Also by the 1980s, the revisionist history and sociology of mental illness that had helped to fuel contemporary anti-psychiatry had itself come under attack. Such criticism encompassed self-criticism among some revisionists themselves, who now recognized the inadequacy of social control theory in explaining the complexities and problems of psychiatry.[48]

Mental disorder, whatever its origins, is still with us; American society is still dealing with the consequences of deinstitutionalization; psychiatry, though changed, is not endangered; and chronically ill patients are still neglected. To some observers the clock has been turned back to preasylum days two centuries ago. Many Americans have abandoned the belief that it is possible, or economically feasible, to eliminate poverty and to provide for the needs of the disadvantaged, be they physically or mentally ill. This loss of nerve defeats not only the optimism attending the birth of modern psychiatry but also that form of anti-psychiatry that sought to force psychiatry to live up to its best and most hopeful ideals.

Anti-psychiatry is in a sense both a return to the past and a perverse "fulfillment" of psychiatry. Initially, psychiatry sought to treat and cure, and ultimately, ideally, to eradicate conditions today called psychoses. Much of anti-psychiatry has sought to negate mental illness altogether. And psychiatrists themselves in effect adopted this

approach. Those who spearheaded deinstitutionalization and the community mental health movement, along with the radical critics within psychiatry, often ignored and thereby virtually denied the presence of psychosis. The problem that brought psychiatry as a profession into existence, insanity, is "solved" by disregarding it or by defining it away. But the sufferers do not go away.

Notes

1. A somewhat more detailed discussion of American Protestant attitudes toward insanity, plus a bibliography, appears in my "Madness and the Stigma of Sin in American Christianity" in Paul Jay Fink and Allan Tasman (eds.), *Stigma and Mental Illness* (Washington, D. C.: American Psychiatric Press, 1992), 73–84.

2. Attributing melancholy to sin was not confined to clergymen but was rather a commonly held view in Colonial New England. See, for example, Mary Ann Jimenez, *Early American Attitudes and Treatment of the Insane* (Hanover, New Hampshire: Published for Brandeis University Press by University Press of New England, 1987), 15; and Nancy Tomes, "Historical Perspectives on Women and Mental Illness" in Rima D. Apple (ed.), *Women, Health, and Medicine in America* (New Brunswick, New Jersey: Rutgers University Press, 1990), 154–156.

3. Otho T. Beall, Jr. and Richard H. Shryock, *Cotton Mather, First Significant Figure in American Medicine* (Baltimore: Johns Hopkins University Press, 1954); Kenneth Silverman, *The Life and Times of Cotton Mather* (New York: Columbia University Press, 1985), 309; Cotton Mather, *The Angel of Bethesda*, edited by Gordon W. Jones (Barre, Massachusetts: American Antiquarian Society and Barre Publishers, 1972); Jonathan Edwards (ed.), *An Account of the Life of the Late Reverend Mr. Brainerd* (Boston: 1749); Jonathan Edwards, *The Life of David Brainerd*, edited by Norman Pettit (New Haven: Yale University Press, 1985). Edwards, like Mather before him, considered "melancholy as a bodily disease which lowered men's resistance to secondary infections of satanic origin" (Gail Thain Parker, "Jonathan Edwards and Melancholy," *New England Quarterly*, xli [1968], 202).

4. For a history of healing and Christianity see Morton T. Kelsey, *Healing and Christianity in Ancient Thought and Modern Times* (New York: Harper & Row, 1976), 223ff; Leslie D. Weatherhead, *Psychology, Religion and Healing* (London: Hodder and Stoughton, 1951); on religious healing see also J. A. C. Murray, *An Introduction to a Christian Psycho-Therapy* (New York: Scribner, 1938).

5. See A. M. Bellwald, *Christian Science and the Catholic Faith, Including a Brief Account of New Thought and Other Modern Mental Healing Movements* (New York: Macmillan, 1922); Charles S. Braden, *Spirits in Rebellion: The Rise and Development of New Thought* (Dallas: Southern Methodist University Press, 1963); Sarah Elizabeth Titcomb, *Mind-Cure on a Material Basis* (Boston: Cupples, Upham, 1885).

6. The literature on Christian Science is very extensive; the following titles were most useful to me: Mary Baker G. Eddy, *Science and Health, with Key to the Scriptures* (Boston: Published by the Trustees under the Will of Mary Baker G. Eddy, 1934); Mary Baker Eddy, *Miscellaneous Writings, 1883–1896* (Boston: Christian Science Publishing Society, 1918); Mary Baker Eddy, *The First Church of Christ Scientist and Miscellany* (Boston: Published by the Trustees under the Will of Mary Baker G. Eddy, 1913); *A Century of Christian Science Healing* (Boston: Christian Science Publishing Society, 1966); Bellwald, *Christian Science and the Catholic Faith*; Charles S. Braden, *Christian Science Today: Power, Policy, Practice* (Dallas: Southern Methodist University Press, 1958); Horatio W. Dresser (ed.), *The Quimby Manuscripts* (New York: Julian Press, 1961); Edwin Franden Dakin, *Mrs. Eddy*, (New York: Grosset & Dunlap, 1929); Stephen Gottschalk, *The Emergence of Christian Science in American Religious Life* (Berkeley: Univer-

sity of California Press, 1973); Donald Meyer, *The Positive Thinkers' Religion as Pop Psychology, from Mary Baker Eddy to Oral Roberts* (New York; Pantheon, 1965); Frank Podmore, *Mesmerism and Christian Science: A Short History of Mental Healing* (Philadelphia: George W. Jacobs, 1909?); Julius Silberger, Jr., *Mary Baker Eddy: An Interpretive Biography of the Founder of Christian Science* (Boston: Little, Brown, 1980); Mark Twain, *Christian Science, with Notes Containing Corrections to Date* (New York: Harper, 1907); Sibyl Wilbur, *The Life of Mary Baker Eddy* (Boston: Christian Science Publishing Society, 1938); Irving C. Tomlinson, *Twelve Years with Mary Baker Eddy: Recollections and Experiences* (Boston: Christian Science Publishing Society, 1954); Stefan Zweig, *Mental Healers: Franz Anton Mesmer, Mary Baker Eddy, Sigmund Freud* (New York: Frederick Ungar, 1932); Robert Peel, *Mary Baker Eddy: The Years of Discovery* (New York: Holt, Rinehart and Winston, 1966).

7. Evans's views are expressed in the following books: W. F. Evans, *Soul and Body; or, The Spiritual Science of Health and Disease* (Boston: H. H. Carter, 1876); W. F. Evans, *Mental Medicine: A Theoretical and Practical Treatise on Medical Psychology*, 4th ed. (Boston: Carter & Pettee, 1872); W. F. Evans, *The Divine Law of Cure* (Boston: H. H. Carter, 1881); W. F. Evans, *The Mental-Cure, Illustrating the Influence of the Mind on the Body, Both in Health and Disease, and the Psychological Method of Treatment*, 6th ed. (Boston: Colby and Rich, 1884); W. F. Evans, *The Primitive Mind-Cure: The Nature and Power of Faith; or, Elementary Lessons in Christian Philosophy and Transcendental Medicine* (Boston: H. H. Carter, 1885).

8. For a historical treatment of dangerous and criminal insanity see Janet Colaizzi, *Homicidal Insanity, 1800–1985* (Tuscaloosa, Alabama: University of Alabama Press, 1989). On the history of early American psychiatry and the law, see also James C. Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* (New York: Oxford University Press, 1993); Janet Ann Tighe, "A Question of Responsibility: The Development of American Forensic Psychiatry, 1838–1930" (Ph.D. Diss., University of Pennsylvania, 1983); Norman Dain, *Concepts of Insanity in the United States, 1789–1965* (New Brunswick, New Jersey: Rutgers University Press, 1964).

9. See Norman Dain, *Clifford W. Beers, Advocate for the Insane* (Pittsburgh: University of Pittsburgh Press, 1981).

10. On the discussion about the Gheel system see Norman Dain, *Disordered Minds: The First Century of Eastern State Hospital in Williamsburg, Virginia, 1766–1866* (Williamsburg, Virginia: The Colonial Williamsburg Foundation, 1971), 128–134; and Gerald N. Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920* (Chapel Hill: University of North Carolina Press, 1966), 94–97.

11. Pliny Earle, *Memoirs of Pliny Earle, M.D., with Extracts from His Diary and Letters (1830–1892) and Selections from His Professional Writings (1839–1891)*, edited by F. B. Sanborn (Boston: Damrell & Upham, 1898), 273; Pliny Earle, "The Curability of Insanity," Read before the New England Psychological Society, on Retiring from Office as Its President, December 14, 1876; and Published by That Society (Utica, New York: Ellis H. Roberts & Co., Printers, 1877); see also Pliny Earle, "The Curability of Insanity," *American Journal of Insanity*, xlii (1885), 179–209 and Pliny Earle, *The Curability of Insanity: A Series of Studies* (1887; reprint, New York: Arno Press, 1972).

12. In the late eighteenth century, for example, Dr. Benjamin Rush, the so-called father of American psychiatry, advanced his political views by criticizing his opponents' actions as harmful to mental health. A Jeffersonian, Rush warned of the dangers to mental health in Federalist Alexander Hamilton's financial program: "The funding system, and speculation in bank script, and new lands have been fruitful sources of madness in our country." (Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind*, 4th ed. [Philadelphia: John Grigg, 1830], 64.)

13. Letter from Mitchell to Clifford W. Beers, 2 April 1908 (copy), quoted in Dain, *Clifford W. Beers*, 98.

14. I do not suggest that in fact Freud or his followers were not initially committed to viewing

themselves as scientists, and indeed many Viennese psychoanalysts were neurologists who "shared with biologists a common interest in the biological foundation of mental and psychic processes," as historian Alfred Springer observes. "Because of this their interpretation of the impact of somatic structures and functions on the psychic and mental processes differed from that of early biological psychiatrists solely in the assumption that the relationship of brain structure and 'the soul' is not unidirectional but should be understood as a complex interrelation." (Alfred Springer, "Historiography and History of Psychiatry in Austria," *History of Psychiatry*, ii [1991], 257–258.)

15. The idea that insanity as well as emotional disorder was the price for civilization was a common view of many midnineteenth-century psychiatrists. See, for example, Edward Jarvis, *Cause of Insanity, An Address Delivered before the Norfolk, Massachusetts, District Medical Society* (Norfolk: 1851), 17. This view differed from Freud's in that those early American physicians and their successors assumed that one could reform society and thereby preserve civilization while eliminating insanity. Conversely, anti-psychiatry advocates who also believed that society was capable of being perfected sought a world free of insanity by eliminating psychiatry and its institutions.

16. On the relationship between the Roman Catholic church and psychiatry see Francis J. Braceland (ed.), *Faith, Reason and Modern Psychiatry: Sources for a Synthesis* (New York: P. J. Kenedy, 1955).

17. See David Musto, "What Happened to 'Community Mental Health,' " *Public Interest*, (Spring 1975), 59–60; Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991); Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981).

18. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, New York: Anchor Books, 1961).

19. For a somewhat more extensive discussion and bibliography of recent anti-psychiatry, especially among ex-patients, see my "Critics and Dissenters: Reflections on 'Anti-Psychiatry' in the United States," *Journal of the History of the Behavioral Sciences*, xxv (1989), 3–25. Among the most important and influential examples of the ex-patient literature are Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (New York: Hawthorn Books, 1978); Lenny Lapon, *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States* (Springfield, Massachusetts: Psychiatric Genocide Research Institute, 1986); Sherry Hirsch et al. (eds.), *Madness Network News Reader* (San Francisco: Glide Publications, 1974); David Hill, *The Politics of Schizophrenia: Psychiatric Oppression in the United States* (Lanham, Maryland: University Press of America, 1983). A compilation of anti-psychiatry writings by psychiatrists, psychologists, philosophers, legal scholars, and political scientists is Rem B. Edwards (ed.), *Psychiatry and Ethics: Insanity, Rational Autonomy, and Mental Health Care* (Buffalo, New York: Prometheus Books, 1982).

20. Szasz's most influential works are *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Hoeber-Harper, 1964); *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963); and a collection of articles by various authors, *The Age of Madness: The History of Involuntary Mental Hospitalization Presented in Selected Texts*, edited with preface, introduction, and epilogue by Thomas S. Ssasz (New York: Jason Aronson, 1974).

21. See R. D. Laing, *The Politics of Experience* (New York: Ballantine Books, 1967).

22. See Thomas Scheff, *Being Mentally Ill: A Sociological Theory* (London: Weidenfeld & Nicolson, 1966) and *Labeling Madness* (New York: Prentice-Hall, 1975).

23. See, for example, David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown, 1971), and Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St.

Martin's Press, 1979). Michel Foucault's major work on the subject is *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965).

24. Hans Eysenck, *The Future of Psychiatry* (London: Methuen, 1975), 16.

25. Hans Eysenck, *You and Neurosis* (Glasgow: Fontana, 1978), 17; see also Lawrie Reznek, *The Philosophical Defence of Psychiatry* (New York: Routledge, 1991), ch. 3.

26. Peter Sedgwick, *Psycho Politics* (London: Pluto Press, 1982), 30 (Sedgwick's italics).

27. James. S. Gordon, "Alternative Mental Health Services and Psychiatry," *American Journal of Psychiatry*, cxxxix (1982), 653–656.

28. An excellent study of the effects of deinstitutionalization is Ann Braden Johnson, *Out of Bedlam: The Truth about Deinstitutionalization* (New York: Basic Books, 1990). On the role of the law in the process see Rael Jean Isaac and Virginia C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: Free Press, 1990).

29. The National Alliance for the Mentally Ill has grown rapidly in size and power. Psychiatrist Melvin Sabshin notes that the "families of severely ill mental patients . . . felt attacked by psychotherapeutic and sociotherapeutic concepts in psychiatry" and find a somatic approach much more acceptable. The alliance's "passionate espousal of biological psychiatry" has been, moreover, of great help to psychiatry. (Melvin Sabshin, "Turning Points in Twentieth-Century American Psychiatry," *American Journal of Psychiatry*, cxlvii [1990], 1271.)

30. *Look Magazine*, 26 January, 1965, 28–32.

31. Ibid., 30–32. See also *The Doctors Speak Up: An Answer to Irresponsible Attacks on the Mental Health Program*, Prepared as a Public Service by the San Fernando Valley Doctors Committee on Mental Health, in collaboration with the San Fernando Valley Mental Health Association (n.p.: 1961?); and *The Facts . . . a Reply to the Anti-Mental Health Critics* (New York: National Association for Mental Health, 1962).

32. Important historical studies of the Right are Gary K. Clabaugh, *Thunder on the Right: The Protestant Fundamentalists* (Chicago: Nelson-Hall, 1974); George M. Marsden, *Fundamentalism and American Culture: The Shaping of Twentieth-Century Evangelicalism, 1870–1925*, (Oxford, New York: Oxford University Press, 1980); Richard Hofstadter, *The Paranoid Style in American Politics* (New York: Random House, 1965); Richard Hofstadter, *Anti-Intellectualism in American Life* (New York: Knopf, 1963); Daniel Bell (ed.), *The New American Right* (New York: Criterion Books, 1955). A brief overview of recent studies of the Right is Michael Kazin, "The Grass-Roots Right: New Histories of U.S. Conservatism in the Twentieth Century," *American Historical Review*, xcvii (1992), 136–155.

33. Marc Galanter, "Cults and Zealous Self-Help Movements: A Psychiatric Perspective," *American Journal of Psychiatry*, cxlvii (1990), 543–551, quotations from pp. 547, 545; Wade Clark Roof, *American Mainline Religion: Its Changing Shape and Future* (New Brunswick, New Jersey: Rutgers University Press, 1987); Richard John Neuhaus, *The Naked Public Square: Religion and Democracy in America*, 2d ed. (Grand Rapids, Michigan: Eerdmans Pub. Co., 1986).

34. See, for example, Karl Menninger, *The Crime of Punishment* (New York: Viking, 1969).

35. See Alexander D. Brooks, *Law, Psychiatry and the Mental Health System* (Boston: Little, Brown, 1974), 145–149; Bruce J. Ennis, *Prisoners of Psychiatry: Mental Patients, Psychiatrists, and the Law* (New York: Harcourt Brace Jovanovich, 1972); Jonas Robitscher, *The Powers of Psychiatry* (Boston: Houghton Mifflin, 1980); Lee Coleman, *The Reign of Terror: Psychiatry, Authority, and the Law* (Boston: Beacon Press, 1984); David Ingleby (ed.), *Critical Psychiatry: The Politics of Mental Health* (New York: Pantheon Books, 1980); Martin L. Gross, *The Psychological Society: A Critical Analysis of Psychiatry, Psychotherapy, Psychoanalysis and the Psychological Revolution* (New York: Random House, 1978). See also Reznek, *The Philosophical Defence of Psychiatry*, on the social origins of the determination of what is mental illness or disorder.

36. For brief discussions of these issues see Louis McGarry and Paul Chodoff, "The Ethics

of Involuntary Hospitalization'' in Sidney Bloch and Paul Chodoff (eds.), *Psychiatric Ethics* (Oxford, New York: Oxford University Press, 1984), 203–219; Bick Wanck, ''Two Decades of Involuntary Hospitalization Legislation,'' *American Journal of Psychiatry*, cxli (1985), 33–37; and Paul S. Appelbaum and Loren H. Roth, ''Involuntary Treatment in Medicine and Psychiatry,'' *American Journal of Psychiatry*, cxli (1985), 202–205.

37. D. A. Treffert, ''Dying with Your Rights On,'' Presented at the 12th Annual Meeting of the American Psychiatric Association, Detroit, Michigan, *American Journal of Psychiatry*, cxli (1974), 6–10; see also Morton Birnbaum, ''The Right to Treatment: Some Comments on Its Development'' in F. J. Ayd (ed.), *Medical, Moral and Legal Issues in Mental Health Care* (Baltimore: Williams & Wilkins, 1974), 97–141. For a graphic example of the ruinous effect on one person and his neighborhood of the failures of the recent policies regarding mental illness see *New York Times*, 3 Sept. 1992, A1, B4.

38. *New York Times*, 10 Sept. 1992, A18.

39. This was the well-known Tarasoff case, decided by the Supreme Court in 1974, and upon rehearing, again in 1976. See Loren H. Roth and Alan Meisel, ''Dangerousness, Confidentiality, and the Duty to Warn,'' *American Journal of Psychiatry*, cxxxiv (1977), 508–511. See also Colaizzi, *Homicidal Insanity*, ch. 9.

40. Sabshin, ''Turning Points in Twentieth-Century American Psychiatry,'' 1271.

41. Thomas Szasz, *Insanity: The Idea and Its Consequences* (New York: Wiley, 1987), 346ff.

42. E. Fuller Torrey, *The Death of Psychiatry* (Radnor, Pennsylvania: Chilton Book Co., 1974). See also his *The Mind Game: Witchdoctors and Psychiatrists* (New York: Emerson Hall Publishers, 1972).

43. E. Fuller Torrey, *Freudian Fraud: The Malignant Effect of Freud's Theory on American Thought and Culture* (New York: HarperCollins, 1992).

44. Ibid., 191.

45. Peter Breggin, *Toxic Psychiatry* (New York: St. Martin's Press, 1991), 58, 59, 60. A very different perspective is offered in, for example, Frank Ervin, ''Biological Intervention Technologies and Social Control,'' *American Behavioral Scientist*, xviii (1975), 617–635, and C. R. Jeffery and Ina A. Jeffrey, ''Psychosurgery and Behavior Modification: Legal Control Techniques Versus Behavior Control Techniques,'' *American Behavioral Scientist*, xviii (1975), 685–721.

46. Breggin, 408–409.

47. For the latter view see Reznek, *The Philosophical Defence of Psychiatry*; Aviel Goodman, ''Organic Unity Theory: The Mind-Body Problem Revisited,'' *American Journal of Psychiatry*, cxlviii (1991), 553–653; Jerome C. Wakefield, ''The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values,'' *American Psychologist*, xlvii (1992), 373–388; Patricia Smith Churchland, *Neurophilosophy: Toward a Unified Science of the Mind-Brain* (Cambridge: MIT Press, 1986); Stephen Priest, *Theories of the Mind* (Boston: Houghton Mifflin, 1991), 113.

48. A recent critique and review of social control theorists is Abraham S. Luchins, ''Social Control Doctrines of Mental Illness and the Medical Profession in Nineteenth-Century America,'' *Journal of the History of the Behavioral Sciences*, xxix (1993), 29–47. The work of Michel Foucault has spawned a prolific literature, including of late critiques as well as explications; see a recent biography, James Miller, *The Passion of Michel Foucault* (New York: Simon & Schuster, 1993).