

1. Introduction

Objectives of the Thesis

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

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

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

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

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

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

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

Methodology and Underlying Theoretical Perspective of the Thesis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Brief Description of Schizophrenia

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

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

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

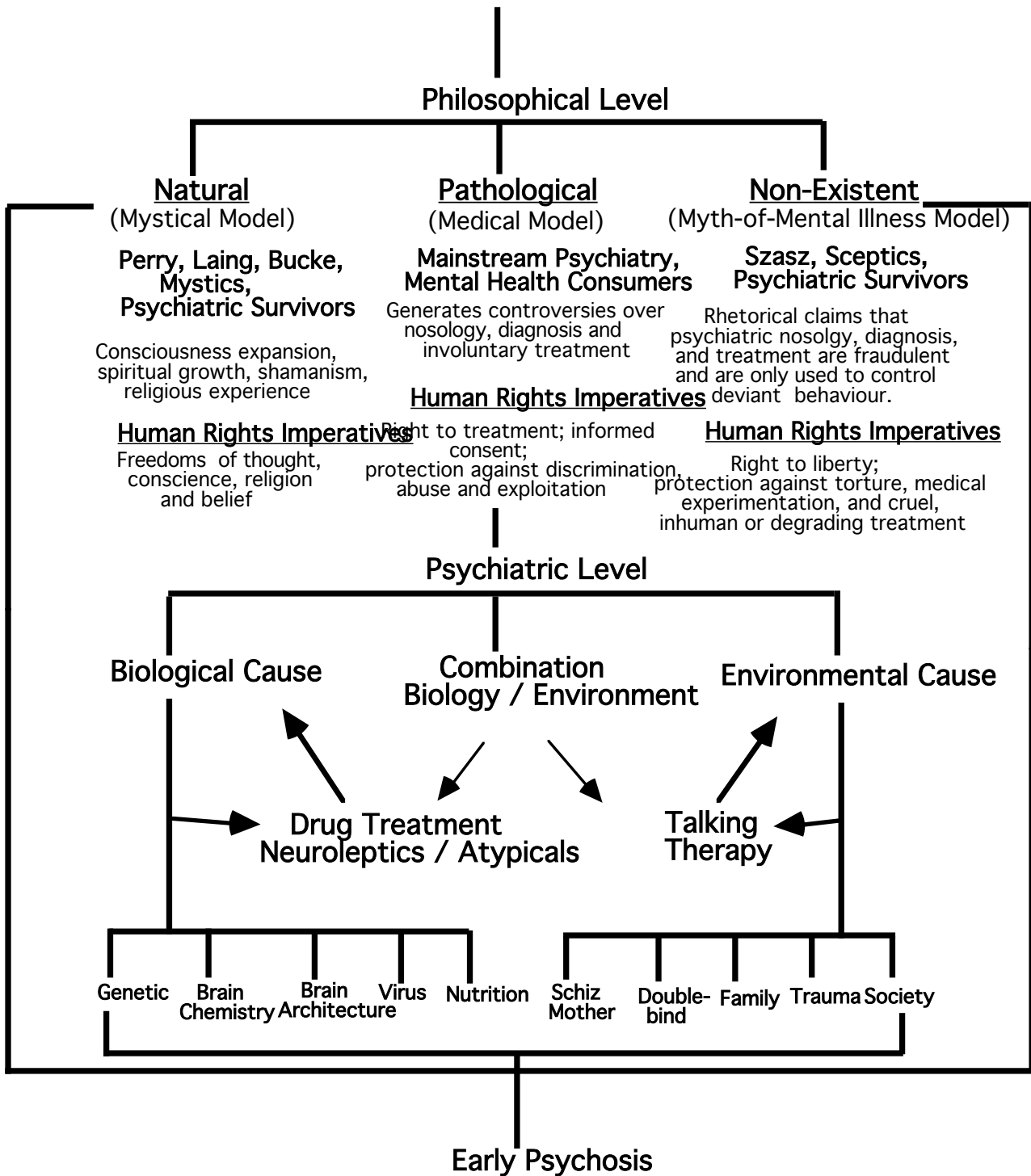
²⁷ Thomas Szasz, 'Idleness and Lawlessness in the Therapeutic State', Society, Vol. 32, No. 4, 1995, pp. 30-36.

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

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

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

Controversies Over The Cause Of The Symptoms Of Schizophrenia



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

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

Schizophrenia Controversies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expanding the Diagnostic Net

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

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

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

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

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

⁴⁷ American Psychiatric Association, op.cit.

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

⁴⁹ Ibid., p. 128.

⁵⁰ Ibid.

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

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

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

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

The DSM Diagnostic System

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

⁶⁴ *Ibid.*, p. 60.

Growth of the Mental Health Industry

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

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

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

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

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

⁶⁵ *Ibid.*, p. 8.

⁶⁶ *Ibid.*, pp. 8-9.

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

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

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

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

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

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

Social Control, Youth and Unemployment

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

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

⁷⁰ Ibid., pp. 631.

⁷¹ Ibid., p. 632.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

⁸¹ *Ibid.*, p. 132.

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

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

Social/occupational dysfunction.

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

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

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

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

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

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

⁸³ *Ibid.*, p. 285.

⁸⁴ *Ibid.*, pp. 277-278.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

⁹² Ibid., p. 13.

⁹³ Ibid., p. 20.

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

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

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

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

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

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

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

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

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

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

¹⁰⁰ Ibid., p. 18.

¹⁰¹ Ibid., p. 20.

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

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

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

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

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

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

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

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

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

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

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

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