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## **FROM THE EDITOR-IN-CHIEF**

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### **Psychiatry's Reliance on Coercion**

Probably from the very origin of the species, human beings have used force to obtain their ends. Anthropologists have conjectured that the evolutionary triumph of homo sapiens over other bipeds may owe more to our penchant for violence than to our intelligence. History seems to confirm that most organizations of human beings—from tribes and nations to churches and professions—will tend to use force to achieve their ends unless someone stops them. Unfortunately, too few people seem interested in stopping organized psychiatry's thirst for coercive power which is once again on the increase.

Like most coercers, psychiatry justifies the use of force by stirring up fear of violence by others, in this case, fear of the "violent madmen." Whenever a "former mental patient" commits a seemingly irrational crime, organized psychiatry raises the flag of fear about psychiatric patients and uses it to justify forced treatment with drugs.

When a woman was pushed to her death in front of a subway train in New York City by a man who was later identified as "schizophrenic," organized psychiatry and its lobbying group, the National Alliance for the Mentally Ill (NAMI), jumped at the media opportunity to call for increased mental health funding ("Munoz Sets the Public," 1999). NAMI advocated a program of total coercive control, including "assertive community treatment programs," "short-term involuntary inpatient commitment," and "regular monitoring for medication compliance."

Often the use of violence is further justified on the grounds of helping the subject of control. In retrospect, we think it farfetched that witches were burned not only to protect the community from heresy, but also to cleanse their souls. Someday it may seem equally strange that we locked up, poisoned, and assaulted the brains of "patients" in order to rid them of irrationality.

In modern times psychiatry has increasingly relied on biological justifications for using force. If "mental illness" is genetic and biochemical, the argument goes, the "patient" should not be treated as an autonomous being with ordinary human rights, such as freedom of speech or the right to a trial by a jury of peers.

People labeled mentally ill are commonly locked up for what they say or think rather than for what they do. But regardless of the reason for it, the incarceration

is accomplished by the certification of physicians, sometimes involving commitment by a judge. Rarely if ever does involuntary psychiatric incarceration or treatment involve the kind of due process and protection afforded accused criminals.

Jay Joseph's scholarly, detailed review of genetic studies in this issue of *Ethical Human Sciences and Services* should lay to rest any claim that there is a genetic basis for the diagnosis of schizophrenia. Joseph aptly underscores the absurdity of studies that attempt to locate a specific gene for a putative syndrome that has never been proven to be genetic. Al Siebert's critique of the medical model for schizophrenia further debunks it. No, schizophrenia is not like Parkinson's or Alzheimer's disease—neurological disorders that lead to central nervous system deterioration. It is wrong and demoralizing to give this false impression to people labeled schizophrenic who have no demonstrable disorder of the brain—people who often triumph over their anguish in order to live increasingly productive and creative lives. It is a very flimsy excuse for locking them up and drugging them against their will. People who do have real central nervous system disorders, such as Alzheimer's disease, deserve to be protected from toxic psychiatric medications that can only worsen their brain dysfunction.

In previous decades and centuries, the use of force by psychiatry was largely focused on how to incarcerate patients as expeditiously as possible. Once behind walls, the victims were routinely made to undergo treatment with drugs, shock, or lobotomy without further legal process. Then during the 1960s, there was a civil libertarian backlash. Attempts were made to narrow the criteria for involuntary commitment and to provide incarcerated patients with the right to refuse intrusive, brain-damaging treatments.

Now, armed with the same old biological theories but with much more drug company money, psychiatry has once again begun to expand its use of force. The newest thrust is the establishment of involuntary treatment "in the community." The patient remains outside of walls, but locked up within the system of enforced drugging.

Two additional articles in this issue of *Ethical Human Sciences and Services* point to threatening new expansions of involuntary treatment. Tomi Gomory critiques Programs of Assertive Community Treatment (PACT) that push coercive, potentially harmful interventions into the lives of vulnerable individuals, in this case long-term patients labeled schizophrenic who are living outside of hospitals. In PACT the details of the person's everyday life are under the control of the mental health system. Anything from refusing to take drugs to failing to get to work on time can lead to a coercive intervention. Gomory finds that once again, enthusiasts of the medical model and medication promote their programs in the absence of any scientific justification.

NAMI is the lobbying force behind PACT in the United States. Misleadingly labeled a "consumer organization," NAMI is an association of parents who favor involuntary treatment as a means of control over their grown offspring. Their unofficial motto seems to be "We are not to blame," and they advocate force to resolve their conflicts with their adult children by locking them up and treating them with brain-disabling treatments. According to one investigative reporter, NAMI is "awash in drug company money," with the New York State chapter alone receiving at least \$3 million per year from drug companies (Montero, 1999).

NAMI has successfully lobbied many U.S. state legislatures to provide funding for PACT. Since involuntary drug treatment is a major thrust of PACT, it guarantees the drug companies an infinitely expandable, if involuntary, market for their products.

In a most daring twist, drug companies like Eli Lilly and Pfizer, which manufacture neuroleptics, are lobbying state legislatures to provide funds to pay for medication for “patients” who cannot afford it (Kingrey, 1999). The drug companies would be guaranteed no disruption in the estimated \$300 per month per patient that flows into their coffers.

Meanwhile, human rights groups that advocate on behalf of “survivors” of psychiatry have identified PACT as the greatest new threat to the well-being of anyone labeled “mentally ill.” These advocates paint an accurate but scary picture of PACT officials invading private homes to force “patients” to take mind-blunting, neurologically damaging drugs (Oaks, 1998-99).

Richard Gosden examines burgeoning efforts worldwide to prescribe neuroleptic drugs to “prepsychotic” adolescents. These research projects cast a net over youngsters who have done nothing to draw the attention of mental health professionals. Instead, they are unwittingly caught up in screening programs through their schools and communities. Although these young people often seem like typical adolescents, they are labeled as potentially “prepsychotic” and experimented upon with the most toxic drugs in psychiatry.

Gosden shows how drug companies and mental health professionals are promoting these dangerous, humiliating intrusions into the lives of vulnerable young people. It is scandalous and abusive; and it is growing in popularity among drug companies and their advocates.

Can the youngsters in these “prepsychotic” programs be considered voluntary? No, they are too young to be considered competent to volunteer for psychiatric experiments. Besides, who would volunteer themselves or their children for these experiments if they were genuinely informed about the enormous hazards inherent in taking these drugs?

What is the scientific basis for involuntary treatment and forced drugging?  
There is none.

Gomory’s review demonstrates the lack of evidence for the usefulness of PACT, and its dangerousness. Looking further into the root principles of involuntary treatment with drugs, there is no scientific basis for it. Long-term psychiatric medication, voluntary or not, has little or no evidence to support it. While we can be certain that nearly all long-term patients subjected to neuroleptics will develop irreversible neurological disorders, such as tardive dyskinesia and tardive dementia, we cannot be certain that any of them will be helped (Jain, 1996; Simpson, Pi, & Sramek, 1996). Furthermore, there is equally little evidence for any benefit from involuntary psychiatric treatment. We use force because we can use force; we use force because we want to use force—not because it’s good for the recipients. Instead, those who advocate force almost always blind themselves to its negative impact. And beyond questions of “effectiveness,” the western traditions of human rights cry out against involuntary treatment.

We don’t need controlled clinical trials to know the dangers involved in involuntary psychiatry. The entire history of psychiatry demonstrates the tragic results of using violence in the name of doing good. Over a 300-year span, the

state mental hospital system has emotionally abused, physically tortured, sterilized, surgically lobotomized, and even killed untold numbers of involuntary inmates. To this day, involuntary patients run the constant risk of being poisoned and shocked in the name of treatment. To call for an increase in the coercive power of psychiatry is to invite further disaster.

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