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Tactical Biopolitics

Art, Activism, and Technoscience

edited by Beatriz da Costa and Kavita Philip
with a foreword by Joseph Dumit

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2. ACT UP's original Working Document, http://www.actupny.org/documents/firstworkingdoc.html (accessed February 18, 2007).

3. M. Harrington with J. Eigo, D. Z. Kirschenbaum, and I. Long, *A Glossary of AIDS Drug Trials, Testing and Treatment Issues* (New York: ACT UP/New York, July 5, 1988).

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5. October 43, *AIDS: Cultural Analysis/Cultural Activism*, ed. by Douglas Crimp (Cambridge, Mass.: MIT Press, 1988; also reissued in paperback by MIT Press).

6. Harrington et al., *A Glossary of AIDS Drug Trials, Testing and Treatment Issues*, pp. 26–27.

7. Larry Kramer, "The FDA's Callous Response to AIDS," *The New York Times*, March 23, 1987, also in Kramer's *Reports from the Holocaust*.

8. Section 102 (c) of the 1962 Kefauver-Harris Drug Efficacy Amendment amends the Federal Food, Drug and Cosmetic Act to read:

(5) . . . [If] there is a lack of substantial evidence that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended or suggested in the proposed labeling thereof . . . he [the Secretary of HHS] shall issue an order refusing to approve the application . . . The term "substantial evidence" means evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved. . . . .

9. In the 1970s, the U.S. Supreme Court held that the FDA could prevent people from importing laetrile, the putative anticancer drug, and could prosecute people for selling or buying laetrile. *U.S. v. Richardson*, 588 F.2nd 1235 (9th Circuit, 1978); certiorari denied, 440 US 947 (1979); rehearing denied, 441 US 937 (1979).

10. Margaret McCarthy, transcript of FDA meeting, August 5, 1988.

11. Philip M. Boffey, "At Fulcrum of Conflict, Regulator of AIDS Drugs," *The New York Times*, August 18, 1988.

12. Vito Russo, "AIDS Is a Test of Who We Are as a People," speech delivered in Albany, New York, May 7, 1988, and in Washington, D.C., on October 10, 1988.

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The Politics of Rationality

Psychiatric Survivors' Challenge to Psychiatry

E. Gabriella Coleman

The moral logos of contemporary biomedical psychiatry, no matter how clearly entrenched in our current medical topography, exists in the midst of various forms of political challenge. Here I will examine the significance of one of the most striking political countercurrents to the new biomedicalization of mental health: the psychiatric survivor movement, also known as "mad liberation." These advocates refer to themselves as psychiatric survivors to underscore the trauma experienced through various forms of forced treatment, such as electroshock therapy, forced drugging, hospitalization, seclusion, and restraints. This movement, whose historical roots extend back to the radical milieu of the 1970s and grew in the 1980s to include a more reformist strain of consumer advocacy, mobilizes the cultural ideal of freedom and self-determination, along with the law of human rights and informed consent, to undermine the moral, scientific, and legal claims furthered by the pharmaceutical companies and other authoritative psychiatric institutions (Morrison 2005; Lewis 2006b; Chamberlin 1990).

The psychiatric survivor movement has significantly contributed to a refiguring of the relationship between madness and rationality via an avenue of engaged, radical, and at times risky politics. While the line drawn in science between experts and non-experts is significant, the disjuncture between psychiatrists and those labeled as mentally ill has existed more like an impassable gulf, for the latter, as one advocate reminds us, "have been assumed to be irrational—to be 'out of their minds'" (Chamberlin 1990: 323). The size of this gulf has diminished as those diagnosed or labeled as mentally ill have forcefully nullified entrenched stereotypes of their incapacity through vibrant political expression, and eventually have been understood to hold a rational capacity to speak credibly about their condition and their treatment, and even to comment on the science of psychiatry.[1] Acting for the first time as a visible collective and in a broader context of social unrest and upheaval, these activists drew upon some of the most culturally charged

discourses of freedom, individuality, and human rights to make their claims bear cultural weight. These discourses still figure prominently in their political messages after thirty years of organizing.

While there are various political positions and critiques launched by consumers, survivors, and ex-patients (sometimes collectively designated by the term "c/s/x movement"), together they affirm a right to self-determination in the face of coercive treatments, and they seek to expose what they see as the scientifically suspect claims put forth by the pharmaceutical industry and institutional psychiatry. They often do so by challenging not the general enterprise of science, but what they see as particular instances of fraudulent science. In this chapter I examine cases and examples that demonstrate how survivors have challenged authoritative psychiatric practices and science in support of their own political project—to establish the right to unconditional self-determination in the face of their subjectivity and rationality being deemed pathological and irrational by medicinal diagnosis. In particular, I seek to understand how these activists have maintained a radical stance in the face of shifting though related contextual conditions—such as the transition from the radical political landscape of the 1960s and 1970s to that of neoliberal materialism in the 1980s, the growing legitimacy of a neurochemical model of mental illness, and a pervasive culture of seeking, prescribing, and taking drugs—that have worked against their ability to sustain a visible articulation of radical politics.[2]

Thus, while the present face of the psychiatric survivor movement challenges the current biological paradigm of mental illness by undermining its presumed certainty, those involved have launched their claims from the foundation of a longer historical engagement with psychiatry at different epistemological moments and in different political climates. And these contexts have significantly facilitated *and* dampened the radical voice of the movement. For example, as I will argue below, the politics of ex-patients and survivors arose in a period in American history ripe for a radical critique of psychiatry, one that was able to communicate with cultural ease due to the broader climate of dissent as well as the more uncertain state of psychiatry.

However, just as these advocates gained a voice, mainstream psychiatry reinvented itself so as to become a more legitimate enterprise, one that provided the public with a morally enticing model of mental illness. As part of this shift, institutional psychiatry came to focus primarily on one object for therapy: the brain. Viewing the brain as an organ existing in isolation from its social environment, mainstream psychiatric practice sought to alter a range of behavioral symptoms, largely exclusively through the psychotropic manipulation of brain chemistry, notably neurotransmitters. It is this limited scientific framing of normalcy and illness, mandating a cocktail of pharmaceutical interventions, which survivors have had to contend with in their struggle to remain radical over time.

Along with these changes internal to psychiatry, survivors faced broader political and economic shifts that facilitated the rise of the more moderate expression of consumer activism. In the mid-to-late 1980s, it seemed that psychiatric survivors and ex-patients

were doomed, like many other political activists from that period, to languish and vanish in an era that championed primarily consumer and lifestyle politics. In these changing social and medical contexts, freedom, the governing rallying call of the movement, seemed capable of communicating only one message: individual choice over treatment options, which, however expansive-sounding, was in reality being narrowed down to choosing from an extensive array of psychiatric drugs. Indeed, at first blush, the ascendancy of consumer advocacy in the 1980s and the marginalization of survivors and ex-patients seem to provide an apt example of David Harvey's recent insight that "[a]ny political movement that holds individual freedoms to be sacrosanct is vulnerable to incorporation into the neoliberal folk" (2005: 41).

However, despite a substantial commitment to individual freedoms and the growing visibility of consumer rhetoric, the radical message of this movement was not, in fact, so easily engulfed by neoliberal logics. Since the mid-1990s, survivors have demonstrated their ability to stand the test of time, remaining relevant by building extensive alliances with more moderate political activists, by reemphasizing more inclusive political vocabularies, such as those of disability rights, by tactically shifting messages, and by entering a territory—the neurochemical basis of mental illness as formulated by mainstream psychiatry—where few others were willing to venture.[3]

As part of this venture, they have been one of the few groups to get the American Psychiatric Association (APA) to address and admit to the uncertainty surrounding the current biological theories of mental illness. After a small group of psychiatric survivors held a hunger strike in the summer of 2003, demanding that various groups, including the APA, "produce scientifically valid evidence" for the biological basis of mental illness, the APA eventually released a statement that admitted "brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive bio-markers of a given mental disorder or mental disorders as a group."[4] In an era during which biological explanations for behavioral conditions have become part of the largely unquestioned terrain of explanations, this was an exceptionally rare, and thus historic, political admission. The hunger strike represents one of the most potent examples of how psychiatric survivors, often marginalized as "non-experts," "too radical," or "the political fringe," have in fact, via decades of continuous, though continuously shifting, political action, successfully created an arena for critical debate in the medical biosciences.

I raise this striking example as a starting point from which to examine the role, importance, and limits of radical politics for the creation of participatory publics in the biological sciences. What follows, it must be emphasized, is not a straightforward empirical history, much less a detailed account of survivors, American political culture, or transformations in psychiatry. Instead, it proceeds with a more modest and highly selective account of examples drawn from the psychiatric survivors' initial forceful appearance in the early 1970s, tracks the rise of consumer advocacy in the 1980s, and ends with a more

detailed examination of this hunger strike. Since I focus primarily on ex-patients and survivors, who tend to put forth a radical critique, I disaggregate them from consumers, especially in the earlier part of my narrative, before I address the rise of consumer advocacy in the 1980s. I nest these partial examples within some of the most salient political, medical, and economic currents at play during this thirty-year period (especially dominant trends in psychiatry) so as to offer a critical and conceptual appraisal of the moments in which the political message of psychiatric survivors held more widespread cultural and political purchase. In so doing, it is clear that while larger forces enable *and* constrain political activity, these activists' ability to survive as central protagonists in a critique of institutional psychiatry follows from their willingness to shift political message and tactics within a tide of changing conditions.[4]

The Beginnings of Radical Politics of Freedom

The 1960s and early 1970s are recalled as a tumultuous period in American history when the vibrant fire of political dissent burned bright, illuminating and, in some cases, transforming a plethora of social ills, institutions, and legal mandates. From attacks on segregation to feminist clamoring for equality, academic critique was in significant harmony with a blizzard of imaginative political action. In this period, activists and academics alike seized the concept of madness as a means by which to understand the very nature of social injustice, inequality, and political interventions. To take one of the earliest and most forceful examples, in 1955 Martin Luther King delivered one of what were to be many fiery speeches on civil rights, "Montgomery Story," during which he urged his listeners to "keep the ball of civil rights rolling to the end" by adopting a seemingly counterintuitive tactic. In short, he suggested the path toward liberation lay in embracing madness.

In future speeches he would expand on this message, urging audience members to stand maladjusted in the face of racial discrimination and segregation, religious bigotry, militarism, and physical violence.[6] For example, in a speech delivered in 1965 at the University of Western Michigan, he proclaimed, "I am proud to be maladjusted. . . . I say very honestly that I never intend to become adjusted to segregation and discrimination."[7] For African–Americans to adjust to the unquestioned norms and laws of racial segregation was in fact to inhabit the territory of true madness. To achieve justice and freedom, King ostensibly sanctioned the embrace of "madness" and thus, in turn, diagnosed the norms of society as mad. His proclamation is just one important example of how the meanings of normalcy and madness in this period of American history were starting to shift under the weight of vigorous social unrest, academic critique, and legal populism.

In the 1960s, a steady stream of civil rights and anticolonial movements, and other challenges to authority—from the antiwar protests to the countercultural turn—diagnosed society in similar terms, speaking powerfully and collectively about and to the social abuses of power. In particular, this decade saw an efflorescence of academic literature that

deployed "madness" as a means to conceptualize, and thus unearth, abuse, coercion, and injustice. The academic champion of the New Left, Herbert Marcuse, for example, wrote in the late 1960s about the ways the power of social dissatisfaction, and thus potential political dissent, was categorically nullified by being collapsed and associated with insanity, and thus worked to obscure the real locus of sickness: the affluent, wasteful society (1968: 248–252). And of course, most famously, there was body of widely read and influential academic literature by Michel Foucault, Erving Goffman, and Thomas Scheff, as well as critiques put forth by dissent psychiatrists, such as Ronald Laing and Thomas Szasz, that specifically addressed psychiatry, its institutions, and its schemes of classification as modalities of coercion. This literature animated what grew to become a primarily academically oriented yet influential critique that also came to be known more broadly as that of anti-psychiatry (Crossley 2006).[5]

It was within this charged milieu and following in the wake of an extensive academic critique of psychiatry in which a group of people, primarily those who were deemed insane and who shared experiences of abuses of psychiatric power, banded together to initiate what became a grass-roots "mad liberation movement." As Nancy Tomes argues, this new development was historic insofar as "[t]he claim to have special insight into mental illness by having actually experienced it was a novel assertion" (2006: 722). The first step taken was to form organizations and collectives run by ex-patients, such as the Insane Liberation Front, founded in Portland, Oregon, in 1970, followed by groups in New York, Boston, western Massachusetts, and San Francisco. Though activists emphasized the importance of self-determination in the face of psychiatric power, among peers they cultivated a social message of peer support and mutual aid (Chamberlin 1990: 323; Morrison 2005). The publication of the *Madness Network News* in 1972 increased the movement's scope significantly, providing a medium in which to formulate the nascent ideals, and linked people across space and time through the circulation of home-brewed news and art, written and edited by a host of actors who included ex-patients, survivors, dissent psychiatrists, and sympathetic lawyers. In 1973, survivors helped to organize and participate in their first conference, "Committee of Human Rights and Psychiatric Oppression," and similar yearly conferences since then have played an important role in the movement. As a result of these activities, these activists started to build a realistic picture of psychiatric patients as an oppressed group.

These advocates took it upon themselves to challenge the legal regulation of their bodies not only though the law of informed consent and human rights, but also through the regulation of the meanings of mental illness, madness, and rationality. Echoing Martin Luther King's call to stand maladjusted in order to reveal the madness of society, psychiatric survivors challenged authoritative medical institutions by laying bare the irrationalities of psychiatric care and reformulating the meanings of normalcy and madness. Some advocates questioned the state of madness altogether, and others coded it as a real and valid human experience that should not be pathologized, but instead celebrated due to

its deviancy and its ability to provide insight into the human condition.[9] Amid these varied positions, one stance was eminently clear and nearly unanimous: forced treatment, which at the time was entirely buttressed by the law, was a form of violence, for it denied participants the self-determination of their own bodies and often placed them in situations that were experienced as injurious, and thus were traumatic.

As Linda Morrison vividly demonstrates in her extensive account of the mad liberation movement, psychiatric survivors, along with other mental health advocates, through this type of activism not only crafted a "voice" to "talk back" to psychiatry on questions of care, treatment, and harm, but also sought to more fundamentally change the terms of engagement to create an alternative epistemological, material, and moral reality to the one provided by mainstream psychiatry. Eschewing a desire for normalcy as dictated by dominant understandings of mental illness, they sought instead to validate "their local, regional knowledge as *knowledge* and not only as data for the psychopharmaceutical research-industrial complex" (Morrison 2005: 23).

At the time, many of the political claims made by advocates held considerable public sway, in part due to the charged countercultural milieu in which various intersecting antiauthoritarian currents were working in synergy to bolster each other. With society assiduously and so visibly attacked as mad by so many various social groups, there was a political opening by which those deemed mentally ill could communicate a critique of psychiatry more forcefully than ever before.

However, what must be emphasized is that at the time of this political outpouring, the field of psychiatry was also at a crossroads, undergoing significant epistemological turmoil and lacking the types of hard scientific insignias that it now is supposed to bear. For example, the development of neurochemical theories of the brain was in its infancy, only beginning to challenge the authority of psychodynamic approaches—often Freudian in orientation—which had been one of the dominant paradigms in psychiatry until the early 1960s.[10] In the early 1970s, these techniques were increasingly subject to a critical gaze, in part because of their tendency to reduce all phenomena to childhood experience, and thus their propensity to breed an overt moralism that placed heavy blame on the family, usually mothers (Dolnick 1998). In addition, the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM*), now the current diagnostic bible, was considered, even within the field of psychiatry, overly vague and thus unable to shore up the forms of authority it now commands. Finally, and most famously, the institution most closely associated with psychiatry, the asylum, was under sustained attack by the political Right and Left, and in the throes of being torn down due to a complicated host of pressures that included over two decades of critiques and exposés, financial crises, and legal attacks from civil liberties organizations.[11]

A body of mental health law was of course the primary tool used to place and keep those identified as mentally ill within the confines of the psychiatric hospital and subject to various forced treatments. Because of psychiatry's dependence on the law, Foucault

rightly notes that the body of the madman was an "object of juridical interdiction," further clarifying that the "law prevailed over medicine in endowing madmen with a marginal status" (1970: 338). In the United States and most other liberal democracies, legal statutes authorized forced treatments and, until the 1960s, informally coded "madmen" either as non-persons or as criminals by stripping them of their civil rights (to vote, marry, hold licenses, for example) once placed in an institution. With an attack on asylums also came an attack on the web of laws that sustained institutionalization.

By the end of the 1970s, due to significant changes that partly followed patient-driven litigation (including that of survivors), and partly through independent initiatives supported by civil rights activism, the law no longer worked in such seamless service with psychiatry. For example, legal changes that upheld the civil rights of patients made it more difficult to involuntarily commit patients, clarified the right to refuse treatment, and outlawed forced labor within hospitals. These changes worked together to designate psychiatry and its institutional locus of the time, the asylum, as far too powerful and coercive, often to the detriment of the well-being of patients.[12]

One well-known example of the more general shaky position psychiatry and the asylum held during this period was produced and conveyed by an experiment conducted by Stanford University Professor David Rosenhan and published in the prestigious journal *Science*. It is worth briefly recounting the experiment here, for it is one powerful token of a more general skepticism that marked psychiatry and asylums at the time. In 1973 Rosenhan sent eight pseudo patients to various hospitals on the East and West coasts to try to gain admission by claiming they were hearing voices. They were admitted without difficulty, and staff immediately diagnosed them as either schizophrenic or manic-depressive. After admission, they resumed their normal behavior. Although they acted normal, they were never detected by the staff, but many fellow patients easily noticed the deception, and a substantial number challenged them: "You're not crazy, you're a journalist or a professor" (1973: 4).

On the other hand, staff members interpreted seemingly innocuous and ordinary actions, such as taking notes, as the manifestation of aberrant, compulsive behavior. The "patients" were forced to stay on average nineteen days, and in one case, fifty-two days. *Science* published the findings in an article, "On Being Sane in Insane Places," that helped to fuel one popular perception that psychiatric institutions were holding pens for people labeled by the psychiatric profession as deviants, as opposed to a place for healing the genuinely ill.

Biological Psychiatry Gains Respectability Through the *DSM III* in the Era of Neoliberal Economics

Because psychiatry was undergoing significant flux, it was particularly vulnerable to critique, especially in an era that was already championing human rights in the face of what

were perceived as impersonal, dangerous, or overly powerful institutions. However, in the succeeding decades, whatever forms of credibility survivors had forged were shaken and transformed by a newfound confidence in the biological foundations of mental illness. Beginning in the 1970s and reaching a zenith in the late 1980s, a neurochemical model of mental illness was consolidated and strengthened to achieve a state of significant respectability. This came about through the convergence of trajectories that included new federal regulations covering drug research and advertising initiated in 1962, the introduction of psychotropic medication on a widescale basis, and the third edition of the *DSM*. Within and through this convergence, psychiatry formulated what Andrew Lakoff describes as a new technical rationality of specificity, which he dubs "pharmaceutical reason," an idea that "targeted drug treatment will restore the subject to a normal condition of cognition, affect or volition" (2005: 7).

Until new psychotropic drugs were developed in the early 1950s, most psychiatric drugs, such as Valium, were tranquilizers, which carried with them two related perspectives. One was that the public and medical professionals often understood them not as therapeutic, in the sense of returning a patient to well-being, but still worthwhile insofar as they provided a brief respite from the onslaught of symptoms. Second, the media and the public often cast them in a critical hue for being dangerous, overabused, and addictive, notably after the FDA mandated stricter advertising regulations in 1962, as part of sweeping changes to the Food, Drugs and Cosmetics Act following public outcry over a sedative, thalidomide, that caused thousands upon thousands of birth defects, even though originally deemed safe by pharmaceutical companies (Healy 1997). As a number of historians, anthropologists, and critics of psychiatry note, these regulatory pressures worked to place psychiatry and new pharmacological developments on a road toward an exclusive and narrow medical model of disease (Healy 1997, 2002; Lakoff 2005). After the regulatory changes of 1962, drug companies were required to establish that drugs were both safe and effective prior to approval (and thus market release). This necessitated, in other words, a much more intimate correlation between drugs and discrete disease entities than previously necessary.

This regulatory requirement to connect drugs' efficacy to specific diseases helped to accelerate an independent initiative within clinical psychiatry and pharmacology to formulate standard classification schemes. An array of standardized classification schemes was devised following a well-publicized comparative study involving the United States and Europe that demonstrated significant disparities in diagnostic regimes between the two. Under the leadership of Robert Spitzer, a researcher from Columbia University's Psychiatric Institute, new instruments and questionnaires, such as the Research Diagnostic Criteria and the Global Assessment of Psychopathology, were created to achieve greater standardization and, it was hoped, specificity in psychiatry.

Robert Spitzer was also one of the main figures directing and driving an ambitious, six-year project to review, renew, and update the *DSM* from its second to its third edition that,

when completed in 1980, not only provided psychiatrists with more standardized criteria by which to evaluate and diagnose patients, but also described in recipe-like detail more than 292 disorders, over 100 more than had existed previously.[13] Approved by the APA, it signaled a new style of thinking, diagnosing, and treating mental illness that had, by the time of its release, eclipsed a more psychodynamic approach popular in the preceding decades.[14] Touted by many in the profession as a genuine scientific instrument, this new tool equipped the psychiatrist to "become a measurer, not interpreter" (Lakoff 2005: 12).

Though its development was often a drawn-out and contentious affair, once released, the *DSM III* quickly made waves in the general public. "There were splashy stories in the press," writes the journalist Alix Spiegel, "and TV news magazines showcased several of the newly identified disorders" (2005: 62). In the period of its initial circulation, it was translated into thirteen languages and was soon embraced by a wide array of interested parties. For the pharmaceutical industry and the insurance companies, in particular, it provided a professionally agreed-upon artifact for pushing efficiency and tracking outcomes in health service and drug provision. "The creation of a discrete set of disorders, such as panic disorder, social phobia, obsessive-compulsive, and other disorders," David Healy argues, "gave the pharmaceutical industry a set of targets at which to aim its compounds" (1997: 237). Eventually, these compounds were presented as "cleaner" and safer than their predecessors because they arguably targeted a definitive set of neurochemicals, such as dopamine and serotonin, that were increasingly being conceptualized as the heart of emotional disturbance, even though definitive links have yet to be established (Rose 2003; Whitaker 2002; Lacasse and Leo 2005).

In this era, through the close combination of a proliferation of therapeutic agents and new technologies of intervention, visualization, and classification, psychiatry, as Brad Lewis argues, came to acquire "an amazingly idealized notion of 'theory neutrality'" (2006a: 1). The power of science to talk and to compel publics, of course, is not a self-enclosed and self-sustaining engine that transports a new model of mental illness to public acceptance. As with any scientific claim or medical therapy, there are various complicated, though often invisible, forms of labor at work, including moral promise, and the one provided by the new pharmaceutical reason proved to be particularly enticing. The neurochemical model of mental illness was seductive, in part, because it provided a pronounced pledge: a moral alibi that could free human persons from certain forms of responsibility, and thus, it was said, from stigma. As Tanya Luhrmann argues persuasively in her analysis of American psychiatry, "[b]iology is the great moral loophole of our age. If something is in the body, an individual cannot be blamed; the body is always morally innocent" (2000: 8).

The promulgation of this model and its moral implications was voiced by psychiatrists, many patients, and more indirectly but no less powerfully, furthered by the pharmaceutical industry through a considerably fortified advertising apparatus. And perhaps more than by any other group, the biological model was heralded by another stakeholder that

appeared a little less than a decade after the establishment of survivor activism: the National Alliance for the Mentally Ill (NAMI). Founded in 1979, NAMI is a large-scale nonprofit, support, and advocacy organization of families and friends of those with severe mental illnesses. It sits in significant tension with survivors for its uncritical endorsement of drug therapy and the neurochemical model of mental illness (Morrison 2005: 85–87, 149–155; Whitaker 2002: 283). With hefty funding, much of it from Big Pharma, NAMI champions, to the general public and the government, the biological model of illness as a path to orient research and therapy, and especially to pave over the bumpy gravel road of stigma. It states on its Web site: "Mental illnesses are, biologically based brain disorders. They cannot be overcome through 'will power' and are not related to a person's 'character' or intelligence."[15]

If mad liberation politics of the 1970s opened a space in which the "mentally ill" demanded a voice and were to some degree granted this rationality, then the growing acceptance of the neurochemical model of illness, with its moral promise for a possible cure and destigmatization, changed the terms of engagement. Now, to be rational meant to accept this model of mental illness and, as a close corollary, the treatment model it entailed: psychotropic drugs. To do otherwise was seen as a stark rejection of what was being presented as transparent and clear scientific evidence and would implicitly, though no less powerfully, recode a person as lacking in rational capacities.

Despite these changes, the language of freedom initiated by the radicals of the 1970s did not all of a sudden vaporize; instead it mutated. The politics of the mad movement unleashed a discursive genie of self-determination and freedom that, due to its enormous popular appeal in the American cultural imaginary (cf. Foner 1998; Norton 1993) and other liberal democracies, did not vanish. During the mid-1980s, in the face of the dominance of a renewed biological model of psychiatry, the public and radical face of the psychiatric survivor movement wilted. In its stead, the consumer reform movement flourished. It retained a language of freedom which, at times, aligned with and reinforced the neoliberal currents still with us today.

And consumerism it was. The 1980s, and especially the 1990s, saw the rise of a fortified pharmaceutical industry whose dizzying profits were the result of many changes in research and development as well as marketing practices. The pharmaceutical industry aggressively engaged in marketing campaigns, pitching directly to doctors and hospitals. In the United States, new laws sanctioned direct-to-consumer advertising for all classes of pharmaceutical treatment. This helped to secure the rise of a handful of blockbuster drugs targeting the management of a range of chronic health conditions from high cholesterol to depression (Oldani 2004; Goozner 2004; Healy 1997, 2002; also see collections in Elliott and Chambers 2004; Sismondo 2004; and Petryna et al. 2006). These changes helped set into motion cultural changes in self-perception (Rose 2003; Dumit 2003a, 2003b) and fueled a growing cultural acceptance of, and perhaps even a desire for, pharmacological interventions to manage the body and its afflictions (Elliott 2003).

Since the 1990s, the pharmaceutical companies have worked assiduously to connect specific drugs to the discrete disorders outlined in the *DSM* by directly providing doctors and hospitals with recommendations and guidelines, known in some places as medication algorithms (Waters 2005). It was more common than ever to be told that mental illnesses were chronic conditions that often required a lifetime of cocktail drug therapy. Within this changed environment, psychiatric patients more than ever were called consumers and clients, labels that some patients, even those critical of psychiatry, started to actively embrace (Tomes 2006; Morrison 2005; Chamberlin 1990).

Indeed, they were granted the rationality of consumers: by the 1980s they were encouraged to participate to some degree in policy-making and development of local community health clinics and other nationally coordinated programs that replaced the large state institutions; in various mental health settings, they were asked to provide feedback so as to create a collaborative relationship between psychiatrists and clients, in the hope of reaching recovery. Given these allowances, Linda Morrison explains, the self-help consumer movement became the visible public face of the consumer, survivor, and ex-patient movement, and its political strategies were geared primarily toward the reformist goals "of obtaining funding, influence, and the power of negotiations, sitting at the table with professionals and policy makers" (Morrison 2005: 85; Tomes 2006).[16]

In this context, any accusations of forced treatment and human rights violations seemed somewhat anemic and pale, perhaps even mute. How could these claims stand as valid or communicate at all to larger publics when patients were now considered consumers exercising their free will, working in collaboration with mental health workers, managing unwanted symptoms by ingesting pills (verified as safe by the FDA) in the privacy of their homes—and the drugs were touted by doctors and pharmaceutical companies as far more effective than an earlier generation of drugs?

Politics in the Age of the Proliferating Pills

In fact the new biologization of mental health also augured different forms of control and coercion over patients, and it became clear that a united front was necessary to continue organizing effectively (Oaks 2006; Morrison 2005: 96–97). Since the 1990s, an older generation of psychiatric survivors and a new cadre of activists have come together to continue forging a radical yet tactical politics that addresses these new medical and economic contexts. The effect has been a more targeted attack against pharmaceutical science and a conscious move to end the evident strife between reformist and radical positions that had grown markedly in the 1980s, so as to accommodate a spectrum of political sentiments and individual views on the nature of illness/experience.

In the mid-1990s came many renewed efforts to reintroduce practices such as electroshock therapy, and especially forced drugging. For example, since 1997 NAMI has continually proposed, and is seeking federal backing for, a program first developed in the

1970s as part of the shift from deinstitutionalization to community mental health: the Program of Assertive Community Treatment, more commonly known as PACT. Now used in twenty states (and legalized in at least twenty more), it is a medication compliance program that provides at-home drug delivery. The idea is that trained mental health workers visit some clients every day at their homes, even twice a day, to inject them or to confirm they have swallowed their pills. New York State NAMI proudly advertises PACT as "in essence, a hospital without walls."[17]

The radical wing of mad liberation, in part because of this specter of "a hospital without walls," resurfaced with revitalized and tactical vigor. "The organized efforts by NAMI and its sympathizers to introduce PACT model of forced outpatient treatment in every state," writes Linda Morrison, "mobilized a c/s/x activist force in the 1990s that was unprecedented in the history of the movement" (2005: 91). Access to the Internet facilitated organizing and allowed for the immediate transmission of information and personal experiences of trauma, many as a result of serious side effects from drugs that were officially touted as safer than the older generation of drugs.

This new iteration of the mad liberation movement is still primarily against forced treatment and electroshock therapy, but has also had to contend with new, powerful institutional actors, notably the pharmaceutical industry and the reality it helped secure: that of a pervasive culture of prescribing and taking drugs. Psychiatric survivors now direct much of their political energy toward this arena, routinely challenging the pharmaceutical industry for false advertising and for concealing potentially harmful side effects that are discovered in their own clinical trials; and they actively support research that seeks to understand how current psychiatric drugs may produce "chemical lobotomies" by permanently altering brain chemistry.

Part of the revitalized agenda among psychiatric survivors also needs to be read as an attempt to widen the scope of rationality that had been whittled and shrunk into a box of consumerism by the popularity of the neuroscientific paradigm validated through new forms of psychiatric diagnosis and treatment in combination with neoliberal trends, such as privatized science and new techniques for advertising. And the survivors do so largely by destabilizing the current state of psychiatric science and exposing the coercion that marks current drug prescription regimes and new laws that sanction forced drugging.

For example, during a protest at the annual American Psychiatric Association meetings held May 20–23, 2006, in Toronto, psychiatric survivors and other advocates handed out a leaflet titled "In the Name of Mental Health—Psychiatry's Human Rights Violations." The first item on the list—the lack of informed consent in treating patients—forms the bulwark of their critique, past and present. This is followed by "forced drugging," which specifies and expands on the theme of informed consent to include psychotropic medication:

> Psychiatrists frequently administer brain-disabling antidepressants and neuroleptics and addictive tranquilizers ("medication") without informed consent of their patients. This is unlawful. Under the Criminal Code of Canada, "unwanted touching" is an assault. Forced drugging is assault. Many psychiatric survivors have been traumatized and disabled (sometimes permanently) by forced drugging (e.g., injections).

While psychiatric survivors do affirm a person's right to take drugs for treatment and have actually moved more than ever before to openly relay and support a pro-choice stance (in part because of the rise of consumer advocacy and in part because some activists do rely on drugs), they also are quick to point to the limits of the current dominant discourse of consumer freedom. For example, the following explanation from The Freedom Center, an advocacy center based in Northampton, Massachusetts, is a fairly common position on drugs among even more radical activists. While they clearly affirm choice, and thus retain a language that is common to a consumer message born in the 1980s, they also, in the same swoop, quickly qualify it so as to demonstrate the limits of this narrative, given an institutional and social context in which there are virtually no alternative treatments and where there is a dearth of clear and honest information on side effects:

> Many of our members take some kind of psychiatric medication. We believe in personal choice and empowerment as opposed to paternalism and control. We believe individuals should, with support and true informed consent, find out what works best for them. We believe that the existing "informed consent" of the psychiatric system is basically a sham. For informed consent to be authentic, everyone should have access to accurate information about "mental illness" and the real nature and toxicity of psychiatric drugs; that real alternatives to drugs should be funded and available; . . . The science behind psych meds is corrupted by drug company money, and studies show placebos (sugar pills), counseling, social supports and alternatives are more effective and safer. Medical doctors and pharmaceutical companies must stop spreading misleading and fraudulent propaganda about psych meds and start telling the truth about how dangerous, ineffective, and often counterproductive they can be. Doctors should stop pushing meds—even putting people on six, seven, or eight different drugs at once. This is abuse.[18]

The organization's co-founder further clarifies that "pro-choice is a way to deal with the reality of individuals on medications who feel judged and alienated. We don't want to be shrinks in reverse. We are a harm reduction movement—we are not advocating abstinence and we respect that people make difficult decisions."[19] However, as they recognize, with no other institutional options provided—much less insurance coverage—than to take drugs, many consider consumer choice an empty promise that works to reassert the neurochemical model of illness that is, as far as they see it, still far from scientifically established, only made worse by the nearly blind faith put in pharmaceutical treatments.

Therefore psychiatric survivors, even while working with more reformist consumer advocates, point to the limits of a model of consumerism as freedom. It reveals the power imbalances concealed in a model that has reached the status of nearly unquestionable truth. Given this status, it is not surprising that so many of their political efforts are currently directed at undermining the confidence that in turn underlies the scientific basis of the neurochemical model of mental illness that in turn supports current practices of pharmacological interventions and, given its hegemonic status, is doing so through more extreme political measures.

In recent times, the most distilled and successful of their campaigns was the hunger strike mentioned earlier, held in Pasadena, California, in August and September of 2003. Six psychiatric survivors were joined by survivors all over the country who organized shorter solidarity fasts in order to draw the attention of the American Psychiatric Association, the National Alliance for the Mentally Ill, and the U.S. surgeon general. Their primary demand was "that the mental health industry produce *even one* study proving the common industry claim that mental illness is biologically-based."[20]

The choice of a hunger strike was significant for pragmatic and symbolic reasons. Despite years of consumer input in the field of psychiatry, one topic was behind barbed wire, off-limits to any sort of meaningful debate: the biochemical nature of mental illness. These psychiatric survivors deployed an extreme political tactic to attempt to force a discussion on a reductive biological theory of mental illness, which seemed to lie largely beyond discussion. Additionally, their hunger strike enunciated strong performative elements. These psychiatric survivors, who have suffered under psychiatric care, are willing to inflict suffering on themselves to demonstrate how those very organizations and institutions that assert they are helping them have instead come to stand for the suffering they claim to have endured.

At the time, I was following the strike with keen interest, in part because this move seemed particularly bold. Even while it was clear there was still a high degree of uncertainty surrounding the neurochemical basis of mental illness, it seemed to me that the APA and related parties could probably produce at least *one* source that, if nothing else, seemed, in the greater public eye, to offer "enough evidence" to validate their claims. And if they did, this would significantly, if not indefinitely, mute and silence the position advocated by these protesters. "The protesters faced the possibility," Brad Lewis rightly notes, "of being labeled 'mad' " (2006b: 339). These actions, in other words, seemed to be risky not only because of the physical injury potentially incurred by fasting but also because, if they failed in their quest, the larger movement would be further discredited by some of the most powerful associations and institutions of psychiatry while under the steady gaze of the mainstream media.[21]

Soon after the start of the hunger strike, the APA refused to release a statement. After twenty days, its medical director had a brief telephone conversation with one protester, telling him that mental illnesses were in fact "brain diseases and that this fact is as

irrefutable as the 'earth going around the sun' " (emphasis added). Surprisingly, a few days later, the APA released an official statement that refuted this earlier claim. Though it was insistent that mental illness was biological, it acknowledged that brain science, as they called it,

> . . . has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive bio-markers of a given mental disorder or mental disorders as a group. . . . Mental disorders will likely be *proven* to represent disorders of intercellular communication; or of disrupted neural circuitry." (emphasis added)

Of course, this revelation neither proves nor fully denies a biological reality for mental illness. More than anything else, it is significant because the APA finally engaged in a debate, as defined by the survivors, on the limits, lacunae, and myopic reductionism of psychiatric science.[22] Specifically, the APA openly admitted to a routine state of any scientific endeavor: being in a state of uncertainty or partial certainty, and the need to orient known variables toward hypothetical future possibilities.[23] As the APA claims, given what we know, it is conceivable that a more sound neurochemical model for mental illness may be found, but as it stands, there are still many pieces missing from this model—too many, perhaps, to warrant the type of uncritical confidence exuded both by institutional psychiatry and, especially, by the pharmaceutical industry. As stated during a media interview with David Oaks, one of the fasting survivors: "They acknowledged that they didn't have the biological evidence [of mental illness], so that's on the record. . . . Now it's time for the APA to implement a far more complex model [of mental illness] that reflects the whole person and not just this narrow, reductionist, biological model."[24]

With an admission of uncertainty there also comes some acknowledgment that treatment may not be as efficacious as routinely presented, and thus there is room for alternative theories, public debate, and ongoing critique. Another way of thinking about the admission of uncertainty is that it places advocates/patients/survivors in a position where they *must* be taken more seriously as experts because so-called experts are operating as much within an uncertain territory as their patients, yet patients are the ones who have to bear the very real consequences of engaging in therapies that, though many personally admit they are helpful and necessary, still carry tremendous, ill-understood risk. In the end, one of the strongest messages this hunger strike conveyed is that many psychiatric survivors are not questioning medical science per se, but are asking for a more open, transparent practice that fully confronts and admits to current uncertainties, verified risks in treatments, and the highly reductionist orientation of current models. This is the only way to end the abuse and unequal power relations so commonly attributed to psychiatry.

One interesting question that follows from the APA admission discussed above is, What sort of treatments should one, or can one, devise in a field of missing pieces? This

question is one that many survivors, consumers, and patients must, and do, confront when they decide to embark on a drug treatment regime whose long-term effects are poorly understood and whose known side effects are often concealed and, when addressed, often grossly underemphasized. But this often is a personal choice that occurs individually, or increasingly collectively among peers on the Internet, or through the support networks of survivor organizations, well outside of open and public debate with mainstream psychiatrists and, most certainly, the pharmaceutical industry.

And what is clear is that while this question is difficult to ask within the context of biomedicine, which eschews uncertainty and, often for good reasons, it is even a more unthinkable question to ask within an industry that works along a curious logic of promise that uses the past as a prop by which to argue for progress, advancement, and thus goodwill. Drawing on the work of Paul Rabinow, Nick Rose distills the nature of today's pharmaceutical-driven psychiatry as one of a tight entanglement between the drive for knowledge and the need to secure high profit margins: "The quest for truth is no longer sufficient to mobilize a production of psychiatric knowledge . . . the profit to be made from promising health has become the prime motive in generating what counts for our knowledge for mental ill-health" (2003: 58). As part of this promise, one claim shines forth unambiguously: that new drugs are a marked improvement, whether in efficacy, in their ability to target more discretely a class of neurotransmitter, or in producing less harmful side effects than their predecessors (Whitaker 2002: 257). Even if they cannot offer a cure, they do offer a narrative of progress prepackaged in good-will.

This polished narrative, however, has lost some of its luster in the last years. There have been disclosures in the mainstream public that have significantly sullied the pharmaceutical industry's fabricated good-will and the intentions that it has striven to promote since the 1980s. The long list is growing, and can be enumerated only in brief. It includes the revelation that the pharmaceutical industry downplayed and hid data on the severity of side effects of a class of anti-inflammatory pain killers, as well as antidepression medications. It also includes two studies, one in the United States and the other in Great Britain, which found that new antipsychotic drugs differ from their predecessors only in price, not safety or efficacy. Most recently, and closest to the politics of psychiatric survivors, *The New York Times*, after obtaining internal documents leaked from an ongoing product liability lawsuit, divulged that Eli Lily systematically downplayed the health risks and side effects of a schizophrenia medication that is best-selling drug, Zyprexa. Many survivors are now involved in a its campaign to circulate and comment on these documents, in the hopes of raising more critical awareness about the dangers of certain psychiatric drugs.[25] Taken together, these revelations have generated increasing critical attention on the FDA's lack of regulatory rigor and integrity in overseeing the scientific testing and market release of these drugs.[26]

Along with this critical media attention on pharmaceutical corporations and the FDA, mainstream medicine and the medication practices it entails, while certainly still

pervasively deployed and admired, have also been met with stiff competition, patient exodus, and often outright suspicion as patients pursue alternative treatments, which have grown exponentially in types and availability since the 1980s (Eisenberg et al. 1998). Patients who remain in mainstream medicine often do so on their own terms, cultivating a pronounced form of self-expertise used in partial self-diagnosis and treatment, often with the aid of new Internet technologies. Both moves are usually accompanied by a vigorous critique of conventional medicine and pharmaceuticals—a message that states treatments, and the power to classify and treat illness, are no longer the exclusive property of established medicine. Thus, amid vigorous public and media scrutiny, the tarnished image of the pharmaceutical industry, and a semi-autonomous zone of peer-to-peer diagnosis and treatment, the critiques heralded by psychiatric survivors regarding the shaky foundations of pharmaceutical science and their call for unconditional self-determination have an opportunity to resonate more profoundly and widely, once again, in the greater public arena.

Conclusion

"The struggle of man against power," wrote Milan Kundera, "is the struggle of memory against forgetting." Though not necessarily one of the best-known sets of political actors, psychiatric survivors, ex-patients, and consumers, by virtue of their persistence and tactical ability to shift messages, have engaged successfully in the struggle against power. As in all social movements, the crucial move is not simply to speak to power, but to cultivate a historical consciousness of this process, for it is by this cultivated memory that a politics is propelled from the present into the future, to respond to changing conditions.

Survivors are well aware of their legacy, and it is made apparent in a number of registers. For example, in current-day speeches, it is common for movement leaders to revive Martin Luther King in reminding their listeners that "[h]uman salvation lies in the hands of the creatively maladjusted" (Oaks 2006). In so doing, the speakers are offering inspirational words about their plight that follows from coercive treatments. The invocation also serves to remind their audience that their movement is a "nonviolent revolution" with historical roots firmly grounded in the civil rights era and with basic goals that remain unchanged.

Starting in the 1980s, however, psychiatric survivors found themselves in a predicament similar to that of a host other radical advocates. The sharp edge of many radical claims, often voiced in a lexicon of freedom and liberty, was blunted by a broader set of economic and cultural shifts that entrenched a new commonsense language of freedom centered on the ideas of lifestyle choice and free market principles. It is also likely that the plethora of laudable legal changes that occured in the 1960s and 1970s bred an unintentional wave of complacency among liberal and progressive publics who were comforted by the fact that the worst forms of segregation, inequity, and mental health abuse were over, for many had been fixed in the law books.

Psychiatric survivors' viability as a radical political movement was also threatened with extinction by a unique set of challenges. They were questioning a set of medical practices that, in the short span of a decade, had changed to become not only more legitimate, but also much more pervasive within the health sciences, the medical profession, and the public at large. The pharmaceutical industry developed and released a wide array of drugs poised to be prescribed by psychiatrists and other health workers (such as family doctors and registered nurses) to people in nearly every age group to manage an equally wide array of proliferating conditions. Along with the multiplication of these medications, a rosy optimism came to mark the field, one in which the past could easily be marshaled to designate the progressiveness and humaneness of the present moment. Because psychiatry's orientation evolved from its psychoanalytic roots, with a firm institutional base in the asylum, to a medical science paradigm, the rhetoric of scientific progress became pronounced. Given this historical dynamic, survivors are easily discredited as fanatical for their inability to accept what is presented as the truth of science. Yet, drawing from their own forms of historical consciousnesses and their legacy built from experiencing, firsthand, treatments that were often provided in the name of care and therapy—and only later acknowledged to be harmful, useless, or even barbaric—survivors approach the field with a skeptic's sword that, when applied in the political sphere, works to make unmistakably clear the risks of *current* treatment and, thus, to disturb this narrative of progress.

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Notes

1. While the c/s/x movement may historically represent the most visible collectivity protesting mental health abuse, there were certainly a number of antecedents. For a discussion of them, see Morrison (2005: 63–67). There is also a rich first-person literature by survivors and other mental health advocates on their plight, history, recovery, and activism. For an extensive list, see Gail Hornstein's bibliography: http://www.mtholyoke.edu/acad/assers/Academics/Hornstein_Bibliography.pdf.

2. By "radical" I do not mean politically Left, for radical survivors span the spectrum from anarchism to libertarianism. What I do mean is a strong, unconditional, and institutionally independent critique of pharmaceutical science and psychiatric abuse.

3. Currently, the most visible organizational face of this revitalized politics is MindFreedom International. MFI helps to coordinate over one hundred other advocacy and political organizations to fight for human rights for those with psychiatric disabilities. See http://www.mindfreedom.org.

4. http://www.mindfreedom.org/kb/act/2003/mf-hunger-strike.

5. The most comprehensive academic account on the c/s/x movement in the American context is Linda J. Morrison's *Talking Back to Psychiatry* (2005), and this chapter is heavily indebted to her analysis. I also draw on Judi Chamberlin's (1990) assessment of the movement. For an account of mental health critique and advocacy in England, see Crossley (2006), and for an examination of a Canadian case, see Barbara Everett (2000). Nancy Tomes (2006) provides a brief history in order to assess the movement's role in changing mental health policy. Brad Lewis (2006b) situates psychiatric survivors and consumers within the wider field of disability rights.

6. http://www.dartmouth.edu/~towardsfreedom/transcript.html.

7. http://www.wmich.edu/~ulib/archives/mlk/transcription.html.

8. Anti-psychiatry and survivor activism are often incorrectly conflated or collapsed; for two recent examples of this, see Rissmiller and Rissmiller (2006) and Sharfstein and Dickerson (2006). Though ex-patients and survivors drew on the anti-psychiatry literature to formulate their politics (evident, for example, in the early issues of *Madness Network News*), some survivors and ex-patients also differentiated their political goals from what they often saw an elitist enterprise (see, for example, Chamberlin 1990: 324). As survivors have moved to clearly broadcast a pro-choice drug stance, it is also harder to sweep them under the rug of anti-psychiatry, and leaders of the movement reiterate this position in public speeches (see, for example, Oaks 2006). My feeling is that some professional psychiatrists and mental health workers, such as the two sets of authors cited above, label survivors as "anti-psychiatry" in order to portray them as fanatical, and thus delegitimate and obscure their message. They also sharply distinguish them from consumers, whom they tend to designate as "the acceptable activists."

9. For the articulation of these early positions, see Hirsch et al. (1974).

10. To be sure, prior to the development of current neurochemical theories of mental illness, and even during the dominance of psychoanalysis, there was a range of popular somatic theories and treatments that also guided psychiatric approaches. For example, through much of the early-to-mid-twentieth century, most patients diagnosed with "severe" mental illnesses underwent therapies that directly manipulated or altered body physiology, most famously insulin coma therapy, lobotomy, and electroshock therapy.

11. For accounts of the demise of institutionalization and the transition to community care, see Brown (1985) and Grob (1991).

12. The reshaping of mental health law followed from a slew of federal and state cases argued and decided primarily in the 1960s and 1970s. Many of the most famous ones were argued by Bruce

Ennis of the New York Civil Liberties Union. In particular, the Supreme Court case of *Donaldson v. O'Connor,* 422 U.S. 563 (1975), which he argued, is regarded as one of the most important. As it regards to civil liberties, the pertinent section reads: "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. . . . In short, a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." For a further discussion of challenges to mental health law in this period, see Brown (1985: 175–193).

13. Though Spitzer wanted the DSM to classify *diseases*, in the end, the committee settled on the term "disorder" to reach consensus with the APA-member psychologists, many of whom opposed the language of disease.

14. For additional critiques of the *DSM*, see Kirk and Kutchins (1992) as well as Brad Lewis's extension of their critique to include the question of power relations (2006a, esp. chap. 6).

15. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness.htm (accessed October 3, 2007).

16. For a specific account of the tensions between consumers and survivors in the mid-to-late 1980s and the demise of the MNN due to waning support, see Morrison (2005: 80–87).

17. http://www.naminys.org.

18. http://www.freedom-center.org/section/about.

19. Personal communication, November 29, 2006.

20. http://www.mindfreedom.org/kb/act/2003/mf-hunger-strike/hunger-strike-debate.

21. The hunger strike generated pronounced media attention. For two extensive pieces, see http://www.mindfreedom.org/know/mental-health-activism/2003/mf-hunger-strike/hunger-strike-media.

22. To be sure, medical textbooks and drug ads openly address uncertainty. However, these acknowledgments, especially in advertisements, tend to operate socially, as they are in fine print, and thus are often minimized in practice (though certainly not by all psychiatrists). Thus, what is significant about the hunger strike and the APA admission is that, for at least one moment in time, the "fine print" was transformed into unmistakably large print.

23. To date, one of the most interesting and important accounts of the political techniques to transform data and information into perceptible and imperceptible knowledge in medical science and among patients is Michelle Murphy's fascinating analysis of sick building syndrome (2006).

24. http://www.mindfreedom.org/campaign/media/mf/losing-the-mind-david-oaks-and-others-in-the-mad-pride-movement-believe-drugs-are-being-overused-in-treating-mental-illness-and-they-want-the-abuse-to-stop/?searchterm=zoloft%20david%20oaks.

25. Eli Lily has tried to halt circulation of these documents, which have been widely posted on Internet sites and blogs for download. On February 13, 2007, a judge ordered a permanent injunction against a group of named people known to possess the documents, barring them from circulating the documents. But he also ruled that at this point "it is unlikely that the court can now effectively enforce an injunction against the Internet in its various manifestations, and it would constitute a dubious manifestation of public policy were it to attempt to do so." For ongoing developments, links to the ruling, and the leaked documents, see http://zyprexa.pbwiki.com.

26. In recent times, the media attention placed on the pharmaceutical industry has been nothing short of remarkably critical and extensive. Coverage can be found in publications with a variety of political perspectives, such as those that are squarely liberal (*New York Times* and *Washington Post*), Left-leaning (*Mother Jones, AdBusters, The Nation*), business-oriented (*Forbes, Business Week, The Economist*), academic (*The New York Review of Books*), and even lifestyle/entertainment (*New York* magazine, *People* magazine).

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