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**BECOMING RATIONAL:
RHETORIC, AGENCY AND MENTAL ILLNESS**

A Thesis in

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by

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ABSTRACT

In the wake of other minorities winning their civil rights mid-century, in the 1970s and 1980s the ACLU, fiscal conservatives, civil libertarians and other groups turned to increasing the liberties of people with mental illness. In the 1970s two significant rhetorical obstacles needed to be overcome by civil rights advocates in order to counter the authority of physicians treating mental patients: people with mental illness needed to be constituted as a single and united group, despite the variety and severity of illnesses represented, and they needed to be given the tools to speak to the broader public about their needs. Later, as people with mental illness became a visible contingent of the long-term homeless, another complication to their agency arose: that of the role of the physical body. In the first chapter of this thesis, I discuss *The Rights of Mental Patients*, which was first published in 1973. This book addresses common legal concerns about civil commitment. In this chapter, I argue that *The Rights of Mental Patients* shifts the agentic orientation of people with mental illness from marginalized group to citizen activists, both in the ways it frames the readers, and by teaching them how to speak. The second chapter examines Kenneth Donaldson's book *Insanity Inside Out*, his memoir about experiences during civil commitment. I argue that the book both demonstrates Donaldson's loss of agency in the institution and restores his agency by entering his experiences into public deliberation about civil commitment. The third chapter examines the ongoing debate in the New York Times about the rights of homeless people with mental illness in the 1980s, specifically during the winter, when the mayor sought to have them removed to shelters. By studying editorials and letters to the editor on this issue, I

show the arguments that were made about the agency of homeless people with mental illness. By studying these texts, I argue that the opposition of the body and the mind in portrayals of mental patients complicates our understanding of rights and agency.

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Chapter 1

Introduction: Mental Illness and the Problem of Agency

In 2005, San Francisco implemented a new program for its homeless entitled “Homeward Bound.”ⁱ Critics, including the director of San Francisco’s Coalition of the Homeless, derided the program as “greyhound therapy” - ridding the local hospital and care facilities of the homeless mentally ill by giving them one-way tickets to other places.ⁱⁱ Although San Francisco’s program purports to only give tickets to people who have family or friends on the receiving end, a year after its commencement it was found that in 958 cases out of 1,132 officials placed no follow-up call to confirm receipt or care of the person.ⁱⁱⁱ Attention was drawn to the matter when officials in a nearby county where a number of the homeless had been exported protested the measure. With improved guidelines, including a more comprehensive and long-term check on the welfare of people who have left San Francisco this way, the program is still in place. However, for many of the long-term homeless population, their living conditions are merely a side-effect of a larger force in their lives: that of mental illness.^{iv} Although mental illness has long been the focus of scientific inquiry, psychiatrists are still trying to understand the complicated interplay between genetic and environmental factors that lead to mental disorders. In a parallel manner, parents, friends, and public policy officials have tried to make sense of the implications of severe mental illness on an individual’s ability to self-sustain and to express their rights as a citizen.

The public discourse about the rights and abilities of the mentally ill reflects a rhetorical problem - how to coherently conceptualize and serve the agential needs of a marginalized other. This thesis examines changing conceptualizations of agency for the severely mentally ill in the 1970s and 1980s, as public policies concerning institutionalization and state services for the mentally ill evolved into their modern form. How we speak about the agency of this varied and often marginalized group reveals underlying assumptions about ability, illness, the mind, the body, and civil rights. Discussing public discourse in the context of the severely mentally ill is a means of interpreting how our understanding of agency is influenced when its subject is a diverse but needy population. How society's rhetoric constitutes this population as a whole, how it interprets their needs, and how it responds to media depictions of the severely mentally ill shapes medical and legal interpretations of the barrier between medical treatment and civil rights.

The Rhetoric of Agency

This thesis will examine how perceptions of ability, illness, and civil rights influence conceptualizations of agency for the mentally ill. While this analysis will focus upon an isolated group with specific (but widely varying) markers of identity, determining proper aid for the disadvantaged based upon contingent variables is the focus of ongoing public deliberation. How we constitute these groups, discuss their needs, and understand agency in the context of their lives guides and influences public policies. In

the course of analyzing the primary texts for this thesis, I will engage broader discourses of agency and constitutive rhetoric.

Karlyn Kohrs Campbell defines agency as “the capacity to act... to have the competence to speak or write in a way that will be recognized or heeded by others in one’s community.”^v She writes that agency is “ambiguous, open to reversal.”^{vi} The agency of the individual must be called into being, and it can be recalled, perhaps by insufficient attention to the constraints of the moment in which the agent acts or speaks. Agency, she further states, is participatory, symbolic, and learned. It is, at its core, about community and relationships amongst people. Erin J. Rand conceives of agency as a dynamic of speaking to the structures of power with her definition: “the capacity for words and/or actions to come to make sense and therefore to create effects through their particular formal and stylistic conventions.”^{vii} In this definition, Rand identifies agency not as an internal ability of the speaker but adaptation to “institutional forces that make the effects of certain actions intelligible.”^{viii}

The emphasis on agency as relational rather than the quality of a person is extended by S.K. Foss et. al., who write that agency must be acted toward or upon something, and they suggest three components to the orientation of agency: “interpretation of structure, the selection of a response to that interpretation... and the experience of an outcome in line with these choices.”^{ix} To enact agency, an individual must adapt it to a structure and his or her interpretation of structural constraints; surveying a range of options becomes central to this conceptualization. Although an individual has limited power over some of his or her external constraints, he or she can choose the means by which he/she responds to those constraints. Foss et al state that “all

agentic positions are produced in the same way – through an interpretation of structural conditions.”^x The individual’s interpretation of events can either be empowering or harmful to his or her conceptions of future responses to constraints.

The relational aspect of agency makes it a central component of individuals to be constituted as part of a group. Michael Calvin McGee questioned the roots of the assumption within rhetorical studies about the collectivity of people with his arguments that individuals in a group or audience must act in order to become so and are not inherently part of that group or audience. Claiming that “from a rhetorical perspective, the entire socialization process is nothing but intensive and continual exercises in persuasion: individuals must be seduced into abandoning their individuality, convinced of their sociality,” he writes that a collective “people” is a fiction that an audience must agree to participate in.^{xi} Although the rhetor plays a role in the construction of the audience, the audience must respond in order for the rhetor’s actions to be successful. Maurice Charland likewise writes that a rhetor must call his or her audience into being.^{xii} Charland appeals to identification as a central marker of this constitution of the audience; it is the narrative of the speaker that causes those who listen to identify themselves as part of a group.

Public policies concerning the welfare and rights of the mentally ill continue to be widely contested by civil rights activists, politicians, family members, and psychologists. There has been no successful move to constitute the mentally ill themselves as an agential force. One of the issues with the way that we have conceptualized mental illness is that we have spoken of the mentally ill as though that label denotes a consistent and coherent

set of identifying markers. This thesis will engage these discourses as it examines a series of texts that reflect changing public dialogues about the mentally ill and agency.

This thesis examines one of the ways in which the relationship between rhetorics of agency and democratic rights and responsibilities can conflict. In the wake of other minorities winning their civil rights mid-century, in the 1970s and 1980s the ACLU and other groups turned to increasing the liberties of the mentally ill. Although this followed the tradition of the earlier movements, the complications inherent in the population for whom these groups were speaking required resolution. Sociologist Suzanne Fleming writes that “of all the minority groups... only that of the mentally ill, cannot, by definition, demand its rights independently. The mentally ill cannot, again by definition, become self-sufficient and take full advantage of their freedom from oppressive laws and practices.”^{xiii} The very characteristic by which they are identified as part of this group, the irrationality of their words and actions which leads to a diagnosis of mental illness, prevents people with mental illness from assuming full political agency. Instead, friends, family members, advocates, or people who have treated the symptoms of their illness speak for those who are more severely mentally ill. A person’s mental illness is often framed as a core part of their identity and also as an impediment to being able to function as an adult citizen. In the extension of the doctor’s authority in severe cases of mental illness, which can result in involuntary commitment, some argue that civil rights are violated. Psychiatrists state that involuntary treatment is necessary for the well-being of the body of the patient, but civil rights lawyers and advocates argue that forcing treatment is an act of violence against the basic rights of a citizen.

In the 1970s two significant rhetorical obstacles needed to be overcome by civil rights advocates in order to counter the authority of physicians treating the mentally ill: the mentally ill needed to be constituted as a single and united group, despite the variety and severity of the illnesses represented, and they needed to be given the tools to speak to the broader public about their needs. Later, as the mentally ill became a visible contingent of the long-term homeless, another complication to conceptualizations of agency arose: that of the role of the physical body. The question became whether it was ethical to allow people with severe mental illness to forgo treatment. Although agency has been discussed in a number of thoughtful rhetorical studies, this thesis problematizes and further develops conceptualizations of agency by examining a uniquely marginalized group whose unifying attribute (mental illness) calls into question assumptions about the ability of all adults to participate in democratic discourse and practices.

Changes in Mental Healthcare

To understand the debates about the rights and abilities of people with mental illness that occurred during deinstitutionalization, it is necessary to recognize the demographic changes in state-run mental facilities, changing perceptions of the nature of mental illness within the mental health community, and advances in technology throughout the 20th century. Each of these elements shaped later debates about the coerciveness of institutionalization and the ability of mental patients to adapt to living in the community.

At the end of the 19th century, many inmates of state institutions were acute cases who were institutionalized for a year or less.^{xiv} However, in the first decades of the 20th century, chronic institutionalization became the norm. From the 1930s onward, the proportion of elderly patients in mental institutions grew, so that they became the dominant population in many state asylums. Medical historian Gerald N. Grob writes that “by the mid-twentieth century the mental hospital was serving in part as a final home for aged persons,” despite the fact that many had more pronounced physical disabilities than mental disabilities.^{xv} They simply had nowhere else to go. The population of patients in mental hospitals in the early 20th century also shifted to include a significant number of people with somatic disorders, or disorders caused by physical illnesses of the brain.^{xvi} The other significant proportion of the mental institution population was composed of people with schizophrenia, many of whom were chronic patients. Their average length of stay was 12.8 years, augmenting the percentage of institutionalized patients who were elderly. Chronic institutionalization could also be seen in the first children’s wards, which were established in the 1930s.^{xvii}

Concern with mental health was not limited to the institution, however; the mental hygiene movement made mental health and well-adjustment central to education in the first decades of the 20th century. Beginning in 1909, the mental hygiene movement influenced public perceptions of mental health. Leaders of the movement aligned mental health with proper communication skills, and taught that the inability to communicate properly was a symptom of mental dysfunction. Pat Gehrke writes that proponents of mental hygiene believed that “the quality of one’s speech was the quality of one’s mental health.”^{xviii} Instructors of speech communication took on the responsibility of ensuring

proper mental adjustment, as well as proper speech instruction. Instructors believed that proper mental health was instrumental in ensuring proper communication between speaker and audience. Gehrke writes that the incorporation of mental health concerns into speech classes was “a matter of improving the broader society by improving the mental health of the general social order. Not only could mental defects be diagnosed, confirmed, treated, and cured, but they could also be exacerbated or even spread.”^{xix} Both schools and the military took measures to try to prevent mental maladjustment within the population.

The efforts of mental hygienists met with some success during World War II with the implementation of troop rotation; however, mental hospitals on the home front suffered. During the Great Depression, funding to mental hospitals, like many other state-run programs, was trimmed, despite growing populations. As the country entered World War II, state and federal funds went towards the effort overseas. States set maximum patient numbers ever higher, and failed to build new hospitals. Although the economy improved, funding for mental patients never recovered to the levels per person that hospitals had enjoyed prior to 1929. Grob writes that overcrowding in state hospitals rose from 9.8 percent in 1940 to 16.3 percent during the war. This also reflected the loss of staff from state hospitals, many of whom were deployed with the troops. This loss of staff meant that “restraint of patients became more common; hygienic conditions deteriorated; individualized attention, medical and occupational therapy, and supervised recreation all suffered.”^{xx} Hospitals had originally been built to house few patients, in order to provide a constructive environment for therapy. However, overcrowding and growing numbers of

chronic patients altered doctors' goals from providing restorative therapy to patient management.^{xxi}

Behind the front lines, the psychiatrists who had shipped out with the soldiers were conducting studies to determine why some soldiers suffered more than others under the pressures of war. Prescreening, a measure introduced in World War I, had proven ineffective in anticipating which soldiers were less hardy, and the descriptions the earlier psychiatrists had given of risk factors were too vague and inclusive.^{xxii} Instead, the psychiatrists noted that environmental conditions seemed to elicit symptoms from men with no previous risk factors. A psychiatric study performed during the 1943 Tunisian campaign concluded that long term exposure to the stress of modern warfare was the cause of "combat exhaustion," and that the level of stress often reflected the duration during which the soldier was in the combat zone.^{xxiii} Prior to this discovery, and the measures taken to reduce combat exhaustion afterwards, a quarter of men in active combat units were hospitalized for mental disorders. In 1944, John W. Appel suggested that the army implement wide-scale troop rotations in order to give units of soldiers rest from combat.^{xxiv} The military also began to provide psychiatric facilities near the front lines to provide early and preventive care. These policies were extremely successful in reducing troop casualties to mental stress, and many soldiers were able to return to the front lines within days of first seeking care. When the psychiatrists returned home, they remembered the effectiveness of preventive care and troop rotation, and introduced the same principles in civilian care.^{xxv}

The success of new psychiatric practices in the military spurred hopes among psychiatrists that similar practices could be used to alleviate mental illness at home.

Although military psychiatrists were accustomed to treating ordinarily healthy men in extraordinary circumstances, the principles of creating a healthy environment and using preventive measures had popular appeal for use for unhealthy men in more ordinary circumstances. The war had demonstrated the ability to identify people prior to significant breakdowns and to prevent such acute illness.

Troubles arising within the psychiatric community also hinted at big changes to come. The American Psychiatric Association became polarized in the years between 1944 and 1950, when psychiatrists differed on the idea of implementing community treatment.^{xxvi} While more traditional psychiatrists favored continuing the mental hospital system, others sought to implement the preventive measures they had witnessed during the war to people in the community. The use of therapies such as electroconvulsive therapy, lobotomy, and insulin coma therapy was also a point of discontent; while some believed that they had therapeutic uses, others questioned their effectiveness and safety.^{xxvii} The postwar introduction of psychoanalytic therapy to mental hospitals also was a contentious move; psychiatrists and psychologists tended to distrust one another's methods and means of determining effectiveness, since they were trained differently.^{xxviii}

Furthermore, the first in a series of exposes of the poor conditions in state mental hospitals alerted the public to the filth and mistreatment that had resulted while their eyes (and public funds) were fixed on the war. Albert Deutsch's articles on psychiatric institutions in 1946 and 1947 graphically depicted the shortcomings of state mental hospitals. These articles, and their contemporaries, urged widespread reform, including better pay for staff, reduced staff to patient ratios, reduced overall size, and the end of mechanical restraint, among other reforms.^{xxix}

Commitment statutes also began to change. Miller writes that “until the post-World War II era, few lawyers were interested in representing mental patients, governmental or charitable immunity shielded the institution and staff, and no alternatives to hospitalization were available.”^{xxx}

The 1950s were the last heyday for the mental institution. Psychologists promoted the idea of the hospital as a “therapeutic community,” and some hospitals instituted an open-door policy. In an attempt to reduce the association with loss of freedom, these open-door hospitals allowed some patients to return to their family homes in the evening and to return in the morning for therapy, and did not include locks on their doors to retain patients who stayed on the premises.^{xxxi} This innovation was introduced to increase patient trust and to reduce the stigma of persons with mental illness in the community. New pharmaceuticals also changed treatment for mental illness, and made living in the community a more attainable goal for many people who had previously lived in institutions. The 1954 introduction of Thorazine, one of the first psychotropic drugs, quickly and dramatically changed healthcare for persons with mental illness. Although American psychiatrists were first wary of the French export, it was found to calm the symptoms of people who had lived in the back wards and whose symptoms had previously been intractable.^{xxxii} Serpazine, another tranquilizer, was introduced the same year, and by 1956, the first antidepressants had been released.^{xxxiii}

By the 1960s, the push for deinstitutionalization had begun. Deinstitutionalization was a public policy introduced to reduce the number of mentally ill individuals in state custodial care. This shift took place largely between the 1950s and the 1980s.^{xxxiv} The nature of the coalition that formed to facilitate deinstitutionalization was an alliance of

civil libertarians who wished to extend the rights of the mentally ill and fiscal conservatives who wanted to cut the expense of public mental institutions from state budgets. Policy tended towards new treatment methods for mental patients, and the Community Mental Health centers Construction act of 1963 was signed by President Kennedy with much aplomb. Furthermore, the introduction of Medicare and Medicaid reduced the number of elderly patients by providing alternative means of attaining care.^{xxxv} The Lanterman-Petris-Short Act, passed in California in 1967 under the governorship of Ronald Reagan, limited the time and circumstances in which a person could be involuntarily committed.^{xxxvi} This act was replicated in other states, and supported by the Supreme Court ruling in *O'Connor v. Donaldson* that "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 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." With this ruling, larger numbers of the civilly committed were qualified for release from state care.

Hospital stays shortened, due to antipsychotic drugs and the reduction of the elderly population, but the lack of coordinated mental healthcare management in the new community system meant that patients often returned to the institution for multiple stays. With additional funding provided to create community mental health centers in 1965, growing numbers of psychiatrists were introduced to the environmental conditions of the cities, a stark contrast to the staid hospital environment in which most of their profession had worked in the past, and took on new problems. The community centers often treated more patients with drug and alcohol

dependency, and some turned to improving social conditions rather than dealing explicitly with mental patients.^{xxxvii} Few regularly dealt with (or met) the needs of persons with severe mental illness.

Chapter Preview:

This thesis is situated in the context of deinstitutionalization and its aftermath. The first two texts examined in this thesis are relics of the high point of deinstitutionalization. *The Rights of People with Mental Disabilities: The Authoritative ACLU Guide*, which was first published in 1972, was written for use by the mentally ill and their family members to better understand court processes, as well as to provide suggestions for courtroom questioning and behavior in the case of a civil commitment hearing. At this point in time, commitment hearings had recently begun to be more formal; previously, they were brief hearings in which the patient was represented by clinicians. This guide provided insight into the new system of hearings and directed the readers to various resources. Examining this document reveals the means by which an organization can intercede to facilitate agency for a marginalized group. I argue that this text constitutes its readers first as members of a stigmatized population, teaching them a new agentic orientation, and then reconstituting them as citizens who are helping to improve the state of civil rights.

The second text, Kenneth Donaldson's book *Insanity Inside Out*, demonstrates the power of rhetoric in the restoration of agency to a marginalized person. Donaldson became an icon for the institutionalized, and was shown as a representative example of

the people who had been committed against their will. His case and his descriptions of other committed patients in his book served as a means of addressing the public's perception of what it meant to be mentally ill. The outcome of his case also changed policy determining what it meant to be institutionalized. His book, which was published after he won the case in the U.S. Supreme Court, provided documentation of the loss of agency that he and other mental patients suffered in the state-run mental facility. I argue that the book restored his agency by entering his experiences into the public deliberation about deinstitutionalization and the dangerousness standard and also argues for mental patients to be given power over their own care.

By the 1980s, the public was beginning to have its doubts about the benefits of deinstitutionalization. The outpatient clinics promised to administer to the mentally ill in the 1960s did not have the funding to fulfill their original purpose, and a number of studies found that many former patients had become homeless for lack of adequate social services for their needs.^{xxxviii} It is in this moment that the final texts for my thesis appear: letters to the editor of the *New York Times* during the city's legal struggle to remove the mentally ill homeless from the streets when the winter cold threatened their lives. The emergence of these concerns in the popular press was centered on the physical body of the homeless mentally ill and the proper exercise of civil rights. I argue that the dichotomy between physical well-being and civil rights which was at the center of the debate reflects a larger conflict between the philosophy of negative liberty and the forces of biopower.

In this thesis, I examine a civil rights handbook, an autobiography, and the myriad brief glimpses of other peoples' lives which constitute the story of the mentally ill

homeless in New York. By studying these three texts, I demonstrate the ways in which conceptualizations of rights, responsibilities, agency, and ability have shaped perceptions of the mentally ill. Personal stories and public priorities alike have shaped the changing rhetoric of what it means to be mentally ill, and also the rhetoric of the needs of the mentally ill.

Chapter 2

Breaching an Enclave

In 1968, the American Civil Liberties Union established its Mental Health Law Project in response to deinstitutionalization and the success of its previous civil rights work.^{xxxix} Bruce Ennis, its first director, was an ACLU attorney at the New York branch. The ACLU had been marginally interested in the rights of the mentally ill since the mid 1940s, when it had drafted a model commitment statute addressing patients' rights. However, most of its efforts from the late 1940s to the mid-1960s were concentrated on protecting alleged communists during the second red scare, the church and state controversy, the rights of union members, and due process.^{xl} In the 1960s, it became involved in civil rights cases for several marginalized groups, eventually turning its attention to the rights of people with mental illness.

Because involuntary commitment can be seen as a violation of civil rights, studying the ACLU's recommendations and rhetoric concerning the issue reaches the core of a debate about the rights and agency of people with mental illness. The ACLU was among the first organizations to challenge the procedure of involuntary commitment in the court system, and its status as one of the highest-profile civil rights groups in the country drew attention to the issue. The ACLU opposed involuntary commitment except in cases of patient violence to self or others. Under Ennis it endeavored to reduce the power of institutions it considered coercive, and the mid-century campaign for a "right to treatment" heightened the organization's leaders' fears that psychiatry may begin abusing its medical legitimacy and its clients.^{xli} In 1973, only five years after the creation of the Mental Health Law Project, Ennis and Loren Siegel released a guide written for people at risk of being involuntarily committed, entitled *The Rights of Mental Patients: The Basic ACLU Guide to a Mental Patient's Rights*.

Ennis and Siegel's book addresses the questions and concerns that a person at risk of being committed may have in non-technical language. The book is structured in question-and-answer format. It defines key legal terms and practices concerning commitment, and suggests ways in which to use the book. Its five appendices include information such as commitment laws in each state, trial techniques, and minimum treatment standards. The book is also very clear about where its authors stand on the issue of commitment, both in its introduction, where it outlines their perspective on the issue, and throughout the text. In the introduction, they write "The authors of this book believe that involuntary hospitalization should be abolished. Completely. And if it cannot be abolished, we believe that prospective patients should be given so many rights and safeguards that it will be extraordinarily difficult to hospitalize anyone against his will. At the same time, we do not oppose *voluntary* psychiatric treatment either in a hospital or on a private, outpatient basis. Our quarrel is not with psychiatry, but with coercive, institutional psychiatry."^{xlii} They carefully delineate which characteristics and circumstances they oppose. In supporting voluntary treatment, they continue the ACLU's past stance on the issue as one of patients' rights. The ACLU's approach to its concerns about psychiatric processes was twofold: the organization provided legal assistance to former patients who charged institutions with abuse and published this manual with suggestions for countering civil commitment.

The Rights of Mental Patients was the first book written for people with mental illness to offer them legal advice. It was also an early step in the ACLU's long-running involvement in the issue of civil rights for mental patients. In later years, it would provide lawyers for people who had been civilly committed and influence the procedures by which people were committed. This chapter will show the ways in which the ideals of the ACLU shaped their plan for restoring the agency to people with mental illness that they believed had been stripped by the process of involuntary commitment to mental institutions.

In this chapter, I argue that *The Rights of Mental Patients* shifts the agentic orientation of persons with mental illness and their families from marginalized group to citizen activists, both in the ways it frames its readers, and by teaching them how to speak. First, I will show how the book's authors constituted its readership. Next, I will analyze the ways in which its structure enables the readers to enact greater agency by showing them the proper way to speak. Finally, I will argue that the book creates an ideal of citizenship for people with mental illness, and seeks to serve the function of reintroducing them to public deliberation.

Rights in the Framework of Negative Liberty

The work of the ACLU has been focused upon preserving the rights of individuals from coercive institutions and laws since its creation in 1920; however, the roots of the organization date earlier.^{xliii} The ACLU began as an offshoot of an older organization, the American Union Against Militarism (AUAM). The AUAM began as an organization devoted to keeping the United States out of World War I. When the AUAM faced criticism and government surveillance for its efforts to prevent a draft and to protect conscientious objectors, the organization was torn. The majority of its members favored a pragmatic approach, hoping that scaling back controversial activities would result in greater influence in other areas.^{xliv} However, a smaller contingent favored focusing on the defense of the principles of civil liberties. From this contingent, a subcommittee named the Civil Liberties Bureau (CLB) was created in July of 1917. However, within months it split from the AUAM and was renamed the National Civil Liberties Bureau (NCLB).^{xlv}

The National Civil Liberties Bureau quickly became embroiled in the public backlash against the war. Its leaders warned President Wilson prior to the passage of the Espionage Act that it may “lend itself to the suppression of free speech, free assemblage, popular discussion and criticism.”^{xlvi} The Act, whose third section prohibited interfering in military enlistment,

promoting unrest amongst military personnel and interfering with military operations, passed.^{xlvi} It was followed by the Sedition Act of 1918, which prohibited speaking against the government.^{xlviii} Free speech was further limited by the power that the Postal Service had over determining which magazines and pamphlets could be delivered through the mail. The American Protective League and other organizations sponsored by the Justice Department seized suspected draft evaders in massive raids.^{xliv} The issues of free speech and the rights of conscientious objectors therefore became the first significant issues that the NCLB addressed. In its first few months, the NCLB attorneys had already taken on approximately 125 conscientious objector cases each week.^l Its president, Roger Baldwin, also wrote to Woodrow Wilson to defend the free speech rights of the Industrial Workers of the World (the IWW), leading Wilson's administration to view the NCLB as a group of radicals.^{li} Despite claims by the leaders of the NCLB that free speech was an American tradition, there was a series of losses in the courts, which ruled in favor of the suppression of free speech under the Espionage and Sedition Acts. Although the Constitution spoke of a right to free speech, it did not exist in practice until after World War I.^{lii} John Durham Peters writes that "The key United States Supreme Court cases that decisively redefined its legal meaning occurred only in the wake of World War I, with the overturning of the crime of seditious libel."^{liii} In 1920, the NCLB decided to rename itself the American Civil Liberties Union.^{liv}

After the end of WWI, the ACLU turned its attentions to fighting for the right to free speech and assembly by unions, the release of imprisoned conscientious objectors, and ending the U.S. Postal Service's ability to censor the mail.^{lv} The ACLU also cemented its stance on free speech with its defense of the Ku Klux Klan's right to free speech and assembly in 1920 and 1923, and of the right to distribute Henry Ford's anti-Semitic newspaper.^{lvi} When the NAACP requested that the Postal Service ban KKK literature, an ACLU representative told them "We do not think that it is ever a good policy for an organization interested in human liberty to invoke

repressive measures against any of its antagonists. By doing so it creates a danger of making a precedent against itself.”^{lvii} The ACLU also frequently defended American Communists, despite the Communists “cynical view of the First Amendment, arguing that reactionaries were not entitled to free speech.”^{lviii} The ACLU’s representation of these groups established the organization as a central proponent of what Peters calls the “free speech story.” The story’s claims include the following: “Censorship is wicked; the truth will come out; the public is best left to its own devices; even (or especially) vile people and doctrines deserve to be heard; the free market and the free press go hand in hand; and defenders of liberty can justifiably fraternize with extremists.”^{lix} Although the Communists openly disagreed with the ACLU’s ideal of free speech, the very right which led to its founding, the lawyers chose to defend them. Ideals were elevated above recognition of the potential effects of the defendants’ actions.

Although largely unsuccessful in its initial endeavors to promote its views of the Constitution, the ACLU began to win its cases in court in 1925. Its fateful decision to challenge a Tennessee law forbidding the teaching of evolution led to significant publicity in the *Scopes* trial, and the ACLU further expanded its breadth with issues such as segregation and movie censorship. These and other issues occupied the ACLU throughout the interwar years, foreshadowing many of the organization’s postwar cases as well.

The ACLU’s first foray into the issue of the rights of mental patients occurred in 1945, when it drafted a Model Commitment Statute in response to exposes of the public mental health system.^{lx} However, the organization did not address the issue further until 1968, when deinstitutionalization had already begun. Ira Glasser, of the New York Civil Liberties Union (the New York subsidiary of the ACLU) focused the group’s attention on “enclaves”- areas of American society where bureaucratic authority prevented the true exercise of civil liberties. He claimed that “four public institutions have traditionally ignored the Bill of Rights: the military, the schools, mental ‘hospitals,’ and prisons.”^{lxi} In 1968 the NYCLU founded the Mental Health

Law Project (MHLP) as its first subcommittee under the enclave theory. Under the influence of Thomas Szasz, who denied the existence of mental illness, the MHLP opposed involuntary commitment except when the individual was considered dangerous to himself or others.^{lxii} Executive Director of the ACLU Aryeh Neier stated that reading Szasz had influenced the ACLU's decision to become active in cases concerning civil commitment.^{lxiii} However, the MHLP did not fully accept Szasz's assertion that mental illness was a metaphor for undesirable behavior. They framed their appeals around ensuring civil liberties rather than abolishing the power of the psychiatric profession. In the next few years, the MHLP published *The Rights of Mental Patients* and represented Kenneth Donaldson in a court case considered one of the most influential in mental health rights. In the 1980s, the NYCLU would defend a homeless woman's rights not to be subjected to emergency mental health care and offer her a secretarial job at their office.

In his history of the ACLU, Samuel Walker writes that “The Encyclopedia of the Constitution defines civil liberties as those rights that individual citizens may assert against the government.”^{lxiv} The decision to highlight this specific set of rights in its name reflects the central nature of the organization and its devotion to what Isaiah Berlin calls “negative liberty.” Negative liberty is defined by Berlin as “not being interfered with by others. The wider the area of non-interference the wider my freedom.”^{lxv} It values limiting the interference of other persons and organizations on the will and actions of the individual. Berlin states that Western liberals, including the ACLU, “believe, with good reason, that if individual liberty is an ultimate end for human beings, none should be deprived of it by others; least of all that some should enjoy it at the expense of others.”^{lxvi} This philosophy of non-interference as a good is central to the ideology of the ACLU, whose long history includes a number of court cases in which an individual or group has petitioned to be protected from coercive laws, organizations, or medical practices. A self-

proclaimed “guardian of liberty,” its website states that “If the rights of society's most vulnerable members are denied, everybody's rights are imperiled.”^{lxvii}

Berlin addresses the influence of social relationships and political structures on the freedom of individuals, which speaks to the roles that these individuals play as well. When Berlin writes about the influence of others’ perceptions of oneself, he states that “to possess these [named] attributes entails being recognized as belonging to a particular group or class by other persons in my society, and that this recognition is part of the meaning of most of the terms that denote some of my most personal and permanent characteristics.”^{lxviii} An individual is unable to be completely removed from the context of society and from the labels, assumptions, and beliefs about ability that living within a society entails being given.

Just as an individual cannot be defined without his or her society and associations with others within society, citizenship cannot be defined without the context that provides the assumptions that build its meaning. Citizenship in the modern sense is founded on a number of “cultural preconditions: a city culture, secularization, the decline of particularistic values, the emergence of the idea of a public realm, the erosion of particularistic commitments, and the administrative framework of the nation-state.”^{lxix} The concept of citizenship is not something innate to human relations within a state, but something that is culturally determined. It is a flexible concept, which has different meanings in different societies. In a democratic society, the capability of a citizen to participate in public life and governmental decision-making results in a conception of the citizen’s ideal qualities. Political philosopher John Rawls writes that one quality of citizens is that “they affirm the values of political justice and want to see them embodied in political institutions and social policies.”^{lxx} Rawls writes that citizens must be able to use “public reason” in order to engage with one another on societal issues. The concept of “public reason” divorces the speaker from his or her doctrines of religion, morality, or other defining characteristics as a means of making his or her speech more palatable and relatable to the public.

Although the concept of citizenship is context-specific, humans are inherently political. Hannah Arendt states that “what makes man a political being is his faculty of action.”^{lxxi} She considers the capability for action and the capacity to be a citizen intimately connected. When the faculty of action is removed, so is the possibility of being a political being and of demonstrating political agency. However, S.K. Foss et al argue that individuals have the capacity to determine their own perception of their power and of the events they are a part of, which restores some of the individual’s agency. Agentic orientation they define as “a pattern of interaction that predisposes an individual to a particular enactment of agency.”^{lxxii} This idea of agentic orientation can inform approaches to restoring the agency of people who have been marginalized by classifying various reactions to that marginalization and suggesting better ways of responding to the pressures they receive from society. Foss states that “all individuals have the capacity to move to different agentic positions and to produce new outcomes in their lives because such changes occur through the act of interpretation.”^{lxxiii} I will argue that *The Rights of Mental Patients* recognizes the constraints of belonging to a marginalized group and then teaches its readers the proper language necessary for self-empowerment. This requires a shift in agentic orientation on the part of the reader.

Identification

The Rights of Mental Patients is written for a specific audience, which it identifies in the earliest paragraphs of its introduction. “One out of every ten Americans will be hospitalized for “mental illness,”” Ennis and Siegel write, “You may be one of them. If you are, this book will discuss your legal rights and warn you of legal pitfalls.”^{lxxiv} In his opening, which appeals to mental patients and their families, the authors cautiously speak to a variety of opinions on the nature of mental health and mental healthcare. The central goal of the introduction is the identification of, and identification with, mental patients who may choose to read the book.

Maurice Charland writes that although identification is rhetorical, it precedes efforts for persuasion; “humans are constituted in these characteristics; they are essential to the “nature” of a subject and form the basis for persuasive appeals.”^{lxv} The numbers of mental patients and variety of characteristics that people with mental illnesses have grant Ennis and Siegel the role of a balancing act; although identification results from persuasive acts, a person or group cannot ever be free of identity or ideology. This is particularly complex in the case of populations with little agency, whose dominant image is constructed by other, more powerful individuals and groups, and projected upon them. To appeal to such a group successfully is made more difficult by the lack of the group members’ own voices in deliberation about matters concerning them. Perceptions of the beliefs of the group’s members better reflect the biases of the people portraying them in public discourse.

Because people with severe mental illness had typically been placed into institutions and considered irrational, the authors’ efforts to help them to protect their civil liberties involved a fundamental change in the perceptions of the identity of the group. In order to change perceptions of a group’s identity, strong appeals are made to the “subject’s character, nature, or essence” that contest the previously held meaning of membership in that group.^{lxvi} In the introduction, Ennis and Siegel question what it means to be mentally ill. They write that “no one knows, for sure, what “mental illness” means or what causes it. Many people argue quite forcefully that the label “mental illness” is not a descriptive label in the same sense that “cancer” and “tuberculosis” are, but is only an unproven theory which is invoked to “explain behavior we don’t understand, in much the same way that the label “bewitched” was used to explain behavior which our forefathers did not understand.” They fall short of dismissing the central identifying feature of their audience, however, writing that “For convenience, however, we have used the terms “mental illness” and “mentally ill” without endorsing them.” While Ennis and Siegel disrupt the central identifying feature of the target population, the diagnosis of mental illness, they do not make the

book irrelevant to people who need help by dismissing it altogether. They suggest that the unifying characteristic of this audience is a moniker, and a powerful one, that ties them together whether or not they accept the predominantly accepted medical implications of it.

To study appeals to a group, such as those that Ennis and Siegel make in the introduction, is to view them through the eyes of the writer or speaker, who has already mediated the characteristics of the group by highlighting traits “favorable to his or her persuasion.”^{lxxvii} Likewise, to study appeals to a group that has little agency is to also see the effects of the dominance over their image in the words of the speaker. The speech acts of people with mental illness are limited by a “void instituted between reason and what is not reason.”^{lxxviii} This void consists of both a legitimate physical illness and the way in which that illness changes how an individual communicates with others. As civil rights lawyers concerned about the effects of potentially coercive medical practices, Ennis and Siegel needed to demonstrate ways in which their advice could help their audience. Therefore, they identified mental healthcare as primarily a civil rights concern. Ennis and Siegel refer to the work-related bias of psychiatrists (and reveal their own) in the introduction of the book, where they write

“Warning. There is an enormous difference between the rights mental patients have in theory and the rights they have in practice. Doctors, hospital officials, and even judges frequently pay no attention to patients’ “rights,” preferring, instead, to do what they believe to be in the patients’ “best interest. . . . There is also an enormous difference between the rights mental patients do have and the rights they should have.”^{lxxix}

This statement, which is on the same page as the caveat about using the term “mental illness,” reaffirms their choice of the unifying characteristic of this audience, reemphasizing the power of the words “mental illness,” and adds another characteristic: that the group is stigmatized by a public disregard for their rights.

A Rupture

The ACLU's decision to address the rights of people diagnosed with mental illness was its first attempt to radically rupture an "enclave." The NYCLU, New York's branch of the ACLU, developed the theory of enclaves, or institutions in which the Bill of Rights had not been duly respected. Institutional frameworks emphasizing obedience had kept mental institutions, prisons, schools, and the military from adapting their rules to allow the people within the new conceptualizations of civil rights.^{lxxx} With vigor, they addressed the task of breaching institutional barriers. This process included challenging state statutes concerning commitment in the courtroom and producing *The Rights of Mental Patients*. Charland writes that "ideology is material because subjects enact their ideology and reconstitute their material world in its image."^{lxxx} If persuasion is successful, the group that is constituted embodies social change. Charland writes that constituting a public is ideologically driven and done with intent that the public will follow to action; "The ends of narratives are fixed before the telling."^{lxxxii} The application of enclave theory via the book sought to make mental institutions places that reflected civil rights.

In order to ensure that each person who faced civil commitment was capable of demanding his or her civil rights, the body of the book was organized in ways that would help readers to find answers quickly. *The Rights of Mental Patients* is organized into sections concerning topics such as "emergency hospitalization," "communication and visitation," "the right to treatment," and "confidentiality of records." Each of these sections is subdivided into questions. For instance, in the chapter about emergency hospitalization, questions include "What does "emergency" hospitalization mean?," "What should you do if someone tries to take you against your will to a mental hospital?," and "What are the "standards" for emergency hospitalization?". Questions range from the definitional and procedural to those that request

advice of the more ideological variety. To the last question listed above, Ennis and Siegel write “you should ask what statute or court decision gives him the right to infringe your liberty, pointing out that if the arrest is not authorized, he can be sued.”^{lxxxiii} This, and other legal advice, is given throughout the book.

The answers to the questions in each section instruct the reader in the proper way to speak the language of the commitment process. These answers teach the reader the proper legal and medical terminology to use in court and when seeing a medical professional. Bordieu defines competence “as the right to speech, i.e. to the legitimate language, the authorized language which is also the language of authority.”^{lxxxiv} He further states that “competence is also the capacity to command a listener. Language is not only an instrument of communication or even of knowledge, but also an instrument of power.” By instructing readers in the proper terminology, Ennis is teaching them to speak competently, and also restoring some of their agency as citizens and as patients by evading the appearance of irrationality. He also demonstrates the ways in which his readership can conform to public ideas of reasonableness and rational communication. A person faced with a friend or neighbor who wants to deliver him or her to a mental hospital for examination might typically panic and act in a way that may reaffirm the concerns of the person who has decided to take them to the hospital. If he or she is familiar with the legal advice and the terminology that Ennis suggests and instead demands that the other people cite the legal support for their actions and then hints at litigation, an entirely different perception of his or her faculties might be formed. The person to be committed would appear to be in greater control of him- or herself. Agency is then restored by instruction in the proper ways to speak.

Michel Foucault writes that “modern man no longer communicates with the madman: on one hand, the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease.”^{lxxxv} A person with mental illness is barred from the language of reason, not just by his or her inability to speak that language, but also because his

or her own language is filtered through the technical language of medicine. This is the second complication to communication and agency by people with mental illness. He writes: “on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason.... As for a common language, there is no such thing.” Ennis and Siegel rupture this relationship in *The Rights of Mental Patients* by rejecting the authority of physicians over the treatment and confinement of people diagnosed with mental illness. They also reject the authority of the physician to interpret their language. In the place of such authority, they try to restore reason in the voice of people deemed insane by providing them the language and jargon necessary to communicate in legal and medical situations.

The restoration of agency through speech is a political action. Arendt writes that human nature is inherently political because of its ability to take action and to participate in group deliberation.^{lxxxvi} The instruction given by Ennis and Siegel gives people diagnosed with mental illness a way to act and to return to being a political being by stripping some of the bounds that prevent them from speaking rationally. Therefore, *The Rights of Mental Patients* serves as an example of a different application of free speech. Appeals to expand free speech typically involve protecting the speech of unpopular groups and philosophies by defending their statements and rhetorical actions in the court of law.^{lxxxvii} In *The Rights of Mental Patients*, the authors use another approach, which teaches individuals how to modify their speech in order to become recognized as speakers and agents. While in the former case the ACLU protects speech that has already received attention (for obscenity or controversial sentiments), in the latter, it ensures that the speakers from a marginalized group can receive attention. The book helps to remove the “enclave” by empowering the people within it with the official forms of speech.

However, the “enclave” of the mental institution must also be broken in other ways as well in order to meet the goals of the writer, and Ennis and Siegel provide their audience with the ways in which its power should be reduced and why. The authors write of ways in which they

believes the rights of their readers should be expanded, explaining the basis of these additional rights with appeals to constitutionality and to scientific studies. They explain the basis for the rights that patients typically retain in mental hospitals, and then list 9 additional rights, saying “if you are denied any of these rights, you probably have good cause to challenge the constitutionality of the law, regulation, or practice that has taken them from you.”^{lxxxviii} In a chapter on civil rights, they discuss the importance of ensuring that institutions do not prevent their patients from voting. Ennis and Siegel note a study in which patients at Bronx State Hospital in New York were given sample ballots to vote in elections in 1966 and 1968. The researchers hoped to determine whether restrictions on voting amongst the mentally ill inmates were necessary. The result was that inmates and community members voted similarly, suggesting that “mental patients are as competent as anyone else to exercise their civil right to vote,” despite restrictions on that action in 36 states at the time.^{lxxxix} Ennis and Siegel also state a way in which the individuals who read this book can act to help themselves and the status of civil rights in mental institutions. They tell their readers that since few lawyers have experience with mental health law, they can help their lawyer to prepare the case. They need only “tell him to start by reading this book.”^{xc}

A Reintroduction to Citizenship

Citizenship is the framework most emphasized within the book, and its readers are conceptualized as citizens first. This both strengthens Ennis and Siegel’s position on the importance of ensuring the rights of people who have been civilly committed and leaves the readers with a charge to action. In some portions of the book, Ennis and Siegel underscore their initial caveat about the validity of mental illness, writing that a policy impacts the “so-called insane.”^{xc} This rhetorical move shifts power from the medical science standpoint to legal facts: it is possible to deny that a person behaving abnormally is mentally ill (perhaps eccentricity or drug

abuse is the cause for his or her behavior), but it is far more difficult to deny that the person, as a citizen, should have basic rights. The book's readers are informed of the activism they are committing throughout the text and are framed as agents for change. Ennis and Siegel state that "the hope surrounding these publications is that Americans informed of their rights will be encouraged to exercise them. Through their exercise, rights are given life. If they are rarely used, they may be forgotten and violations may become routine."^{xcii} The actions this audience, ordinary Americans who have a mental illness or know someone with a mental illness, can take, such as reading a book and exercising rights, are presented as significant. Foss writes that in the framework of agentic orientation, "exigence ... becomes not a constraining force within which agents must work but an opening that enables them to transcend what they previously conceptualized as constraints and limitations." The necessity that their audience to read a book has not made them less than other citizens who do not face the constraints of mental illness, but has instead made them more active citizens by making this humble action an embodiment of patriotism. Importantly, it situates the person who is reading the book as an agent.

Written to as agents, Ennis and Siegel's audience members are given the means to fight for mental health care on their own terms, celebrated as active citizens, and also encouraged to become active in the future appeals for further rights. These rights are primarily those of negative liberty. In the first chapter of the book, they appeal to John Stuart Mill's statement for negative liberty; "the only freedom which deserves the name, is that of pursuing our own good in our own way."^{xciii} Ennis and Siegel provide a test case in a chapter on emergency hospitalization in which they ask what actions are appropriate when a prospective patient is unresponsive to his or her surroundings, which they use to explain the standpoint of the ACLU on the matter of the commitment of people who are unresponsive and appear incapable of caring for themselves. They state that hospitalizing such a person can be an appropriate measure, since there is no way of knowing what he would want to be done if he were aware of his condition. However, Ennis and

Siegel state that at the first sign of protest, the person should be left to his own devices. “We must occasionally be willing to allow people to waste their lives in what we may consider frivolous or degrading pursuits,” they write, “that is a hard thing to do, but it is necessary if the words freedom and liberty are to have any meaning.”^{xciv} Their reduction of these terms (freedom and liberty) to their most extreme form reflects what John Durham Peters calls abyss-redemption. Peters identifies abyss-redeemers by their certainty that defending extreme and unpalatable doctrines and practices in the name of abstract principle “will add up to greater truth in the end.”^{xcv} Although Peters speaks of this practice in the context of free speech advocates, it can also apply in the case of appeals to other basic liberties, or in this case, to “freedom” and “liberty” themselves. It is only by allowing some people to degrade themselves in their illness that we can appreciate the meaning of liberty, Ennis and Siegel claim. To draw any limit on one’s freedom is to deny it altogether. Everyone must determine his own agentic orientation.

Conclusion

The authors of *The Rights of Mental Patients* seek to empower their readers by presenting them with a means of addressing civil commitment. They first constitute the book’s audience, identifying the external constraints of stigmatization and the label of “mental illness.” They next give their audience an understanding of the court and medical procedures that they may face, and the vocabulary to respond to hospitalization in a way that will appear the most rational. In doing so, they affirm the right of their readers to be heard and recognized. Finally, Ennis and Siegel construct their readers as agents and as active citizens who can help to change commitment procedures and practices.

The book ultimately serves to change the agentic orientation of its readers. It recognizes the “victim” role (as Foss calls it) that many of its readers may currently be, and affirms that the feelings of being marginalized are legitimate. However, it also empowers the readers to adapt to

the constraints that society and illness have created for them and envisions them as people who can change the circumstances that civil commitment may occur under. Foss states that one of the components of agentic orientation is that it “is a response to structure rooted in processes such as categorization, invention, and symbolization as employed by the agent.”^{xxvi} While any citizen is influenced by the communicative demands of the situation and faces constraints of rationality, Ennis and Siegel’s book shows individuals who are frequently termed irrational how to use these constraints to their advantage and to respond to them in a way that is advantageous.

Chapter 3

The Voice From the Other Side of Insanity

“The day the fifteen years went down the drain was December 10, 1956:” so begins a story of a man who was confined against his will as a mental patient.^{xcvii} Kenneth Donaldson, the narrator, had a long history of civil commitment for anxiety and paranoid schizophrenia. He became paranoid shortly after his first release from hospitalization for anxiety in 1948. In the early 1950s, he changed his name twice in attempts to escape the persecution he felt he was facing from coworkers, neighbors, and the Republican Party. He believed that his food was being medicated, that he was being slandered and harassed, and that someone was intercepting and reading his mail. In 1956, he was treated for paranoid schizophrenia at Philadelphia General Hospital, and upon his release he visited his parents in Florida.^{xcviii} Concerned about his claims that their neighbor was poisoning the casseroles, his father filed a complaint to have him recommitted. Although he was offered medication and electroshock treatments at the Florida State Mental Hospital in Chattahoochee, he refused them on the grounds that he was a Christian Scientist. In lieu of these, he was given recreational and religious therapy, which consisted of being permitted to attend religious services and interact with other patients.^{xcix} Donaldson stated, and the records uphold, that he rarely saw the doctors in charge of his care, and was instead entrusted largely to the care of untrained attendants. Although there was no record of violence or suicide ideation, and he had held jobs for the

14 years prior to commitment, the defense stated that Doctor O'Connor, who was in charge of his treatment, had not been confident in Donaldson's ability to live on his own.^c Donaldson would later write that he believed the doctors were unwilling to release him because he would not state that he had ever been ill.

Unlike many mental patients, Donaldson became a significant voice to the public on the topic of the process of civil commitment and contemporary treatment methods. He had the opportunity to tell this story in two public ways: before the U.S. Supreme Court, and in his book *Insanity Inside Out*. During his 15 year tenure in the Florida state mental hospital system, he repeatedly fought for his release by filing writs of *habeas corpus*, contacting state officials and lawyers, and running away. His religious convictions prevented him from acquiescing to the demands of hospital doctors that he take medication before being released, a situation Donaldson later described in his book as coercive and unfair. Donaldson submitted 15 legal petitions to state and federal courts for his release.^{ci} His persistent efforts to secure his freedom via a legal means were finally rewarded in 1971. During his 19th round of appeals for release he was discharged from the hospital.

He filed suit against the Florida State Mental Hospital doctors and staff, on behalf of himself and his fellow inmates, stating that they had violated his Constitutional rights by detaining him against his will without treatment.^{cii} Although Donaldson himself was a Christian Scientist, he explains this decision in the book, stating that he and his lawyer had learned through experience that strategy was necessary if they were going to get his case to court.^{ciii} Donaldson states the courts would not be interested in a person fighting commitment, but that his first lawyer, Morton Birnbaum, believed they would be

interested in the cases of people who were held involuntarily and not given treatment. His victory in the 5th District Court was appealed to the U.S. Supreme Court, where the justices ruled unanimously in his favor in the landmark case *O'Connor v. Donaldson*. His case against the head doctor of the mental hospital was instrumental in the release of thousands of mental patients and contributed to the development of the dangerousness standard, which was adopted as the standard of commitment in 47 states in the years immediately following the trial.

Subsequently, Donaldson wrote a book titled *Insanity Inside Out* about his experiences in the hospital. Ironically, his claim that he was going to write an expose of the mental health system had been considered a delusion by his doctors, and written into his medical charts as proof of his troubled condition.^{civ} Both Donaldson's victory in the courts and his book received widespread media attention. The case was covered in newspapers across the country, and when his book was published, he went on a speaking tour, providing his perspective on institutionalization to people in Ohio, New Jersey, West Virginia, New York, Illinois, Washington D.C., Pennsylvania and Missouri.^{cv}

As a public figure during and after the trial, Kenneth Donaldson worked to shape the perceptions of the chronically mentally ill held by the public. The agency he showed in securing his release and the eloquence with which he wrote of that struggle in his book challenged the way that patients at mental institutions were perceived. This chapter will examine *Insanity Inside Out* in three ways. First, I will discuss the way in which it serves to provide ethos to its author. Next, I will identify and discuss key arguments in the book about sanity and the treatment of those deemed insane by the mental health system, with attention to the role of physical space in determining agency. Then, I will demonstrate the

case that Donaldson makes for the dangerousness standard, and the way that it reflected underlying assumptions about agency and power. In *Insanity Inside Out*, Kenneth Donaldson uses anecdotes and vivid language to depict the physical and psychological constraints of institutionalization, demonstrating the importance of physical space in determining agency and ultimately contributing to a larger literature of anti-psychiatry. The book both demonstrates Donaldson's loss of agency in the institution and restores his agency by entering his experiences into public deliberation about civil commitment.

Deinstitutionalization and Kenneth Donaldson

Donaldson's case and his subsequent book are two artifacts of the era of deinstitutionalization, the movement to release large numbers of mental institution patients to the community. Deinstitutionalization reached its peak in the 1960s and 1970s in the United States for a number of reasons. The mental hygiene movement, which had begun in the 1910s, had successfully changed public perceptions about mental disorders and advocated early intervention to prevent decline into serious mental illness. Gehrke states that from the 1910s to the 1940s, this movement taught that proper training in communication could identify, mitigate, and prevent mental illness.^{cvi} The adoption of the new practice of troop rotation during World War II, which had reduced the number of military personnel who had to be treated for mental breakdowns, suggested that life experiences and environmental conditions were significant in the rise of mental illness.^{cvii} The introduction of effective psychotropic drugs mid-century dulled the symptoms caused by certain disorders. New research, drugs, and practices suggested the forthcoming success of releasing persons with mental illness to their families and communities to live more normal lives. Each of these factors was significant in the

creation of the Community Mental Health Centers Act of 1963, which provided funding for centers to treat persons with mental illness in their own communities.^{cviii} The 1950s and 1960s saw large numbers of former patients released to the community; however, for others, the barriers of the institution were still in place. U.S. Supreme Court Case *O'Connor v. Donaldson* helped to create the circumstances under which many more mental patients were released to the community.

O'Connor v. Donaldson was a significant ruling in the U.S. Supreme Court in 1975. When the case was first appealed to the Supreme Court, there was speculation that it may result in a “right to treatment;” however, the Court ruled only on the conditions of commitment pertaining to the abilities of the individual. The opinion stated

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty. 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.

This passage changed the standards for commitment virtually overnight. The ACLU called the decision a great victory.^{ciix} Bruce Ennis, who had begun the Mental Health Law Project and written *The Rights of Mental Patients* a few years earlier, was Donaldson’s lawyer in the appeal to the U.S. Supreme Court.^{cx} The American Psychiatric

Association noted on the verdict that 90% of institutionalized patients were not considered dangerous.^{cxii} The *New York Times* stated that “the ruling appeared likely to force the ultimate release from mental institutions of thousands of the estimated total of 250,000 patients regarded as untreated, harmless, and not likely to become community charges.”^{cxiii} The ruling shifted the standards for commitment considered constitutional from an evaluation of the patient’s illness to an evaluation of the patient’s likelihood to endanger him or herself or others.

The shift from illness to violence as the burden of proof re-imagined the commitment process as something to protect the public from violence (as jails do) rather than to protect the individual from the consequences of his or her illness. When Donaldson filed for damages from his commitment, he did so on the grounds that involuntary institutionalization of a nondangerous individual was a violation of his or her Constitutional rights, an argument accepted by the justices. States Justice Stewart in the opinion, “As we view it, this cases raises a single, relatively simple, but nonetheless important question concerning every man’s constitutional right to liberty.” This shifted the burden of proof from a determination of whether the individual was ill to whether he or she was dangerous, making the commitment decision a parallel to incarceration. This also changed the population of people deemed ill enough to treat from individuals traditionally considered severely mentally ill, such as persons with schizophrenia (who are rarely violent), to people suffering from personality disorders or drug and alcohol abuse, who are more likely to attempt suicide or become violent with others.^{cxiii} This shift in population, in turn, has also raised the percentage of inmates of mental institutions who have a criminal record. Public perceptions of the dangerousness of people with mental

illness have also become more distorted; despite low levels of dangerousness amongst people with mental illness, the public perception that mental illness was a cause of violence became more common between 1950 and 1996.^{cxiv}

The case was one of a series of cases that paved the way for the dangerousness standard. This was part of a larger trend in public discourse about civil rights; Robert Miller writes “During the civil rights of the 1970s, the pressure to apply the procedural protections from the criminal justice system also extended to the substantive criteria for commitment.”^{cxv} This movement to a changed standard of commitment was fueled by radical psychiatrists such as Thomas Szasz and David Cooper, who both wrote books claiming that the concept of mental illness was a creation based on society’s distaste for eccentrics. Notably, public opinion was such that O’Connor’s defense emphasized that the Doctor was following orders and standard procedures rather than claim that Donaldson’s claim to liberty was illegitimate. The defense stressed the extent to which the hospital and its doctors had upheld state law.^{cxvi} In doing so, the defense placed the blame on the bureaucracy of the mental health system, excusing the actions of the individuals the lawsuit was filed against. Hannah Arendt writes that if “we identify tyranny as government that is not held to give account of itself, rule by Nobody is clearly the most tyrannical of all, since there is no one left who could even be asked to answer for what is being done.” Donaldson’s choices once he was released from the hospital reflect a frustration with the tyranny he sees in the mental health bureaucracy.

While the *Donaldson* case resulted in dramatic changes in legislation for commitment and the procedures of commitment, his book helped to contribute to public perceptions of what commitment prior to the changes had looked like by painting a vivid

portrait of institutionalized life. Donaldson's book and actions reflect the shift in agentic orientation that his lawyer, Bruce Ennis of the ACLU, urges in *The Rights of Mental Patients*. Throughout his book, Donaldson appeals to rights and equality before the law, part of the rational Enlightenment discourse that Foucault credits for the medicalization of insanity, and likewise part of the discourse encouraged by Ennis's book. He wrote writs of *habeas corpus* for himself and others while institutionalized, studied legal books, and adopted legal language in his appeals for release. Although ultimately successful in his efforts, Donaldson is able to demonstrate the constraints of this method in his account of life in the institution. Donaldson's book provides an autobiographical account of the circumstances of his institutionalization. He discusses briefly his life prior to being committed, as well as the commitment process and life inside a state institution. He also describes the circumstances of his release and his experiences in the courtroom. At the end of his book, he argues against involuntary commitment and urges his readers to re-examine their bias against people who have been diagnosed as mentally ill. In doing this, he engages in a public discussion about deinstitutionalization.

Readers interested in deinstitutionalization had had prior exposure to negative depictions of institutionalization through books written in the 1960s and early 1970s by a group of radical psychiatrists who denied that mental illness existed; *Insanity Inside Out* gave another perspective of the institution, but largely supported the anti-psychiatrists' claims. One of these radical psychiatrists, Szasz, later wrote a book called *Psychiatric Slavery* explicitly about Donaldson's case.^{cxvii} *Insanity Inside Out* was reviewed by a number of sources and commented upon for its uniqueness and power as a text written by a formerly committed author. A writer for Kirkus Reviews stated "He is a hero. His fierce

determination for himself and his unquestioning assumption of responsibility for his fellow patients transcend sanity. His writing style is . . . powerful, his account of asylum life compressed, flaring, unforgettable.”^{cxviii} The man behind the reform became a public voice for those the reform had released. Through his writing and through his choice to file his court petition on behalf of all of the inmates at the hospital in Chattahoochee, Donaldson represented his peers rhetorically and literally. In this way, Donaldson was able to demonstrate the agency that a mentally ill person could have when removed from the physical and authoritarian barriers of the institution. The disruption of what Donaldson calls “sanism,” or the invalidation of the feelings and communication of people identified as insane, is not limited to his book (it is also evident in his success securing freedom and in his role as a speaker), but the book provides one way in which we can address it.

Anti-psychiatry, Enlightenment Thought and Agency:

A backlash to the practices of modern psychiatry, known as the anti-psychiatry movement, reached its peak in the 1960s and 1970s. Composed primarily of intellectuals, most frequently former or radical psychiatrists themselves, the writers in this movement used personal anecdotes mixed with academic histories of psychiatry to accuse psychiatry of being an instrument of violence. Philosopher Eric Matthews writes that anti-psychiatrists “base[d] their case on the work of a number of writers on the history of psychiatry. Perhaps most influential of these writers has been the late Michel Foucault, particularly in his early work translated into English in an abridged form as *Madness and Civilization*.”^{cxix} Foucault’s work discusses the history of how society treats the people it labels insane throughout the period of Western history he calls the “age of reason,”

beginning in the late middle ages and ending in the late 18th century. Foucault argues that a society's insane are defined by their segregation from the rest of the community, be it by a breakdown in communication or an asylum wall. Foucault also provides a significant commentary on the means by which insanity is identified: "It is judged only by its acts; it is not accused of intentions, nor are its secrets to be fathomed. Madness is responsible only for that part of itself which is visible. All the rest is reduced to silence. Madness no longer exists except as seen."^{cxix} This point would become significant to the writings of the anti-psychiatrists, who would disregard the historical nature of Foucault's critique and apply his insights of the past to the psychiatric practices of the present. By appealing to the work of Foucault and others, which described how conceptualizations of mental illness had changed throughout history, the anti-psychiatrists were able to state that mental illness was a culturally specific and moralistic means of isolating people whose behavior was considered unacceptable.

Central to the claims of the most prominent anti-psychiatrists, including Thomas Szasz and David Cooper, is the belief that mental illness is a metaphor used to medicalize unaccepted social behaviors. Because they are identified by symptoms only, their causes unknown, Szasz and Cooper deny mental illnesses the medical label. Writes Szasz, "the fact that the brain is used in human behavior does not make moral and personal conflicts problems in medicine."^{cxxi} Rather, he states that the inability to identify mental illness through normal medical procedures and to demonstrate it as a physical problem indicates that it is not an illness at all.^{cxxii} Instead, he says, "psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others."^{cxxiii} Cooper speaks to what he calls the "violence" of

psychiatry, defining it as “the corrosive action of the freedom of a person on the freedom of another.”^{cxxiv} Cooper’s application of the principle of negative liberty in this statement equates any infringement of one’s rights to violence. He states that this violence occurs in two stages which invalidate the social being of the patient: first, the person deemed insane is forced to gradually assume a passive role as patient, and second, his or her actions and words are discredited by the excuse of insanity.^{cxxv} Therefore, violence as he conceives of it is primarily a metaphor for control over the way in which the individual sees himself and is seen by others. However, Cooper’s conceptualization of violence in this circumstance also encompasses the more physical aspect of being a patient, which is the possibility of involuntary medical treatment. Thus, both Szasz and Cooper describe psychiatric treatment as a means of invalidating the agency of the individual and further removing him or her from society. Donaldson, whose work quotes Szasz, supports some of these claims with his own anecdotes from the other perspective at the institution.^{cxxvi}

The philosophy of the movement towards deinstitutionalization holds values common to what Isaiah Berlin calls “negative liberty.” Berlin identifies this as an emphasis on freedom as an ultimate good, resulting in a conceptualization of liberty as being the ability to have as few limits on one’s choices as possible. He identifies the presumption that the “essence of men is that they are autonomous beings” among these writers and concludes that this emphasis leads them to consider that all coercion is “bad as such,” while all noninterference is “good as such.”^{cxxvii} Therefore, even actions that may be performed as benevolence may be bad if they are coercive, since they devalue the autonomy of the individual whose life is influenced. Berlin writes that Western liberal political theorists, particularly John Stuart Mill, temper the individual good of liberty

with community living by emphasizing communitarian values such as peace, justice, security, and equality where restrictions are necessary.^{cxxviii} The values of negative liberty place emphasis on the importance of individual agency in decision-making. The anti-psychiatrists argued that the medicalization of behaviors under the label of mental illness removes agency from the individual by indicating that their actions are only legitimate if they have undergone treatment under the authority of a doctor. They emphasized the importance of freedom from medical interference and from the stigma of the label of mental illness. In doing so, they identified a medical problem as instead a political problem – a matter of rights.

The reframing of the issue of mental illness as an impediment to civil rights and the ability to act as any other citizen introduced concerns about agency. Agency is essential to civil rights. In her book *On Violence*, Arendt writes that

“what makes man a political being is his faculty of action; it enables him to get together with his peers, to act in concert, and to reach out for goals and enterprises that would never enter his mind, let alone the desires of his heart, had he not been given this gift – to embark on something new. Philosophically speaking, to act is the human answer to the condition of natality.”^{cxxix}

Action, then is so central to the fact of one’s existence that to live without the faculty of action is like to be stripped of one’s humanity. Following that belief, coercion or preventing another’s action, is then a violent act that infringes on an individual’s very humanity. Anti-psychiatrists’ accusations that the mental healthcare establishment was coercive (either inherently or in practice) reflected the language of negative liberty and

depicted involuntary commitment as the stripping away of agency, rather than a means of treatment. Depictions of mental healthcare treatment emphasized the physical loss of agency: restraints, guarded passageways, brief court hearings. However, Donaldson and the anti-psychiatrists also argued that the social positions and labels within the mental healthcare establishment caused a loss of agency.

Rhetoricians have emphasized the importance of social structures in determining the agency of a speaker. One does not implicitly have agency by speaking, but by being listened to. Nathan Stormer calls the dislocation of the center of rhetorical study and agency from the individual to the society a “posthumanist perspective.”^{cxxx} S.K. Foss et al write that agency must be acted toward or upon something, and they suggest three components to the orientation of agency: “interpretation of structure, the selection of a response to that interpretation... and the experience of an outcome in line with these choices.”^{cxxxi} An individual can enact agency, but must adapt it to a structure and his or her interpretation of structural constraints; surveying a range of options becomes central to this conceptualization. Speakers whose agency is denied by conventional means of communication must find alternative ways to communicate effectively with others, making the properties of a text presented by a member of a disadvantaged group important. When a text becomes physical, as it does with Donaldson’s book, its physical structure speaks to constraints and opportunity alike.

Donaldson’s book vividly addresses the space and practices of the institution, demonstrating the rhetorical power that institutionalization has on agency, freedom, and the perceptions of the public. The institution serves as a site of power, one which is being destabilized by the movement towards deinstitutionalization and cultural artifacts such as

Donaldson's book. Raka Shome writes that there is a "centrality of space in the production, organization, and distribution of cultural power."^{cxviii} The physical qualities of a space delineate power structures and communicate behavioral norms to the people who enter it, according to Mike Green.^{cxviii} However, a space speaks to more than just power; Jolanta A. Drzewiecka and Thomas K. Nakayama state that it influences perceptions of the identity of an individual. They write, "people negotiate cultural identities largely through spatialization of their experiences How and when they move through cultural spaces."^{cxviii} Donaldson's book not only captures the way in which the institution is used and structured, but also gives first and second-hand accounts of how it is perceived by its various inhabitants. The public institution was once a space of very tangible structures of power (of illness and health, with emphasis on medical and legal authority); at the time of the book's release, it was in the process of being scrutinized. The book, which is as much an artifact of institutionalization as deinstitutionalization, disrupts the premises by which Donaldson and his companions were hospitalized and treated in the eyes of the public.

Ethos and Insanity Inside Out

Published in 1976, the year after the ruling in Donaldson's favor, the *Insanity Inside Out* was released at an opportune time, while the public was still familiar with his name and interested in the details of his commitment prior to his appeal to the Supreme Court. At the time of the release, Donaldson had given a number of lectures about life in an institution and his case.^{cxviii} While Donaldson had ethos to speak of his experiences as a former patient at a mental hospital, the issue of his diagnosis of paranoid schizophrenia was a liability. To counter this liability, the book's Foreword is by Chief Judge David A.

Bazelon of the U.S. Court of Appeals, who provides strong support for the contents of the book and the importance of Donaldson in the fight to deinstitutionalize non-violent patients at mental institutions. Bazelon, who was appointed by President Harry S Truman, advocated for the rights of the mentally ill and oversaw several cases that redefined the way in which the mentally ill were treated by the courts.^{cxxxvi} The judge opens with a narrative of redemption – Donaldson’s story, in fact – in which his institutionalization and fight to attain freedom are memorialized. Sig Molen, the editor, further supports Donaldson’s ethos and agency as a speaker by commenting on his demeanor in the Editor’s Note at the front of the book. The choice of a publishing company to distribute Donaldson’s book also creates a space for agency. In the text itself, Donaldson emphasizes the way in which many of the other patients are, like him, motivated by the same things as people who have not been institutionalized, normalizing them in the mind of the audience, and showing the ways in which institutional life can distort the natural behavior process. He also uses his experiences in an institution as a means of speaking to the most common concerns raised about deinstitutionalization.

The medium of Donaldson’s book serves to circumvent the constraints of speaking as a mentally ill person by dislocating the space of discourse from the individual to the printed and published word. The acceptance of Donaldson’s account by a publishing company and the physical act of printing, binding, and selling his narrative grants him ethos and removes the site of agency from the writer to the product. The reader does not come face to face with the author except on the author’s own terms: via the Foreword, the Editor’s Note, and his account of his experiences. The printed page mediates and controls the information that a reader may have about Kenneth Donaldson,

leaving his narrative to be judged on its merits, free of the person who wrote it and any nonverbal communication that a reader may interpret as indication of illness. The book also legitimizes his account by the act of being published, and allows his account to be read by a larger audience than those who heard him speak in person.

Importantly, the book also physically demonstrates how a person who has been diagnosed as having a mental illness may be able to function if removed from limitations of hospital life. The book serves as a rhetorical re-entry into public space for a person who was banished from it for 15 years. In this way, he was able to express himself to people who might otherwise never appreciate the effects of institutionalization on agency. The book shows the constraints of hospital life and paints a compelling picture of the frustration of trying to secure freedom in a bureaucracy in which agency has been stripped by a diagnosis. Donaldson vividly describes a world in which one's voice and actions are always interpreted as symptoms of illness, since one's own word and explanations are not accepted. He shows how a diagnosis can equate with silence. He also shows what may be silenced. The expressiveness with which he writes about the persistency necessary to secure his release demonstrates his ability to function in a way that many people never will (as an author). The book highlights the variety of abilities that its author has and makes clear that having a mental illness does not necessarily mean that one is incapable of being successful.

Sanism and Stigma

Because of the circumstances he describes throughout his book, showing his near-complete loss of agency when committed, there is a deep significance to Donaldson's

discussion of discrimination against persons with mental illness. He calls this “sanism.”^{xxxvii} Donaldson writes “Twenty years before, they had accepted a psychiatric diagnosis which forever rent the fabric of my life. Thereafter, not only society at large but members of my family would see not Ken the son and father and friend, but Ken the mental patient.”^{xxxviii} This reduction to mental patient, he shows, has significant effects on the lives of people who have been committed. Donaldson includes the accounts of others in the discussion of “sanism,” showing the ways in which it has harmed former patients. Donaldson blames neglect of the right to *habeas corpus*, job discrimination, and harassment on public attitudes towards people who have been diagnosed as mentally ill. He argues that the stigma of the institution is internalized by both the patient and his community, harming the agency of the patient long after his or her release.

Place is significant in the identification of people diagnosed with mental illness in Donaldson’s account because the institutionalization is internalized by both the general public and the person who was institutionalized. Donaldson’s comments reflect Shome’s insight that “the issue of how identity becomes a matter of political significance is one that ironically cannot always be answered only through an acontextual framework of identity.”^{xxxix} The effect that the institution had on its patients’ identities was significant in Donaldson’s account. He vividly describes the physical setting of the institution and surveillance from guards and medical attendants; “Beyond the poolroom below the rickety stairs and past a concrete porch enclosed with cyclone fencing, we went most of the way without guards.... Through double-hung sash, covered with wire grilles, I saw the street below as we turned.”^{cxl} He repeatedly states that the physical setting feels

dehumanizing, and he argues that the setting distorts the actions of the men around him. This reflects Foucault's argument that madness is characterized by isolation from the public. The asylum, as Donaldson describes it, segregates its patients physically through the structures such as the one he describes above.

Donaldson argues that the physical space of the institution also colors the actions of the people within it. When a visitor enters the ward, Donaldson asserts his good health to him. The earnest response is "If you weren't sick, you wouldn't be here."^{cxli} However, Donaldson questions whether much of what he has seen is mental illness at all. Donaldson asserts that most people diagnosed with mental illness are diagnosed as such because they are eccentric or rebelling against the norms of society. He claims that the "overwhelming majority" of state mental institution patients are not sick to begin with, and that public fears of a large mentally-ill population in its midst are overblown.^{cxlii} He also states that "judging from the ten thousand souls who filtered through the system and rubbed shoulders with me in fifteen years, there is no epidemiology of mental illness."^{cxliii} Many of the people he encountered while institutionalized, he believes, needed nothing more than the guidance of a mature and trusted person in order to resolve their problems. Donaldson also vividly describes the aftereffects of being institutionalized, which he calls "psychic shock." His descriptions of this include a changed physical stance and bearing of persons released from institutions, weariness, emotional hollowness and internalization of the ward schedule (including bed checks).^{cxliv} The setting of the institution is a significant part of the identity of the people in it in Donaldson's narrative, whether they are there or have been released. By adapting to the constraints in agency that are borne out in the physical structures of the institution as well as the standards of behavior,

patients internalize behaviors that continue to identify them as such after their release, making them susceptible to “sanism.”

Donaldson points to his own unsuccessful attempts for release when discussing the role that the courts play in perpetuating “sanism.” “As for looking to the courts for help, besides my own experience, other people have shown the hopelessness there. And Doctor Birnbaum says that most courts and civil rights organizations go all out to see that criminals get *habeas corpus*, but toward mental patients they are “sanist.”^{cxlv} He emphasizes here, and in other sections of the book, that the place in which he was held, rather than the fact that he was being held, determined whether he had a voice to the court system. While the rights of people in the penal system were attended to, he argues, the removal to a state institution meant a loss of rights. After he and a few other patients filed writs of *habeas corpus*, he writes “it was a blow to my faith in blindfolded Justice when word came the next week that the other three petitions were denied. No doubt about it, Justice had peeked and liked the carryings-on of the asylum doctors.”^{cxlvi} Later, he blames the judiciary as much as the psychologists for his time spent in the mental hospital.

Donaldson writes of his struggles with holding a job in the face of harassment throughout the book, and also includes the account of a former nurse who lost her job because of her mental health history. After his first institutionalization in New York in 1943, Donaldson describes various physical and verbal forms of harassment while on the job; “Men on the job played tricks, like removing the support under a scaffold plank so that I fell six feet to the ground.”^{cxlvii} Each time, he describes leaving, sometimes to move to a new city, in order to find a more hospitable place of work. This discrimination, he

states, is not limited to blue collar workers alone; “even today... the country was afraid of having Eagleton as vice-president.”^{cxlviii} Nurse Shirley Burghard, who prepared a statement for the book at Donaldson’s request, describes the circumstances in which she left her job as a nurse to voluntarily enter treatment. At the time, she was assured that her job would be held for her return. However, several months later, the same superior refused to hire her back to the same position (as a RN) and instead gave her the job of nurse’s aide. At a later job, she was unexpectedly fired after her superior discovered her mental health history. She asserts to readers “I never realized that a supposedly sane person could have such a hatred for somebody whom society had once labeled insane. We must get rid of these labels, if it is the last thing we ever do.”^{cxlix} However, Donaldson stresses that harassment is not limited to the workplace, but is an inescapable part of life for former mental patients. Implicit in the inability to cease the harassment is the implication that someone who has had a mental illness is unlikely to be telling the truth. “Once this harassing starts on an ex-patient, there is nothing he can do to stop it” Donaldson states, “A Syracuse doctor warned me not to appeal to the police for help for, with my record, they would lock me up immediately.”^{cl}

Donaldson’s account of the effects of institutionalization on agency reflects and supports Cooper’s argument about the power that psychiatry has over the way patients see themselves (and others see the patients). Institutionalization alters a former patient’s status in his or her community and limits agency in two ways. The internalization of verbal and nonverbal behaviors that Donaldson describes as “psychic shock” colors communication and agency by former patients long after they have been released from a mental hospital, according to his account. Foucault writes that madness was defined by

its separation (physical and mental) from the rest of the community; in Donaldson's account, physical separation creates or exacerbates language boundaries between patients and the community. Secondly, agency is affected by others' perceptions of the ability or disability of the former patient. Donaldson asserts that it is assumed that a mental patient is relapsing, rather than suffering persecution for his or her condition. "If I had not been carrying the label from Marcy" [the mental hospital in New York], he says, "people would have talked to me on my own level and I would have gotten help to stop the slanderers."^{cli} Donaldson argues that the agency of former mental patients is not restored, even long after a commitment. Threats of recommitment silence them.

The Dangerousness Standard

So far, this chapter has argued that this rhetoric strengthened the agency that Kenneth Donaldson had both through the space of the book and the ethos of the various contributors. It has also addressed Donaldson's account of the Florida State Hospital in Chattahoochee and the rhetorical space of institutions in his book. Ultimately, Donaldson argues for the closure of institutions in favor of community care by likening institutionalization to incarceration. He makes a point of rejecting the lingo of the doctors, calling attendants "guards," and he compares the institution to the jail he was held in prior to his hearing.^{clii} The use of space and place in his argument about institutionalization also demonstrates some of the assumptions in the rhetoric behind the dangerousness standard. He argues that institutionalization after a diagnosis of mental illness is a violation of one's rights, and also states that most people who have been diagnosed are only eccentric or troubled. In this way, Donaldson enters a broader public

discussion about mental illness and involuntary commitment, something he could never have done under other circumstances.

Insanity Inside Out contributed to the existing anti-psychiatry literature published in the 1960s and 1970s by presenting an additional perspective. David Cooper, R.D. Laing, and Thomas Szasz, the leaders of the anti-psychiatry movement, were formally trained mental health professionals with experience working in institutions or clinics. While their books depicted case studies and experimental therapy techniques to support claims against contemporary practices in psychiatry, Donaldson's account provides richer details and more personalized accounts of individual patients. He was able to give a first-hand account of his own interrupted life. The writers also blamed different aspects of institutionalization for the treatment of mental patients in the 1960s and 1970s. Szasz blames his profession for medicalizing behavioral issues, but also blames people being treated for mental illness for their irresponsible actions and maladjusted behaviors in society. He claims "We now deny moral, personal, political, and social controversies by pretending that they are psychiatric problems: in short by playing the medical game."^{cliii} Cooper blames poor familial relations, misinterpretation of communication practices and psychiatric theories for mental illness. Donaldson places blame on the physical conditions of the mental institution, including short-staffing, poor living conditions, and institutional practices he considers coercive. However, the appeals in Donaldson's book reflect the claims of his anti-psychiatrist predecessors. Foucault writes that "Madness was not what one believed, nor what it believed itself to be; it was infinitely less than itself: a combination of persuasion and mystification."^{cliv} The premise of Donaldson's book is that he is able to gaze past the mystification of psychiatric practices and jargon and to

give an unclouded account of psychiatry and the institution. Because he is unable to be persuaded by psychiatry, the schizophrenic can see clearly.

Because of the varying perspectives of who is to blame for poor psychiatric practices, these authors also give varying accounts of how they perceive the dangerousness standard. The introduction of this standard changed the terms of the communal agreement over what constituted the necessity for limiting one's liberty. The previous standard had identified mental health as a higher good, making institutionalization of a relative or acquaintance a response to health concerns; under the dangerousness standard, the respected good was the physical safety of the community and individual. Autonomy could only be removed if a punishable offense was committed. However, there were difficulties with the new standard. Szasz writes that dangerousness cannot be predicted, and must only be responded to – with jail, not hospitalization.^{clv} Some mainline psychiatrists were also disturbed by the new standard – Robert Miller writes that the use of dangerousness to determine whether a person should or should not be committed is too unpredictable to be anything but a straw man – a deliberately weak standard set in order to eliminate involuntary institutionalization altogether.^{clvi} Donaldson considered institutionalization analogous to being jailed, and made comparisons between hospital and jail throughout his book. Like Szasz, he doubted the need for hospitalizing people considered dangerous.

Donaldson's comparison between the treatment of prisoners and mental patients is a consistent theme throughout his book; his emphasis on the (unfavorable) differences between criminal procedure and the contemporary mental health law reflects the sentiments expressed in the *O'Connor v. Donaldson* opinion and by the civil rights

activists involved in mental healthcare cases. They each argue that the treatment of the innocent people diagnosed as mentally ill is worse or equivalent to the treatment of criminals. Of a proper standard for institutionalization, Donaldson quotes radical psychiatrist Thomas Szatz: “I hold that a person should be deprived of his liberty only if he is proved guilty of breaking the law. No one should be deprived of his freedom for the sake of his ‘mental health.’”^{clvii} The occupation with limiting the freedom of people innocent of any crime is also reflected in Donaldson’s narrative; “I sat on a swayback bed, wondering what had happened to the principles of American freedom that would permit the pushing of innocent men back, back, back until there was no place farther back to push them.”^{clviii} He writes that there “were patients who apparently needed to be confined. My argument is that those patients would in the main behave normally in a normal setting.”^{clix} Here he writes about a patient that he dubs “Rackass,” a volatile man who he says threatened and attacked others while at the hospital, but was discharged and now lives independently.^{clx} This man, he writes, is one who he was convinced was institutionalized with due cause, but even he has been able to support himself and live peacefully when removed from the institution. Donaldson asserts that Rackass is not an isolated case; “The experience of other hospitals, which suddenly opened their closed wards and gave town privileges to all patients, is that even unkempt and ill-natured patients usually “straightened out and flew right” when they were freed from the abuses and pressures of closed wards.”^{clxi} In this last assertion is another argument that Donaldson makes: that the actions of the people confined in mental institutions are largely a result of their institutionalization rather than a reflection of the cause of it. Hazing at the institution where he was held, he argues, resulted in patient behaviors that

were misinterpreted by the short-staffed doctors. The prior label of mental illness colored interpretations of patient actions, resulting in explanations of pathology to signs of institutionally related stress.

Donaldson only briefly discusses treatment of persons who he believes would meet true standards of mental illness. “But what about the person who goes about muttering to himself and saying he is Napoleon?” he asks, “If he is living safely and bothering no one, leave him alone.”^{clxii} Donaldson argues that community care, such as that proposed and put into place by the Community Mental Health Centers Act of 1963, can meet the needs of people who have a serious mental illness, and that institutions are the least appropriate place for them.^{clxiii}

Conclusion

Kenneth Donaldson was actively engaged in public deliberation about mental health policy and contributed to public perceptions of the mental health system through his writing and his speaking. He hoped that his book would influence public perceptions about mental illness and the abilities of people who had been diagnosed with it, as his case had in the legal system. Donaldson writes that his “hope is that this book will help families see through the fog of sanism, to be more skeptical of the premixed formulas of state psychiatry” and he calls his readers to action at its close.^{clxiv} He also was involved in local community policy change, and spoke at various conferences and public meetings on behalf of changing the mental health system in the years after his trial.^{clxv} Drawing on his personal experiences, he was able to provide a face and a voice to the institutionalized. He often spoke about the importance of community based care and patients rights.

Insanity Inside Out is an example of a way in which an individual who has been formerly stripped of agency can recover his agency and speak to the needs of others in the same position. Donaldson's text disrupts common conceptions about the people who were held in institutions, as well as conceptions about people who have been diagnosed with paranoid schizophrenia. It recounts the actions he took in order to be released, and it also serves as an example of the rational language of rights and freedoms in the writing of someone diagnosed as insane. His case and his usage of this language catapulted Donaldson into a public discussion about deinstitutionalization.

The book also demonstrates the physicality of agency: agency is connected in significant ways to the rhetoric of spaces. The power of the language used in the mental hospital and its effects on the identity and actions of the inmates is shown throughout Donaldson's narrative. His inclusion of his mental health records from each year in the hospital, which identify his desire to write an expose of the institution, provides additional reminders of this.

Donaldson argues powerfully for the restoration of agency to people with mental illness by limiting the standards of commitment. He illustrates poor treatment by doctors, nurses, and judges alike that disregards human dignity and justice. He argues for stricter commitment procedure by judges and calls for attention to writs of *habeas corpus* filed by people residing in mental institutions. He shows ways in which the label of mental illness can lead to job discrimination and harassment. He argues that even when a person has been released from a mental hospital and has the physical freedom to move freely, the stigma of the diagnosis removes credibility and makes it difficult to get relief from the

harassment of others. Furthermore, the internalization of the space of the institution alters thinking patterns and behaviorisms of patients and changes the perceptions that others have of them. When a person is diagnosed as mentally ill, he implies, that diagnosis removes one's agency as a citizen (including the right to *habeas corpus*), one's agency to work and provide for a family, and one's agency to speak and be treated as an equal. Throughout his book, Donaldson reflects Isaiah Berlin's depiction of the ultimate goods of negative liberty; "The defense of liberty consists in the 'negative' goal of warding off interference. To threaten a man with persecution unless he submits to a life in which he exercises no choices of his goals.... is to sin against the truth that he is a man, a being with a life of his own to live."^{clxvi}

Chapter 4

Dying With Their Rights On

“Of all the homeless, the street people are the most difficult to count. Often they are known to social workers only as ‘Chanter,’ ‘Poor Hearing’ or ‘Painted Jeans.’ Project HELP, a crisis intervention group set up by the city to reach these people, has made a list of 1,200 individuals in Manhattan south of 96th street, with 30 to 40 people being added every month.”

-Deirdre Carmody, for *The New York Times*, Oct 10, 1984

In the 1980s, New York City’s government services and charities were flooded with a rapidly increasing homeless population. Federal housing suffered funding cuts under President Reagan, and a real estate boom resulted in the conversion of many SROs (single room occupancy units) that had been used to house the poor in the city into into luxury apartments.^{clxvii} Crack cocaine addiction incapacitated droves of the young and poor. Deinstitutionalization and a reduction in the number of psychiatric beds gave people who had previously relied upon the mental health system nowhere to go. The public clinics, originally founded during deinstitutionalization to provide outpatient services, provided little for the basic needs of the chronically and severely mentally ill, instead focusing on a new function given them by Congress: treating alcoholism and drug abuse.^{clxviii} Public shelters and armories were flooded to capacity.

The demographic of the homeless population in New York City was also changing in the 1980s. As early as 1982, a city spokesperson stated that “Fifteen years ago, we used to see the classic Bowery bum, the white, middle-age alcoholic. This has radically changed. The people who show up are quite mixed. Now there are a large

number of mentally ill people and younger people who have a variety of problems.”^{clxix}

By 1984, mental illness among the chronically homeless was considered an even more dramatic problem, and was given more press; Bellevue, the city mental institution, often had no open beds, and the number of psychiatric beds in the state had been slashed from 80,000 in 1965 to 21,000.^{clxx} Noted Dr. Kellerman of the New York City Department of Mental Health, the new additions to the numbers of the homeless were “the mental-illness equivalent of the Yuppies, the Young Urban Professionals. They don’t perceive themselves as ill and don’t seek treatment. They are the major current input to the homeless population.”^{clxxi} This can be seen in the rising numbers of people brought to psychiatric emergency rooms in New York City in the 1980s; according to Cohen and Marcos, “in 1983 there were 10,768 visits, in 1986, 16,735, and in 1989, 18,203; or an increase of 69 percent in six years.”^{clxxii} Claimed one social worker concerned with the problem, “they are dying with their rights on.”^{clxxiii} New York State’s Mental Hygiene Law at the time prevented involuntary institutionalization except in cases in which the person has “a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or to others.”^{clxxiv} A number of court rulings after the passage of the law interpreted it to mean that a person must be imminently homicidal or suicidal. When the SROs closed, many of the people with mental illnesses that had relied upon their low rent turned to the streets. Wary of the violence and thieving at the public shelters, some resisted efforts for relocation from the streets, relying instead on the heat from steam vents to stay warm in the winter. This population, dubbed “street people” by the press and letters to the editor, became the focus of many of the appeals made about Mayor Ed Koch’s new program.

In light of the increased visibility of “street people,” who were often mentally ill, Mayor Koch developed a program to remove them from the streets on cold nights and to provide temporary treatment. His program, which involved removing mentally ill persons considered the most at risk from the streets, was an extension of earlier programs, but it amended the standards for involuntary commitment. It was implemented in October of 1987, and was immediately controversial. The *New York Times* regularly covered the program and printed a deluge of editorials in 1987 and 1988. It is this particular moment in public deliberation about the agency and freedoms of mentally ill homeless persons that this chapter will analyze.

This chapter will first discuss agency and its relationship to interpretations of governmental responsibility to citizens, then demonstrate the ways in which the rhetoric of differing interpretations of ethical responsibility is used to defend and denounce Mayor Koch’s program in the editorial pages of the *New York Times*. The ways in which different interest groups attempt to speak for the mentally ill will next be demonstrated. The rhetorical and ethical dilemma of determining the agency of the “street people” was framed in the language of bodily harm and the language of negative liberty in the editorials, and reflects larger concerns about biopower and governmental responsibility.

New York, NY

The rise in homelessness among people with mental illness in the 1980s was partially an ugly and unintended consequence of the policies of deinstitutionalization. In 1983, a task force was assembled of members of the American Psychiatric Association to identify the factors at play in the problem of the growing mentally ill homeless population. The resulting report, which was released in 1984, found that although

deinstitutionalization was not a bad idea as such, it was poorly executed, leaving many former patients of institutions without the support structures necessary to live and be healthy in the community. H. Richard Lamb writes in the report that “in the initial years approximately two-thirds of discharged mental patients returned to their families.”^{clxxv} However, little or no support was provided to these families. With new standards for commitment, which were established in the 1970s with the help of the ACLU and other civil rights groups, families also had less power over the care of their mentally ill parents, siblings, or children.^{clxxvi} Although the report celebrates the improved liberty of many former patients who have been released to the community, it warns that “a small proportion of long-term, severely disabled psychiatric patients lack sufficient impulse control to handle living in an open setting” and emphasizes the importance of structured and coordinated services for members of this group.^{clxxvii} Without such services, the report warns, such people will remain homeless. One of the cities that was hardest-hit with this reality was New York.

In many ways, New York City was a test case for how other city governments could deal with issues of homelessness and mental illness as a cause of homelessness in the 1980s. New York City’s homeless population was surveyed by a number of interest groups and government workers as a means of determining the best way to address their growing numbers.^{clxxviii} This demographic data, and the variety of ways in which various groups attempted to assuage the suffering of the homeless demographics, gives a more detailed picture of homelessness in New York City than is available for many others. New York’s city government and private organizations also contributed far more resources for the homeless. Of the nation’s 10 largest cities in 1984, “Houston, Dallas,

San Diego, Phoenix and Baltimore provide no public shelters for the homeless. Detroit houses 60 people a night in private shelters; Chicago has one shelter with 100 beds; Philadelphia has one shelter with 120 beds plus other programs that house 2,800 people a night, and Los Angeles averages 2,000 people a night in hotels in a program financed by Los Angeles County.^{clxxxix} In contrast, in 1984, New York expected to house nearly 10,000 people that year in public and private shelters, for a cost of \$100 million.^{clxxx}

Homelessness was a topic of much public deliberation in 1980s New York City. The growth of the homeless population meant that traditional shelters were unable to hide them from view, as had been the case in previous decades. Street people began to live on grates on Park Avenue and Madison Avenue, areas of affluence. Laws meant to discourage taboo actions by the homeless, including vagrancy or jumping the turnstiles to the subways, ceased to be enforced by police.^{clxxxi} Concern about the lifestyles and health of street people was captured in a number of articles written by the *New York Times*, and many citizens wrote letters to the editor about their own experiences with homeless people in their neighborhoods. These letters capture the concerns that various individuals and interest groups had about the rise in the number of the homeless population, and in the number of homeless persons of mental illness in particular. A common theme in many of these letters, the deterioration of the physical body, was central to arguments about the agency of persons with mental illness; the dichotomy created between the agency of the individual and the state of his or her physical body was used to argue for varying (and often conflicting) public policies.

Negative Liberty and Agency

Kwame Anthony Appiah notes that the first known thinker to assign government the role of caring for the souls of the people was Plato.^{clxxxii} Plato's distrust of the virtue and competence of citizens (and his corresponding distrust of democracy) notwithstanding, the role of government in shaping the ethical decisions of its citizens is the subject of ongoing contention. This conflict is shaped by changing perceptions about what behavior is ethical and the extent to which the government should protect its citizens from the harm that unethical behavior results in.

This debate about the role of government in the lives of individuals is at the root of American democracy; John Dewey notes that "the events which finally culminated in democratic political forms were deeply tinged by fear of government, and were actuated by a desire to reduce it to a minimum so as to limit the evil it could do."^{clxxxiii} Therefore, matters of ethics often turn into a debate of the good and harm that may result if the government interferes. The democratic ideal emphasizes the dissolution of political power both in its practice of government by the people, and in the ideal of restricting government influence on the life of the individual.

The extent to which the American government seeks to shape the ethical development of its citizens is shaped by what Appiah calls the "want-regarding" orientation and what Isaiah Berlin calls "negative liberty." A modern element of the Western understanding of the role of government in the lives of its citizens is the "want-regarding" orientation, which indicates that "attempts to change what people want, or hold to be valuable, infringe upon a sphere of self-management that is legitimately their own.... [and] that we are each equally entitled to the satisfaction of our lawful desires."^{clxxxiv} This holds that the government should not try to make anyone to better fit

an ideal, and particularly that the government should not try to change individual tastes, desires, and goals, regardless of whether changing them may improve the person's standard of living. Berlin writes that "if I am prevented by others from doing what I could otherwise do, I am to that degree unfree; and if this area is contracted by other men beyond a certain minimum, I can be described as being coerced, or, it may be, enslaved."^{clxxxv} Also central to arguments against providing involuntary care was the idea of "negative liberalism," explained by Appiah as the concern that "the government should not interfere in the ethical dimensions of our lives, should not be guided by notions as to what lives are good and bad for a person to lead, once he or she has met the enforceable demands of moral duty. And so, more specifically, the government should not seek to make me a better person for my own sake."^{clxxxvi} Freedom from interference is the most significant value in these philosophies. Appeals to this orientation were central to court rulings on involuntary institutionalization and the removal of "street people" from the era of deinstitutionalization onward.

Negative liberty and the want-regarding orientation also colored the philosophy and actions of the ACLU during and after deinstitutionalization. The ACLU book *The Rights of Mental Patients* sought to inform its readers of strategies for practical actions to reduce the chances of involuntary psychiatric treatment in their lives and those of others in 1973. The organization's involvement in changes in mental health law with the case *O'Connor v. Donaldson* also laid emphasis on restricting government power over the care of its citizens. In the 1980s, the organization became involved again in this issue, defending a homeless woman's right to remain living on the streets.

The code of morality expressed in negative liberty is based upon the enlightenment ideal of rationality. This ideal for government action in the ethical lives of others reflects an interpretation of the utilitarianism of John Stuart Mill, a type of ethics based the idea that “actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.”^{clxxxvii} Happiness itself Mill defines as pleasure with the absence of pain. This ethical goal is what is valued by negative liberalism, in the sense that it cherishes the rights of the individual to seek happiness in a variety of ways (with no single way more correct than others) and fiercely defends this ideal from attempts to intervene. The want-regarding orientation provides the rationale that what people want, what makes them happy, is best for them, and is therefore the most ethical means of governing. However, in an attempt to evade accusations of hedonism in his moral philosophy, Mill argues for higher and lower pleasures, and argues that the greatest happiness comes from the higher pleasures, which could include the reading of great works of literature, over the lower, hedonistic pleasures. Mill also suggests that the sense of well-being that individuals feel after contributing to a just cause contributes to their happiness. The writings of David Hume, a Scottish moral philosopher known for his theory that morality can be derived from the human feeling of benevolence, support this last point as well. This nuance that Mill and Hume provide creates the space for the perfectionist ideal, which encourages efforts “to promote the ethical flourishing of its citizens, while relying on a more-than-want-regarding notion of what such flourishing consists in,” within the utilitarian paradigm by allowing that there are pleasures that should be prioritized over others.^{clxxxviii}

In some ways, negative liberalism and the want-regarding orientation may be considered supportive of the agency that individuals have. Negative liberalism and the want-regarding orientation both support the lawful (rational) desires of the individual above the influence or interference of the government or other persons or institutions. This places value upon the preferences and corresponding actions of the individual, hypothetically granting the individual greater agency over his or her actions. However, agency is often conceptualized as something that must take into account the ability to communicate and be listened to. The emphasis on rationality in the Enlightenment philosophy that infuses our political system disadvantages certain groups whose communication falls outside that standard.

Agency requires certain preconditions, including the capacity to speak, the power to speak, and the willingness of others to acknowledge the words of the agent. Erin J. Rand conceives of agency as a dynamic of speaking to the structures of power with her definition: “the capacity for words and/or actions to come to make sense and therefore to create effects through their particular formal and stylistic conventions.”^{clxxxix} In this definition, Rand identifies agency not as an internal ability of the speaker but adaptation to “institutional forces that make the effects of certain actions intelligible.”^{cx} Pierre Bourdieu’s discussion of “competence” in the speech act also relies upon the participation of the audience.^{cxci} To be listened to is to have power endowed by the receiver. When a person does not (or is unable to) conform to standards of communication, as Michel Foucault writes is the case in some instances of mental illness, they do not have agency ascribed to them.

An individual's options for enacting agency are limited by the power structure of the society and community in which he or she lives. Foucault writes that power in Western societies is based upon regulatory norms, which are used to discipline the population into preferred behavioral patterns.^{cxcii} Among the regulators is the medical profession, which has power to insist upon regimens to maintain the health of the general population.^{cxciiii} However, individuals are also expected to self-regulate to society's standards; they are to internalize the pressures of biopower from authority.^{cxciiv} Furthermore, when an individual is incapable of self-regulating, the medical establishment and the state, which are the original source of bio-power, undertake that regulation.^{cxciiv} In cases of groups that require government services, these same forces of biopower interpret needs and the role of the government or private sector in providing them. Discourse about those who receive government aid for housing or living expenses is generally derogatory and casts recipients as deviants and without agency.^{cxciiv}

Policies regarding involuntary commitment from the era of deinstitutionalization seek to interpret the wants of persons unable to express them in verbally acceptable ways via the expression of their bodies. These interpretations have widely varied, depending on the biases and interests of the person seeking to explain the desires of the individual with mental illness. An example of the various ways that government, individuals, and interest groups have attempted to speak for people with mental illness can be found in public deliberation over New York City Mayor Ed Koch's 1987 program meant to secure treatment and social services for severely mentally ill street people.

Koch's Program

In 1987, the problem of homeless people with mental illness was addressed in earnest by Ed Koch, New York City's Mayor. Aware of past failures to mitigate the sufferings of "street people," not least because of scathing criticism from interest groups during his time in office, Koch assembled a task force of psychiatrists and social workers to address the growing numbers of mentally ill "street people."^{cxvii} Together, they developed a policy that was meant to address the problem in a humane way. Koch was heavily invested in the project, and spent time visiting with those who would be affected to learn more about their living situations. The outcome of their efforts was an expanded policy to provide care for mentally ill homeless persons who lived in neglect of their physical needs, particularly during the city's harsh winters.

The program was first implemented in Manhattan on October 28, 1987. A list of 50 homeless people deemed in danger was targeted by the four vans commissioned by the city with teams of psychiatrists, social workers and nurses.^{cxviii} Once picked up, the men and women were washed, given treatments for lice, clothed in new garments, informed of their legal rights and interviewed by social workers and psychiatrists before being admitted to Bellevue until a hearing could be held, within 5 days.^{cxix} Social workers and psychiatrists would continue to work with each person to determine an appropriate long-term placement.

The program was immediately controversial. The first person picked up, a middle-aged woman named Joyce Brown, appealed to the NYCLU (New York's division of the ACLU) to help her to secure her release from Bellevue.^{cc} Norman Siegel, the director of the NYCLU, organized teams of volunteers to meet "street people" and tell them of their legal rights. The president of the Partnership for the Homeless, Peter Smith,

chastised the mayor for not waiting until more psychiatric beds were available before implementing the program. However, others deemed the measure necessary. The vice president for mental hygiene in the city's hospital system, Dr. Luis Marcos, stated "for the first time there is a recognition of the patients' right to treatment, and their freedom from the prison of mental illness, rather than the freedom to die in the streets."^{cci}

Marcos's statement about freedom would foreshadow the conflict between arguments for the perfectionist ideal of caring for souls and the ACLU's arguments from negative liberty in this conflict.

Blaming and Shaming

Various groups and persons who wrote in to the *New York Times* claimed to speak for the good of homeless people with mental illness. Although their perspectives and suggestions on the lifestyles of homeless persons with mental illness vary, they commonly spoke of the physical condition of this portion of the homeless as a means of discussing their abilities to make life decisions. This standard of argument may have been established by the writing of Josh Barbanell, the *New York Times* news writer assigned to many of the articles that the paper published on the issue. Barbanell's articles on mentally ill homeless persons frequently discuss the physical condition of the "street people" (the group most often written about), placing their physical welfare at the center of public deliberation over the matter. A number of the articles and editorials responded to a high profile test case concerning a homeless woman named Joyce Brown, but others were more general. The editorials chosen to illustrate public deliberation about Mayor Koch's new program begin in October of 1987, when the program was first implemented, and

include letters submitted until April of 1988. Each letter to the editor or OP/ED has been grouped with others similar in tone or perspective.

In the notable case of Joyce Brown, the first woman who was picked up by Koch's program, family members came forward to comment on the way in which her case was handled. Brown, the woman who called the NYCLU from Bellevue, became the test case for the program, and her time as an inpatient and then as a hostel resident was publicly documented. One of 6 children, her 4 sisters had been searching for her since her disappearance from one of their homes in New Jersey in 1986. When television programming depicted a sketch of Joyce Brown, they contacted city officials to lay claim to their kin. Although the sisters of Joyce Brown did not contribute an editorial of their own, they were interviewed for several newspaper articles, and their perspective, as the only perspective provided by any family member of a person affected by the program, is valuable. The sisters stated that they came forward to represent the perspective of all families with mentally ill and homeless members. Spoke one sister, "what we want everyone to understand is that behind every homeless person there is a family that just wants to find them and help them."^{ccii}

Like many of the other writers and people quoted in articles about Koch's policy, the sisters appealed to concerns about the physical body as a means of arguing for mental treatment. One sister stated, after being informed of the NYCLU lawyers' claim that her sister had chosen homelessness as an "alternative lifestyle," "you might be able to survive one winter, or even two. But you can't survive that way forever."^{cciii} A week later, after Brown was ordered to be freed by a judge, the sisters protested, calling his ruling "racist" and "sexist;" stated one, "the streets are good enough for her, not for him or his kind."

Apart from Brown's illness, her sisters pointed out the ways in which her identifying characteristics disadvantaged her, and perhaps more importantly themselves. They charged that race and sex had played a role in discrediting their statements and limiting their agency. They asserted that the judgment was made without empathy or conviction and that Brown deserved to live under better conditions. These accusations suggest the problematic effects of negative liberty as an ethical guideline, particularly in cases in which people with social disadvantages caused by predominant attitudes against their disability find their concerns dismissed by people in positions of power. Utilitarianism places ethical weight on the most happiness and less on the quality or equality of that happiness. Unfortunately, a lack of interference for an individual who is marginalized can also be a lack of intercession.

The opinion to which the sisters objected was printed in the paper; wrote the judge, "I am aware her mode of existence does not conform to conventional standards, that it is an offense to esthetic senses. It is my hope that the plight she represents will also offend moral conscience and rouse it to action."^{cciv} The justice appeals to perfectionism and the want-regarding orientation by shaming the public for not better caring for the homeless but also stating that what the individual wants is the highest priority in the case. He simultaneously suggests that the public is to blame for Brown's homelessness and states that her choice to remain homeless, rather than be placed in a group home or kept in a psychiatric unit, is a noble expression of her right to make decisions regarding her lifestyle. "Who among us is not familiar with the tattered, filthy, malodorous presence of the wretched homeless? The blame and shame must attach to us, not to them," he claimed.^{ccv} The Justice is unwilling to force Brown's self-regulation to the norms of

society. He instead credits society, which creates the norms by which it expects individuals to live, with the blame, because it has created an ideal that is unrealistic for part of its population.

A central difference between the perspective of the judge and the sisters of Brown is the way in which each sees the interaction between Brown's body, her illness, and her decision to live on a steam grate. Brown's sisters described an active and social young woman who held a secretary job for 10 years prior to the deterioration of her mental health. For them, Brown and her illness are not one and the same; the illness is an intrusion on the ordered mind of their sister and is the cause of her choice to live on the streets. For the judge, the semi-coherent way in which Brown represented herself in court and the contradictory psychiatric reports from the city and the NYCLU was enough to value her wants over the needs stated by the city's psychiatrists. To the judge, Brown was the expression of her symptoms, rather than someone whose needs and healthy self may have contradicted that expression.

The New York Civil Liberties Union applauded the ruling and the precedent that it set for the future of the program. The ACLU considers negative liberty, or the freedom from coercion, to be a central political value in the cases it takes on. The organization represented Brown in court, and briefly hired her as a secretary at the NYCLU office. Levy and Gould stated in an editorial published in the *New York Times*, "It is quite possible to mistake homeless, unconventional or unesthetic behavior for serious pathology. An invasion of a homeless person's privacy may provoke hostility or verbal abuse, as it did with Ms. Brown, yet not indicate hostility."^{ccvi} The editorial argued that the policy was a "public relations ploy" by the city government to make the streets look

better without caring for the rest of the homeless population. Furthermore, they charged that psychiatrists would abuse their power if the program was sustained. They also stated that the government program violated civil rights and showed how the government could continue to violate individuals' rights and abuse its power if it was allowed to expand its power. The want-regarding orientation was central to their argument; above all, they emphasized that Joyce Brown had contacted them and sought their help resisting Koch's program.

Many psychiatrists and social workers objected to the negative characterizations of the program by the NYCLU and other interest groups. "To be seriously mentally ill and to have it not treated and deteriorate to the point of being dangerous to self or others, is not a right, it is a cruel neglect on the part of society," stated Dr. Luis Marcos.^{ccvii} Marcos' words create a reversal of priorities by claiming that neglect, not constitutional rights, is the cause for homelessness among mentally ill persons. Social worker Diane Sonde said of one unidentified homeless person, "She is blind, but she crosses the street and stands in front of traffic. She was threatening people and she is extremely fearful."^{ccviii} Still another psychiatrist wrote in to establish the importance of humanitarian measures in policies for the mentally ill homeless. In direct response to the editorial by leaders at the NYCLU, he stated "no amount of dialogue and specious reasoning will change [the disgrace of homelessness among the mentally ill] or cleanse our system's shame."^{ccix} He emphasizes that following the law is a falsely ethical appeal when the law itself is unethical. These voices emphasized the dangers that a homeless lifestyle posed to this population and emphasized their vulnerability to crime and the elements.

The vastly different perceptions of Koch's program evidenced in the letters from the NYCLU and members of the mental health profession reflect the goals and ideologies of each professional group. Since doctors, by profession, study methods of treating illness and ensuring the future physical well-being of the patient, the role of the doctor and the treatment of mentally ill persons is complicated and expanded by how mental illness is branded in our society. Unlike most physical illnesses, mental illness is represented as a significant part of the core identity of the person who is afflicted by it. However, in the extension of the doctor's authority in severe cases, the NYCLU and others state that civil rights are violated. Psychologists state that involuntary treatment is necessary for the well-being of the body of the patient, but civil rights lawyers and advocates argue that forcing treatment is an act of violence against the basic rights of a citizen. Both groups claim to speak for the well-being of the mentally ill, but on different grounds. There is a split between an emphasis on the body (physicians) and the mind (civil rights advocates) in this discourse. While Marcos, Sonde and others made appeals based on the physical state of the mentally ill persons taken into custody, the NYCLU denied that their client had suffered prior to being picked up by Koch's program, asserting that mental suffering had taken place rather than physical.

This portion of the debate also reflected the struggle against one of the centers of power in modern society. Psychiatry (and other forms of medicine) is one of the means by which biopower is enforced, and its normalizing of behaviors felt. Biopower concerns an assertion of power over another's body or lifestyle by the implementation of standards of behavior. In the case of the "street people," who were in the eyes of the public at all times, knowledge of their bodies and lifestyles was readily apparent. The physical risks

of living in such a way, which include being the victim of violence and weather, caused the psychiatrists and other writers to frame their appeals around the safety of the physical body and lifestyle norms.

Op/Ed columnist A.M. Rosenthal wrote twice on the subject of Koch's program. In her first column, she wrote as a neighbor to a homeless person and a civil libertarian; "the New York Civil Liberties Union says her rights have been violated; other civil libertarians, myself included, think that they Mayor is protecting the most essential of her rights, the right to life."^{ccx} Despite similar political allegiances, Rosenthal inverted the concern for civil liberties expressed by the NYCLU as a means of compromising a hard stance on individual liberties with morality. "In decency the question is not whether the city has the right to remove the mentally injured from the sidewalk and try to help them, but whether it has the right to let them just lie there in the street, bleeding in the mind," she stated.^{ccxi} Like Brown's sisters, Rosenthal expresses concern for the person behind the illness. She uses graphic imagery of external suffering to argue for the internal agony she attributes to mental illness. In one column, she compares ignoring the needs of the "street people" to the neighbors ignoring the cries of Kitty Genovese in the iconic 1964 case. Rosenthal's analogy between another case in which people were aware of the suffering of someone else but did nothing and the modern suffering of the homeless reminds her readers of the embarrassment and shame that Genovese's case brought to New Yorkers.

Likewise, residents familiar with mentally ill homeless persons in their neighborhoods used graphic descriptions to argue for the program. "On the corner of Canal Street and Broadway, a ragged man with a wild stare methodically tosses coins

into a storm drain,” writes one contributor arguing for additional resources for the mentally ill population and the homeless.^{ccxii} Another notes repeated experiences with one homeless woman who lives on her block, stating “I’ve listened to her angry screaming at some invisible man. She’s passed me by on her walks around the block, her eyes glazed, without looking from side to side, muttering. I know more than I want to about the state of her health from her toilet habits.”^{ccxiii} Mental illness is often differently understood by the public from other physical illnesses because it is conceived as part of who the ill person is, rather than an intrusion upon them. When a person is driven to the street because of lifestyle factors resulting from mental illness, his or her symptoms are expressed in a tangible and external way. The individual has been reduced to an illness, but corporeal suffering restores the element of the body so that it speaks for the disease. Contemporary New York mental hygiene law meant that a person with mental illness must act in a violent manner with the intent to kill or cause significant harm before involuntary commitment could be considered. With the growing visibility of the mentally ill homeless population during Koch’s administration, nonviolent (or less violent) socially taboo behaviors stood in for the requirements for involuntary admission. With the turning away from more violent means of behavior regulation (including the reluctance of law enforcement to remove homeless people from sidewalks), biopower stood in.

Some writers also questioned whether allowing the mentally ill homeless to live on the streets was truly beneficial to their freedom. Kathryn Nikodem wrote of the Brown case, “Justice Lippmann’s “poor huddled masses” allusion notwithstanding, she is not really at liberty on the streets; she guards her hot-air grate jealously.”^{ccxiv} Nikodem argues

that the poverty and illness of the “street people” creates new and more dangerous confines for them. If Brown were to leave her steam grate, it may be taken by another person, leaving her at a higher risk of dying in the cold. An anonymous contributor who labels New York “Calcutta, U.S.A.,” writes “there is neither humanity nor enlightenment in upholding the “right” of the demented to deteriorate in the street.”^{ccxv} Each of these writers reject the language of rights and liberty used by opponents to Koch’s policy, and use the same language to counter those claims.

Conclusion

Rhetoric about the agency of the mentally ill shifted to concerns about the physical body in the 1980s. This reflected the effects of the dangerousness standard and the greater visibility of the mentally ill homeless. The perceived agency of people with mental illness has long been correlated with their outward bodily expression because it is through their verbal and bodily actions that illness of the mind is revealed. However, with the implementation of the dangerousness standard as the sole means for justifying involuntary institutionalization in the late 1970s, the line between ability and unacceptable disability became skewed. The dangerousness standard, as set in New York state law in the 1980s, stipulated that a person must present a “clear and present danger” to him or herself or others in order to be involuntarily committed.^{ccxvi} In earlier decades, a person could be involuntarily institutionalized for the failure to provide for him or herself – in effect, institutionalized for self-negligence due to disability. With the implementation of the dangerousness standard, the involuntary institutionalization of the ill person was based upon his or her ability instead – the ability to act in a legitimately dangerous way to him or herself or others. This standard, far from being a response to legitimate need on

the part of an ill person, was based upon the perceived threat that the illness could cause to the person or others around the person. People who were not dangerous, or people whose threats of violence were considered illegitimate because their disability due to illness was too great, were no longer prioritized because they were unable to act in ways that threatened the public good. Instead of being hospitalized for an illness that diminished agency, they were hospitalized only if they were able to express agency in a socially taboo way.

Each of the individuals and groups that wrote in to the *New York Times* or were interviewed for interest pieces on the Koch program claimed to speak for the mentally ill. By appealing to different values and to the bodies of the persons affected by the policy, each person made a case for their understanding of the best way to address the situation. Family members appealed on the basis that every mentally ill and homeless individual was a loved member of a family unit, to whom the welfare and safety of that individual was of great importance. A judge asserted that individuals should be able to make their own choices about how they live, even if those choices offend or upset others, but also claimed that society should take responsibility for people living on the streets. The NYCLU highlighted the shortage of low cost housing and stated that mental health professionals were abusing their power over the health and bodies of the homeless. Columnist Rosenthal stated that despite Brown's objections to her hospitalization, she was better off for it. Neighbors, noting the circumstances in which mentally ill homeless people lived, called those circumstances inhumane.

Persons affected by the program were largely unable to represent themselves in the paper during the controversy. None were able to write and be published in the paper.

Only Brown publicly contested her hospitalization, and her explanations for her homelessness, past history, her decision to provide multiple names for herself, and commentary from various people who had known her while she was homeless largely discredited her to the public. Although she gained access to the public structures of power via her appeal to the NYCLU and the high profile of her case, not everyone accepted her competence to speak. While one judge determined that she was competent to be freed, another decided that she was rightfully committed. While the NYCLU celebrated her release as a sign of ongoing freedoms for everyone, her sisters attributed the lack of compassion they felt the judge had shown concerning Brown's mental health to racism and sexism.

Public deliberation about Koch's program to remove the mentally ill homeless population from the streets of Manhattan reflected larger concerns in discourse about the limits of government. Is it the role of government to raise the ethics of its population above the want-regarding orientation? Is negative liberalism enough or does adhering to that ideal harm the "souls" of the population? Does negative liberalism diminish or increase the agency of the people who live in a state whose government holds to that ideal? Is biopolitical control coercive or crucial?

Ignoring the needs of the "street people" and allowing the public deterioration of their bodies further depletes their agency by casting them as deviants who are unable to care for or speak for themselves. This is reinforced when public deliberation about their fate ignores the limits of their options to live elsewhere and otherwise. Although some of the mentally ill, when untreated, are incapable of communicating in ways that are understood by the rest of the public, this stereotype also removes much of their power as

agents by reducing the likelihood that others will listen to what they have to say. In the case of people whose agency is already diminished by the external or internal conditions in which they live, negative liberalism does no favors. It merely upholds the status quo and favors the voices of those who are able to conform to the standards of public discourse. The inability to adapt to “institutional forces that make the effects of certain actions intelligible,” forces that are too inflexible to change for the variety of communicative impairments of the citizenry, prevents those individuals from attaining the agency to speak for themselves. Adhering to a higher ethical ideal that provides the resources necessary for disadvantaged groups to change discredits the lowest level of happiness Mill speaks of for an ideal that can provide a better quality of life and the ability to legitimately control the forces in one’s life. By separating the person from the illness and addressing their physical needs first, a government’s seemingly coercive measures may counterbalance the inherent coerciveness of the power structures of discourse and an individual’s surroundings.

Chapter 5

Agency and Ethics

Mental health policy has changed in dramatic ways in the past half-century, and so have the ways in which people speak about the rights and abilities of the mentally ill. At the peak of mental institutionalization, there were nearly 560,000 people living in mental institutions in the United States.^{ccxvii} The introduction of new technologies, such as antidepressants and anti-psychotics made it easier for people to be released from institutions, as did the introduction of Medicare and Medicaid, which diverted elderly patients whose needs were primarily physical illness to nursing homes that were better suited to their care. In 1963, President John F. Kennedy signed the Community Mental Health Centers Act, which proposed funding to provide services to former mental institution patients once they were released to the community. When advocates for the rights of mental patients began to make appeals to legislators and the public in the late 1960s, they appealed to the language of civil rights and negative liberty to argue for reform. These advocates, including the ACLU, argued that civil commitment measures at the time were coercive and harmful to the agency of citizens with mental illness. While this language dominated the discussion of civil commitment and deinstitutionalization throughout the 1960s and 1970s, by the 1980s, there was a public backlash against deinstitutionalization, due to citizens' concerns about the physical health and safety of homeless people with mental illness.

In 1968, the New York Civil Liberties, New York's branch of the ACLU, formed a mental health law project in response to the difficulties members felt mental patients faced. In 1972, after representing some community members in commitment hearings, Bruce Ennis, the leader of the project, and Loren Siegel wrote a book called *The Rights of Mental Patients: the Basic ACLU Guide to a Mental Patient's Rights*. The book addressed concerns that individuals or their families may have in the face of civil commitment. It defined legal and medical terms, provided advice, suggested ways in which the rights of mental patients could be expanded in the future, and provided a state-by-state breakdown of commitment procedures in a glossary. People with mental illness are a vast and varied population, and *The Rights of Mental Patients* took steps to constitute them as a group by unifying its readers around two qualities: the label of mental illness and the stigma attached to it. By appealing to the shared sense of stigma readers felt, the book was able to overcome the varying levels of disability and perceptions of mental illness among its audience. The authors then showed their readers how to speak and act in varying situations, in an effort to restore their agency. Finally, *The Rights of Mental Patients* cast its readers as citizens and as advocates, rather than as victims, changing their agentic orientation. Although Ennis and Siegel acknowledged the stigma of the label of mental illness, they explained ways in which their readers could take small steps that would help themselves and others.

Kenneth Donaldson provided another face to the agency of people with mental illness in 1975, when he successfully filed charges against the Florida State Hospital at Tallahassee for holding him against his will without providing treatment for 15 years.^{ccxviii} Diagnosed a paranoid schizophrenic, Donaldson was committed after his

father reported him to police as mentally ill and possibly dangerous in 1956. Because he was a Christian Scientist, he refused medication, and he also refused to admit that he was ill. After writing 15 legal petitions, he was released from the mental hospital. He filed charges against the hospital and against its head, Doctor O'Connor. The case reached the U.S. Supreme Court, which ruled in Donaldson's favor, setting the new standard of commitment to one based on dangerousness to oneself or others. Donaldson then did what his psychiatric records throughout his tenure had suggested was a delusion and credited as a sign of his illness: he wrote a book about life in the mental hospital.^{ccxix} When it was published in 1976, *Insanity Inside Out* received attention from a number of newspapers and reviewers. *Insanity Inside Out* provided another perspective to discussions about deinstitutionalization and described in detail the ways in which agency was stripped from mental patients both within and outside of the mental hospital. The rhetoric of the book granted Donaldson ethos and it became part of an ongoing conversation amongst anti psychiatrists about mental illness and the proper circumstances in which a person could be committed.

By the 1980s, the public was beginning to have its doubts about the benefits of deinstitutionalization. The outpatient clinics promised to administer to the mentally ill in the 1960s did not have the funding to fulfill their original purpose, and a number of studies found that many former patients had become homeless for lack of adequate social services for their needs.^{ccxx} Between 1955 and 1980, the state mental hospital populations decreased from 559,000 to 132,000 by moving patients elsewhere.^{ccxxi} Some patients were re-institutionalized in private facilities, some were placed in nursing homes, and some became homeless. In New York City, the city government was overwhelmed with

large numbers of homeless people. In 1984, the city expected to house nearly 10,000 people that in public and private shelters, for a cost of \$100 million.^{ccxxii} However, the homeless who caught the public imagination the most were those who were too afraid or unwilling to go to shelters, which newspaper articles dubbed “street people.” Many of the people in this population were severely mentally ill, and in 1988, New York City’s mayor implemented a program to remove them from the streets on particularly cold nights. From the streets, they were delivered to Bellevue, the City’s mental hospital. A fervid public discussion took place in the Op/Ed pages of the New York Times, in which citizens and public figures wrote about the program in terms of bodily needs and basic freedoms. These two ideals were pitted against one another in the letters.

The rhetoric promoting agency for people with mental illness shifted from the era of deinstitutionalization to the 1980s. The rhetoric of the ACLU’s Mental Health Law Project in the 1970s emphasized teaching people with mental illness how to speak rationally and with authority as a means of regaining agency. By providing their readers with the proper language, Ennis and Siegel sought to empower them. A few years later, Kenneth Donaldson adapted this language after studying legal books, earning freedom from the Florida state mental hospital at Chattahoochee and eventually publishing a book about his experiences. However, Donaldson’s book also demonstrated the limits of speaking to the public as a person with mental illness. Although Donaldson’s ethos was supported by the materials in his book, his discussion of what he calls “sanism” and the effects it has on the day-to-day lives of people with mental illness even after leaving the institution demonstrates the limits of the agency that speaking rationally can provide. In the 1980s, the rhetoric about the abilities of people with mental illness shifted to concern

about their physical bodies as a visible contingent became homeless due to the lack of a comprehensive community support system. Notably, the ethical appeals changed as well; during deinstitutionalization, activists appealed to negative liberty, but by the 1980s, ethical appeals were framed around the health and safety of the physical body.

The problem of public perceptions of the agency of people with mental illness is made distinctive by the constraints that the disparities in disability among this population provide. Studying appeals to agency for people with mental illness raises questions about negative liberty and the principles of law that follow from it. It shows the problematic effects of adopting a rhetoric of ethics based upon negative liberty when seeking to improve the conditions of a marginalized group. Appeals to bodily health over agency could also be problematic, and it is worth considering the role of biopower in restricting agency.

Effects of Deinstitutionalization

The effects of the policies of deinstitutionalization have been widespread and varied. Many people who would have spent much of their lives in institutions prior to deinstitutionalization are now able to live productively in the community, due to the proper therapies and advances in prescription medications for depression, bipolar disorder, and schizophrenia. Others left the institutions and found that there were not sufficient community resources to help them to secure housing, jobs, and medication.^{ccxxiii} Still others ended up in prison, often for nonviolent crimes that were directly connected to their illness.

Where community services or family support were high, released patients saw an improvement in their quality of life.^{ccxxiv} Because patients have the option to take

antidepressant and antipsychotic drugs (among others), which control symptoms that might otherwise potentially overpower their lives, more people are able to successfully live in the community. Recent laws, such as the 2008 Mental Health Parity and Addiction Equity Act, require insurance companies that offer policies for mental illness to provide better coverage for patients with these disorders.

During deinstitutionalization, patients who were released to the community but did not have families able or willing to support them often ended up in halfway houses, other facilities, or homeless. Halfway houses were presented as one positive alternative to mental hospitals because they could be a means of introducing individuals to the community while still monitoring their health and progress. However, many are in poor neighborhoods and have fallen into disrepair. When states do not properly fund or regulate the halfway houses that former patients are sent to, they can become squalid and violent, traumatizing residents, rather than preparing them for autonomy.^{ccxxv} Other facilities that increased the number of beds for psychiatric patients include general hospitals and nursing homes, although nursing homes are considered one of the worst settings for their care, due to the discrepancy in needs between typical residents and people with mental illnesses. The people who live on the streets face other problems. The mentally ill are targeted for petty crimes as well as assault by delinquents. Homeless women are much more likely to be victims of rape than the general population, and often they report being raped repeatedly.^{ccxxvi} During the winter, they are at risk of freezing to death, even in Southern cities.^{ccxxvii}

Unfortunately, many people with mental illness have been institutionalized in a new setting – prison. According to Bernard E. Harcourt, a professor of law and

criminology at the University of Chicago, “after more than 50 years of stability, federal and state prison populations skyrocketed from under 200,000 persons in 1970 to more than 1.3 million people in 2002.”^{ccxxviii} According to a study done by the Justice Department in 2006, 64 percent of prison inmates in the United States reported experiencing mental health problems such as schizophrenia, bipolar disorder, and depression within the past year.^{ccxxix}

Changes in Mental Health Law

Although this thesis only discusses texts through the 1980s, new policies have developed in response to concerns about the health and safety of people with mental illness. The federal government has taken steps to ensure better coverage of mental health benefits by insurance companies, and an additional form of treatment, called “assisted outpatient treatment,” or AOT, has been incorporated in many states’ mental health programs to provide community health support for people with mental illness. Although some states passed acts for mental health parity in the early and mid-1990s, many of these had limited effectiveness, due to the limited jurisdiction for enforcement. Under the Clinton administration, the first federal law to expand health coverage for the treatment of mental disorders was passed. The Mental Health Parity law of 1996, which reduced the ways in which insurers who covered mental health costs could restrict coverage, went into effect in 1998.^{ccxxx} In 2008, President Bush signed the Paul Wellstone and Pete Domenici Mental Health parity and Addiction Equity Act, which further expanded the minimum benefits insurers could provide for mental health treatment, including treatment for substance abuse.^{ccxxxi}

After two shocking and widely publicized cases in 2001 in which schizophrenics who had been discharged from the mental health system shoved passers-by under the subway tracks in New York City, New York legislators developed a modified standard. The law that introduced this standard of treatment, colloquially called “Kendra’s Law” after one of the victims, was one of the first departures from the policies of deinstitutionalization. Kendra’s Law requires that mentally ill adults who have been hospitalized for their illness before, are incapable of surviving in the community, have a “history of lack of compliance with treatment for mental illness,” are considered in need of treatment to prevent relapse or deterioration but are unlikely to voluntarily receive it, and/or have threatened or committed acts of violence against themselves or others due to their mental illness receive what is termed “assisted outpatient treatment.”^{ccxxxii} “Assisted outpatient treatment,” or AOT, consists of assigning a community management team to the individual, whose purpose is to ensure that he or she is taking medication, attending therapy, receiving vocational training, being tested for harmful substances, and has a stable living environment, where applicable. Kendra’s Law furthermore states that the severely mentally ill have a “right to treatment,” meaning that their case workers are required to align the services necessary for their care and that they cannot be discharged without a hearing demonstrating signs of improvement and compliance to taking their medications. After the law survived challenges in New York courts from the NYCLU, versions of it were adopted in 44 other states. Five years after it passed in New York, a study of 2,700 people who were treated under its provisions found that “the rate of homelessness in the population fell by 74 percent, the number who needed to be rehospitalized dropped by 77 percent and the number arrested fell by 83 percent.”^{ccxxxiii}

The law is currently in the process of being considered for another 5 year extension. By adopting policies of AOT and providing better health coverage services, states have implemented a program that better matches the goals of the Community Mental Health Centers Construction Act of 1963. Community services and care are now more accessible to people with mental illness than they have been for decades.

The balance between rights and necessary medical intervention is a tenuous one, and one that will likely continue to shape the rhetoric of mental health policy. The rhetoric of this balance reflects the larger dilemma of the balance of power between government and citizen. Can there be a successful rhetoric of agency for people with severe mental illness? How can rhetoric reduce the stigma in the public perception of mental illness? Does an ethical code based upon the well-being of the body better serve the agential needs of people with mental illness? How should the government justify policies that intervene in the lives of private citizens for their ethical benefit? Here it is perhaps best to return to political theorist Isaiah Berlin, who is careful to explain the boundaries of negative liberty and coercion. He does not count poverty, weakness, or physical inability as signs that one's liberty is being infringed upon, and sets it as an external force. "Coercion implies the deliberate interference of other human beings within the area in which I could otherwise act. Mere incapacity to attain a goal is not lack of political freedom."^{ccxxxiv}

Selected Bibliography

- Appiah, Kwame Anthony, *The Ethics of Identity*. Princeton, NJ: Princeton University Press, 2005
- Arendt, Hannah *On Violence*. USA: Harvest Books, 1970
- "About the ACLU," <http://www.aclu.org/about-aclu-0> accessed 2 August 2010
- Berlin, Isaiah *Four Essays on Liberty*. New York, NY: Oxford University Press, 1969
- Barbanel, Josh "Homeless Woman Sent to Hospital Under Koch Program is Ordered Freed," *New York Times* November 13, 1987
- Barbanel, Josh "Koch's Program Faces a Test," *New York Times*, November 11, 1987
- Barbanel, Josh "Ten Homeless People Held at Bellevue Mental Unit," *New York Times*, October 30, 1987
- Barbanel, Josh "Mentally Ill Homeless Taken Off of New York Streets," *New York Times*, Oct 29, 1987 A1
- Bordieu, Pierre "The Economics of Linguistic Exchanges," *Social Science Information*, 16 (1977)
- Bourgois, Philippe "Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States," *Culture, Medicine, and Psychiatry*, 24 (2000)
- Campbell, Karlyn Kohrs, "Agency: Promiscuous and Protean," *Communication and Critical/Cultural Studies*, 2 (Spring 2005)
- Carmody, Deirdre "The City Sees no Solutions for Homeless," *New York Times* Oct 10, 1984, A1
- Charland, Maurice "Constitutive Rhetoric: The Case of the People Quebecois," *The Quarterly Journal of Speech*, 73 (1987)
- Cohen, Neal L. and Luis R. Marcos, "Law, Policy, and Involuntary Emergency Room Visits," *Psychiatric Quarterly*, 61 (1990)
- Coid, Jeremy W. "Dangerous Patients with Mental Illness: Increased Risks Warrant New Policies" *British Medical Journal*, (April 1996)
- Cooper, David *Psychiatry and Antipsychiatry*. New York, NY: Ballantine Books, 1967
- Daley, Suzanne "As Summer Ends, City is Sheltering as Many Homeless as Last Winter," *New York Times* Sept 23, 1982, A1
- Dewey, John *The Public and its Problems*. Athens, OH: Swallow Press, 1927
- Donaldson, Kenneth *Insanity Inside Out*. New York, NY: Crowne Publishers 1976
- Drzewiecka, Jolanta A. and Thomas K. Nakayama, "City Sites: Postmodern Urban Space and the Communication of Identity," *The Southern Communication Journal* 64 (Fall 1998)
- Duckworth, Ken "The Virginia Tech Tragedy: Distinguishing Mental Illness from Violence," the National Alliance for Mental Illness, accessed April 2010,

- http://www.nami.org/Content/ContentGroups/Press_Room1/20076/April6/The_Virginia_Tech_Tragedy_Distinguishing_Mental_Illness_from_Violence.htm
- Ennis, Bruce and Loren Siegel, *The Rights of Mental Patients: The Basic ACLU Guide to a Mental Patient's Rights*. New York, NY: Avon Books, 1973
- "Espionage Act of June 15, 1917," Ed. Haig A. Bosmajian, *The Principles and Practice of Freedom of Speech*. Latham, MD: University Press of America, 1983
- Foss, S.K. et al, "Toward a Theory of Agentic Orientation: Rhetoric and Agency in Run Lola Run," *Communication Theory*, 17 (2007)
- Foucault, Michel *Madness and Civilization: a History of Insanity in the Age of Reason*. New York, NY: Random House, 1965
- Foucault, Michel *Society Must be Defended*. New York, NY: Picador Press, 2003
- Nancy Fraser, *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory*. Minneapolis, MN: University of Minnesota Press, 1989
- Freitag, Michael "Four Women Reach Out to their Homeless Sister," *New York Times* November 7, 1987 A29
- Gonzales, Richard "S.F. Paying to Send the Homeless Back Home," *National Public Radio Transcript*, 17 February 2006
- Gould, Robert E. and Robert Levy, "Psychiatrists as Puppets of Koch's Roundup Policy," *New York Times*, November 27, 1987, A35
- Gralnick, Alexander "What Else Can New York City Do for the Homeless Insane?" *New York Times*, December 18 1987, A38
- Grob, Gerald N. *Mental Illness and American Society: 1875-1940*. Princeton, NJ: Princeton University Press, 1983
- Grob, Gerald N. *From Asylum to Community*. Princeton, NJ: Princeton University Press, 1992
- Holmes, Dave and Denise Gastaldo, "Nursing as Means of Governmentality," *Journal of Advanced Nursing*, 38 (2002)
- Jordan, John W. "The Rhetorical Limits of the "Plastic Body"," *Quarterly Journal of Speech*, 90 (2004)
- Jouvenal, Justin "Homeward Bound Broke Rules," *The Examiner*, 21 April 2006
- Lamb, H. Richard M.D. and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52 (2001)
- Lamb, H. Richard *The Homeless Mentally Ill: A Task force Report by the American Psychiatric Association*. The American Psychiatric Association: Washington, DC 1984
- Levy, Clifford J. "Here Life is Squalor and Chaos," *The New York Times* 29 April 2002
http://www.nytimes.com/2002/04/29/nyregion/here-life-is-squalor-and-chaos.html?scp=3&sq=deinstitutionalization%20former%20patient&st=nyt&page_wanted=1
- Linde, Paul *Danger to Self: On the Front Line with an ER Psychiatrist*. Los Angeles, CA: University of California Press, 2010
- Link, Bruce G. et al. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance" *American Journal of Public Health*, September 1999

- Marback, Richard "Detroit and the Closed Fist: Toward a Theory of Material Rhetoric," *Rhetoric Review* 17 (1998)
- Marcos, Luis R. "Political Psychiatry: the New York City Homeless Mentally Ill Initiative," *Administration and Policy in Mental Health*, 18 (1990), 81-90
- Matthews, Eric "Moralist or Therapist? Foucault and the Critique of Psychiatry," *Philosophy, Psychiatry, and Psychology* (1995)
- McGee, Michael Calvin "In Search of 'The People': a Rhetorical Alternative," *The Quarterly Journal of Speech*, 61 (Fall 1975)
- "Mental Illness and Homelessness," July 2009
<http://www.nationalhomeless.org/factsheets>
- Meyer, Robert G. and Christopher M. Weaver, *Law and Mental Health: A Case-Based Approach*. New York, NY: The Guilford Press 2006
- Miller, Robert D. *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*. Springfield, IL: Charles C. Thomas, 1987
- Patterson, Randi and Gail Corning, "Researching the Body: An Annotated Bibliography for Rhetoric," *Rhetoric Society quarterly*, 27(1997)
- Peters, John Durham *Courting the Abyss: Free Speech and the Liberal Tradition*. Chicago, IL: University of Chicago Press, 2005
- Rand, Erin J. "An Inflammatory Fag and Queer Form: Larry Kramer, Polemics, and Rhetorical Agency," *The Quarterly Journal of Speech*, 94 (2008)
- Rawls, John *Political Liberalism*, New York, NY: Columbia University Press, 1993
- Rocheffort, David A. *Handbook on Mental Health Policy in the United States*. Westport, CN: Greenwood Press, Inc., 1989
- Rosenthal, A.M. "Question to a Judge," *New York Times* Nov 27, 1987 A35
- Sassen, Saskia *Losing Control? Sovereignty in an Age of Globalization*. New York, NY: Columbia University Press, 1993
- Shome, Raka "Space Matters: The Power and Practice of Space," *Communication Theory* 13 (2003)
- Spandler, Helen and Tim Calton, "Psychosis and Human Rights: Conflicts in Mental Health Policy and Practice," *Social Policy and Society*, 8 (2009)
- Stormer, Nathan "Articulation: A Working Paper on Rhetoric and Taxis," *Quarterly Journal of Speech*, no. 90 (2004)
- Szasz, Thomas "Civil Liberties and Civil Commitment," *The Freeman*, 53:12 (2003)
- Szasz, Thomas *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, NY: Harper and Row, 1960
- Szasz, Thomas *Psychiatric Slavery*. New York, NY: The Free Press, 1977
- Trotter, Robert J. "Open Sesame: The Constitution and Mental Institutions," *Science News* 108 (1975)
- Walker, Samuel *In Defense of American Liberties: A History of the ACLU*. Carbondale, IL: Southern Illinois University Press, 1990
- Walsh, Elizabeth and Alec Buchanan and Thomas Fahy "Violence and Schizophrenia: Examining the evidence" *The British Journal of Psychiatry* (2002)
- Weaver, Warren Jr. "High Court Curbs Power to Confine the Mentally Ill" *New York Times* June 27, 1975

-
- ⁱ Justin Jouvenal, "Homeward Bound Broke Rules," *The Examiner*, 21 April 2006
- ⁱⁱ Richard Gonzales, "S.F. Paying to Send the Homeless Back Home," *National Public Radio Transcript*, 17 February 2006
- ⁱⁱⁱ Justin Jouvenal, "Homeward Bound Broke Rules"
- ^{iv} "Mental Illness and Homelessness," July 2009 <http://www.nationalhomeless.org/factsheets/> - According to the National Coalition for the Homeless, 20-25% of the homeless are severely mentally ill, compared to 6% of the general population. Severe mental illness is the 3rd most prevalent cause of homelessness.
- ^v Karlyn Kohrs Campbell, "Agency: Promiscuous and Protean," *Communication and Critical/Cultural Studies*, 2 (Spring 2005): 3
- ^{vi} Campbell, "Agency," 2
- ^{vii} Erin J. Rand, "An Inflammatory Fag and Queer Form: Larry Kramer, Polemics, and Rhetorical Agency," *The Quarterly Journal of Speech*, 94 (2008): 299-300
- ^{viii} Erin J. Rand, "An Inflammatory Fag and Queer Form," 308
- ^{ix} S.K. Foss et al, "Toward a Theory of Agentic Orientation: Rhetoric and Agency in Run Lola Run," *Communication Theory*, 17 (2007): 207
- ^x Foss et al, 225
- ^{xi} Michael Calvin McGee, "In Search of 'The People': a Rhetorical Alternative," *The Quarterly Journal of Speech*, 61 (Fall 1975): 242
- ^{xii} Maurice Charland, "Constitutive Rhetoric: The Case of the People Quebecois," *The Quarterly Journal of Speech*, 73 (1987)
- ^{xiii} David A. Rochefort. *Handbook on Mental Health Policy in the United States*. (Westport, CN: Greenwood Press, Inc., 1989)
- ^{xiv} Gerald N. Grob *Mental Illness and American Society, 1875-1940*. (Princeton, NJ: Princeton University Press, 1983), xi
- ^{xv} Gerald N. Grob. *From Asylum to Community*. (Princeton, NJ: Princeton University Press, 1992): 159
- ^{xvi} Grob *Mental Illness and American Society*, xi and Bell, 97, in Rochefort
- ^{xvii} Nina Ridenour, *Mental Health in the United States: A Fifty Year History* (Cambridge, MA: Harvard University Press, 1961): 41
- ^{xviii} Pat J. Gehrke, *The Ethics and Politics of Speech*, (Carbondale, IL: Southern Illinois University Press, 2009), 22
- ^{xix} Gehrke, *The Ethics and Politics of Speech*, 23
- ^{xx} Grob *From Asylum to Community*, 9
- ^{xxi} Grob *Mental Illness and American Society*, 4
- ^{xxii} Grob *From Asylum to Community*, 11
- ^{xxiii} Grob *From Asylum to Community*, 12
- ^{xxiv} Grob *From Asylum to Community*, 13
- ^{xxv} Grob *From Asylum to Community*, 16
- ^{xxvi} Grob *From Asylum to Community*, 24
- ^{xxvii} Grob *From Asylum to Community*, 37
- ^{xxviii} Grob *From Asylum to Community*, 140
- ^{xxix} Grob *From Asylum to Community*, 74
- ^{xxx} Robert D. Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*, (Springfield, IL: Charles C. Thomas, 1987): viii
- ^{xxxi} Grob *From Asylum to Community*, 148
- ^{xxxii} Grob *From Asylum to Community*, 148
- ^{xxxiii} Grob *From Asylum to Community*, 149
- ^{xxxiv} Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*
- ^{xxxv} Grob *From Asylum to Community*, 240

- xxxvi Robert D. Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*
- xxxvii Grob *From Asylum to Community*, 255
- xxxviii Robert D. Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*
- xxxix Samuel Walker, *In Defense of American Liberties: A History of the ACLU*, (Carbondale, IL: Southern Illinois University Press, 1990): 309
- xl Walker, *In Defense of American Liberties*, 173-260
- xli Walker, *In Defense of American Liberties*, 309
- xliv Bruce Ennis and Loren Siegel, *The Rights of Mental Patients: The Basic ACLU Guide to a Mental Patient's Rights* (New York, NY: Avon Books, 1973): 13
- xlvi Walker, *In Defense of American Liberties*, 47
- xlvii Walker, *In Defense of American Liberties*, 17
- xlviii Walker, *In Defense of American Liberties*, 18
- l Walker, *In Defense of American Liberties*, 19
- li "Espionage Act of June 15, 1917," Ed. Haig A. Bosmajian, *The Principles and Practice of Freedom of Speech*, (Latham, MD: University Press of America, 1983)
- lii Walker, *In Defense of American Liberties*, 14
- liii Walker, *In Defense of American Liberties*, 15
- liv Walker, *In Defense of American Liberties*, 24
- lv Walker, *In Defense of American Liberties*, 25
- lvi Walker, *In Defense of American Liberties*, 28
- lvii John Durham Peters, *Courting the Abyss: Free Speech and the Liberal Tradition*, (Chicago, IL: University of Chicago Press, 2005): 142
- lviii Walker, *In Defense of American Liberties*, 29
- lix Walker, *In Defense of American Liberties*, 54-55
- lvi Walker, *In Defense of American Liberties*, 61-62
- lvii Walker, *In Defense of American Liberties*, 62
- lviii Walker, *In Defense of American Liberties*, 63
- lix Peters, *In Defense of American Liberties*, 19
- lx Grob, *From Asylum to Community*, 289
- lxi Walker, *In Defense of American Liberties*, 299
- lxii Walker, *In Defense of American Liberties*, 309 "The ACLU was prodded by radical psychiatrist Thomas Szasz who challenged the whole concept of mental illness, believing it to be a "myth." Though not going as far as Szasz urged, the ACLU did oppose involuntary commitments except when the danger was clearly a danger to himself or herself or society. Even then, it pressed for more formal hearings to determine this dangerousness."
- lxiii Thomas Szasz, "Civil Liberties and Civil Commitment," *The Freeman*, 53:12 (2003)
- lxiv Walker, *In Defense of American Liberties*, 6
- lxv Isaiah Berlin, *Four Essays on Liberty*, (New York, NY: Oxford University Press, 1969): 170
- lxvi Berlin, *Four Essays on Liberty*, 172
- lxvii "About the ACLU," <http://www.aclu.org/about-aclu-0> accessed 2 August 2010
- lxviii Berlin, *Four Essays on Liberty*, 201
- lxix Saskia Sassen, *Losing Control? Sovereignty in an Age of Globalization* (New York, NY: Columbia University Press, 1993): 32
- lxx John Rawls, *Political Liberalism* (New York, NY: Columbia University Press, 1993) 31, xxii – Rawls states that justice is reasonable and situational, rather than based on foundational truths.
- lxxi Hannah Arendt, *On Violence*, (USA: Harvest Books, 1970): 82
- lxxii Foss et al, "Toward a Theory of Agentic Orientation" 206
- lxxiii Foss et al, "Toward a Theory of Agentic Orientation" 225, They qualify this statement by noting that agentic orientation is not meant to blame victims of oppression, but to help them to realize opportunities that may appear in other orientations. They also state that actions (or lack thereof) that may seem harmful or agency-less may not actually be, and may be legitimate and helpful responses a given situation.
- lxxiv Ennis, *The Rights of Mental Patients*, 11
- lxxv Charland, "Constitutive Rhetoric," 134

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- lxxvi Charland, "Constitutive Rhetoric," 137
- lxxvii Michael C. McGee, "In Search of 'The People,'" 249
- lxxviii Michel Foucault, *Madness and Civilization: a History of Insanity in the Age of Reason*, (New York, NY: Random House, 1965): x
- lxxix Ennis and Siegel, *The Rights of Mental Patients*, 11
- lxxx Walker, *In Defense of American Liberties*, 299
- lxxxi Charland, "Constitutive Rhetoric," 143
- lxxxii Charland, "Constitutive Rhetoric," 140-141
- lxxxiii Ennis and Siegel, *The Rights of Mental Patients*, 19
- lxxxiv Pierre Bordieu, "The Economics of Linguistic Exchanges," *Social Science Information* (1977) 16, 648
- lxxxv Foucault, *Madness and Civilization*, x
- lxxxvi Arendt, *On Violence*, 82
- lxxxvii Peters, *Courting the Abyss*, 86
- lxxxviii Ennis and Siegel, *The Rights of Mental Patients*, 48 he further states "We suggest that if a hospital employee prevents you from exercising a constitutional right, you request that a notation of that denial be made on your record. Then you should contact a lawyer." The nine rights are the right to treatment, communication and visitation, civil rights, control of personal property, notice of rights, payment for working, religious freedom, confidentiality of records
- lxxxix Ennis and Siegel, *The Rights of Mental Patients*, 53
- xc Ennis and Siegel, *The Rights of Mental Patients*, 12
- xci Ennis and Siegel, *The Rights of Mental Patients*, 23
- xcii Ennis and Siegel, *The Rights of Mental Patients*, 9
- xciii Mill, in Ennis and Siegel, *The Rights of Mental Patients*, 25
- xciv Ennis and Siegel, *The Rights of Mental Patients*, 26
- xcv Peters, *Courting the Abyss*, 86
- xcvi Foss et al, "Toward a Theory of Agentic Orientation," 207
- xcvii Kenneth Donaldson, *Insanity Inside Out*, (New York, NY: Crowne Publishers 1976): 1
- xcviii Robert G. Meyer and Christopher M. Weaver, *Law and Mental Health: A Case-Based Approach*. (New York, NY: The Guilford Press 2006): 132
- xcix Meyer and Weaver, *Law and Mental Health*, 132
- c Meyer and Weaver, *Law and Mental Health*, 133
- ci Robert J. Trotter, "Open Sesame: The Constitution and Mental Institutions," *Science News* 108 (1975) 2
- cii Opinion, *O'Connor v. Donaldson*
- ciii Donaldson, *Insanity Inside Out*, 331, He states his lawyer knew "that the courts were becoming interested in the fact that thousands of people were locked up for treatment but given no treatment. By establishing a precedent, we hoped to benefit my fellow patients languishing in wards all over the country, which was always our primary object."
- civ Donaldson, *Insanity Inside Out*, 93
- cv Donaldson Papers, Yale, Box 14, folder 41
- cvi Pat J. Gehrke, *The Ethics and Politics of Speech*, 21
- cvi Grob, *From Asylum to Community*, 15
- cvi Grob, *From Asylum to Community*, 237
- cix Warren Weaver Jr. "High Court Curbs Power to Confine the Mentally Ill" *New York Times* June 27, 1975
- cx Donaldson, *Insanity Inside Out*, 296
- cxii Trotter, "Open Sesame," 2
- cxiii Weaver, "High Court Curbs Power to Confine the Mentally Ill"
- cxiv Paul Linde, *Danger to Self: On the Front Line with an ER Psychiatrist* (Los Angeles, CA: University of California Press, 2010), see also Jeremy W. Coid, "Dangerous Patients with Mental Illness: Increased Risks Warrant New Policies" *British Medical Journal*, April 1996, and Ken Duckworth, "The Virginia Tech Tragedy: Distinguishing Mental Illness from Violence," the National Alliance for Mental Illness, accessed April 2010,

http://www.nami.org/Content/ContentGroups/Press_Room1/20076/April6/The_Virginia_Tech_Tragedy_Distinguishing_Mental_Illness_from_Violence.htm

“The greatest risk of violence is from those who have dual diagnoses, i.e., individuals who have a mental disorder as well as a substance abuse disorder. There is a small elevation in risk of violence from individuals with severe mental disorders (e.g., psychosis), especially if they are noncompliant with their medication.... Yet to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small.” Elizabeth Walsh, Alec Buchanan, and Thomas Fahy “Violence and Schizophrenia: Examining the evidence” *The British Journal of Psychiatry* (2002) 180, 142 “The probability that any given patient with schizophrenia will commit homicide is tiny (approximate annual risk is 1:3000 for men and 1:33 000 for women).” Patients with schizophrenia are far more likely to self-harm, and violence against strangers is especially rare.

^{cxiv} Bruce G. Link et al. “Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance” *American Journal of Public Health*, 89 (September 1999)

^{cxv} Robert Miller *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*

^{cxvi} Meyer and Weaver, 133

^{cxvii} Thomas Szasz, *Psychiatric Slavery*, (New York, NY: The Free Press, 1977) In this book, Szasz includes a number of the legal documents pertaining to the Donaldson case, as well as a discussion of interpretations of the Supreme Court ruling. Each document is given its own chapter. In the final two chapters, titled “A Right to Treatment or a Right to Treat?” and “Chattel Slavery and Psychiatric Slavery,” Szasz roundly condemns Donaldson and his ACLU lawyers for stating that mental illness might exist and fighting for mental patients to be treated if they are to be held in institutions. Szasz also states his belief that Donaldson faked illness in order to go undercover in a mental hospital and change commitment standards.

^{cxviii} Donaldson Papers, Box 14, 41

^{cxix} Eric Matthews, “Moralist or Therapist? Foucault and the Critique of Psychiatry,” *Philosophy, Psychiatry, and Psychology* (1995): 24

^{cxix} Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, 250

^{cxxi} Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, (New York, NY: Harper and Row, 1960): 26

^{cxixii} Recall that this was written in 1974, prior to the breakthroughs in identifying the role of biological and hereditary factors in mental illness

^{cxixiii} Szasz, *The Myth of Mental Illness*, 267

^{cxixiv} David Cooper, *Psychiatry and Antipsychiatry* (New York, NY: Ballantine Books, 1967): 22

^{cxixv} Cooper, *Psychiatry and Antipsychiatry*, viii

^{cxixvi} Donaldson, *Insanity Inside Out*, 152 “Doctor Szasz has written: “... the advocates of involuntary mental hospitalization raise the second justification: protection of the public. This, of course, is a legitimate interest. But following in the libertarian tradition, I hold that a person should be deprived of his liberty only if he is proved guilty of breaking the law. No one should be deprived of his freedom for the sake of his ‘mental health.’”

^{cxixvii} Berlin, *Liberty* 183 and 175, respectively

^{cxixviii} Berlin, *Liberty*, 171

^{cxixix} Arendt, *On Violence*, 82

^{cxixxx} Nathan Stormer, “Articulation: A Working Paper on Rhetoric and Taxis,” *Quarterly Journal of Speech*, no. 90 (2004): 277

^{cxixxxi} Foss et al, “Toward a Theory of Agentic Orientation,” 207

^{cxixxxii} Raka Shome, “Space Matters: The Power and Practice of Space,” *Communication Theory* 13 (2003):39

^{cxixxxiii} Green, 234

^{cxixxxiv} Jolanta A. Drzewiecka and Thomas K. Nakayama, “City Sites: Postmodern Urban Space and the Communication of Identity,” *The Southern Communication Journal* 64 (Fall 1998): 1, 25

^{cxixxxv} Donaldson, *Insanity Inside Out*, 332

^{cxixxxvi} Judge David L. Bazelon, <http://www.bazelon.org/about/judgebazelon.htm> One of these decisions, the Durham rule, is disparaged by Donaldson (on page 185) for allowing people who were not legitimately ill

to be assigned to the mental hospital when they committed a crime. The ruling changed the standard from the old test of “irresistible impulse” to “the product of mental disease or mental defect.”

^{cxvii} Donaldson, *Insanity Inside Out*, 41 He credits the term “sanism” to Dr. Morton Birnbaum, who used it “to describe the assumption of the “sane” world that because the patient is in a state mental institution he is therefore sick and belongs there”

^{cxviii} Donaldson, *Insanity Inside Out*, 321

^{cxvix} Shome, “Space Matters” 43

^{cxl} Donaldson, *Insanity Inside Out*, 73

^{cxli} Donaldson, *Insanity Inside Out*, 110

^{cxlii} Donaldson, *Insanity Inside Out*, 332

^{cxliii} Donaldson, *Insanity Inside Out*, 332

^{cxliv} Donaldson, *Insanity Inside Out*, 325-326

^{cxlv} Donaldson, *Insanity Inside Out*, 177

^{cxlvi} Donaldson, *Insanity Inside Out*, 63

^{cxlvii} Donaldson, *Insanity Inside Out*, 39

^{cxlviii} Donaldson, *Insanity Inside Out*, 39

^{cxlix} Donaldson, *Insanity Inside Out*, 324

^{cl} Donaldson, *Insanity Inside Out*, 324

^{cli} Donaldson, *Insanity Inside Out*, 41

^{clii} Donaldson, *Insanity Inside Out*, 72

^{cliii} Szasz, *The Myth of Mental Illness*, 182

^{cliv} Foucault, *Madness and Civilization*, 276

^{clv} Szasz, *Psychiatric Slavery*, 135

^{clvi} Miller, *Involuntary Commitment in the Post-Reform Era*, 25

^{clvii} Szatz, quoted in Donaldson, *Insanity Inside Out*, 152

^{clviii} Donaldson, *Insanity Inside Out*, 93

^{clix} Donaldson, *Insanity Inside Out*, 332

^{clx} Donaldson, *Insanity Inside Out*, 332

^{clxi} Donaldson, *Insanity Inside Out*, 333

^{clxii} Donaldson, *Insanity Inside Out*, 333

^{clxiii} Donaldson, *Insanity Inside Out*, 334

^{clxiv} Donaldson, *Insanity Inside Out*, 32 and 332

^{clxv} Donaldson Papers, Box 14, Folder 41

^{clxvi} Berlin, *Liberty*, 174-175

^{clxvii} Deirdre Carmody, “The City Sees no Solutions for Homeless,” *New York Times* Oct 10, 1984, A1

^{clxviii} Grob *From Asylum to Community*, 262, 255 Between 1968 and 1974, Congress passed amendments to the Community Mental Health Centers Act of 1963, expanding the role of community centers to treatment for alcoholism and drug addiction.

^{clxix} Suzanne Daley, “As Summer Ends, City is Sheltering as Many Homeless as Last Winter,” *New York Times* Sept 23, 1982, A1

^{clxx} Carmody, “The City Sees no Solutions for Homeless,” 1984

^{clxxi} Carmody, “The City Sees no Solutions for Homeless,” 1984

^{clxxii} Neal L. Cohen and Luis R. Marcos, “Law, Policy, and Involuntary Emergency Room Visits,” *Psychiatric Quarterly*, 61 (1990): 197-204

^{clxxiii} Carmody, “The City Sees no Solutions for Homeless,” 1984

^{clxxiv} Carmody, “The City Sees no Solutions for Homeless,” 1984

^{clxxv} H. Richard Lamb *The Homeless Mentally Ill: A Task force Report by the American Psychiatric Association*, The American Psychiatric Association: Washington, DC 1984, 62

^{clxxvi} Lamb, *The Homeless Mentally Ill* 66

^{clxxvii} Lamb, *The Homeless Mentally Ill* 66

^{clxxviii} Carmody, “The City Sees no Solutions for Homeless,” These groups included Project HELP, the Human Resources Administration, and the Coalition for the Homeless. In 1981, New York City agreed to a decree that bound it to provide shelter for everyone in the city who applied. In the following years, the

homeless population grew dramatically due to a poor economy, loss of low cost housing, crack cocaine addicts, and the loss of federal subsidies for housing projects.

clxxxix Carmody, *The Homeless Mentally Ill* 1984

clxxx Carmody, *The Homeless Mentally Ill* 1984

clxxxii Carmody, *The Homeless Mentally Ill* 1984

clxxxiii Kwame Appiah, *The Ethics of Identity*, (Princeton, NJ: Princeton University Press, 2005): 155

clxxxiiii John Dewey, *The Public and its Problems* (Athens: Swallow Press, 1927): 86

clxxxv Appiah, *The Ethics of Identity*, 157

clxxxvi Berlin, *Liberty*, 169

clxxxvii Appiah, *The Ethics of Identity*, 158; John Dewey also notes this, saying that freedom “signified in fact liberation from oppression and tradition.... Thus “individualism” was born, a theory which endowed singular persons in isolation from any associations, except those which they deliberately formed for their own ends, with native or natural rights.” *The Public and its Problems* (Athens: Swallow Press, 1927) 86-87

clxxxviii John Stuart Mill, *The Basic Writings of John Stuart Mill: On Liberty, The Subjection of Women, Utilitarianism*. Ed. Schneewind, J.B. (New York: Random House, 2002).

clxxxix Appiah, *The Ethics of Identity*, 157

clxxxix Erin J. Rand, “An Inflammatory Fag and Queer Form,” 299-300

cx Erin J. Rand, “An Inflammatory Fag and Queer Form,” 308

cxci Pierre Bordieu, “The Economics of Linguistic Exchanges,” *Social Science Information*, 16 (1977)

cxcii Michel Foucault, *Society Must be Defended*, (New York, NY: Picador Press, 2003)

cxciiii Dave Holmes and Denise Gastaldo, “Nursing as Means of Governmentality,” *Journal of Advanced Nursing*, 38 (2002) See also Philippe Bourgois, “Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States,” *Culture, Medicine, and Psychiatry*, 24 (2000)

cxciiv Randi Patterson and Gail Corning, “Researching the Body: An Annotated Bibliography for Rhetoric,” *Rhetoric Society quarterly*, 27(1997)

cxciv John W. Jordan, “The Rhetorical Limits of the “Plastic Body”,” *Quarterly Journal of Speech*, 90 (Summer 2004) see also Helen Spandler and Tim Calton, “Psychosis and Human Rights: Conflicts in Mental Health Policy and Practice,” *Social Policy and Society*, 8 (2009)

cxcivi Nancy Fraser, *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory*, (Minneapolis, MN: University of Minnesota Press, 1989)

cxciivii Luis R. Marcos, “Political Psychiatry: the New York City Homeless Mentally Ill Initiative,” *Administration and Policy in Mental Health*, 18 (1990), 81-90

cxciiviii Josh Barbanel “Mentally Ill Homeless Taken Off of New York Streets,” *New York Times*, Oct 29, 1987 A1

cxciix Barbanel “Mentally Ill Homeless”

cc Barbanel “Mentally Ill Homeless”

ccci Barbanel “Mentally Ill Homeless”

cccii Michael Freitag, “Four Women Reach Out to their Homeless Sister,” *New York Times* November 7, 1987 A29

ccciiii Freitag, “Four Women”

ccciiv Josh Barbanel “Homeless Woman Sent to Hospital Under Koch Program is Ordered Freed,” *New York Times* November 13, 1987

ccciv Barbanel ““Homeless Woman Sent to Hospital”

cccivi Robert E. Gould and Robert Levy, “Psychiatrists as Puppets of Koch’s Roundup Policy,” *New York Times*, November 27, 1987, A35

ccciivii Josh Barbanel, “Koch’s Program Faces a Test,” *New York Times*, November 11, 1987

ccciiviii Josh Barbanel, “ Ten Homeless People Held at Bellevue Mental Unit,” *New York Times*, October 30, 1987

ccciix Alexander Gralnick, “What Else Can New York City Do for the Homeless Insane?” *New York Times*, December 18 1987, A38

cccx A.M. Rosenthal, “Question to a Judge,” *New York Times* Nov 27, 1987 A35

cccxii Rosenthal, “Question to a Judge”

cccxii “Dumped on the citizen’s doorstep,” *New York Times*, July 15, 1987, A26

- ccxiii Kathryn Nikodem, "Can't We Aid New York's Homeless Without Locking them Up?" *New York Times*, November 16, 1987, A30
- ccxiv Kathryn Nikodem "Can't we Aid New York's Homeless Without Locking Them Up?"
- ccxv "Dumped on the citizen's doorstep," July 15, 1987
- ccxvi "Overview of Mental Health in New York and the Nation," New York State Archives, http://www.archives.nysed.gov/a/research/res_topics_health_mh_timeline.shtml
- ccxvii David A. Rochefort, *Handbook on Mental Health Policy in the United States 559,000 in 1955*
- ccxviii Donaldson, *Insanity Inside Out*
- ccxix Donaldson, *Insanity Inside Out*, 93, 149
- ccxx Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era*
- ccxxi Rochefort, *Handbook on Mental Health Policy in the United States*
- ccxxii Carmody, 1984
- ccxxiii Clifford J. Levy, "Here Life is Squalor and Chaos," *The New York Times* 29 April 2002
<http://www.nytimes.com/2002/04/29/nyregion/here-life-is-squalor-and-chaos.html?scp=3&sq=deinstitutionalization%20former%20patient&st=nyt&pagewanted=1>
- ccxxiv H. Richard Lamb, M.D. and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52 (2001)
- ccxxv Levy, "Here Life is Squalor and Chaos," In this article, Levy describes a halfway house in which there is regularly at least one resident death each month. In 3 cases, dead residents were not found until the scent of decomposition alerted workers. Inmates of the house are not given medication or therapy. No rehabilitative services or vocational training are provided in the home, which was reported to the state by a former employee after she was forced to falsify treatment records prior to a state inspection. Current and former employees interviewed for the piece state that 2 residents of the home are crack cocaine dealers and that others rely on loan-sharking or prostitution in order to support themselves each month. Although the home is particularly bad, it is described as representative of many other such halfway houses in New York State.
- ccxxvi Heslin, K., Robinson, P., Baker, R., Gelberg, L. "Neighborhood Characteristics and Violence Against Homeless Women in Los Angeles County." *Academy Health*. Meeting (2004 : San Diego, California). In this study, 33% of homeless women interviewed in Los Angeles in 1997 had been physically assaulted in the previous year. 14% had been raped in the previous year.
- ccxxvii Colley Charpentier, "Freeze Kills two Homeless People in City," *New Orleans Metro* 4 January 2008
- ccxxviii Bernard E. Harcourt, "The Mentally Ill, Behind Bars," *The New York Times*, 15 January 2007
<http://www.nytimes.com/2007/01/15/opinion/15harcourt.html>
- ccxxix Harcourt "The Mentally Ill, Behind Bars"
- ccxxx Haneefa T. Saleem, "New Law Moves Insurance Plans Closer to Total Mental Health Parity," *Bureau of Labor Statistics*, 22 September 2003, <http://www.bls.gov/opub/cwc/cm20030909ar01p1.htm>
- ccxxxi "Federal Parity for Mental Illness and Addictions," *National Alliance for Mental Illness*, June 2009, http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=94885
- ccxxxii New York State Mental Hygiene Law Article 45, §9.60
- ccxxxiii E.Fuller Torrey, "Make Kendra's Law Permanent," *The New York Times*, 28 May 2010
- ccxxxiv Berlin, *Liberty*, 169