BOOK REVIEW

Psychiatry and the Business of Madness: An Ethical and Epistemological Accounting. Bonnie Burstow. London, United Kingdom: Palgrave Macmillan, 2015, 316 pp., $40.00 (paperback) $95.00 (hardcover).

This book is arguably the most comprehensive and brilliant critique of psychiatry that I’ve ever read; it’s a devastating expose of psychiatry’s discredited medical model and institutional psychiatry, “a regime of ruling.” Bonnie Burstow’s book is absolutely awesome in its numerous, thoroughly researched facts and original insights and scholarship frequently voiced with passion. Burstow uses the research analytic tool of institutional ethnography—“ruling happens through texts, particularly through the activation of texts” (p. 18). With this powerful intellectual probe, she deconstructs “boss texts” and takes us on an incredible journey into psychiatry, its alarming methods of social control, its intrusive brain-damaging drugs and electroshock. Burstow ends this awesome work in the spirit of hope and humanity she calls “Eutopia,” a vision of a better world of compassion, empathy, mutual caring, respect for freedom and human rights.

She begins with a short and concise history of psychiatry featuring mad doctors and “alienists” (an apt word) during the 18th century, including Philippe Pinel who unchained poor people with mental illness in a Paris asylum but instituted a reign of terror of close surveillance and control. In the 19th century, there’s Benjamin Rush, the notorious “father of American psychiatry” whose face appears on the American Psychiatric Association’s logo; he invented the traumatic “tranquilizer chair” and advocated fear as therapeutic; he also labeled black slaves with the disease of “drapetomania,” running away to be free; he also committed his son to an insane asylum. The gentler “moral treatment/moral management” of country retreats in the late 18th and early 19th centuries soon died; by the late 19th and early 20th century, it was replaced with eugenics/genetics-based, physically intrusive biological psychiatry, which unfortunately dominates today. This is a small but telling fragment of psychiatry’s dark history of social control, medical fraud, coercion, and violence.

Burstow asserts that two fundamental principles underlie psychiatry and the book: parens patriae and police powers. Parens patriae (literally “father of the country”) refers to power of the state to control, imprison, and forcibly treat citizens; police powers are mainly expressed as coercion, arrest, and use of force. Psychiatry, Burstow asserts, is essentially a regime of ruling; however, given psychiatry’s hegemonic social control, the terms psychiatric dictatorship and psychiatric police state seem more appropriate.

In Chapter 4 (“Probing the Boss Text: DSM—What? Whither? How? Which?”), Burstow brilliantly analyzes the Diagnostic and Statistical Manual of Mental Disorders (DSM), psychiatry’s bible of fraudulent diseases. Unlike medical diagnoses, the approximately 350 diagnostic labels in DSM-5 (the current edition) are not only subjective and unscientific but also frequently lead to serious life-changing consequences such as loss of freedom (involuntary commitment), psychiatric drugging, and/or electroshock (electroconvulsive...
therapy [ECT]). DSM labels, Burstow asserts, serve no medical or scientific purpose, instead they routinely marginalize and stigmatize. Burstow succinctly summarizes major problems of the DSM, “subjectivity . . . masquerading as objectivity . . . nothing less than the essence of who the person is . . . constitutes a disorder” (pp. 94–95). She calls this activating text a “patient-processing system,” denounces it as having absolutely no scientific validity or reliability; like the late psychiatrist Thomas Szasz and other dissident health professionals, Burstow correctly states there is “no mental illness” because there is no biological or medical evidence of cellular disease in anybody labeled mentally ill. With surgical precision, she exposes the fraudulent nature of DSM diagnoses while examining constructs such as “personality disorder,” “oppositional defiant disorder,” “schizophrenia,” and “attention deficit/hyperactivity disorder (ADHD),” all allegedly types of “brain disease” caused by the discredited “chemical imbalance” theory. What’s going on here is irrationally medicalizing nonconformist behavior, in fact virtually any intense emotional state—for example, sadness or grief labeled “depression,” joy labeled “hypomania,” and most everyday problems as “mental disorders.” The DSM is the modern equivalent of the Inquisition’s Malleus Maleficarum, a medieval boss text of written instructions (“criteria” or “symptoms”) designed to identify and demonize heretics and witches—today’s “mental patients.” In short, “human existence itself [is] . . . theorized as . . . a disorder” (pp. 89–90); “problems are located exclusively within the individual . . . something that conflicts with Aboriginal experience, not to mention that of most of the world” (p. 92). This is not medical diagnosis or “medical science,” it’s psychiatry-and-state-sponsored quackery.

Another clear and important message is “psychiatry is an agent of the state.” In this connection, Burstow examines relevant sections of Ontario’s Mental Health Act (MHA; Chapter 5, “The Beast/Inside the Belly of the Beast: Pinioned by Paper”). Like virtually all mental health laws and regulations, the MHA legitimizes preventive detention as involuntary committal (incarcerating citizens without charge and public hearing or trial); it also falsely assumes that psychiatrists can predict dangerousness. As an example, Burstow cites these sweeping and vague criteria for involuntary committal:

The patient is suffering from mental disorder of a nature or quality that likely will result in:

(i) Serious bodily harm to the patient,  
(ii) Serious bodily harm to another person, or  
(iii) Serious physical impairment of the patient unless the patient remains in the custody of a psychiatric facility. (p. 107)

The term mental disorder is not specifically defined here or anywhere else in the act. Also, the term likely will result is a guesstimate, not medical evidence or scientific fact, because psychiatrists admit they cannot predict dangerousness; the term serious physical impairment is obviously, if not deliberately, vague and open to multiple interpretations. As ruling words, these criteria make it very easy for psychiatrists to label and lock up and chemically restrain (forcibly drug) innocent citizens for at least 72 hours under the “Observation and Assessment” provision in Form 1. The incarceration and forced drugging of Irit Shimrat, a close friend, courageous survivor, and author, is very relevant; her story is a frightening object lesson in psychiatric-and-state-sponsored coercion and violence (pp. 123–124). Compounding this injustice, during the initial “period of observation and assessment,” the person cannot appeal or launch any legal action. Even more alarming, Burstow points out
that people can also be involuntarily committed (lose their freedom) if they refuse to “take
their meds,” or if they’ve “previously received treatment or from a mental disorder . . .
and likely to suffer substantial mental or physical deterioration or serious physical impairment”
(p. 109). Again, this major term is not defined or explained. Equally alarming, the MHA
greatly expands police powers such as authorizing police officers in Ontario the power to
diagnose mental disorder, predict dangerousness, arrest, and forcibly transport citizens to
psychiatric facilities for psychiatric examination mainly based on subjective belief:

A police officer has reasonable and probable grounds to believe that a person is acting or has acted
in a disorderly manner and has reasonable cause to believe that the person,

(a) Has threatened or attempted or is threatening or attempting to cause bodily harm to himself
or herself;
(b) Has behaved or is behaving violently toward another person and has caused or is causing
another person to fear bodily harm from him or her; or
(c) Is showing a lack of competence to take care of himself or herself, and in addition the police
officer that the person is apparently suffering from a mental disorder of a nature or quality
that will likely result in,
(d) Serious bodily harm to the person,
(e) Serious bodily harm to another, or
(f) Serious physical impairment of the person.

Burstow comments, “. . . evidence that officials are permitted to use in making their
assessments includes not simply what they directly observe but also what is relayed by
others. The ‘mentally ill person’ becomes ‘an easy target.’ People can be committed against
their will simply because they are not taking their meds.” Many survivors stop or try to stop
taking antidepressants and/or neuroleptics (antipsychotics) for good reason—they can’t
tolerate the incredible suffering and disability the drugs cause (p. 110).

Once the person ends up in a psychiatric hospital or mental health center, he or she
is subjected to more violence, what Burstow calls “cosmeticized violence . . . students
are socialized to give and force damaging treatments on people”. In the chapter “The
Psychiatric Team,” psychiatric and nursing staff violence inherent in physical restraints,
forced drugging, and “seclusion” (solitary confinement), for example, is rationalized as
self-defence from the perceived or imagined violence of patients “in need of control.” In
this environment ruled by a hierarchy of psychiatrists, psychologists, nurses, and social
workers, violence serves a double purpose—control of patients and enforcement of unity
among team members. In this controlled and controlling environment, whistleblowers are
nonexistent; team solidarity trumps care, compassion, and empathy.

“Marching to ‘Pharmageddon’: Polypharmacy Unmasked” (Chapter 7) is an impor-
tant consciousness-raising object lesson on psychiatric drugs as a major method of social
control. The brain-damaging effects of psychiatry’s “safe and effective” neuroleptics
(antipsychotics)—for example, blunting of emotions, apathy, indifference, cognitive
impairment; so are akathisia, tardive dyskinesia, neuroleptic malignant syndrome, and
parkinsonism, all are clinical indications of brain damage sanitized as “side effects” of
psychiatry’s “safe and effective medication.” Burstow draws heavily on the consciousness-
raising critiques of dissident psychiatrist Peter Breggin, investigative journalist Robert
Whitaker, and other independent researchers, as well as her own professional knowledge
and experience. Although not a medical doctor, Burstow clearly and critically explains
how these drugs, particularly the “atypical” neuroleptics such as Risperdal, Zyprexa, and Abilify that impact several parts of the brain; they seriously disrupt the neurotransmitter dopamine in the mesocortical and mesolimbic systems, invariably causing brain damage or chemical lobotomy. The antidepressants have similar if not more serious brain-damaging effects in addition to causing suicidal ideas, suicide attempts, mania, and sudden violence. The biological psychiatrists, Burstow asserts, falsely claim “chemical imbalance” or lack of dopamine in the brain as the major cause of schizophrenia, for example; psychiatrists, medical doctors, and researchers, largely funded by the drug companies (Big Pharma) continue ignoring the fact that psychiatric drugs cause this chemical imbalance and brain damage, including the tragic and disabling neurological disorders—an admission they’re afraid to acknowledge. A person with a previous psychiatric history can be kept on psychiatric drugs virtually indefinitely, thanks to a community treatment order, another boss text that authorizes doctors, not just psychiatrists, to prescribe psychiatric drugs for years or indefinitely to patients after they’re released to the community (see Tranquil Prisons by Erick Fabris). Under this draconian mental health law, refusal to “take their meds” can result in people being committed for longer periods. The transnational drug companies also come in for well-deserved criticism for their unscientific research and unethical marketing practices, including mislabeling and hiding many health-threatening effects of psychiatric drugs during clinical trials, major findings are often kept secret. Also, government regulators such as the Food and Drug Administration (FDA) in the United States and Health Canada are shown to be frequently incompetent and complicit in failing to fully warn and protect the public about high-risk drugs.

Burstow is at her most critical in powerfully exposing and denouncing “Electroshock” (ECT), arguably psychiatry’s most destructive procedure today, one that many shock survivors and activists have been protesting against for almost 40 years and want banned (Chapter 8). Contrary to popular belief following the film One Flew Over the Cuckoo’s Nest, ECT never stopped and never banned but has increased worldwide. Burstow accurately and concisely describes the ECT procedure involving sedative, muscle paralyzer (“muscle relaxant”), oxygen, and electricity; 150+ V are delivered from a shock machine to electrodes placed on one side (unilateral) or both sides (bilateral) of the brain. ECT always causes a grand mal seizure—dishonestly called therapeutic by shock promoters Richard Abrams, Max Fink, the American Psychiatric Association, and Canadian Psychiatric Association. Also, every ECT causes an immediate convulsion, coma, memory loss, and brain damage. Burstow bluntly and concisely comments,

iatrogenically created dysfunction, Diminished capacity. Lobotomy-like unawareness. Anosognosia—the cognitive impairment that involves inability recognize that one is impaired Compliance itself. Euphoria caused by brain damage . . . after four weeks, this brain-damaging treatment is no more effective than placebo . . . people . . . are being brain-damaged for nothing . . . The most pervasive themes . . . are: memory loss; cognitive impairment; loss of skills, prospects, ability to function, connections itself, with diminishment of the person emerging as an overarching theme. (pp. 215, 224)

The American Psychiatric Association’s promotional mantra that ECT is “safe and effective treatment” is directly challenged by several scientific studies that Burstow summarizes. For example, she succinctly explains the significance of Harold Sackeim’s landmark comprehensive 2007 study in which he conclusively proves the brain-damaging and memory-destroying effects of electroshock—regardless of type or mode of ECT, placement
of electrodes, age, and gender; as prime targets, women and the elderly suffer the greatest damage, reflecting sexist and ageist biases in ECT (pp. 212–213). Electroshock’s many devastating and tragic effects come to life with excerpts of Burstow’s interviews with several Canadian shock survivors and some of their personal testimony at the 2005 Enquiry into Psychiatry public hearings in Toronto. The statements by Connie, Wendy, and “C’s” story are particularly memorable and riveting; they courageously speak truth to power (pp. 216–222).

As organizational-systemic analysis, Burstow’s graphic illustrations of the “The ECT Empire” (p. 204) and “Rule by ECT Scholar/Capitalists” (p. 208) are original, accurate, and chilling in their details. They clearly show the interconnections and conflicts of interest among shock promoters such as Richard Abrams, Max Fink, and Richard Weiner with the American Psychiatric Association’s task force reports, close links to journals, textbooks, shock machine manufacturers (e.g., somatics owned by proshock psychiatrist Richard Abrams), hospitals, and government regulators such as the FDA and Health Canada. Near the end of this chapter, these conclusions are worth quoting and remembering: “People’s lives are essentially obliterated—erased” (p. 217).

The authorities most influential in framing psychiatry’s position on ECT are themselves the arch capitalists who receive the primary benefit . . . the treatment is buoyed up by shoddy research and research flagrantly misrepresented . . . after four weeks, this brain-damaging treatment is no more effective than placebo . . . people . . . are being brain-damaged for nothing . . . The most pervasive themes . . . are: memory loss; cognitive impairment; loss of skills, prospects, ability to function, connection itself, with diminishment of the person emerging as an overarching theme. More psychological themes include: trauma, torture, and punishment. Control is of the essence. ECT . . . should not be paid for by our ministries of health, nor should it be offered by medical practitioners . . . [ECT] should be phased out. (p. 224)

Although no province, state, or country has officially banned ECT, there is worldwide resistance: The first International Day of Protest Against Electroshock, organized by three shock survivors, was held on May 16, 2015, in 28 cities in 6 or more countries including the United States, Canada, United Kingdom, New Zealand, Scotland, Ireland, Uruguay, and Chile.

The antishock movement is obviously a major priority action in the antipsychiatry movement, which, hopefully, will spread globally as Burstow and other activists including myself advocate. If you’re a psychiatric survivor, activist, supporter, or ally, Burstow urges you to ask yourself these three key questions:

1. If successful, will the actions or campaigns that we are contemplating move us closer to the long-range goal of psychiatry abolition?
2. Are they likely to avoid improving or giving added legitimacy to the current system?
3. Do they avoid “widening” psychiatry’s net? (p. 258)

Thanks to Bonnie Burstow, this book moves us closer to the day when there will be no medical model of “mental illness,” no electroshock, no psychiatry, but Eutopia—a world based on mutual caring, emotional and social support, empathy, respect for our human rights, and humanity.

DON WETZ
Toronto, Ontario, Canada
QUERIES:

AQ1: APA calls for being sensitive to labels, please confirm if changing this instance of “poor lunatics” to “poor people with mental illness.”

AQ2: Please confirm if supplied expanded form of the abbreviation “ECT” is correct.

AQ3: Please supply inclusive page numbers for cross-reference of this block quotation.

AQ4: Please confirm if this cross-reference should be included in the reference list; if so, please supply complete reference information.

AQ5: Please supply author's academic degree(s).