



Mad In America by Robert Whitaker

Reviewed by Charles Sigler, D.Phil.

In the Preface to *Mad in America*, the author points to a startling fact, that over the past twenty-five years, outcomes for people suffering with schizophrenia in the U.S. have worsened. More than 2 million Americans suffer with schizophrenia. Many end up homeless, in prisons, or in and out of psychiatric hospitals. Schizophrenia is estimated to cost the U.S. more than \$45 billion annually. These facts led Whitaker to ask, “If the medications work so well, then why do ‘schizophrenics’ fare so poorly in the United States?”

Ironically, schizophrenia outcomes in the U.S. and other developed countries are much worse than in the poor countries of the world. If you suffer a psychotic break in a poor country like India or Nigeria, in a couple of years you have a good chance of improvement. But if you have the same break in the U.S. or another developed country, you become chronically ill. This is despite the ready availability of neuroleptic¹ medications in the developed countries.

World Health Organization (WHO) researchers found that at both two-year and five-year follow-ups, “patients in three poor countries—India, Nigeria, and Colombia—were doing dramatically better than patients in the United States and four other developed countries.” (p. 227) At five years, 64% of the patients in the poor countries were asymptomatic and functioning well. Another 12% were neither fully recovered or

¹ The term ‘neuroleptic’ was coined in 1955 from a Greek word meaning to “take hold of the nervous system.” It described the way in which chlorpromazine (Thorazine) and other phenothiazines acted as chemical restraints (p. 144).

chronically ill. The final 24% were still doing poorly. This contrasted with only 18% of the patients in the richer, developed countries who were asymptomatic; 17% who were in the “so-so” category; and nearly 65% who had poor outcomes. When these results were first published in 1979, they were largely dismissed as flawed; probably the result of misdiagnosis in the poor countries.

With this criticism in mind, the WHO launched a follow-up study that addressed the concerns, but found almost exactly the same results: In the poor countries, nearly two-thirds of schizophrenics had good outcomes; only slightly more than one-third became chronically ill. In the rich countries, barely more than one-third had good outcomes. Investigators looked at family involvement, childhood experiences, and societal attitudes to account for the differences, but failed to find any explanation. They concluded that for some unknown reason, schizophrenics in developed countries generally failed to “attain or maintain a complete remission of symptoms.” (p. 229)

Whitaker pointed out that the obvious difference was in the medical care provided to schizophrenics within poor and rich countries. “Doctors in the poor countries generally did not keep their mad patients on neuroleptics, while doctors in the rich countries did. In the poor countries, only 16 percent of the patients were maintained on neuroleptics. In the rich countries, 61 percent of the patients were kept on such drugs.” But this obvious difference was so threatening to Western medicine that it went unexplored (p. 229).

As a society, Whitaker observed that we are estranged from the “mad” or “insane” in our midst. He suggested that a history of mad medicine reveals little about what it means to be “ill with schizophrenia,” but it reveals a great deal about the society that would “cure” these patients. Mad medicine provides a prism through which to view that society. The medical treatments for schizophrenics will also reflect the social and philosophical values of the day (pp. xiv-xv).

The picture that emerges is disturbing in the extreme in what it suggests about American society. Beginning with a survey of historical treatments for schizophrenia and ending with an assessment of the “not so atypical” neuroleptic medications released in the 1990s, Whitaker is unrelenting in the documentation he presents to support the final, prophetic sentence of his book: “The day will come when people will look back at our current medicines for schizophrenia and the stories we tell to patients about their abnormal brain chemistry and they will shake their heads in disbelief.”

I was shaking my head in disbelief repeatedly as I read *Mad in America*. The ironic thing is that I had prior knowledge of some of what he wrote about. I knew about the horrors of electroshock treatment, lobotomies and insulin shock therapy; the debilitating effects of neuroleptics and the poor treatment of the insane in institutions. It seems I didn't realize the extent of our cultural madness in how we've treated the insane.

I've taught about the display of the insane like carnival freaks at Bethlehem Hospital (Bedlam) in England, not knowing I had a closer to home example in the Pennsylvania Hospital of colonial times. Even an iron fence couldn't keep out the curious public. So in 1762, Pennsylvania Hospital began charging a visitor's fee. The depth of cruelty, often in the name of helping the insane, was shameful.

Medical therapeutics for the mentally ill, and how they are used, invariably reflect underlying societal values. In the 1700s, European societies conceived of the mentally ill as beings that, without their reason, had descended to the level of animals, and they developed harsh therapeutics to tame and subdue them. In the early 1800s, the Quakers in York, England, viewed the mentally ill as brethren, as fellow human beings worthy of their empathy, and fashioned a therapeutic that emphasized kindness and the comforts of a good home. In the first half of the twentieth century, America conceived of the mentally ill as hereditary defectives, without the rights of 'normal' citizens. This set the stage for therapeutics that were designed to alter who the mentally ill were, with such remedies to be applied even over their protests. (p. 136)

Whitaker gives historical credence to Thomas Szasz's claim that mental illness is a myth; and that psychiatric treatments can be seen as "medically administered tortures."² He persuasively demonstrated that so-called "treatments" such as forced electroshock, lobotomy and others were medical solutions consistent with an eugenics-based conception of the mentally ill. The American Eugenics Society (AES) referred to the mentally ill as "cancers in the body politic." Franz Kallmann, chief of research at New York State Psychiatric Institute, said the mentally ill were not "biologically satisfactory" individuals. Ernest Hooton, a Harvard professor of anthropology and

² Szasz, Thomas. (1988). *The Theology of Medicine*. Syracuse University Press: Syracuse NY. p. 27.

member of AES, argued in his 1937 book, *Apes, Men, and Morons*, that America “must stop trying to cure malignant biological growths with patent sociological nostrums. The emergency demands a surgical operation.” (p. 56) The Holocaust was based upon similar sentiments.

Once again we can turn to Szasz, who concluded that psychiatrists actually deal with personal, social, and ethical problems in living. Attempts to describe and alter human behavior without coming to grips with the issue of ethical values are doomed to failure.³ When you read *Mad in America*, be prepared to be challenged in your assumptions regarding the treatment, diagnosis and medication of madness. I agree with Whitaker that the poor outcomes for those diagnosed with schizophrenia raise questions for all of us.

³ Szasz, Thomas. (1974). *The Myth of Mental Illness*, revised edition. Harper & Row Publishers: New York. p. 263.