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Antipsychiatry and the Gay Rights Movement

To the Editor: The Open Forum, "Evolution of the Antipsychiatry Movement Into Mental Health Consumerism," in the June issue by David and Joshua Rissmiller (1) contains statements about the antipsychiatry movement and the removal of homosexuality as a disorder from the *DSM-II* that deserve clarification. The Rissmillers write: "In May 1970, hundreds in the antipsychiatry movement joined gay activists in forming a human chain barring psychiatrists from entering the American Psychiatric Association's 124th annual meeting. During a similar disruption the following year, gay activist Frank Kameny grabbed the podium and declared war on psychiatry for its *DSM* classification of homosexuality as a psychiatric disorder."

Standard histories of the gay rights movement and the declassification of homosexuality as a psychiatric disorder, including Ronald Bayer's *Homosexuality and American Psychiatry* (2) and *Out for Good: The Strug-*

gle to Build a Gay Rights Movement in America (3) by Dudley Clendinen and Adam Nagourney, fail to mention the participation of "hundreds in the antipsychiatry movement" in the disruptions in 1970 in San Francisco by gay rights activists that were pivotal to the inclusion of activists such as Kameny in programs on homosexuality that were presented at the 1971 APA meeting in Washington, D.C.

Kameny now states: "I was not then aware, and am today still unaware, of an actual, organized 'anti-psychiatry movement.' My—our—sole intent was to reverse what we (and I, as a scientist by training and background) considered a scientifically baseless characterization of homosexuality as pathological. Institutions, such as the APA, often require a very strong nudge to reverse longstanding past positions. That was the case here. Remember, when I seized that microphone, I was present there at the Convocation by formal, official invitation. . . . Antipsychiatry I am not" (Kameny F, personal communication, 2006).

The Rissmillers also write: "Wanting the protests to stop, the American Psychiatric Association formed a task force, which, by a vote of 58 percent, officially deleted homosexuality as a mental illness in 1973." This statement perpetuates the incorrect assertion that the deletion of homosexuality as a psychiatric disorder from the *DSM* was primarily a political, not a scientific, decision. In 1973 the APA's Committee on Nomenclature, including Robert Spitzer, reviewed the existing scientific literature on homosexuality and concluded that the available evidence did not support classifying homosexuality as a psychiatric disorder. After this decision was made, a contingent within the APA, led by psychoanalysts that viewed homosexuality as pathological, called for a vote by the entire membership of the APA to reinstate homosexuality as a disorder. This political act failed in 1974 when APA members voted by 58 percent to 42 percent to sup-

port the original scientific decision to declassify homosexuality as a disorder from the *DSM*.

Benjamin McCommon, M.D.

Dr. McCommon is assistant clinical professor of psychiatry at Columbia University, New York City, and a member of the APA's Gay, Lesbian, and Bisexual Issues Committee.

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In Reply: The authors appreciate Dr. McCommon's letter and the opportunity to respond. As stated in our Open Forum, founders of the antipsychiatry movement were closely aligned with other counter-culture movements of the day, including the gay rights movement. Foucault's *The History of Sexuality*, which has become "canonical" for both gay and lesbian studies, warned that the scientific description of sexuality may be part of the state's agenda of controlling it. Laing's phrase "the personal is political" was a key rallying cry for the Gay Liberation Front. In 1965 Szasz took "direct aim at the pathologization of homosexuality" (1).

The statement attributed to Mr. Kameny—"I was not then aware, and am today still unaware, of an actual, organized 'anti-psychiatry movement'"—is in marked contradiction to the views of other authors. In *Homosexuality and Psychoanalysis*, Dean and Lane (2) stated that "the most powerful influence on the British and French gay movements arguably was the antipsychiatry movement." Bébout (3), writing about the genesis of the gay and lesbian periodical *The Body Politic*, which ran for 15 years, noted, "Psy-

chiatry, or rather antipsychiatry, preoccupied the early gay movement in a way many might now find surprising.” In *A History of Bisexuality*, Angelides (4) wrote that the “gay liberation critique of psychomedical discourses of sexuality was made possible by (and indeed often explicitly grounded in) traditions of antipsychiatry.” He pointed out that the “more militant gay liberation movement . . . in many ways served as an adjunct of the broader movement of antipsychiatry.”

As to the specific militant action at the APA annual meeting, some contextual background may help. The protest occurred during the first week of May 1971 in Washington, D.C, during one of the most disruptive actions of the Vietnam War era. Antiwar activists were trying to shut down the federal government. The threat caused by these May Day protests culminated in the largest mass arrest in U.S. history. The APA held its meeting in the midst of this unrest. Rennie Davis, a prominent leader of the antiwar protest, spoke at the meeting. The antipsychiatrist Szasz was there protesting the labeling of drug addiction as a mental illness. Psychiatrists from both of these groups were intermingling; some undoubtedly believed in multiple antiestablishment causes. In an article about Kameny, Johnson (5) described the scene: “Along with members of the Gay Liberation Front and anti-war protesters, Kameny stormed the convention.”

Even if the entire group that participated in interrupting and shouting down psychiatrist speakers is not considered part of the antipsychiatry movement, we believe that within the group there were a number of antipsychiatrists. Although Kameny’s grabbing the microphone and proclaiming “Psychiatry is the enemy incarnate” might be construed as antipsychiatry rhetoric, the authors will accept his view that he was never an antipsychiatrist, and we apologize for any unintentional inference. In addition, we do not know whether public pressure prompted or accelerated the 58 percent psy-

chiatric vote to delete homosexuality from the *DSM* in 1973.

**David J. Rissmiller, D.O.
Joshua Rissmiller**

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Conditional Hospital Release: Interpreting the Message

In the November Taking Issue, Robert Bernstein (1) commented on three of our research reports published in the same issue. He wrote that reliance on conditional hospital release sends the wrong message because it implies that professionals must turn to the courts to ensure effective postdischarge treatment. Whether a research message is judged to be right or wrong depends not only on content but also on the preconceived notions and political agenda of the stakeholder-reader.

We endeavored to present a message based on a decade’s experience of 24,973 individuals who required psychiatric hospitalization. Within acknowledged limits, the protective oversight provided by conditional release was associated with saving 709 years of life and reducing the probability of death by 14 percent among 8,879 patients given conditional release compared with the other 16,094 patients released without such oversight. Conditional release was also associated with shorter inpatient episodes and, when used ear-

ly in a patient’s illness, prevention of a revolving-door dependence on hospitalization.

The evidence documents the positive effects of being on conditional release over and above the treatment provided, although our methods do not permit us to make causal attributions with the same confidence as for a randomized controlled trial. Our analyses indicated that conditional release is not for all patients—nor is it an intervention without problems. Our focus on the utility of early use of conditional release early—and on use of extended court orders for community treatment (2)—is an effort to improve understanding of the timing and objectives of different modes of conditional release in order to specify its benefits and liabilities.

Unlike Dr. Bernstein, we see the mental health system’s engagement of the courts as perhaps well considered in view of the vulnerabilities of this population. The Mental Health Review Board played a positive role, providing oversight that protected individual rights, health, and safety. The consequences of failing to ignore the vulnerabilities of these severely ill patients (3) in view of increasing evidence that protective oversight reduces vulnerability (4) are of grave concern.

We agree with Dr. Bernstein’s characterizations of the mental health system’s failures and dependency-producing aspects, yet we see these as challenges to overcome through provision of empowering recovery-focused and well-monitored programs. The system’s failures do not seem to require the elimination of conditional release procedures; in most jurisdictions the consequences of noncompliance with the conditions of release is return to the hospital for evaluation. Such action may be viewed as a demonstration by the state that it cares enough about its citizens to provide oversight during their time of need.

In reviewing the literature on outpatient commitment Geller (5) notes that it “has been characterized by considerably more opinion than fact. . . . Its assets and liabilities are all too

often lost sight of in a cacophonous bluster that obscures reasoned positions.” We hope that our investigative effort will result in selective use of conditional release and that our findings will promote the design of better research to understand its assets and liabilities and how to employ it in a way that preserves the dignity and hope of patients to the greatest extent possible while protecting their health and safety.

Steven P. Segal, Ph.D.
Philip M. Burgess, Ph.D.

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Appropriate Use of Police Officers?

To the Editor: A column in the November issue (1) and a research report in the February issue (2) describe crisis intervention training (CIT) for police officers in Ohio. These reports are important because they offer a possible solution to the dilemma of sending police officers to interact with mental health patients in critical situations. As a psychiatric nurse and the wife of a police lieutenant, I appreciate the authors’ attempt to address this problem. Their emphasis on encouraging partnerships between law enforcement and mental health providers is a progressive approach.

The Ohio CIT program trains officers to recognize persons who are ex-

periencing acute symptoms of mental illness and provides them with deescalation tools. Officers are also informed about available community resources. The authors describe an alternative paradigm that would benefit the health care and law enforcement communities and, more importantly, place responsibility for the care of these patients in more appropriate hands. A crisis intervention model could be developed in which dispatchers are trained to identify mental disturbance calls and dispatch emergency medical technicians and paramedics.

A primary concern, however, involves training police officers to handle mental health crises. Police officers are not health care providers. A 40-hour course will provide much-needed information but should not be viewed as a solution to the emergency needs of mental health clients. The study in the February issue demonstrated an increase in the number of dispatch calls “related to mental disturbances” after the training. Heightened awareness of mental health issues among dispatchers as a result of the CIT training is the likely explanation. However, the dispatchers were given no additional training about how to triage these individuals appropriately. Dispatchers need to be trained to evaluate the situation by asking the correct questions and reporting the right information to the most appropriate emergency medical technicians and paramedics.

Law enforcement officers are being assigned greater responsibility in our communities. In addition to providing for the safety of citizens and property, many are required to participate in activities such as Drug Abuse Resistance Education, community policing, Neighborhood Watch, bioterrorism preparation, and public education. Is it the best use of training dollars to prepare law enforcement officers to become experts in dealing with health care conditions?

Paramedics have the background to deal with acutely ill patients. The Emergency Medical Technician Paramedic: National Standard Curriculum (3), a course for paramedics of-

fered by the National Highway Transportation Safety Administration, covers topics such as communication, clinical decision making, and management of the combative mental health client, which provide a foundation for handling mental disturbance calls. Educational standards for police officers differ between states. However, a review of training options for police officers, including degree programs at Missouri Southern State University and training offered by California Peace Officer Standards and Training (4) and the New York Police Department (5), reveals that most offer little or no education about persons with mental illness. Dispatching police officers to determine whether patients require emergency treatment, placement, or arrest further criminalizes and demoralizes persons with mental illness. Emergency medical service personnel are the appropriate resource for crisis intervention for the mental health client.

Elaine Boyd, R.N., M.A.

Ms. Boyd is a psychiatric nurse at Crittenton Children’s Center, Kansas City, Missouri.

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In Reply: We appreciate Ms. Boyd’s thoughtful comments about our work on the crisis intervention team (CIT) program. We agree with Ms. Boyd that mental disorders are health con-

ditions requiring a health care response. We also agree that a 40-hour course for police officers is not “a solution to the emergency needs of mental health clients.” The police-based CIT program is complementary to a mental health system’s emergency mental health services, creating an effective partnership.

We agree with Ms. Boyd that training of dispatchers to better recognize mental illness and to facilitate appropriate triage is critical. In fact, dispatch training has been offered in the Akron CIT program and is considered one of the core elements of CIT in Ohio’s Expert Consensus Document (1). Regarding the use of limited law enforcement training dollars, the beauty of CIT is that the training is provided free of charge by volunteers in the mental health and advocacy communities.

We agree with Ms. Boyd’s suggestion that emergency medical service personnel are integral players in dealing with people in crisis resulting from mental illness. Emergency service personnel were included in Akron’s first CIT class. However, although training these personnel is necessary, it is clearly not sufficient. In Akron’s relatively resource-rich community, both emergency service personnel and police are dispatched on calls that are identified as involving mental illness. About half require the police to take control, most often when challenging behavior is present. In these difficult situations the police are the professionals best trained to preserve the safety and well-being of all people involved in the crisis. Also, in our state, law enforcement officers, not emergency service personnel, are empowered to initiate involuntary psychiatric evaluation. Furthermore, we found that approximately 25 percent of CIT calls in Akron are not identified initially as involving mental illness. CIT officers are trained to recognize illness on the scene and intervene appropriately.

Like Ms. Boyd, we have had concerns about the possibility of unintended consequences from the CIT program. Could CIT unintentionally

further criminalize mental illness or increase stigma? Because CIT is not simply a police training program but a partnership between law enforcement, the mental health system, and consumers of mental health services and their families, we do not believe this has been the case in our community or in other areas of the country where CIT has been implemented. Patients and family members in our community have come to recognize and trust officers wearing the CIT pin. CIT officers appear proud of the contributions they make with their expanding skill set. We are struck by our finding reported in the February issue that CIT officers were more likely to transport individuals to treatment rather than leave them on the scene. Further studies are needed to ensure that CIT officers do not suffer excessive burnout and that individuals with mental illness are not inadvertently criminalized or stigmatized. Our ongoing studies hope to address some of these important issues. Although more data are needed, everyone involved with CIT experiences it as a community-transforming program.

Mark R. Munetz, M.D.

Jennifer L.S. Teller, Ph.D.

Ann Morrison, M.D.

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“Paternalism” and Recovery

To the Editor: The Open Forum in the November issue by Patricia Deegan and Robert Drake (1)—“Shared Decision-Making and Medication Management in the Recovery Process”—is important. The authors state, “Mental health professionals commonly conceptualize medication management for people with severe mental illness in terms of strategies to increase compliance or adherence.” They write that compliance interventions “are often de-

signed to increase clients’ behavioral conformity to a practitioner’s view of optimal treatment.” We hope that not all clinicians view compliance in this way. The authors state that “shared decision making assumes that two experts—the client and the practitioner—must share their respective information and determine collaboratively the optimal treatment.” Who could argue against this approach, especially for persons with mental illness who are higher functioning?

There is deep truth here but also a deep problem. Medication compliance may diminish symptoms, but there is much more to recovery than symptom relief. Recovery goals today include the ability to work and to have relationships with family, friends, and coworkers. The pursuit of these goals may well require participating in psychoeducation and group and family work, learning interpersonal and occupational skills, and finding housing, medical care, and other support to achieve self-government and increase self-esteem and empowerment. Astute treating psychiatrists must listen to and work with their patients, not impose preconceived notions of their own—either by undue pessimism regarding the patient’s recovery or by encouragement of unrealistic expectations. Working with patients always includes consideration of side effects and unwelcome consequences of even the most helpful medications.

The authors do not give us specifics, but both the devil and the deity are in the details. Disability and disempowerment of patients arise not just from the profession of psychiatry and society but, more importantly, from biopsychosocial pathology and patients’ life stresses. The clinician must be experienced in understanding the interplay between patients’ biopsychosocial vulnerability and their degree of stress.

“Paternalism” is given a pejorative connotation by the authors, but in psychic crisis, isn’t someone in the parental role often what the troubled person needs and is looking for? Deegan and Drake use the

word “client,” which derives from a Latin word meaning “leaning on”—referring to “leaning on” a benevolent expert to help and who listens, understands, and works with another as much as and whenever possible. The two clearest examples of the need for so-called “paternalism” are in the case of co-occurring disorders (substance use disorders and other mental illnesses) and of acute psychosis with delusional thinking. Patients in the former group can often spend their disability check on alcohol and drugs before they pay

for housing and food, and patients in the latter group are dangers to themselves or others if they stop taking medication.

Whenever possible, and certainly for patients with milder mental disorders, we strongly support “shared decision making with medication management.” But for patients with co-occurring disorders and acute psychosis, shared decision making is not always possible because the disease can be serious, even dangerous. Such a client may not be able to be “an expert” and needs to be ap-

proached in a so-called “paternalistic manner.”

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***Psychiatric Services* Invites Submissions by Residents and Fellows**

Psychiatric Services has introduced a continuing series of articles by trainees in order to highlight the academic work of psychiatric residents and fellows and to encourage research by trainees in psychiatry.

Submissions should address issues in the planning and delivery of psychiatric services in any setting, including those of special interest or concern to trainees. Submission of original research is encouraged. Literature reviews will be considered only if they are mentored or coauthored by a senior scholar in the field.

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