Surfaces

BREAKDOWN

Phoebe Sengers

Article abstract

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ABSTRACT

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RÉSUMÉ

L'institution psychiatrique mécanise le patient. Absorbé par l'engrenage de la machine psychiatrique, le patient est réduit à l'état de signe. L'ambiguité du mot l'anglais <<breakdown>> pointe vers une réalité où la machine excède sa propre logique et le patient excède l'emprise totalisante de l'institution. Références de base à Deleuze et Guattari, Blanchot et Goffman.

Institutionalization -- the very terminology already begs a question. How does institutionalization operate? How does someone become *institutionalized*? Deleuze and Guattari say any social machine - -- of which the psychiatric institution with its streaming in/out flow of people is certainly one -- works in the places where it breaks down. "The social machine's limit is not attrition, but rather its misfirings; it can operate only by fits and starts, by grinding and breaking down, in spasms of minor explosions."[1] The breakdown of its patients is reflected onto the ward; in its case, however, breaking down is productive and creates the institutional moment. To break down this breakdown we must resort to the psychologist's tools: discourse analysis via the hermeneutics of suspicion (Ricoeur). We will read a story of a breakdown, writing into it the narrative written under the surface of the story.

In the middle of September, I started to get depressed. By the middle of October, things had progressed to the point that I could no longer function: I couldn't read or write and was having trouble walking. I went to see a counselor at school and told him, "I think I need to go to the hospital. " He took me to Western Psychiatric Institute and Clinic.[2]

The quickest way into and out of theorizing about insanity is to state, "people are labeled insane if they fail to correspond to social norms." Such a statement fails to take into account the experience of many mental patients who have committed themselves or of people who are seeking treatment outside the institutionalized stream. For these people the experience of being "crazy," schizophrenic, depressed, or anxious, to follow the clinical classification -- is routed through feelings of misery and, often, physical symptoms such as an inability to concentrate, insomnia, or involuntary movement. This is not to deny that these physical symptoms bear the mark of the social formation ("[I]t is a founding fact -- that the organs be hewn into the socius, and that the flows run over its surface..."[3]). It is merely to state that insanity and institutionalization are more complicated than a mere labeling on the part of a social organization. Insanity is something experienced both from the individual and from the social point of view.

I do not pretend to be able to (re)present the real institutionalization, the real experiences of mental patients. Instead, I want to consider the period of institutionalization as a moment where two flows come into contact with each other: that of the institution, with its labels and categories, ready to take in new input, and that of the individual, who leaves his or her everyday life to become, for a while, a more-or-less functioning member of the social community under the auspices of the ward. Corresponding to these two flows are two points of view or modes of representation of the conjunctural period to be considered, that of the institution and that of the patient.

For the institution, any particular institutionalization is just a moment in its history, though each of these moments is in the strictest sense *essential*- the institution really consists only of the sum of these institutionalizations. For the individual, ripped from his or her normal existence and deprived of his or her accustomed social context, being committed is a traumatic event, but one that is not constitutive. The meeting of the institution and the patient is a point of conjunction of the paths of two very different social machines. In this paper, I would like to consider the dis- and conjunctions between the ways in which these two social machines deal with their shared moment. By considering their respective representations of that moment -- particularly the gaps between those representations -- I hope to gain an understanding of how the processing of both machines comes to constitute the process of treatment in the institution.

I had to wait a long time in the emergency room before I was checked in. After a long wait someone took my temperature. After another long wait I talked to a counselor. After yet another long wait I talked to the psychiatrist. While I was waiting, someone was brought in from the state penitentiary. They locked him in a little room. He was screaming and kicking the door. The screaming went like this: "Society has made me this desperate! I was only arrested because I'm black and living in a white world." All the staff in the room, including the receptionist, put on latex gloves. They put a crying woman in a private room so she wouldn't be bothered by this man. They asked me to move, too, so I wouldn't be so dangerously close to the room where they had him locked up.

As the soon-to-be-patients stand on the threshold of entering the institution, they are immediately confronted with its first moment of breaking down. There is a conflict between two functions of the mental hospital: its function as a site of medical care or rehabilitation and its role as custodian of certain more dangerous elements of society. As Erving Goffman discusses in "The Medical Model and Mental Hospitalization," the stresses and gaps between these two models are felt keenly within the institution, which currently prefers to underscore the service model.

Each time the mental hospital functions as a holding station, within a network of such stations, for dealing with public charges, the service model is disaffirmed. All of these facts of patient recruitment are part of what staff must overlook, rationalize, gloss over about their place of service.[4]

Nevertheless, the institution continues to be able to operate on both registers ("No one has ever died from contradictions"[5]).

This presents a quandary for the mental patient. S/he is generally all too aware of being incarcerated despite the staff's assurances that s/he is only there "for your own good."

[O]ur conversation [had] the character of an authoritarian interrogation, overseen and controlled by a strict set of rules. Of course neither of them was the chief of police. But because there were two of them, there were three...."[6]

Though the institution claims to work according to the medical metaphor, it is apparent that it differentiates patients in terms of how well they fit into the service model. In the case of the man in the emergency room, the

patients (i.e., I and the other woman) that are more or less "normal" are treated courteously and are even physically separated from the "problem patient." He is considered dangerous and alien; the staff dons gloves to avoid coming into contact with him. The patient occupies a troubled status; s/he is at the same time the "good patient," being treated for an illness more or less external to him or her, and the "bad patient," fundamentally flawed and not allowed to go outside; the latter status is all the more real for being denied.

Then two big white men went into the room and gave the black man a shot. He was still kicking and screaming. Later they went into the room again. I heard the receptionist talking on the phone. She said, "They've already given him twice the normal dosage and he's still not calm." They brought me papers to sign myself in. I joked with /pp. 8-9/ the nurse. "This is so I can still run for president, right?" She didn't think it was funny.

The moment of entrance into the institution is a symbolic one. It is accomplished through what Deleuze and Guattari call "order words"[7] -- deeds that occur entirely through an act of signification. In the case of the institution, the order word is the signature. The papers I sign mean that I no longer have a right to speak for myself before the law. Once I have signed the paper, my signature is worthless. This gives the signature on the commitment form an eerie status -- a signature, sealing its own inability to seal.

The signature, despite or perhaps thanks to its paradoxical status, is central to the institution. It is what binds the patient to the institution; it is what controls the flow of patients into and out of the institution. The patient arrives, bound by his or her own signature or by that of a doctor. The patient may not leave, even if s/he came voluntarily, without the signature of a proxy: [8] the psychiatrist, competent, as though by an act of conservation of agency, to speak for two.

The signature is itself a *proxy for the law*. Maurice Blanchot writes,

Behind [the doctors'] backs I saw the silhouette of the law. Not the law everyone knows, which is severe and hardly very agreeable; this law was different. Far from falling prey to her menace, I was the one who seemed to terrify her... She would say to me, "Now you are a special case; no one can do anything to you. You can talk, nothing commits you; oaths are no longer binding to you; your acts remain without a consequence."(14-15)

In this respect, the patient stands beyond the grasp of the arm of the law. But it would be more appropriate to say the patient is jettisoned by the law. "When she set me above the authorities, it meant, you are not authorized to do anything"(Blanchot 15). The law deprives the mental patient, not only of his or her culpability, but also of his or her ability to speak. The category of the "insane," then, is defined by its inability, socially speaking, to speak for itself. It is a category without legal status in the narrowest sense.

The breakdown of the institution at the moment of entrance, then, is mirrored by a breakdown of the social machine of the patient. It would be better, perhaps, to speak of a break out: the patient is no longer seen as a functioning member of society. This is a Catch-22 for the patient trying to affect reform or even just trying to voice his or her experience; how can a group of people defined by *an inability to speak find a voice in society*? By definition this should be impossible, except perhaps for the gap between "insane" (insane as a social label, from the point of view of the institution) and insane (insane as an experiential label, from the point of view of the labeled individual). In the mental reform movement, one finds most such voices stemming from ex-patients: "We, of the Mental Patients' Liberation Project, are former mental patients."[9] "Insanity" in the first person is invoked as a category of nostalgia.

The Mental Patients' Liberation Project approaches this problem by a loosening of the term "we," which is used alternately to mean the "former mental patients"("Statement" 521) of the project and patients currently in asylums. "We have drawn up a Bill of Rights for Mental Patients...Because these rights are not now legally ours we are now going to fight to make them a reality..."(522). By blurring the categories patient/ex-patient the Project also blurs their respective legal statuses, pulling the patient into a realm of the law occupied by the ex-patient. The Project still speaks for the patient, but with some sleight of hand its voice appears to come out of the patient's mouth.

The Liberation Project also plays the role of the law for the mental patient. The Project presents the patient with a Bill of Rights, rights the Project grants without true legal status but "which we unquestioningly should have"(522). A major concern of this Bill is the legalization of the mental patient: "You are an American citizen and are entitled to every right established by the Declaration of Independence and guaranteed by the Constitution of the United States of America"(523). The project thus solves its theoretical problem handily - -- it plays the parts of the constituencies that cannot or do not want to appear on the stage.[10]

After I had waited for a total of seven hours they took me upstairs. When we got to the 11th floor (the depression ward) I was met by a disoriented-

looking patient, who said, "You'll like it here. We all help each other get better." I thought to myself, "Oh no! I'm going to be locked on a floor with all these strange people."

The moment of the signature has passed. As far as the hospital is concerned, the patient has already been classified into the type that will determine how s/he will be processed for the rest of the stay. For the patient, however, the order word is not enough to change his or her entire system of functioning. His or her point in the social hierarchy has changed but this change has not yet manifested itself in the realm of action. The machine is still running, just as it did before. On entry into the social situation of the ward its old system of functioning will choke; the machine will have to reprogram itself.

My clothes and all my belongings were searched and they took everything they thought was "dangerous" out of it. That includes my contact lens solution and my tampons. I said, "What could I possibly do with my tampons?" The staff person checking me in couldn't think of anything. But those were the rules.

Although the commitment took place at the moment of the signature, the institutionalization *really begins here*. This is the moment at which the patient is made to realize the rights and privileges s/he has lost by seeking help within the institution. The incoming patient is stripped, searched, given hospital clothing, and led onto the ward identified only by a hospital bracelet. No one on the ward knows the patient, who is reluctant to circulate with the other patients, people from whom until recently s/he was protected by the comforting arm of the law. Any attempts to identify with the staff, however, will soon be rebuffed; the patient becomes forcibly alienated from the person s/he thought s/he was and must assume a new role.

From the point of view of the institution, this is a dangerous moment. A new element has been absorbed but at this point it still retains marks of the outside world. These now out-of-date attributes must be removed as quickly as possible. Erving Goffman points out,

Many of [the admission] procedures depend upon attributes such as weight or fingerprints that the individual possesses merely because he is a member of the largest and most abstract of social categories, that of human being. Action taken on the basis of such attributes necessarily ignores most of his previous bases of self-identification."[11]

The institution must create a deterritorialized space onto which to reterritorialize its input.

Once the incoming patient has been *sanitized*, s/he is more easily adapted to the role the institution has planned for him or her.

Admission procedures might better be called 'trimming' or 'programming' because in thus being squared away the new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations. (Goffman, "Total Institutions" 16)

Institutionalization becomes mechanization; the humanity of the patient is stripped away and replaced by a robotic faciality. The issue is not whether the patient is comfortable in the new role; from the point of view of the institution, the patient can only be dealt with in so far as s/he is mechanized. [12] The model for the psychology of mental patients is a robot psychology, working mechanically in the roles of the automated patient, PARRY,[13] and his analyst, ELIZA.[14] /pp. 13-14/

After a while, I had a headache. I went to the nurses' station and knocked. After a couple of minutes of ignoring me, someone came. I asked for a Tylenol. "Has your doctor approved it?" She asked. "I don't have a doctor." "Well, then you can't have any." After a couple more equally humiliating trips to the nurses' station I gave up, even though by then my new doctor had given me permission to take two Tylenol every four hours.

Changing arbitrary people into cogs in a machine takes some filing down of resistance. In the institution, the most innocuous requests are taken as an opportunity to regulate the life of the patient more closely.

[T]he inmate's life is penetrated by constant sanctioning interaction from above, especially during the initial period of stay before the inmate accepts the regulations unthinkingly.... The autonomy of the act itself is violated. (Goffman, "Total Institutions" 38)

The patient is made to feel that any unusual activity -- one that is not already structured by the institution -- requires too much effort. S/he becomes more passive; the authority of the institution is reinforced.

The power of deciding over the patient's life does not disappear; it is given to the psychiatrist.

Incarcerating institutions operate on the basis of defining almost all the rights and duties the inmates will have. Someone will be in a position to pass fatefully on everything that the inmate succeeds in obtaining and everything he is deprived of, and this person is, officially, the psychiatrist. (Goffman, "Medical Model" 35)

The psychiatrist has an enormous amount of power over his charges. As Blanchot writes: "[T]hese men are kings"(14). But it is not the individual psychiatrist who has gained agency; s/he too must play within the parameters of the game. "Almost any of the living arrangements through which the patient is strapped into his daily round can be modified at will by the psychiatrist, *provided a psychiatric explanation is given*"(emphasis mine).[15]

Paradoxically, the institution's control over the patient is limited by the very mechanisms it uses to gain control over him or her. The institution can only control the patient insofar as s/he is mechanized. There are aspects to the patient that the institution cannot even see, let alone do anything about. For instance, some (perhaps many) patients have gotten very good at playing the part of the patient. These patients may use their acting abilities to shorten their length of stay or to get a hospital bed as an alternative to sleeping in prison or on the street. I myself took advantage of their ignorance to read what might be considered subversive literature (*Anti-Oedipus* and *The Birth of the Clinic*) without any problems. *One Flew Over the Cuckoo's Nest* is usually cited as an example of the power of the institution over its charges: McMurphy places himself in the way of smooth running and is crushed by the institutional machine. But in the same novel Chief Bromden has staked out a territory of agency: he pretends to be deaf, stays away from the moving parts and hence finds space to maneuver.[16]

Soon I started meeting the other patients. At first I thought that would be a little scary. But it turned out they were no weirder than the average person you meet on a bus. One of them was even a psychologist himself! When I arrived, there was only one patient on the ward who had lost grips with reality. She talked a lot, very enthusiastically. I've met a lot of people like that on the bus, too. There was only one scary person on the ward. She showed up a couple of days after I did. She wore latex gloves all the time, thought she had all sorts of horrible diseases and tried to get everyone to take care of her. We were afraid of her and thought she should have been on a different floor.

As far as the institution is concerned, all patients on a ward are the same (except as differentiated by whatever deed-reward system has been put into place). The patients, however, continue to differentiate among themselves as they always have. Thus the patients will coalesce into social groups on the basis of educational level, race, intelligence and so forth. The patients on the ward repeat (though without institutional support) the same status differentiation of sane/insane as on the outside; those patients perceived to be "more insane" are treated with a similar kind (though not a similar level) of distancing as the 'saner' patients themselves receive at the hands of social organization. Thus, the patients think the strange woman should have been on a different floor just like the rest of society, they want to be separated from her.

The paradox is that the strange woman (we dubbed her "Latex Lady") actually comes to embody the institution. Her preoccupation with disease and desire for care reflect the "medical model of hospitalization" Erving Goffman points towards, while her perpetual donning of latex mirrors the less appetizing aspects of the institution. We considered it in bad taste; it reminded us of our loss of agency, which we were all too willing to gloss over just as the staff did. She brings forth the same kind of stratification within the hospital that the hospital brings forth in society. This stratification is different in that it has no legal backing and this is what brings about the fear in other patients. They realize that under the law they have no protection against her because they belong to the same class of undesirables.

I started meeting the staff then, too. That is when you realize what your status is. The patients still treat you like a human. The staff treats you like you've lost the right to speak about yourself. Everything you do is treated as a symptom. You'd better not confide in any of them since they report to each other. You run into your psychologist and he says, "I hear you had a hard group therapy session. " In that respect, there is no privacy.

The mental hospital treats the "whole patient" (as much of him or her as the hospital can recognize): for the institution there is no room for excess. "All of the patient's actions, feelings, and thoughts -- past, present, and predicted -- are officially usable by the therapist in diagnosis and prescription.... None of a patient's business, then, is none of the psychiatrist's business; nothing ought to be held back from the psychiatrist as irrelevant to his job." [17] All information about the patient is funneled to his or her psychiatrist. For all intents and purposes s/he becomes the patient's institutional alter ego. "Throwing open my rooms, they would say, 'Everything here belongs to us.' They would fall upon my scraps of thought: 'This is ours'"(Blanchot 14). The psychiatrist takes over the legal role of the patient: s/he alone can make decisions about what kind of medication (including over-the-counter) the

patient can take, what kinds of "privileges" the patient can have and whether the patient will be allowed to go home.

Now that the psychiatrist has taken over the agency of the patient, everything the patient does is treated as symptomatic. The patient can no longer act, only signify. "Right before their eyes, though they were not at all startled, I became a drop of water, a spot of ink"(Blanchot 14). The patient's actions only function insofar as they are informational -- they only *act as ciphers*, which it is then the responsibility and right of the doctor to decode. The institution makes a double movement -- it ciphers the patient in order to decipher him or her. Though the patient cannot speak, the patient is always -- already -- signifying, against his or her will.

We already noted that the patient has lost the right to speak. Now we see how his or her language is re-routed, being cited to the patient as the rationale of his or her loss of control -- "my story would put itself at their service"(Blanchot 14). In turn, the staff often no longer considers the patient as a worthy addressee. Goffman notes,

Often he is considered to be of insufficient ritual status to be given even minor greetings, let alone listened to. Or the inmate may find that a kind of rhetorical use of language occurs: questions such as, "Have you washed yet?" or "Have you got both socks on?" may be accompanied by simultaneous searching by the staff which physically discloses the facts, making these verbal questions superfluous. ("Total Institutions" 44)

By this point, the patient *qua* human agent has been written out of the institutional picture. The patient has no social choice but to turn to his or her fellows.

The main kind of therapy is talking to the other patients. Once you realize your status in the hospital you'd much rather talk to them than the staff anyway. There is no hope of fruitful discussion with the psychologist at all. He or she is just someone you see for five minutes a day and who asks if you've been feeling suicidal. We patients talked about a couple of different things. We were all depressed so we spent a lot of time talking about how pathetic we were and about our miserable problems. Another popular topic of conversation was medication. Almost everyone was medicated, so we spent a long time discussing our medication and rumors about what different drugs (or treatments, such as shock therapy) would do to you. Finally we spent a lot of time complaining about being in the hospital and being treated like a mental patient. This was usually done when there was no staff around. One common comment was, "The people on the outside are just as crazy as we are. We just had the sense to get treatment. "

Modern psychiatry has had a hard time determining at whose door to lay the blame for the genesis of insanity. It has developed the notion of "schizophrenogenic" and other dysfunctional families to describe a situation in which someone becomes insane because of the madness of his or her world. "Madness, that is to say, is not 'in' a person but in a system of relationships in which the labeled 'patient' participates."[18] Indeed, it seems that if one's world lacks logical coherence the only sane response is to go mad. All this calls into question the utility of labeling the individual patient as insane in contrast to the rest of society.

[The law] exalted me, but only to raise herself up in her turn. 'You are famine, discord, murder, destruction.' 'Why all that?' 'Because I am the angel of discord, murder, and the end.' 'Well,' I said to her, 'that's more than enough to get us both locked up.' (Blanchot 16)

The end result was that many patients felt a strong bond with the other patients but were a lot less enthusiastic about the staff and doctors.

After a couple of days in the hospital I was starting to get claustrophobic (in its usual metaphoric sense). None of the windows open - -- since patients might be tempted to jump out -- so the ward never got fresh air. I started to feel like I was living in a fishbowl, constantly observed.

That is the one real difference between patients and non-patients: the very experience of being in the hospital itself. This is particularly true of people with schizophrenia, whose terms of hospi/pp. 19-20/ talization are generally longer than those of anxious or depressed people. Some psychiatrists claim they "[need not] fear that it is [their] diagnosis which separates a schizophrenic person from his family and peers."[19] But in a very real sense it does.

In fact, the notion that the institution itself participates in the construction of its patients' insanity has developed currency in the psychiatric community, who label it "institutional neurosis"(Cooper 129). The effect of the institution is not limited to the changes we have already seen a person must make to adapt to the hospital situation. David Cooper sees the structure of the hospital ward as reproducing the conditions of the schizophrenogenic family, thereby creating, not a curative climate, but one that fosters the development and maintenance of insanity. Documented effects of the asylum on its inmates lead some people to believe that "[w]hat

[psychiatry] attempts to cure us of is the cure itself"[20] and to speak of "the artificial schizophrenic found in mental institutions."[21] "One is left with the sorry reflection that the sane ones are perhaps those who fail to gain admission to the mental observation ward. That is to say, they define themselves by a certain absence of experience"(Cooper 129).

I wanted out. But that wasn't so simple. If I checked myself out (since I was a voluntary) I would have to wait three days before they let me go. A number of my fellow voluntary patients were committed by the hospital (or threatened with commitment) when they tried to leave. This was rumored to be because the hospital was afraid of being sued. And even if they did let me go, it would be 'AMA, ' against medical advice, and I would forfeit my right to come back if I should take a turn for the worse. The only option was to fool the doctors into thinking I was better.

The anti-psychiatric community is well aware that many patients manipulate the doctors into letting them out prior to any basic change in them that can be correlated with cure. "I am quite sure that a good number of 'cures' of psychotics consist in the fact that the patient has decided, for one reason or other, once more to play at being sane."[22] But consider what a patient needs to be able to do in order to "play at being sane." Among other things, the patient must have enough control of him- or herself to be able to play a role, s/he must be able to monitor him- or herself well enough to understand what his or her social role is expected to be, and s/he must be suspicious of the doctors and/or the psychiatric institution. In short, s/he must be able to function in his or her role to the satisfaction of the institution. Fooling the doctors is therefore equivalent to being healthy for the institution. The nature of the institution means there can be no question of whether the patient is "really" better, or only pretending; the two states are identical.

Again, this is a question of the gap between the institution's mechanized view of the patient as symbol and the patient's view of him or herself. The patient as agent always exists in a space beyond the totalizing view of the institution and is hence after a certain point invisible to it.

The whole of me passed in full view before them, and when at last nothing was present but my perfect nothingness and there was nothing more to see, they ceased to see me too. Very irritated, they stood up and cried out, 'All right, where are you? Where are you hiding? Hiding is forbidden, it is an offense,' etc. (Blanchot 14)

On the one hand, this gap between agent and role means there can be no question of a "real" or "objective" cure; on the other, it provides some play in the system where the denied agency of the patient can work.

I actually was feeling somewhat better. The pressure of constant observation was returning me to a normal level of repression and I got some tips from some of the more seasoned patients on what the doctors looked for. After three more days I was allowed to go home. Now when I think back to my time in the hospital the main impression I have is one of being trapped. I also got pretty good at ping-pong. A few weeks after I got out of the hospital, I received a final reminder -- the bill, $11,000.

Money is a theme running discreetly under the surface of the institutional situation. Many of the deprivations of freedom the patients suffer (not being able to go for a walk, for example) can be traced to worries on the hospital's part of being sued. The fact that the patient is paying to be in the hospital runs in strange counterpart to this loss of agency. After all, the patient is being held accountable for the bill, even though s/he has no control over the length of the stay (witness recent allegations of hospitals unnecessarily committing people for their insurance money). This brings a new twist to Henry Miller's comment: "The analyst has endless time and patience; every minute you detain him means money in his pocket";[23] in this case, it is every minute he detains you.

In the end, then, the legal status of the patient is restored to him or her in the form of the bill. The hospital says, in effect, "You are now a legally responsible person -- we entrust you with the ability to pay us."[24] But the patient is not merely returned to his or her former existence. As we have noted, the hospital stay leaves marks, both intended and unintended, on the functioning of the now ex-patient, while the hospital churns on, processing new patients.

The stated function of hospitalization is to take in those who are labeled "insane" and return them to some level of normality. We see that the institutional machine does not function at this ideal level in its performance of its task. The institutional nature of the ward, with its emphasis on a mass-produced patient, demands a total abandonment of agency on the part of the patient, who is reduced to a cipher. At the same time it leaves an unmonitored gap between the ideal and the actual patient, a space where the real patient can maneuver. The institutional moment works both through and despite the point where the institution breaks down: the point at which the mechanical is not identical to the real.

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[1] Gilles Deleuze and Felix Guattari, *Anti-Oedipus: Capitalism and Schizophrenia*, trans. Robert Hurley, Mark Seem, and Helen R. Lane (New York: Viking Press, 1977) 151.

[2]This is my story in my words. I wrote them with this paper in mind, but before I wrote the paper.

[3]Deleuze and Guattari, *Anti-Oedipus* 149.

[4]Erving Goffman, "The Medical Model and Mental Hospitalization," *Radical Psychology*, ed. Phil Brown (New York: Harper Colophon, 1973) 30.

[5]Deleuze and Guattari, *Anti-Oedipus* 151.

[6]Maurice Blanchot, *The Madness of the Day*, trans. Lydia Davis (New York: Station Hill Press, 1981) 18.

[7]Deleuze and Guattari, *A Thousand Plateaus: Capitalism and Schizophrenia*, trans. Brian Massumi (Minneapolis: University of Minnesota Press, 1987) 80.

[8]If a patient voluntarily commits him- or herself, s/he can sign him- or herself out, but must wait three days before s/he can leave. In the meantime, s/he can be, and often is, committed by the hospital against his or her will.

[9]Mental Patients' Liberation Project, "Statement," *Radical Psychology*, ed. Phil Brown (New York: Harper Colophon, 1973) 521.

[10]Compare to Thomas Szasz: "[M]ental health is the ability to play whatever the game of social living might consist of and to play it well. Conversely, to refuse to play, or to play badly, means that the person is mentally ill."(T.S. Szasz, "Politics and Mental Health," *American Journal of Psychiatry* CXV [1958]: 509; cited in Erving Goffman, "Medical Model" 43).

[11]Goffman, "On the Characteristics of Total Institutions," *Asylums* (New York: Anchor Books, 1961) 16.

[12]Consider, for instance, that in many mental hospitals there is no individual psychotherapy; all treatment is done in group mode.

[13]PARRY is a program that simulates a paranoid schizophrenic. See Kenneth Mark Colby, *Artificial Paranoia: A Computer Simulation of Paranoid Processes* (New York: Pergamon Press, 1975).

[14]ELIZA is a computer program intended as a study in natural language communication. It plays the part of a Rogerian psychoanalyst. It is described in J. Weizenbaum, "ELIZA - A Computer Program for the Study of Natural Language Communication Between Man and Machine," *Communications of the Association for Computing Machinery*, 1 (1965) 36-45. To the shock of its programmer it was received with enthusiasm by the psychiatric community and was recommended for eventual therapeutic use in K.M. Colby, J.B. Watt, and J.P. Gilbert, "A Computer Method of Psychotherapy: Preliminary Communication," *The Journal of Nervous and Mental Disease*, 2 (1966) 148-152.

[15]Goffman, "Medical Model" 36. Compare to Ralph Ellison in *Invisible Man*: "[Y]ou don't have to worry about the brothers' criticism. Just throw some ideology back at them and they'll leave you alone provided, of course, that you have the right backing and produce the required results" (New York: Vintage, 1972) 350.

[16]Ken Kesey, *One Flew Over the Cuckoo's Nest* (New York: Signet, 1962).

[17]Goffman, "Medical Model" 34-35.

[18]David Cooper, "Violence and Psychiatry," *Radical Psychology*, ed. Phil Brown (New York: Harper Colophon,1973) 149.

[19]Daniel X. Freedman, M.D., foreword, *The Meaning of Madness: Symptomatology, Sociology, Biology and Therapy of the Schizophrenias*, by C. Peter Rosenbaum, M.D. (New York: Science House, 1970) xviii.

[20]Mark Seem, introduction, *Anti-Oedipus* xvii.

[21]Deleuze and Guattari, *Anti-Oedipus* 5.

[22]R.D. Laing, *The Divided Self* (Baltimore: Penguin, 1959) 148.

[23]Henry Miller, *Sexus* (New York: Grove Press, 1965) 429; cited in Seem xv.

[24]It might be interesting to speculate on the status of health insurance...