The Origins of Coercion in "Assertive Community Treatment" (ACT): A Review of Early Publications from the "Special Treatment Unit (STU) of Mendota State Hospital (2002). *Ethical Human Sciences and Services, 4* (1), 3-16.

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Abstract

This article argues that Assertive Community Treatment (ACT) is fundamentally and historically based on the uncritical but societally well accepted view that medically justified coercion (punishment or unwanted treatment) is therapeutic. It documents this claim by reviewing the early professional history and the resultant publications of the inventors of ACT (originally known as Training in Community Living), consisting of psychiatrists, social workers, and psychologists who trained and worked during the 1960s through the 1980s, at Mendota State Hospital (eventually renamed Mendota Mental Health Institute) in Wisconsin.

> We are all here on earth to help others; what on earth are the others here for, I don't know.
>
> W. H. Auden (1968)

Introduction

Programs of Assertive Community Treatment (ACT) are aimed at individuals labeled as "severely mentally ill". According to two ACT experts, including psychiatrist Leonard I. Stein, one of the inventors of this approach, ACT

> …is best conceptualized as a service delivery vehicle or system designed to furnish the latest, most effective and efficient treatments, rehabilitation, and support services conveniently as an integrated package. …ACT services are mostly delivered "in vivo," that is in the community where clients live and work. (Stein & Santos, 1998, p. 2)

ACT has been researched for nearly 30 years. It began as a program called Training in Community Living (TCL):

> Training in Community Living was the name given to the original ACT program; the name change took place many months into the experiment when it became clear that the program was doing much more than training and that the staff had to be quite tenacious in their work with clients. …The program was "assertive"; if a patient did not show up for work, a staff member immediately went to the patient's home to help with any difficulty that might be causing the problem. …Medication was routinely used for persons with

> schizophrenia and manic-depressive disorders. (p. 20, emphasis added)

Stein and Santos echo an official consensus opinion in the mental health field when they claim in a manual on ACT implementation, that

> No psychosocial intervention has influenced current community mental health care more than ACT. It has truly revolutionized how we provide services to help people suffering from severe mental illnesses … Further, the model is the most widely researched and validated service system available for the care of this group of disabled individuals. (1998, p. 3)

As of the year 2001, there were over 250 research articles on ACT in the PsycINFO database with 34 states using ACT or an adaptation and consuming well in excess of 160 million dollars per year. This apparent validation of the approach has led to a national effort begun in 1996 by the National Alliance for the Mentally Ill (NAMI)-- an organization made up of family members of psychiatric patients founded in 1979 in Madison, Wisconsin (Mosher & Burti, p. 343), the original site of TCL—and the TCL inventors to establish a national nonprofit agency (Allness & Knoedler, 1998) with the following agenda:

> Design and implement a means of rapid and effective replication of the PACT model of ACT;
>
> Promote a consensus among public mental health authorities, advocates, and service providers for adoption of national standards to set minimum criteria for ACT programs; and

> Influence state and local mental health authorities that have not already done so to adopt ACT as a core program within their service delivery system.
>
> To carry out the work of the NAMI/PACT Initiative, a new organization will be established, Programs of Assertive Community Treatment Incorporated (PACT, Inc.). PACT Inc. will be a private, nonprofit corporation with national focus and representation of consumers, family members, clinicians, administrators and researchers dedicated to the dissemination of the PACT model as the gold standard of ACT.
>
> (Community Support Network News, 1997, p. 10, emphasis added)

Given the number of publications, the expert consensus opinion, the political advocacy by supporters and the federal financial support all seeming to confirm the success of ACT, one could expect that no reasonable concern remains as to the efficacy of this program to

> …lessen psychoses (duration, intensity, frequency), maintain a substance free lifestyle, maintain decent and affordable housing in a normative setting, minimize involvement with law enforcement and criminal justice, acquire and keep a job, maintain good general health status, [and] meet other individual goals. (Stein & Santos, 1998, p. 2)

Indeed, one of the latest articles to appear in Psychiatric Services, a flagship journal of the American Psychiatric Association, is titled, “Moving Assertive Community

Treatment into Standard Practice" (Phillips, Burns, Edgar, Mueser, Linkins, Rosenheck, Drake, & McDonel Herr, (2001).

However, when critically evaluated, the empirical evidence contradicts this vast justificationary confidence. I have elsewhere offered an analysis of all the major claims of ACT programs (Gomory, 1998, 1999) and have shown that the statistically significant findings putatively favoring these programs are not the result of ACT-specific technology but are clearly due to such factors as:

> tautological outcomes (for example reduced hospitalization) based on administrative rules differentially applied to PACT and CONTROL groups, or are misattributions of worker activity as patient outcome (in employment), or are based only on data supporting various outcomes and the ignoring or minimizing [the] negative results which contradict such claims, or are based on manipulation of data to indicate significance for variables which are not supported by the data (by for example collapsing various outcome variables some of which are statistically significant, but are tautological, like number of hospital stays, and some which are not statistically significant but empirically important like less homelessness, or less time spent incarcerated, and suggesting that the significance found [derived from the tautological components] indicates treatment effectiveness for the non tautological components). Finally the conceptual analysis of this model demonstrates that this model is coercive and may lead to harm

> (excessive suicide among its treatment population for example).
>
> (Gomory, 1998, abstract)

ACT and Coercion

Researchers and psychiatric survivors have pointed out that ACT is highly coercive. For example, Diamond (1996), intimately familiar with ACT, pointed out that, along with various similar mobile, continuous treatment programs, [ACT] has made it possible to coerce a wide range of behaviors … Paternalism has been a part of assertive community treatment from its very beginning" (pp. 52-53). On the other hand, its proponents contend that ACT, like any other treatment model "has some potential to be used in a coercive manner" (Phillips et al., 2001, p. 777), but that coercion is only an unfortunate result if the program is misused.

One of the difficulties of addressing such questions rigorously in the field of mental health is that its professional knowledge tends to be ahistorical; given the enormous practical importance of this knowledge, little critical interest exists among mental health workers or academics for reviewing how psychiatric concepts, diagnoses, diseases or treatments evolve or develop over time (Bentall, 1990; Boyle, 1990; Szasz, 1976). The historical review of the issue of ACT coercion, how it was initially conceptualized and refined over time by the consensus experts, can provide important information for analysis bearing on the validity of ACT and can help in understanding the professional development (the learning history) and subsequent work of such professional authorities. According to Karl Popper (1979), the historian's task is

> to reconstruct the problem situation as it appeared to the agent, [so]
>
> that the actions of the agent become adequate to the situation. …

> Our conjectural reconstruction of the situation may be a real historical discovery. It may explain an aspect of history so far unexplained; and it may be corroborated by new evidence, for example by the fact that it may improve our understanding. (p. 189)

I propose to do this by an analysis of the ACT originators' publicly available writings and by testing their ideas against the particular era's best empirical research in an attempt to falsify the originators' assertions. This approach is associated with fallibilistic critical thinking explicated elsewhere (Gomory, 2001a, 2001b).

In this article I contend that the ACT model is innately coercive and rests on a view of mental health patients held by its developers as aggressive, willful actors who use various "weapons of insanity"

> in an unflagging war of attrition against staff's therapeutic efforts. The "hard core" patients are those who have successfully met and worn down staff group after staff group. (Ludwig & Farrelly, 1966, p. 565)

ACT clients are forced by aggressive workers to comply involuntarily with program demands and this activity results tautologically in the misattribution of worker behavior for that of the client (i.e., client is forced to show up at an employment site and is "helped" to stay there, which is then counted as a day spent by the client in voluntary employment for the purpose of ACT validation)

> In the early stages of PACT, consumer empowerment was not a serious consideration …it was designed to "do" for the client what the client could not do for himself or herself. Staff were assumed to

> know what the client "needed." Even the goal of getting clients paid employment was a staff driven value that was at times at odds with the client's own preferences.... A significant number of clients in community support programs … have been assigned a financial payee.... This kind of coercion can be extremely effective.... Obtaining spending money can be made … dependent on participating in other parts of treatment. A client can then be pressured by staff to take prescribed medication…. The pressure to take medication … can be enormous.... Housing is often contingent on continuing a particular treatment program or continuing to take medication. While control of housing and control of money are the most common … methods of coercion in the community other kinds of control are also possible. (Diamond, 1996, pp. 53-58)

In a coercive climate, forced or imposed client change is passed off as internalized or learned client change (Gomory, 1998, 1999).

The ACT technology does not do what its promoters claim for it and other interventions are available which do not present the additional burden of the possible adverse effects of ACT (Gomory, 1998, 1999). Coercive measures may result in involuntary compliance but may not win the hearts and minds of those so treated. As I will show in this paper, the development of the original model of ACT, Training in Community Living (TCL), and its coercive core was strongly influenced by the early experiences of its inventors doing research and providing community mental health treatment in a Wisconsin state mental hospital. These experiences defined TCL founders'

view of mental illness and of those who "suffer" from it, and have shaped the nature of the theories and methods the founders applied in the development of the TCL model. To evaluate whether or not coercion is the very essence of ACT, I offer the following review of the historical record of the developers of this program as they worked at Mendota State Hospital (renamed later Mendota Mental Health Institute).

The Early Coercive Activities of TCL Founders and of Their Teachers

The mainstream mental health historian Gerald Grob has provided a useful description of some circumstances characteristic of the problem situation in psychiatry between the two world wars that provided the framework which influenced our ACT developers when they began their careers some 20 years later,

> Having been trained and socialized as physicians, institutional psychiatrists were receptive to somatic therapies that went beyond custodial care of patients. The autonomy and independence enjoyed by physicians also precluded any legal or informal barriers that might have been imposed against the introduction of novel therapies whose effectiveness was questionable. … The receptivity toward therapeutic innovation was understandable. In one sense it grew out of psychiatry's attempt to emulate the alleged successes of scientific medicine. Just as surgery symbolized the success of scientific medicine, so too novel psychiatric interventions would demonstrate the specialty's ability to influence the outcome of mental diseases (Grob, 1983, pp. 289-291).

The relevant Mendota State professionals who impacted ACT development are (1) psychiatrist Arnold M. Ludwig, (2) the inventors of ACT, psychiatrists Arnold J. Marx, Leonard I. Stein, and psychologist and Professor of Social Work Mary Ann Test, and (3) somewhat less directly clinical social worker Frank Farrelly and psychologist Jeff Brandsma who together created a therapeutic approach called "provocative therapy" which was developed and tested at Mendota State (see Farrelly & Brandsma, 1974). Most of these individuals began their work at Mendota State in the late 1950s, early 1960s and many continued through the 1980s. In their edited book reporting on the first ten years of the TCL effort (The training in community living model: A decade in experience), Stein and Test (1985) corroborate my point that the development of professional thinking is strongly informed by the contextual learning history of the individual. They state:

> Ideas rarely arise de novo; they are generally formed from the building blocks of prior knowledge and experience. To become lasting, they must be nourished in an environment that is willing to set aside the accepted attitudes and practices that resist new concepts. (p. 7)

Stein and Test describe in the previous quote and the one following, what they believe was valuable about their experience at Mendota State Hospital that contributed to their own development as well as to the development of TCL:

> In the mid 1960's ... several psychiatrists [Marx and Stein] who had just finished their residency joined the hospital staff. These psychiatrists were imbued with the therapeutic zeal frequently found in young, uninitiated physicians. In addition, Arnold Ludwig joined

> the staff as director of research and education. His first two projects involved many members of the hospital staff. The projects represented … an effort to transform the hospital … into an institute whose primary goals were research, demonstration, consultation and training.
>
> One of Ludwig's projects involved the formation of a Special Treatment Unit (STU), a research unit whose primary goal was the development of new ... treatment techniques for chronic schizophrenic patients that could reduce or otherwise modify the chronicity that these patients had established. Through the programs of the STU, Ludwig, Marx, and Test demonstrated that a variety of novel psychosocial treatment techniques could make an impact on previously unresponsive patients and significantly enhance their in-hospital functioning. .... When Ludwig left in 1970 ... Stein took over his position as director of research and education, and Marx and Test assumed leadership of the STU. These changes in leadership made possible a ... shift in the direction that ... STU programs would take. ... The new project, ... Prevention of Institutionalization Project (PIP) was an extension and outgrowth of findings from the STU's research treatment programs for chronic schizophrenic patients. It extended what had been learned about chronicity and its treatment to ... prevention of chronicity. (pp. 7-9)

This quote establishes the intimate involvement of all the creators of TCL in the research done at Mendota State after the appointment of Ludwig as director of research and education, and suggests that what they learned from these projects formed the core of their understanding and treatment of patients (inpatient and TCL). Stein and Test (1985, pp. 15-16) provide a list of 9 articles published in mainstream American psychiatric journals during the heyday of the STU experiments roughly from the mid-1960s to the mid-1970s. Based on a selection from these sources and one article not referenced although co-authored by Stein (Brandsma & Stein, 1973), and mostly allowing the authors to speak for themselves, I will highlight the research done and the "lessons" learned by this group of professionals credited with pioneering ACT.

Client Descriptions

> It is becoming fashionable to view mental patients, especially chronic schizophrenics, as poor, helpless, unfortunate creatures made sick by family and society and kept sick by prolonged hospitalization. These patients are depicted as hapless victims impotent against the powerful influences which determine their lives and shape their psychopathology. Such a view dictates a treatment philosophy aimed at reducing all the social and institutional iniquities responsible for the patient's plight. However, in the process of leveling the finger of etiologic blame for the production and maintenance of chronic schizophrenia, theoreticians and clinicians have neglected another culprit--the patient himself. Professionals have overlooked the rather naive possibility that

> schizophrenic patients become "chronic" simply because they choose to do so. … In our own experience, the problem is not so much modifying factors outside the patient, but rather in changing certain patient attitudes and consequent behaviors … If he so desires, he can defecate when or where he chooses, masturbate publicly, lash out aggressively, expose himself, remain inert and unproductive or violate any social taboo with the assurance that staff are forced to "understand" rather than punish behavior. (Ludwig & Farrelly, 1967, p. 737-741)

Ludwig and Farrelly (1966) identified what they describe as the "Code of Chronicity" through the research conducted in the STU:

> Implicit in our discussion of the "code" are five important clinical "facts" which, we believe, underlie the behaviors of chronic schizophrenics. First, these patients can use their insanity to control people and situations. Second, they have an indomitable will of their own and are hell bent on getting their way. Third, one of the basic difficulties in rehabilitating these patients is not so much their "lack of motivation" but their intense, negative motivation to remain hospitalized. Fourth, insanity and hospitalization effectively pay off for these patients in a variety of ways. Fifth, these patients are capable of demonstrating an animal cunning in provoking certain reactions on the part of staff, family, and society at large which guarantee their continued hospitalization and its consequent rewards

> … in this article we shall term them the "weapons of insanity."
>
> (Ludwig & Farrelly, 1967, p.738)

The researchers found these patients to be

> Obviously ... not ... a group of fragile, broken-spirited persons but rather ... tough, formidable adversaries who were "pros" and who had successfully contended with many different staffs on various wards in defending their title of "chronic schizophrenic" (Ludwig & Farrelly, 1966, p. 566).

The treatment for such "tough adversaries" as mandated by Ludwig and Farrelly was remarkably similar to the powerful coercive paternalism practiced in ACT:

> To become well patients would have to think, feel, and behave as persons, similar to staff. The concept of normality and sanity as therapeutic goals were too intangible and vague; we would have to deliberately concretize these concepts by insisting that patients employ staff persons as models for behavior. Despite our visible faults, foibles, and inconsistencies, we would expect patients to "be like staff – warts and all." Furthermore, we would <u>not</u> play at democracy in therapeutic community meetings; not the majority, but health and sanity, <u>as defined by staff</u>, would rule. (pp. 566-567 emphasis added)

Compare Ludwig and Farrelly's description of STU treatment to a description of TCL from a sympathetic insider, psychiatrist Ronald J. Diamond:

> In the original PACT research project that began more than 20 years ago in Madison, Wisconsin, staff from a nearby state hospital provided community-based treatment for clients…. Paternalism was to a large extent accepted with little question. … Staff were assumed to know what the patient "needed." Even the goal of getting clients paid employment was a staff-driven value that was at times at odds with the client's own preferences. Current assertive treatment programs continue to be influenced by traditions … from this … history. Paternalism continues to be reinforced by mandates from the community to "control" the behavior of otherwise disruptive clients. (Diamond, 1996, p. 53)

Treatment Approaches used by this group

Stein, the Director of Research and Education at Mendota State Hospital in 1973, by which time TCL/ACT research was well on its way (see Marx, Test, & Stein, 1973), co-authored a study with the "provocative therapy" advocate Brandsma entitled, "The Use of Punishment as a Treatment Modality: A Case Report" (Brandsma & Stein, 1973). This study examined the value of using electric shock by means of a cattle prod without patient consent, as punishment to reduce allegedly unprovoked assaultive behavior of a "retarded, adult, organically damaged" (p. 30) 24-year-old woman. This single case design study was a follow-up to Ludwig, Marx (one of the ACT originators), Hill and Browning's (1969) study of the use of electric shock on a paranoid schizophrenic patient, "The Control of Violent Behavior Through Faradic Shock." These authors justified this last study by its "uniqueness." They listed four attributes of uniqueness, the third of

which was “the fact that this procedure was administered against the express will of the patient” (p. 624, emphasis added). The selection of the cattle prod as the “aversive conditioning agent” of choice by the STU researchers in both studies was explained this way:

> There were a number of reasons for choosing the cattle prod as the means of delivering the aversive stimulus or punishment. From a technical standpoint, this instrument (Sabre-Six model, Hot Shot Products Co.) seemed to represent an excellent device for providing a potent, noxious stimulus. It was capable of producing a faradic shock spike of approximately 1400 volts at 0.5 milliamperes, the resulting pain lasting only as long as the current was permitted to flow. … Moreover, when compared to the dangers and relative unpredictability of onset and duration of action of other aversive agents, such as emetic and muscle paralyzing drugs this instrument was far safer and could be applied in a more specific manner with a minimal time lag between appearance of the undesirable behavior and the aversive stimulus. Also from a practical standpoint, the instrument was portable, inexpensive and easy to use. (Ludwig et al., 1969, p. 627)

Prior to Brandsma and Stein's “experiment” the “organically damaged” subject named “Carol”, while at an another institution, had been

> secluded ... permanently and [had received] various drug therapies including Mellaril, Prolixin, Stelazine, Compazine, Phenobarbital, and Dilantin. These efforts failed to significantly affect her behavior and ... Carol was transferred to ... the state hospital [Mendota State Hospital] with the recommendation that she receive electroconvulsive therapy (Brandsma & Stein, 1973, p. 31).

At Mendota State Hospital the following "therapies" were tried:

> 1) High doses of Phenothiazines and combinations of phenothiazines: Results: no apparent effect on her behavior. 2) Primidone in the vain hope that her attacks represented adherent psychomotor seizures. .... 3) Dexedrine in the hope that the paradoxical inhibition often found in hyperactive children would result. Result: the patient got "high," but there were no affects on her assaultive behavior.[1] 4) Daily electroconvulsive therapy [twenty sessions]. Results: she became progressively more aggressive. (Brandsma & Stein, 1973, p. 31)

Evidently, these institutions were not providing thoughtful, high quality treatment, or even "standard" treatment based on empirical research (see Gelman, 1999, for the medication treatment research history on schizophrenia), but rather arbitrarily throwing every available chemical and physical agent (most of them highly toxic and dangerous) at this brain damaged individual who had been institutionalized from the age of 9 months,

[1] Surely some behavior was affected, since these and other drugs Stein's team administered at Mendota State Hospital were known to cause brain damage (tardive dyskinesia) in a high percentage of patients. As early as 1972 estimates ranged up to 41% of long term drug users being affected by tardive dyskinesia (Crane, 1968; Kazamatsuri, Ching-piao, & Cole, 1972); and by 1973 estimates ranged to over 50% of

to make her stop contextually problematic behaviors which were likely, due to her real physical problems (which included abnormal electroencephalograms, total Wechsler IQ score of 47, difficulties in moving about, partial deafness, history of grand mal seizures, possible tardive dyskinesia), to have been out of her control (Brandsma & Stein, 1973, p. 31).

The methodology of the experiment itself reveals how the authors approached another human being. To get a "baseline" measure of this brain-damaged patient's assaultive behavior, she was baited and ridiculed in order to get her to react aggressively,

> During the first session heavy canvas mittens were placed on the patient. ... The staff (five or more) people would sit very close to patient with a young female within striking distance. The patient was required to sit in an armchair throughout. .... During the base rate week the staff quickly developed a consistent provocative approach in order to ensure a high frequency of behavior from the patient and be generalizable to the frustrations she would encounter outside of treatment. This consistently involved: 1) ignoring the patient in conversation; 2) refusing to give the patient candy or snacks when others were eating them; 3) denying all requests, for example, during the session if she asked if she would be able to go for a walk that afternoon, she was immediately told, "No you can't."; 4) refusing to accept her apologies or believe her promises of good behavior; 5) The above mentioned female sitting next to her

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people suffering from this disorder among those patients using such drugs for 3 years or longer (Crane, 1973).

> often leading the provocation; 6) using provocative labels for her behavior, i.e., "animalistic, low grade"; 7) discussing family related frustrations, i.e., her mother's refusal to write or visit, how her dead grandmother would be displeased with her present behavior if she were alive. It should be noted that throughout the program the patient was kept in a seclusion room at all times except when involved in a baseline or treatment session. (Brandsma & Stein, 1973, p. 32-33, emphasis added)

In sum, rude, aggressive, artificial incitement by the staff was used to provoke an angry response from the patient; this elicited behavior then was used as a representation of the allegedly natural unprovoked, "baseline" assaultive behavior of the client. A true baseline for assaultive behavior would have to have been collected when it occurred, in situ, without artificial provocation by staff.

The administration of involuntary electric shock[2] as punishment is a clear human rights violation, even in the case of war. This "experiment" on a lifelong institutionalized person who is organically diminished due to repeated grand mal seizures and suspected brain damage (Brandsma & Stein 1973, p. 31), is reminiscent of the pseudo-scientific justifications for the inhumane experimentation on the frail, the deviant, and the racially impure during the Nazi era in Germany (Szasz, 2001, pp. 144-150). Brandsma and Stein's research is especially troubling because "punishment" had by this time (1973) been shown to be ineffective in increasing desired behaviors in human subjects (Azrin and Holz, 1966, pp. 438-443). Ironically, Brandsma and Stein cite the Azrin and Holz

[2] Not electroconvulsive therapy (ECT) or electroshock which is a highly problematic and controversial but widely accepted psychiatric tool (Breggin, 1979).

source to support their use of punishment: "These clinical reports back up the more controlled animal studies on punishment. For example … Azrin and Holz" (Brandsma & Stein, 1973 p. 36). In fact, Azrin and Holz's classic review argued the opposite, that punishment is ineffective in many situations, especially those involving human subjects, as a method of behavioral change. These authors actually argued that punishment has many disadvantages,

> The principal disadvantages of using punishment seem to be that when the punishment is administered by an individual, 1) the punished individual is driven away from the punishing agent, thereby destroying the social relationship; 2) the punished individual may engage in operant aggression directed toward the punishing agent; and 3) even when the punishment is delivered by physical means rather than by another organism elicited aggression can be expected against nearby individuals who where not responsible for the punishment. These three disadvantages seem especially critical for human behavior since survival of the human organism appears to be so completely dependent upon the maintenance of harmonious social relations. …We may conclude, therefore that the disruption of social behavior constitutes the primary disadvantage to the use of punishment. The changes in the punished response per se appear to be distinctly secondary in importance to the social products of the use of punishment. (Azrin & Holz, 1966, p. 441 emphasis added)

Despite the clear refutation of their claims in the very article Stein and his co-author cite as support for using a cattle prod for their brand of "behavioral" treatment, they go on to argue that as a result of their research,

> The extant literature now supports the assertion that "punishment therapy" is a useful tool to modify certain behaviors. … An ethical issue arises when it is contemplated for patients who do not volunteer for it as in the present case. Volumes can be written on that question. It seems to us, however, that when the patient's behavior is physically dangerous … it does seem ethical to utilize this technique with professional if not familial or personal consent. (Brandsma & Stein, 1973, p. 37)

But a close reading of their actual results demonstrates that the "punishment therapy" was not effective.

> Unfortunately the intensity of her now low frequency, occasional attacks was still sufficient to relegate her to a life of relative social isolation. (p. 36)

The researchers declared rationales for using the cattle prod in the first place—Carol's violent behavior and her social isolation—both continued, even one year after the experiment:

> The punishment contingency continues, Carol now continues in seclusion with only a few hours out per day when accompanied by a male aide (p. 35).

The client was left no better off after the coercive "treatment" than before and perhaps even worse off by being relegated to permanent solitary confinement.

Special Treatment Unit Research Publications

Overall the papers reporting on STU research activities cited by Stein and Test (1985) make for fascinating, if chilling, reading but are difficult to summarize briefly. A review of these articles suggests that the researchers followed their personal whims in deciding to what they should subject the captive STU clients. To obtain the full flavor of the researchers' attitude toward the inmates requires extensive quotation from their work. For example, in one article, Ludwig (1968) described an artificial social system concocted by STU researchers to propel 16 male and 14 female patients who were residing in the STU, into "sanity" - that is, the researchers' sanity:

> Rather than settle for the unhealthy and unstructured social system of patients, we decided to create a new artificial system based on certain rational principles of responsibility and sanity. Within the framework of this artificial patient society, we wanted to minimize reinforcement for crazy and maladaptive behavior and to maximize the rewards for responsible, healthy behavior. Since we felt it would be helpful for patients to gain a clear conception of where they stood in relation to other patients in terms of sanity, we constructed a social caste and class hierarchy consisting of seven separate levels. This artificial social system was designed to encourage vertical mobility, whereby patients could move up or down the levels depending on scores they received on their weekly behavior rating.

> The privileges and responsibilities of patients are strictly contingent upon their weekly social level. (p. 391, emphasis added)

Overall it appears that this early pre-TCL research sets the methodological tone for all the future research. No validity measures were reported for any of the numerous instruments described in this study. Ludwig (p. 396) did report a very high (.95) inter-rater reliability for one instrument, the STU Behavior Report, and claimed a study was done to ascertain it. He provided no citation for such a study or the methodology used. This behavior report (Chart D, Ludwig, 1968, p. 392) utilized a points system ranging from 0 to 4, for various sets of behaviors. This chart is reproduced in Table 1. Table 1 reveals the subjective and prejudicial nature of the various "behavioral" categories. For example, the awarding of 0 points, a low score (bad), to men for "queer" behavior (undefined), and a high score (good) of 4 for "masculine" behavior (undefined) or similarly for women, 0 points for "lesbian" behavior (bad) and 4 points for "feminine" behavior (good) discloses the biases held by the clinicians about sexual behavior.

These behavioral ratings were made by the clinicians. Depending on the weekly totals, which could range from 0 to 100 points, the clients were put in one of the seven "social castes" each week with their commensurate rewards and punishments (see Ludwig, 1968, Chart E, p. 393). No criteria were provided as to how these assessments were made. Ludwig did write that:

> Where disagreement concerning particular [behavior] ratings occurred among the staff, a vote was taken in the presence of the patient - the patient receiving the majority staff rating. (1968, pp. 391-392)

Another example of the approach employed by the researchers is the name they gave to one of the social levels (1968, see charts E & F, p. 393 & p. 395 respectively):

> In order to handle certain forbidden patient behavior … we constructed a special punishment category … We christened this level the "Mortal Sin" category. This category was reserved for patients who exhibited certain tabooed behavior – namely provoking or initiating fights, elopement from the hospital, fornicating, or performing perverted sexual activities on the ward. (p. 394)

For a "mortal sin", the following immediate restrictions applied:

a. Restricted to ward
b. No visitors, no presents—packages; restricted mail
c. No money
d. No desserts; no milk or coffee at all
e. No tobacco in any form.
f. No RT; no TV
g. None of other usual privileges

> The offending patient … additionally … will be required to confess his sin before his fellow patients in Community Therapy, to apologize to other patients … and to express his intent to behave better in the future. (Ludwig, 1968, p. 395)

Here is, finally, a description of one representative element of the Experimental Treatment Program at the STU apparently using "provocative therapy":

> Although brainwashing procedures at first appear alien to healing practices, they are indeed often similar in terms of techniques and desired goals. … Given these considerations, we have formulated a group designed to produce the maximal amount of emotional response and arousal in patients. In general, the group leader openly confronted patients with taboo topics and voiced criticisms of an unsympathetic society toward their deviant attitudes and behaviors. The crazy behaviors of patients were parodied and caricatured. Patients were badgered, pestered, confronted, challenged, derogated, ridiculed, and belittled in an effort to provoke protest, anger, irritation, discomfort and self-assertion. (pp. 387-388)

Discussion

From the potpourri of experiments carried out by the STU staff emerges a bewildering lack of ethics, logic, empirical coherence, scientific reliability or validity. It appeared to be no problem for these researchers to replace science with the methods of popularity contests (behavioral contingency points awarded to STU clients by worker consensus, see Ludwig, 1968, pp. 391-392). The kinds of coercive and intolerant approaches exemplified by these "research" efforts speak for themselves as to their social and therapeutic usefulness. They have none. The treatment methods and assessment instruments used were arbitrary, subjective and biased, without any credible evidence offered by the authors for their use or their reliability and validity. The authors simply

declared the scientific validity of their experiments while using professional authority to impose them on the clients, who were all confined in the institution involuntarily. It should be noted that all of these articles were published in "top draw" psychiatric journals (e.g. Archives of General Psychiatry; Journal of Nervous and Mental Disease).

These researchers disregarded the then available scientific evidence invalidating their approach; and disrespected the personal autonomy and human rights of their clients. They substituted a justificationary euphemism "professional consent" for the reality of their imposed coercive authority on unwilling inmates when applying their "punishment therapy" (Brandsma & Stein, 1973, p. 37). This empirical work is in dramatic contrast to the ACT/TCL model originators' self-serving contemporary declarations about mental health client suffering and courage, which do not mention these never repudiated experiments. The authors theorized about the nature of the problems of their charges and contrived experiments to alter the clients' "problematic" behavior as if their imprisoned status had no impact on their behavior or on the outcomes. I believe that this research created the framework from which ACT/TCL grew. The expressed view that these patients were cool calculating customers "hell bent" on making trouble and therefore in need of severe punishment and "provocative" therapy in order to force them to be "sane", currently more palatably discussed as aggressive/assertive treatment or involuntary treatment/paternalism, permeates this early research.

The ACT inventors have continued to resist seeing their so-called treatment as the problem itself. In fact, against published evidence to the contrary (some of it quoted in the present article), they deny ever-using coercive methods in ACT.

> The assertive community treatment approach never was, and is not now, based on coercion. (Test & Stein, 2001, p. 1396, see the extended debate between the present author and Test & Stein: Gomory, 2001c; Gomory, 2002; Test & Stein, 2001)

The ethical disconnect is indeed deep in the field of mental health. There is a thriving body of research examining the therapeutic value of coercion supported by the National Institute of Mental Health and major foundations such as the MacArthur Foundation (Dennis & Monahan, 1996, p. 15). The deprivation of autonomy and freedom is increasingly seen as a therapeutic tool rather than a human rights violation. An entire text entitled Coercion and aggressive community treatment: A new frontier in mental health law, is devoted to exploring and thereby legitimating this view (Dennis & Monahan, 1996). Coercion as treatment is manifested in the current ACT approach by procedures which predicate the freedom of clients from being involuntarily hospitalized on such things as taking highly-toxic psychotropic medication prescribed by psychiatrists (regardless of research suggesting little if any efficacy outside of tranquilization), or by submitting to court ordered treatment, or by accepting mandated financial payees who control the clients' entitlement monies. Even the power to coordinate community services among clients' treatment and support systems in ACT (argued to be a good thing by proponents) "allows enormous pressure to be applied … [to] 'follow the plan' in any number of ways [and] can be …as coercive as the hospital … but with fewer safeguards" according to Diamond (1996, pp. 53-58).

The ACT approach relies on the notion that any means including coercion of the individuals composing the target population are justified to attain societally "desired"

"healthy" ends (for a strong critique of such putatively helpful "public health" treatment policies see Szasz, 2001). Like many totalitarian and authoritarian dogmas that rely on coercion (e.g., Communism or Fascism) once the coercion is removed the oppressed group rejects the dogma. This is demonstrated in our case both by the well-known disappearance of ACT "treatment effect" once treatment is discontinued (Gomory, 1999) and by the existence of a very active psychiatric survivors protest movement.

Assertive Community Treatment or ACT is largely a euphemistic label for coercion, which has a long history in institutional psychiatry and is exemplified by the research done in the STU of Mendota State Hospital during the Ludwig, Stein, Marx, Test, Farrelly and Brandsma era. This era was the proving ground for the developers of ACT-type programs. If we ignore such history or the lessons to be learned from it, then, as the adage goes, we might be condemned to repeat it.

I conclude this paper by citing the views of Arnold Ludwig, founder of the STU and the Director of Education and Research at Mendota State Hospital, on punishment. Arguably, these views represent the past and current thinking of the ACT researchers quoted (Stein, Test and the deceased Marx), since none of them has to my knowledge ever renounced them and since references to the articles reviewed in this paper appeared in later publications on the TCL model, by these researchers (Stein & Test, 1985, p. 15). Typically, Ludwig's comment provides an earlier era's more honest, unvarnished justification for all the mental health technologies of coercion including those currently camouflaged as "aggressive" or "assertive" community treatment (Diamond, 1996) or "outpatient commitment" (Torrey & Kaplan, 1995):

> One of the immediate ethical issues involves the use of punishment for patients. Without delving into all the aspects of this problem, ... we will simply say that this issue is largely artificial or moot, for there are no psychosocial techniques for instituting human behavioral change which do not employ the very potent tools of both reward and punishment. Even those programs, which espouse only benevolent approaches, make liberal use of such negative reinforcements as withholding privileges, withdrawing love or approval, restraints, and seclusion, ECT, and drugs for the avowed purpose of "controlling" patient behavior, but the rationales offered are often only euphemistic or socially condoned excuses for subtle or blatant punishments. The issue is not whether punishments should be used; they are and will be--this is simply a fact of all clinical and social life. The real issue is whether punishments will be administered openly, non-apologetically, and in a consistent, systematic, goal-oriented manner rather then on a disguised, apologetic, whimsical and haphazard basis. (Ludwig & Farrelly, 1967, p. 746-747)

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Table 1: STU Behavior Report (reproduced from Ludwig, 1968, chart D, p. 392)

0 points	2 points	4 points
Personal Appearance		
1. Dirty	So - so	Clean
2. Sloppy	So - so	Neat
3. Bad taste (clothes)	So - so	Good taste
4 Lousy Posture	So - so	Good posture
Personal Housekeeping		
5. Dirty	So - so	Clean
6. Sloppy	So - so	Neat
Work		
7. Goof-Off	So - so	Good worker
8. Snotty	So - so	Respectful
9. Inefficient	So - so	Efficient
General Behavior		
10. Crazy	So - so	Sane
11. Obnoxious	So - so	Pleasant
12. Big mouth	So - so	Tactful
13. Hating	So - so	Considerate
14. Belligerent	So - so	Peaceable
15. Greedy	So - so	Generous
16. Irresponsible	So - so	Responsible
17 Stubborn	So - so	Cooperative
18. close-mouthed	So - so	Open
19. Glob	So - so	Alive
20. Lazy	So - so	Energetic
21. Passive	So - so	Initiative
22. Blah	So - so	Creative
23. Vulgar	So - so	Polite
24. Tramp	So - so	Modest
25. a. Queer	So - so	Masculine
b. Lesbian	So - so	Feminine
Total Behavior Points		
Less: 1/2 # wrong on weekly quiz		
Total Score		