Reviews & More

Genie: A Scientific Tragedy. By R. Rymer. NY: Harper Perennial, 1994. **REVIEW AVAILABLE ONLINE @ www.srvip.org**

Reviewed by Bill Forman

This harrowing story describes how Genie, a young girl, is raised by an abusive father to have almost no contact with other people from a very early age. She is tied into her bed or on a potty training seat, and shut in a darkened room. Her father does not permit any contact with her, and intermittently barks like a dog at her door when she makes noises. When, upon her father's death, she is finally liberated, she becomes an object of curiosity for the professionals who uncover her. Despite the efforts of one loving social worker who wants to make a home for her, Genie becomes a scientific commodity. The fact that she acquires a certain level of language proficiency disproves the Chomskian theory of language development, but at a terrible cost to the child. For the Social Role Valorization instructor, this book is invaluable, however horrific. It does indeed make an inarguable point about the developmental model but, more importantly, it shows the importance of family and the dangers of professionalism run rampant. Genie's humanity is first denied by the abusive conditions of her home, and then consumed by the dehumanizing machinery of professionalism that swallows her up.

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This Mayor's Decree: Smile. By C. Kilgannon. New York Times, online version 22 March 2013; print version 24 March 2013. **REVIEW AVAILABLE ONLINE @ www.srvip.org**

Reviewed by Bill Forman

The 'Local Character:' A Social Role with Real, but Tenuous Value

Occasionally, various popular media feature stories about someone who is a fixture in a local neighborhood or community, but who occupies few, if any, major normative roles. The person is often viewed with affection by others in the neighbourhood; the stories tend to be quite sentimental and inspirational in both intent and content. Typically, the person described has a (sometimes great) number of regular contacts and activities, some attached to minor social roles. Often, these people are eccentric or disabled in some way, and differ in their behavior, lifestyle and competencies. They are treated as colorful 'local characters.'

One such story, 'A Keeper of Memories,' in the March 24, 2013 edition of *The New York Times*[1] describes the lifestyle and some of the life history of a man named Bobby Fibel, who lives on Broadway, in New York City, near Columbia University. The article begins "Every neighborhood in New York City has its unofficial mayor, and Morningside Heights has Bobby Fibel." Elsewhere in the article he is referred to as the "King of Broadway."

Mr. Fibel did not finish grammar school, and took odd jobs as a boy. Now 69 years old, he still earns spending money by running errands for the merchants of his neighborhood. The article attributes his lack of a "more regular job" to his being "intellectually delayed."

Stories like Mr. Fibel's are often held up as proof of the continuing existence of 'community' in a broad sense: social comity, good will and a commitment to one's vulnerable neighbors, albeit in small, contained locales. From the article:

> *"This neighborhood is his universe," said Michael Zoulis, co-owner of Tom's Restaurant. "The way he lives, it's like something you'd have in a small town, not in Manhattan."*

It is difficult to characterize the social role for people such as Mr. Fibel. In earlier times, such people may have been 'village idiots.' The village idiot was at one time a formal role, to which one was elected or relegated by the consensus of one's community. In later times, the role and its title persisted, but were informally attributed. In modern parlance, it is a pejorative.

The village idiot role may not, however, be an adequate term for people such as Mr. Fibel. In spite of his disability, lack of typical major social roles and (in some regards) low social status, Mr. Fibel does seem to enjoy a level of personal respect and affection from his neighbours.

People in similar circumstances might also be seen as mascots for socially valued others. The mascot role is a common one for many devalued people, and can be imposed at all stages of the lifespan. It is a variation of the role of trivium.

Some valued persons found in valued social roles may have characteristics in common with the ones in question here. Privileged people sometimes filled the roles of 'man about town,' 'bon vivant,' etc. Many people who occupy such roles are not dependent on employment for income, and so have no work or career roles. Their activities and roles focus on socialization. One social role useful for a comparative SRV analysis of people like Mr. Fibel might be that of the 'flâneur.'

The concept of the flâneur seems to be peculiar to French urban culture and language, though it has wider use[2] and multiple meanings. Webster's Online Dictionary[3] defines it as an "an idle man about town." The term may still apply in Parisian life. A headline in a recent *New York Times* travel section is titled "Paris: Four restaurants for the flâneur."

Even if one were to choose the life of the flâneur, many modern cities, especially North American

ones, are not characterized by either neighborhood stability or a vibrant street culture, both of which work against the achievement of the flâneur role.

There are some important differences between Mr. Fibel's social roles and that of the flâneur. One is the protection provided to the latter through social status and economic means. The flâneur is someone who has the economic means to pursue his lifestyle without holding down regular employment and relying on the income. He also enjoys a high social status as part of café society.

Mr. Fibel, on the other hand, is reliant on his social security cheques, pocket money earned through errands, and free meals provided by the restaurateurs and barkeeps of his neighborhood. (He does, interestingly, have more than sufficient shelter–a 5 bedroom (!) rent controlled apartment on Broadway.)

Mr. Fibel was raised by an aunt and, one assumes from the article, continues to live in her apartment. He has a part-time home attendant on weekdays. The article states that he is supported by neighbors, and receives much in the way of free goods, food and services from sympathetic shop owners in the neighborhood. It also describes some less appealing aspects of his lifestyle: his apartment is "sparsely furnished" and he sleeps on a couch, covered by a thin blanket. He sits in a folding chair, watching television while keeping "one eye on Broadway."

Though not always attributed to SRV or Wolfensberger, many human services support people with disabilities to attain and maintain social roles, including avocational ones. Roles that are enacted during the day that are not work or career related are challenging to imagine and construct, as most people of working age are at their workplaces, acquiring skills and competencies for a career, or looking for work. The work roles in turn lead to fulfilling social relationships.

Often, human service workers and agencies will default to accompanying the people they support, either individually or in groups, to a patchwork quilt of activities that hold little potential for either social inclusion or relationships, and contain little or no elements of role identity. These activities, based in community settings, are counted as successful 'inclusion,' ranging from walking through shopping malls to sitting in coffee shops to recreating and exercising.

While Mr. Fibel's life and lifestyle does include more positive elements than those described above, it also contains some vulnerabilities. His neighborhood is, for the moment, filled with places where he is known and welcome, and includes many people who seem to 'look out' for him. Neighborhood gentrification can change all that quickly. When just a small number of people, businesses or social locales (or even only one), disappear, the character and comity of a neighborhood can change rapidly. As Mr. Fibel lives alone, one wonders if any of the neighborhood people currently concerned with his well-being would sustain their relationship with and commitment to him, should they be displaced or choose to move. Mr. Fibel's current lifestyle is sustained by a network of such relationships, and contains few major social roles or essential responsibilities to tie him to others. As he ages, the question raised is how much more support he will require to care for himself. Living alone may present new challenges, and he may require the concerted, committed advocacy of one or a number of people around him to ensure his well being, independence and participation in community life.

There are, to be sure, many positive aspects to Mr. Fibel's story, which can be instructive to human services and others struggling to help people acquire non-vocational social roles during the day. Mr. Fibel lives his life and is seen as a unique individual. He is not part of a group of people with disabilities that participates in community settings and activities, mediated by human service involvement. Mr. Fibel's roles and lifestyle seem, from the evidence in the article, to have been almost entirely constructed not by human services, but, rather, voluntarily by his fellow citizens in

Morningside Heights. As such, it may be more organic; free from the constraints of human service priorities, funding and regulations, and derived from a freely given and affectionate motivation.

The article is also written in the vernacular, and so is both understandable and compelling to non-professionals. The narrative is inspiring in how it describes how caring citizens can respond to potential vulnerability without formal intervention from human services. It does describe some instrumental support he receives from his community, some genuine, though minor, roles and responsibilities, and some affectionate relationships. Lastly, it does describe a neighborhood where some degree of social cohesion and comity does exist, however tenuous that might be.

It is not constructive, however, to be romantic or seduced by this type of story. As noted earlier, the good life that Mr. Fibel currently enjoys (at least as described in the article) may be tenuous, and secured only by the good will in his current relationships. He has many vulnerabilities and the article does not indicate that any conscious analysis or planning has taken place to safeguard against these. It would be misleading to equate his role with that of the man about town or flâneur, as the latter have many other powerful safeguards in the form of income, social roles and high social status.

William Stringfellow describes a similar phenomenon in his book "My People is the Enemy,"[5] when he talks about the plight of African Americans in New York , who are similarly trapped in a vocational underclass.

> *Kids like Bob go to school and receive nothing there which fits them for life and work in the city. If the young person is conscientious, as Bob was for a while, he tramps the streets and tries and tries to get a job. But because of his … functional illiteracy, and because his clothes may not be as presentable as other applicants,' because he's not a member of a particular union, and finds that he can't get into it when he applies, he ends up, if he's lucky, with some part-time, short-term, marginal, menial job.*

Articles like this one could be very useful in teaching the implementation of SRV, especially if the instruction includes an analysis of their shortcomings. Another resource is a documentary film called "The Collector of Bedford Street." It describes a man, Larry Selman, who also lives in a neighborhood of New York City.[6] Like Mr. Fibel, he had little in the way of typical career roles (though he was a dedicated and tireless fundraiser for charities), and was seen as something of a 'local character.' Unlike Mr. Fibel's story, the film describes how his neighbors undertake a very conscious and concerted strategy to address his vulnerability. When the family member upon whom he relied for financial and instrumental support, monitoring and decision-making was no longer able to carry out that role, Mr. Selman's neighbors formed an "Adult Supplemental Needs Trust," sponsored by the Bedford-Barrow-Commerce Block Association, through the UJA-Federation Community Trust for Disabled Adults. This trust established by his neighbors was the first time a group other than family had done so through the UJA Federation. It allowed Mr. Selman to continue living in his apartment and neighborhood. Mr. Selman died on January 20, 2013 at age 70.

Yet another danger is that articles such as this one can paint 'community' as magical, and romanticize its capacity. Deinstitutionalization and community inclusion efforts have fallen prey to this, with disastrous results. Efforts to secure vulnerable people in social roles and community life typically require analysis and coherent strategies and models. To merely hope that the good things in life will emerge by 'being in community' is naïve at best.

References

1 *New York Times*. March 24, 2013 (no author).

2 "There is no English equivalent for the French word flâneur. Cassell's dictionary defines flâneur as a stroller, saunterer, drifter, but none of these terms seems quite accurate. There is no English equivalent for the term, just as there is no Anglo-Saxon counterpart of that essentially Gallic individual, the deliberately aimless pedestrian, unencumbered by any obligation or sense of urgency, who, being French and therefore frugal, wastes nothing, including his time which he spends with the leisurely discrimination of a gourmet, savoring the multiple flavors of his city." (Cornelia Otis Skinner, *Elegant Wits and Grand Horizontals*, 1962, New York: Houghton Mifflin).

3 Webster's online dictionary.

4 *New York Times*. Sunday, April 21, 2013. (no author)

5 Stringfellow, W. (1964). *My people is the enemy: An autobiographical polemic.* New York: Holt, Rinehart & Winston.

6 Elliott, A. (2002). *The collector of Bedford Street (*film). Welcome Change Productions.

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The Lobotomy Letters: The Making of American Psychosurgery. By Mical Raz. Rochester, NY: University of Rochester Press, 2013, xii, pp 166, illustrations, endnotes, index, $85 US hardcover. **REVIEW AVAILABLE ONLINE @ www.srvip.org**

Reviewed by Thomas Malcomson

The Story Is In The Letters

Dr. Mical Raz has written a detailed account of America's most avid promoter of lobotomy, neurologist and pathologist Walter Freeman. It is a different approach than other histories of psychosurgery, in that it attempts to let the contemporary context carry the evaluation of this procedure rather than to look back at it with distain. He also focuses on one physician's (albeit a major proponent of and innovator in the technique of lobotomy) use of the method to treat people experiencing mental disorders. To this end he uses the personal files and letters of Dr. Freeman to tell the story. The book that is produced is interesting but it is not for the novice; some general knowledge of the brain, psychosurgery and basic psychoanalytic theory is required to get the most out of the volume.

In the first section of the book, Raz locates lobotomy in the context of the psychiatric and medical thinking of the mid-20th century. It is apparent that lobotomies were developed within the professional conflict that arose between neurologists, psychiatrists and neurosurgeons during the late 1920s and early 1930s. Each of these areas attempted to use the new research into the brain and mental disorders to create an approach that could give them an effective treatment over the seemingly untreatable problems. The second half deals with Freeman's use of lobotomy, his innovation, how he judged success, and his abundant correspondence with ex-patients and their families.

One of the major issues in understanding the brain at this time was the debate over whether capacities or functions were localized at specific spots or distributed more holistically across the brain. Freeman rejected the holistic approach, instead holding that specific functions had specific spots in the brain. In terms of mental disorders, the problem was the interaction between the person's foresight and insight, two elements of the personality located in the frontal lobes (at the front of the brain behind a person's forehead) and the thalamus, a brain structure located slightly lower in the brain, which controlled emotional responding (among other things). Freeman saw mental disorder as an imbalance in the thalamus's involvement with the frontal lobe; the emotional element invading, in a sense, the personality's abilities of foresight and insight, causing a person with a disorder to focus too much on their own emotional interpretation of the world. The theory suggested that lobotomy disconnected the frontal lobe from the thalamus and thus turned the emotional focus away from the individual and outward to their surroundings. What the person lost in the process was their foresight and insight.

Originally the lobotomy was performed in a surgical procedure where the neurosurgeon would drill a hole in the skull of the patient just above each temple (called a craniotomy). A surgical blade would then be inserted to a pre-determined depth, moved back and forth and then removed, the hole being closed over. In this format the patient would be anesthetised and x-rays used to guide the insertion of the blade. This was a lengthy procedure and, with exposing the brain, patients could contract fatal infections. While he learned to do lobotomies this way Freeman developed a radical alternative procedure. In 1947 he created an instrument, called the leucotome which resembled a long thin ice pick, with markings to indicate the distance along the shaft from the sharp point. This instrument was inserted between the patient's nose and their eye. When the leucotome reached the back of the eye and the transorbital bone of the eye socket, a small hammer was employed to drive the instrument through the bone

and into the brain. After moving it back and forth horizontally and then vertically in a prescribed arc the instrument was removed. The same area cut by the craniotomy procedure was sectioned by the transorbital method. The difference was that Freeman's innovation was quicker to perform, could be done by non-neurosurgeons, on an outpatient basis and led to fewer cases of infection. It did not use x-rays to guide the placement of the instrument, occasionally resulting in patients having to have the procedure done more than once to get it correct. Failure to know the exact position of the leucotome sometimes caused profound impairment and even death, when the instrument was placed too far into the brain. Not everyone approved of the new technique, especially the neurosurgeons who saw themselves being excised from the procedure. Dr. James Watts who had practiced, explored and wrote about lobotomy with Freeman eventually stopped working with him over disagreements about the new technique.

Freeman employed a childhood metaphor to address the condition many patients' found themselves in after the procedure. Freeman suggested that the lobotomy reduced the person to an infant-like state requiring them to re-learn appropriate behaviour (much like a child), in order to be socially competent. Raz states that seeing them as child-like "was a form of management of frustration, as caregivers and nurses were encouraged to punish and even spank the patient [an adult] as part of their treatment" (p. 4). The best case scenario was the return to adult-like behaviour without symptoms of the former mental disorder. This ideal state did not occur often and when it did it was usually short lived as symptoms of mental disorder returned. Many lobotomy patients lost the ability to plan or coordinate their daily life, were emotionally flat, many fell silent, incontinence was not uncommon, along with the failure to understand the consequences of behaviour, and occasionally epilepsy resulted from the procedure. This state which Freeman labeled as child-like was a permanent state for many. SRV's greatly discouraged image of the eternal child was within the practice of lobotomy a totally acceptable state (if not the preferred state) and considered at least a partial success.

It is clear that Freeman saw the operation as the last opportunity for patients with major mental disorders to be cured and to return home to their families. He followed up each case with repeated examinations and letters asking for an update from the patients who were no longer near to where Freeman's practice was located. He appears to have kept all correspondence with his patients. When travelling across the United States, he would visit former patients to see for himself their progress or lack thereof. This man believed totally in his method and did care deeply about his patients though only within his framework of the cause and treatment of mental disorders. He viewed failure to improve as not so much his fault but resting in the profoundness of the patient's mental disorder or the failure of patient or family to engage in the proper post-surgery rehabilitation.

Success for Freeman was judged by the patient's ability to assume some form of employment, from paid work or performing unpaid house cleaning chores. Work was a sign of adulthood and adjustment. It also meant the person could leave the institution, provide for themselves or help maintain a household and not be dependent on the state. If we stopped here with his view on work and returning home, SRV theory's position on valued roles and good living arrangements would appear to be met. But Freeman's perspective did not value the job or home as the ultimate end goal; it was rather to save tax dollars needed for institutionalization and/or care in the community, a true utilitarian perspective. He held that saved public funds even outweighed the grievous side effects many patients lived with for the rest of their lives.

For this reviewer, the most troubling aspect of the book is the clear sense from the letters of patients and their families that many of them saw (like Dr. Freeman) this treatment as a last hope

to end the patient's struggle with mental disorder and return them home to their family. The disturbing element is that they tended to view the outcome as fulfilling that wish, regardless of the physical and psychological impact the lobotomy actually had (see p. 93). Letters to Freeman from patients and their family members speak of dealing with the side effects of the operation, in some cases the operation's clear failure to 'cure' their relative by any stretch of the imagination, but none given in the book criticize or blame Freeman. Most matter-of-factly report the patient's condition, thanking Freeman for his letters asking for an update on the patient. A few speak of the agony of the return of the mental disorder and the patient's deterioration, one even asking for another lobotomy (which Freeman said was not possible). Some even asked Freeman's opinion on other life decisions, clearly respecting and admiring the man who performed the lobotomy on them or their relative. There is a profound sense of strength in the "voices" of the patient and the family in the letters, but they are here largely in the role of supplicant to the great physician.

Raz views the praise and acceptance of the outcome (even when it is poor) by patient and relative as the same as the acceptance of this procedure by neurosurgeons, neurologists, psychiatrists and other physicians and institutional administrators as providing the context in which lobotomies could be continued to be performed, even without truly significant patient improvement (p. 99). Only when the "new" psycho-pharmacological approach was shown to alter symptoms of mental disorders and the understanding of the brain advanced past that of the 1950s did lobotomy begin to look primitive and ill-advised. Freeman performed his last lobotomy in 1967, killing the patient and thus losing his hospital privileges. The remainder of his professional career was marked by Freeman's descent from notoriety and the rejection of his ideas.

The faith in "new" technologies to bring healing and cure is a big part of this narrative, though not really touched on by Raz. The story of Freeman and that of his patients and their families, as told in the letters, is about the way that an idea, not truly tested, escapes into the theatre of practice where it is enacted repeatedly and is hailed as a success, even though it often left a person impaired. The rush to acceptance is fueled by a desperate hope within physician, patient and/or family to find a cure, a fix, for the patient's troubling state of being. In the case of the lobotomy, it would appear an emotionally flattened, lethargic, uncommunicative outcome was considered better than being in the grips of the mental disorder.

The book's three images include two photographs from Freeman's work with lobotomy patients and a cartoon representation of the relationship between lobotomy and a variation on the psychoanalytic model of id, ego and super-ego. One image in the book is that of an "adult" patient's teddy bear, sitting on a bed. The teddy bear has a bandage around its head, we are told, like that of its' owner (112). The lone figure is an example of a follow-up chart for a lobotomized patient. Ample endnotes provide direction to both primary and secondary sources used in the book. The index is brief but workable.

Those with an interest in medical history, especially in psychosurgery, will find this book informative. People engaged in studying or involved in the application of SRV will find the book provides a clear example of three things; 1) the casting of patients into the role of eternal children, 2) compliant response of patients and their families to the physician's explanations and treatments of the patients' mental state, and 3) the use of a physical 'fix' for conditions deemed problematic even after the 'fix' does not deliver.

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A Beautiful Mind: The Life of Mathematical Genius and Nobel Laureate John Nash. By Sylvia Nasar. New York: Touchstone Book (Simon & Schuster). Trade Paperback, 461 pages. **REVIEW AVAILABLE ONLINE @ www.srvip.org**

Reviewed by Ray Lemay

This biography is the now famous story of John Forbes Nash, the American mathematics genius, born in 1928, who is the subject of a fictionalized film biography by the same title. There is much in this story that is instructive about schizophrenia and the power of social roles to protect and to aid in a person's eventual recovery. This story allows one to ponder Social Role Valorization's possible application in a field other than intellectual disability.

John Forbes Nash was an odd little boy growing up, and though he showed sparks of genius, it was only when he got to the university that it was clear that he had a great mathematical mind.

He first took up engineering at the Carnegie Institute of Technology in Pittsburgh and then, because he showed real promise, was offered a scholarship to attend Princeton University, then the epicenter for mathematics in the United States, where one found individuals such as Albert Einstein, Kurt Gödel, J. Robert Oppenheimer, and John von Neumann, some of the leading lights in physics and mathematics in the world.

Nash reached Princeton in the fall of 1948, but he attended few classes and mostly worked on his own. He was a good-looking man, physically fit and very brilliant, he had an incredibly intuitive mind that could make great leaps of logic that quickly grasped unforeseen and surprising solutions for very difficult and arcane mathematical problems.

Nash had an inquisitive mind and worked on many problems at once. He sought out the great names at Princeton, not as a student, but rather as an equal trying to work on some of their problems. For instance, he looked up Albert Einstein at one point to discuss a mathematical solution for a problem that Einstein had been pondering.

The Princeton department of mathematics was then a place where there was much camaraderie, discussion, much informality, and much game playing, particularly chess, go, and many other games with mathematical permutations. In 1949, Nash invented a game that quickly took over the common room where everybody played it. The game was independently invented by another mathematician, and the board game company, Parker Brothers, eventually marketed the game as HEX.

Nash's claim to fame concerns what is now called Nash's Equilibrium, a game theory that deals with the process of bargaining. It is a complex but, we are told, elegant theory that explains how individuals behave when competing against each other. The theory challenged the orthodox economic beliefs of the day that were then still tied to Adam Smith's theory of free markets and competition, and it has far reaching implications for economics, political science, world trade, bargaining, and international relations. He developed this theory over time, however he finally published it in 1949 in his second year at Princeton University. The equilibrium theory also served as Nash's Ph.D. thesis and eventually won him the 1994 Nobel Prize for economics.

Nash went on to be a consultant with the RAND Corporation, a very high profile military think tank, and in 1951 became an instructor at the Massachusetts Institute of Technology (MIT). In 1952, Nash had an extended affair with a woman called Eleanor Stier who was somewhat older than he. He never married Eleanor but he did have a child with her, John David. At the same time, Nash's life was becoming fairly erratic and he was already showing early signs of his coming breakdown. His erratic behavior also showed up at work. However, mathematicians, by and large, are pretty bizarre people and there is usually a very high level of tolerance in mathematics departments for eccentricities and bizarre behavior. He was involved in a few brief and short-lived homosexual relationships over this period of time

and in 1954, while still working at the RAND Corporation, Nash was arrested for exposing himself and soliciting a homosexual encounter in a public bathroom. He was not prosecuted, but he was fired from the RAND Corporation.

In the same year at Cambridge, he started going out with one of his former students, Alicia Larde, a very beautiful and brilliant young woman from a distinguished South American family. Nash courted Alicia for a fair amount of time and they were finally married in 1957. Alicia was aware of his now ended affair with Eleanor and of the existence of his first son.

From 1950 to 1956, Nash published a number of papers on important mathematical problems and his repute as a first class mathematician became well established. He was now known at MIT, in the United States and elsewhere in the world as one of the finest mathematical minds in the world.

In 1957, he started to tackle one of the most important problems in mathematics that remains unsolved today: the unresolved contradictions in quantum theory. Indeed, in 1995, Nash suggested that it was this work that eventually led him off the deep end and to his schizophrenia. Nash's first breakdown occurred in February 1959 when he was just barely 30 years old. It would seem that age here might have been an important factor in the onset of his schizophrenia. Mathematicians usually achieve greatness when they are very young. Indeed, Albert Einstein achieved his fame in his early twenties working in a patent office in Switzerland, his great works are early works, and he spent the rest of his life doing important things, but he was never able to match the brilliance of his early career. This is quite true for many other mathematicians. Nash was undoubtedly very much aware of this and, as his thirtieth birthday arrived, it is quite clear that he might have been struck by a sense of foreboding about the possible decline of his mental powers. In February 1959, he had a serious breakdown with moments of deep paranoia, delusions and hallucinations. He was hospitalized against his will at McLean Hospital, near MIT, which is a beautiful estate-like hospital that looks much like a New England college of the late nineteenth century. It is not so much described as a mental hospital but rather as a kind of sanatorium where one finds high-strung poets, professors and graduate students. Alex Beam (2001) describes how McLean was famous for its practice of the "moral therapy" that attracted many a famous person requiring a "luxurious rest cure;" he describes a scene where the Pulitzer Prize-winning poet Robert Lowell was holding court with a "small crowd of patients and staff while sitting on the bed of a young man named John Forbes Nash" (6).

One important difference between the facts of Nash's life and the Hollywood rendition of it in the Academy award-winning movie, is that Nash never suffered from visual hallucinations, which are rare and usually induced by chemical agents. Nash's hallucinations were auditory–voices in his head. Silvano Arieti (1974), writing about schizophrenia, suggests that a person who maintains a certain responsibility for such voices has a much better prognosis than a person who comes to believe that the voices in his head are controlled by some external force. In his treatise on schizophrenia, he describes that

> *In some cases he may give little importance to the phenomenon, but in others he undergoes a sudden, profound, and shaking experience. He hears a powerful voice, or sound, with a message directed to him, only for him, a message which is related to his whole psychological being. In several cases it is the response of the patient to this first experience that determines the course of the illness. Although badly affected and frightened, the patient may say to himself, "What I perceive is not true; it is only my imagination." If he is able to respond that way, he still has the power to resist schizophrenia. (p. 267)*

Indeed, Nash describes his efforts to control such voices and their effects on him as the result of his desire to continue working and interacting with his peers–indeed the maintenance of his professional roles, his need for social acceptance, and his continued social integration were important factors in his efforts to maintain such self-control.

During Nash's stay at McLean, Alicia refused to countenance all forms of invasive treatments such as shock treatment and the like. We are told that she was very concerned with preserving Nash's genius, she didn't want any drugs or shock treatments that would interfere with his brain. Also during this first stay, his friends at the university (or more likely his acquaintances, because the prickly Nash we are told rarely did have any friends), organized the visitors' schedule so that people from the university would be with him at all times.

At McLean, Nash was given a diagnosis of paranoid schizophrenia. "McLean's treatment philosophy boiled down to the notion that it was impossible to be social and crazy at the same time. The staff was dedicated to encouraging all new patients, no matter what the diagnosis, to relate. Along with the milieu therapy, as it was called, intensive, five-day-a-week psychoanalysis was the main mode of treatment. At that time, nobody thought of Thorazine as anything but an initial aid in preparing the way for psychotherapy. Stanton's [a lead psychiatrist at McLean's] attitudes harked back to early days of moral treatment of patients, said Kahne, which included having expectations of them and having staff become close to patients. The idea was to involve patients in decision-making and to abolish some of the hierarchy of medical institutions" (259). Alicia was pregnant when Nash was hospitalized and she gave birth to her son, also called John, on May 20th while Nash was still hospitalized. Interestingly, because of all the turmoil going on in their lives, the baby remained nameless for almost a year.

Nash returned to work for a time, went on to Europe, particularly France, and tried to get involved in establishing a world government, a grand delusion indeed. He became fervently anti-American and attempted a number of times to give up his American citizenship. We are told that he even escaped to East Germany for a while but was returned by East German authorities when they found him to be quite out of his mind. Alicia accompanied him during this trip and attempted to stay with him most of the time but Nash was very unpredictable. At one point Alicia left Nash to spend some time with her girlfriend in Rome and during this time Alicia's mother cared for their newborn son.

Nash would briefly recover but then fall again into his delusions and hallucinations. In 1961, he was hospitalized once again at the Trenton State Hospital. The State Hospital was a public hospital, and here the care was of a different quality. Nash was given insulin treatment that is also called insulin shock.

For a period of two years after this hospitalization, Nash was able to return more or less to a semblance of normal life and his work at the university. Nash also tells, however, that one thing he learned during his latest hospitalization was to keep his overt behavior in check to show as few signs of delusions and hallucinations as possible. In fact, what he learned was to conform and not let on about the turmoil that was continuing to go on in his own mind. However, this period of calm only lasted approximately two years. During this time, Nash was somewhat productive, but he also complained that his brilliant intellect had been dulled, and that this in fact is what probably led him to this next period of sanity. In this period, he learned French and published a paper in a French mathematics periodical. In 1963, Nash was hospitalized in the Carrier Clinic in a locked ward for over five months. Nash tried to escape from the clinic a few times and it seems that he was not treated with electroshock at Carrier, though it was used there with alarming frequency.

It was during this period that Nash was placed on a treatment of Thorazine, though Alicia convinced the doctor to keep the dosage as light as

possible. After his hospitalization, Nash again departed for France where he once again engaged in very bizarre behavior.

Nash didn't like the Thorazine and its side effects. Upon his return to Boston in 1965, he saw his psychiatrist on a weekly basis, and that was pretty much the only regular human contact he had over this period of time. He was by then estranged from his wife. From 1967 to 1970, he stayed with his mother in Roanoke.

The author, Sylvia Nasar, points out that it is very difficult to distinguish the effects of the disease from those of the treatment when it comes to schizophrenia. The medication is truly powerful, especially in its production of devastating side-effects.

Nash and his wife divorced in 1963, but upon his return from Roanoke, and around 1970 when he was living almost as a derelict, Alicia took him back in as a boarder. From 1970 to 1990, John Forbes Nash was like a phantom who wandered the grounds and the halls of Princeton University in the math or physics departments or in the old library. Students would brush up against him without knowing exactly who he was. "Within a few days or weeks, the embryo scientist or mathematician would discover a very peculiar, thin, silent man walking the halls, night and day, with sunken eyes and a sad, immobile face. On rare occasions, they might catch a glimpse of the wraith–usually clad in khaki pants, plaid shirt, and bright red high-top Keds–printing painstakingly on one of the numerous blackboards that lined the subterranean corridors linking Jadwin and New Fine" (332).

Over this 20 year period, Nash slowly but surely awoke from his insanity, he read at the library and learned about computers. The staff in the computer room always allowed him to run programs and allowed him to learn about computers. Indeed, over time, Nash became quite adept with computers, which was to serve him later on.

The author tells us that the prevailing wisdom is that there is little likelihood of recovery from schizophrenia. Manfred Bleuler, "a German psychiatrist, was the first researcher to systematically challenge this view. In a twenty-year follow-up of more than two hundred patients, he found 20 percent fully recovered. Moreover, he concluded that long-lasting recoveries did not result from treatment and hence appeared to be spontaneous" (352). A longitudinal study of 500 schizophrenic patients found the following results: 25 percent had died mostly of suicides, another smaller number were still institutionalized and receiving treatment, another group was living with their families but still had some symptoms, and finally another "quarter–25 percent–seemed to be symptom-free, living independently, with a circle of friends, jobs in the professions for which they had been trained or had held before they got sick" (352).

We are also told that Nash refused to take antipsychotic drugs after 1970, which of course might be quite fortuitous because some of the terrible side effects like tardive dyskinesia never developed.

Thus, from 1970 to 1990, Nash made a gentle reappearance on the scene at Princeton and started to engage to the world around him. In 1994, when he was quite completely recovered, he was nominated and was awarded the Nobel Prize for economics based on his first work on the Nash Equilibrium Theory. From 1994 on, Nash recommenced his career as a teacher and started publishing again. Today, he continues to work successfully on many difficult problems of pure mathematics. The Wikipedia site about John Nash indicates that he and his wife Alica remarried in 2001.

Certain aspects about this story from an SRV perspective

First, Nash's role as a mathematician and genius provided a great deal of insulation against devaluation and having a lot of bad things done to him. First and foremost the role of genius, particularly in mathematics, comes with a great deal of tolerance for eccentricity and even insanity. Moreover, since Nash mostly hung around other mathematicians, he wasn't the only one who seemed bizarre. Indeed, there is the running joke about how you

can tell an extroverted mathematician from all the others: he looks at your shoes rather than his own when he speaks to you.

Moreover, Nash's notoriety as a genius also led to a number of protective measures being placed around him including a safeguarding of his mind-brain; thus he was not subjected to some of the more powerful and devastating treatments that were and are still currently used for schizophrenia: he only received a few insulin shock treatments, never received electroshock, and only received low doses of Thorazine for a short period of time. Moreover, it was tolerated that he would not take Thorazine and other medications from 1970 on. Indeed, the choice of McLean Hospital and its country club setting and "A" list patients was likely influenced by his status as young-genius.

Another important feature of his role as mathematician-university-professor is the brotherhood and camaraderie that occurs in university settings. Nash was a star and a fellow professor and when he was hospitalized or traveling around the country or in Europe with many of his insane delusions, professors would welcome him, tolerate him, and provide him with shelter and assistance, and this despite the fact that Nash was not a particularly likable or socially adept individual. Moreover, his years at Princeton from 1970 to 1990 showed the extent to which his professorship and his genius were protective in that other professors tolerated his presence and even attempted to make him feel at home at the university as much as possible. For instance, he was allowed to use the computer system at Princeton at no cost to himself. He used the library, the university facilities, and wandered the grounds unobstructed. Indeed, during this time, many of his former colleagues attempted to maintain at least an acquaintanceship with him and would sometimes stop and talk. When he "reawakened" in the late 1980s and early 1990s, they engaged him in conversation and in game playing.

Nash's description as very good-looking also probably served him well.

Throughout his life and his illness, Nash maintained a firm grip on his identity as a professor, as a mathematician and as a genius; those around him and his surroundings kept on reminding him of this identity and allowed him to stay well-anchored to it. There is no doubt that this in some way allowed the man to survive and indeed recover.

This story also confounds the hypothesis that proposes an organic basis for schizophrenia, and especially its degenerative nature. Firstly, as is noted in the book, it is hard to distinguish the effects of the drugs and treatments from the actual mind and behavior disorder. There is a high likelihood that the degenerative "nature" of the "disease" is caused by the treatments, the long-term use of the powerful medications and the social consequences of the attendant devaluation that comes with the diagnosis. Moreover, Nash, on his own (with a tremendous amount of social support from his ex-wife and acquaintances, and his powerful role identity) was able to re-establish control of thought processes and of his life. Nash thus gained competence in controlling his disordered thoughts: this is a story of the developmental model having ascendancy over the medical model. This is certainly a story of resilience, positive development, and the power of valued social roles.

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Announcing

Advanced Issues in Social Role Valorization Theory

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About Social Role Valorization (SRV)
Social Role Valorization (SRV), a human service theory based on the principle of normalization, proposes that positively valued social roles are needed for people to attain what Wolfensberger has described as the good things of life (well-being). This is of particular importance for individuals with impairments or otherwise at risk of being socially devalued by others, and therefore of great importance for human services to them.

About the book
The first two chapters explain SRV, and give depth and background to SRV as an empirical theory that is applicable to human services of all kinds, to all sorts of people. The remaining chapters are all revised and expanded versions of presentations that Dr. Wolfensberger had given at previous international SRV conferences. The topics treated in the chapters move from the general (chapters 2, 3 and 4) to the more specific (chapters 5, 6 and 7).

The contents of the book are especially useful for people who do, or want to, teach SRV; for SRV researchers; and for those interested in implementing SRV in a systematic way, especially in service fields where SRV is new, not yet known, and not widely—if at all—embraced.

About Wolf Wolfensberger, Ph.D. (1934-2011)
World renowned human service reformer, Professor Wolfensberger (Syracuse University) was involved in the development and dissemination of the principle of normalization and the originator of the program evaluation tools PASS and PASSING, and of a number of service approaches that include SRV and Citizen Advocacy.

Book Chapters
- Foreword
- Preface
- Chapter 1: A brief overview of Social Role Valorization
- Chapter 2: The role of theory in science, and criteria for a definition of Social Role Valorization as an empirically-based theory
- Chapter 3: The hierarchy of propositions of Social Role Valorization, and their empiricality
- Chapter 4: The relationships of Social Role Valorization theory to worldviews and values
- Chapter 5: Values issues and other non-empirical issues that are brought into sharp focus by, or at, occasions where Social Role Valorization is taught or implemented
- Chapter 6: Issues of change agentry in the teaching, dissemination and implementation of Social Role Valorization
- Chapter 7: The application of Social Role Valorization principles to criminal and other detentive settings
- Conclusion to the book

List of Items to be Reviewed

In each issue of *The SRV Journal*, we publish reviews of items relevant to SRV theory, training, research or implementation. These include reviews of books, movies, articles, etc. We encourage our readers to look for and review such items for this journal. We will be happy to send you our guidelines for writing reviews, or they are available on our website (http://www.srvip.org/journal_submissions.php). We are open to reviews of any items you think would be relevant for people interested in SRV. We also have specific items we are seeking reviews of. (We strive to include items which might have relevance to SRV theory, one or more SRV themes, and/or social devaluation. If, however, a reviewer finds that a particular item is not so relevant, please let us know.) These items include:

Drunk Tank Pink: And Other Unexpected Forces That Shape How we Think, Feel, and Behave. By Adam Alter. NY: Penguin, 2012.

Social Inclusion at Work. (2008). By Janis Chadsey. Annapolis, MD: AAIDD, 49 pages.

Inclusive Livable Communities for People with Psychiatric Disabilities. (2008). Washington, DC: National Council on Disability, 84 pages.

Body & Soul: Diana & Kathy. (2006). By Alice Elliott (Director). 40 minutes.

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Hall, A., Butterworth, J., Winsor, J., Gilmore, D. & Metzel, D. Pushing the employment agenda: Case study research of high performing states in integrated employment. (2007). *Intellectual & Developmental Disabilities, 45*(3), 182-198.

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Abernathy, T. & Taylor, S. Teacher perceptions of students' understanding of their own disability. (2009). *Teacher Education & Special Education, 32*(2), 121-136.