A CHANGING FAITH?

A HISTORY OF DEVELOPMENTS IN RADICAL CRITIQUES OF PSYCHIATRY SINCE THE 1960'S

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by

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Summary

The thesis examines the emergence of anti-psychiatry since the early 1960s, addressing two questions:

1. Why did anti-psychiatry emerge at this time?

2. How influential is anti-psychiatry today?

Anti-psychiatry was found not to consist of one identifiable set of proposals, but a shifting package of views. One factor remains consistent across versions of anti-psychiatry: criticism of medicalisation of mental disorder.

Anti-psychiatry emerged during the 1960s for two reasons:

a) Psychiatrists had adopted positivistic conceptualisations of human disorder, which reduced psychiatric patients to 'malfunctioning machines'. Anti-psychiatry restored the patient's subjectivity to the centre of psychiatric practice.

b) The mid-twentieth century saw the expansion of state planning and a reduced emphasis upon individual liberty. Anti-psychiatry was part of the counter-culture, which criticised the welfare state as a machine for producing 'normality'/conformity. 1960s Anti-psychiatry was more libertarian than Marxist.

By the 1970s, anti-psychiatry divided into two distinct forms: radical psychotherapy and Marxist anti-therapy. Versions of Marxist anti-therapy fail to propose alternatives to therapy which are not themselves therapeutic or paratherapeutic. This problem derives from excessive reliance upon Szasz's libertarian critique which is flawed.

Anti-psychiatry is less influential today, having suffered from academic criticism and failed to offer solutions to the problems posed by 'community care'. It competes with critiques which are pro-democracy, rather than anti-medicine. Italian reforms provide one possible model. MIND's mental health campaigns are democratically rather than anti-psychiatrically based. The user movement includes both anti-psychiatric users and democratically-minded ones. Democratisation of mental health provision is complicated by the continuing need for expert professionals and some compulsory treatment, and by problems inherent within the user movement. However, democracy rather than anti-psychiatry now offers the best basis for political critiques of psychiatry.

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Chapter One: Introduction

1. Aims of thesis.

The aim of the thesis is to chart and explain the emergence and development over the past three decades of a group of ideas loosely termed 'anti-psychiatry'. Specifically, two questions will be addressed:

a. Why did this particular set of ideas emerge at this particular moment in the history of Western psychiatry?

b. To what extent are these ideas still influential in current thought?

Anti-psychiatry is basically a position of extreme opposition to medically based theories of and treatments for mental disorder, particularly (but not solely) when these are administered without the patient's consent. Theorists associated with anti-psychiatric positions have usually, but not always, regarded themselves as politically left-wing, and have argued that mental disorder and its treatment ought to be approached from an explicitly political perspective. This emphasis upon the value-laden and political nature of psychiatric theory and practice is associated with criticism and rejection of positivistic forms of science (positivism is discussed fully in Chapter 2). The term 'anti-psychiatry' is usually associated with the work of R.D.Laing, David Cooper, Thomas Szasz, Thomas Scheff, Erving Goffman and sometimes Michel Foucault (for example, Sedgwick, 1982).

For the purposes of this thesis I have assumed the following propositions to be characteristic of the anti-psychiatric attitude. These propositions are

referred to throughout the thesis; for example, as 'Proposition 1, Proposition 2' etc.

1.1 Mental illness is a mythical concept, invented by doctors as a pseudo-scientific basis for the control and coercion of deviant people.

1.2 Psychiatry is a form of social control which perpetuates the social and political status quo, and is therefore pernicious.

1.3 Mental distress is caused by social oppression, rather than by biological or psychological malfunction within the individual.

1.4 Mental distress should not be treated by doctors, because it has no physiological basis.

1.5 A schizophrenic experience can be a useful process of self-discovery, and people should be assisted through the experience rather than have their symptoms suppressed by medical forms of intervention.

1.6 All psychiatric hospitals should be closed as soon as possible, ending the compulsory hospitalisation of patients, and breaking the influence of the medical profession over the provision of mental health care.

1.7 Electro-convulsive therapy (ECT) should be abolished, because it is both harmful and fails to address the causes of distress.

1.8 Psychotropic medication should be abolished, because it is both harmful and fails to address the causes of distress.

1.9 Compulsory treatment ought to be abolished, because individuals should never be compelled to receive medical treatment against their will.

1.10 All institutional psychiatry is coercive, because until the threat of compulsion is removed from people who choose not to co-operate, no patients can be said to be in receipt of treatment as a result of genuine free choice.

1.11 Individuals should be held responsible for their actions at all times, even if they are mentally disordered, because to regard a person as not responsible for their actions is to deprive that person of a fundamental aspect of their humanity.

It should be noted at this stage that this complete constellation of ideas is not in fact associated in its entirety with any of the theorists named above. Each named theorist has at some time adhered to some of the opinions, but, to the extent that the constellation as presented does represent an identifiable attitude towards psychiatry shared by some people, it is one which has been created by a somewhat uncritical amalgamation of the ideas of these theorists. As will become apparent throughout the thesis, the named theorists originated from within quite different philosophical and political traditions, and the attempt to integrate their ideas in an uncritical fashion leads to fundamental contradictions within the anti-psychiatric stance as a whole.

The anti-psychiatric position is neither the first nor the only attempt to bring a political critique to bear upon psychiatry. Psychiatry has been subject to suspicion and challenge throughout its history; for example, earlier this century, Kingsley Davis (1938) attacked the mental hygiene movement of the 1930s on the grounds that it represented no more than an

attempt to spread and enforce middle class values in the name of health. However, anti-psychiatry does constitute a particularly extreme and comparatively widespread opposition to psychiatry emerging at a time when psychiatry appeared to be increasingly accepted as a bona fide branch of twentieth century medicine. Its history and continuing influence are subjects well worth examining.

2. Methodology.

2.1 Method of analysis.

The disciplinary background of this thesis might be described as historico-sociological. The material presented is historical in the sense that I have sought to present and explain the emergence of anti-psychiatry as a series of events unfolding over several decades. However, the material is also sociological in the sense that I have attempted to produce a theoretical account of the development of political ideas in relation to psychiatry and anti-psychiatry during this period, appealing to two different but complementary forms of explanation for the evolution of anti-psychiatric ideologies.

2.1(i) Logical, or 'a priori', progression of thought.

This form of explanation assumes that argument is essentially rational. Ideas and opinions are assessed in terms of their internal consistency. When inconsistencies are found, attempts are made to reframe the argument until it exists in a form which is internally consistent. Theory progresses in this fashion. Purely theoretical analysis of this form will be included in this

thesis. I shall chart how anti-psychiatric arguments have been challenged, their inconsistencies revealed, and, as a result, new forms of argument have been produced; for example, Chapter 4 addresses an internal contradiction within anti-psychiatry which is finally resolved by acknowledging a political dimension to general medicine as well as to psychiatry.

2.1(ii) Changes in ideology in response to material conditions, or 'a posteriori' revisions of ideology resulting from unforeseen outcomes of ideological positions.

Ideas do not emerge solely as a result of logical progression. They become influential at particular times because they address the historical conditions existing at those times in ways which appear satisfactory or appealing to particular social groups. I shall relate the emergence of particular ideas to the historical conditions within which they became especially appropriate; for example, a recent decline in the influence of anti-psychiatry amongst academics is related in Chapter 8 to increasing disenchantment with the reality of 'care in the community'.

2.2 Data

My approach to data collection is similar to that of 'grounded theory' (Glaser and Strauss, 1968). That is, theoretical formulations were not specified in advance, and hypotheses derived and tested. Rather, theoretical formulations grew out of the process of data collection, and the kinds of data collected were dictated by the theoretical framework as it developed. Thus, issues and concepts were constantly being developed as the research progressed.

The thesis is based largely upon qualitative data, as a qualitative approach was most appropriate both to the aim of theory construction, and the nature of the material under investigation.. Rose (1982:130) points out that theory-building research is generally based upon qualitative data, and theory testing research upon quantitative data. This thesis matches that generalisation. In addition, the nature of the thesis being developed made a qualitative approach particularly appropriate. As Rose (1982:129) comments:

> the major successes of the [qualitative fieldwork] approach seem to be in research...where the focus of the inquiry is the 'here and now' of group dynamics, the ideology or world-view of the group, or a specific process or experience.

This thesis is centrally concerned with the development of a particular form of ideology.

In Bryman's (1988:10) terminology, my selection of a qualitative methodology was technical, rather than epistemological. The type of data presented in this thesis requires an analysis of the assumptions and processes of reasoning of the individuals concerned. Such data could not be quantified in a manner which would allow me to address the questions with which this thesis is concerned.

Naturally, this limits the conclusions which can be drawn from the data; for example, I am able to state that anti-psychiatry is an important influence upon the thinking of individuals of importance within the 'user movement' as discussed in Chapter 9, but I am not able to indicate what percentage of service users fully understand or adhere to anti-psychiatric views. Answering that kind of question would involve conducting further quantitative research; for example, by means of a large scale survey of psychiatric service users.

The thesis is based upon two sources of data. Much of the material presented is the product of library-based research methods. Library-based searches were made for relevant material published during the last 3-4 decades. This material is fully referenced throughout the thesis, but includes:

Published books and papers by the major theorists associated with anti-psychiatry, as named above.

Critiques of the work of these theorists in books and journals.

Existing accounts of the history of psychiatry.

Research studies from journals of psychiatry and psychology.

Newspaper reports.

'Underground' press magazines, particulary those published by anti-psychiatric groups.

Parliamentary debates.

Material produced by pressure groups and organizations which have adopted an anti-psychiatric stance.

The thesis refers also to material drawn from interviews conducted specifically for the purposes of this thesis.

2.2 Interviews with professionals and service users known to be critical of mainstream psychiatry.

These interviews were conducted for two purposes. Firstly, they enabled me to obtain in systematic form the opinions and arguments of people already known by me to be critical of psychiatry. I was able to request clarification from people whose published views seemed ambiguous or unclear. Some of my

interviewees had not published their opinions, and for them this was my sole source of data. This data also enabled me to compare different interviewees' answers to similar questions. Secondly, I used the interviews to gather additional historical information from my interviewees, adding an oral historical dimension to the thesis. Generally, therefore, the interviews were conducted in two parts. I began with a series of personal historical questions, designed to elicit information about the interviewee's past involvement with anti-psychiatric groups and theorists, the extent of their reading in the area of anti-psychiatry, and any other information to which that interviewee was particularly likely to have access. There then followed a series of standard interview questions designed to elicit the opinions of the interviewee about a range of 'anti-psychiatric statements' based upon the constellation of ideas outlined at the beginning of this chapter.

The interviews were semi-structured; that is, they were based upon an interview schedule which specified which opinions were to be discussed during the course of the interview, derived from the characteristically anti-psychiatric propositions listed in Section 1 of this chapter. However, interviewees had much freedom to expand upon their views, and introduce such other perspectives as they themselves found relevant. Thus, although all the interviews include material in relation to similar subjects, the precise content and ordering of the interviews varied considerably.

These interviews lasted between about 60 and 90 minutes. The majority were tape-recorded, except where interviewees objected, or the interview was conducted by telephone. Tape-recorded interviews were transcribed in full.

The interviewees were selected by the technique of 'snowballing'; that is, initial contacts were made by me with individuals whose opinions I already knew to be appropriate to the thesis. I then asked these interviewees to name other people who they thought it would be appropriate for me to interview, and contacted these people. In this way I generated a sample of 13 interviewees. The technique of snowballing does not, of course, generate a statistically representative sample. People contacted tend to remain within a limited social network, which increases the probability of their sharing similar views, and decreases the variety of opinion within the sample. In one sense, this was unimportant for my purposes. I needed and chose a technique which allowed me to pre-select people whose opinions I could predict would be critical towards psychiatry. In another sense, the technique was problematic since although I wanted all my interviewees to share a critical viewpoint, I did want to perceive enough variation in their opinions to be able to compare different arguments. The interviews themselves constitute evidence that I did manage to include a wide range of radical opinion. Also, I am able to compare the range of opinion contained in my interviews with that revealed by my library-based research. I am confident that all the major categories of opinion derived from the library-based research are also apparent in the interviews.

The list of interviewees presented below includes a local co-ordinator of the National Schizophrenia Fellowship (NSF), which is a somewhat conservative organization not generally noted for adopting a radical political critique of psychiatry. My justification for including the NSF interview is that the co-ordinator requested that the NSF viewpoint should be heard, and I also felt that the interview offered an interesting comparison with the views of my other interviewees.

Interviewees (interview tape-recorded unless otherwise stated):

Dr Aaron Esterson - this was a purely historical interview conducted with a colleague and contemporary of R.D.Laing. No interview schedule is presented. Interview also included Mary Esterson, who worked with David Cooper at Villa 21 (see Chapter 3).

Dr S. Ticktin - professional involved in the promotion of alternatives to psychiatry, and colleague of David Cooper. One of the founders of 'Asylum' magazine, a publication intended to promote democracy in the psychiatric system, which originated in Sheffield.

Dr D.Hill - clinical psychologist, Director of Camden MIND, and opponent of medical psychiatry. Author of The Politics of Schizophrenia (1983).

Prof. F.A.Jenner - Professor of Psychiatry at Sheffield University and personal friend of R.D.Laing. One of the founders of 'Asylum' magazine and proponent of the Italian reforms in Britain (see Chapter 6).

Mike Lawson - service user and vice-chair of MIND. Interview not recorded, because conducted by telephone.

Peter Campbell - service user and secretary of Survivors Speak Out.

The co-ordinator of a local branch of the National Schizophrenia Fellowship.

Two service users involved with a local branch of the National Schizophrenia Fellowship. Interviewed separately.

Two service users involved with a local group affiliated to Survivors Speak Out. Interviewed together. Interview not recorded because of their objections.

Social worker attached to an Afro-Caribbean mental health pressure group based in Sheffield.

Data from these interviews is not presented in one body within the thesis, but has been integrated into the text wherever appropriate. Quotes from interviews are clearly distinguished from material taken from written sources.

The schedule for the semi-structured interview is included in Appendix 1 of this thesis.

PAGE

NUMBERING

AS ORIGINAL

Chapter 2 Psychiatry by the 1960s

Anti-psychiatry acquired its initial popularity during the 1960s within a particular psychiatric and social context, and in order to understand its emergence it is necessary to comprehend that context. This chapter serves as a historical introduction, outlining the salient characteristics of psychiatry by the 1960s, and psychiatry's relationship with broader social and political values of that era.

1. Organicism in medical psychiatry.

The predominant theoretical approach within mainstream medical psychiatry by the early 1960s was organicist. That is to say, most psychiatrists believed that the serious illnesses which they treated would eventually be demonstrated to result from gross and identifiable disease processes of the brain (for example, Stafford-Clark, 1963). This belief was in part the result of the nature of the patient population with which most psychiatrists worked. Most psychiatrists worked within the large old purpose-built institutions, which housed a huge number of chronically ill patients whose condition had been steadily declining over a period of many years. The extent of such patients' deterioration, combined with the inability of any form of therapy to restore them to ordinary living, indicated to most practitioners the existence of a slow but irreversible disease process. Many of these patients were psychotic, and had been given the specific diagnosis of schizophrenia. Hays (1964:45) reported that schizophrenia was the commonest reason for long-term hospitalisation.

The belief that serious mental illnesses would eventually be demonstrated to result from organic diseases of the brain had been encouraged also by the confirmation in 1913 that the symptoms of general paresis were the final stage of development of syphilis as it affected the central nervous system. General paresis accounted for a sizeable proportion of asylum inmates at that time. Warner Jauregg's discovery in 1918 of a method of treatment for syphilis strengthened confidence in the efficacy of medicine to treat insanity by physical methods.

Belief in organicism was supported further by appeal to the types of therapy used by medical psychiatry, which were primarily physiologically based. Prior to the 1950s, insulin coma therapy, electroconvulsive therapy (ECT) and leucotomy were hailed as great advances in treatment (Clark, 1964:4-5). During the 1950s, what has been hailed as the 'pharmacological revolution' (Jones, 1972:291) began to transform psychiatry with the advent of the phenothiazines, or major tranquillizers. The major new drug, chlorpromazine, was developed in France by Rhone Poulenc in 1950, and available in England as Largactil by 1954 (Unsworth, 1987:259). The major tranquillizers were the first group of drugs to appear to exercise any specific effect on the symptoms of schizophrenia, rather than a general sedating effect on functioning as a whole. Subsequently, the impact of the major tranquillizers upon the symptoms of schizophrenia has been particularly important in producing apparent support for speculative physiological theories of schizophrenia. The 'dopamine hypothesis' asserts that drugs which relieve the symptoms of schizophrenia exercise an inhibitory effect upon the dopaminergic system in the brain, which suggests that schizophrenic symptomatology results from a chemical imbalance of this system; for example, Carlsson and Lindquist (1963). This line of reasoning was buttressed further by apparent similarities between the effects

of amphetamine overdose and the symptoms of schizophrenia; for example, Angrist, Lee and Gershon (1974). However, empirical research has failed to identify dopaminergic abnormalities in schizophrenic patients (Birchwood et al, 1988:47-56). The thought process by which the dopamine hypothesis was produced can be compared to arguing that headaches are a result of aspirin deficiency on the basis that aspirin cures headaches.

2. Psychological and social theories in psychiatry.

Rose (1986a) has suggested that, although theories within psychiatry had become increasingly organically based by the latter half of this century, in fact there has never been a time since psychiatry's inception when psychiatrists rejected entirely the influence of psychological and social factors upon mental illness.

> In the early decades of the twentieth century, when 'organicism' in psychiatry was in its heyday, medicine was already establishing a social terrain for its operations. (Rose, 1986a:45)

Throughout the twentieth century, the extent of psychiatrists' attention to social and psychological phenomena in relation to mental health has increased immensely. During the 1950s, there is substantial evidence of psychiatrists' interest in non-organic factors.

2.1 The critique of the institution

Within the mental hospitals, psychiatrists' inability to treat effectively serious forms of mental illness was not presumed to be entirely the consequence of scientific ignorance of chronic disease processes. Awareness

was developing of the negative therapeutic impact of the institutional environment itself. Barton's (1959) Institutional Neurosis argued that much of the chronically disordered behaviour of long-term mental patients, which was commonly regarded as symptoms of their primary psychiatric disorder, was in fact the result of institutional living. He argued that institutional neurosis, the syndrome resulting from exposure to institutional life, was a psychiatric condition in its own right. Goffman's (1962) Asylums provided a graphic account of life in an American mental hospital, arguing that much 'pathological behaviour' was in fact a comprehensible coping response to the conditions of institutional life. These books represent the culmination of a dissatisfaction with the location of provision of psychiatric care which had been developing since the early decades of the century.

The deleterious social and psychological effects of the mental hospitals had been used actually to buttress the claims of psychiatry to possess scientific medically based expertise for the treatment of mental disorder. Prior to the Mental Treatment Act 1930, it was argued that psychiatrists' abilities to treat and to cure were not being used to their potential effect because their benefits were being outweighed by the negative effects of the institutions. For psychiatry to be truly therapeutic, it was necessary to transform the institutions into properly medical hospitals. By the 1950s, and the passage of the Mental Health Act 1959, the prevailing view was that long-term institutionalisation of any form was harmful. Patients would be far more effectively treated if they were not subjected to institutionalisation, but as far as possible retained their status as ordinary members of society. The socially therapeutic effects which had once been ascribed to the asylums in the early days of their existence now began to be ascribed to the community, and the policy of care in the community was born.

2.2 Psychoanalysis

The theories of Freud had a substantial impact upon mainstream psychiatric theory. This influence was greatest in America, but is also apparent in British psychiatry.

Psychoanalysis is based upon the theory that all human behaviour is motivated, but that the majority of motivation takes place at an unconscious level and is not accessible to consciousness. Unconscious motivation can, however, be inferred from clues revealed in people's conscious experience and behaviour; for example, slips of the tongue, jokes, dreams and neurotic symptoms. Unconscious motivations are almost invariably sexual, within Freud's very broad definition of what constitutes sexuality, and have their origin in early childhood experience. Mental pathology is the result of intrapersonal conflicts arising out of these unconscious motivations. Freudian theory places pathology along a continuum from normal through neurotic to psychotic.[1] Relief from neurotic symptoms can be attained by interpreting the unconscious motivations in the light of consciousness, through psychoanalytic therapy, thus allowing resolution of conflicts. Psychotic symptomatology is viewed as the result of conflicts whose origins date back to the earliest years of life, before a secure sense of self in relation to others was formed. Because of their very limited ability to form relationships with other people, or their <u>primary narcissism</u> in Freud's terms, psychotic patients were not thought by Freud to be suitable for psychoanalytic psychotherapy. Psychoanalysis developed as a therapy for patients with those comparatively less severe forms of mental disorder termed neurotic, which would not ordinarily result in long-term institutionalisation in a mental hospital.

Therefore, psychoanalytic therapy was from its earliest days most commonly available on a private, fee-paying, contractual basis, rather than within mainstream public services. However, a major triumph for psychoanalysis in terms of its acceptance into the psychiatric mainstream occurred during World War 1, when psychotherapy was applied to the problem of shell-shock, and found to be considerably more effective than physiological approaches (Brown,1961:56).

The British Psychoanalytic Association pursued psychoanalysis in the somewhat purist and dogmatic fashion of which mainstream medical psychiatry was highly suspicious. In 1920, Dr Crichton Miller founded the Tavistock Clinic in London, with the intention of promoting a more eclectic and practical use of psychoanalysis within the psychiatric mainstream. The Tavistock was:

> one of the first out-patient clinics in Great Britain to provide systematic major psychotherapy on the basis of concepts inspired by psychoanalytic theory for out-patients suffering from psychoneurosis and allied disorders who were unable to afford private fees. (Dicks, 1970: 24)

By 1939, the Tavistock was prestigious enough to be given responsibility for the co-ordination of army psychiatry during World War 11.

In 1948, the Tavistock joined the newly formed NHS. However, within the new financial climate of welfare delivery, the Clinic's pre-eminence was short-lived, as it became apparent that funding for psychotherapy was not to be a priority. Dicks (1970: 138) reports that by 1950:

> The whole problem of the value (and economics) of psychotherapy was once again under very considerable nationwide scrutiny. The overall psychiatric trend was back towards priority for

psychosis, and hence the new and rapidly developing physical methods to be given in psychiatric in-patient units. This put psychotherapeutic theory and training into the shade.

2.3 Behaviour therapy

Behaviour therapy was the invention of the comparatively new and rapidly expanding profession of psychology. Basing their practice upon the learning theory approaches of J.B.Watson and B.F.Skinner, behaviourally oriented psychologists assumed that pathological behaviour was the product of 'faulty' or maladaptive learning. The 'cure' for pathological behaviour was therefore to substitute 'correct' learning. For behaviourists, learning was conceptualised as a highly mechanistic process. An organism, be it person or animal, learns by being repeatedly exposed to positive or negative events associated with particular pieces of behaviour, and thereby becoming conditioned to respond to its environment in a patterned and predictable way. Behaviour therapy consists of systematically changing the patient's pattern of behaviour by changing the pattern of reinforcements; that is, rewards and punishments. A patient should be given 'positive or negative reinforcement' for correct pieces of behaviour, and punishment for incorrect pieces of behaviour. This would result in the patient acquiring new, normal and adaptive patterns of behaviour.[2]

In practice, behaviour therapy, like psychotherapy generally, was reserved for milder, neurotic conditions, the psychoses continuing to be the province of medical psychiatry. However, behavioural theory was applied on an organizational level to the management of hospital wards by the principles of token economies (for example, Ayllon and Azrin, 1968). 'Healthy' behaviour,

such as dressing oneself, would be rewarded with tokens which were exchangeable for privileges or luxuries, such as cigarettes. On a more individualistic level, elements of behavioral theory could be incorporated into the day-to-day pattern of patient care; for example, nurses might be taught not to pay attention or respond to the delusional content of a patient's beliefs, as this would positively reinforce the symptoms, making them more persistent.

2.4 Expansion of mental health related professions throughout welfare.

Paralleling the rapid development and expansion of psychology as a profession, a range of psycho-social interventionist welfare services was attaining prominence by the late 1950s. Social work was becoming established as a profession, and basing its rationale upon an individualistic, psychoanalytically-derived theory of social intervention. Psychological services were becoming widely available; for example, through the education system, the prison system, and in the workplace. Services offering psychologically-based assistance for a range of mild forms of disturbance and sub-optimal performance were becoming increasingly common across a variety of sites of delivery.

In summary, it is true to say that hospital based medical psychiatry, concerned with serious and often psychotic forms of disorder, was becoming increasingly organic in orientation by the 1950s. However, organic theories were not expanding to the exclusion of psychosocial schools of thought. In fact, at this time the expansion of psychology and psychoanalysis as academic fields was resulting in more varieties of relatively mild psychological

disturbance being catalogued and targeted for treatment by new groups of mental health professionals.

3. Positivism as the dominant philosophy of science.

The range of non-organic aspects of psychiatry described above demonstrates that psychiatry was not an entirely organicist discipline during this era, but that its organicist aspects co-existed alongside a range of alternative and supplementary views about the likely origins and best treatment of psychiatric conditions. However, by the 1950s the various 'psy professions' (Castel et al, 1982) involved in the treatment of mental disorder tended to share the common epistemological framework of <u>positivism</u>. What is probably the most consistent and uncompromising account of the theory was provided by Alfred J. Ayer's (1971) <u>Language, Truth and Logic</u>, first published in 1936. Ayer emphasized that scientific knowledge must be empirically based in order to be accepted as proper knowledge. He insisted that empirical research must not be contaminated by 'metaphysics'; that is, by explanatory concepts which are not themselves directly observable, but are hypothesized to explain events which are directly observable. Metaphysics would thus include references to free-will, agency, mind, and so forth. Since even causation cannot be directly observed, but only inferred, Ayer insisted that 'causation' should be redefined to mean 'constant conjunction'.

> In nature one thing just happens after another. Cause and effect have their place only in our imaginative arrangements and extensions of these primary facts. (Ayer, 1976:183)

Ayer's account of 'logical positivism' is probably the most tightly and narrowly defined instance of this school of philosophy. The term positivism

is generally used more widely and less precisely than this to refer to a range of basically empiricist views of science. As Bryman (1988:14) comments:

> even among more sophisticated treatments of positivism a wide range of meanings is likely to be discerned. Different versions of positivism can be found...Even where there is a rough overlap among authors on the basic meaning of the term, they rarely agree precisely on its essential components.

Bryman identifies five essential components of positivism:

(i) The belief that the methods and procedures of natural science are appropriate to social science.

(ii) Only phenomena which are 'observable' in the sense of 'being amenable to the senses' can validly be warranted as knowledge.

(ii) Many accounts of positivism suggest that scientific knowledge is arrived at through the accumulation of verified facts. Theory expresses and reflects the accumulated findings of empirical research in the form of 'laws'.

(iv) Scientific theories form the backcloth to empirical research in the sense that hypotheses are derived from them - usually in the forms of postulated causal connections between entities - and then subjected to empirical test.

(v) Positivism rejects values as having any role to play in scientific method in two senses. Firstly, the scientist is to be completely objective and purged of any values which might undermine objectivity. Secondly, a sharp distinction is to be drawn between scientific issues and statements, which deal with and express facts, and normative issues and statements, which deal with and express subjective opinions.

Positivism was presented as an account of how natural science ideally operates, and why it is so successful, and thus, by extension, a prescription of the standards to which human sciences such as psychology and psychiatry

should aspire. In fact, positivism does not constitute a good explanation of how any science works. Kuhn's (1962) The Structure of Scientific Revolutions argued convincingly that science is not merely a process of accumulation of observable data points, but depends for progress upon periodic revolutions in whole areas of theorising in order to make better sense of the data points; for example, the shift in physics from the Newtonian paradigm to the Einsteinian. In fact, observation can only take place within the context of a theory, which systematically orders and defines the observations into meaningful patterns. However, despite their limitations, by the late 1950s positivist-derived approaches were endemic in psychiatry and psychology. The reason for this was that human scientists were aware of the success and prestige of natural scientists, and wanted their own fields of enquiry to be included within that category. In order to legitimate their demand that they be ascribed equal status alongside natural science, they perceived that what was necessary was to demonstrate that human science shared the methods of natural science. Since the predominant form of philosophy of science available at that time was positivism, emulating the natural sciences was widely regarded as synonymous with adopting positivist approaches. As human scientists adopted the methods and philosophy which they regarded as appropriate to a mechanistically conceived natural science, this had the unfortunate effect of producing explanations of human behaviour in terms which were crudely deterministic. Many of the concepts rejected as metaphysical by positivists are precisely those which, in every day usage, we apply to understanding human beings; for example, motivation, ethics, meaning, agency and purpose. Once human science was purged of these concepts, human behaviour was regarded as essentially similar to the behaviour of molecules, and to be explained in causal, mechanistic and deterministic terms.

In fact, the influence of positivism was not equally evident across all the various mental health related disciplines. The purest attempts to put positivism into practice were found amongst behaviourist psychologists. This group of psychologists acquired their name as a result of having decided to limit psychology to the study of what is public and observable; that is, overt behaviour rather than internal psychological processes and subjective experience. Their aim was to break complex patterns of behaviour down into smaller and simpler chunks, and observe consistently appearing relationships between these chunks and external environmental stimuli. It was hoped that all behaviour, normal and abnormal, would be reducible to chains of stimulus-response associations. A leading proponent of behaviourism, B.F.Skinner, produced a fictional 'blueprint' for a behaviouristically designed utopia, in which 'unscientific' concepts such as justice and freedom would be replaced with social control by positive and negative reinforcement (Skinner, 1948).

Organicism in psychiatry did not derive directly from positivism, as behaviourism did, but was readily accommodated to positivist demands. Interest in 'metaphysical' thoughts and ideas being experienced by the patient was neglected in favour of the search for observable physical events to which the disorder could be reduced, and which could be physiologically treated. The aim of psychiatrists was perceived as being to identify behaviour which was abnormal in form and structure and reducible to organic states, an aim to which consideration or understanding of the content of behaviour or experience was irrelevant.

Psychoanalysis was very ambiguously positivistic. Freud had believed that he was founding a new science, and had been very concerned to justify his

practices by reference to the standards of science. Psychoanalysis had been presented by him as consisting of objectively observed phenomena which offered a total explanation of human behaviour, couched in very mechanistic and deterministic terms. However, psychoanalytic explanatory constructs, such as the notions of id, ego and superego, are all metaphysical concepts. They are hypothetical structures or processes within the individual's 'psyche' which are not directly observable, but are postulated as theoretical constructs which explain the observed phenomena. Also, psychoanalysts rejected experimental method as a means of testing their hypotheses, and based their findings entirely upon the case study method. Positivist methodologists demand that scientific evidence must be based upon controlled experimentation to be valid. Post hoc theorisations and explanations, no matter how convincing, are not thought to be admissible. Thus, psychoanalysis was probably the least positivistic approach common within mental health practice at this time. However, Freud's own scientistic attitude and insistence that his theories were to be understood mechanistically and deterministically bequeathed to psychoanalysis certain positivistic tendencies. More recently, psychoanalysis' less positivistic tendencies have been rediscovered and expounded (see Chapter 5).

Therefore, although positivism was not uniformly adopted in its pure form, its standards of science were enormously influential before the 1960s in three respects: limitations on the kinds of explanation considered acceptable in human science; neglect of consideration of problems of value; and the position of the client in relationship to mental health practitioners.

3.1 Types of explanation viewed as acceptable in human science.

Scientific explanation came to be regarded as synonymous with mechanistic, causal explanation. The notion of behaviour as motivated rationally began to be regarded as meaningless, and explanations couched in terms of intent or purpose regarded as hopelessly unscientific. For example, a psychologist writing for the Journal of Mental Science believed:

> It has been shown that the ideas of responsibility and of punishment, derived from a background of outmoded "body-mind" dualism and theological "free-will", subserve [sic] no useful purpose and that, on the contrary, they obscure clarity of thought and obfuscate issues of practical human importance. The feeling of "free choice" and the awareness of "alternative" paths of action have been interpreted as properties peculiar to the human symbolic system and not to the external universe.
>
> In a world of science, based on determinism, the old ideas of "responsibility" and "punishment" should be discarded. (Macdonald, 1955:717)

This has the effect also of blurring the distinction between behaviour which is believed to be pathological and behaviour which is simply deviant. If no behaviour is freely chosen by a rational agent, then any behaviour which is perceived as undesirable can be regarded as both deviant and pathological. The way is open for psychological theories of criminal behaviour to propose forms of diagnosis and 'therapy' for criminality. For example, Grendon, the psychiatric prison which opened in 1962, adopted a therapeutic community rationale for the 'treatment' of anti-social behaviour. Similarly, a rationale was created for mental health professionals to target, research and

'treat' a range of mild forms of deviance via social work and educational interventions.

3.2 The problem of value freedom.

Positivists were very concerned to exclude from science issues of value and ethics. Measurement and experimentation must take as their object publicly observable and verifiable entities, which do not depend for their existence upon the particular viewpoint of one investigator. Questions of value are not empirically decidable, and therefore cannot form part of any scientific investigation. Psychology and psychiatry became very concerned with demonstrating the objectivity of their investigations; for example instruments such as psychometric measures of intelligence were created. Through frequent use, established statistical norms could be derived for whole populations with reference to a particular test. A measure had then been created which was objective in the sense that all psychologists who used that instrument would have data which was comparable. Once a common definition of abnormality had been agreed, in terms of statistical deviation from the average, abnormality could also be discussed with some degree of certainty that all psychologists were discussing the same research object. Therefore, research on intelligence could be regarded as objective and value-free, and the problem of value had been removed from the field of enquiry.

However, attaining consensus does not constitute achieving value-freedom. The problem of value is controlled, rather than removed. A concept such as intelligence is a socially-defined and value-laden concept. Agreeing on standards for its measurement does not make it less so. This is plainly the case if we observe how judgements of abnormality are made and the consequences

which they have for the individuals concerned. Intelligence is normally distributed throughout the population. That is, most people cluster around the average score on an intelligence test, with a small number of people placed very high and very low. People who score very low are regarded as abnormal, and treated as a problem. People who score very high are regarded as unusual, but not abnormal. This decision is not scientific, but is based upon a socially produced consensus. This problem has been illustrated here with reference to the field of intelligence testing. However, it has been a problem for psychology and psychiatry generally; for example, psychiatrists have been very concerned to produce standardised diagnostic categories to ensure comparability of findings between cultures and societies. But reaching a consensus about a definition in order to standardise diagnosis does not indicate that the concept defined amounts to a value-free object for scientific research.

Again, an additional effect of the refusal to consider explicitly problems of value has been the blurring of the distinction between pathology and deviance. Rather than question why a piece of behaviour is regarded as pathological or deviant, human scientists working within positivistic assumptions tended to accept the behaviour as a naturally occurring category and proper object for scientific investigation. Thus, homosexual behaviour amongst men changed from being the object of criminal law to being the object of psychiatric investigation as a form of pathology without question as to the assumptions involved in regarding homosexuality as an illness.[3] Similarly, rebelliousness amongst women who were dissatisfied with their socially-allotted role could be regarded as a form of pathology solely on the basis of their deviation from the role of wife and mother, which was 'normal' for women during the 1950s (Friedan, 1963).

3.3 Relationship between client and professional.

The implications of positivism for human sciences which have been discussed so far have been of a theoretical nature; that is, they have suggested why positivistic methodologies produced knowledge of limited value in the fields of psychiatry and psychology. The third implication of positivism is practical, and refers to the effect of positivism upon the way a professional regards a client.

Positivism teaches that scientific knowledge can only be attained by maintaining an attitude of objectivity and detachment from the problem being considered. Over-involvement will almost certainly lead to subjective biases being introduced. The correct stance for a clinician attempting to apply the scientific discoveries of psychiatry or psychology is therefore one of clinical detachment. The assumption is that the scientist is a person who, by special training, has learnt a particularly pure method of observing the world, at which she is now an expert. The client, who is most often a lay person, has not acquired this expertise and is probably not very well educated. Therefore, the client has nothing to contribute to the exchange. He is present solely in the capacity of object of scientific scrutiny, whose symptomatology and pathology will be diagnosed and treated by the expert. Clearly, this is not an approach which would tend to encourage professional empathy with the client's predicament or needs as defined by himself.

4. Improving social status and increasing influence of psychiatry as a profession.

Much of the material which has already been presented in this chapter is relevant to a discussion of the increasing status of mental health professionals as a whole throughout the first half of this century. Medical psychiatry was claiming to have made theoretical advances in the understanding of some forms of mental disorder. Practical advances were also being claimed in the form of physiological treatments, whose efficacy was, it was argued, being hindered only by the institutional context within which psychiatry was compelled to work. Psychology, psychoanalysis and related professions were expanding rapidly, and extending the field of mental health intervention into a range of new fields. Psychiatry and psychology were increasingly successful in legitimating themselves as bona fide sciences by positivist standards of science. The purpose of this section is to demonstrate the level of success which psychiatrists and psychologists had achieved in promoting their disciplines and achieving support for their ends amongst educated lay people.

At the end of the nineteenth century, psychiatry had been the object of much suspicion and distrust. The nineteenth century wave of curative optimism, which had resulted in the establishment of purpose-built asylums throughout Britain, had collapsed. The asylums were overcrowded with deteriorating patients who were not expected to leave. The asylum system had become plainly carceral, rather than therapeutic, providing fuel for the popular belief that mental disorder was associated with violence and dangerousness, and that mental patients needed to be kept locked away for the benefit of the general public. A series of scandals, in which sane persons had been improperly incarcerated in asylums, had increased distrust of psychiatry. The Lunacy Act

1890 had been passed, severely curtailing psychiatrists' freedom to hospitalise and treat patients. Specifically, admission to an asylum was permitted only upon certification by a magistrate. Psychiatry was not at that time widely regarded as a credible branch of medicine.

Throughout the first half of the twentieth century, this view of psychiatry was systematically reversed, as psychiatrists and psychologists exploited the advances they claimed to have made, worked towards closer integration with other health services, and promoted the benefits which their disciplines had to offer. The main thrust of the mental health lobby's argument was that psychiatry did now have a proper scientific basis, and the legal restraints upon its practice were in the contemporary context merely handicapping its ability to help needy people. Legal restrictions prevented them from treating patients early, at a time when chronic deterioration could still be prevented. The stigma involved in the legal process of admission to an asylum contributed also by discouraging people from presenting themselves for treatment sufficiently early for effective treatment to be possible. The very existence of the asylum system, separate and distinct from the rest of the health services, was itself stigmatic enough to make people reluctant to enter as mental patients. The provision of an adequate psychiatric service depended upon the separation of psychiatry's therapeutic function from the custodial function of the asylums. A major triumph was achieved in 1930, with the passing of the Mental Treatment Act (MTA). Section 20 of this Act stipulated that asylums would henceforth be referred to as mental hospitals. Provision was also made within the Act for voluntary admission to a mental hospital in cases where the prospective patient was able to make an application in writing (MTA 1930 s.1).

In 1948 a closer relationship between psychiatric services and general medical services was facilitated by the establishment of the National Health Service. For the first time, psychiatry was placed within the same administrative framework as the rest of medicine. Psychiatrists were themselves arguing for still closer integration of psychiatry into general medicine, and suggesting not only that psychiatry had scientific knowledge with which to treat mental disorder, but that psychiatric and psychological knowledge could be of benefit to medicine as a whole. Harris (1955) devoted his Presidential Address to the Royal Medico-Psychological Association to 'The Contribution of Psychological Medicine to General Medicine'. He referred to the importance of emotion in the etiology and treatment of many physical symptoms and the need to take into consideration 'not only the local pathological process, but the patient as an individual and how he reacts to his illness' (Harris, 1955:9). Furthermore:

> Psychology should not be regarded as a part of the speciality of psychiatry, but as a basic subject in the medical curriculum as are anatomy and physiology, which should be taught to students in order to enable them to gain the fullest possible knowledge of the human individual. (Harris, 1955:9)

The continuing existence of separate institutions for mentally disordered patients was a major barrier to the full integration of psychiatry and medicine. From the 1950s onwards it was increasingly assumed by politicians and service providers that psychiatric treatment in the future would not be provided in separate institutions, but would be provided in purpose built acute psychiatric units within the grounds of local general hospitals. These units would not provide long-term care, because the purpose of a modern hospital is not to provide social care, but medical treatment. Whatever non-medical care was necessary would be provided within the community by the newly created welfare services. The old mental hospitals would become redundant as

their existing patient populations died or were rehoused elsewhere. This perspective is reflected in Enoch Powell's 'watertower speech' to the National Association of Mental Health, delivered in 1961, in which he challenged the apparent permanence of the mental hospitals, which appeared:

> isolated, majestic, impervious, brooded over by the gigantic water-tower and chimney combined rising unmistakable and daunting out of the countryside. [Quoted in Unsworth, 1987:262]

The Mental Health Act (MHA) 1959 was created with the assumption that future mental health provision would be based upon a policy of care in the community. It was both the first new piece of mental health legislation since 1930, and the first to offer explicit support for the new policy. However, the MHA is better known for the radical changes it introduced into the process of admission to hospital. The willingness of Parliament to enact this legislation is itself an indication of the social approval which mental health professionals had attained amongst educated lay people. The Lunacy Act 1890 had been passed with the intention that its provisions for certification of patients entering asylums would constitute civil safeguards, preventing wrongful detention. The MHA reflects the belief of Parliament, during the late 1950s, that wrongful detention by doctors was a less serious or probable threat than was failure to receive treatment for a treatable mental disorder. Voluntary admission, introduced by the Mental Treatment Act 1930, was abolished and replaced by informal admission, under which provision a patient could admit themselves to a psychiatric facility with no more formality than was necessary for admission to any other medical facility. The vast majority of patients who had previously been involuntary became informal. Compulsory or formal admission no longer required the signature of a magistrate, or any other civil official. Admission to hospital for most formal patients would

be obtained on the authority of two doctors, one of whom must be a psychiatrist, plus either a relative of the patient or a social worker. Unsworth (1987) classifies the difference between the provisions of the Lunacy Act and the MHA 1959 as representing a transition from a legalist approach to mental health legislation to a therapeutic approach. That is, the Lunacy Act's sole aim was to protect the liberty of people who were not insane. It played no role in ensuring provision would be made, or would be adequate, for those who were in fact in need of treatment or care. The MHA was not passed primarily with a view to protecting liberty. It assumed modern psychiatric practice to be benign, humane and scientific, and not a serious threat to civil liberty. Its intent was to ensure that treatment and care would be available to those who might require it with as little bureaucratic interference as possible.

The level of confidence in psychiatry which the MHA reflects can also be seen in the reports and Parliamentary debates which preceded the act. Prior to the legislation being drafted, a Parliamentary Royal Commission, headed by Lord Percy, was created to report on the existing state of mental health legislation in England and Wales. The subsequent report, the Percy Report, was published in 1957. The commission was evidently swayed by the claims of psychiatrists to have made great advances over the previous half century, as it concluded:

> Disorders of the mind are illnesses which need medical treatment. Great progress has been made during the present century in developing methods of treatment for many forms of mental disorder. Even when the disorder cannot be completely cured, it is often possible for the patient to live a happy and useful life in spite of some continuing mental weakness. (Percy Report:5).

Similar confidence was expressed both in the House of Commons and the House of Lords. A major contributor to the debate was Edith Summerskill MP, herself a medical practitioner, who felt:

> the public is not aware of the modern methods of treatment such as electro-conclusive therapy, insulin treatment, and improvements in psychotherapy, which have not only revolutionized our attitude to mental treatment but have, indeed, provided cures for people who would in the past have been regarded as hopelessly insane. (HC debates, 573:45)

Speaking in the House of Lords, Lord Taylor commented:

> This revolution has not come about as the result of the processes of law, but as the result of advances in medical treatment. There have been a staggering series of advances in physical treatment, and I have no doubt that those advances will continue. (HL debates, 216:704)

Some caution was expressed about the extent of expertise which was being attributed to medical practitioners, and the power which the proposed legislation would allow psychiatry to exert over patients. Reservations were expressed particularly with respect to the new diagnostic category of psychopath, which was to be given legal recognition in the Act. The concept of psychopathy was revolutionary in that it was defined neither in terms of impaired intelligence dating from childhood, nor in terms of gross changes in function in adulthood. Its symptoms were quite simply persistent anti-social conduct. This diagnosis is a very clear example of the expansion of psychiatry beyond its traditional, seriously disordered patient group, and out of its traditional asylum-based locus of delivery, into new forms of deviance and disorder, in this case the prisons and criminal deviancy. The best known

objections to the inclusion of psychopathy in the act are those of Baroness Barbara Wootton in the House of Lords:

> the medical profession carries a very high prestige in the world today, and there may be a tendency to attribute to persons who are learned in medicine a wisdom in all spheres which they would be the first to disown...
>
> I see the creation of this new category of psychopaths as one stage in a very important social development which seems to me characteristic of our age; that is, the encroachment of the science of medicine into the province which was formerly reserved for morals. (HL debates, 216:717-8)

Others did not perceive the powers to be given to doctors over the 'psychopathic patient' as problematic, and indeed welcomed them as evidence of scientific and social progress. Edith Summerskill, who expressed general enthusiasm about the Bill, thought if anything the problem of psychopathy should be still more firmly handled.

> Now, I am glad to say, many prison officials and many judges are beginning to appreciate that those who are so afflicted are distinctive types, emotionally and instinctively unstable, who have no more power to control their conduct than the epileptic can control his fit. It seems to me that the whole problem of psychopathy is not tackled with the necessary conviction and firmness, considering the huge number of people involved. (HC debates, 573:50-1)

Dr Reginald Bennett's contribution to the debate around psychopathy is particularly interesting as it reflects a total lack of concern for the rights and liberty of people who might be diagnosed psychopathic, and an interest

solely in the medical control of a potentially deviant group of persons. Dr Bennett was not even confining his comments to people who had broken the criminal law, as he thought:

> We ought to try to get them before they are criminals, and before they are labelled with a far worse stigma than mental illness. (HC debates, 573:74)

Many of the comments reproduced above, particularly in support of the concept of psychopathy, reflect the impact of positivism upon psychiatry, as discussed in section 3. Deterministic theories and a refusal to consider issues of value in psychiatric theory produce a situation where the distinction between mental disorder and social deviance becomes increasingly blurred. Medical approaches are extended to include forms of behaviour which are not overtly disordered, but simply deviant. The third impact of positivism is also present, in the lack of awareness of, or interest in, the potential patient's view of her circumstances. Dr Bennett's contribution above constitutes a particularly clear example of the way in which positivistic approaches regard the patient as an object for scientific intervention. To propose that individuals should be identified and subjected to treatment on the basis that it is believed that they might possibly become criminal in future constitutes a negligent attitude towards the rights of individuals which, in a Western liberal society, is quite unacceptable. However, Dr Bennett's attitude towards psychopaths is only an extreme example of a more general disinterest in the patient's viewpoint which is exhibited throughout the debates. Dr Summerskill plainly regards psychiatric patients as entirely helpless in the absence of expert assistance:

> Often a nurse is attracted to nursing because of her maternal instinct, and in the mental hospital she can, indeed, express

> that maternal instinct in a very fine and noble way, because the patients there are, in fact, her helpless charges. (HC debates, 573:46)

The primary exception from this attitude towards the patient is found in the contribution of Dr Donald Johnson, who expressed by far the greatest sensitivity for the feelings of the patient, and is worth quoting at length:

> At the risk of continuing in heresy, I maintain that no-one can give us better criticisms of what is wrong than the patient, even when the patient, as occasionally he does complains. After all, there is nothing like being at the receiving end...
>
> We are united in this House this afternoon in our anxiety to take the stigma out of mental illness. In this process we can start now, because if there is one thing more than anything else on which the mental patient and the ex-mental patient feel they are stigmatized it is that they are discredited people, that no-one will believe them, no-one will listen to them and give them facilities for putting their case...
>
> Their complaint is, first, the attitude with which they are regarded by those they meet in the institution when they enter it. Coming from the outside world as they do, and being not always dull people but frequently especially sensitive people, they feel that very strongly. (HC debates, 573:83)

It might be regarded as strange that both the most and the least paternalistic contributions to the debate were contributed by MP's who were also medical practitioners. However, the difference between Dr Johnson and Drs Summerskill and Bennett is that Dr Johnson was speaking as an ex-mental patient.

5. Implications of the provisions of the Mental Health Act for the doctor-patient relationship.

Donald Johnson's speech to the Commons during this debate highlights a contradiction within the intentions of the legislators. Traditionally, psychiatrists had treated people who had been declared insane and therefore incompetent. Such people were expected to be removed to an asylum against their will, and be kept there and treated without consent until such time as the doctor declared them fit to leave. Therefore the asylums constituted an institutional context within which the patient-inmate could be treated as an object without reference to her own expressed interests. Her very presence in the asylum indicated that she could not determine her own best interests, and that the psychiatrist was the appropriate expert to decide when she had been restored to her right mind and could be released into the freedom of once more pursuing her own interests. Thus, the asylum system was one within which positivist approaches to behaviour could flourish without contradiction.

However, the aim of the MHA was to place psychiatry within a similar institutional context to general medicine. Patients within general medicine choose to enter into treatment in hospital, and are free to choose to leave treatment. If they do choose to leave, this action is not generally interpreted as being itself the consequence of the illness for which they were initially admitted, as a general physician does not normally expect his diagnosis to extend to casting aspersions upon the patient's status as a free agent. However, a psychiatrist is explicitly concerned with the personality and behaviour of the patient as a whole. Thus, within the context of psychiatry, a patient might be deemed to have entered hospital freely as an informal patient, but his subsequent decision to leave might be interpreted

by the psychiatrist as itself evidence of pathology, and he might then be discouraged or even prevented from leaving on the grounds that his mental condition prevented him from really understanding what he was doing. Indeed, during his stay in hospital, any behaviour or demands which the medical staff regard as undesirable might be interpreted as further evidence of illness, and disregarded or punished on those grounds. Particularly within a positivist approach to psychiatry, within which the emphasis is placed upon the psychiatrist as recognised expert and the patient as object of intervention, it is likely that the patient's attempts to operate as a free agent will not meet with a great deal of sympathy from the medical staff. Thus, a contradiction is likely to become apparent between the patient's belief that he has entered hospital as a matter of choice, and the psychiatrist's belief that because the patient is in hospital he cannot really be thought capable of free choice.

That members of Parliament contributing to the debate preceding the passing of the MHA were not aware of the importance of this contradiction is apparent from many comments made during the debate and quoted above. Provisions for informal and formal admission are regarded primarily as means of ensuring that psychiatrists have easy access to patients needing treatment. It is not expected that patients will have good reason to argue with their psychiatrists about the nature of the treatment on offer. Only Donald Johnson appears aware that admission to hospital as either an informal or a formal patient has implications for the patient's credibility as a person worth listening to. Given the existence of this contradiction between the theoretical and legal status of the majority of psychiatric patients subsequent to the 1959 MHA and their actual status in the eyes of mental health professionals, the emergence

in subsequent years of a movement of patients and ex-patients determined to improve their status within the services is unsurprising.

6. Psychiatry in relation to the social and political climate of the 1950s.

The improvement in the status of psychiatry and related professions during the twentieth century did not take place in isolation from broader social and political change. In fact, the fortunes of psychiatry at this time can be related directly to a more general shift in social and political philosophies during the period.

In the nineteenth century, classical liberal ideology exercised an important influence on the development of the relationship between state and society, although the Victorian period was also characterized by increasing interventionism in areas such as public health and factory conditions. During the first half of the twentieth century, however, the emphasis shifted towards progressive or 'the new' liberalism.

Classical Liberalism had its roots in the thought of philosophers such as J.S.Mill, whose aim was to lay out rationally the extent and limits of liberty which could be allowed to the individual, and thus to define the point at which the state could legitimately intervene in the activities of the individual. The purpose of this exercise was to defend the liberty of individuals against the encroachment of the state. The Lunacy Act 1890 has in fact been interpreted as a classical liberal reaction to burgeoning collectivism. Unsworth (1987: 145) has characterised the New Liberalism as attempting:

> to reconcile the essential Liberal devotion to individual freedom and a state limited by the rule of law, with a new perception of social interdependence and the need for principles of social reciprocity and collective responsibility to order political priorities.

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The basis of the New Liberalism is to be found in twentieth century confidence in modern civilisation's ability to build a scientifically planned social and economic system which would work for the good of all. It involves a compromise of the classical liberal demand for individual negative liberty in the interests of a greater collective good. The new confidence in social planning was shared also by more Left Wing groups, who did not share the Liberal concern for the liberty of the individual at all, but were entirely collectivist in outlook; for example, the Fabian Socialists, who were supportive of the project for a planned society to the extent of advocating eugenics before World War 11. By the post-World War 11 era, a large measure of consensus had been reached about the form which a planned social system ought to take, and the plans were in place for the development of the Welfare State. The bulk of the Welfare State legislation was passed by the Labour Government of 1945-51. The Mental Health Act 1959 represents the final building block in the creation of a comprehensive system of welfare.

Fabian Socialism was resolutely pro-interventionist, and saw the role of the state as being the promotion of the well-being of society as a collective unit. The New Liberalism had compromised its allegiance to individual freedom by conceding the need for a sizeable input of centralised social planning. The result was that the welfare state legislation as a whole reflected a concern not only for the needs of the individual, but for the needs of society as a whole; for example, it was necessary for workers to enjoy a minimum level of wealth and medical care, not only for their own benefit, but to enable Britain as a whole to compete effectively in industry with its competitors abroad. It tended to be assumed even by Liberals that in a properly planned society there was no conflict between the good of the individual and the good of the collective, and specifically that there would be no circumstances where

pursuing the good of the collective would result in serious injustice in terms of the good of individuals. Unsworth (1987: 231) refers to the 1950s as characterised by:

> the dominance of a consensual reformist optimism that society was becoming more humane and civilized and that this progressive social enlightenment would foster unilinear development in social policy.

This political consensus that the society being created would be the most just and desirable possible for everyone in it also had the effect of ensuring that dissent from that prevailing belief would not be taken seriously. Adequate provision of welfare for all was expected to herald the end of class conflict and social injustice. Consequently it was expected that the grounds for political dissent, activism and discontent had been removed. People who refused to be contented, and continued to engage in political activism, could be regarded as not merely nonconformist, but as irrationally and pathologically deviant. Just as criminality was being increasingly defined by mental health 'experts' as pathology, extreme political dissent was categorised in the same way. An example can be found in the Proceedings of the British Student Health Association (1963) [quoted in Madison, 1972]:

> One is struck very forcibly by the external appearance of students with regard to hygiene, clothing and C.N.D. badges. You only have to look at them to tell they are unstable.

However, this era of apparent political stability was, by the late 1950s, already drawing to a close. Clarke et al (1975) have suggested that the illusion of stability rested upon three very fragile pillars: affluence, consensus and embourgeoisement. It lasted only as long as did those pillars.

Increased affluence, measured in absolute terms, was undeniable during the immediate post-war era, although relatively the economic position of the classes remained virtually unchanged. But by the end of the decade, the boom was drawing to an end and Britain was entering a period of seemingly irreversible economic decline in terms of its position in world markets. The Conservatives maintained power by a series of give-away budgets, which preserved their own popularity at the expense of long-term economic security, until a Labour Government was finally returned in 1964. By then, the economic growth which had characterised the immediate post-war period had slowed dramatically. The funding necessary for the comprehensive welfare policies which had been promised was no longer available. Cross-party political consensus was similarly short-lived. Consensus had been formed around the provision of welfare. Conservative commitment to welfare policies constituted co-option of territory which had previously been distinctively that of Labour. Without a distinctive platform, Labour lacked a clear alternative to offer to the electorate and offered broad support to Conservative government policies. Likewise, working class voters, Labour's natural electorate, both supported the new welfare state values and enjoyed increased wealth. The bases for intra-societal conflict appeared for a time to have been removed and the working classes appeared to be undergoing a process of embourgeoisement, actually becoming more middle class in outlook and aspiration. But this apparent embourgeoisement was itself merely the product of affluence and consensus, and dissolved as the boom ended, and funding for welfare became less and less adequate. By the early 1960s, mainstream political divisions were again becoming apparent.

Cultural forms for the expression of dissent already existed in pockets by the early 1960s, and emerging dissent built upon these foundations. The youth

culture had begun to emerge during the 1950s. Since the War, age had been emerging as a more visible form of social division than class. Full employment and high wages resulted in young people being materially better off and enjoying more independence than at any time previously. New industries, such as the music industry, began to target youth. Early youth sub-cultures emerged during the 1950s among working class youth, in the form of groups such as the Teddy boys. These groups offered young people a distinctive identity and sense of group membership. Clarke et al (1973) have suggested that these mainly working class groups served a sociological function for their members in enabling them to deal meaningfully with the contradictory demands inherent in the roles they were expected to play. Specifically, working class youth experienced heightened expectations of their place in society, whilst in reality social inequality continued to exist. During the 1960s, the youth culture began to include more middle class groupings, in the form of the counter-culture and the hippies, who used such groupings to express their own dissatisfaction with their society.

Young people were also important supporters of protest movements which emerged during the late 1950s. The most important such movement was the Campaign for Nuclear Disarmament (CND), formed in 1958. Bogdanor and Skidelsky (1970:13) have commented:

> Both C.N.D. and the 'Teddy boys', in their highly dissimilar ways, were a foretaste of the new power of youth to fascinate, alarm and disrupt adult society, as well as being early symptoms of an alienation from the meritocratic, technological goals of the affluent society. It was, above all, the arrival of youth on the political stage that marked the beginning of the end of consensus.

Movements had existed since the dropping of the atomic bomb on Hiroshima and Nagasaki in 1945 to protest against the rapid proliferation of nuclear weaponry amongst the western nations. However, a number of factors caused the issue to draw widespread public attention by the late 1950s. The Suez crisis of 1956 caused general alarm. Also, Britain was stating her willingness to use nuclear weapon in case of attack by the USSR whilst acknowledging her own inability to cope in case of nuclear attack. Medical evidence was growing on the effects of radiation. In 1957, J.B.Priestley published an article in the New Statesman expressing support for unilateral disarmament (Taylor, 1970). C.N.D. was formed in January 1958, and the first Aldermaston march took place at Easter 1958. C.N.D. rallies during 1958 produced the largest crowds in Trafalgar Square since V.E. day, giving an indication of the level of popular support the movement attained at the end of this most quiescent of decades. C.N.D. did not achieve its goal of preventing the escalation of the nuclear arms race. Taylor (1970: 250-1) has commented:

> C.N.D. never evolved from being a movement of emotional and moral protest...
>
> [But] although its success was partial and its momentum lost after 1961, C.N.D. brought some fresh air into the stuffy atmosphere of British politics...But its importance lies in the fact that it became a liberation movement of the younger generation.

Also in evidence during the 1950s was a cultural phenomenon which would provide a springboard for middle-class counter-cultural youth protest during the 1960s. This 'movement' was made up of the writers and philosophers who attracted the label 'Angry Young Men'. Their work constituted an aggressive rejection of the values of post-war society. Cooper (1970) dates the movement

from the publication of John Wain's Hurry on Down in 1953. However, it reached its apex towards the end of the decade with publication of Colin Wilson's The Outsider (1956) and the first performance of John Osborne's Look Back in Anger (1957), from which the phenomenon derived its name.

The novels and plays of the 'Angries' presented an entirely negative critique of the materialism, snobbery and self-seeking of the affluent society, without offering any kind of positive alternative. For example, John Osborne's Jimmy Porter is a man at war with a world which he finds trivial, superficial and hypocritical. Cooper (1970) regards this anger as directed against an effeminate society, and suggests that the Angries' often savage treatment of women is an indication of this basic stance. However, the rejection of bourgeois affluence does not connote a commitment to an alternative; for example, Marxism is not favourably viewed.

The absence of any positive critique amongst the novelists and playwrights is rectified by Colin Wilson's (1956) The Outsider. For Wilson, the problem is that society is dominated by the three outlooks of Materialism, Humanism and Rationalism. For Wilson, these three outlooks entail a catastrophic limiting of man's potential.

> the problem is a metaphysical one. It is a problem of man's consciousness. Man is sick, in 'despair', because at present his consciousness is limited, and lacks all intensity...
> [The Rationalist conception of knowledge] fails to realise that the knowledge to be gained from such methods is only a fraction of 'real' knowledge, which requires 'intuition' and 'involvement'. (Cooper, 1970:269-70)

The Outsider of Wilson's title is the rare and creative man who has not become trapped within the limited consciousness of Western society, but has 'seen too much and too deep' and 'for whom the world as most men see it is a lie and a deception' (quoted in Cooper, 1970: 270). The broad social and political solution to society's problems is revealed by Wilson in his second book, Religion and the Rebel, in which he proposes that the 'outsiders' should be entrusted with leadership of society for the benefit of all. If those people of lower consciousness who do not share the outsiders' vision object, their objections are to be dismissed. The outsiders are to remain in power even if this entails the deception of the mass of the ordinary people. The vision is based upon the existentialist tradition, dating back to Nietzsche, with whom Wilson is very impressed. It is in places highly authoritarian, totalitarian and very unpleasant. As Cooper (1970: 270) points out, The Outsider is:

> little more than a much needed potpourri of the writings of thinkers of a certain ill-defined tradition - the anti-rationalist and nihilist-cum-existentialist-cum-mystical.

The Angries' books express a dissatisfaction with the affluent, technologically sophisticated and non-visionary nature of Western society. This is expressed in more sinister form in a number of the science fiction novels which became popular during the post-war era. Orwell's 1984 (1949) presents a vision of a future in which society is almost perfectly engineered by an omnipotent state working for the 'collective good'. However, the vision is not of a Utopia, but of a nightmare world in which individuals have no option but to believe whatever the state tells them and obey its dictates. Huxley's Brave New World is a fictional account of a culture in which technology produces absolute conformism. In the context of the position of psychiatry within the technological society, a particularly interesting

example of this genre is Kesey's One Flew Over the Cuckoo's Nest (1962), a fictional account of patients' life in a male psychiatric hospital. The novel's hero, McMurphy, is admitted to the hospital having pleaded insanity in an attempt to avoid a prison sentence Once admitted, he becomes the rebellious catalyst who stirs his fellow inmates into a new sense of their own capacity for self-determination. In response, the hospital staff arrange for McMurphy to be subjected to brain surgery, thus defusing his capacity to break the hospital's grip on its patients. A particularly interesting facet of the novel is the point at which McMurphy discovers that all of his fellow patients are 'voluntaries' and could in theory leave the hospital whenever they chose. They are not kept there by physical restraint, but by their own inability to resist the authority of the doctors and nurses. The extent to which the legal status of psychiatric patients is meaningful or important is a theme with which anti-psychiatry has been greatly concerned.

In conclusion, although the consensus of political opinion during the 1950s appeared to point to an increasingly stable, affluent and controlled society, in which conflict would not occur, in fact numerous factors indicated that this stability was largely illusory. The economic base upon which the consensus rested was itself less stable than was believed, and by the early 1960s the affluence which had promised abundant funding for welfare and the end of class conflict was at an end. Existing minority protest movements and cultural critiques began to gain popular audiences. These protest movements and critiques were concerned with challenging the fundamental basis on which post-war society had been built: the ideals of consensus, adjustment, and reasonableness. Psychiatry, as one of the technologies for the promotion of consensus, adjustment, and reasonableness would shortly find its new-found

status under serious attack, and this attack would achieve itself achieve remarkable prominence in the emerging counter-culture.

Footnotes to Chapter 2

1. In fact, absolute normality never occurs. We are all neurotic to a greater or lesser extent.

2. This description is intended to be a simplified presentation of behavioral therapies as practised before the 1960s. Behavioral therapy as it exists today combines behaviourist approaches with cognitive elements in a far less mechanistic fashion, and is a highly effective treatment for disorders such as phobic states.

3. Finally, in 1973, the American Psychiatric Association decided that homosexuality was not a form of mental illness by process of a majority vote!

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Chapter 3 Emergence of New Approaches within Psychiatry

By the early 1960s, approaches to psychiatry were emerging which challenged the positivist consensus.

1. Social psychiatry and the therapeutic community

Social psychiatry was an outgrowth of mainstream psychiatry, and not anti-psychiatric. However, at the time of its emergence it was perceived as quite radical and threatening to psychiatry as traditionally practised. It constitutes the first attempt during this era to link psychiatry and politics in an explicit fashion, being based in 'anti-Fascism and a democratic communalist response to totalitarian values' Unsworth (1987: 263-4). Social psychiatrists argued that the causes of pathology in the individual were to be found not in the internal processes of the individual, be they conceived as psychological or physiological, but in his social relationships. Therapy for the individual must, therefore, involve treating his immediate social relationships and, ultimately, the kinds of relationships characteristic of society as a whole. This involved challenging the commonly accepted values and standards of society. Maxwell Jones (1968:30) described Social Psychiatry as:

> an 'elastic' concept, to include all social, biological, educational, and philosophical considerations which may come to empower psychiatry in its striving towards a society which functions with greater equilibrium and with fewer psychological casualties.

Probably the best known form of Social Psychiatry is the therapeutic community (TC), associated especially with Maxwell Jones.[1] Jones derived his theory of the TC from his experiences as an army psychiatrist during the war. He was placed in charge of a psychosomatic unit studying 'effort syndrome', a disorder characterised by symptoms such as pain over the heart region, breathlessness, palpitation, postural giddiness and fatigue, arising fundamentally from psychological rather than physical causes. Therapy involved explaining to patients how their symptoms arose, and teaching techniques whereby they could be brought under the patient's control. Staff shortages meant that the only practical way in which the educative component of treatment could be implemented was by delivery of a didactic lecture. Jones discovered that the most effective teaching took place when patients became involved in a two way interaction involving doctors and other patients in discussion. Patients were more than happy to become involved in teaching the skills they had acquired to other patients, and this appeared to have a therapeutic effect for both educators and educated. By the end of the war, Jones was convinced that the interaction taking place amongst patients could be promoted as a powerful therapeutic tool. Specifically, patients and staff alike benefited from examining in daily community meetings what they were doing and why they were doing it (Jones, 1968).

After the war, Jones organized a treatment unit for British ex-prisoners of war returning from prison camps, which he ran as a 'transitional community' according to principles formed within his psychosomatic unit. The success of this venture prompted the Ministries of Health, Labour and Pensions to initiate a treatment unit for 'social misfits' under his direction. This was initially known as the Industrial Neurosis Unit, Belmont Hospital, later changed its name to the Social Rehabilitations Unit, and in 1959 became a

separate hospital, the Henderson Hospital. At Belmont, Jones developed his theories about the therapeutic potential of community to extend beyond the immediate therapeutic environment experienced by the patient, and to include the social organization of the hospital as a whole (Jones, 1968:18).

The fundamental principle underlying the philosophy of the TC in its final developed form was the breaking down of hierarchies within the hospital and the democratisation of the therapeutic process. Everything which happened in the hospital was to be regarded as potentially an opportunity for therapeutic intervention. Everyone on the ward was both potentially a therapist and potentially a patient. This democratic and egalitarian approach was put into practice by means of regular meetings of the whole ward, staff and patients, during which any person's behaviour or any issue on the ward could be raised for discussion. Decisions were to be made by open discussion and consensus within the group of patients and staff. The aim was to encourage patients to achieve higher levels of insight into their behaviour, and to learn new and more effective ways of functioning in society.

A distinction between the theory of TC and anti-psychiatry is that TC did not question the attribution of pathology to the patient. That is, it did not consider at all the view expressed in Proposition 1 of the anti-psychiatric attitudes listed in chapter 1, that mental illness is a myth. It traced the roots of the pathology to the society within which the individual lived, and to some extent redefined the location of the pathology as existing within the society as a whole rather than solely within the individual. The therapy experienced by the individual was intended to be a contribution not only to his own well-being but to the transformation of society as a whole in the direction of more democratic and less authoritarian ways of functioning. But

TC did not share the view of anti-psychiatry that the concept of mental disorder as an internal characteristic of the individual was a 'myth'. However, TC did offer something of a challenge to positivist conceptions of psychiatry in that it tempered the view of the psychiatrist as expert, and redefined the relationship between psychiatrist/professional and patient as a more equal dialogue, to which the patient was expected to contribute.

It is notable that Jones did not work with acutely disturbed psychotic patients. The ward at Belmont was intended to provide therapy for patients who had been diagnosed psychopathic. It aimed to provide the kind of community within which anti-social behaviour could be systematically eradicated by publicly challenging it and training patients in more pro-social forms of behaviour. Two points are noteworthy here. Firstly, the notion of the TC constitutes a form of the psychiatric faith in the therapeutic power of community which was also driving the move towards the policy of care in the community throughout mainstream psychiatric practice. Although Jones actually worked with specialised communities within hospitals, the ultimate goal of Social Psychiatry was to transform the whole of society into a therapeutic community designed for the promotion of mental health. Secondly, Miller (1986) has identified the extent to which the opposition of psychosocial therapies to strictly medical approaches to mental disorder has resulted in an expansion of mental health interventionism, such that the main endeavour of psychiatry is ceasing to be cure. Instead, psychiatry is becoming a prophylactic endeavour whose object is the whole of society, and whose aims are those of normalisation in the name of a high standard of mental health. The focus of Jones upon patients who attracted the dubious diagnosis of psychopath would suggest that TC was more closely related to the project of normalisation rather than the traditional aim of cure.

The view of TC as a technique of normalisation, rather than a genuine attempt to democratise psychiatry, is born out by accounts of TC as it was put into practice. The level of democracy achieved within the TC's was not great. Jones' own comments reveal the limitations of what was achieved; and the extent to which medical staff retained control. Within Belmont, although most meetings were open to staff and patients, the staff continued to hold separate meetings for staff only. Jones justified this practice by the argument that patients need to feel that staff members' problems are not overwhelming in order to be able to trust staff to deal competently with patient needs. He foresaw that it would be necessary to continue to hold staff meetings separately 'until such time as community techniques have reached the point of perfection when patients can safely be told the whole truth' (Jones, 1956). A continuing distinction was therefore being made between staff, who needed to be shielded from the danger of being revealed to patients as incompetent, which would undermine their therapeutic authority, and patients, who were expected to be incompetent and to look to the staff for guidance. It is of interest that Jones views the ongoing need for this distinction of roles as a technical problem which will be solved rather than a political problem which will be negotiated. For Jones, democracy is a therapeutic tool rather than a fundamental political right.

A similar perspective emerges from Rapoport's (1960) account of Belmont; for example, Rapoport points out that staff and patients do not define patients' problems in the same way.

> Patients' complaints are seen [by staff] as manifestations of underlying problems of personality organization, and are re-defined in socio-psychiatric terms. (Rapoport, 1960)

In other words, ultimately patients do not define their own reality: doctors define it for them. Similarly, in evaluating the effectiveness of the treatment, Rapoport favours the doctors' judgements over those of the patients:

> While the doctors are the principal enthusiasts for the Unit methods, they are also the most sophisticated in clinical experience...Accordingly, we shall rely on the doctors' rating of improvement rather than on the 'patients', which seem to be coloured with wishful thinking. (Rapoport, 1960)

In conclusion, the TC approach does represent a more politically aware and less straightforwardly positivistic approach to psychiatry than was common during the 1950s. In particular, TC questioned to some extent the values of society at large, and approached the patient within the context of those values, rather than assuming that the goal of psychiatry was to adjust the individual to fit into society as it exists now. However, TC failed to address fully the political issues posed by traditional psychiatric practice. Democracy was promoted in theory, but not fully implemented in practice. Patients remained very much constrained within staff-defined limits, and patients' subjective views of their own circumstances continued to be secondary to the 'expert' opinions of staff. In fact, TC actually extended the range of aspects of the patient's life in respect of which staff could claim expertise, defining the patient's entire social existence as legitimate territory for therapeutic intervention. In addition, TC was not intended by Jones to cater for the needs of acutely disturbed patients, but for forms of socially deviant behaviour on the borderline between mental health and criminal law. TC was at the spearhead of the expansion of psychiatry into milder forms of social disturbance, with the aim of normalisation rather than

cure, whilst leaving the type of provision available for psychiatrists' most disturbed patients largely unmodified.

2. Non-positivist Psychotherapeutic Approaches

By the late 1950s, a number of schools of psychotherapy had come into existence which rejected the positivist scientism of both psychoanalysis and behaviourism, and aimed to offer alternatives. Although these alternatives originated in America, they were influenced powerfully by the European existentialist philosophy popularised during the post-war period by Jean-Paul Sartre. Existentialist philosophers reject the causal, mechanistic view of human beings associated with positivism. Instead, people are regarded as beings whose fundamental nature is to form themselves through choices and actions. The value of life for the existentialist is to be found in the pursuit of authenticity; that is, the state of having freed oneself from the falsehoods and illusions which separate a person from the pursuit of her true self. The philosophy tends towards both nihilism and heroism. Nihilism results because the truth for existentialism is that there is no meaning inherent in the human condition. Life has only the meaning which human beings give to it. But a kind of heroism is manifested when a person succeeds in giving his life authentic meaning in the face of bourgeois pressure merely to conform (Macquarrie, 1973:32-33).

In Europe, psychoanalysis and existentialism were being synthesized in the work of therapists such as Ludwig Binswanger. In 1958, May, Angel and Ellenberger published Existence: a new dimension in Psychiatry and Psychology, which included an english language translation of Binswanger's celebrated case history of Ellen West, a young anorexic patient who committed suicide.

Binswanger interpreted the woman's disorder not in terms of unconscious dynamic forces which determined her behaviour, but in terms of her pursuit of meaning and authenticity in her own life, and her ultimate decision to bring her life to an end.

In America, existentialism was a major influence upon the new schools of humanistic psychotherapy which were developing. The founder of humanistic psychotherapy, Carl Rogers, criticized traditional psychotherapy for being concerned only with the alleviation of the patient's symptoms, and the process of readjusting the patient to society as though he was a malfunctioning machine. Rogers argued that the focus of therapy ought not to be the resolution of problems, in respect of which the therapist was thought to have some technical knowledge. Instead, the focus ought to be upon the client as a whole person, striving to form an identity and find meaning in life. The problems which the client brought into therapy ought not to be regarded as isolated symptoms to be eradicated, but rather, in the context of the client's whole self, as opportunities for growth to realized. As such, the patient ought to be at the centre and in control of the therapeutic process, actively exploring and developing his own identity and role in life. The role of the therapist was to provide the correct kind of relationship with the patient within which such psychological growth and development could take place. Rogers believed that this relationship should be characterised by three attitudes of the therapist towards the client. The therapist should be genuine with the client, show him unconditional warmth and acceptance, and exercise empathic understanding of the client. The existence of these three attitudes on the part of the therapist is, for Rogers, the most important condition for successful therapy (Fonagy and Higgitt, 1984:88-89).

Although influenced by existentialism in his view of the fundamental nature of humans, Rogers' theories do not reflect the more negative and nihilistic aspects of the philosophy. Rather, his view of human nature was extremely optimistic. He believed that humans are born essentially good, with the potential for immense psychological growth, but that this potential is warped and damaged by the relationships they experience as they grow up. The therapist can provide a 'corrective relationship', characterised by the unconditional warmth and acceptance which has been missing from earlier relationships, within which the client can realise the potential which has been frustrated since birth.

The humanistic therapy movement includes a range of widely-known therapists who share Rogers' belief that it is the basic nature of human beings to develop and realize their potential. Fritz Perls conceptualized such growth as the increasing realization of wholeness and unity of the personality. Abraham Maslow wrote in terms of the ultimate human need for 'self-actualization', or the realization of one's true potential.

3. Thomas Szasz

The early 1960s witnessed the beginning of the long publishing career of Thomas Szasz. Szasz is the first theorist to be discussed here who attracted the label 'anti-psychiatric'. Szasz was (and is) a psychiatrist working in private practice as a psychodynamically-oriented psychotherapist in America, and Professor of Psychiatry at the University of Syracuse. In 1960, he published an article in The American Psychologist entitled The Myth of Mental Illness, followed by a book of the same name (Szasz, 1972), elaborating his arguments. The basic thesis of the work is, as the title indicates, that

mental illness is a myth (see Proposition 1 of the 'anti-psychiatric attitudes' listed in Chapter 1). That is to say, the states of mind and behaviour which psychiatrists identify and treat as mental illnesses cannot constitute illnesses at all in any meaningful sense of the term. Illness means organic malfunction of the organs of the body. As the mind is not an organ, it cannot be said to be ill, other than in the metaphorical sense in which we might call a joke 'sick'. The states which we identify as mental illnesses are simply examples of deviant behaviour and belief which break the norms for conduct in our society. Szasz goes on to argue that the myth of mental illness has been created and perpetuated to provide a pseudo-scientific justification for the state to detain forcibly individuals whose behaviour it does not like, but who cannot be detained under the criminal law. Even individuals who apparently volunteer for state-provided psychiatric treatment cannot be genuinely regarded as voluntary patients as long as the threat of compulsion can be used if they refuse to co-operate voluntarily. Szasz proposes that state-provision of psychiatric care for 'mental illness' ought to cease. He suggests instead a 'game-playing' model of human interaction in which social transgressions are approached quite explicitly as deviations from the rules of a social game. Individuals ought to be free to enter into a contractual relationship with a therapist in order to improve their effectiveness at playing such games. Individuals who do not enter into such a contractual relationship ought to be subject to the powers of criminal law, if their behaviour is criminal, and left alone if it is not. Szasz (1973) elaborated the analysis further, comparing the status of psychiatric patients in the twentieth century to that of the 'witches' and 'heretics' persecuted for their views in earlier periods of history. Since the early 1960s, Szasz has published a prolific output of journals articles and books developing his thesis. The basic premises of his argument remain unchanged.

Szasz is the originator of many of the views which were identified in chapter 1 as characteristic of anti-psychiatry, notably the views that mental illness is a myth (Proposition 1), psychiatry is a form of social control (Proposition 2), compulsory treatment ought to be abolished (Proposition 9), and individuals ought to be held responsible for their own behaviour at all times (Proposition 11). However, closer scrutiny reveals that Szasz's psychiatric agenda is not radical in the sense of being politically progressive. Szasz objects not only to compulsory psychiatric treatment provided by the state, but to any form of state provided psychiatric treatment at all. One side of the Szasz 'myth of mental illness coin' states that involuntary psychiatric patients are victims of state oppression. The other side states that voluntary psychiatric patients, and those who use the insanity defence to avoid the penalty of the law, are malingerers, and that, in this case, we the tax-payers are the victims. Szasz's blueprint for the future of psychiatry is a straightforward plea for a free-market approach to provision of psychiatric care. Therapy is to be based upon a contract between client and therapist, where the therapist provides the care which the patient approves and for which the patient pays. Szasz does not object to people pursuing their own myths, provided they can and do pay for them.

Szasz's argument constitutes an entrenched restatement of the classical liberal position which was so severely undermined during the first half of this decade. He believes that the only values worth pursuing are individual freedom and responsibility for self. Anything which weakens the promotion of individual freedom and responsibility is a bad thing, and a particularly bad thing if the tax payer is to be expected to pay for it. Sedgwick (1982) has described Szasz as an intellectual descendant of Herbert Spencer, the American philosopher best known for his application of the evolutionary principle of

selection of the fittest to human society. Szasz is best viewed not as a progressive in the field of mental health, but as a reactor against the growing tendency to state-controlled provision of welfare, which characterised the first half of this century in both the United States and Britain (see Chapter 2). The incorporation of Szasz's ideas into Left wing political critiques of psychiatry is at the root of many of the problems which characterise anti-psychiatry.

4. Sociological critiques of psychiatry.

The 1950s and 1960s saw not only the rapid expansion of social science as an academic discipline, but also the production of new and more critical approaches to social science. Much sociology had tended to be positivistic in the sense of accepting socially-defined concepts uncritically as valid and scientific objects for research. For example, Durkheim's 1897 classic study of suicide had relied on official statistics for rates of suicide in populations (Durkheim, 1951). However, suicide is not a naturally occurring category of behaviour, but one which is constructed by members of a particular society as a result of assumptions about motive, social desirability and so forth. That is, the decision that a person's death will be recorded as suicide is the result of a series of value judgements. Fluctuating rates in official data will be affected not only by changes in the 'real' rate of suicide, but by changes in the definition of suicide, the standards used to judge when it has taken place, and the readiness of coroners to reach that verdict. A similar problem exists for psychiatric epidemiology generally. The rate of a particular psychiatric disorder in a population depends not only upon 'real' fluctuation, but upon factors such as changes in how mental illness is conceptualised, and willingness of individuals to present

themselves for diagnosis. A good example of this is the decision of the American Psychiatric Association to stop categorizing homosexuality as a form of mental illness, taken in 1973. This decision resulted in a dramatic decrease in the prevalence of 'sexual deviation' in the population simply as a result of the changed definition. This decrease was slightly offset by the creation of a new category of 'disorder', 'sexual orientation disturbance', to be applied to gay men and women who are disturbed by their sexual orientation (Davison and Neale, 1982:363). This new category might itself be expected to fluctuate over time, as the experience of feeling disturbed about one's sexual orientation is undoubtedly linked to the way society at large views one's sexual orientation, which would change as a result of the APA's own decision.

There had been some earlier criticism by sociologists of the use of concepts such as 'mental hygiene' to justify social control of working class populations; for example, the work of Kingsley Davis (1938). In America during the post-war years, sociologists began to become increasingly concerned to question categories of social behaviour produced within other disciplines. Forms of deviance theory, such as symbolic interactionism, or labelling theory, emerged as a technique for questioning the process by which labels came to be attached to particular pieces of behaviour. Deviance theorists approached the object of their enquiries by 'bracketing off' the 'real nature' of the behaviour in question, and investigating instead the process by which that behaviour came to be defined as deviant, and the consequences of that label for the deviant person. They recognised explicitly that deviance is not a universally applicable category, but one which is constructed in different ways by particular societies at particular times.

Edwin Lemert (1951) argued that deviant behaviours, including mental disorder, were merely culturally unusual behaviours which met with socially and culturally formed disapproval and sanctions. The social reaction and sanctions played a part in shaping and actually perpetuating and increasing primary deviance. Labelling theory was most powerfully applied to the situation of psychiatric patients by Thomas Scheff (1966). Scheff hypothesized that:

1. Residual rule breaking arises from fundamentally diverse sources (ie. organic, psychological, situations of stress, volitional acts of innovation or defiance).
2. Relative to the rate of treated mental illness the rate of unrecorded residual rule breaking is extremely high.
3. Most residual rule breaking is "denied" and is of transitory significance.
4. stereotyped imagery of mental disorder is learned in early childhood.
5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.
6. Labelled deviants may be rewarded for playing the stereotyped deviant role.
7. Labelled deviants are punished when they attempt the return to conventional roles.
8. In the crisis occurring when a residual rule breaker is publicly labelled, the deviant is highly suggestible and may accept the label.
9. Among residual rule breakers, labelling is the single most important cause of careers of residual deviance.

Goffman's (1962) perspective is similar to that of Scheff in so far as Goffman attempts to comprehend asylum inmates' strange behaviour as a comprehensible response to the roles they have been allocated, rather than as a manifestation of internal pathology.

Scheff has become widely accepted as one of the founders of anti-psychiatry. The view that mental illness, and the various diagnostic categories included under that generic title, are 'only labels' is traceable to Scheff's labelling theory. However, the question must be raised of the extent to which Scheff intended his theory to be proposed as an absolute alternative to psychiatric theories, rather than as a more critical commentary upon psychiatric self-confidence. Certainly, Scheff (1966) appears to place great emphasis upon the role played by the labelling process in continuation and exacerbation of deviant behaviour, stating 'Labelling is the single most important cause of residual deviance.' However, in his first hypothesis Scheff proposes a list of possible causes of residual rule-breaking, including organic and psychological sources. Therefore it would appear that, although Scheff views deviance as primarily a matter of social attribution, he does acknowledge that behaviours which become labelled deviant might have an identifiable cause. Certainly, by the mid-1970s, Scheff was attempting to distance himself from the anti-psychiatric position.

> Although I had hoped that my work might have some effect on psychiatry, my primary purpose was not related to psychiatric theory or practice...
>
> the purpose of a purely sociological model is not to replace the psychiatric perspective, but to serve as a corrective to the exclusive emphasis of the medical model on the isolated individual. (Scheff, 1975:254-255)

In the 2nd edition of Being Mentally Ill (1984) Scheff amended his view that 'labelling is the single most important cause of careers of residual deviance' in favour of the view that labelling is 'among the most important causes'.

5. Early work of Laing.

The name most commonly associated with anti-psychiatry in Britain is that of R.D.Laing. However, Laing's written work was produced over a period of several decades, and does not form one complete and internally consistent whole. In fact, his work can be divided into three fairly distinct phases. During 1955-1964 he pursued a basically orthodox, although quite innovative, psychodynamic approach to psychiatry. Between 1964 and about 1970 he was publishing the work and advocating the forms of practice which are most readily identified as anti-psychiatric. From 1970 until his death in 1989, he was practising as a psychotherapist, with an interest in rather fringe approaches, such as the exploration of pre-birth experience and the promotion of natural childbirth. This section will deal with the first phase of his thought, which was pre-anti-psychiatric. Laing's interests at this time derived from two main sources. Firstly, he was interested in the application of existentialist philosophy to psychiatric disorder, and particularly the integration of existentialism with psychoanalysis. Secondly, he was very interested in social psychiatry and the therapeutic uses of community.

5.1 Existentialism and Psychoanalysis

Laing began his career as a psychiatrist with the British Army, where he completed his national service between 1951 and 1953. Already, he had a keen interest in those philosophers who offered an alternative to a

positivistically conceived 'technosociety' during the 1950s; for example, Heidegger, Sartre, Merleau-Ponty, Husserl, Kierkegaard and Nietzsche (Laing, 1985:89). Subsequently, Laing worked as senior registrar at the Southern General Hospital, where Glasgow University's Department of Psychological Medicine was based. Here, he was attached to Ferguson and Rodger's ward, which was psychoanalytically oriented. He met Aaron Esterson (co-author of Sanity, Madness and the Family, 1964), who shared his interests in philosophy, and particularly existentialism. Indeed, Aaron Esterson (interview) recalled Laing and himself as being the only two people there who shared an existentialist view of psychiatry, and the belief that orthodox psychiatry was damaging people. In 1957, Laing moved to London to take up a post at the Tavistock Clinic and to undergo four years of training at the Institute of Psychoanalysis. Esterson moved also to take up a post at a hospital in London, and he and Laing began the joint research which would form Sanity, Madness and the Family.

Laing began to publish his work on psychoanalysis and existentialism in 1957, beginning with a paper entitled An examination of Tillich's theory of Anxiety and Neurosis. In 1959, The Divided Self was published, a book which Laing had begun writing in Glasgow. Laing described his intention in this book as being:

> to make madness, and the process of going mad, comprehensible... A further purpose is to give in plain English an account, in existentialist terms, of some forms of madness. (Laing, 1965:9).

The Divided Self advocates a novel approach to understanding psychosis. Laing approaches psychosis as resulting from an attempt by the patient to solve an existential dilemma. In his view, the psychotic person is someone who fears other people because they pose a threat to her continuing existence, not in

the sense that they are a threat to her actual life, but in the sense that they threaten her being. Specifically, the psychotic person fears that others threaten her existence as a separate person because she experiences them as wanting to engulf her, to depersonalise her, or to cause her to implode.[2] The psychotic person employs avoidance strategies which take the form of constructing what Laing identifies as a schizoid personality; that is, the person defends her 'real self' by keeping it hidden, and relates to others only through a false self system constructed for public presentation. However, one's 'true self' is able to develop and thrive only in and through interaction with the outside world. Kept from interacting with that world, it becomes increasingly unreal and lacking in substance. Laing argues that psychosis results when, eventually, the 'true self' becomes so divorced from reality that it is based entirely in fantasy. If the false self system then breaks down, and the true self begins to appear, the person appears in a state of psychosis; that is, completely out of touch with reality. In addition to his use of existentialist terminology, Laing adapts concepts from mainstream British psychoanalysis; for example, his notion of the 'false self system' is derived from Winnicott's work. The Divided Self is notable as a presentation in popularly accessible form of some of the ideas of British psychoanalysts working on the nature of psychosis, a form of psychological disturbance in whose treatment organicist medical psychiatry held an increasing monopoly.

The aim of The Divided Self is to make madness and the process of going mad comprehensible, and Laing succeeds in providing a clear account of the experiences and anxieties of the psychotic patient in a way which has been recognised and appreciated by many people. The Divided Self aims to render the behaviour and experience of psychosis comprehensible, not through the characteristically esoteric codifications of psychoanalytic theory, but

through the same processes of understanding which we would apply to any piece of 'normal' speech or behaviour. Laing acknowledged an important debt to Freud, as the first person to attempt to make sense of the apparently incoherent utterances of psychosis. However, he considered that even Freud had approached his patients from a standpoint of alienation and difference, rather than from one of sympathy and understanding.

> The greatest psychopathologist has been Freud. Freud was a hero. He descended to the 'Underworld' and met there stark terrors. He carried with him his theory as a Medusa's head which turned these terrors to stone. We who follow Freud have the benefit of the knowledge he brought back with him and conveyed to us. He survived. We must see if we now can survive without using a theory that is in some measure an instrument of defence. (Laing, 1965:25)

It is perhaps Laing's willingness to take seriously at face value the viewpoint of his patients which is his real legacy to the user movement within mental health services today.

But Laing's belief in the readily accessible meaningfulness of all human behaviour, has also proved to be a highly problematic aspect of his work, even at this early stage. In The Divided Self, although Laing attempts to make his patients' behaviour comprehensible, it is apparent that he continues to regard it as nonetheless pathological. Schizophrenia is still regarded as a bona fide diagnosis, associated with particular psychological and psychodynamic difficulties which take place within the patient. Laing appears to have rejected an organic 'disease' theorisation of schizophrenia, but still adheres to the concept as an identifiable syndrome of psychodynamic disorder. However, even at this early stage, Laing's reformulation of psychoanalytic

theory through a marriage with existentialism was being subjected to criticism from within the psychoanalytic establishment.

For psychoanalysis, mental pathology is explained in terms of unconscious conflicts which come to be expressed through the symptom formation of neuroses and psychoses. Neurosis is believed to stem from conflicts formed comparatively late in childhood, after the development of a coherent sense of self, capable of interacting rationally in relation to reality and other people. Thus neurosis does not impair globally the structure of personality, but manifests itself in comparatively isolated forms of symptomatology. Psychosis, on the other hand, is believed to stem from a much earlier period of childhood, when the infant was still at a stage of 'primary narcissism', and unable to interact or form relationships with other people. The symptoms of psychosis reflect the state of the person trapped within her own world of phantasy, unable to relate to those around her. Psychoanalysis identifies the rational thought processes of the mature ego, capable of interacting with others, as 'secondary process'. The primitive processes of the unconscious, as expressed in dreams, are 'primary process', and essentially non-rational. Whilst the neurotic patient's symptoms are expressions of primary process thought, the majority of the neurotic's conscious thought is secondary process. However, the psychotic patient is thought to be trapped entirely in a world of primary process thought, with no means of interacting realistically with other people. Thus, psychoanalysis distinguishes neurosis from psychosis on the basis of a distinctly different pattern of symptomatology. For Freud, his interpretations were not a defence against relating directly to his patients, but an acknowledgement that their speech and behaviour had to be interpreted to make any sense in terms of rational secondary process conscious thought. Therefore, in refusing to accept the classical psychoanalytic

framework for the interpretation of psychosis, Laing weakened the distinctive psychoanalytic theory of psychosis, and surrendered that in psychoanalysis which explained why psychotic patients are so incomprehensible. Freeman (1961:80), reviewing the book for the British Journal of Medical Psychology, criticised Laing for committing himself to a theory of psychosis indistinguishable from that of neurosis, and dismissed Laing's claim that:

> the concepts of clinical psychiatry, and Freud's psychoanalysis are inadequate for the task of understanding the nature of the mental disturbance and for appreciating the patient's unhappy state. This is a claim for which there is not the slightest justification.

Brierley (1961:291) in the International Journal of Psychoanalysis viewed Laing's ideas as falling within the boundaries of psychoanalytic theory, but cautioned against too radical a rejection of the basics of psychoanalytic theory.

Subsequently, however, Laing's work took him in precisely that direction, towards more drastic reformulations of psychoanalytic theory which would render it compatible with existentialism and phenomenology; for example, the emphasis within Sartrean existentialism upon free will and action does not coincide with the emphasis of Freudian psychoanalysis upon unconscious determination of behaviour. Laing began his second book, <u>The Self and Others</u> (1961) with a re-examination of the psychodynamic theory of the unconscious with the aim of rendering it more consistent with existentialist philosophy. Within Laing's reformulation, unconscious experience becomes that which a person does not communicate either to other people or to himself. Unconscious

processes contain those things which an individual has yet to work out about himself and admit to himself. The irreducible strangeness and irrationality of the unconscious as it breaks into consciousness in the state of psychosis, as conceived in classical Freudian terms, is very much absent. Psychotic experience is regarded as highly comprehensible in commonsense terms.

The Self and Others (1961) offers the basis for a theory of the origins of psychosis. In The Self and Others, Laing traces the origins of psychosis to early childhood and familial relationships, basing his argument upon the work of American psychoanalytic theorists who had been studying the dynamics of families of psychotic patients. Laing and Esterson were particularly influenced by Bateson's theory of the 'double bind' (Bateson, Jackson, Haley and Weakland, 1956). Aaron Esterson (interview) recalled that the discovery of the Bateson et al double-bind paper was very important to the way his and Laing's work progressed. The theory is discussed at some length in The Self and Others. 'Double bind' denotes a particular pattern of familial communication, which is maintained over an extended period of time. This pattern takes the form of a 'primary negative injunction' of the form 'don't do that or I will punish you', accompanied by a 'secondary negative injunction', which conflicts with the first, and is present at a more abstract and covert level. There should also exist a 'tertiary negative injunction', which prevents the victim of the double bind from simply leaving the situation. Laing (1971:146) provides an example of such a situation:

> A mother visits her son, who has just been recovering from a mental breakdown. As he goes towards her
>
> (a) she opens her arms for him to embrace her, and/or
>
> (b) to embrace him
>
> (c) As he gets nearer she freezes and stiffens.

(d) He stops irresolutely.

(e) She says, 'Don't you want to kiss your mummy?' - and as he still stands irresolutely

(f) she says, 'But dear, you musn't be afraid of your feelings.'

Bateson et al and Laing argue that there is no way in which to respond rationally in such a situation. Repeated exposure to this kind of scenario will systematically undermine one's capacity to deal with reality, resulting in behaviour which appears increasingly bizarre and outlandish, and ultimately results in a diagnosis of psychosis. However, closer examination of the behaviour seen in context reveals it as a wholly comprehensible response to an impossible social situation.

In Sanity, Madness and the Family (1964) Laing and Esterson applied their conclusions about family dynamics and psychosis to a sample of eleven female inpatients at the London hospital at which Esterson was employed. The purpose of this study is somewhat obscure. The method employed was to take lengthy tape-recordings of discussions during which a psychiatrist was present with various combinations of family members, with or without the patient. The patients' 'psychotic' symptoms and experiences could then be reconsidered not in isolation, but in the context of the communication network of the entire family. Laing and Esterson claimed to have demonstrated that much of what patients said and did was a comprehensible response to the familial situation within which they lived. However, it is unclear what conclusions the reader is expected to draw from this claim. Laing and Esterson state that they regard schizophrenia as a hypothesis, rather than as a proven clinical fact. They reference Szasz's The Myth of Mental Illness as part of their justification for this belief and they state that the purpose of the

publication is not to argue a psychodynamically based theory of the origins of schizophrenia.

> Inferences about experiences that the experiencers themselves deny, and about motives and intentions that the agent himself disavows, present difficulties of validation that do not arise at that phenomenological level to which we have restricted ourselves. (Laing and Esterson, 1970:26)

They do, however, promise that later publications will include more psychanalytic perspectives upon the material.

Neither is their purpose to argue for a theory of family pathology, in which the patient is merely the symbol and embodiment of a pathology which involves the entire family system.

> The concept of family pathology is..., we believe, a confused one. (Laing and Esterson, 1970:22)

Laing and Esterson claim that this work constitutes an entirely new and different approach to schizophrenia:

> We believe that the shift of point of view that these description both embody and demand has a historical significance no less radical than the shift from a demonological to a clinical viewpoint three hundred years ago. (Laing and Esterson, 1970:27)

It is difficult to avoid the conclusion that the studies are intended to provide evidence for what Siegler et al (1972) have termed a 'conspiratorial theory' of schizophrenia; that is, the claim that the 'psychotic' person has been allocated that diagnosis simply in the interests of other members of the family, and exhibits no distinctive pattern of disturbance or pathology at all.

Some further light is shed upon this issue by Esterson's (1972) <u>The Leaves of Spring</u>. This comprises a more detailed account of the case of Sarah Danzig, one of the women included in <u>Sanity, Madness and the Family</u>. The volume presents a more detailed phenomenological account of the Danzig family dynamics. Again, the emphasis is placed upon the coherence, when placed in familial context, of Sarah's apparently crazy statements. As promised in <u>Sanity, Madness and the Family</u>, more psychoanalytic interpretations are included. However, these interpretations are not interpretations of the content of Sarah's psychosis in the classical psychoanalytic sense. They are predominantly interpretations of how other family members relate to Sarah in terms of their own phantasies; for example, her parents' behaviour is interpreted by Esterson as their responding to their daughter as a potentially incontinent bowel (Esterson, 1972:117).

Finally, Esterson concludes with a discussion of his conclusions about the nature of psychosis. He considers that:

> A person subjected to prolonged and intense mystification may be driven crazy or frantic as if crazy if he is placed in a position in which he can no longer maintain a feasible identity. This happened to Sarah Danzig and the others labelled schizophrenic described in <u>Sanity, Madness and the Family</u>. (Esterson, 1972:253)

The distinction between being crazy and being frantic <u>as if</u> crazy is then developed.

> There is, of course, considerable difference between being labelled mad, and being mad. Some labelled schizophrenics are mad by any criterion that I know. While some, in my experience,

> are not, but have been mystified into believing that they are.
> And some have been driven frantic as if they were mad.
> And even the mad ones are not necessarily mad in the way they are said to be by those who label them. (Esterson, 1972:261-2)

In summary, it appears that for Esterson the root problem is that positivistic psychiatry fails to distinguish people who are really mad from people who are merely either the focus of a familial conspiracy or being driven frantic by their family. Laing and Esterson's phenomenological approach appears to be intended as a device for rectifying this situation by identifying those patients whose behaviour makes sense when placed in familial context. The approach is, therefore, a conspiracy theory approach, in so far as it claims to demonstrate that the patients studied by Laing and Esterson were the victims of a kind of conspiracy, albeit one which was largely unconscious in a psychodynamic sense. However, according to Esterson the authors did not intend to imply that there are no people who are really mad. Interestingly, neither does Esterson intend his work as an argument against all classifications of madness.

> Nor is it an argument against all forms of classifying mad persons. Classification is necessary as the analytic moment of the dialectic, but it should be on the basis of understanding their existential problems, not on the basis of assuming they are suffering from a clinical one. (Esterson, 1972:266)

The primary difficulty which is now posed by Laing and Esterson's collaborative work, as viewed by Esterson (1972), is the problem of how those who are 'really mad' are to be distinguished from those who are the victim of a familial conspiracy. This problem is particularly aggravated by the notion that some people who are 'really mad' have been driven mad by their families,

and are therefore still victims of some kind of conspiracy, and that all people who are 'really mad' must in any case be approached in existential terms. This problem would be eased had Laing and Esterson chosen to present case studies of some of these patients who turned out to be 'really mad', which would allow the reader to draw some kind of conclusions about how the authors define 'real madness'.[3] In fact, not only are such case studies not presented, but Laing and Esterson (1969:14) have argued that:

> Surely, if we are wrong, it would be easy to show it by studying a few families and revealing that schizophrenics really are talking a lot of nonsense after all.

But Esterson's own stated viewpoint would suggest that he himself thinks that at least some schizophrenics 'really are talking a lot of nonsense'.

Sanity, Madness and the Family appears to represent the culmination of this direction of Laing's thought in a fully fledged conspiracy theory. Laing and Esterson's stated position towards the concept of schizophrenia is ambivalent. They do not reject the possibility of schizophrenia as an identifiable syndrome, but they do elect to ignore it.

> we...described the family relationships phenomenologically. Neither organic pathology, nor psychopathology, nor for that matter group pathology...is assumed to be or not to be in evidence. This issue is simply bracketed off. (Laing and Esterson, 1969:19)

However, the thrust of the presentation is such as to lead one to believe that such pathology has not only been 'bracketed off', but has ceased to exist for the researchers. The case histories are presented in a fashion which highlights the function served for the whole family of having one of its members identified as the patient and admitted to hospital. The 'patient' is

recast as victim of a family conspiracy, albeit one which is largely unconscious.

In short, the attempt to marry psychoanalysis to existentialism fails, as the distinctive contribution of psychoanalysis to the understanding of psychosis is ultimately sacrificed in the interests of promoting the existentialist emphasis upon freedom, choice and rationality.

The publication of these three of Laing's early works precede the development of anti-psychiatry as a popular political outlook. It must be asked to what extent they already embody some anti-psychiatric assumptions. This is a difficult question to answer unequivocally. Arguably, neither Laing nor Esterson argued overtly that schizophrenia does not exist as an identifiable disorder, but only that some people who have been diagnosed schizophrenic are more the victims of their social and familial nexus than of any internal organic or psychological pathology. However, Laing and Esterson's work suggests that they are confident that the majority of clinical diagnoses of schizophrenia are made in respect of persons whose behaviour is potentially entirely comprehensible in the light of their familial context. In relation to these patients, Laing and Esterson are agreed that schizophrenia is a label applied by doctors in collusion with families for purposes of social control, and that mental illness is a myth justifying social control. Although the 'anti-psychiatric phase' of Laing's work does represent an identifiable transition from this earlier body of work, the seeds of many ideas which are associated with anti-psychiatry were already in place by 1964.

5.2 Social Psychiatry and the Therapeutic Community

Much space has been devoted here to Laing's attempt to unite existentialism and psychoanalysis, and the difficulties which that was already producing, by 1964, in accounting for the pathologically disordered behaviour which attracts the label 'schizophrenic'. As was noted at the beginning of this chapter, Laing's work was based also upon the theories of social psychiatry and the therapeutic community movement. His interest in the potential of community was demonstrated as early as 1955, in a report of a social psychiatric research project conducted on a chronic Ward at Glasgow Royal Mental Hospital (Cameron, Laing and McGhie, 1955). Laing and his colleagues arranged for a group of patients on the female refractory ward to be exposed daily to a more stimulating social environment, where they had the opportunity to become involved in various kinds of occupations and to interact with each other and with nursing staff. The patients showed marked improvements and lost many of the features of chronic psychosis (Cameron et al, 1955:1386). The philosophy behind this experiment plainly shows allegiance to social psychiatric approaches, with the authors concluding that 'the most important therapeutic element in the environment is the people in it' (Cameron et al, 1955:1384).

In London, Laing and Esterson continued to pursue together an interest in the therapeutic potential of communities. They had set up a study group on existentialism and psychiatry, and during the early 1960s were contacted by David Cooper, a psychiatrist who had recently arrived in London from South Africa. Cooper was then employed at Belmont Hospital, although not on Maxwell Jones' ward. Subsequently, Cooper moved to Shenley Hospital in London, where he set up the 'Villa 21' experiment. Laing, Esterson and Cooper believed that Jones' therapeutic communities constituted an immense step forwards for psychiatry, but were limited in that they continued to be overly controlled by their staff. Mary Esterson (interview) recalled visiting the therapeutic

community run by Pippard at Claybury in about 1964, which was a well-known example of the therapeutic community ideal in practice.

> We were just raising our eyebrows at each other at what was going on. There were these community meetings of the whole community, staff and patients, which was run by the chief male nurse. [a] psychiatrist would come along and there were various sub-meetings afterwards including the staff meeting. And the meetings all went in a very conventional way, and afterwards we got to talk to the nursing staff and they were beside themselves with all the usual complaints about the psychiatrists, complaints about the patients, complaints about the system. It was exactly the same old [set-up] which had all been disguised.

Aaron Esterson (interview) added:

> The other influence in this country was Maxwell Jones at Belmont with his psychopath unit. Now that was supposed to be another place where people were being treated with a democratic system. But that was fairly closely controlled.

Cooper set up a therapeutic community at Shenley, which became known as Villa 21. The outcome of this experiment is described in Psychiatry and Anti-Psychiatry (1970). Mary Esterson worked at Villa 21 and was able to supply additional historical detail. Villa 21 was considered a very radical project, as it aimed to offer therapy to young first-time admission male schizophrenic patients without use of drugs, but with careful structures of group meetings and group therapy. Within 1 to 2 years of its having been established, Cooper was given authority to select his own staff, and took the opportunity to promote a nurse called Frank Atkin from staff nurse to charge nurse. Mary

Esterson identified Atkin as having provided much of the impetus behind the development of Villa 21.

> Frank was listening to the...music behind it, if you like, and actually started to play to that tune...If we are going to...abolish the staff-patient conflict...'Let's do it! Come on, let's do it. The tradition in mental hospitals is for patients to work, keep the place nice and tidy, and polish the floors. It keeps them out of mischief and you get a nice tidy ward that everybody's proud of. And we said, if there's no...staff-patient dichotomy, how can I tell Joe Soap to get on and polish the floor, or even to wash the dishes. Everybody must do it together or it doesn't get done, and the answer of course was that it didn't get done, because what we had was a group of...adolescent males who too had problems and who had probably never washed a dish in their lives anyway. But at the same time that kind of atmosphere was good for people. It didn't offer enough support - the people were very disturbed - but it didn't take anything from them either. It didn't undermine them, and it was real...People sat up all night around the fire talking - talking about families, talking about issues, talking about the theory of schizophrenia and so on.

The Villa 21 experiment was, predictably, a source of controversy within the hospital as a whole.

> Female nurses locked up their...young female patients for instance. You never saw them walking around the hospital, and the reason was Villa 21, all these wild young men...the hospital was terrified. These were...madmen who were not being drugged,

who were being given no drugs whatever, and they were being allowed to roam free.

Laing, Esterson and Cooper were becoming increasingly aware that working within the NHS set very narrow constraints upon what they were able to achieve, and began to examine the possibility of building communities outside the NHS where they would be free to put their ideas into practice. The Philadelphia Association (PA) was set up as a trust to manage such communities. Esterson (interview) identified the 'blueprint' for such a project as being derived from a community in Israel which he had visited. This community was run along the lines of a kibbutz. The patients ran everything: the ambulance, the administration, the kitchen and the restraint section. The only staff were the psychiatrist and one social worker. In 1965 the PA leased Kingsley Hall and the first and best-known PA community was established.

The plans and development of Kingsley Hall up to the time of its opening belong within the early phase of Laing's thought, the period of involvement with existentialist and phenomenologically based forms of psychotherapy. However, events at Kingsley Hall itself will be discussed in the following section, on anti-psychiatry proper, as the total history of the project falls most naturally within that context.

6. Laing and Cooper and the beginnings of antipsychiatry proper.

During the early 1960s, alongside publications in academic journals and books published by Tavistock Press, Laing was producing an increasing volume of work

directed at a broader cross-section of the population, particularly on the burgeoning counter-cultural soft-Left. His adaptation of Sartre's views on series and nexus to apply to family dynamics, which formed the theoretical basis of Sanity, Madness and the Family, was summarised in a paper for the New Left Review in 1962. In 1964, he contributed a further paper to the New Left Review, and in 1965 he published in Peace News and the Psychedelic Review. Laing was thus becoming well-known as a psychiatrist sympathetic to broad Left ideas, and prepared to connect his views about psychiatry to those ideas. He was beginning to present his psychiatric ideas in the context of a broader, if rather vague, political critique of Western societies. However, his ideas were also developing in a wholly new direction, which was very distinctively counter-cultural.

The counter-culture which was developing and becoming increasingly popular towards the middle of the 1960s was based around the rejection of conformity and the promotion of individuality, particularly the validity of individual subjective experience. LSD was a fairly newly discovered drug, which produced changes in consciousness, and was widely believed to result in a heightening of consciousness. During the early 1960s it was not yet illegal, and provided opportunities for many people to experience new, and apparently profound, psychological/spiritual 'trips'. Aldous Huxley and Timothy Leary had been promoting these benefits in the United States. Parallels had been drawn already between LSD induced experience and the symptoms of acute psychosis, with some researchers wondering whether schizophrenia might be explained by brain chemical changes similar to those artificially induced by LSD. For a person who found LSD use beneficial, a related conclusion might be that schizophrenic patients were quite fortunate to be able to experience

'naturally' states of consciousness which had to be chemically induced in other people.

Similarly, the rejection of conformity, and of notions of normality, was producing a tendency within the counter-culture towards libertarianism. The emphasis upon immediate and direct experience produced a rejection of deferred gratification and planning for the future, in favour of maximising experience in the present. Together, these two sets of values tended to result in a rejection of rationally thought out behaviour, in favour of spontaneous, instantaneous behaviour. Madness could be regarded as the epitome of the rejection of rationality and the embracing of uninhibited, liberated action.

At this point, Laing produced a new theory of psychotic experience, in which schizophrenic symptomatology was no longer to be regarded as a problem, but as one stage in a natural psychic healing process. The schizophrenic patient was to be regarded as having embarked upon a journey of self-discovery, exploring uncharted areas of 'inner space'. According to Laing, medical psychiatry mistakes the external signs of this journey for the symptoms of a disease process, and intervenes to terminate it. However, if the person was allowed to live through the experience, complete the journey and return to ordinary experience in her own time, she would experience a form of natural healing and personal transformation.

Parts of The Politics of Experience (1967) reflect these views; for example:

> Instead of the mental hospital, a sort of re-servicing factory for human breakdowns, we need a place where people who have travelled further and, consequently, may be more lost than

> psychiatrists and other sane people, can find their way <u>further</u> into inner space and time, and back again. (Laing, 1967:105-6)

Laing's production of this set of ideas can be explained almost entirely in terms of the influence of the counter-culture. Sedgwick (1972:34-5) has noted that the introduction of Laing's new views was both sudden and confident. They were presented to predominantly non-medical audiences, through the media of left wing and counter-cultural publications and events. Sedgwick noted:

> Laing's presentations before medical audiences have continued in the vein of his pre-1964 theorizing: he does not usually try to tell doctors and psychoanalysts that their schizophrenic patients are super-sane voyagers into aeonic time. (Sedgwick, 1972:35)

Sedgwick (1972:39), speculating about the reasons for this sudden change of direction in Laing's thought, concludes that the 'psychedelic model' must be regarded as a logical progression out of Laing's previous views. Discussing <u>The Bird of Paradise</u> (1967), which is presented by Laing as the account of his own journey into inner space, Sedgwick speculates about the nature of this experience, and concludes that it is too coherent to have resulted from a personal breakdown. He notes that Laing himself rejected the suggestion that the experience was induced by LSD. However, there is ample evidence that Laing was deeply involved in the use of LSD during the early 1960s, and this undoubtedly had an effect upon the progression of his ideas at that time.

Similar, but not identical, ideas are found in Cooper's <u>Psychiatry and Anti-Psychiatry</u> (1970). Cooper falls short of making an identification between madness and true sanity. He does not suggest that the mad are really sane,

and vice versa. However, he comes close to this position, suggesting that madness may be closer to 'true sanity' than the state which most people accept as 'normal'. At this time, Laing and Cooper agreed that Western societies' definitions of madness and sanity are themselves a fundamental part of the problem. They differed about the nature of 'true sanity'. Laing appears to regard it as a state which can be approached as an individual via psychosis. Cooper believed it could approximate to psychosis, but that madness is ultimately not a route to sanity. This difference perhaps reflects Cooper's greater commitment to macro-politics and the pursuit of fundamental social change. For Cooper, sanity could never be the product of simple individual transformation. The whole of society must be transformed.

The development of Kingsley Hall reflects very clearly the counter-cultural progression and change of direction on the part of Laing and, to some extent, Cooper. For Aaron Esterson, Kingsley Hall was a great disappointment. He attributed its failure to the publicity which accompanied its opening, and its continuing association with popular, counter-cultural lifestyles and the promotion of 'dropping out' as a way of life. Aaron Esterson (interview) said that Kingsley Hall had only functioned as a community for psychiatric patients for a very brief period. In fact, it only ever housed two residents who could be classified as psychiatric patients, and it was doubtful whether one of those would have been diagnosed schizophrenic. He considered the project to have been 'spoiled by the publicity', which had resulted from its identification from the very beginning as a centre for the counter-culture. Mary Esterson and Aaron Esterson believed that the ethos had resulted in the romanticisation of serious psychiatric disorder. Mary Esterson recalled working with a party of film students at Kingsley Hall, and being shocked to

discover that one of them was disappointed at being informed that she was not schizophrenic.

> [At] that time, among the intelligent young people....that was the exciting thing to be. Laing had made it exciting, sound exciting to be schizophrenic....when you get somebody with a poor sense of their own identity, and you feed them the idea that it's exciting to be schizophrenic, that there's something very, very special about being schizophrenic, you have them turning up in droves saying me too, me too. And that's what you got.

Aaron Esterson commented upon the connection between Laing's ideas and the culture of the period.

> It had become 'fashionable'. You have to remember this was a time when the '60's were taking off with drugs. Cannabis was being smoked..And being mad was part of the thing. And...LSD...was started with Metzner and Alpert. 'Tune in, turn on, drop out.'...everybody wanted to drop out...This was 1964...being mad was a way of dropping out. All these things were coming together.

Laing and Aaron Esterson appear to have begun to disagree with one another from this time, both about Laing's increasingly romanticised conceptualization of schizophrenia, and about his use of LSD as a means of mimicking the psychotic 'trip'.

> I've never called myself, and I've always rejected the term, for me, anti-psychiatry....I'm against coercive psychiatry, I'm against the medical model of psychiatry. I do not regard schizophrenics at the fount of all wisdom. That being schizophrenic or being mad immediately puts you in touch with a

superior wisdom...I disagree with any implication of that in Laing's work...The main thing that we...diverged over was the use of drugs...I regarded LSD as a useful adjunct to be used carefully at times...Laing used to dish it out quite indiscriminately.

The best known product of Kingsley Hall is Mary Barnes, Barnes and Berke's (1973) account of Mary Barnes' time as a resident of Kingsley Hall between 1965 and 1968. The account has often been taken as a description of Laingian therapy in practice; for example, Szasz (1976). However, in fact Barnes and Berke had a private therapist-patient relationship, in which Laing was not involved. The account is relevant to Laing's work in so far as Barnes was resident at Kingsley Hall, and Berke's approach was influenced by Laing.

Barnes came to live at Kingsley Hall at the age of 44, following numerous admissions to psychiatric hospitals throughout her adult life. At Kingsley Hall, she was given freedom to experience and explore a total disintegration of her adult personality and regression to infantile modes of functioning for as long as she felt this was necessary, and to emerge when she felt ready to do so. She passed through a period when she insisted on being fed by Berke from a baby's bottle, and smeared faeces on the walls of her room. Finally emerging from her regressed state, she discovered some talent for painting, and her finger paintings were exhibited publicly. The story of Mary Barnes has been used to justify the validity of the Laingian approach. However, the account has not escaped criticism. Szasz (1976) argued that Mary Barnes' recovery owed less to anything therapeutic about her relationship with Berke than to the simple change in status which her new-found fame afforded her.

> Mary Barnes was reinflated, and inflated herself, with self-esteem. A crucial aspect of her relationship to Laing, Berke, and Kingsley Hall...lay in her transformation from 'paranoid schizophrenic'...into 'gifted painter'...
> This is very touching. But it is hardly a conceptual or moral breakthrough in treating children, psychotics, or others who need encouragement and are easy prey for flattery by superior persons on whom they are dependent. (Szasz, 1976:10)

Mary and Aaron Esterson offered similar criticisms.

> there were no patients except the famous and ubiquitous Mary Barnes, who did her own little take over of the place. And then she became, God help her, she became the star patient. She played a very determined part in making herself the star patient, but there were people around who ought to have known better...they knew what allocating roles of that kind did to people and here it was happening, you know, like somebody from Bedlam, somebody that people came from thousands of miles away to see. A spectacle, a woman who was running around in the altogether and smearing faeces on the walls.

Another well-known event associated with the anti-psychiatry of this era was the Dialectics of Liberation conference held at the Roundhouse, Chalk Farm in summer 1967 (Cooper, 1968). This event owed more to Cooper than to Laing, and aimed to draw explicit connections between the micropolitical analyses, with which the British 'anti-psychiatrists' were concerned, and macropolitical analyses of world events. The speakers at the congress were radical

psychiatrists and political activists of international repute, including Gregory Bateson, Herbert Marcuse, Lucien Goldman and Stokely Carmichael.

I have referred to this period, the latter half of the 1960s, as the time during which 'anti-psychiatry proper' emerged. The use of the term suggests that an identifiable constellation of ideas emerged at that time which can be categorised as anti-psychiatric. It is the case that Laing and Cooper shared views at that time which justify treating them as co-founders of an identifiable school of thought. Both had come to share the view that medical psychiatry was not in essence therapeutic, but was a tool for the maintenance of the status quo by the suppression of any individual subjectivity which threatened the status quo (Proposition 2 of the 'anti-psychiatric attitudes' listed in Chapter 1). Psychiatry was viewed as a set of techniques for suppressing dissent and creating conformity. The phrase 'anti-psychiatry' was coined by David Cooper to denote the alternative approach which was being developed through experiments such as Villa 21 and Kingsley Hall.[4] However, within the broad consensus which Laing and Cooper shared about the problems associated with medical psychiatry, there existed disagreements about the nature and significance of psychosis and the appropriate response, particularly with respect to the political analysis of the problem. The views of Laing and Cooper cannot be taken to be identical. Specifically, Laing did not adhere to a political analysis as explicitly worked out or as thoroughly Marxist as that of Cooper. That is, Cooper was more committed to proposition 3 than Laing. Cooper did not share Laing's view of psychosis as a form of natural healing. That is, Laing was more committed to proposition 5 than Cooper. These differences became more publicly apparent during the early 1970s, as the counter-culture disintegrated, and the anti-psychiatric group based around Kingsley Hall broke up. Laing and Cooper's attitudes towards the

more Szaszian anti-psychiatric propositions (propositions 1, 9 and 11) is less clear. Laing quoted Szasz in support of the approach to schizophrenia presented in _Sanity, Madness and the Family_, and Cooper quoted him in _Psychiatry and Anti-Psychiatry_. However, the quotes are not extensive, and both Laing and Cooper expressed minimal interest in the debate around psychiatry and the law. Szasz (1976) commented upon the British-based group of anti-psychiatrists' disinterest in the legal status of their own patients. These developments will be dealt with in Chapter 4.

Footnotes to Chapter 3

1. A less well-known therapeutic community approach was being developed contemporaneously with, but independently from, Jones' work by Tom Main of the Tavistock. Main's work was more psychoanalytically-based than that of Jones. It resulted in the establishment of the Cassel Hospital as a therapeutic community.

2. In fact, these are all common existential fears experienced by most people at some time. The psychotic person is distinguished by having organized her whole life around avoidance of these possibilities.

3. As things remain, those women patients who <u>are</u> studied are never reported to have spoken or behaved in a way which would indicate how even <u>they</u> came to be diagnosed schizophrenic in the first place. As Sedgwick (1972:26) has commented, nowhere in the interviews recorded in Sanity, Madness and the Family do any of the research subjects speak in a fashion which would lead one to suspect they might be in any way psychologically disordered. Rather, the contributions of the 'schizophrenic' women are presented as lucid and sane by comparison with the behaviour of their families.

4. The term 'anti-psychiatry' has been commonly assumed to denote a simple opposition to psychiatry; for example, Szasz (1976) rejected the term as applied to his own work because it suggested that he rejected everything which psychiatrists do which, as a practising psychiatrist, he found patently absurd. However, Cooper (1974) has claimed that the term was never intended to be used in that fashion. 'Anti' was not used to imply opposition, but to imply an absolute alternative, as in the phrase 'anti-art' to denote Dada. A similar parallel might be 'anti-Pope' to denote an alternative Pope to the established head of the Roman Catholic church. Although 'anti-' does denote opposition to the mainstream, it is in the sense of 'creative alternative to' rather than 'abolition of' the established figure. However, during the 1970s Cooper was distancing himself from all forms of therapy, including those proposed by his ex-colleagues in the Philadelphia Association, and proposing exclusively political solutions to the problem of mental disorder. Cooper's stance of opposition to all forms of therapy is discussed further in Chapter 4.

Chapter 4 Developments in British and American Anti-Psychiatry, 1970 Onwards

1. The Political Environment of the Early 1970s

In chapter 3, it was noted that anti-psychiatry in Britain derived from several roots. Laing, Esterson and Cooper's early work was based within mainstream psychiatric practice, albeit at the fringes of that practice, deriving from existentialist psychoanalytic approaches and the theory and practice of the therapeutic community, as popularized by Maxwell Jones. However, as the 1960s progressed, the British group acquired influences from diverse sources which were viewed sympathetically by the counter-cultural soft-left of the late 1960s. Thus they came to be influenced by the libertarian views of Thomas Szasz, a libertarian reading of labelling theorists such as Thomas Scheff, and by various counter-cultural influences. Laing was mainly influenced by notions of changed consciousness, derived from psychedelic and Eastern mystical experiences. Cooper's views on psychiatry were increasingly derived from Marxism. By the late 1960s, it is probably appropriate to regard the position of the British group as being less that of the vanguard of avant-garde approaches to psychiatry, and more that of gurus of the soft new-left generally. Although overtly claiming to address the problems of psychiatry, Laing and Cooper were mainly engaged in addressing the personal and political problems of the counter-cultural middle-classes. It was not so much that psychiatric problems were being politicized, as that politics were being reinterpreted within a framework which viewed the capacity for psychosis as paradigmatic of human freedom, and psychiatry as paradigmatic of all the ways in which the modern capitalist state represses and suppresses the capacity for freedom.

The belief of the counter-culture was that political transformation could, and would, result from personal transformation. If sufficient people underwent the LSD experience, adopted Eastern approaches to meditation and consciousness, were allowed to complete the voyage of psychosis, and by a variety of means transformed their consciousnesses, then revolution would be produced. This political outlook informed the events and 'happenings' of the late 1960s. The belief that one could alter society by a sheer effort of will-power lay behind the events of May 1968 in France as much as behind Timothy Leary's attempts to cause the Pentagon to levitate in America.

Needless to say, the strategy failed. The revolution did not take place. The result was a swift reappraisal of the counter-cultural strategy, which now fragmented in two distinct directions. On the one hand, the counter-cultural young generation abandoned its claims to radicalism. The examination and transformation of consciousness ceased to be expected to lead to social transformation, and became an end desirable in itself. The new therapy and human potential movements abandoned by and large any pretence to be aiming to improve the general lot of mankind, and restricted themselves to a more limited role of improving the well-being of their clients and providing a pseudo-religious framework for those who perceived their primary problem as being a lack of meaning in their daily existences. On the other hand, the failure of the counter-culture resulted in a sweeping rejection of that whole approach and demands for a return to a more orthodox Marxist theory of society and promotion of macro-political revolutionary solutions. Therefore, a distinction was made increasingly between those people whose ideas were genuinely Left wing, and those whose ideas in fact amounted to no more than a bourgeois, privileged demand for individual freedom of subjectivity and consciousness. Friedenberg (1973) criticised:

> The confusion...of those who lump together as left-political quasi-revolutionary compeers persons who criticise society primarily because it alienates people from themselves and their capacities for growth, and critics who complain primarily of society's gross inequalities [which] has caused a great deal of difficulty in the past few years. It seems to be straightening out, now, with those who are most disturbed by alienation and repression becoming increasingly stigmatized as reactionary by political activists and self-styled revolutionaries. (51-2)

Friedenberg's comments appear to refer to both the American and the British developments. Turkle (1979) describes similar developments in French politics. The failure of the student-led protests of May-June 1968 to produce radical change in French society led to a reassessment of the Left's political critique. Turkle notes that the student and intellectually dominated French 'gauchistes' had never had the support of the traditional French Communist Party, who refused to take their activities seriously. After 1968, the gauchistes themselves were compelled to analyze their own failure. However, Turkle (1979:73-4) considers that the French gauchistes were more successful than the American counter-culture supporters in preventing their political stance form degenerating into individualistic self-indulgence, and that this success rested upon the gauchistes ability to turn to structuralism for the basis of a new form of political critique, which could embrace effectively both the individual subjective and social levels of politics.

The realignment of political life amongst French intellectuals will be examined in more depth in Chapter 5, where the emergence and impact of a new critique of psychiatry, derived from structuralist and post-structuralist thought, is examined. Here it is sufficient to note that Europe and America

were both, by the early 1970s, witnessing a crisis of confidence of the counter-cultural New Left. As British anti-psychiatry had emerged within the context of the philosophies of the New Left, and had not only supported, but been supported by, counter-cultural humanistic political approaches, this loss of confidence had implications for the future of British anti-psychiatry. This chapter charts the fragmentation of British and, to some extent, American anti-psychiatry during the 1970s.

2. Emerging Critique of the British Anti-psychiatrists.

Contemporary with the demise of the counter-culture as a serious political force came the publication of a large amount of material criticizing the work of Laing and his co-workers in the Kingsley Hall project. The crux of the criticisms revolve around the contradictions inherent in the theory which the British group had produced to justify its practice, and in particular the contradictions within the writings of Laing.

The origins of Laing and Esterson's early thought in existentialism were discussed in Chapter 3. It was also observed that existentialism and psychoanalysis are problematic when taken in combination, because the emphasis within psychoanalysis upon the irrational determination of behaviour is at odds with the emphasis within existentialism upon freedom of choice and the ability of the individual to act. Emphasising the schizophrenic patients' capacity for meaningful and comprehensible action led Laing and Esterson to produce a conspiratorial model of schizophrenia, in which the patient's behaviour was regarded as entirely comprehensible and reasonable when viewed within the context of highly disturbing family relationships. The families studied were viewed as having chosen, unconsciously, to identify one member

as insane rather than address their own irrational behaviour. The patient was thus not sick, but the victim of a familial conspiracy, albeit one which was not consciously formulated. For Laing, the subsequent production of a psychedelic model of schizophrenia was merely one step beyond regarding psychotic behaviour as meaningful to regarding it as purposive and leading to psychic healing.

However, logically, if psychosis is a freely chosen path with growthful potential for the individual, all that ought to be needed by the psychotic individual is a policy of non-intervention. If the psychotic person is simply left alone to get on with it, they will eventually emerge from the psychosis into a new, more fulfilled and authentic state of being. Such a stance would indeed with the approval of Szasz, who is opposed to coercive psychiatric interventions, but is quite happy for people to purchase or not purchase any form of assistance they wish, provided it is not used upon them against their wishes and not funded by the state as a legitimate branch of the discipline of medicine. (The contradictions inherent within Szasz's own position will be examined later in this chapter.) But this is not the position which the British-based anti-psychiatrists adopted in practice. What Laing and his co-workers actually did was to acquire premises where people who continued to be labelled psychotic by doctors could go in order to receive a new and supposedly more effective form of psychotherapeutic treatment for their psychosis. There is a basic contradiction between the British-based group's statement that schizophrenia is a label, whose only purpose is to legitimate social control and the suppression of individual freedom, and their claim to have discovered the only valid way to treat this condition.

This contradiction was nicely expressed by Siegler, Osmond and Mann (1972) who originated the analysis of Laing's approach in terms of a psychoanalytic model, a conspiratorial model, and a psychedelic model, all three models being present to some extent in The Politics of Experience. They conclude that:

> Laing's conspiratorial model is an account of how he thinks schizophrenics are presently treated; his psychedelic model...is an account of how he thinks schizophrenics ought to be treated. His psychoanalytic model, which seems to have crept into the book by mistake, is an account of what he actually does. (112)

A critique based upon a similar analysis of the contradictions within the British group's work is found in a celebrated article which Szasz wrote for the New Review (Szasz, 1976). By the mid-1970s, Szasz, who had always considered himself to be politically non-Marxist, had begun to take exception to the way his ideas were being used by the British-based group to justify Marxist critiques and interventions. He produced the New Review article in order to distance his own work from the British developments. Szasz's own position is made quite clear. He objects to legal coercion and state funding for psychiatry, and advocates the adoption of a free market in contractual therapy. He describes British anti-psychiatry as a completely different sort of approach, amounting to an inversion, rather than a rejection, of the values of traditional psychiatry. He finds a total lack of interest in the arguments he had proposed around coercion and medical mystification. Instead, he finds a practice which continues to revolve around the concept of schizophrenia. 'Schizophrenic patients' are now classed as victims of the contemporary capitalist economic system. He suggests that it would be considered immoral, in the anti-psychiatrists' 'Marxist Utopia', for such victims to be able to purchase therapy by use of wealth. But they can purchase therapy by use of

suffering. The rest of society is expected to produce the funds necessary for such therapy to take place. Thus, in Szasz's view, his demand that all human beings should be treated as free moral agents at all times (expressed in Proposition 11 among the 'anti-psychiatric attitudes' listed in chapter 1) is not met. The anti-psychiatrists' patients are being treated as special cases, more deserving than anyone else, on the basis of their socially inflicted suffering. Anti-psychiatry consists of no more than an inversion of the values of medical psychiatry, because whilst medical psychiatry identifies 'schizophrenics' in order to denigrate them morally by comparison with 'normal' people, anti-psychiatry identifies 'schizophrenics' in order to exalt them morally by comparison with 'normal' people. Laing and his co-workers are still identifying a group of people who 'need' special treatment to be provided at the expense of everyone else. All they have achieved is to use Marxist ideology to remove the stigma from needing such treatment. Their claim that mental illness is a myth (Proposition 1, Chapter 1), borrowed from Szasz, is contradicted by their claim that psychotic patients need some form of special facility and treatment.

Szasz produced a plethora of examples drawn from the work of the anti-psychiatrists to illustrate his claims that Kingsley Hall was just another medical institution and that the anti-psychiatrists were all 'self-declared socialists, communists, or at least anti-capitalists and collectivists' (1976:2). Placing to one side his aversion to left-wing rhetoric, Szasz's critique amounts to a claim, like Siegler et al's, that there is an unbridgeable gulf between what British anti-psychiatry said during the 1960s and what it actually did.

3. Developments among the British Anti-Psychiatrists, 1970 onwards.

The criticisms discussed above suggest that there was a major contradiction within the position which the British-based group of anti-psychiatrists adopted during the late 1960s. This is the contradiction between stating that mental illness is only a label, and stating that persons who receive that label still need and deserve some form of specialised help. As the counter-culture failed to produce any major re-structuring of society, and the political Left subsequently fragmented into an individualistically oriented, libertarian group and a more traditionally Marxist group, the contradictions within the anti-psychiatric position became more apparent. The effects of this split are well illustrated by the different paths chosen by the British-based group of anti-psychiatrists after about 1970.

By the 1970s, the majority of the British group had allied themselves with radical therapists within the broader movement critical of medical psychiatry. Esterson had left Kingsley Hall and the Philadelphia Association at an early stage, having taken exception to the turn events took as Kingsley Hall became established as a centre for the counter-culture, and continued to practice privately as a psychotherapist. Laing left Britain in 1971 to travel to Ceylon to practice Theravada Buddhism. Bharati, the Chairman of the Anthropology Department of Syracuse University, New York, informed Sedgwick that Laing:

> has virtually broken his bridges with things British and psychiatrical...
>
> He does not have any plans whatever to return to Europe...Nor to write anything - though in a somewhat vague manner he indicated

> that, if he ever writes again, it will be from the viewpoint of meditation consummated. (Quoted in Sedgwick, 1972:46)

In fact, Laing had returned to England by 1976 and resumed chairmanship of the Philadelphia Association. He also continued to publish. However, his publications now took a markedly different turn. Any explicit or implicit macro-political comment vanished as he concentrated his efforts upon presenting in poetic form the tangles of communication, misunderstanding and mystification in which human relations are enmeshed (Knots, 1972) and pursuing the importance of pre-birth experience (The Facts of Life, 1977). He continued in practice as a private psychotherapist, as is depicted in the BBC's documentary 'Did you used to be R.D.Laing'. Claude Steiner and Spence Meighan interviewed Laing in 1974 for the American publication 'Issues in Radical Therapy' (Steiner and Meighan, 1975), and found:

> I felt that neither R.D.Laing nor Jutta [Laing's wife] opened their hearts to us and that their responses were guarded and almost suspicious. In retrospect, it seems that they saw us as representatives of the Radical Left, which we weren't, and with which R.D.Laing seems to have a quarrel. (Steiner and Meighan, 1975:4)

Joseph Berke left the Philadelphia Association in 1970, taking with him Morton Schatzman, and founded the Arbours Association. The concept of the Arbours Association derived from Kingsley Hall, but it was set up with the intention of attracting less publicity and providing more professional structure for the benefit of bona fide clients. Berke's (1979) description of the work of Arbours indicates the extent to which the philosophy underlying the new project is derived from the philosophy of Kingsley Hall, as practised in the

much-celebrated case of Mary Barnes (Barnes and Berke, 1973). Berke (1979) prefaces the book:

> This book is about..people...who seem impelled to retreat from all outer concerns into an inner world of space and time removed from all usual constraints and prohibitions. It has been my repeated observation that this journey and the experiences associated with it are not inherently harmful. They can provide an opportunity for personal growth and development, as well as collapse and chaos. (11)

However, Berke is keen to point out that he is not advocating psychosis as liberation. Although the experience can be productive, it remains an extremely painful one for the person who goes through it, and persons in a state of psychosis require an extensive amount of sympathetic care.

> [T]he transformation of the psyche is not fun. Those who have entered the breakdown phase may do anything to have it stopped, even to the extent of yielding responsibility for their lives to complete strangers. (12)

At this stage, Berke was opposed to physical remedies, whose aim he regarded as being to suppress an experience which would produce its own psychological healing if it was allowed to run full course (see Propositions 5,7 and 8, chapter 1). However, the approach remained within the broad field of orthodox psychotherapy. Berke viewed himself as a therapist faced with suffering people whose pain he wished to help to alleviate. There was no exaltation of the psychotic patient as prophet or revolutionary. This impression is confirmed by material included in the Arbours Newsletter between 1973 and 1976. In 1973, plans were reaching fruition for the Arbours to begin its own training programm in psychotherapy, and to accept social work students on placement. Berke's aversion to the extreme politicisation of psychiatry is

revealed in his review of Phil Brown's Radical Psychology (Berke, 1974). (Brown's book is examined more closely later in this chapter.) Berke is sharply critical of the direction taken by the Radical Therapist magazine under the editorial rule of Brown.

> Under his direction the magazine was sharply politicized. More and more articles appeared about anti-imperialism and fewer about psychological practice. Regarding the latter, what articles did appear were boneheadedly black power, red power, gay power and anti-power power...
>
> If you can put up with Brown's introductions which are militantly anti-psychological (i.e. anti the psychological approach) anti-capitalist and anti-male chauvinist, there is a lot of good stuff in the book. (37)

By 1986, Arbours had established a crisis centre and three long term therapeutic communities in London (Berke, 1987). The aims of Arbours were regarded as similar to those with which the project had begun; that is, the provision of a space where people could go through the crises in which they were involved. However, Berke's description of the crisis centre in 1987 reveals a very orthodox and structured psychotherapeutic approach. At that time, three resident therapists lived at the crisis centre permanently, and people who came to live with them came as their guests. Referral to the project came mainly from psychiatrists, general practitioners, social workers and other professionals, although self-referral was also acceptable. When I visited the crisis centre on an open day in 1989, one of the therapists was keen to emphasize that the project was no longer 'radical'. It presented itself as a humane and respected psychotherapeutic option within a range of services in the local area.

This summary of the destinations of ex-Kingsley Hall supporters indicates the extent to which Laing and his co-workers had become integrated into a movement which was anti-psychiatric in the sense that it rejected extremely coercive medicalised psychiatry, but was not anti-psychotherapy, anti-therapy or even anti-coercion per se. This group appears to have interpreted Szász's statement that mental illness is a myth to mean that the attribution of organic states to mental pathology is mythological, rather than that pathological mental states are themselves mythological. This is born out further by the responses of this group of people to Szasz's (1976) New Review article. Esterson simply disowned the whole Kingsley Hall project, dissociated his own work in <u>Sanity, Madness and the Family</u> from the anti-psychiatry movement, and applauded Szasz's critique.

> The damage this movement [ie anti-psychiatry] has done to the struggle against coercive, traditional, psychiatry is enormous. And Dr Szasz, who has played the leading part in the struggle, is to be congratulated on his critique. It is quite devastating in its accuracy and quite extraordinarily comprehensive. (Esterson, 1976:13)

Redler, writing on behalf of the Philadelphia Association, repudiated any involvement of any member of the PA with anti-psychiatry.

> Neither Laing nor any current member of the Philadelphia Association Ltd. of which he is chairman has considered or called himself an 'anti-psychiatrist' or part of an 'anti-psychiatry' movement! (Redler, 1976:13)

He claimed that Laing had repeatedly stated that he was not an anti-psychiatrist, but a physician and a psychiatrist. The PA is not opposed to 'psychiatric relations between consenting adults' and is even not opposed to compulsion being used on rare occasions. 'Neither Laing nor any other member

of the PA is a self-declared or apparent socialist, communist, etc' (1976:14). Most residents paid for their own time at Kingsley Hall, and those who did not were resident at a lower cost than would have been incurred had they been hospital in-patients. 'There is no 'idealisation of insanity' in Laing's writing, lectures, practice or that of the PA' (1976:15).

Berke (1976:21) referred to the confusion over the precise meaning of the term anti-psychiatry:

> This term has been used to denote: A) criticism of organic psychiatry - theory and practice; B) criticism of any non-contractual intervention by one person against another in the name of psychiatry; C) several alternatives to traditional psychiatric practice especially as developed in London by Drs R.D.Laing, D.Cooper, A.Esterson, M.Schatzman, L.Redler, myself and others; D) politically radical (usually left-wing) alternatives to psychological interventions and as articulated in Europe and the United States...since the 1960s...Dr Szasz ignores these differences, for he has generally applied the term as articulated in category 'D' towards individuals who hold positions 'A', 'B' or 'C', but not 'D'. (21)

It is noticeable here that the position which Berke explicitly sets aside is the overtly political option which rejects all interventions. He went on to state that he had long since ceased to describe himself as 'anti-psychiatry', finding the term unhelpful.

The sole member of the Kingsley Hall group who appears to have rejected therapy entirely in favour of a political solution is David Cooper. Cooper left the PA in 1971, having been an inactive member since 1968 (Redler, 1976) and travelled to Argentina. Ticktin (1986) recalled meeting Cooper at a

conference in Canada at this time, at which he was making it apparent that his relationship with his British-based colleagues was over, and that the reason was that he did not consider British anti-psychiatry to be sufficiently political. Ticktin pointed out that it was in fact Cooper who had coined the phrase 'anti-psychiatry', and that his views had always been markedly different from those of Laing.

> He made it clear that he had left England, left the Philadelphia Association, and was no longer collaborating with Laing and co. The latter, he said, was on a spiritual trip. He, David, was on a political one. (Ticktin, 1986:15)

By 1974, Cooper had virtually severed all his links with his former colleagues in the Philadelphia and Arbours Associations. He had renounced psychotherapy for political reasons and 'was wont to say at the time that there were no personal problems, only political ones' (Ticktin, 1986:15).

Cooper was at this time continuing to write and to publish, his work being based on a form of existentialist-Marxist political theory; for example, the following statement taken from The Death of the Family (1972):

> If we are to talk of urban guerilla warfare as the decisive strategy in first-world countries we have to recognize a multiplicity in the weaponry that people might use. Molotov cocktails certainly have their place in a significantly organized student-worker rebellion, organized anti-crimes such as looting shops and burning anti-popular institutions obviously are dictated by the objective context of a black-ghetto rebellion.

In 1974, Cooper was invited to speak at a meeting on alternatives to psychiatry in Portugal. Through this meeting, Cooper was introduced to Franco Basaglia, the Italian psychiatrist and founder of Psichiatria Democratica; Robert Castel, the French post-modernist critic of psychiatry influenced by

Foucault; and Felix Guattari and Gilles Deleuze, who had recently published their book Anti-Oedipus: Capitalism and Schizophrenia. Cooper settled in Paris where he lived until his death in 1986, and became part of the French intellectual milieu following Foucault and Lacan, which will be described in Chapter 5.

Cooper was the only member of the Kingsley Hall group whose views were not represented among the replies to Szasz's (1976) attack in the New Review. However, he was referred to by the other correspondents, who personally disowned any Left-wing implications which may have appeared to inhere in the Kingsley Hall project, which were now represented as the sole responsibility of Cooper. Redler commented:

> Dr Cooper, a former member...was responsible for the introduction and popularisation of this term [anti-psychiatry] over the last decade. Much of the attack on Laing and the PA is based on Cooper's writing. (Redler, 1976:13)

Berke wrote also:

> Dr David Cooper first employed 'anti-psychiatry'. Dr Szasz has not, to the best of my knowledge, sought to ascertain who, if any, of Dr Cooper's former colleagues, share some or any of his current beliefs, but has simply used the existence of a previous working relationship to attack present and quite different practices. (Berke, 1976:21)

It is in my view not reasonable to hold Cooper solely responsible for the negative aspects of British anti-psychiatry. Laing did produce material which encouraged the romanticisation of psychosis as a prophetic spiritual state, and linked psychosis by implication with the LSD 'trip'. Esterson (interview)

was very much of the opinion that Laing was responsible for events at Kingsley Hall and the failure of that project. Laing appears to have repudiated much of his work during the 1960s at later dates; for example, David Reed reports being told by Laing that he felt he knew less about psychosis in the 1970s than he had as a young doctor first beginning his career (Reed, 1977: 69). Clare (1989) in his obituary of Laing stated that Laing in his later years retracted many of his earlier views, as indicated by an appearance on Clare's radio programme In the Psychiatrist's Chair:

> He readily agreed that were he ever to become severely depressed...he would expect someone like myself to prescribe anti-depressants and he certainly would take them. It seemed a remarkable turn-about...and I personally found it difficult not to feel that Laing looked back on many of his previous positions with considerable doubt and even regret.

However, it is probably true that Cooper was mainly responsible for the more radical politicisation of psychiatric practice and disorder, being the theorist who linked psychiatry most firmly with capitalism viewed through Marxist theory. Although Laing and Esterson were prone to borrowing concepts from Marxist theoreticians when they found such a practice helpful, neither of them seem ever to have declared themselves Marxists in the sense of advocating socialist revolution in the very explicit way which Cooper was to do. Esterson and Laing seem to have found Sartre's existentialist-Marxist concepts useful for analyzing family dynamics, but when the political climate demanded more organised and larger scale collective political action, both retreated swiftly into a position of advocating critical but relatively orthodox forms of psychotherapy. Thus, when Kingsley Hall broke up at the end of the 1970s, Laing and the bulk of the British group returned to their

basically apolitical starting points. Cooper at that point abandoned therapy entirely in favour of politics.

In this way, both Cooper and the main group finally evaded the central contradiction of anti-psychiatry: how can you claim both that mental illness is a mythical construct and a label devoid of real content, and that you have discovered a superior treatment for it? Laing and those connected with the PA and Arbours Association during the 1970s evaded the contradiction by adopting an explicitly psychotherapeutic approach to mental distress. They regarded mental illness as mythical only insofar as the term implies that problematic psychological states are reducible to pathological organic states within the individual, whilst regarding pathological mental states as themselves real. Cooper adopted an approach which was wholly political, and which viewed psychiatric symptoms as legitimate responses to capitalist social structures and all forms of psychiatry as attempts to individualize the problem and mystify the sufferers. Both psychiatry and the 'symptoms' of 'mental illness' would cease to exist in a socialist society.

4. Radical Psychotherapeutic Approaches Among Mental Health Professionals Beyond the 'British Anti-Psychiatrists'.

The British anti-psychiatrists had, during the late 1960s, maintained an uneasy position somewhere between a total denial of the reality of mental disorder and the promulgation of a new form of therapy for mental disorder. By the early 1970s, this position had broken down into, on the one hand, a clearly psychotherapeutic position and, on the other, a clearly Marxist anti-psychiatric position ("anti-psychiatric" now in the sense of an opposition to

all forms of psychiatric or psychological therapy). A similar divide is found emerging amongst the broader group of radical professionals at this time.

Baruch and Treacher (1978) are amongst those professionals advocating a purely psychotherapeutic approach to be adopted within the psychiatric system as a whole. A common tool of opposition to medical treatment in psychiatry is the historically based critique, which presents the history of psychiatry in such a way as to demonstrate that medicalisation of the discipline was not the result of scientific progress, but of power-grabbing by doctors (for example, Scull (1982)). Baruch and Treacher present such a critique of psychiatry as a medical specialism, and propose the replacement of medical and organic therapies with psychotherapy. Baruch and Treacher's preferred form of psychotherapy is not, however, classical psychoanalysis or any of the psychotherapies practised in contemporary psychiatric institutions. They advocate a form of psychotherapy founded upon principles derived from growth movement ideas, associated with therapists such as Carl Rogers, Fritz Perls and Abraham Maslow (see also chapter 3). This therapy will be based around principles such as relating to patients as whole human beings, being aware of the therapist's influence upon the patient, and treating the client as an equal partner striving to make sense of his world and his behaviour (Clare and Thompson, 1981:39).

The derivation of ideas from the growth or human potential movement is a common theme amongst advocates of this form of psychotherapeutic "anti-psychiatry", reflecting the increasing popularity and influence of this school of thought in Britain. In 1969, Quaesitor was set up in London to develop and promote the growth movement and human potential in this country. Quaesitor offered services such as Rogerian encounter therapy, body massage,

transactional analysis, psychodrama, eastern meditative approaches and gestalt (Clare and Thompson, 1981:69-70). Brandon's (1977) account of his involvement with therapy groups through Quaesitor leaves one with the impression of a movement whose political commitment was entirely abstract and theoretical, with no practical implications at all. The political philosophy appears to have amounted to a belief that it is necessary to change one's own consciousness before embarking on the more ambitious task of transforming society. In practice, Brandon's own consciousness never appears to have reached the point where he felt ready to start on society. His period of therapy appears only to have transformed his existence to the extent that by the time he left the group he was teaching social work rather than practising it, and his marriage was greatly improved. (Although this may be due to the fact that it was being involved with the Quaesitor form of therapy which was threatening his relationship with his wife, and the act of leaving therapy was itself of benefit to that relationship). Some of the practices witnessed by Brandon during his involvement with Quaesitor are disturbing to say the least. Exercises within the groups resulted in occurrences such as one group member breaking down and saying to his image in a mirror:

> You're such a great big fat slob...Why don't you get wise to yourself? Afraid of being hurt? You great stupid thick twit, you're not worth hurting. You're too stupid to be hurt. (Brandon, 1977:31)

It is difficult to imagine what is supposed to be therapeutic about this example of public humiliation. Brandon himself found his first experience of working in the group so traumatic that:

> One week later, just the thought of going to the group made me feel physically sick. I had a dazed week of going about my social work tasks in an automatic manner. (1977:10)

However, he did return to the group, and despite descriptions in his account of situations which would strike many people as patently untherapeutic and undesirable, he never reached the conclusion that the sorts of "therapy" offered at Quaesitor might be described as anything from self-indulgent to clearly harmful.

In fairness to the radical therapy movement, it should be noted that there were in existence other radical forms of therapy which were not only less extremely distressing in their tactics than Quaesitor, but demonstrated a rather more serious commitment to political change. In 1974, a group of twenty-three men and women formed as a collective to do therapy together under the name Red Therapy. (Boynton and Young, date unknown) Red Therapy adopted many of the assumptions and techniques which underpin the growth movement. However, Boynton and Young stressed that the difference between Red Therapy and organisations such as Quaesitor was political. Members of Red Therapy had experience of growth centres, and had encountered difficulties over political issues such as sexism and authority. They were seeking a form of therapy which would encompass their political views (Boyton and Young, date unknown:25).

Another way in which Red Therapy differed from Quaesitor was that its groups were leaderless. This decision was taken because group members felt that it was important for them to retain control over the ways in which they were changing their lives. However, it should be emphasised that Red Therapy's decision to do therapy in a leaderless group did not constitute a rejection of the role of the professional expert psychotherapist. The skills and knowledge of professional therapists continued to be recognised. Boynton and Young (date unknown:25) argue that leaderless therapy resembles 'self-health'

(sic) groups, in which the aim is not to reject the knowledge and skills of doctors, but to share the knowledge they possess amongst lay people.

> A lot of what we have learnt about the techniques of doing therapy has come from some people doing professional groups. We try to share this knowledge with each other. (25)

An interesting development at this time, related to the rapid expansion of feminism taking place during the 1970s, was the emergence of therapy which was not only politically radical, but specifically feminist. The Women's Therapy Centre, established in 1976, offered a professional psychotherapy service from a feminist perspective (Orbach and Eichenbaum, date unknown). In 1975, two women members of Red Therapy left to form a feminist self-help therapy group for women (Ernst and Goodison, 1981). Like Red Therapy, the group used ideas and techniques derived form the growth movement (although now purged of patriarchal aspects), but was leaderless. Again, the leaderless nature of the group was seen to have positive advantages politically, in helping people to realize that they have capacity to help themselves without turning to experts. Also, leaderless groups were felt to offer more scope for challenging the status quo (Goodison, 1981:12).

But, again, this preference for a leaderless group does not involve a dismissal of all forms of professional psychotherapy or psychotherapeutic expertise, but merely the institution of another service within the psychotherapy movement as a whole. Goodison (1981:12) acknowledges that although training is not necessary to do self-help therapy, 'some experience of professional therapy of whatever kind certainly helps'. She envisages that for some people self-help will be an adjunct to professional therapy. For women who are extremely distressed, self-help is presented as having nothing

to offer, as the support offered would be inadequate, and a person in such distress would be unable to honour her commitment to offering reciprocal support (Goodison, 1981:12).

Radical therapies derived from growth movement principles continue to exist. The Women's Therapy Centre is still open as a source of politically aware professional counselling and therapy for women. Forms of self-help therapy now include co-counselling, which is regarded as a helpful means of obtaining psychological support without the power relationship of professional therapy or counselling. In co-counselling, two people undertake to offer one another counselling on a reciprocal basis. Following training in basic counselling skills, such as listening and reflecting, the two parties meet on a regular basis for a set length of time. For half the time, one acts as counsellor and the other as client, and for the second half the roles are reversed. Thus, both are able to receive support on a reciprocal basis.

Thus, the radical therapy movement includes a range of services derived from human potential theories and practices. These practices vary in the depth of their political commitment. The purer forms of growth movement practices, such as Quaesitor, are in fact virtually purely apolitical. They locate responsibility for individual well-being and fulfilment entirely within the individual's personal control. They differ from conventional psychotherapy in being much more vaguely expressed pseudo-religious techniques, aimed primarily not at people with serious problems which might merit orthodox psychiatric intervention, but at people who are already functioning within the 'normal range' and who wish to increase their 'personal potential'. The growth movement has also influenced independent groups, such as Red Therapy and the Women's Therapy Centre, which display a political commitment of a

quite different order. These groups are committed explicitly to the view that many people's psychological problems are not due to pathology which emerges from within the individual, but to socio-politically inflicted stresses which impact on the individual's state of psychological well-being. The purpose of therapy is not only to alleviate distress but to equip the client to alter the socio-political order in such a way as to prevent the stress recurring. This viewpoint could be viewed as a variant of social psychiatry, individual problems being related to broader social structures, but still recognised as individual problems which can be addressed with some validity at the individual level.

This viewpoint would probably not be found threatening by many medical psychiatrists, who would readily agree that psychiatric difficulties are sometimes the result of intolerable social stress, and that mental ill health is related to poverty and socio-economic status. There would probably be two points at which medical psychiatry would wish to take exception. Firstly, it is a somewhat sweeping generalisation to assume that all forms of psychiatric disorder can be explained solely in terms of psychological responses to socio-political injustice. To believe this is a statement of political belief, not fact. Secondly, there is a lack of real evidence that the forms of psychotherapy used by the radical therapists have any real impact on the clients who volunteer for them. There is certainly no evidence to suggest that they have any long-term impact at all upon the sorts of serious psychiatric disorders which would attract a diagnosis of psychosis. Most psychiatrists would take exception to the view that the whole of medical psychiatry ought to be discarded in favour of the adoption of a narrow range of poorly researched approaches of dubious efficacy for the main group of their patients. However, in reality radical therapy practices do not tend to

impinge greatly upon the practices of mainstream psychiatrists. Criticism of the radical therapy approach has been offered less by the psychiatric profession than by radicals who are both critical of medical psychiatry and who have adopted an absolute anti-therapy stance.

5. Radical Rejections of all forms of Therapy

The position which considers itself to be politically radical and rejects all forms of therapy on such a basis corresponds to that adopted by David Cooper during the early 1970s. This position takes literally the view that mental illness is both a myth and a label used by the state to control deviance which threatens the status quo (see Propositions 1 and 2 among the anti-psychiatric attitudes listed in chapter 1). To some extent, people who hold this position regard the category 'mental illness' as consisting entirely of behaviours which do not handicap the 'sufferer', but are distressing and challenging to everyone else. However, such people also frequently acknowledge the extreme suffering of some people whose distress is labelled mental illness. They then argue that this suffering is not a symptom of some pathological condition within the individual, but a comprehensible response to oppression inflicted upon the individual by the capitalist social system (Proposition 3 in Chapter 1). The only legitimate strategy to end this suffering is one which ends capitalism. 'Radical' forms of psychotherapy are viewed as a trivial attempt to limit the suffering which the oppressed experience under capitalism. Also, they tend to individualise suffering by appearing to place the causes of distress within the individual sufferer, and to imply that the remedy may also be found within the individual psyche. At best such therapies are merely a distraction from the central task, which is to produce socialist revolution. At worst, they contribute to the process of mystification which tells

distressed people that their problems are the product of their own maladaptation.

For a comparatively pure example of the rejection of all forms of therapy on political grounds, I will examine the American publication Rough Times, formerly The Radical Therapist, as it developed under the editorial collective influenced heavily by Phil Brown (and already discussed earlier this chapter in reference to Berke's review of Radical Psychology (Brown, 1973)). The political position of Rough Times was presented clearly by the paper's collective editorial board, and included statements linking the psychiatric system to capitalist oppression, which must be overthrown by revolution, and claiming mental illness to be a myth. 'Radical therapies' were not awarded privileged status, but viewed as part of the problem to be abolished.

> "Alternative" and "hip therapies" must be exposed as part of the system rather than as anti-establishment forces. The new trend in wide-scale therapy and encounter, etc. typically involves "hip" professionals or would-be professionals who retain their oppressive attitudes as well as high fees. Such people offer rip-off, cooling-out, individualistic diversions to meet the problems caused by oppressive social conditions. (Rough Times Collective, 1972:2)

In 1973, Brown (1973) published a collection of papers entitled Radical Psychology which purported to represent the political position of The Radical Therapist\Rough Times. This volume is interesting in terms of the use it makes of the work of the British anti-psychiatrists, papers by whom are included in the collection. Brown assumes throughout that the work of Laing,

Cooper, Esterson, Barnes, Szasz, Goffman and Scheff is all essentially supportive of his own Marxist revolutionary position, although he acknowledges that none of these authors has, in the papers included, provided a Marxist analysis as thorough-going as his own. Specifically, these authors lack 'a well-defined class analysis of mental illness and psychiatric commitment' (Brown, 1972:5) and need to 'go further into revolutionary situations' (Brown, 1972:65-66).

Brown (1973a:19) reviewed Esterson's The Leaves of Spring and likewise concluded that it constituted a Marxist methodology, on the justification that the book included a section on the theory and methodology of dialectical materialism as applied to psychology. He then criticized Esterson for 'still trying to rescue Freudianism and patch it onto Marxism'. Whilst it is the case that Esterson's explanatory tools are borrowed from Marxist theory, nowhere does he advocate that the solution to the Danzig family's problems is socialist revolution. When Brown criticizes Esterson for not taking his analysis that far, he is criticizing him for not adopting a position which he never intended to adopt. Esterson is a committed psychotherapist. It is Brown who is trying to push him, and the other British anti-psychiatrists, into the role of Marxist revolutionaries.

Brown's (1973) Radical Psychology rejects all forms of therapy. Discussing attempts to combine Freud with Marxism, he writes:

> the two are incompatible - Freud was the apostle of bourgeois values of sexual repression, delayed gratification, and social control. (188)

However, his contempt is not reserved solely for traditional forms of psychotherapy. He is suspicious and dismissive also of the expansion during

the 1970s of those new forms of therapy which claim to have abandoned the abusive aspects of traditional psychotherapy:

> The traditional stigma attached to going to a therapist is gone, but that is about the extent of it. "New" forms of therapy differ little from older ones, except in that they are more publicly known, and often appear as innovative and "open". As a whole, therapy continues to maintain the traditional view that emotional problems are internal to the person, or at best are a function of interpersonal relationships, but that they are hardly ever based on social living. (481-2)

6. The Legacy of the Marxist Anti-psychiatric Approach in the 1980s.

This Marxist anti-psychiatric approach continues to be influential in the contemporary era in the work of David Hill. Hill's (1983) The Politics of Schizophrenia offers a critique of the concept of schizophrenia, in which Hill argues that the use of this concept is unscientific and invalid, and continues to occur only for purposes of social control. He concludes that:

> whether the relationship between 'mental illness' and certain oppressed groups is explained by 'social causation' or by 'labelling theory' matters little once we realize that both exploitation by a capitalist economy and discrimination by mental health professionals are expressions of the debilitating structure of our society. (258)

Hill (interview) attributed a great deal of influence to the work of Laing in the formation of his own position, although his is a view which I would suggest goes considerably beyond the position which Laing himself adopted throughout most of his working life.

> I was a psychology student myself at the time, when I first read Laing. He was the first person in psychology who made any sense to me whatsoever about why people engage in unusual behaviours and experience feelings that are more extreme than other people, and do all the things that were and still are labelled as mentally ill and schizophrenic and so forth. So I do think that Laing's set of views...is probably the most valuable set of writings, set of books, in the whole of psychiatry...in terms of individual people who have written in the field of psychiatry there's no question he's the greatest influence in my work.

Hill also emphasized that his views were not only the product of theories he had read, but of personal experience as a psychologist. His view of Szasz is particularly interesting. He commented that he initially valued Szasz far more than he does now. This was due to his realisation of the extent of Szasz's libertarianism.

> He takes a libertarian view which is almost a freemarket view...His conclusions are that all of psychiatry is all right so long as there's no coercion involved, so long as everyone has a completely free choice. He suffers from an illusion in my view of a thing called free choice.

However, Hill continues to praise Szasz's critique of the concept of mental illness.

> I valued his critique of the concepts of mental illness. He's extremely good at taking apart the logical construction of psychiatry and dismantling it and showing there is no basis logically or factually to psychiatric theories. I've come to differ from him quite radically in a political sense.

Hill is himself wholly opposed to all the current major medical treatments for mental disorder: surgery, drugs and ECT, (see Propositions 7 and 8, Chapter 1) believing that none of them addresses the real nature of mental disorder, and that all are seriously damaging. He considers that medical or organically based theories of disorders such as schizophrenia will never be established because such 'illnesses' are heterogenous concepts.

> It is like looking for a genetic predisposition to being a member of the Labour Party or a member of the Church of england...schizophrenia involves nearly every broken social norm that is not covered by the law. And it certainly involves opposites of behaviours.

Hill was very specific as to what he meant in claiming that mental illness is a myth (Proposition 1, Chapter 1): he meant that the conditions which are labelled as various forms of mental illness are psychological and not organic. They have no medical basis, and individual constructs such as schizophrenia have no reliability or validity. However, he emphasized that the experiences which cause people to be labelled schizophrenic are real and frightening. He identified psychiatry as being primarily a form of social control, and one which serves to disguise the real nature of psychiatric distress.

> It is a convenient way, the diagnoses and the drugging of people, is a convenient way to explain away and dismiss a massive amount of human alienation and despair and distress. Which if we looked at the real causes, in my view the real causes, would have enormous political consequences in two ways. First of all we couldn't hide away the failure of the current political system to meet human needs, we would have to address the fact that there are literally hundreds of thousands of people who are living miserable lives...it's a propaganda value...But the other

function is much more direct - it silences people. It silences women at a rate of two to one.

Hill was clear that 'almost all of what is labelled...what comes under psychiatric diagnoses I would say is socially induced'.

Hill shared Szasz's views on responsibility, believing that people should be held responsible at all times for their behaviour (Proposition 11, Chapter 1), on the grounds that to deny responsibility is cruel and dehumanising. For Hill, to be classed as non-responsible is to be classed as a non-human being. Hill's position on freedom and responsibility appears to be somewhat muddled. He denigrates Szasz for 'suffering from an illusion of a thing called free choice' (above). He himself believes that individuals are trapped and limited by capitalist society. And yet he believes that it is dehumanising to decide that an individual was not responsible for behaviour in particular circumstances. Hill's contradictory position appears to stem from a failure to realise that Szasz's critique of mental illness is not separable from his political views. The Szaszian position as a whole is irreducibly libertarian.

Hill's views are placed systematically within the context of his own belief in the possibility and desirability of socialist revolution. Ultimately, the only valid approach to 'mental illness' is a fundamental restructuring of society, which would remove the social injustices and problems which he believes are at the root of mental distress. However, working during an era in which socialist revolution appears increasingly unlikely, Hill finds himself compelled to make some concessions towards therapy for distressed people in the present. Hill (1983:235) argues:

> In light of how hopeless and depressing it can be to hold on to 'utopian' visions of the future when those in power seem so intent...on maintaining the status-quo...it is easy to understand attempts to find gratification in helping distressed individuals to get back on their feet and, somehow, to carry on. I have known such satisfaction in my own work as a therapist.

This tendency for some form of therapy to reappear in contemporary anti-psychiatric practice will be returned to later in this chapter.

More thoroughgoing rejections of therapeutic interventions are found in the work of several contemporary American writers, whose position is wholly and consciously libertarian, rather than Marxist. These arguments are derived directly and uncritically from Szasz's views. American ex-therapist Jeffery Masson (1990) states:

> Once we give <u>anybody</u> the right to decide who or what is normal and abnormal we have abdicated a fundamental intellectual responsibility (to repudiate the very idea of making such distinctions) and we should not be surprised when it is 'misused' by people who come from a different psychiatric orientation. It cannot but be misused. (298)

Masson does not claim any influence from Laing or British anti-psychiatry. In fact, he includes Laing within the radical therapy tradition whose work he dismisses (pp 267, 270 and 282). His writings resemble in many ways those of Szasz, with their emphasis on individual liberty. They do not offer any Marxist theory at all. However, although Masson does not lay claim to a feminist perspective in his work, he has acknowledged a debt to American radical feminist groups, which would seem to indicate a preparedness to adopt a political agenda as part of the solution to the problem of psychiatric distress.

A further and very clear cut American example of the continued refusal of therapeutic options in any form is found in Chamberlin (1988). Chamberlin rejects totally what she terms 'mentalism'; that is, discrimination on the grounds of mental state, analogous to racism, sexism, heterosexism.[1] In Chamberlin's view, any attempt to offer therapy of any sort constitutes mentalism. Like Masson, Chamberlin is critical of the 'radicalism' of anti-psychiatry, but adopts in fairly complete form the critique of Szasz. Her proposals are libertarian. Also like Masson, Chamberlin acknowledges the influence of feminism, particularly in her promotion of 'consciousness-raising' as an alternative to therapy. For feminists, consciousness-raising constitutes a tool for increasing individual women's awareness of ways in which they are oppressed by patriarchal society on a day-to-day basis. Similarly, in the context of anti-psychiatry, consciousness-raising is a tool for increasing the awareness amongst psychiatric patients and psychiatric ex-patients of ways in which they are oppressed by 'mentalism' on a day-to-day basis.

The explicit contribution of feminism to the anti-psychiatric debate will be examined in more depth in the next section of this chapter, section 6.

These three contemporary theorists, Hill, Masson and Chamberlin provide interesting contrasts. As a socialist, Hill is committed to the view that individual freedom is not the goal. He is left struggling to reconcile two views: a rejection of the encroachment of psychiatry on individual freedom, and the view that the individual in a capitalist society needs some form of help, at least until after the revolution, when socialism will have led to the abolition of distress. Masson and Chamberlin, on the other hand, have rejected the overtly socialist analysis to which Hill is committed, which

states that the need for assistance will be dramatically reduced once we have a socialist state. What is left is then Szasz's explicitly libertarian philosophy, but now with the proviso that one ought not to request help even on a contractual basis. Masson and Chamberlin are thus finally more libertarian than Szasz. These three theorists exemplify the continuing attempts of contemporary anti-psychiatrists to offer people assistance for conditions which they claim have only mythological status, without resorting to something that looks very like psychiatry. Generally speaking, once these theories are examined closely, all are found to contain within them an argument for returning to something which resembles a form of therapy, whether or not it is defined as therapy within the terms of the theory.

7. Feminist critiques of Psychiatry

Before I examine more closely the claims of these theories to have rejected a therapeutic approach to psychiatric distress, I will examine the impact of feminism upon critiques which theorize psychiatry as a form of social control. I have already noted that both Masson and Chamberlin acknowledge the influence of American radical feminism upon their thought. The feminist interest in psychiatry is not recent, but can be dated back at least as far as the emergence of Marxist critiques during the early 1970s. The earliest detailed study of psychiatry and gender oppression is Phyllis Chesler's (1972) Women and Madness, first published in America. The form of argument in this book resembles closely that of Brown's critiques of psychiatry and psychology, discussed above, with the sole difference that the thesis that psychiatry is fundamentally an instrument of class oppression is now replaced with the thesis that psychiatry is fundamentally an instrument of gender oppression. Otherwise, the argument is identical. Chesler assumes that psychiatry

oppresses women in two ways. Firstly, it labels as 'mental illness' any behaviour which deviates from the traditional role, thus compelling women to conform to the social straitjacket which is the only existence patriarchal society is prepared to allow them. Secondly, when the stress involved in struggling to conform to this social role causes a woman to break down, her distress is also labelled mental illness, reducing her state to a pathological process within the woman, rather than an understandable response to an unlivable situation. This version of a 'social causation' hypothesis resembles Proposition 3 among the anti-psychiatric attitudes listed in Chapter 1, where the social oppression involved is specifically identified as gender-related oppression. Thus, psychiatry oppresses both by labelling and by social causation of distress. The impossibility of women gaining any real understanding or properly therapeutic assistance in a patriarchal culture is illustrated with reference to the past and present practices of psychiatry, including a critique of the work of the British anti-psychiatrists. Laing is criticised for failing to realise the importance of gender for understanding properly the situation of the patients presented in Sanity, Madness and the Family (Chesler, 1972;91-96). Cooper misunderstands the role of the body in female oppression, and fails to analyze the humiliation to which women are subjected. Failing to understand the oppression of women, he romanticizes madness (100-1). Szasz is more sympathetically reviewed, but ultimately castigated for believing that private therapy on a contractual basis is possible in a culture where female submission and sacrifice is deeply conditioned (106).

A particularly virulent feminist attack upon all forms of therapy is found in the work of Mary Daly, who is one of the American radical feminists who have influenced the thought of Masson. Daly (1979) regards all therapy as an

inherently male pursuit, and believes that to allow women to practice as therapists is no safeguard against oppression, but merely involves the extension of the grip of patriarchy.

> Since the age of the Holy Ghosts is a time of Dionysian boundary violation, it is predictable that the mantle of male motherhood will be shifted to the shoulders of more and more women deemed worthy by Dionysian men...the downward spread of therapy itself inevitably renders it more accessible as a respectable occupation for upwardly mobile women in male-monitored society...
> the Thoroughly Therapeutic Society must not only castrate potential witches as victims/patients. It must craftily con some of its stronger potential deviants into the role of unwitting token victimizers, in the name of Feminist Therapy. (280)

Elaine Showalter's (1985) The Female Malady, a study of women and madness in English culture,presents a thesis which is in essence identical to that of Chesler. Showalter's criticisms of British-based anti-psychiatry are more detailed and lengthier than those of Chesler, but are essentially the same. Laing created a typically male role for himself as the hero\saviour of a group of patients, never seriously considering the import of the fact that all these patients were women, on whose behalf he continued to speak. Berke's approach to Mary Barnes was constrained by his continuing to work within a sexist psychoanalytic theory. Cooper abused his female patients sexually (Showalter, 1985;247).

The most recent addition to the collection of feminist accounts of psychiatry is Jane Ussher's (1991) Women's Madness: Misogyny or Mental Illness? This book is particularly interesting because in it the author expresses her own

feeling of helplessness, as a mental health worker, faced with the gulf between the academic anti-psychiatric critiques of psychiatry and gender politics, and her working experience of women needing and expecting help. Finally, Ussher left her employment as a clinical psychologist because she could not reconcile her day-to-day practice with the academic work on which she was attempting to base it. She examines at length the history of psychiatry and misogyny, and then proceeds to examine also the critiques of psychiatry which have emerged, both anti-psychiatric and feminist. Her conclusion is modest, but interesting.

> I am not going to offer a recipe for happiness, a formula for alleviating distress, for treating madness, because there is no one formula. Each woman is different. Each woman's pain has its own history, its own roots - and its own solution...
> ...there are many solutions. In reality, we need them all.Each individual woman may benefit from a different group of solutions. (297-8)

Ussher solves her dilemma by opting for a pragmatic solution: to offer each woman what seems most helpful and appropriate in her individual case. However, she fails to produce a theoretical solution to the contradiction which exists between theories which argue that all psychiatry is oppressive, and the existence of large numbers of women in need of psychiatric assistance.

8. The radical anti-psychiatric dilemma analyzed.

There is much in the Marxist, feminist and other social control-based theories of psychiatry to be recommended, both in accounts of how mainstream medical psychiatry has embodied value judgements of an oppressive nature, and

particularly in the critique of the 'radical' therapies. Examples can be found scattered throughout the 'radical' literature of the 1970s of highly pertinent comments on what passed as alternative therapy; for example, Penn (date unknown:29) chastised Humpty Dumpty, the Radical Psychology magazine for offering therapy as a universal prescription for all ailments, serious and slight, underpinned by no theory except 'a vague self-congratulatory ideology which could be paraphrased as "I feel therefore it is" '. Penn proposes, as a different alternative to medical psychiatry, non-individualistic solutions to be pursued through community work, thus identifying herself to some extent with support for the Marxist anti-psychiatric solution of widespread restructuring of society.

Rough Times (1972) published the following anonymous parody of Fritz Perl's famous 'Gestalt Prayer', now retitled 'The Getsmart Prayer':

> I do my thing, and you do your thing.
> I am not in this world to live up to your expectations
> And you are not in this world to live up to mine.
> You are you and I am I,
> And if by chance we find
> Our brothers and sisters enslaved
> And the world under fascist rule
> Because we were doing our thing -
> It can't be helped?

To turn to a more recent example, Masson's (1990) critique of psychotherapy is problematic in that it constitutes a sweeping and nihilistic rejection of all forms of therapy, with no positive suggestion as to what might be offered as an alternative. But prior to this conclusion, the book presents much

factual material cataloguing abuses of psychotherapy in America which deserve serious consideration by practising psychotherapists.

However, the flaw which characterises all these theories, despite their sometimes pertinent critiques of both orthodox and radical forms of therapy, is that political critiques such as the ones discussed above fail to suggest alternatives which are either better, or practical. Ultimately, it is Utopian to imagine that the level of psychiatric distress existing in western societies can be treated in a laissez-faire fashion, pending the socialist or feminist revolution which will remove the cause of the distress. All critics must ultimately address the problem of need in the present.

And many of the critics discussed above have opted finally, however cautiously, for the existence of some form of radicalised psychotherapy. Among the Marxists, David Hill (1983) accepts some forms of therapy as potentially beneficial at least in alleviating distress pending the revolution. Chesler (1972:112) was critical of the reality of radical therapy as it usually turned out in practice, pointing out that radical clinicians are not 'hot headed nihilistic extremists', but mainly young, white, male and middle-class, with more ideals than power to bring about change. But she confessed that:

> The ideas and alternative structures of a "radical" or feminist psychotherapy both excite and disturb me. (113)

Most of the theorists discussed here, however, shy away from advocating any form of intervention under the title 'therapy'. Their solutions are what Ussher (1991:205) terms 'para-therapeutic proposals', which include

consciousness raising, crisis intervention, or social and practical support such as is found in women's refuges or community interventions.

Mary Daly (1979) believes in the possibility of properly woman-centred provision of some sort. It transpires that:

> I am not saying that genuinely woman-identified counselling cannot and does not take place, nor am I denying that, given the state of alienating structures in which we live, there is an urgent need for drop-in centres and other places for women to go in crisis situations. My criticism concerns therapy as a way of life, as an institutionalized system of creating and perpetuating false needs, of masking and maintaining depression, of focusing/draining women's energy through fixation upon periodic psychological "fixes". (280-1)

Chamberlin (1988) emphasises repeatedly that therapy is to be avoided at all costs, but consciousness-raising is absolutely essential to alternative mental health projects in order to prevent the resurgence of mentalism. Chamberlin's insistence on the need for consciousness-raising is particularly interesting, because it provokes the question: how do you define therapy? An interested lay-person would probably find it difficult to distinguish between a group therapy session and a consciousness-raising session. Perhaps the primary distinction would be that consciousness-raising has a more explicit political agenda and therefore involves more systematic and overt forms of indoctrination. However, whether this is the case or not, it would appear that at this point the distinction between therapeutic and para-therapeutic interventions has become blurred to the point where it constitutes a semantic

quibble. If one puts aside the political justification for the label used, and examines the practices as they occur on the ground, it becomes increasingly difficult to believe that what is being offered is a non-therapeutic intervention for a condition which cannot be identified by a label. Mental health services, however, radical, non-medicalised or collectively organised, continue to exist for the benefit of a minority of the population who experience particularly acute psychological distress. Their purpose is to alleviate the distress. The group of people who require such provision constitute an identifiable, and thus potentially 'labelable' group of persons, even if the only label we choose to apply is 'person in acute crisis'. Thus, the majority of people proposing an entirely political-structural analysis of mental health are doing so only in theory. In practice they are advocating the provision of some form of mental health service. The service proposed may be somewhat different in kind from that advocated by the radical therapy lobby, but it forms part of the same range of services.

Like the radical therapy approach, it tends to produce a similar sort of response from psychiatrists. Many psychiatrists are aware that some of the conditions they come across are primarily psychological and social in origin and causation. They are aware that all the conditions they come across are affected to a great extent by social stress and poverty. They welcome any form of service which will help to alleviate such conditions. But they regard it as a statement of faith, not fact, to adopt the position that all conditions can and ought to be treated by purely psychological or social means. They will resist any implication that the input of psychiatry ought to be replaced by that of either psychotherapy or social work.

This section has examined attempts over the last twenty years to uphold the claim that mental illness is a label applied for purposes of social control, and, therefore, that all forms of psychiatry and psychotherapy ought to be abolished. It has been argued that this attempt has run aground because of a contradiction inherent within the argument. This contradiction is that, logically, if mental illness does not exist, then it ought to be sufficient to release the patients from the hospitals and do no more. However, in practice, whenever this has been attempted by persons who have themselves worked in mental health, the level of real suffering being experienced by psychiatric patients has been such that the critics of medicine have felt compelled to offer some assistance to sufferers in the present. The assistance offered has only constituted an attack upon medical psychiatry to the extent that it has amounted to a replacement of medical provision for distressed people with psycho-social provision, even where workers have made it clear that they do not consider what they are offering to constitute therapy for illness.

Therefore, attempts to implement Szasz's view that mental illness is a myth have tended to produce new forms of psychiatric practice, rather than the abolition of psychiatric practice. It is my belief that the explanation for this paradox is to be found within the contradictions of Szasz's own argument. The following section will present a theoretical analysis of contradictions within Szasz's views.

9. Critique of Szasz's views on psychiatry and mental illness: a theoretical interlude!

Szasz (1960, 1972) claimed that illness was by definition an entirely organic phenomenon. Disorders of the mind are not organic, or at least not demonstrably so, and it is therefore incorrect to regard mental disorders as illnesses, other than when 'illness' is used metaphorically, in the sense of a sick joke. Related to this claim was a further assumption that attributions of physical illness are objective and do not involve value judgements, whereas attributions of mental illness are subjective and do involve value judgements. Szasz regarded this as true in two senses. Firstly, he considered attributions of physical illness to be objective in the sense that they left no room for differences of opinion between physicians. All doctors could readily agree when a person had, for example, tuberculosis because there was an identifiable viral infection. This was not the case with, for example, schizophrenia, where there was plenty of room for disagreement and no one identifying symptom to which appeal could be made. Secondly, Szasz regarded physical illnesses to be objective in that they do not carry implications of moral disproval or blame. TB is something which simply happens to one, not something which one does. In the case of mental illness, however, the symptoms are not something which happens to one, but precisely things which one does. The symptoms of mental illness are inseparably enmeshed in the question of agency. Szasz considered it to be vital to a person's status as a human being that agency continued to be attributed, and that a person's actions were not interpreted as the result of a disease process. His demand for mental illness to be accorded its properly mythological status was basically a demand that disease processes ought not to be confused with morally meaningful actions.

However, Szasz's rigid division of medicine into the physical, objective and caused, and the mental, subjective and freely chosen had been systematically criticized by the early 1970s.

a) Distinction between value-free physical conditions and value-laden mental ones.

The fundamental flaw underlying Szasz's critique is his adoption of the position that general medicine is underpinned by objective ascriptions of pathology, whereas diagnosis in psychiatry is an entirely subjective affair. Consideration of the reality of practice in general medicine reveals this distinction between general medicine and psychological medicine to be highly problematic.

Friedson (1970) provided a comprehensive sociological analysis of medicine as a profession. He addressed the question of illness as a form of social deviance. This issue had been approached earlier by Talcott Parsons, in the late 1950s, in his investigation of the sick role. Parsons had argued that medicine operates as legitimater of the sick role, being the institution which has socially ascribed authority to arbitrate when a person may adopt the sick role and become a patient, and when a person must relinquish the sick role, and adopt his ordinary position within society. Friedson extended Parsons' analysis to examine the role of the medical profession not only in declaring when a person can legitimately adopt the sick role, but in determining what conditions shall count as illness and what shall not. He argued that 'by virtue of being the authority on what illness "really" is, medicine creates the social possibilities for acting sick' (Friedson, 1970:205-6). Doctors determine what is normal and who is sick in the same way that judges determine

what is legal and who is innocent, and priests determine what is holy and who is profane.

Friedson acknowledges that attributions of sickness are not purely arbitrary, but are based upon some existing physical or mental state which is itself real. However, the declaration that any particular state is an example of illness is not an objective statement of fact, but a judgement, depending on a particular set of values. The group within western societies which has achieved the status of sole determiners of illness is the medical profession. Doctors have succeeded in achieving this status at the expense of all the more traditional forms of healer. The status enables doctors to approach illness not only from the point of view of the health and well-being of their patients, but with an eye to preserving and extending the jurisdiction and status of the profession. Doctors' judgements of illness are, therefore, not merely not objective in the sense that they require a negative evaluation of whatever is to be defined as illness, but also not objective in the sense that they tend to be at least partially a function of the medical profession's self interest.

> The jurisdiction that medicine has established extends far wider than its demonstrable capacity to "cure"...the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively. (251)

Friedson's analysis is developed in highly polemical form by Illich (1975), who attacks the function of medicine as not merely irreducibly moral in character, but also irreducibly political. He argues that the expansion of the highly technologised profession of medicine in the west is actually

causing more distress than it is alleviating. It is achieving this by the use of unnecessary technical interventions, the medicalisation of normal phases of life such as pregnancy and old age, and the increased reliance upon medication. In addition, it is encouraging the destruction of traditional cultural ways of making sense of sickness and death, which are superseded when westernised concepts of technological medicine take over, and is thus undermining the capacity of people to cope with naturally occurring forms of distress in a meaningful way. Illich calls for the deprofessionalisation of health care, restoring responsibility for well-being to the individuals whose well-being is at issues, and affirming a commitment to technologically simple measures and preventative strategies .

The analyses of Friedson and Illich bear some resemblance to that of Szasz, who insists that state provision of psychiatric treatment is not a value free enterprise, but functions as a form of social control. What Friedson and Illich add to Szasz is the discovery that this social control dimension does not exist because psychiatric practice is essentially different from other forms of medicine, but because it is essentially the same. The realization of the flaw in the distinction between objective physical illnesses and subjective mental ones was applied to the critique of anti-psychiatry quite swiftly. Clare (1976:3) dismissed Szasz's argument that disease must mean bodily disease as 'semantic gymnastics', and argued for an eclectic but basically medical approach to mental illness. A more detailed and interesting application of the critique is found in Sedgwick (1982). Sedgwick notes the failure of all the radical thinkers discussed in this book (Goffman, Laing, Foucault and Szasz) to address the question 'what is illness?'

> The immanentists of anti-psychiatry <u>have accomplished the feat of criticising the concept of mental illness without ever examining</u>

> the (surely more inclusive, and logically prior) concept of illness. They have focused a merciless lens on psychiatric treatment, detailing its foibles, its fallacies, and its destructiveness towards human self-respect, while at the same time maintaining a posture of reverent myopia towards the chemical, surgical and other therapeutic procedures that are directed by doctors against the many targets of the human organism that lie outside the grey and white matter of the cerebrum. (27)

In Sedgwick's view, what unites the theorists reviewed in his book is a quite legitimately mounted attack upon positivist methodology in psychiatry, united with a wholly unjustified assumption that positivism in general medicine is appropriate (Sedgwick, 1982:26). Once this error is corrected, and it is conceded that positivism is a fallacious epistemological theory throughout medicine, the distinctive platform upon which Goffman, Laing, Foucault and Szasz were believed to stand disappears, and the irreconcilable differences between the writers emerge. (See chapter 2 for a discussion of positivism.) The failure of the radical critics to address the issue of positivism in medicine generally produced the two further errors into which these theorists fell: dualism and an over-emphasis on free will.

b) Dualism.

The distinction between conditions which are physical and conditions which are psychological necessarily involves an assumption of dualism, because it involves the assumption that it is possible to define some states in wholly physical terms and some in wholly psychological terms to begin with.

There is, perhaps, one sense in which such a division is possible. One can begin from the non-dualist position that conscious processes and physical brain processes must be related. One can then assume that this relationship is analogous to the relationship between computer software and computer hardware. A computer is subject to two distinct forms of fault, hardware failures and software errors. Hardware errors are caused by gross mechanical failures in the machinery which drives the computer. Such faults can be identified and corrected by engineers operating at a purely mechanical level. Errors in software, however, are of a fundamentally different order. They are failures of programming which occur when a computer is mechanically functioning correctly. Although the programme relates to the mechanical functioning of the computer and is not independent of it, one cannot correct a programming error with the mechanical help of an engineer. One must look for the assistance of a computer programmer to find and correct the fault. Similarly, with respect to human cognitive functioning, one can describe some faults as being due to failures of mechanism, that is to gross and identifiable changes in brain function, such as those which result from tumours or epilepsy. Such conditions are amenable to mechanical surgical and medicinal intervention. Other faults may be compared to programming errors, occurring at the level of psychological or cognitive error, and involving no gross change in brain function; for example, some phobic states. The solution to such difficulties may be to enlist the assistance of the psychological equivalent of a computer programmer, the psychotherapist. (I am glossing over the problems of value which are involved here in order to produce a clear epistemological discussion of the mind\body problem.) As the computer programme is dependent upon the computer hardware, so all conscious events are dependent on brain processes. 'Pathological' psychological events must depend on 'pathological' brain processes in the sense that they must depend on some

brain process, and if the psychological event is deemed pathological then in some sense one might argue that the brain process which underpins it is pathological. However, this pathology is not identical with gross mechanistic forms of pathology. The judgement of pathology is derived solely from the 'software' level, without reference to the actual underlying brain processes. In fact, there is reason to believe that it is not possible for particular psychological events, normal or pathological, to be identified with particular brain processes. To attempt to achieve that would be analogous to attempting to reconstruct a computer programme by looking at the computer hardware. Although related, the two dimensions are of a quite different order. The belief that all psychological processes will eventually be reduced to physical ones, and manipulable at that level, is a reductionist science fiction fantasy. The necessary relationship of consciousness to brain process is of epistemological rather than practical importance. In this sense, the distinction between conditions which are physical and conditions which are psychological is sustainable.

However, the picture is more complicated than this. The comparison between the functioning of a computer and that of a human being works solely by analogy, which finally breaks down. In the case of a computer, the hardware and software are purely man-made and mechanical, and completely distinguishable in so far as what one does to the software has no effect on the hardware. There is substantial evidence that in the case of humans, psychological processes do have direct impact on physical processes in a way which is not fully understood. But it is apparent that, for example, the psychological experience of anxiety has hormonal and other bodily consequences which impact on the actual gross physical functioning of the nervous system. There are no psychological conditions which do not have bodily repercussions,

and equally no bodily ones which do not have psychological repercussions. Thus, dualism with respect to types of illness cannot ultimately be sustained by appeal to the computer analogy. The distinction between 'physical' conditions, which can legitimately be termed illnesses, and 'psychological', ones which cannot, cannot be sustained.

c) The problem of free will - freedom versus meaningfulness?

The radical critique of psychiatry during the 1960s assumed a distinction between physical illnesses which were objectively identified, and psychological illnesses which were subjectively identified. It went on to assume that physical processes are properly described and explained in causal, mechanistic terms, but that psychological processes are properly described in terms of free will and action. It is perhaps this assumption which has caused the most problems for the critique and brought it most unfailingly into ill-repute. It is the over-emphasis on the capacity of individuals to act freely which characterizes Szasz as right wing and libertarian. It is the same over-emphasis on freedom which allowed Laing and Cooper to neglect the suffering of psychosis and to regard it as a valid and valuable psychological or political trip. And it is the over-emphasis on voluntarism which has resulted in all radical mental health workers struggling to reconcile the freedom of suffering individuals with their need for some kind of therapeutic or welfare based help, as described throughout this chapter. Some light can be shed on the fallacy of the argument by returning to the computer analogy outlined above in relation to the critique of dualism.

The functioning of a computer at the level of programme, rather than hardware, cannot be reduced to causal mechanisms. Computers process information

rationally and produce conclusions which are determined by the processes of logic, not by the processes of a steam engine or a chemical reaction. In one sense computers 'think' in a process which perhaps resembles to some extent the way in which human beings think. They process information, extract meaning from it, within the terms of existing programmes, and produce conclusions. Cognitive psychologists base their work upon this assumption when they attempt to model human cognitive processes by computer analogy. The interesting point about the computer analogy here is that although computers 'think', they do not exercise free will. The output of a computer is determined by a combination of the information which is fed into it with the existing structures for information processing. In the functioning of a computer, it is possible to witness a rationally functioning system which clearly does not act freely.

Again, it would be unwise to push the computer/human analogy too far. Computers are not creative. They are only able to carry out functions which human beings have programmed them to carry out. The remarkable feature of human beings is their capacity to produce infinite quantities of new ideas and meanings. It is this feature more than anything else which compels us to believe in our own freedom and agency, in the face of the inability of philosophy to make sense of the metaphysical notion of free will. However, the computer analogy does show how our common daily existences might be made up to a vast extent of behaviour which is meaningful, but arguably not free, being determined by the available information and constructs, and our limitations of understanding. Here can be found the beginnings of a theory of human behaviour which could regard pathological behaviour as pathological and not freely chosen, whilst continuing to regard it as meaningful. It may

also provide a pathway into an analysis of problems of value in psychiatry which is not reducible to a straightforwardly libertarian approach.

10. Two British examples of critiques of psychiatry which attempt to distinguish meaningful behaviour from voluntaristic behaviour.

The possibility of separating freedom from meaningfulness was explored by Ingleby (1981). Ingleby addresses the anti-psychiatric work of Laing and his colleagues and Szász's analysis of the concept of mental illness, and identifies these as 'normalizing' approaches; that is, they operate by assuming that the piece of behaviour in question would be normal if seen in its appropriate context. He argues:

> The normalizing approach exaggerates the extent to which rational free-will operates in psychiatric conditions; they are not just, as Szasz would have it, 'problems of living', but a breakdown of the problem-solving ability itself. (Ingleby, 1981:60)

He then argues that a simple opposition of free-will and determinism is not tenable. What is needed is an approach which attributes meaningfulness to human behaviour, without necessarily assuming that the behaviour is rationally chosen or fully understood by the agent from whom it originates. Ingleby identifies psychoanalytic theory as one tool which such an approach might adopt. He particularly favours Lacan's reading of Freud, with its structuralist emphasis upon the unconscious and its relationship to language. (The work of Lacan and the origins of structuralist and post-structuralist critiques of psychiatry will be discussed in more depth in chapter 5.)

A similar critique of anti-psychiatry is provided by Coulter (1973). Coulter set out to examine from a theoretical aspect contemporary competing theories

of schizophrenia, the classical form of madness. He examined evidence for schizophrenia as an (organic) disease process, as an experiential product (for example, Bateson et al, 1956), and viewed from a phenomenological perspective (for example, Laing, 1964). He concluded that none of these approaches brings us any closer to discovering what schizophrenia really is. Organic theories fail because their proponents persist in claiming unwarranted objectivity and generality for concepts such as schizophrenia. Reactions against positivist organicism have not constituted an improvement since:

> Psychogenic and sociogenic positivism have also been involved in the framing of contrived and logically inappropriate frameworks of conceptualization, and some studies of this type have required an illicit redefinition of insane persons as more or less desperate strategists presenting themselves _as_ insane for ulterior purposes. The phenomenological intervention of the Tavistock clinicians has only succeeded in obscuring a number of critical issues...by confusion and polemic, and this has undoubtedly hindered the development of non-positivistic alternatives to orthodox psychopathology. (112)

Coulter suggests, by way of remedy, that sociological approaches to mental illness cease to concern themselves with the 'true nature' of mental illness or madness, and turn instead to examining the process of insanity ascription; that is, why do some people come to be regarded as insane? What values are being expressed in our ascriptions of mental illness? This involves a shift away from consideration of what is really going on inside the psychiatric patients' heads, and onto what is going on within psychiatry. It involves an examination of the derivation of our cultural standards of rationality and competence, an ascription of insanity being above all else a judgement that

an individual is not competent in terms of the cognitive capacities necessary to negotiate his or her own culture successfully. The role of the sociologist vis a vis mental illness is therefore entirely that of researcher of values. Coulter emphasises that this position in no way constitutes a rejection of medical psychiatric practice, theory or research. It is a critical exercise, but one intended to be constructive and complementary.

> I am in no sense oblivious to the need for research which could prove practically useful in helping suffering people. Much of what I have said has purchase at the level of the logic of <u>theoretical</u> research programmes, and in no way detracts from the pursuit of psychopharmacology and humanitarian psychiatric practice. I am persuaded, however, of the epistemologically critical position of a science of psychopathology which appears inevitably bound up with inappropriate conceptualizations of mental disorders. (161)

I have included a presentation of Coulter's critique here because I believe that it represents an important step forward in critical approaches to psychiatry. Coulter does not become involved in arguments about whether psychological symptoms can legitimately be termed illnesses, or whether they are reducible to organic conditions, or whether all actions ought to be assumed to be produced by free agents. He asks the question, why do we decide some people are mad, and locates the answer squarely within discourse about comprehensibility and rationality.

Both Ingleby and Coulter, in somewhat different ways, locate the problem for psychiatry as being psychiatry's definition of rationality and competence. Ingleby perceives the solution as being the construction of theories which

explain the meaning of behaviour which is irrational and incomprehensible when viewed in common-sense terms. He sees psychoanalysis as the theory most likely to form a basis for that kind of approach. Coulter addresses the issue from the opposite side: he does not ask 'how can we explain irrational behaviour?' but 'how can we justify our own standards of rationality?' In the following chapter, I shall examine critiques of psychiatry which have emerged from France since the mid-1960s, and which are usually termed structuralist, post-structuralist, or post-modernist in outlook. These are critiques which have addressed themselves quite explicitly to the nature of reason and rationality. They have viewed psychiatry as an attempt to impose rationality at the micro level, upon individuals, and at the macro level, upon the whole structure of society. These theories provide a different kind of political critique of psychiatry from that offered by anti-psychiatry, and one which is becoming increasingly influential in this country.

Footnotes to Chapter 4

1. This argument will be returned to in Chapter 9 on the user movement.

Chapter 5 The Impact of Structuralism and Post-structuralism on Anti-Psychiatry

Chapter 4 concluded with a brief summary of new forms of political approach to psychiatry proposed by Coulter (1973) and Ingleby (1981). Coulter's views originate from within the intellectual school of ethnomethodology (Taylor et al, 1973). Ethnomethodologists rejected the positivism of mainstream sociology and deviance theory, in favour of an approach derived from phenomenology which prioritised the commonsense understanding and explanations of ordinary people. Thus, ethnomethodologists such as Coulter were concerned to elucidate everyday conceptions of rationality and comprehensibility, without relating these to 'grand theories' or appealing to concepts such as deviance, norms and structures.

Ingleby, whilst sharing Coulter's interest in the issue of rationality as a source of social values, draws explicitly upon structuralist and post-structuralist theorists. He proposes as the basis for his new approach to mental disorder a version of psychoanalytic theory which draws heavily upon Lacan. Ingleby's work is thus a comparatively early (in terms of British thought) instance of the influence of the largely French intellectual schools of structuralism and post-structuralism. These schools of thought have become increasingly influential as a tool for criticising both contemporary mainstream psychiatry and anti-psychiatry, and offering an alternative political critique to that proposed by anti-psychiatry. The purpose of this chapter is to describe the origins and content of structuralism and post-structuralism, particularly in relation to the work of Jacques Lacan and Michel Foucault, the two theorists most relevant to psychiatry. The impact of these theorists on British thought will also be examined.

1. Emergence of structuralism and poststructuralism.

Structuralism and post-structuralism are problematic terms to define, particularly since those about whose work they have been used have been reluctant to apply labels to themselves. The four major 'structuralist theorists have been identified as Claude Levi-Strauss, Louis Althusser, Jacques Lacan and Michel Foucault. However, Foucault in particular has been assiduous in disowning the label of structuralist (Merquior, 1985:13-15).

Foucault is perhaps better classified as a post-structuralist theorist, and Merquior (1985;13) does accredit him with the joint leadership, with Jacques Derrida, of post-structuralism. However, the papers contained in Featherstone's (1988) collection of commentaries on post-modernist social theory do not refer to Foucault with any frequency or in any depth. The major theorists emerge as Lyotard, Derrida, Baudrillard, Rorty and Barthes. Certainly, there are clearly identifiable differences amongst the approaches of all these theorists, and especially between them as a group and the more coherent and structured writings of Foucault. Foucault is perhaps best approached as occupying a somewhat problematic position situated on the dividing line between structuralism and post-structuralism. Indeed, Merquior (1985:13) has described post-structuralism as:

> the love-hate relationship with the structuralist mind which came to prevail, in Parisian culture, from the late 1960s on.

Structuralism derives from the deep concern which developed from the early twentieth century onwards within philosophy with the nature of language. Classical philosophy had assumed that language was the unproblematic medium through which truth could be expressed. Twentieth century thought was

occupied with analyzing the nature and limits of linguistic expression. In England, Wittgenstein's early work, expressed in the Tractatus Logico-Philosophicus, focused upon defining the limits of what could meaningfully be expressed in words. His theories were of immense importance for the development of logical positivism and the ejection of metaphysical theorising from science. The linguistic theorist who became central for the development of the continental school of structuralism was Ferdinand de Saussure. Saussure is generally accredited with the foundation of the science of semiotics, the study of sign systems. His contribution was the establishment of an approach to language, and indeed all systems of meaning, which was non-referential. A referential theory of meaning is one which assumes that words (and symbols generally) refer to objects which exist 'out there' in the 'real world'. Saussure approached words and symbols as referring to concepts which are themselves expressed in words and symbols. He proposed that the basic unit of analysis of his new science would be the sign, which is made up of the signifier (the word or symbol which signifies) and the signified (the concept which the signifier signifies). It is of the utmost importance that the signified is a concept, and not a 'real' object. Because of this, Saussure's approach assumes that language is a completely enclosed, self-referential system. The aim of linguistics is no longer to theorise the relationship between words and objects, but to comprehend systems of meaning as unified systems which operate according to rules and principles which are internally specified. These rules and principles are the structures which determine and limit what can be expressed in language, and what developments are possible in language. They are the universal necessary attributes of all human forms of expression. The aim of this approach to language is not to determine the truth of what is expressed in sign systems, but to comprehend the internal

rules which govern the production of communication within the given sign system.

The structuralists adapted Saussure's approach to language to the study of social systems generally. Ehrman (1970:ix) views structuralism as a method of analysis before being a philosophy. It is a technique for identifying combinations of formal elements to reveal their logical coherence. Applied to the sciences of man, it is firstly a way of studying language which was subsequently generalized to study a wider range of systems of meaning. Broadly speaking, of the four main structuralist thinkers who were identified above, Levi-Strauss applied the structuralist method to the study of other cultures, Althusser applied it to the analysis of capitalist and socialist societies, Lacan applied it to the unconscious, and Foucault applied it to the historical development of political, scientific and philosophical thought.

Politically, structuralism is a profoundly pessimistic form of thought, because it emphasizes deeply unconscious, inevitable and deterministic structures which limit the extent of possibility of change in social structures. For this reason, structuralism in France during the early 1960s existed in a state of opposition with the gauchistes of whom the French New Left and counter-culture consisted. The gauchistes based their analysis upon Sartre's Marxist existentialism, which was a humanistic form of philosophy emphasising the capacity of humans to exert choice and to control and change their circumstances. The gauchistes also regarded themselves as in opposition to the traditional forces of the academy, which were seen as preventing change and operating to uphold the social status quo. Structuralism was regarded as the bastion of the traditionalist academy (Turkle, 1979:71-72).

The gauchiste attempts to bring about revolution and major social change by mass action culminated in the events of May-June 1968, with a series of strikes, sit-ins, occupations of factories and institutions, and civil disobedience. However, the activity was short-lived and France returned very rapidly to its previous state of order. Following the failure to produce the expected revolution, a more conciliatory relationship between structuralist and the May activists began to be forged. Turkle (1979) has suggested that the gauchistes were faced with the necessity of explaining the failure of their own actions. They had been brought face to face with the realisation that they were in fact limited in their capacity to produce social and political change by exertion of will. In the United States, the failure of the counter-culture had produced a similar dilemma. Turkle suggests that America, lacking a radical intellectual tradition, had lapsed into the politics of self-indulgence, the pursuit of individual psychological change becoming an end in itself, rather than a necessary facet of social change (see chapter 4 for political critiques of the counter-culture/Growth movement). However, the French gauchistes were able to turn to structuralism as a tool for theorising the inability of individuals, even acting en masse, to bring about change. Simultaneously, the structuralists themselves began to adopt a more conciliatory position towards the gauchistes. In particular, they ceased to emphasize the intransigence of the structures which they had uncovered, and began to imply that they purpose of uncovering structures was to be able to change them. Foucault was rapidly adopted by the Left, and showed himself willing to offer support to Leftist programmes of social change.

> In the years after May, Foucault became something of a hero to May veterans. His work on the asylum, on psychiatry, on prisons, on medical repression, became central to their newly developing

> interests in the politics of medicine and madness. And Foucault did far more than meet existential humanism halfway by making a very substantial concession to voluntarism. Two years after the 1968 events, he suggested that in his work the whole point of finding structures (which he had always presented as immutable) was to be better able to be rid of them. (Turkle, 1979:77-78)

It is at the point at which structuralism begins to acknowledge the impermanence of the structures which it uncovers that structuralism begins to transform itself into post-structuralism. As structures become malleable, the notion of a structure begins to decay. The hope of being able to theorise social systems as internally consistent entities, whose change can be accurately described, controlled and predicted gives way to the notion of a system which is inherently chaotic and incomprehensible, embodying a host of transient purposes and values. As the structures which supposedly underpin the unconscious are seen to be impermanent and shifting, the notion of personal identity ceases to have any meaning beyond an illusion. The hope of using social theory to improve the lot of mankind or to produce a more just or rational society ceases to be thinkable. This is the kind of outlook which characterizes post-structuralism in the work of thinkers such as Derrida, Baudrillard and Rorty. Typically, the notion of the individual self or ego is considered to be entirely illusory. Individual subjectivity is approached as a channel for language and meaning over which the individual has no control. The idea that a person speaks is replaced by the organism as a channel through which language itself speaks. Truth ceases to be defined in terms of a correspondence between what is said and reality, and is instead theorised as correspondence of what is said with the self-referential rules

of the language game; that is, truth is defined as a matter of social convention. Thus, everything becomes analyzable in terms of ideology. The distinction between science and art breaks down completely, as both become fields of rhetoric with their own internal rules. As a result, the pursuit of both truth and progress become meaningless. The function of post-structuralist social commentary is to provide an ironic commentary upon contemporary ideology and the notion of truth itself. Macro theories of society, such as Marxism, become unthinkable. Revolution is now a matter of localised resistance to attempts to impose any totalised structure upon society.

Ryan (1988:559) has provided a useful summary of the sorts of concern which typify postmodernist and poststructuralist work:

> Postmodern is to art what poststructuralism is to philosophy and social theory. The two came into being at about the same time, with postmodernism emerging in the late 1960s, as structuralism was moulting into poststructuralism. It is the name for a movement in advanced capitalist culture, particularly in the ares - literature, the pictorial and plastic arts, music, performance and video art, etc. - that emphasizes reflexivity, irony, artifice, randomness, anarchy, fragmentation, pastiche and allegory. Cynical regarding the progressivist dreams of modernism, which hoped to shape the cultural world in the image of technology, industry and science, postmodernism is resolutely ironic regarding the enabling myths of art, culture, society and philosophy. In philosophy, it exposes the concealed mechanisms that produce conceptual meaning, and in art, it puts on display

the hidden workings of artistic production, demystifying its pretensions to expressive truth.

Social theory of this form is clearly highly ambivalent in its political implications. Its refusal to accept as inevitable the status quo and its associated 'truths' gives post-structuralism a superficial veneer of radicalism. However, the refusal to theorise rationally, and the insistence upon irony, rhetoric and ideology as appropriate tools for approaching social problems, results in an approach which can be anti-rational, nihilistic and devoid of positive proposals. Merquior (1985:16) suggests that the appeal of post-structuralism lies in the need of left wing academics to find an approach which preserves their radicalism in the face of the general failure of traditional left wing politics. He comments of Foucault:

> A discourse on power and on the power of discourse - what could be more attractive to intellectuals and humanities departments with an increasingly entrenched radical outlook, yet who have also grown sick and tired of the traditional pieties of left revolutionism?

Bauman (1988) has argued that post-structuralist theories tell us more about academics than about social change. Traditionally, the function of academics has been twofold. The minor role has been to assist the ruling group within society in its control of other groups by the provision of information which would make this possible. However, Western societies no longer control their members by predominantly repressive means, as the majority of their members have succumbed to the seductive powers of liberal democracy and consumerism. The second and major role of academics has been to act as arbiters of

aesthetics and morality, setting out to define the parameters of the 'good life' and how these might be attained. However, during the twentieth century, the very belief in the value of academic theories in all these areas has been eroded. Increasingly, we live in a democratic and consumer-based society, where judgements of aesthetics and morality are regarded as matters of individual taste, constrained only by the necessary negotiations to ensure that we do not trample each other to death in the pursuit of our own personal preferences. Increasingly, the insistence that one form of art is inherently better than another, or that one set of morals is more correct than another, is giving way to the belief that any such insistence is ethnocentric and intolerant. Thus, the major function of the intellectual has been rendered redundant. Bauman points out that intellectuals enjoy more freedom of speech now than at any other time in the past. But they enjoy this freedom of speech precisely because they are no longer a threat, having been deprived of their claims to dispense absolute truth. Post-modernism, which is the response to this realization, consists of a 'falling upon oneself' (Bauman, 1988:218) that is a turning of the tools of one's trade back upon one's own interests. Academics in the social sciences are now most heavily concerned with examining and criticising their own assumptions, without interest in what the impact of their work will be upon society at large. As Bauman comments:

> Release from the often burdensome social duty sociology had to carry in the era of modernity may be see by some with relief - as the advent of true freedom of intellectual pursuits. It is, indeed, an advent of freedom - though freedom coupled with irrelevance: freedom <u>from</u> cumbersome and obtrusive interference on the part of the powers that be, won at the price of resigning the freedom to influence their actions and their results. If

what sociology does does not matter, it can do whatever it likes. (230)

To the extent that post-modernism does have anything to say to contemporary society, Bauman sees its role as being to embrace as a conscious choice the aims which modernism embraced as logical conclusions:

> the possibility of a reason-led improvement of the human condition; an improvement measured in the last instance by the degree of human emancipation. (Bauman, 1988:231)

The purpose of this section has been to describe the development of post-structuralism as a general philosophical approach and to place it within a context in which its emergence can be understood. The intellectual lineage of structuralism and post-structuralism has been traced from the linguistic theories of the early twentieth century. Some indication has been given of their content and the reasons for their contemporary academic popularity during the 1980s and 1990s, years which have seen a consensus develop throughout the western world, and some of the former communist world, as to the desirability of liberal democracy and market economics over academically theorised socialism. The following section will consist of a more detailed consideration and critique of the ideas of Lacan and Foucault, and how these have influenced the politics of mental health in France and Britain.

2. Jacques Lacan

Lacan is the academic figure most responsible for the rehabilitation of Freudian psychoanalysis as a respectable theory for Left-wing theorists to espouse. Freudianism had long been regarded by the Left as a bourgeois theory which promoted the adjustment of 'disturbed' individuals to contemporary

social norms in the name of therapy. Lacan offered a route by which Freud's theories could be interpreted as socially and politically subversive. Lacan's version of psychoanalysis was markedly at odds with that espoused by the International Psychoanalytic Association. His views, and his refusal to abandon his practice of offering unusually brief therapy sessions to clients, resulted in his resignation in 1953 from the Societe Psychanalytique de Paris, the only officially recognised analytic society in France. Consequently his membership of the International Psychoanalytic Association was deemed also to have lapsed. Lacan was vehemently opposed to both the bio-deterministic interpretation of Freud and the American school of 'ego psychology'. Uniting Freud's psychoanalytic insights with Saussurean linguistics, he produced a structuralist account of psychoanalysis which emphasised the importance of language and the unconscious for understanding human culture. Lacan was able to pursue his unorthodox version of psychoanalysis for some years before the disapproval of the international psychoanalytic community was fully expressed. This was largely due to France's status until the 1960s as a psychoanalytic backwater, whose theorists and practitioners did not receive a great deal of attention. The centre of development of psychoanalytic theory was regarded as the United States. Lacan was able to develop his ideas comparatively free from the attention of the notoriously dogmatic international psychoanalytic community for several decades. As Turkle has commented:

> Jacques Lacan [is] an "indigenous heretic" whose structuralism and linguistic emphasis were resonant with the French Cartesian tradition...Lacan denigrates "humanistic" philosophy and psychology that treat man as an actor who wills his action and instead sees man as a submitting object of processes that transcend him...

The Lacanian paradigm is structuralist, emphasizing the individual's constraints rather than his freedoms; it is poetic, linguistic, and theoretical rather than pragmatic and tends to open out to a political discourse which raises questions beyond the psychoanalytic. French intellectual life is among the most ideological and politicized in the world, and Lacanism's strong political valiance helps to mark it as "French indigenous". (Turkle, 1979:49-50)

Lacan developed his theories over a period of five decades, and his views are extremely complex even to those familiar with psychoanalytic terminology and discourse. Here, I shall confine myself to describing those aspects of Lacanianism most important for understanding the theory's appeal to the Left.

2.1 Lacan's view of the ego.

Lacan's earliest difference with international psychoanalytic opinion was his view of the ego. The prevalent view of the ego was that proposed by the largely American 'ego psychologists'. This school of thought regarded the ego as the psychic structure which was the focus of the patient's capacity for health. The ego is the psychic structure which operates according to the 'reality principle'; that is, it mediates between the individual's desires and phantasies and the 'real world' outside, forming rational plans as to how the individual's needs can most realistically be met. Psychological disorder results because the ego is constantly being bombarded by the blind instinctual demands of the id and the harsh ethical demands of the super-ego, which must be either met or repressed out of consciousness. For ego psychologists, the solution is to strengthen the ego, increasing its capacity to stand up against

the demands of id and superego. This view corresponds well with the traditional American view of society, which is highly individualistic and emphasises the capacity of the individual to progress and achieve greater control over her own life. It is a view which Lacan rejected totally.

From 1936 to 1949, Lacan explained his view of the formation of the ego in what he termed the 'looking glass phase' (Lacan, 1966). (English language translations of Lacan's most important writings can be found in Sheridan's (1977) Ecrits: a selection.) The looking glass phase is that period of very early development when the young child first begins to acquire a sense of itself as a being separate from other beings, and to form a sense of its own identity. This identity is formed from a process of observing the reactions of others to its own behaviour; that is, by observing its reflection in the mirror of other people's reactions. Thus, the child's identity is inseparable from the identity ascribed to it by others. In other words, the child's ego is created in a state of alienation. It is necessarily a structure which consists largely of unconscious projections and denials, and which is almost wholly unable to distinguish between its own desires and those of other people. According to Lacan, the ego achieves an illusion of coherence through the resolution of the Oedipus complex, and the consequent attainment of the capacity to symbolise, but it remains throughout a person's life an extremely fragile and treacherous structure. It is therefore extremely foolhardy for an analyst to imagine that the ego represents a sound ally for the purposes of a therapeutic alliance.

The significance of this view for the Left wing is that it offers a theoretical basis for rejecting the bourgeois view that liberal democracy, with its emphasis upon the freedom of the individual, represents social

progress. As was noted above, the view of the ego psychologists fits neatly with the traditional view of 'the American dream': achievement through individual effort. If Lacan is correct, then no amount of individual effort can yield full insight into one's own behaviour, and the increased rationality which we regard as evidence of progress is a myth supported by the ever-fickle ego. The concepts of rationality and individual freedom are in fact politically expedient fictions. This is a view to which I shall return shortly in examining the work of Deleuze and Guattari.

2.2 The importance of linguistics for psychoanalysis.

Bowie (1991:45) observes that by the 1950s Lacan had:

> reached an impasse in his rewriting of the Freudian account of the ego, having created a new theoretical edifice that was often only fortuitously connected to psychoanalysis as a therapeutic method...He needed a new theoretical position that could be linked robustly to the clinical work of psychoanalysis and that would explain and justify his own methods as a clinician.

He created such a position by wedding his psychoanalytic insights to the methods of Saussurian linguistics. His new position is described fully in two papers: The function and field of speech and language in psychoanalysis 1953, and The agency of the letter in the unconscious since Freud, 1957 (Lacan, 1966). In Freud's own work, two distinct forms of theory can be found existing in some degree of tension. Some of his writings, particulary his later works, adopt a clearly bio-deterministic concept of the human mind, in which psychic energy is channelled and operates according to principles which seem to have been borrowed from hydraulics. However, his early works, notably _The Interpretation of Dreams_ (1976) and _Jokes and their Relation to the_

Unconscious (1976), display a far greater interest in the nature of language and symbolisation, as revealed by the content of jokes, puns and day-time and night-time phantasies and dreams. Lacan chose to disregard entirely Freud's tendency towards bio-determinism, and to recast psychoanalysis wholly as a form of linguistics. He justified this as an attempt to purge psychoanalysis of errors into which it had fallen since Freud's discoveries:

> I consider it to be an urgent task to disengage from concepts that are being deadened by routine use the meaning that they regain both from a re-examination of their history and from a reflexion on their subjective foundations. (Lacan, 1966:240 trans. M.Bowie)

He adopted the view that language is the context from which psychoanalytic concepts and discourse cannot be separated. Psychoanalytic concepts do not refer to processes which are non-linguistic and take place inside the client's psyche. The processes and the concepts are indistinguishable. Psychoanalysis then becomes a kind of language game in which the discourse of the client and the discourse of the therapist engage in creative dialogue exploring the hidden meanings which operate at a level below consciousness. Lacan's views on language and the unconscious are encapsulated in the phrase which has become a watchword for his disciples: 'the unconscious is structured like a language'. Unconscious processes are conceptualised as associative chains of signification. Analysis is the process by which these associative chains are explored and identified, links which have become lost to consciousness being restored and made visible. Lacan has suggested:

> analysis consists in playing on all the many staves of the score that speech constitutes in the registers of language, and on which overdetermination depends, which has no meaning except in that order. (Lacan, 1966:291 trans.M.Bowie)

Lacan's view of the relationship between language and the unconscious explains his own complex and frequently tortuously obscure form of expression. For Lacan, psychoanalysis is not a theory about the unconscious, but rather the conscious mind in direct dialogue with the unconscious. Therefore, the analyst needs to speak language of the same form as that understood by the unconscious, with full expression of the forms of word play with which the unconscious is familiar. In essence, Lacan intends to bypass the conscious ego, and work directly on the unconscious.

Like Lacan's view of the ego, his view of the importance of language for psychoanalysis gives his theories a particular appeal for the politically Left wing. If a bio-deterministic reading of psychoanalysis is adopted then the theory does become conservative in effect, arguing that the existing social order is finally the product of biology, and therefore inevitable and unalterable. However, a theory which proposes that the unconscious consists of the fluctuating and shifting systems of meaning underpinning culture would seem to imply the view that the unconscious is not determined, but potentially open to modification. Such modification might be a tool for furthering an aim of macro-political and social change.

Lacan's own views in this respect are somewhat unclear. As a structuralist, he would take the view that the structures which he was revealing were immutable and thus deterministic, even though the determinism would be cultural rather than biological. Nothing in his writings indicates that he did not take this view. Where his theories have been used to underpin explicitly political agendas for social change, this has been done by his disciples rather than himself. However, Lacan was not quick to reject such explicitly political usages of his work. Turkle (1979) has suggested that

Lacan allowed his ideas to be used to promote the Left wing political cause, relishing the publicity and popularity which this brought him amongst that group of people. For a time, Lacan's seminar was a central focus for fashionable Left wing thought, and for what Turkle has termed 'radical chic'. However, Lacan successfully avoided becoming associated with any overt political commitments of his own. The following section will examine the use which more overtly politically motivated disciples of Lacan have made of his ideas in France.

3. The influence of Lacan on the politics of psychiatry.

Perhaps the best known application of Lacanian psychoanalysis to the politics of psychiatry is found in the theories of Gilles Deleuze and Felix Guattari (1977) as expressed in Anti-Oedipus: Capitalism and Schizophrenia, first published 1972. Deleuze and Guattari adopt a position which Turkle (1979) calls 'naturalism', referring to the attitude of this group of people towards symbolic thought. For structuralist thinkers, man becomes human only as and when he enters into the realm of the symbolic. That is, humanness is bound up inextricably with the acquisition of language. Althusser described this process as:

> The extraordinary adventure...transforming an animal born of man and woman into a human child. (Althusser, 1964-5:97 trans. S.Turkle)

As was observed above, Lacan also regards the acquisition of the capacity for symbolisation, at the Oedipal stage, as the point at which the child's developing ego acquires a fragile illusion of unity and identity. The naturalists reject the view that symbolisation is necessary for humanity, and

regard the attainment of the capacity for symbolisation and subsequent entrance into society and structure as a tragedy. They argue that a return to the imaginary 'pre-Oedipal' state is necessary to end sociopolitical repression. Anti-Oedipus: Capitalism and Schizophrenia, is 'a diatribe against Oedipisation, a refusal of the moment when society enters man' (Turkle, 1979:83). It is an attack upon psychoanalysts' acceptance and celebration of the entry into the Oedipal order of society, including Lacan. But it is an attack which depends for its coherence upon theorising Oedipisation along Lacanian lines. Thus, theoretically it grows out of the Lacanian structuralist school of psychoanalysis. However, it is better termed post-structuralist, rather that structuralist because of Deleuze and Guattari's rejection of the permanence or necessity of the structures identified by Lacan.

Deleuze and Guattari's approach produces an exaltation of schizophrenic experience. They extol the schizophrenic's direct and immediate relationship with her own desire, unmediated by the social constraints and alienation which symbolisation brings. They see this spontaneous expression of pure desire as a virtue from which political activists can profitably learn, and as qualities which were much in evidence during the events of May 1968 in France. They propose that psychoanalysis be replaced by 'schizoanalysis', a form of psychoanalytic theory which rejects the inevitability and desirability of Oedipisation and celebrates psychosis as a form of political action. This account depends upon Lacan's account of the formation and nature of the ego as a fragile and illusory structure. However, it takes that account much further, arguing for a total rejection and dissolution of the ego.

Deleuze and Guattari followed also Lacan's path of attempting to make their text a '"therapeutic" instrument' (Turkle, 1979:148), the reading of which would directly impact upon and change the reader's experience. The very language in which it is written is designed to challenge and disrupt the reader's understanding of self and identity. They present a view of the person as in no way unified or coherent, but as a fragmented collection of 'desiring machines', relating to one another in a constant state of flux. The text is constructed in such a way as to by-pass the illusory ego and impact directly upon these 'desiring machines' within the reader. Thus, the book is not merely intended as a theory, but as a tool for undoing the Oedipisation which Deleuze and Guattari regard as a characteristic peculiar to capitalist societies. It is itself therefore an instrument of revolutionary change.

Deleuze and Guattari have been described as 'the R.D.Laing and David Cooper of French anti-psychiatry' (Turkle, 1979:83). Their romanticised presentation of schizophrenic experience makes such a comparison superficially credible. However, Turkle identifies also the ways in which Deleuze and Guattari's celebration of the schizophrenic differs from that of Laing. For Laing, the schizophrenic person is spiritually and morally privileged over other people. For Deleuze and Guattari, the schizophrenic person is epistemologically and politically privileged (Turkle, 1979:153). Epistemological privilege arises from the refusal to enter into the symbolic dimension. The schizophrenic continues to experience directly the fluxes of desire, unmediated by the symbolic mode of expression which flattens and distorts desire. Political privilege arises because capitalism depends for its continued existence upon the triumph of the symbolic. Capitalism cannot tolerate the free flow of directly experienced desire. Thus, the schizophrenic offers the most threatening challenge possible to the existing socio-political order. Unlike

Laing, Deleuze and Guattari do not expect that the schizophrenic will embark upon this experience willingly or that she will ultimately be made more happy or fulfilled as a result of it. What is important is that the schizophrenic has resisted the way in which capitalism 'normally' controls our psyches.

One approach to criticizing this form of anti-psychiatry is to examine the effects of the theory as it is translated into practice. If this approach is applied to the theories of Deleuze and Guattari, it becomes apparent that the theory does not have any very obvious implications for psychiatric practice and is in fact rarely put into practice in any very meaningful sense. Poststructuralism tends to reduce issues of value and politics to a linguistic game, in which the fun that can be had with discourse becomes divorced from practical decisions. It is notable that Deleuze and Guattari's text does not offer suggestions for improving the lot in society of people who have actually been diagnosed schizophrenic. It is, rather, a tool for simulating the schizophrenic experience in people who have not been psychiatrically diagnosed, with the intention of reproducing the schizophrenic state of epistemological and political privilege in others.

In their clinical practice also, the group of Lacanian psychiatrists working at the Clinique de la Borde at cour-Cheverny, which included Guattari, did not seem to operate in a fashion radically different from that adopted by most medically oriented psychiatrists. They published a magazine, Cahiers pour la folie, which included work and visual art by psychiatric patients, and which offered a consistently poetic and artistic view of psychiatric disorder and a glamorized account of life at a psychiatric clinic. But the Clinique de la Borde's therapeutic methods continued to be biassed heavily towards medication and electro-shock, as is the case in most mental hospitals. Also, the anti-

psychiatric leadership proved uninterested in supporting less glamorous grass roots campaigns for change, requiring serious political organisation; for example they failed to offer their support to student psychiatric nurses at Villejuif, who had been sacked for publicising conditions at their hospital, including a reproduction of the design of the keys to the hospital's closed ward. Turkle concludes that:

> in the Parisian intellectual context much of anti-psychiatry is really intellectual and social play. The sense of antipsychiatry as play is reinforced by the romanticism of much of the French antipsychiatric movement. (Turkle, 1979:155)

Much of French anti-psychiatry is little more than 'radical chic' (Turkle, 1979:162).

Deleuze and Guattari' proposals in Anti-Oedipus are open to criticism on theoretical grounds also. Deleuze and Guattari are committed to a politics of irrationality. They are proposing a reversion to a more 'natural' anarchic state in which the expression of pure desire will be possible without mediation of reason to limit the negative affects of such freedom. The abandonment of rationality has, historically, rarely resulted in the reduction of Fascism, which Deleuze and Guattari envisage, but has more generally been associated with its rise.

Even were such a total abandonment of reason judged to be desirable, it is difficult to envisage its ever becoming possible, as it would involve a mass reversion to a primitive pre-lingual state. Deleuze and Guattari's notion of a kind of schizo-society is no more than a romantic and Arcadian pipe dream

of the kind associated with counter-cultural social theory (see Pearson, 1975). The impossibility of abandoning rationality and reverting to a more 'natural' imaginary mode of existence is apparent in the limitations of Deleuze and Guattari's own text. Although it is intended to by-pass the symbolic and resonate directly with the imaginary unconscious, in fact the authors cannot avoid a large degree of conventional symbolic expression to make their ideas intelligible. Whilst rejecting the notion of truth as itself fascist, and claiming to promote the direct experience of desire, Deleuze and Guattari in fact propose a theory of schizophrenia which is symbolically expressed and at least implicitly presented as true; that is, that schizophrenia is characterised by the direct experience and expression of desire, and is the more natural state of humans. The abandonment of the symbolic would not entail the adoption of a poetic and fragmented use of language, as Deleuze and Guattari appear to envisage. It would entail the abandonment of the use of language altogether.

The work of Deleuze and Guattari exploits all the implications of structuralism and post-structuralism which are most anti-rational. This is a theme to which I shall return in assessing the work of Foucault later in this chapter. However, the work of Lacan has been used more productively to investigate the problems of value, power and politics which are embedded within our use of language, but without claiming to wish to abandon entirely the structures which the use of language to communicate renders necessary, and which involve assumptions of rationality and truth. Such a use of structuralism and poststructuralism might acknowledge tacitly that language is a self-referential game, whose relationship with the real world 'out there' in space is highly problematic. In theory, alternative grammars and forms of logic might one day come into use. But in the present, we are bound by the

structures of grammar, semantics and logic which are all we have available, and it is impossible to imagine what an alternative grammar or logic might be. Thus, we are committed to an investigation of value, power and politics situated within the contemporary rules of the language game. Again, Left wing groups which have used Lacan's work for these ends have done so without his explicit approval.

A radical political groups which called itself Scription Rouge adopted Lacanian theory for use as a form of political consciousness-raising. Far from celebrating the disunity and fragmentation of personality outside capitalist control, Scription Rouge assumed that this disunity was itself solely a product of capitalism.

> Lacan's theory of the divided, decentered ego does not describe something inherent in the human condition, but simply an artifact of capitalism...Through analysis, the capitalist subject can learn that his crisis extends to the very deepest levels, and in so doing achieve a higher level of personal and political consciousness. (Turkle, 1979:79)

This approach involves an extension of the assumptions of Lacanian psychoanalysis which Lacan himself would no doubt have regarded as illegitimate. He never considered the notion that the structure of the personality investigated by psychoanalysis was especially related to capitalist social structure. Indeed, the view that the unity of the ego could be restored in a socialist society might be regarded as a covert attempt to reintroduce the assumptions of the ego psychologists, whose views Lacan rejected, disguised by political gloss. However, it demonstrates a use of Lacanianism which is political whilst not anti-rationalist. Its politics reside in its questioning of the accepted values of contemporary society.

A similar use was put to the work of Lacan by French feminists. Feminists were rejecting the work of Freud as patriarchal at the same time as the anti-psychiatry's critique of psychiatry was being mounted (for example, Friedan was published in the United States in 1963.). Mitchell (1974) deals specifically with the feminist rejection of Freudian psychoanalysis. She argues for the adoption of Freudian theory as a basis for a critique of how the feminine woman is constituted within contemporary society. Freudian theory is not to be read as prescriptive of what a woman should be, as many feminists have assumed, but as descriptive of how women become what they are. The theory then provides the basis for a critique of society. Mitchell's rehabilitation of Freud relies on the adoption of many ideas derived from Lacan. Mitchell is a member of the Paris-based French feminist group Psychanalyse et Politique, which seeks to bring Lacanian-influenced psychoanalytic theory to bear on issues of feminism and femininity.

> it explicitly opposes what it sees as bourgeois and idealist tendencies within, largely, American radical feminism. It denounces radical feminism's rejection of psychoanalysis, but this does not imply...an acceptance of the present patriarchal practice of psychoanalysis, nor of the many patriarchal judgements found within Freud's own work....Their concern is to analyze how men and women live <u>as men and women</u> within the material conditions of their existence - both general and specific (Mitchell, 1975:xxi-xxii).

Mitchell draws upon Lacan's critique of the trivialization and Americanization of psychoanalytic theory, with the result that the theory became increasingly used not as an instrument of subversion, but to bolster the status quo (Mitchell, 1975:297). She also emphasizes Lacan's theory of the ego as a

fragmentary and largely illusory construct which comes into existence as a result of the child's entering the symbolic mode, and society coming to dwell within the child in the form of the law of the father. Following Lacan's concern with language and meaning, Mitchell places her emphasis less upon the physiological differences between the sexes than upon the meaning with which those differences are endowed.

3. Michel Foucault

Foucault's first major text was Histoire de la Folie, published in French in 1961 and available in an abridged English translation in 1964 under the title Madness and Civilisation. The English translation was published by the Tavistock as one in Laing's series of books on psychiatry and existentialism, with a foreword by David Cooper. Thus it appears that Laing and Cooper thought that they recognised affinities between Foucault's views and their own, although Foucault's profoundly anti-humanist stance fitted somewhat poorly with Laing and Cooper's existentialism. The book did not become popular amongst French Left wing academics until the late 1960s, when it became a cause celebre in the years following 1968. Foucault's thesis in this book is that madness had not always been separated out from reason. There was a time, a 'Golden Age', when both 'Reason' and 'Unreason' were accepted as valid aspects of the human condition, and reason and madness existed in dialogue with one another. This state of affairs ceased with the coming of the Enlightenment, and the dominance of reason. The mad were first of all set to sail the seas on ships of fools, which transported their unwanted cargo from port to port. Latterly, from the eighteenth century onwards, they were incarcerated in huge institutions built for that purpose. Here, Unreason was

separated from Reason, marginalized and confined. There is no longer dialogue between Reason and Unreason. Reason, the tool of the bourgeois, isolates Unreason, and talks about it. There is much theorising about the nature and causes of madness, or mental illness. Unreason is denied speech. It has nothing to say about its own condition which Reason would regard as worth hearing. Unreason has become the object of Reason's monologue.

Madness and Civilisation was initially adopted as another text of the 'anti-psychiatry movement', along with the works of Laing, Cooper, Berke, Szasz, Scheff, Goffman and a host of other theorists who were for a time perceived as purveying a similar message. However, the starting point of Madness and Civilisation was in fact very different from that of any of the other theorists listed here. Foucault was not interested in the cause or nature of the symptoms which lead to a person being labelled mad or mentally ill, even to the extent that he was uninterested in whether such people are biologically different from the sane. He was interested in the process by which during the Enlightenment Reason separated itself out from Unreason, and proceeded to disempower and repress Unreason, depriving it of its voice. That is, he was interested in the values which the emergent profession of psychiatry espoused, and which the society in which psychiatry operates has accepted.

Madness and Civilisation reads as a vitriolic rejection of reason and rationality. However, as Sedgwick (1982:142) comments, Foucault was himself later critical of his aims in writing the book.

> There is evidence that he has forsworn some of the larger, trans-historical ambitions of Madness and Civilisation. More recently, he has remarked that in this book 'one was still close to

admitting an anonymous and general subject of history', and he has satirically repudiated the quest, explicitly undertaken in Madness and Civilisation, 'to reconstitute what madness might be, in the form in which it first presented itself to some primitive, fundamental, deaf, scarcely articulated experience'.

However, as Madness and Civilisation has become a received text amongst some of those who regard it as further fuel for the argument for the total abolition of psychiatry, it is perhaps as well to note some of the historical criticisms which have been addressed to the book. Foucault preferred to base his work upon analysis of the broad sweep of history, rather than its empirical details, and Madness and Civilisation is notable as a book in which attention to details of historical accuracy was particularly absent. As Sedgwick (1982) has noted, Foucault's portrait of an era when Reason and Unreason coexisted in a state of happy dialogue is an Arcadian myth. The Ship of Fools was a literary invention, not based on fact. The Age of Confinement did not involve the incarceration of the mad in institutions recently vacated by lepers. And many of the 'treatments', such as cold water douches, which Foucault regards as being particularly the product of Enlightenment discourse about madness, and particularly appropriate in that period, in fact have histories stretching back long before the Enlightenment. The belief that insanity could be cured by the application of physical shocks is not one which emerged as a result of Enlightenment dialogues about Unreason. There is much in Madness and Civilisation to give cause for criticism. But, in spite of this, Foucault's approach to the politics of mental health contains much which is fresh and more promising than the dead ends into which the radical approaches discussed in the previous chapter finally led.

In Les mots et les choses (1966) (translated into English as The Order of Things (1970)) Foucault developed an archaeological approach to the writing of history. The purpose of his work is no longer regarded as being to comment upon past events, but to chart the conditions of emergence of the present. Foucault introduced the notion of the episteme: a system of largely unconscious assumptions which are made across disciplines at a particular time in a particular cultural context. In The Order of Things he demonstrated the presence across the fields of economics, natural history and biology, and grammar and philology of similar assumptions during the classical era. The Order of Things is Foucault's most clearly structuralist book. Merquior (1985; 55) has commented of it:

> Foucault honoured the heartland of the 'structuralist revolution': the province of Saussure, Levi-Strauss and Lacan.

In 1969, Foucault published his methodological text, L'Archeologie du savoir (English translation The Archeology of Knowledge, 1972). This was intended to offer a critique and justification of the methods used in his earlier books, Madness and Civilisation, The Birth of the Clinic and The Order of Things. In fact, The Archeology of Knowledge argued for the abandonment of the concept of the episteme, and substituted a new explanatory concept: that of discourse as practice. He emphasized the distance between his own method and that of the structuralists:

> Structuralists are treated as mere latter-day idealists. Nietzsche, by contrast, wins a widespread if largely tacit acceptance. In 1967...Foucault stated that archaeology owed more to Nietzschean genealogy than to structuralism. (Merquior, 1985:77)

Discipline and Punish (published in French 1975 as Surveiller et punir: naissance de la prison, English translation 1977) represents Foucault's point of commitment to a ' 'political' history of knowledge' (Merquior, 1985:85). By this time, Foucault had redefined the role of the intellectual from the viewpoint of the demise of the traditional view of theory. Henceforth, the role of the intellectual is not to be to enlighten the masses by supplying theoretical knowledge. Instead, it is to undermine and capture authority. In the words of Merquior (1985:85):

> Theory is not like a pair of glasses; it is rather like a pair of guns; it does not enable one to see better but to fight better.

Until this point, Foucault's interest in power, as expressed in Madness and Civilisation, had been concerned primarily with the repressive use of power to exclude and suppress. In Discipline and Punish, he introduced a positive understanding of power as not merely repressive (although that is frequently the case) but also productive and creative. The discourses of society determine not only who is to be excluded and controlled, but also what kinds of people the members of a society become. Foucault's analysis is based upon Jeremy Bentham's design for the Panopticon, the archetypal enlightenment prison. The Panopticon consisted of a circular viewing tower surrounded by a circle of individual cells with the bars pointing inwards. The warder, situated within the viewing tower, was in a position from which he was potentially able to observe any prisoner any of the time. The viewing tower was designed so that the warder could look out, but prisoners could not look in. Therefore, a prisoner had no way of knowing when he was being watched and when he was not. Thus, from the prisoner's point of view, he was effectively being observed all the time, and would control his own behaviour in accordance

with this belief. Bentham had designed an institution within which prisoners would learn to become self-disciplining with the minimum of input from the prison authorities. In fact, very few prisons were ever built according to Bentham's design. Foucault uses the design as illustrative of what he sees as the typifying features of the Enlightenment approach to social control. He finds similar projects of discipline emerging in the army and the schools and the asylums. A pattern emerges of regimentation, examination, and an increasing expectation of self-discipline bound not to the expectation of punishment, but to the expectation of more regimentation and examination. This is the era of emergence of 'technologies of the self', by which Foucault means all those techniques by which people are encouraged to reflect upon their own person and constitute their selves in a particular way. One learns through contemporary discourses to define and create oneself in accordance with those discourses. This process is the result not of a process of transgression and punishment, but of self-discipline in accordance with the expectations of societal discourses. In previous epochs, deviance was controlled by chains placed upon the deviant. The chains are now within the deviant. Locations of possible transgression are transformed into 'docile bodies' with the full co-operation of the potential deviant.

Foucault's final work, the three part History of Sexuality, consisted of a continuing elaboration of the themes of power, discourse and technologies of the self, or techniques of the soul. The emergence is charted of man as a 'confessing animal'. Western civilisations do not regiment and control sexual behaviour as previous civilisations have done. Rather, they regulate sexuality as a subjectively experienced aspect of personality. Through the repeated injunction of examine one's self and confess one's deviations and

desires, humans learn to constitute themselves as a particular sort of subject.

Foucault's work has produced a variety of reactions. Foucault's English translator, Sheridan (1990:225-6) celebrated Foucault as one of the most important and original thinkers of the century, concluding:

> It is difficult to conceive of any thinker having, in the last quarter of our century, the influence that Nietzsche exerted over its first quarter. Yet Foucault's achievement so far makes him a more likely candidate than any other.

Merquior (1985:159), by contrast, describes Foucault as:

> a central figure in a disgraceful metamorphosis of continental philosophy.

Certainly, there are problems within Foucault's analysis which require critical attention. Firstly, as was indicated above in relation to Madness and Civilisation, Foucault's attention of the accuracy of historical detail is frequently inadequate. Merquior (1985) has charted the historical inadequacies of the work, and pointed out that the group of academics for whom Foucault has least appeal is professional historians, who find his methods shoddy.

Secondly, the epistemological status of Foucault's work is problematic. He has been accused of sharing the anti-rationalist outlook which has been attributed to many post-structuralists; for example, Deleuze and Guattari, as discussed in section 2. However, Foucault's own attitude to rationalism is

less clearly apparent than that of Deleuze and Guattari. Merquior (1985:160) is unremitting in his criticism of Foucault's attitude to rationality.

> The new skepsis, of which Foucault was the first master, has the 'subversive cynicism'...of preaching irrationalism and intellect-debunking highly placed in core institutions of the culture it so strives to undermine: it constitutes an 'official marginality'. In its negativism it profits from this, without the least moral qualm.
>
> Leo Strauss used to say that in modern times, the more we cultivate reason, the more we cultivate nihilism. Foucault has shown that it is not at all necessary to do the former in order to get the latter.

For Merquior, the most fundamental and cynical flaw in Foucault's work is his attitude towards the concept of truth (1985:146-7):

> Foucault is...deeply suspicious of truth-claims; to him, every knowledge, even science, is a tool of the will to power.
>
> Foucault does not give up at least one truth-claim: that his own analytics of power is true...
>
> There arises a contradiction between the truth criteria stated by the theory (truth is might, not light) and the apparent claim of the theory to be itself accepted as true, regardless of such criteria

The critique of post-modernism and post-structuralism's rejection of reason has been taken up by the Frankfurt School of Critical Theory, notably by Jurgen Habermas. Habermas (1981) argued that the various forms of post-modernism were a form of attacks on modernity which had precursors in irrationalist and counter-Enlightenment theories, including the work of Nietzsche and Heidegger. He considered that postmodernism exhibits disturbing

kinship with fascism (Kellner, 1988:263). Habermas does not defend modernism as a complete world view. He criticizes the 'aesthetic modernity' of the nineteenth century, which he concludes is now dead, but distinguishes between that and societal modernization, interpreted in the Enlightenment sense of a process of cultural differentiation. Societal modernization entails the development of autonomous criteria of rationality and universality in fields such as knowledge, morality and justice. Habermas considers that, in spite of the problems produced by the expansion of the technological-scientific world view, modernity still has 'unrealized potential in increasing social rationality, justice and morality.' (Kellner, 1988:264).

Foucault did at times consciously and deliberately identify himself with post-structuralist theorists who were blatant in their rejection of reason. For example, Foucault contributed the preface to the English translation of Anti-Oedipus, and offered his whole hearted support to this use of Lacan. In his preface to the book he wrote:

> Anti-Oedipus is a book of ethics...How does one keep from being a fascist, even (especially) when one believes oneself to be a revolutionary militant?...one might say that Anti- Oedipus is an Introduction to the Non-Fascist Life...This art of living counter to all forms of fascism...carries with it a certain number of essential principles.

These principles include rejecting the use of thought 'to ground a political practice in Truth'. In addition, one must not ask politics to restore the rights of the individual, since the individual is the product of power. The aim of the struggle against fascism must be de-individualization (Foucault in Deleuze and Guattari, 1977:xiii-xiv). Conventionally, de-individualization

is a process more commonly associated with fascism than with any struggle against it, lending support to Habermas' (1981) thesis that poststructuralism is itself a version of fascism.

However, other interpreters of Foucault's work have adopted an approach which casts Foucault as a questioner, rather than a rejector, of the power of reason. His critique of the Enlightenment may be taken not as a rejection of Enlightenment principles, but as a turning back of the principles of Enlightenment upon themselves in order to examine whether the Enlightenment can withstand the power of its own scrutiny. For example, Gordon (1986:271) draws a distinction between abandoning rationality as the lynch-pin of academic discourse, which is what Foucault has on occasion been interpreted as having done, and turning rational scrutiny back upon itself in a self-critical fashion, which is what Foucault in fact aimed to do in Gordon's view:

> Esteem for the Enlightenment idea is one thing; unwillingness to scrutinize its sequels, on the other hand, itself a pious betrayal of its real meaning. (271)

Gordon believes that such an interpretation of Foucault's work alters dramatically the use which can legitimately be made of it. Specifically, it prevents the use of Foucault to bolster the arguments of social control theories opposing psychiatry. A social control theorist might argue that psychiatry is simply a pseudo-scientific tool for the control of deviance. Foucault has demonstrated that even rationality is merely a form of social control. Therefore Foucault supports the view that psychiatry is merely a form of social control which ought to be abolished. However, if Foucault is regarded as an explorer of the limits of rationality, then the question to be asked of psychiatry is how the discipline constructs its view of rationality

and whose values this rationality exists to serve at a particular time and place. In Gordon's words:

> The deviancy theorists who thought Foucault supported their positions were in fact inverting his argument...Foucault places the concept of deviance as part of the problem, not part of the answer, for a history of madness...
>
> To concede the existence of 'madness' as an anthropological quasi-universal arguably makes it easier to allow proper weight to the immensely variable character and effect of what Foucault called the 'experience of madness', a term intended here to mean principally the social experience of the treatment of madness within a society and corresponding structures of general social experience.

Gordon (1986) examines the emergence and role of psychiatry in Western liberal democratic societies and concludes that democracy and psychiatry are inseparable, mutually supportive social systems. This is a view to which I shall return in future chapters, in reference to contemporary critiques of psychiatry whose basis is in democracy rather than anti-psychiatry.

Notably, Habermas (1986) came to conclude also that the contradictions which existed within Foucault's work were perhaps more productive than otherwise. Habermas continues to believe that Foucault's own accounts are deprived of the normative yardsticks which he would have to borrow from conventional concepts of truth. But he also suggests that the value of Foucault's work lies in:

> the seriousness with which he perseveres under productive contradictions. Only a complex thinking produces instructive contradictions...Perhaps the force of this contradiction caught

up with Foucault in this last of his texts, drawing him again into the circle of the philosophical discourse of modernity which he thought he could explode. (Habermas, 1986:107-8)

In conclusion, the work of Foucault has been a source of great controversy, and perhaps epitomises in clear form 'the love-hate relationship with the structuralist mind which came to prevail, in Parisian culture, from the late 1960s on' (Merquior, 1991:13). Some commentators, for example Merquior, have rejected his work entirely as dangerously anti-rationalist in outlook. However, an alternative reading of Foucault regards him not as a rejector of reason and preacher of anti-rationalism, but as a sober critic of the limits of reason, and the political uses to which the Enlightenment ideal has frequently been put. For example, Gordon reads Foucault as a commentator upon the values which modern societies have espoused, and the ways in which rationalism has been used to promote and enforce these values. This is a use of Foucault and postmodernism which may be a constructive basis for a political critique of psychiatry.

An example of this use of Foucault's approach, in the context of French anti-psychiatry, is found in the work of Castel, Castel and Lovell's (1982) work on mental health expansionism in America. Castel et al use Foucault's concept of technologies of the self, and the dispersal of forms of discipline throughout society, to question the wisdom of the expansion of the 'psy' professions throughout America. They suggest that the anti-psychiatric opposition to overtly coercive and medicalised forms of social control has produced the supplementation of such techniques with a range of less overtly coercive 'psy' techniques for the production of docility. Such techniques operate with the full consent and co-operation of the subject, and can thus

expand unchecked throughout society. Castel et al question the innocence of such practices.

5. Impact of Structuralist and Poststructuralist Theories on British Thought.

5.1 The impact of Michel Foucault.

Generally, the work of Foucault has had a greater impact upon British thought than that of Lacan. The use to which Foucault's theories have been put has varied along the dimensions already discussed; that is whether Foucault is read as a poststructuralist prophet of unreason, or as a theorist engaged on the more modest task of subjecting Enlightenment claims of rationality to self-scrutiny. Where Foucault has been adopted in pure poststructuralist form, he has become a straightforward adjunct to existing theories of social control. The mental health literature is full of examples of this use of Foucault to supplement existing social control theories; for example, Ussher (1991) quotes extensively from Foucault in support of her argument that psychiatry is, and historically always has been, used to oppress women. However, she does not identify anything within Foucault's approach which might offer a route out of her dilemma, which is the contradiction between academic feminist critiques of psychiatry as social control and the reality of need for assistance amongst ordinary women (see also chapter 4). Rather, Foucault is quoted as simply one more theorist exposing the pernicious political function of psychiatry.

An alternative use of Foucault is to be found in Miller and Rose's The Power of Psychiatry. Matthews (1989) considers that Miller and Rose's (1986) reading of Foucault:

offer[s] a distinctly different theoretical approach and one which allows an understanding of social regulation which is not reduced to the operation of the state on one hand and avoids the vague generalisations which have become associated with the social control perspective on the other.

Miller and Rose criticize earlier approaches to the politics of psychiatry for being overly concerned with the repressive, coercive and institutional aspects of psychiatry. Anti-psychiatry was concerned largely with opposing the medicalisation of deviance and the application of physical treatments to deviants, frequently against their will. The attack on psychiatry was based upon:

> The assertion that the object of psychiatric knowledge and technique - 'mental illness' - either did not exist as an objective phenomenon or did not exist as an illness appropriate for medical attention. (Miller and Rose, 1986:2)

Such critiques did not deal adequately with the reality of severe and crippling mental distress. Since the 1960s, Miller and Rose note that there has been a greater willingness to take seriously the problems of the mentally distressed, but they consider that to approach the politics of psychiatry from this angle is fundamentally flawed.

> an analysis of the reality of mental distress cannot serve to establish what psychiatry is, or where it could or should go....Rather than seeking to base our criticism of psychiatry upon the truth of madness, these studies reverse the direction of

investigation; they suggest that it is more productive to take the reality of psychiatry rather than the reality of mental distress as the point of departure for our inquiries. (Miller and Rose, 1986:3)

Miller (1986) extends this critique to the critical sociologies of madness which emerged during the 1970s and theorised psychiatry as a form of social control serving the capitalist state. He regards Andrew Scull as the leading British proponent of this view. The approach is criticised for adopting a dogmatically simplistic understanding of what psychiatry is and does, based upon the assumption that its functions have not been modified at all since its emergence five hundred years ago (Miller 1986:27-8). However, Miller considers that the important factor which has developed out of the continued effort to make social control theories of psychiatry work is a refined understanding of the concept of social control. Miller notes that it is only recently that social control has become a term of scorn. In the writings of Ross and George Herbert Mead it was a term of approbation. Miller discusses French historiographies of madness, primarily the work of Foucault and Castel, and the importance of social control as a positive notion becomes apparent. He adopts the Foucauldian view that power is not merely repressive but also productive and constitutive. It is not the case that human beings consist of a potential 'real self' whose emergence to its full glory is hindered to a greater or lesser extent by repression from a powerful source, as was the scenario described by Laing. Rather, the self is the product of discourses which are themselves the expression of power relations in society as a whole. As Miller and Rose comment, this is:

> an analysis [which] would not view power as some kind of monolithic and malign presence, to which we must oppose ourselves and which we must strive to abolish. Rather, it would analyze the power of psychiatry in terms of what it makes thinkable and possible, the new objectives to which it allows us to aspire, the new types of problem it allows us to conceive, the new types of solution it inserts into our reality. (Miller and Rose, 1986:2)

A further difference between this account and the social control accounts lies in their understanding of the source of power. For the social control accounts, power is invested in the capitalist state, and operates to preserve the capitalist economic and social system. This 'Foucauldian' account sees power as not a unitary phenomenon, but one which is dispersed throughout society, amongst different social groups and individuals. This power consists primarily of the ability to control the discourses which dominate a given society, and therefore to define reality, including understandings of selfhood. This account of psychiatry and mental health is one which has achieved much popularity in recent years in academic circles. It is the reading of Foucault which underpins Gordon's (1986) account of the relationship between psychiatry and democracy.

5.2 The impact of Jacques Lacan.

An example of the use of Lacanian psychoanalysis to found an alternative political critique of psychiatry to that offered by anti-psychiatry is illustrated by Ingleby (1981). Ingleby reiterated the critique of positivist approaches to mental illness. He then offered a critique of what he termed 'normalizing' interpretative approaches. He used this term to refer to

approaches such as that of Laing and the British anti-psychiatrists, whose thrust was to reduce the apparent pathology of psychotic conditions, by demonstrating that such experiences and behaviour could make sense if approached within the framework of their proper social context. He noted that two key ideas in anti-psychiatry were the views that 'sick' behaviour is either a form of protest or a kind of self-cure. Ingleby considers these two views to be the weakest plank in the anti-psychiatric platform, and one which in fact was attacked most strongly by the Left (including Sedgwick, Mitchell, Gleiss and Jacoby) as a romanticisation of the circumstances of mentally ill people. Ingleby argues that:

> the real point, surely, is not that psychiatric problems lack political significance, but that they are not <u>effective</u> forms of social action.
>
> For the 'symptom as protest' view glosses over the differences between the kinds of behaviour that psychiatrists deal with, and conscious, socially intelligible and potentially effective forms of protest. (56)

Similarly, in the case of 'symptom as self-cure',

> If such symptoms are attempts at self-cure, they are neither deliberate nor effective ones. (57)

Ingleby regards the problem with normalizing approaches as very obvious: 'if the behaviour is really intelligible in commonsense terms, why was it regarded as a psychiatric problem in the first place? (Ingleby, 1981:60) He

acknowledges that there are possible answers to this question in terms of ignorance and deliberate malice. However, he concludes that to explain all psychiatric diagnoses in these terms constitutes 'a tall story'. There is a residue in most 'mental illness' which defies ordinary understanding and empathy.

> The normalizing approach exaggerates the extent to which rational free-will operates in psychiatric conditions; they are not just, as Szasz would have it, 'problems of living', but a breakdown of the problem-solving ability itself. (60)

The problem is essentially that identified by Coulter (1973), in arguing that ascriptions of insanity are made by reason of cultural cognitive incompetence. Ingleby identifies the problem as being one of trying to reconcile free-will and determinism. Positivist accounts offer a view of the behaviour of mentally ill people which is straightforwardly deterministic. Normalizing approaches counter this with an approach which simply opposes determinism with free-will. Ingleby argues for an approach which can transcend this simple opposition.

> What is required is a way of accounting for experience and behaviour in terms of meanings, but not necessarily ones which are consciously appreciated either by the agent or his fellows; ...What has to be replaced is not only the positivist myth of man as machine, but also what Marcuse calls 'the myth of autonomous man'. which interpretative theorists are equally prone to. (Ingleby, 1981:61)

Ingleby proposes replacing the notion of the unity of the self with Freud's conception of man as 'fragmented, self-contradictory, and alienated from his own experience'. This will allow an appreciation of the meanings hidden in 'mad' behaviour and experience to emerge without losing sight of the suffering and vulnerability which accompanies them. There follows an account of psychoanalysis which owes much to Lacan.

Ingleby here provides a great step forward in the debate around anti-psychiatry, in acknowledging the distinction between behaviour which is meaningful and behaviour which is rational and effective. Thus, he transcends the problematic association between anti-psychiatry and right wing libertarianism. However, he perpetuates the argument that a radical approach to psychiatry must be one which argues that psychiatric theory must be psychological rather than physiological in its forms of explanation. Mental illness must be a psychologically theorisable response to social conditions which is able to be rendered meaningful in Lacanian psychoanalytic terms, even though it is not classifiable as effective and rational action. Thus, although he has been influenced by Coulter's (1973) argument, that insanity ascription must be considered in terms of cognitive competence, Ingleby continues to propose a theory of the origin and truth of mental disorder which is derived from psychoanalytic theory. It is not until the emergence of Miller and Rose's (1986) account of psychiatry, based upon a reading of Foucault which is not anti-rationalist, that anybody produced an account of psychiatry similar to Coulter's view; that is, that the key to understanding psychiatry is cultural cognitive competence. A political sociology of psychiatry must address itself to the standards of rationality existing within a liberal democratic society (cf. discussion above of Miller and Rose (1986) and Gordon (1986).)

In general, Foucault has been a more popular and influential theorist in terms of the politics of mental health in Britain than has Lacan. The main impact of Lacanian psychoanalysis has been in the field of cultural studies, where post-structuralist forms of psychoanalysis have been brought to bear upon the analysis of texts; for example, Donald, 1991).

6. Related Viewpoints in the Context of contemporary British Thought.

An interesting viewpoint in the context is provided by Prof.Jenner, Professor of Psychiatry at the University of Sheffield until 1992. Jenner's views do not appear to be poststructuralist in origin, but bear some resemblance to that school of thought, and are influenced by the work of Wittgenstein, another twentieth century philosopher who shared the emphasis upon language as the embodiment of values. Jenner began his psychiatric career as a researcher into the biochemistry of mental disorder, an occupation which he continued into the 1970s. However, he already had a long-standing interest in more philosophical approaches to mental disorder, and what he described in interview as 'the philosophy of knowledge'. Jenner knew Laing from the 1960s onwards and was interested in his ideas. However, his own views differ quite substantially from those of Laing, notably with respect to the degree of freedom and responsibility which Laing was prepared to attribute to people regardless of their mental state.

> Laing it seems to me is really a follower of Sartre...Sartre and Laing took the view that it's totally inauthentic to see man as not really free, it's predicated on this...[view] that they can be cowed by all sorts of bad faith or being fooled and so on but there is a sense in which they are free to produce their

world...I think [Laing's] concept of what is possible in terms of human freedom is wrong.

He was similarly critical of Laing's insistence on the mystical value of psychotic experience:

> He was a mystic really, he was always trying to find mystical answers to the nature of the universe and so on, and I think when he sees psychosis as a valuable mystical experience, I didn't think much of that.

Although Jenner disagreed with those elements in Laing's work which he felt overemphasized the possibility of freedom, he regarded this overemphasis on freedom as far more characteristic of and central to the work of Szasz, whose views he disagreed with on political grounds.

> Szasz has a right wing philosophy which on the whole I don't like. I mean he says that his views are necessary in order to preserve the American society, by which he's sort of saying that the individualistic capitalist enterprise of the jungle, really, is the only basis on which human beings can live...I think there's an element in Szasz which lacks compassion.

He also rejected on logical grounds Szasz's view that mental illness is a myth (ie. Proposition 1 of the 'anti-psychiatric attitudes' listed in Chapter 1):

> Sedgwick's criticism of Szasz...I would accept that...I would take the Wittgensteinian view that words...have meaning in

context...There's something unphilosophical about [Szasz's] failure to see the similarity of the concept of illness in mental and physical illnesses. But even more than that, I would be rather sort of critical, I mean, I don't mind what you call the problems this person has in living...I'm more interested in what we're going to do about it.

Jenner's own views were similar to poststructuralist theorists in reflecting an interest in how values are embodied in and expressed through language, and the extent to which 'reality' is a product of social consensus rather than direct experience. This was a view which Laing did not share:

> I held a theory of course which is not really Laing, he used to push it on one side, that normality is always complicity really. What we call a normal person is a person who's complicit with the norms of his society.

He illustrated this by means of a metaphor, comparing society to a caravan travelling through the desert. If a group of people decide they don't agree with the way the caravan is travelling, and set off together in a different direction, you have a sub-culture. But if one person leaves the caravan alone, then she disappears into the desert in isolation:

> My concept of this problem is really that we are almost trapped in a sociological prison, it's a very historistic [sic] sort of view of the very limited nature of reality outside a historical position...the problem with the schizophrenic is that at a very

> fundamental level he tries to live out of it because it doesn't pay him to live in it, he doesn't see it pays him.

Jenner was not impressed by the extreme anti-psychiatry of some user groups. Asked whether he thought the user movement was fundamentally anti-psychiatry, he replied:

> Well, it is profoundly so, isn't it, in a way. Necessarily so, but a little stupidly so...they're...frightened of the psychiatrists in a way.

However, he made an interesting point in relation to anti-psychiatric users seeking to abolish psychiatry, which again relates to his poststructuralist-like view point.

> I tell the students that psychiatry is like a country in Europe, it's a product of socio-historical processes and battles between different professions and it now owns an area which has been given it by society and it owns an area which is defined by words like mental illness, and then of course there's no defence of the borders of Luxembourg other than tradition. So I think in a way the users' group is out to abolish psychiatry, but doesn't realise of course that when you've got rid of the state of Luxembourg it still exists. What I mean by that is that the territory exists, the problems exist, the problems are real...

> I think the intelligent part of the user movement does realise what I'm saying. That there needs to be some sort of helping situation.

Jenner supported far greater user-involvement in the management and delivery of mental health services than exists at present. But in similar context, he expressed doubts about the extent to which user-involvement was possible, and doubted whether a 100% user-run service would be possible or desirable simply because of the extent of handicap experienced by a proportion of psychiatric patients.

> You can dismiss psychiatry...even you can dismiss the word mental illness, but you can't dismiss the whole problem. That there are states in which human judgement is very damaged, you can't contract out of having the courage to say to some people I know I'm usually wrong and often wrong and I'm a human being and fallible but I'm pretty sure that you're in a bad way at the moment.

Jenner's views about the problem of responsibility are also interesting. Jenner has little interest in abstract concepts such as responsibility or justice.

> On the whole my view is that if people are in the hospital violent or - these sorts of things should be dealt with by the police and society, and asking how much we're going to tolerate of this. The psychiatrist should only be asked can you stop it,

> which is frankly not a matter of justice. I think justice is one of these illusory concept in a way.

The question of responsibility arises for Jenner only insofar as he regards it as untherapeutic for a patient not to be held responsible:

> To have it said to you that you can't help it because you're ill is anti-therapeutic.

Ideally, he would wish to hold people responsible for their actions as far as possible, and to reduce the distinction between criminal institutions and psychiatric institutions.

> I think society has to decide what it's going to do with its violent members really. On the whole I am in favour of sending them to prison. But spending a lot of time making prisons humane places and also of involving people therapeutically in them.

Conclusion

This chapter has examined the origins and impact of structuralism and post-structuralism on the politics of mental health, with particular reference to the impact of Lacan and Foucault. Both thinkers have been found influential in providing the foundations for a new political approach to psychiatry. There ideas have been subjected to criticism, particularly at the point at which structuralist analysis mutates into post-structuralism, and the truth status of narratives which themselves purport to deny truth and rationality

becomes problematic. The problems inherent in such an approach become apparent when post-structuralism is used to argue against the use of knowledge in the service of social control. Social control critiques have a tendency to degenerate into a nihilistic rejection of whatever policy is proposed, leaving anarchy as the only tenable 'policy'. However, the work of Foucault in particular has laid the foundations for a new critique of psychiatry, the focus of which is now removed from issues concerning the 'true nature' of mental illness, and is turned towards a consideration of the political functions of psychiatry as a technology. A promising start in this type of analysis has been made in Britain by Miller and Rose (1986).

Chapter 6 The Italian Experience

1. Historical Account.

The events taking place within the Italian mental health system did not really begin to impact upon British thought until the mid-1970s. However, the background to the changes began far earlier, during the early 1960s. The changes in Italy originate from the campaigning and reforming zeal of one psychiatrist, Franco Basaglia (1924-1980). Lovell and Scheper-Hughes (1987:3) have asserted that 'the itinerary of the Italian psychiatrist, Franco Basaglia...marks an epistemological break, and hence a new chapter in the contemporary history of European psychiatry.'

Firstly, to place the changes in Italy in context, the psychiatric system in Italy was extremely backward by European standards at the time when Basaglia first went to work at Gorizia. The Italian asylums were then still regulated by the law of 1904, the Italian equivalent of the English Lunacy Act 1890, which allowed admission to an asylum only as a compulsory patient. The emphasis of this legislation was upon protecting society from those who were deemed dangerous by reason of mental illness (Tranchina, Archi and Ferrar, 1981:182). Not until 1968 did Italy pass the equivalent of the Mental Treatment Act (MTA) 1930 or the Mental Health Act (MHA) 1959, legislating for any form of non-compulsory admission and treatment at all. Thus, the situation in Italy was very different from that in Britain. The MHA in this country was passed as a result of liberalisation within the psychiatric profession and amongst the educated public. It then became itself a target for the critics of psychiatry, who centred their critique of psychiatry upon the medicalisation and compulsory control of psycho-social deviance. The

British and American radical mental health movements both tended to launch a legalistically based 'anti-therapeutic state' backlash against the welfare state type legislation, based upon an individualistic concept of negative rights. However, the Italian 1968 equivalent of the MHA was itself the result of pressure for reform from the worker and student movements (Tranchina et al, 1981:183). The impetus of radical reform in Italy has subsequently tended to press for more changes in the same direction: more collectively organised welfare and national health services, and less formal legal control. The Italians have not adopted an individualistic defence of individual negative rights. The British MHA has often been regarded as a triumph for the power of psychiatry (for example, Baruch and Treacher, 1978:4). The Italian law of 1968 was and is received as a triumph for the radical opponents of psychiatry. In Britain, 'radical' psychiatrists are viewed with some suspicion by other mental health workers and service users. In Italy, the changes were largely driven by radical psychiatrists.

Basaglia graduated in medicine in 1949, and from then until 1961 held a position at the Neuropsychiatric Clinic of Padua. During this time, he embraced existential phenomenology as the only existing alternative to the dominant organicism of Italian psychiatry. In 1961, he became director of the mental hospital in Gorizia. Here he found that, in practice, the phenomenological approach was inadequate in that it failed to address the reality of his patients' suffering (Lovell and Scheper-Hughes, 1987:7).

However, Basaglia did not abandon phenomenology. He continued to approach his patients with a concern for their subjectivity which caused some critics to accuse him of denying the existence of mental illness. But he was beginning to search for more effective ways of helping his patients than the

individualistic therapies derived from existentialist and phenomenological analyses.

During the 1960s, Basaglia visited England and was impressed by the work he saw being done by Maxwell Jones at Dingleton. The theory of the therapeutic community became the starting point for Basaglia's reform of the mental health system in Gorizia. He and his colleagues at Gorizia began to institute an open door policy, involving two main changes in the way the asylum was run (Lovell and Scheper-Hughes, 1987:13ff). Firstly, they created paid work within the hospital. This gave patients a reason to leave their wards, and ended the stagnation and emptiness which characterised life on the wards. Such work was very different from the 'ergo-therapy' which had been practised previously, and had amounted to no more than the exploitation of patients as cheap labour. Secondly, Basaglia instituted the daily assemblea, a gathering of patients and staff. Such meetings were derived from the theory of the therapeutic community, but operated in ways which were quite different from a therapeutic community group meeting, operating as a 'stage for confrontation', and avoiding the psychoanalytic interpretations which characterised the traditional therapeutic community meetings (Lovell and Scheper-Hughes, 1987:14-15).

The assemblee became part of a process of 'collectivization of responsibility for the consequences of behaviour'. That is, through the large meetings, hospital patients and staff began to feel responsible for one another's actions and their outcome. All accepted that they had some responsibility for mutual care and support, and that no one individual was isolated form the care and intervention of the others. A good example of this occurred in 1968, when Basaglia was indicted for manslaughter after a patient he had released into

the community murdered his wife. The assemblee refused to allow Basaglia to be held responsible, and accepted shared responsibility for the error of judgement.

Already, by the late 1960s, the staff at Gorizia had moved far beyond the therapeutic community techniques they had borrowed from England. The therapeutic communities in England had never questioned their own underlying power-structures and lines of authority. At Gorizia, the operation of power was regarded as fundamental to the institution as it had evolved, and the process of reforming the institution necessarily involved analysing and rendering explicit the power relationships which existed. Finally, Gorizia moved beyond the therapeutic community approach altogether, the second stage of Basaglia's reform being the total abolition of the institution.

In 1968, the group decided to begin to spread their reforms to other regions of Italy. The decision was timely because, as in the rest of Europe and America, the student and worker movement was at its height and promoting values which corresponded well with the anti-hierarchical and anti-authoritarian nature of the Gorizian experiment (Lovell and Scheper-Hughes, 1987:20).

In Italy, students and worker occupied in protest not only factories, universities and schools, but psychiatric hospitals. It was an appropriate moment at which to be launching a movement for the liberation of mental patients. The publication of Basaglia's Instituti Negata in 1974 provided a further impetus to the spread of his ideas.

In 1969, Basaglia moved to Parma, where he began to recognise the necessity of working not only with the patients themselves, but with the community to which they were to be returned. The community must be educated and assisted so that the people would be more than merely passively tolerant of the ex-patient population being moved into their midst. A further very practical problem was to provide alternative provision to prevent those discharged from the hospital from becoming an added burden on already poor and struggling families.

Also at this time, Basaglia's colleagues from Gorizia were moving to other cities to spread the work: Giovanii Jervis to Reggio Emilia, Agostino Pirell to Arezzo. The city of Perugia had begun its own reform programm similar to that in Gorizia in 1965. In 1970. Perugia set up a network of 9 community health centres. Lovell and Scheper-Hughes (1987:26-7) observe that these community centres became increasingly psychotherapeutic in orientation, and that this highlights a divergence which emerged in the Italian movement between those who thought that psychiatric suffering has a specificity of its own which required specific interventions, and those who believed that a totally depsychiatrized model of welfare assistance was more appropriate. This division parallels the division noted amongst the British anti-psychiatry movement during the early 1970s, with a split developing between those most interested in new and radical forms of psychotherapy, and those interested primarily in social reform. It is a division which continues to exist in the contemporary British user movement, between those who regard all forms of 'expert' theorising and intervention pernicious, and those who argue that it can be helpful and non-coercive. Interestingly, Lovell and Scheper-Hughes (1987:27) argue that the two approaches are ideal types which are, in practice, far less divergent than may at first appear. They point out that,

although Basaglia and his followers never codified their approach to working with patients, they nevertheless clearly did follow a method of working with people which could be termed therapeutic. The distinction between psychotherapeutic and non-therapeutic interventions cannot be finely drawn. Thus, Scheper-Hughes and Lovell appear to be arguing that there can be no professional intervention at all without some at least implicit expert theory of the causes and treatment of distress. Psychotherapy cannot be abolished as long as there are any professionals remaining at all. A similar issue emerges within those user groups which wish to see therapy abolished entirely. In practice, such groups tend to reinstate practices which are para-therapeutic, although this is not overtly acknowledged. (See Chapters 4 and 9 for full discussion.)

The anti-institutional movement produced its most complete expression in Trieste. Basaglia became director of the Psychiatric Hospital of Trieste in 1971. The movement here took place on two fronts, the hospital and the community. A new legal status was created, that of <u>ospite</u> or guest. This category consisted of those who were either unable or unwilling to leave the hospital. But as ospite they suffered none of the restrictions of civil rights or liberty which they had experienced as patients. No treatment was mandatory. In addition, the hospital property was opened up as a resource for the whole local community. The traffic in Trieste was not one way, out of the hospital, but involved people coming and going and the transformation of function of the actual bricks and mortar which remained of the hospital into a centre for local arts and culture. The arts were used not only to give local people an incentive to come into the hospital, but to illustrate the aims of the work being done and sensitize local people to the issues. Eventually, six alternative community mental health centres were set up to

provide care outside the institution. By the time Basaglia left Trieste to take over psychiatric services in Rome in 1979, the hospital was completely empty.

In 1976, professionals involved and interested in Basaglia's work organised themselves into a political group which they named Psichiatria Democratica (PD), which translates as Democratic Psychiatry. This group was involved not only in implementing actual reform within the hospitals, but in lobbying for political support for the reforms. During the 1970s, the Left in Italy were concerned with issues of health and welfare. By 1977, most of the political parties were drafting proposals for a national health service, within which the mental health services were to be included, and which was to involve overall reform of mental health legislation along similar lines to the reforms introduced throughout Europe in earlier decades and embodied in Britain in the MHA. However, before the legislation could be passed, the Radical Party produced a petition calling for a referendum which, if passed, would have resulted in the total abolition of commitment procedures and public mental hospitals without alternative community-based provision. In response to this threat, the Christian-Democrat Party supported by the Communist Party pushed through legislation very quickly to avert the disastrous consequences which would ensue. This legislation was drafted in close consultation with Basaglia, and became Law 180.

Lovell and Scheper-Hughes (1987:35) note that the law was a compromise measure, although it did reflect some basic tenets of Basaglia's work, particularly the dismantling of the asylum system and the decriminalization and depsychiatrization of mental illness. Compromises included the retention of a form of involuntary commitment, and the exclusion of forensic hospitals,

private hospitals, and university clinics from its jurisdiction. The basic premise of Law 180 is that all psychiatric treatment and evaluation should be voluntary. New admissions to psychiatric asylums were frozen and all current and chronic patients were to be gradually discharged. In the meantime existing hospitals were to be unlocked and their patients' civil rights returned to them. No new hospitals were to be built. Evaluation and treatment were to be provided in community facilities. Some crisis beds were made available in local general hospitals, but these were to provide no more than 15 beds, and compulsory hospitalization was not to last more than fifteen days, with judicial reviews required after two and seven days. The significance of the law is that its unambiguous goal is the total abolition of the state mental hospital system and, more importantly, that it recasts the relationship between law and psychiatry so that dangerousness is no longer the rationale for compulsory treatment and segregation. Law 180 destigmatises the psychiatric patient: mental illness is no longer treated as a special case of illness that allows for special violations of the patient's civil rights. 'Commitment is no longer hidden behind a medical mask and confounding psychiatric language and expertise' (Lovell and Scheper-Hughes, 1987:35-6).

Once in place, the law proved more difficult to implement than had been expected. Opposition to Basaglia's work came from biodeterministically-oriented psychiatrists and classical psychotherapists. Hospital nursing staff joined the backlash out of fear of losing their jobs. Ministers of health after 1978 repeatedly delayed full implementation of the law, and offered no consistent leadership. By 1983, implementation of the law had been extremely patchy. Cities which had been advanced in reform prior to 1978, such as Trieste, Arezzo, Ferrara, and Perugia, had acted most completely in accord with the spirit of the law. In some other northern cities such as Genoa,

Turin, and Venice, deinstitutionalization efforts were underway, but progress was limited. In the South particularly the law had either not been implemented, or was applied in a solely negative manner, local authorities and service providers treating it as an opportunity to relinquish responsibility for the care of patients (Lovell and Scheper-Hughes, 1987:37).

Lovell and Scheper-Hughes (1987:38ff) consider that neglect, sabotage and incompetence can explain only part of the problem of the failure of Law 180 to secure reform. At least some of the blame must be placed on structural aspects of the law stemming from its origin as a compromise measure. Firstly, the only service that is specifically required to be provided by law is the Diagnosis and Treatment Unit (SDC), containing a maximum of fifteen beds. Such units are generally locked and heavily reliant upon medication as the treatment of choice. This highly medicalized provision is quite contrary to the spirit and purpose behind the work of Basaglia and his colleagues. Community services have not been mandated and therefore tend not to be funded, so that the SDC is frequently the only place patients can fall back on in times of acute distress. In addition, the fifteen day limit on compulsory admission has been subverted by multiple readmissions. Secondly, the legislation did not provide adequate regulations, mechanisms and funding for community alternatives, so that there is wide variation across the country in the level of provision different areas have found it possible or desirable to provide. Giannichedda (1989:13) identities three different 'Italies', characterised by: the successful implementation of Law 180; north-European reformism (which retains a greater use of hospital wards); and the south of the country, where little has changed.

Tranchina, Archi and Ferrara (1981:189-90) acknowledged some of the ways in which the law had still by that time not met achieved its objectives. They too noted the growing divide between the north and South of the country in implementation of the law. They identified the main problems as being a lack of community-based facilities, existing repression in many of the services of cure and diagnosis based in general hospitals, and administrative delays. In addition, they also identified flaws within the legislation, such as the failure to integrate criminal asylums within the reform, and the retention of some provision for compulsory treatment. However, on a more positive note, they record also that the first year's statistics on the effect of the law showed a 17% decrease in number of patients in the hospitals, a 63% decrease in compulsory admissions, and a 34% decrease in voluntary admissions. Neither the number of suicides nor the number of admissions to private clinics were found to have increased.

By the mid-eighties, patients' families were emerging as a major new block critical of existing provision. Some, such as the Association of Families, which is similar to the British national Schizophrenia Fellowship, were anti-reform and demanded that the hospitals be re-opened. Others demanded that Law 180 be properly implemented (Giannichedda, 1989:13). The continuation of the reforms looks at present under quite serious threat.

Franco Basaglia's widow, Franca Basaglia (1988), to the extent that she conceded they had not been wholly successful, was unhesitating in attributing the failure of the reforms to deliberate political sabotage.

> the law is only being applied in a restricted way which emphasizes only one aspect, namely the abolition of outdated

mental institutions by incorporating psychiatry into medicine. Any attempt to go further than this and call into question the established social order is condemned as an idealistic fancy.

In fact a process of disaffection on the part of those government forces which had favoured the reform has taken place. The reform which had required some very radical changes has consequently been left drifting. This disaffection has been increasing gradually where inaction and lack of resources for implementing the reform have been causing problems and difficulties in terms of local political consensus. (Basaglia, 1988:276-7)

2. Philosophy Underpinning Basaglia's Work.

The Italian reforms, and their theoretical justifications in the work of franco Basaglia, in some ways resemble British-based anti-psychiatry, and in other respects diverge in important ways from anti-psychiatry. This section will examine some of the points of similarity and divergence.

2.1 The influence of non-positivist philosophies.

The Italian reforms emerged during the same historical period, the 1960s, as anti-psychiatry, and drew upon some of the same philosophical sources as Laing and Cooper. Ticktin (1991:32) notes that the work of the Basaglias emerged at a time when anti-psychiatry was 'in vogue', and presenting a challenge to existing institutional and theoretical aspects of the psychiatric system, and the concept of mental illness itself. An important commonality between the leading British-based anti-psychiatrists, Laing and Cooper, and Basaglia was

the origin of their approaches in phenomenology and existentialism. As Laing and Cooper adopted a phenomenological existentialist analysis, as the only salient alternative to the prevailing positivism of both medical psychiatry and psychoanalysis during the 1950s, Basaglia also adopted phenomenology. Although by the early 1960s Basaglia came to realise the limitations of phenomenology, in terms of its limited awareness of the suffering involved in mental disorder, and the need to take account of this suffering, his continuing interest in the subjective reality of his patients, as opposed to the medical view of their condition, is a clear parallel with the work of Laing and Cooper.

Like Laing, Basaglia regards orthodox psychiatric diagnosis as a technique not for understanding one's patients, but for distancing oneself from them, to protect oneself from their disturbance. Basaglia sees the power relationship which ensues between patient and doctor as determining the course which the patient's illness will take. The doctor then uses his power not to learn more about his patients and their illnesses, but to defend himself from them. A colleague of Basaglia, Maria Giannichedda (1988:254) believes that:

> Drawing up a list of the symptoms merely acts as a screen between the psychiatrist and the patient allowing the psychiatrist to distance himself from the patient and the problems of his illness.

The alternative to this unfortunate state of affairs is to acknowledge that the psychiatrist is a part of the patient's world, and that doctor and patient exist in relationship. This view is similar to Laing's insistence that the patient's behaviour must be viewed within its proper social context.

Basaglia, like Laing and Cooper, recognises also the function which positivism plays in legitimising psychiatry's claims to objectivity.

> The concept of a causal connection between the phenomena, mechanistically determined by the natural sciences, flattens and confounds the biological, psychological, and social elements of which every human experience is constituted, by placing within parentheses the contradictions, present at every level, that arise from the dialectic between individual and organization. (Basaglia and Basaglia, 1987:248)

Jenner (1986:5) notes that Basaglia was aware of the differences between post-war Italy, France, Britain and the USA, but that he identified certain constants across these separate contexts, including the conceptualisation of illness, and the failure to appreciate the meaning of suffering and the validity of the patient's subjective viewpoint.

The work of the labelling theorists, Scheff and Goffman, was also influential in informing Basaglia's view of the process by which deviant behaviour and deviant individuals become institutionalised in societies which identify and exclude them. Again, labelling theory offers a critique of the positivist view which refuses to consider the questions of value implicit in psychiatric and medical diagnosis. However, as will be seen, Basaglia did not subscribe to the view that labelling theory supports anti-psychiatry by explaining away the whole process by which an individual comes to be labelled as insane. He retained a belief in the reality and distinctiveness of unreason as a problem which confronts all western societies.

2.2 The critique of the institution

Basaglia identified the institution as the focus of psychiatry's function of excluding and marginalising distressed people. His critique of medical psychiatry was predominantly bound up with his critique of the institution. For him, diagnosis and institutionalism are closely related means of not relating to one's patients as people. He was beginning from the point of challenging the institution rather than the medical profession per se. Where Basaglia challenges the power of medicine, it is as an aspect of the institution rather than as medicine itself that the challenge is issued. Basaglia has no fundamental argument with medicine. His objection is to the alliance which medicine has formed with the judiciary through the institution. On the relationship between psychiatry and the judiciary he comments (1980:20-21):

> The governing norms have...contributed, to a considerable extent, to forcing the development of psychiatric knowledge into certain channels, nearer to those of the state's judiciary apparatus than those of medicine. As is the case with the judiciary apparatus, it is the danger represented by deviant behaviour which is the real object of psychiatry's attention.

He considers that, throughout Europe, the scope for psychiatry to develop its medical (ie. therapeutic) side was restricted by its forced association with segregation and containment. Basaglia continues in a vein which is highly sympathetic to the medical profession's efforts to free psychiatry from its unholy alliance with the judiciary in order to practice psychiatry more effectively free of the institution. His critique of the liberalisation of mental health law and the

introduction of voluntary forms of hospitalisation is based on the conclusion that this doesn't make enough difference to result in the abolition of the institution, allowing medicine to fulfil its proper role as therapy.

> The old norms governing compulsory admission to the institution...are accompanied, though neither replaced nor modified, by regulations facilitating voluntary or informal admission...in practice, psychiatrists still operate within the limits of the old ideology reaffirming its basic worth and only slightly mitigating its rigidity (for example, the very limited application of voluntary and informal admission). (Basaglia, 1980:24)

He refers to the implications for psychiatry itself of his attack upon the institution, and views the functions of psychiatry as a branch of medicine as having been 'dragged into the crisis of the asylum model'. Clearly, the implication is that the two are potentially separable, and psychiatry has within itself the possibility of becoming a politically benign practice. He objects to psychiatry because of what it has become through its relationship with the institution. He does not object to what it could have been and might yet become.

Like Laing and Cooper, Basaglia's critique of the institution was influenced by the burgeoning therapeutic community movement. He began by rooting his practice firmly in the belief that mental state was a product of social milieu. Giannichedda (1989:13), who worked with Basaglia in Trieste, recalled that the first book which Basaglia instructed new colleagues to read was the history of the therapeutic community. Like Laing and Cooper, Basaglia

considered that the therapeutic community as proposed by Maxwell Jones remained too controlled and failed to tackle the central issues of psychiatry. As Jenner (1986:5) has commented:

> Basaglia's reforms began with a conventional attraction to Maxwell Jones' concepts of therapeutic communities...[But] the therapeutic community movement was a subtle coercive device which didn't confront the society which is responsible, and which needs to be made therapeutic in the broken homes and orphanages, etc, from which these people so often come.

Basaglia's response to the realisation that the therapeutic communities still involved a great deal of control was very different to that of Laing and Cooper during the 1960s. Laing and Cooper responded by leaving the state services and founding their own communities, within which the doctor-patient relationship could be as informal and unstructured as possible. At this stage, both believed that it was possible to provide alternatives to existing services, and thus to challenge the medical system from outside. Basaglia came to believe that what was necessary was to extend the therapeutic community approach to the entire community. Working from within the institution, radical professionals must work to dismantle the institution from the inside, and reintegrate its residents into the general community. This would involve everyone - patients, professionals, and the general population - in reassessing their attitudes towards madness, unreason and illness. This viewpoint relates to the Marxist analysis of society which both Cooper and Basaglia shared, which sees macro-political change in the structures of society as the only means for ensuring real and lasting change. It was not a view which Laing seems ever to have held. Ticktin (interview) thought that PD:

very much responded well to David Cooper, they didn't respond so well to Laing...they seemed to be very put off by Laing.

For Laing in particular, humanism and faith in free action caused him to believe that it was possible to stand outside the oppressive structures of society and fight them from a position of moral superiority. This risk of this approach was that in practice it tended to produce elite alternatives to the central structure which ultimately supplemented the system they were intended to replace. Such alternatives thus, if anything, extended the scope of mental health and psychiatric intervention, whilst leaving the most coercive and repressive structures untouched. Basaglia's determination to work within the system stemmed from his refusal to accept the individual as able to stand outside his collective group. For Basaglia, society exists not solely as something outside the individual, coercing his natural inclinations into a different direction. Rather society exists within all individuals, in the sense that all are inextricably involved in the rules and orderings of the society they inhabit. The individual cannot be isolated outside societal rules and norms. Thus, to make any attempt to work from outside the institution is doomed to failure, because wherever the individual goes, he is inevitably involved in the society whose needs the institution serves. He is inevitably complicit to some degree. Reform of the institution must therefore involve reform of the whole society.

This difference between Laing and Basaglia is apparent in an interview in which Laing and Basaglia responded to each other's approaches (Basaglia and Laing, 1987). Basaglia referred to the debate as to whether one should work for change from inside or outside the institution.

> The debate about whether to work inside or outside institutions, inside the system or outside, presupposes that inside and outside exist as clearly separate and antagonistic positions. Inside and outside are created as opposite and completely separate poles by a social system that is based on divisions at all levels. If we accept this premise, we are already playing into the hands of administrators. Perhaps we should try to work on uniting the inside and the outside, since in reality they are constantly linked and it is only the ideology of the inside and the ideology of the outside that separates them....In reality there is no total outside; it is assumed because it confirms the existence of a total inside. (Basaglia and Laing, 1987:195)

Laing, however, asserted his belief that the distinction between inside and outside the institution was meaningful in terms of the level of radical action which is possible. He claims that it is possible to be a radical outside the institution, because you have the freedom to do so, whereas within the institution you are restricted heavily by the power structures.

> If Franco [Basaglia] thinks he can significantly change things in the direction he wants by remaining inside institutions, and he thinks that is possible, I respect his opinion and hope he succeeds with his intentions. I made enormous efforts to do what I intended inside the system ten years ago, but there was no room to do it. I had a choice either to stay in the system and try to accomplish what I wanted, without succeeding, or to get out. I got out. Obviously. I didn't completely leave, because I still

hoped to influence the system from the outside. (Basaglia and Laing, 1987:195-6)

Lovell and Scheper-Hughes (1987:202) whilst expressing sympathy for Laing's approach, regard it as very different form their own work and that of Basaglia, and fraught with particular dangers associated with the failure to confront the role of the institution within social structures more widely considered. Specifically, Laing's 'alternatives', because they do not challenge the power of the institution directly, run the risk of becoming themselves institutionalised and failing to offer a continuing and effective challenge to the institutional mainstream.

The difference between Laing's attitude to psychiatric reform and that of Basaglia is related to their different political commitments. For Laing, individual subjectivity is the central concern. For Basaglia, individual subjectivity is intimately related to the collective, and it is the collective as such which must be challenged. Lovell and Scheper-Hughes (1987:194), discussing the difference between Laing and Basaglia, suggest that Laing tends to focus and concentrate upon individual subjective change, whereas Basaglia tends to concentrate upon social transformation. Basaglia worked in reference to a more developed theory of the existing structures as related to, and existing in the service of, capitalism, and not open to attack and change other than from within. The attack upon the institution must be representative of, and take place alongside, an attack on the social structures in their entirety.

2.3 The absence of influence of Szaszian libertarianism upon Basaglia.

A substantial difference between Laing and Basaglia (and ultimately Laing and Cooper) is the depth of Marxist analysis brought to bear upon psychiatry. Notably, Basaglia was not influenced by the views of Szasz. Szasz places a high value on individual freedom and non-interference, which is wholly antithetical to the collectivist spirit of the Italian reforms. Ramon (1983:310) suggests that both Szasz and Illich's writings have had little impact upon the Italian movement, because of their basically conservative beliefs and opposition to state intervention.

The Italian critique of psychiatry does not utilize Szasz's claim that 'mental illness is a myth' at all (Proposition 1 in the 'anti-psychiatric attitudes' listed in Chapter 1). Tranchina, Archi and Ferrara (1981:181), whose work originates from that of Basaglia, emphasize that they do not wish to deny the reality of what is defined as mental illness, but they do want to question its significance for the individual and for society, and understand how it has reached its institutional destination.

Basaglia's rejection of the libertarian critique of psychiatry is also seen in his understanding of the relationship between psychiatry and law. Psychiatry and law have often been regarded as fundamentally at odds with one another because their forms of discourse are based upon apparently irreconcilable assumptions about human behaviour. Legal discourse assumes a high level of conscious, rational, free choice on the part of its subjects. Psychiatry has usually tended to regard the capacity for free choice as a metaphysically derived myth, and to assume that all behaviour is causally determined. Thus, psychiatrists and lawyers have often been portrayed as

being in a state of conflict (for example, the trial of Peter Sutcliffe, where lawyers were perceived as wanting to hold him responsible for murders he had committed, and as being at odds with psychiatrists, who did not). However, Basaglia regards law and psychiatry as having formed a contract with each another to exclude different types of deviance, which came to be portrayed as threatening and dangerous.

> Illness, psychiatry, and the hospital were reduced to pure nominalism; illness became the dangerousness that presumably has to be contained; psychiatry became a branch of law that punishes anyone suspected of dangerousness; and the hospital became a prison in which this presumed dangerousness is segregated. Psychiatry became a science that is born and dies the very moment the contract between medicine and law is actualized. From that moment on, psychiatry sided definitively with law, hence with power, forgetting the subject for whom it exists and whose suffering justified its very birth. (Basaglia and Basaglia, 1987:242-3)

Basaglia regards the functions of law and psychiatry as having become confused, and needing to be separated from one another. It is the proper function of law to punish deviance. It is the function of psychiatry to heal. Thus, although Basaglia rejects, or rather ignores, Szasz's argument that mental illness is a myth, he reaches by an alternative route Szasz's conclusion that compulsory treatment ought to be abolished (Proposition 9 in Chapter 1). Jenner (interview) referred to Basaglia's use of the law as 'sort of Szaszian'. But this statement disregards the point that for Basaglia the

individual is not placed in prison as an alternative to psychiatric treatment, but as an accompaniment. Jenner added:

> [In Italy] it's very difficult to get a psychiatrist to appear in court...what he will say much of the time is that the court must decide, the people must decide what to do with this sort of behaviour. The function of a court is to protect the society. My function is to look after the individual...but if you send him to prison I will go on seeing him...There's a sense in which Psichiatria Democratica attacks the concept of justice, it says that prisons and police are for the protection of society, they're not a matter of justice. Whereas the English law has always and still has a great element of justice. (Jenner, interview)

Basaglia had no clearly developed theory as to the nature or etiology of mental disorder. He simply accepted it as a social reality that some people exist in a state of extreme distress which handicaps them. Although Basaglia does not appear to have become drawn into the Anglo-American debate, inspired by Szasz, as to the existence or non-existence of mental illness, he was interested in the value judgements which underpin all attributions of illness, and the tendency to neglect the social and political dimensions of many forms of ill-health. For example:

> Could Lombroso, upon entering the asylum at the beginning of the twentieth century, where he found vagabonds, derelicts, peasants who had migrated to the city, and victims of pellagra, all locked up together under the label of mental illness, have sorted out illness from misery the way Pinel did with delinquency? Backed

by the thought of the Enlightenment, Pinel had the possibility of creating an institution for illness that left delinquency intact, because that scientific, humanitarian gesture did not disturb the relationship with misery that a separate segregation continued to guarantee.

But suppose Lombroso, spurred on by the social movements of the beginning of the century, instead of recognizing pellagra as an illness, had denounced it as having to do with hunger. Where could he have put this misery that was confused with illness? Would he have brought it back to the streets where it had been banished so as not to be visible? Who would have listened to him, if this process of sorting out presupposes a social and political response to misery? The liberal state is not inclined to give such a response, and misery remains confused with illness, whose face it takes on so that it can save the face of the liberal state. (Basaglia and Basaglia, 1987:246)

Thus, Basaglia is not concerned with the notion of mental illness as a myth, opposed to physical illness as a reality. He is concerned with the use of illness as a term attached to all forms of distress, physical and mental, and which has the effect of individualising the problem, placing it within a pathologised individual, rather than seeking the causes within the socio-political sphere. Jenner (1986:4) has commented that 'Basaglia would not have denied the way in which the term 'madness' is used, or a near synonym', but he would have challenged the view that mental illness or madness exists in a concretised form, separable from and predating in essence the society within

which it is to be found. Rather, our contemporary concept of madness emerged within the specific framework of industrial society.

Basaglia makes it clear that he does not regard it as inevitable that psychiatry should be a matter of value judgements in any sense different from that of physical medicine. He argues that 'psychiatric diagnosis has become a value judgement' (Basaglia, quoted by Giannichedda, 1988:254, italics mine).

> If we now want to succeed in facing up to the patient and the reality of his disorder, we must put 'illness', i.e. its nosographic classification, to one side...We have never faced up to mental illness, only denied it...What should be the sensible honest acceptance of our own limitations is actually transformed and fanatically divided into what we do understand and what we do not understand. The anxiety caused by our inability to communicate and understand must be calmed quickly by a process of labelling. This denies value to the problem in question and takes it out of its context. It is precisely for this reason that the labelling process is so aggressive. (Basaglia, in Giannichedda, 1988:254-5)

We should seek to return to the original meaning of 'therapy':

> a concept of treatment linked to provision of a service, in which the patient forms part of a reciprocal relationship with whoever is helping him. Therapy would then be based on the reciprocal nature of the relationship between both parties. (Basaglia, in Giannichedda, 1988:255-6)

In short, Basaglia approaches mental disorder as a social issue, rather than a medical one, but does not deny that mental disorder is properly termed illness. His Marxist analysis is, however, more subtle and sophisticated than a simple opposition between a labelling theory approach and a social causation approach would suggest. Mental disorder may be both simultaneously a distressing response to oppressive conditions, and a form of deviance which is threatening to the capitalist mode of production. Psychiatry has traditionally taken on itself the role of excluding and marginalising this distress. The function of a Marxist based psychiatry is then to restore the distress to the community within which it originated, compelling the community as a whole to deal with its more vulnerable and disturbing members, and not allow them to be shut away and forgotten. Tranchina, Archi and Ferrara (1981:181) identify the fundamental elements of the Movement for Democratic Psychiatry as:

> tied to an ideal which sees human subjectivity as an inalienable fact beyond any therapeutic label or institutional protection. But the condition for which this subjectivity might assume greater significance is that it should not be reduced to individualism; instead, it should find its confirmation and power in the collective.

It is Basaglia's belief that the exclusion and marginalization of mental distress which has resulted in our societies' institutions is a product of capitalism. He was highly influenced by Hollingshead and Redlich's research on mental illness and class, with its revelation that mental illness is found overwhelmingly amongst the poor and disadvantaged. He developed a theory of the vulnerable underclass who were unable to survive under the harsh

capitalist system, and whose resulting distress was then called mental illness and completely marginalised and isolated through hospitalization and institutionalization.

> The rules of social life make sense for those who are part of this life, who find in it at least a partial response to their own needs. But for those who find only a confirmation of their exclusion, these rules represent the language of violence and oppression.

Jenner (1986:4) has suggests that Basaglia would take the view that 'too much human wretchedness had to be fitted into the new means of production'. That is, capitalism imposed its own standards of rationality upon society, and dictated that it is unreasonable to be unwilling or unable to fit into the capitalist scheme. Therefore, people who do not or cannot fit in must be abnormal or sick in some way. Basaglia takes the view that psychiatry as currently practised is complicit in supporting the power games of the ruling class.

> By making diagnoses and using various techniques, psychiatry plays a part in the power game of the ruling class which has already established who has to pay and how, in order to maintain its own equilibrium. (Basaglia in Giannichedda, 1988:257)

Jenner (1986:4) identifies Basaglia's rejection of the medicalisation of mental illness not as an attempt to underplay the suffering of psychiatric distress, but as an attempt to emphasize that inability to cope with the conditions of modern industrial society does not indicate a defect within the

person, but a defect within the society. However, because Basaglia always recognises the reality of distress, his proposed solution is not simply to oppose psychiatry as irredeemably oppressive, but to reidentify the proper function of psychiatry as being to reintegrate and empower the oppressed and marginalised.

2.4 The influence of structuralism upon Basaglia.

Basaglia's version of Marxism owes a great deal to structuralism, particularly to the early work of Foucault on the rise of the asylums (Foucault, 1967). It is Foucault's analysis of rationality after the Enlightenment which allows Basaglia to develop a view of madness as a valid form of subjectivity without adopting a highly individualistic politics of subjectivity. Madness is not something to which any individual has a 'right', but a quasi-universal human experience to which all societies need to respond on a collective basis. Since the Enlightenment, the response of Western capitalist societies has been to attempt to exclude madness by housing it within institutions. The aim of Psichiatria Democratica is to restore madness to its rightful place within the community. This aspect of Basaglia's collectivist, as opposed to individualist, approach is to be found in his attitude towards the voice of madness. Laing regards the psychotic voyage as an individual experience to be embarked upon by particular privileged individuals. Unreason is presented as a form of mystical adventure or coping or healing mechanism which particular people embark upon at certain times for particular purposes. Basaglia regards madness as something which exists in everyone alongside the capacity for reason. However, capitalism cannot cope with the power and unpredictability of madness disrupting its smoothly functioning system of production. So madness, with all its weakness, distress and vulnerability,

must be banished. It must not merely be offered no place in the rewards of production, but isolated, marginalised and removed from the system. Thus, for Basaglia, the de-marginalisation and de-institutionalisation of madness involves not merely restoring to the mad the right to live alongside the rest of the community, but restoring to the community the right to own its own madness, its own distress and oppression and vulnerability. Basaglia's argument is based upon the premise that society cannot rid itself of its madness by calling it mental illness and inventing technological 'cures'. It can only live with its madness, accommodating it, and alleviating the social factors, such as poverty and exclusion, which transform madness into misery. Basaglia and Basaglia comment:

> Science finally is concerned with an illness (about which it is totally ignorant, except for the nominalistic specifications it has given to it), contained in custodial and treatment institutions. But the nature of this illness and of these institutions, and hence the nature of the treatment and the custodial care that will be carried out inside them, will remain closely tied to the relationship that bourgeois rationality continues to maintain with misery. For it is the obligation of the institutions, through the mediation of illness, to contain and control this misery. (Basaglia and Basaglia, 1987:241)

These concerns of Basaglia's relate more closely to European structuralist thought than to the British anti-psychiatry of the 1960s. Basaglia's wish to restore madness to its rightful place within the community is redolent of Foucault's insistence that madness was not deprived of its dialogue with

reason until the industrial revolution and rise of capitalism. The Basaglias comment:

> Mental illness and the medical science that begins to deal with it are translated into one of the essential instruments through which bourgeois reason, having become the dominant ideology, manages to face the contradictions which belie it. Thus begins the slow separation between normal behaviour, which corresponds to the rationality of power, and abnormal behaviour, which is endowed with a rationality of its own that is not subject to the rules so foreign to it. (Basaglia and Basaglia, 1987:238)

The emphasis upon irrationality as central to the human condition, possibly more central than reason, can also be related to Lacanian psychoanalytic ideas, with their emphasis upon letting the unconscious speak. Deleuze and Guattari's understanding of the revolutionary nature of psychosis as pure unOedipalised desire carries a similar message of the importance of madness for demonstrating the unreason and distress which is the universal lot of human beings disguised by a superficial veneer of rationality.

Lovell and Scheper-Hughes (1987:48) find in Basaglia's work 'a willingness to heed Foucault's early call to "give madness back its voice." ' This is to be contrasted with the post-Enlightenment view of madness, characterised by:

> the ideologies that justify and mechanisms that produce and perpetuate the exclusion of all that is different in society. It is a difference that, since the beginning of the Enlightenment...is measured against reason...With the progressive rationalization of society...all that does not fit the goals of

capitalist production must be excluded. (Lovell and Scheper-Hughes, 1987:227-8)

Referring to an encyclopedia entry on the subject of <u>Madness and Delirium</u> (Basaglia and Basaglia, 1987), Lovell and Scheper-Hughes (1987:228) state that 'the Basaglias read Foucault with a Marxist key'. That is, the Basaglias accept Foucault's account of the Enlightenment as the era during which Reason and Unreason were separated, and Unreason became the object of surveillance and control. However, they develop this analysis further, relating the separation of Reason and Unreason to the requirements of capitalist modes of production.

Basaglia observes that psychoanalysis does acknowledge the unreason at the heart of normality, thereby ending the rigid distinction between rationality and irrationality and leading to the blurring of 'the boundaries between normal and pathological' (Lovell and Scheper-Hughes 1987:229). But this only takes place within the analyst's office, and outside the real realm of social conflict. Psychoanalysis does not therefore affect the roots of the separation between reason and unreason. In the words of Basaglia and Basaglia (1987:252-3):

> Freud broke the certainty of reason and introduced doubt into the discourse...Unreason is inside us, it is part of our nature, not in the sense understood by an enlightened reason that would recognize it only in the moment in which it restrained and disarmed it; but in the sense that man is tragically harnessed by his own unreason...

> [B]ut the practical conclusion arrived at by psychoanalysis is a different, subtler, and deeper form of mastery of the self, split between reason and unreason, dominated by whatever interpretation is made about this division. The circle closes: the door opened on subjectivity is now shut by the objectification of the self.

Here Basaglia and Basaglia seem particularly close to the perspective adopted by Lacan, that Freud's theory was initially highly radical and subversive, but was very quickly turned to the advantage of adaptationist psychiatry and put in service of reason. This perspective is perhaps adopted even more completely by Deleuze and Guattari (1977) in their questioning of where psychoanalysis 'went wrong', and their conclusion that the error is to be found at the very heart of the theory in the acceptance of Oedipization.

However, according to Basaglia, despite its domestication unreason will continue to make itself heard, and reason will strive to manage it in such a way as to defuse its potential power. The irrational will be experienced as a threat and contained, or recognised in the work of the artist and rendered safe and manageable within the category of 'art'.

> Just as the split of the self is resolved in the analyst's office and madness and misery disappear when locked away, the mad gesture of whoever breaks down the barrier of this rationality will be quieted by applause, in the museums and emporiums of Art in which its voice will be harnessed and neutralized. (Basaglia and Basaglia, 1987:254)

Basaglia and Basaglia call for:

> [the liberation of] madness as the only "experience" that vindicates the right of irrationality against the madness of dominant rationality. (Basaglia and Basaglia, 1987:254)

Basaglia's determination to restore unreason to the communities from which it has been excluded does not imply an anarchistic commitment to a society free of social control. Basaglia recognises the need for order, and Lovell and Scheper-Hughes (1987:45) acknowledge that Italy's deinstitutionalisation also creates a new circuit of control. But Basaglia believed that social control within a Marxist context would be fundamentally different from the situation within the capitalist context. Social control would operate in the interest of the controlled, not for their exclusion, but to bring them and other people together in such a way that they would support one another and face their problems together. (Lovell and Scheper-Hughes, 1987:48)

Laing and Cooper's anti-psychiatry tended to adopt Szasz's assumption that what was necessary was to abolish the power of psychiatry, and restore the liberty of the individual, and that, combined with increased toleration on the part of society at large, would be enough to solve the problem of 'mental illness'. Basaglia regards the problem of mental illness as one which is real and exists independently of the existence of psychiatry as a means of dealing with it. His solution is not to abolish the power of psychiatry, but to redistribute it so that the people who have previously been victims both of their own distress and of the psychiatric system are increasingly able to control both to their own advantage.

British critiques of psychiatry have tended to emphasise individual rights to freedom and non-interference. MIND's campaign to reform the law is an example (see chapter 7). The Italian reforms are based not upon individual rights but upon collective solidarity, and regard individual rights as a bourgeois concern. Similarly, Basaglia's understanding of democracy is not that which is enshrined in the concept of electoral democracy, in which decisions are made by representatives elected by the people. As Jenner (1986:4) has observed, PD conceptualises democracy as the willingness to care for other people's evident needs. It is a democracy based upon social responsibility rather than individual liberty.

By 1979, Basaglia was ready to address the lack of identity which psychiatry faced as a result of his critique. His work had made it apparent that he did not advocate the abolition of psychiatry, but its transformation into something completely different. What that was to be remained to be established. Basaglia himself saw this as a positive situation from which to begin.

> The need for a new 'science' and new 'theories' is part of what is inappropriately termed 'ideological void'. In reality this is the fortunate time when problems could start to be tackled in a different way. It is the time when we are obliged to really relate to anguish and suffering, because we have been deprived of all the devices designed to protect us from recognizing it. (Basaglia, in Giannichedda, 1988:260)

Conclusion

Basaglia's approach to psychiatry resembles that of British anti-psychiatry of the 1960s in some respects. Like the British anti-psychiatrists, Basaglia is anti-positivist. He regards the 'objective' assessment and diagnosis of patients as a means of distancing oneself from their subjective experience, and therefore as a way of not understanding the real problem. He regards this as inextricably linked to psychiatry as an institutional practice. In his own work, he regarded the subjectivity of the patient as central. Also like the British anti-psychiatrists, Basaglia's practice has grown out of social psychiatry, particularly the therapeutic community as developed by Maxwell Jones. This is an approach in which mental disorder is managed within a context which is explicitly recognised to be social, and which for Basaglia is also recognised to be political.

Italian democratic psychiatry is, however, quite different from the British work of the 1960s in its political basis. It is based upon a much more clearly theorised Marxism than was adopted by any of the British anti-psychiatrists, with perhaps the exception of David Cooper during the 1970s. The individualistic rights-based critique of Szasz is not influential at all. Subjectivity is approached as a problem to be managed at a collective level. Individuals do not have a 'right' to be mad, but the collective has a responsibility for integrating its vulnerable and suffering members, and offering assistance in a way which does not invalidate their experience. This is a responsibility which Western capitalist societies have abandoned, as mental disorder has become conceived of as a threat to, and a waste product of, capitalist forms of production dominated by rationality. The view of rationality and capitalism as inextricably linked, and compelling the

separation and exclusion of unreason, is closely related to Foucault's structuralist critique of psychiatry. Basaglia's understanding of the nature of madness and the role of psychiatry in capitalist societies owes much to Foucault.

This combination of ideas produces a radical approach to mental distress which is markedly different from anything which has been produced in Britain or America. Where British and American radicals have retained a Marxist analysis, it has tended to be one which uses a labelling theory/social causation approach which is very anti-psychiatry. There has been very little theorising of a radical democratic approach such as that founded by Basaglia.

3. British evaluations of the Italian reforms

3.1 Positive evaluations

Events in Italy have provoked great interest in Britain, especially amongst those critical of current policies towards care in the community. Anti-psychiatry was able to regard the hospital closure programme as unequivocally a good thing, as anything which reduced the coercive power of psychiatry was conceived as desirable. However, the reality of care in the community in practice has caused much doubt to be cast upon the desirability of closing the hospitals per se, with no clear cut programme of alternative services. Some commentators on the left have also become aware of the potential of the hospital closure programme becoming no more than a cost-cutting exercise for the Conservative administration, with which the far left has colluded by its own emphasis upon individual freedom. (The care in the community debate in

Britain is dealt with more fully in Chapter 8.) The Italian approach is perceived to have two advantages over the British approach.

Firstly, it is perceived as being more attractive to the Left wing in that it is concerned less with the restoration of the individual to a state considered desirable by societal norms, and more with the recognition of individual vulnerability, and the need for society to accept responsibility for integrating its vulnerable members. There is less emphasis on individual therapy, and more upon collective responsibility. That is, for the Italians, care in the community does not mean simply that patients live outside the hospital. It means that they are accepted as full members of society with access to the same facilities and possibilities as other members. Healing is considered as much a matter of reintegration into the community as individual therapy.

Secondly, care in the community in Italy is associated with a different approach to treatment. In Britain, community care often seems no more than a change in where one lives in between doses of medication or brief admissions to hospital, the medical input constituting the real treatment and any other services being social support. In Italy, social issues, such as poverty or isolation, seem more likely to be tackled as issues central to the individual's distress and not merely attendant upon it. Great efforts are made to integrate the individual into the community in order to ensure his continued well-being. Jenner (1986:5) identifies Basaglia's approach as preferable to the English version of community care because England has succeeded only in moving the institutions into the community, whereas he perceives Basaglia as having produced the key to abolishing the institutions.

Consequently, the developments in Italy have been the focus of much attention on the part of mental health workers in Britain seeking a Left wing critique of psychiatry more powerful than that offered by anti-psychiatry. The depth of this interest is indicated by the wealth of material already quoted in this chapter, which has included both English language translations of the Basaglias' own writings and accounts by sympathetic English language observers of the Italian experience.

MIND has consistently promoted the Italian approach to community care in Britain. In 1984, MIND organized exhibitions and workshops held by Psichiatria Democratica in Britain, which publicized the Italian changes. MIND has also included frequent updates on the situation in Italy in its in-house journals, MIND OUT and subsequently OPENMIND. Articles describing the changes favourably have also appeared in the social work publication, Community Care. Heptinstall's (1984:18) article, which accompanied and commented upon, the MIND-sponsored exhibition by PD, concluded 'Clearly, there are lessons for Britain in the Italian experience'. Hanvey (1978:24) was more cautiously complementary, but concluded that 'the fascination of observing a mental health programme which realises the political analysis of psychiatric problems was a rare and unique experience'.

The Italian psychiatric system has also been a central focus for Asylum, a magazine published at Sheffield University whose founders seek to promote democratic psychiatry in Britain. Asylum has published highly favourable accounts of the reforms. Jenner (1986:4) reported an exchange visit with Italian psychiatrists which 'inflamed my preoccupation with the legitimation of psychiatry.' He describes Basaglia as 'the Italian Laing of that period, and in fact more influential in actually changing institutional life'.

However, he also is cautious about the long-term impact of the Italian reforms, or their viability for this country.

Asylum has also included an interview with Maria Giannichedda (1989), who had worked with Basaglia, and provided a highly positive account of the reforms in Trieste, although she acknowledged the difficulties which had been encountered in applying Law 180 throughout the remainder of the country. Similarly, McCarthy (1985) concluded that the reforms had been a success in those parts of the country where they had been implemented, and a failure mostly only in those areas where they had been ignored.

Bucalo (1989) produced an account of a village in Sicily, reported in Asylum, where psychiatric services do not exist at all. Jenner introduced the piece as claiming 'In many villages in Sicily, the whole population accepts "madness", and the people manage to live together.'

Ticktin (1991:32) notes that:

> The professionals around ASYLUM were inspired by the notion of 'democratic psychiatry', as espoused by the work of Franco Basaglia and the group he initiated of the same name: Psichiatria Democratica.

Jenner (1988:111) has adapted Basaglia's account of marginalization of users and providers to apply to Britain, and called for a new preparedness on the part of psychiatrists to engage with the political, moral and socioeconomic dimensions of their practice. Like Basaglia, Jenner does not reject the paradigm of medicine as inappropriate for psychiatry, but points out that

issues of value within psychiatry are more contentious than those within general medicine.

A leading proponent of the Italian reforms in this country is Shulamit Ramon. Ramon (1988:xiv) begins from the point of identifying the two alternative paths which care in the community in Britain can now take.

> We can use it as an opportunity to create a new service and attempt to put right some of the wrongs of the old system. Or we can recreate the old system by establishing mini-hospitals and merely transfer the residents of the large hospital to yet another institution.

Ramon regards the Italian model as the inspiration Britain needs if it is to take up the first option, and use current changes as an opportunity. She identifies her own position, and that of the other contributors to her book, as not anti-psychiatric.

> We all believe that mental distress does exist primarily as a personal experience of suffering and confusion within a specific social context. It is very much the outcome of the combination of the personal and the social...
>
> Because we believe in the existence of mental distress, we also believe that society has to respond collectively to its members who suffer from it. Put in other words, we are not taking an 'anti-psychiatry' position, but a 'radical reformist ' stance. (Ramon, 1988:xv-xvi)

The papers in Ramon's book are grouped into pairs, each pair dealing with one aspect of psychiatric deinstitutionalization, one of each pair being descriptive of The British context, one of the Italian. The overall impression given is that changes in Italy are more favourably viewed than those in Britain. Davis (1988:35), writing about user perspectives and community care in Britain, notes that:

> Most medical, nursing and social services staff retained in their hearts and minds the notion of consumers as damaged individuals who needed advice and management...The consequences for consumers has been that most community-based provision has replicated the all too familiar relationships of institutional life.

The corresponding paper on Italy, by Giannichedda (1988b), noted the familiar variations amongst quality of service delivery in different parts of Italy, but wrote favourably of the impact of users in those areas where the reforms have been more completely implemented, and of ongoing efforts to stem the tide of reaction which is demanding a return to the old system.

A contribution from MIND Manchester Group states that the authors 'believe it is possible to create the foundations of a mental health service based on the principle of human dignity and the right to personal autonomy' (MIND Manchester, 1988:227). Aware of the somewhat utopian nature of their vision, they appeal directly to the success of the Italian reforms as evidence that such a scenario is possible.

> For those people who are sceptical about the likelihood of the success of such a challenge we would point to the experience of

Psichiatria Democratica in Italy, described by the Italian contributors to this book. (MIND Manchester, 1988:227)

3.2 Negative evaluations of the Italian reforms

The Italian experiment has not met with unreserved approval in this country. A paucity of hard data on the results of the reforms has made objective evaluation difficult. Becker (1985:254) has argued in relation to Italy that 'A few hard data...are more useful than personal opinions, no matter how sophisticated these may be'. In the absence of such hard data, judgements have inevitable been based upon subjective accounts informed by personal inclinations towards particular political ideologies. Critics have argued that adherence to political ideologies has prevented British enthusiasts from appreciating the true extent of the problems being experienced by mentally disordered people and mental health professionals in Italy.

The most outspoken critic has been Kathleen Jones. Jones and Poletti (1985:347) have claimed that, at a time when Britain is at an impasse in its community care programme, uncertain where to proceed next, the Italian experience is being used as a lever to keep events moving in the direction of more hospital closures. Jones and Poletti arranged for their own study trip to Italy, to take in the whole country and form an impression of the state of services right across the nation. The impression they formed, particularly in the South, was that hospital closures were either not happening - patients continuing to be admitted to the hospitals officially as 'ospiti' (guests), but in reality as patients - or that patients were simply being dumped outside the hospital with no support and with resulting casualties and tragedies. They noted that:

> Most accounts in the British professional press - the majority in nursing and social work journals - have presented the results as one of the great success stories of psychiatric history. (341)

Jones and Poletti (1985) were of the opinion that the law had been rushed through to save Italy from the catastrophe of a referendum, with no proper planning or consideration. They referred to highly coloured anecdotal accounts of the plight of patients post-1978. These parallelled those pre-1978 accounts which had preceded the referendum and caused public outcry about the state of the mental hospitals. However, the post-1978 accounts had been much slower to reach the British press. They claimed that many of the supposedly revolutionary changes in Italy were merely semantic, consisting of changes in terminology with no change in conditions. A lack of support in the community was reported to have resulted in a sharp increase in the population of forensic hospitals and a mushrooming of private nursing homes (both these claims were disputed by De Girolama, 1985)

Jones and Poletti (1985:345) acknowledged the lack of hard data on which to base their judgements and the difficulties of interpreting anecdotal evidence, but felt that 'nevertheless, some points seemed capable of empirical testing'. On the basis of their experience in Italy, they concluded that the law operated very patchily, and the 'overwhelming consensus' was that it would have to be changed. They found many hospitals still open, but very understaffed. In some areas patients were officially called ospiti or guests, but this did not prevent them from being confined in locked wards or strait-jacketed. Because the hospitals were officially closed, no maintenance work was being carried out, there were no support services, and patients were wholly unoccupied. Large doses of drugs were administered. 'Alternative

structures', such as 'family homes' or 'villas', resembled ordinary mental hospital wards so closely that Jones and Poletti often failed to realise they were supposed to be alternatives. Diagnosis and Cure Units were locked, and staff were finding it impossible to diagnose within 48 hours, let alone cure. The renewal of the detention order was a mere formality. Provision became less as they went further South.

Jones and Poletti (1984) described conditions encountered in some hospitals:

> The male open ward is frankly a doss-house...The men sit around and play cards and smoke - there is nothing else to do. They have no hope of a job. The only treatment is by heavy doses of psychotropic drugs, plus basic physical care, of which de-lousing forms an important part...Some guests are in straitjackets or arm-muffs, one guest is strapped to his bed. (10)

The need for constantly renewed seven day orders to keep patients in hospital involved a great deal of paper work, but the mayor tended to be happy to sign a renewal with the minimum fuss or investigation. Workers did not view the legislative changes favourably, verdicts upon Law 180 ranging from "impossible" to "criminal" (Jones and Poletti, 1984:12).

Jones and Poletti (1985:346) posed the question 'Is the amount of misery caused greater or less than under the old system?' They concluded that, although human misery is not measurable, they found much of what they had seen unforgettable. The absence of training facilities, which PD justified as a policy of 'deskilling', meant that the situation was unlikely to improve. They concluded that whatever lessons Britain sought to learn from the Italian

experience, they were certainly not those being promoted by the pro-Italy lobby. Better lessons might include:

> Mental hospitals cannot be abolished by legislative action and good intentions: they have a way of appearing in disguise. Patients do not automatically become well if they are discharged from hospital - they and their families still need help. Ideas about de-skilling and the abandonment of professional roles are not a substitute for good training programmes - they can only be utilised by relatively mature and well-trained personnel. Above all, political pressure-groups are not a substitute for a broadly-based and well-informed mental health movement: there is much public education to be done, but not by means of slogans, catch-phrases and horror pictures. (Jones and Poletti, 1985:346)

The pro-Italy lobby answered these criticisms by arguing that Jones and Poletti had not seen the failure of Law 180, but the failure to implement Law 180 (Tansella, 1985:450). She needed to visit Trieste to appreciate the real impact of reform when properly implemented (Ramon, 1985b:208). Jones and Poletti had deliberately omitted Trieste from their first visit, feeling that enough had been written about services there for them to be justified in visiting other cities instead. However, they accepted the offer and visited.

They acknowledged that services in Trieste were much better than services in other parts of the country. However, they did have criticisms of the services. Firstly, publicity had created the impression that Trieste had no in-patient services except for its 15 bed Diagnosis and Cure Unit. This was

not true. Trieste had more than two hundred patients for whom no outside accommodation could be found, including some who were very deteriorated. This number included 48 patients suffering from senile dementia who were kept on a locked ward. In addition, there were 15 beds in an alcoholic unit, 20 beds for severely mentally handicapped young people, 40 beds in a traditional university clinic, an unknown number of beds in a hostel, about 50 beds in the centres, and 8 beds in the Diagnosis and Cure Unit. In addition to these, approximately 1/3 to 1/2 of beds in the city's public lodging house were occupied by patients, and an unknown number of beds in private nursing homes to which patients over 65 were transferred.

Secondly, the scope of the service was very limited, being targeted primarily at younger psychotic patients, and the containment of bizarre episodes. This might overlook the needs of 'quietly deteriorating patients'. There is also no provision for the elderly senile, unless they were hospitalised before 1980. And Trieste provides no regular programmed therapeutic activities. There is no use of psychoanalytic insights, no group therapy and no family therapy.

More recently, other evidence has supported Jones' negative evaluation of the reforms as they have effected Italy as a whole. Palermo (1991) reported that between 1978 and 1983, commitments to psychiatric hospitals for the insane in Italy increased by 57.6%, the number of suicides attributed to psychiatric disturbances increased by 19%, and the number of deaths due to psychiatric disturbances increased by 43.5%. However, Palermo's conclusions have been questioned by two commentators on his work. Wilkinson (1991) referred to three other recent publications which:

are written by Italian authors, take distinct medical perspectives, are based on empirical observation, and seem to provide information of sufficient reliability and validity for worthwhile contemplation. (557)

In the light of Bollini and Mollica (1989), Wilkinson (1991;557) concluded that the Italian reform has successfully generated a psychiatric system without asylums, but that these services are somewhat deficient in failing to reach those with the most disabling disorders and parts of the country, particularly the South. In the light of Crepet (1990), Wilkinson (1991; 558) concluded that 'the quality of mental health care provided in Italy is, to generalise, unacceptable.' And in the light of Tansella (1991), which examined services in one particular area, that of South Verona, he concluded (Wilkinson, 1991:558) that the reforms there had been fairly successful. He suggested that, 'four uncomplicated and familiar messages emanate from the Italian experience', derived from Tansella and Williams (1987). These were that transition to community care cannot be achieved simply by closing hospitals - alternative structures must be provided; efficient functioning of community based services requires both professional and political and administrative commitment; monitoring, planning and evaluation of services was vital; and the successful implementation of community care depends to a great extent upon the input of general practitioners. He noted Italian interest in modifying Law 180, but expressed the difficulties in achieving this owing to the peculiarities of the Italian system of law-making.

Craig (1991), the third commentator, referred explicitly to:

> what [Palermo] sees as inevitable consequences of the enactment of a political ideology in the absence of either the economic or societal infrastructure to translate the ideal to functional reality. (559)

However, he noted that Palermo did not consider the reforms to have failed everywhere (559). He criticised Palermo for failure to substantiate his opinions with up-to-date empirical data, writing, 'we have little more than an opinion based more on personal frustrations than on fact' (559). His conclusion is particularly interesting:

> The debate is not really about whether community-based treatments can work, but rather about whether the results obtained by highly committed pioneers can be obtained in ordinary health service delivery. (560-1)

This comment is of interest because it relates to the crux of the debate, which is the interaction between the evidence for the Italian reforms in terms of their practical results, and the perceived viability of the Marxist ideology which has been the inspiration behind the results. The empirical findings are scarce, and tend to be often anecdotal. They constitute also a very piecemeal view of the country as a whole. They are thus difficult to interpret in an unbiased fashion. However, broadly speaking the conclusion seems to be that PD have achieved much in the North of Italy in instituting a workable system of care in the community, but that the south remains extremely backward and the situation there may actually have deteriorated as a result of Law 180. PD argue that the failure is not theirs, but is the fault of the people responsible for failing to implement the law. Those who

are more suspicious of the ideology which is the driving force behind PD would dismiss this argument on the grounds that it was highly predictable that the law would fail, because the level of ideological commitment and faith generated by PD is a rare phenomenon and cannot be expected to last. Not everyone can be expected to share PD's analysis of the situation, or their enthusiasm for correcting it. The level of commitment, both financial and emotional, required by PD was not possible on a nationwide level. This appears to be the kind of concern which has led Jones consistently to emphasize the failures of the Italian reforms, rather than their successes, and to attribute the successes to particularly fortuitous local circumstances. Equally, those on the Left, who believe a Marxist society to be possible and desirable, emphasize the successes of the reforms, and attribute their failures to political ill-will and sabotage.

Thus, the main aspect of Jones' disagreement with PD is now revealed as ideological. Jones believes that mentally ill people are marginalised because they are unable to function in mainstream society without a great deal of support and management. No amount of rhetoric or education will make their integration into society significantly easier. PD believe that whatever the source of the problems of the mentally ill, these are aggravated to a great extent by poverty, marginalisation and isolation which are the result of capitalism. They believe it is possible to fashion a society which will integrate its mentally disturbed members as full members. This belief is informed by Marxist theory, which Jones finds unpalatable and unbelievable. For Jones, mental disorder is most profitably approached as a problem for particular individuals rather than for the community as a collective.

Jones suspicion of the Marxist underpinnings of the movement had emerged by 1985, when, referring to Basaglia's paper delivered to the Fourth International congress on Law and Psychiatry (Basaglia, 1980) she wrote:

> Much of Basaglia's paper is frankly difficult to follow. The combination of neo-Marxist grand theory and Italian-in-translation makes for some curiously opaque sentences - what exactly did he mean by "the homologation of the individual" or "a hypothetical scale of coincidence between juridic norms and psychiatric technique"? (Jones, 1985:342)

However, the full force of Jones rejection of the Marxist ideology is revealed in Jones and Poletti (1986:147):

> Behind the innocent and frolic radicalism, there are more serious political implications. We did not wish to enter into ideological debate, but most issues in Italian life are highly politicised, and we were repeatedly told that it was impossible to divorce the practice from the ideology...
>
> The same phrases were used so frequently in discussion that we came to the conclusion that this was a closed system of thought, insusceptible to rational argument...
>
> The Trieste experience appeals to the non-rational side of the human mind. Demands for liberty, equality, and fraternity still create resonances and enthusiasms, powerfully reinforced by symbols and slogans of a highly imaginative kind. But these

> points stand out: first, the demand is for total acceptance; analysis and questioning are swept aside or treated as evidence of adherence to 'the medical model' or extreme Right-wing politics. There are also rigidities of thought on the Left. (147)

This suspicion of the Marxist ideology underpinning PD is apparent in many of the more cautious or negative appraisals of Italy. Becker (1985:259) referred to the feeling in opposition quarters that the reforms are too ideologically motivated to have been given careful empirical consideration before their implementation.

Hicks (1984) notes that:

> The movement saw itself as part of a wider Italian political tradition, and was influenced by Marxist ideology in a way which most professionals in the UK would find difficult to grasp....
>
> The teams work according to the PD's collectivist, non-hierarchical principles and seem to have abandoned traditional roles to an extent which would send a chill up the spines of many of their British counterparts. (17)

Hicks notes that the collectivist perspective means that social factors take precedence over other explanations, and that the emphasis is upon developing an ability to live with others rather than upon self-sufficiency. However, the attempt to abandon traditional approaches because of their political implications have not led to the abandonment of drugs. The problems facing

the reforms are reported as enormous, both in terms of a lack of resources for new services and facilities, and the backlash form traditionally-minded psychiatrists, who are pressurising the government to modify the law, and the general public, many of whom will not tolerate the visibility of chronically disturbed people in their midst. Hicks notes that even some of those most intimately involved with the reform process are now disillusioned; for example, PD founder Giovanni Jervis, who now regards PD itself as institutionalised (Hicks, 1984:18).

Perris and Kemali (1985:10) have lamented that:

> Unfortunately, attention is paid more on its ideological background and on the prescribed closure of the existing mental hospitals than on the fact that the law 180 has definitively sanctioned the break of the isolation in which Italian psychiatry had operated for longer than half a century, and its complete reintegration into a comprehensive National Health Service.

They warn readers that some of the articles to be presented in the volume which they are introducing may be found to be over-loaded with ideological statements and political biases by non-Italian readers (Perris and Kemali, 1985:13).

Criticism of the Italian ideology has been expressed also by British theorists influenced by the later work of Foucault. Such criticism has focused directly upon Basaglia's view of community, rather than upon the Marxist underpinnings of his thought. Miller (1986) has argued that Basaglia's work constitutes one more instance of an ideological commitment to the power of community to heal

mental disorder, which has been the underlying theme of developments in psychiatry throughout the second half of the twentieth century. Community has come to be regarded as the panacea which will solve the problem of mental disorder in Italy just as it has been in Britain and America, and the level of expectation which has been attached to the policy is unrealistic and doomed to failure.

Whatever may be said about the situation in Italy as a whole, the services in Trieste are acknowledged by many people to be among the best in the world. Those who regard these reforms as the result of a false Marxist ideology are therefore obliged to explain how a Marxist ideology has come to produce such an effective system. Commentators have usually pointed to local advantages which make Trieste much better suited for the provision of such services than other cities; for example, the ready availability of housing (interview with local National Schizophrenia Fellowship co-ordinator). Jones and Poletti (1986) point out that Trieste has advantages which make applying the principles of PD simpler than elsewhere, and that the other three cities visited on that trip hadn't done nearly so well. Some have argued that even Trieste retains some secure services for those who cannot be reintegrated, which are not much discussed (interview with local NSF co-ordinator). Jones and Poletti (1986:149) ascribe British misconceptions about what has actually happened in Trieste to a failure to appreciate the language being used by the Italian movement.

> In common parlance, a prison or a mental hospital is merely a building, a physical landmark; but in Marxist sociology, which has been very influential in Trieste, it is also a power-structure, constraining and controlling the inmates. So San

Giovanni is 'closed' in the sense that the hospital administration ceased to exert power over the inmates, but it is not 'closed' in the sense that some of them continue to live there and to receive psychiatric and nursing services. The distinction is not a particularly subtle one, but it has led to massive misunderstandings.

Certainly, the failure of the implementation of Law 180 effectively across the country indicates that such reforms are not easy to introduce or to maintain without a high level of ideological motivation and material resources. Strong and supportive communities do not simply happen, but have to be created and maintained. Whether the achievements which PD has made can be expanded, or even sustained remains to be seen. The existence of widespread support for modification of the law suggests that further radical change is unlikely.

4. The implications of the Italian reforms for individual liberty.

A further cause for concern in the Italian services might be expected to stem from their very informality and absence of legal control. It is apparent from some writings produced by Italian mental health workers that employees of the Italian services expect to take a great deal of responsibility for service clients' behaviour and well-being, to the point of feeling responsible for supervising patients who are not always co-operative. It must be suspected that a large degree of informal coercion operates within the Italian services which is not even formally open to scrutiny or regulation by law, and therefore goes unchecked and unmonitored. This must cause occasion for some concern. An example of such informal coercion is to be found in Dell'Acqua and Mezzina's (1988) description of community services in Trieste, in which

it is made plain that increased client power and autonomy is not to be confused with 'calling upon sterile guarantees for defending patients' rights as individuals' (64). Dell'Acqua and Mezzina continue:

> Sometimes a user will leave the centre, renewing the refusal and breaking the relationship of trust and friendship which has been established. In this event the workers are obliged to find them, re-establish contact, and review their demands at the new contractual level suggested by breaking the relationship. The flexible management structure, as well as the ways of taking responsibility described above, does not mean that the service fails to recognize the need to protect individuals who behave alarmingly and who risk being exposed to sanctions from instruments of social control (for example, an ordinary or psychiatric prison). (65)

> In all of these situations the centre assumes responsibility for keeping control and providing safeguards for patients, but it never uses physical means of restraint or closed doors...But the work is personalised by the figure of the worker who follows, assists and 'accompanies' the patient continually. S/he also gives explanations to and motivates the patient by trying to create a greater awareness. (66)

Similarly, del Giudice, Pasquale and Reale (1988; 203) emphasize that psychiatrists having lost control of responsibility for custodial confinement of their clients ought not to mean psychiatrists abandoning all responsibility

for their clients well-being and conduct. They refer to a recalcitrant group of psychiatrists who:

> did not see their contribution as a secure alternative to internment. They did not accept the innumerable problems posed by the new 'citizens with mental illness', such as refusing care, not attending at meetings, devaluing the therapist's role and being constrained by social problems. Therefore many families and citizens who are concerned with - or feel threatened - by reintegration or non-care, protest against this irresponsibility and neglect of the users by the workers of the psychiatric services. (203)

> The extreme limit of this practical responsibility concerning the user is <u>making therapeutic intervention compulsory</u>. This can happen both when the person refuses any therapeutic relationship at all - because s/he is subject to delirious illusions or to a compulsive vision of a changed world - or when s/he needs to be removed from social or institutional neglect. It is here that the real concern of a public service towards an individual can be measured. Substantial defence barriers can be put up by individuals, and these have to be overcome if the service is to succeed in taking responsibility for him/her. (203)

Del Giudice et al then note that Law 180 does make provision for some compulsory treatment where persuasion has failed. Again, the impression is created of a system which depends upon a high level of informal persuasion bordering upon coercion. There may be a danger of much de facto coercion

taking place beyond the limits of legal regulation because of the Italian movements failure to prioritise individual legal rights.

Jenner (interview) commented that the Italian system contains a sizeable amount of hidden coercion:

> The Italian system's actually better [than the American]. There's no soup kitchen, there's not much in the way of the down and out. There's a lot of hidden coercion of course...I think it's unavoidable in a way.

Jenner (interview) has also suggested that the Italian services are in many ways less democratic than existing services in Britain, because of the differences in education between Italian service users and Italian psychiatrists. In practice, Italian doctors are so much better educated than the ordinary people, that they find it relatively easy to demolish users' arguments and their own approaches prevail. This would appear to be a very practical example of a situation where knowledge is power. Although the psychiatrists in Italy no longer tend to exert control through legally enforceable coercion, they still exert control through greater expertise. Until doctors and users are able to discuss mental distress and its treatment from similar educational perspectives, and psychiatric knowledge is more evenly distributed through the population, it seems that the level of democracy in Italy will be limited. Basaglia's reforms seem to have produced a service which is less adversarial than is indicated by the British experience of demands being made by users against professionals. Lovell and Scheper-Hughes note that the absence of users from the Italian movement has provoked criticism, but that users in Italy have been more successful in

forming alliances with professionals than have patients' rights groups in the USA (Lovell and Scheper-Hughes, 1987:45).

Conclusion

Overall, it is extremely difficult to reach firm conclusions about the results of the Italian reforms, because of the paucity of quantitative data measuring change, and the problems of relying on anecdotal evidence. As McCarthy (1985:279) has observed:

> The picture of the Italian mental health services that emerges is of substantial variation across the country, with some highly innovative services matched by some very traditional, unsatisfactory ones. The reforms described by Ramon and others have depended on innovations by a minority of progressive psychiatrists in favourable political circumstances. Jones, on the other hand, found poor quality services, and concluded that the reform "has failed". Evidently, the descriptions reflect what each visitor wanted to see.

McCarthy suggests that the reason why British psychiatrists have been so suspicious of the developments in Italy is because they fear that treatment in the community along Italian lines would indicate acceptance of an environmental aetiology for mental illness, and a reversal of psychiatry's recent and hard-fought integration into mainstream medicine. I would add to these probable reservations the awareness of psychiatrists that the Italian reforms are based upon an explicitly political and Marxist interpretation of

mental health, and appeal most strongly to the Left, for whom the Italian democratic approach has become a substitute for the now largely discredited and abandoned anti-psychiatry.

The message of the Italian reforms would appear to be that, given enough ideological enthusiasm and enough resources, it is possible to produce a community-based psychiatric service which relies far less on institutional coercion than has been the norm in most European countries. However, even at its best, such a service cannot completely obviate the need for some secure detention of those patients who pose a serious threat to society, either within the mental health system or within the prison system.

With respect to the poorer parts of Italy, especially in the south of the country, it must be viewed as not only utopian, but highly irresponsible, to pass legislation removing the existing duty of care for patients before ensuring such a service as is found in Trieste is feasible everywhere. PD should not have created a situation in which the majority of local authorities could legitimately abandon responsibility for their vulnerable members when PD was aware that its own enthusiasm and confidence was not shared by the majority of their colleagues or the majority of political administrations. It appears that PD believed that once the legislation was in place the enthusiasm would follow. As is now apparent this was not the case. PD's enthusiastic advocacy of its own Marxist ideology proved no substitute for a slower and more considered approach to reform, driven by an increasing understanding, drawn from empirical evidence, of what was possible. PD have claimed that the situation in Italy is not the result of their reform; but of failure to implement the reform, and they are not therefore responsible. It is arguable that PD should have realised that what they were demanding could

not be magicked into existence overnight, and was always doomed to failure in those areas which did not already support its radical agenda. As Jones (1991:557) has commented:

> If there is a lesson to be learned from the distressing muddle of the Italian mental health situation, it is a very old one: law, unfortunately, does not cure patients.

It is a pity that the group did not limit its aims to spreading the message of institutional reform more slowly through professional debate and persuasion, rather than attempting to force its own views to be enshrined in legislation without the support of many service providers.

Finally, the wide-ranging abolition of legal powers and controls in relation to mentally disordered people in Italy has increased greatly the liberty of patients who were previously institutionalised. However, the reforms have not resulted in the creation of legal powers which would protect individuals from improper practice by doctors in case of informal coercion and 'persuasion' bordering upon coercion. There is perhaps room for concern at the unknown volume of unregulated de facto coercion actually taking place within the Italian mental health system.

Chapter 7 MIND's policy and campaigns from the 1970s to the present day.

1. Theoretical underpinnings of MIND's legal campaign.

The theoretical basis of the MIND campaign can be related both to the political critiques of psychiatry which emerged during the 1960s, and to the resurgence of support for a legalistic, as opposed to therapeutic, approach to mental health legislation.

It has been seen (chapter 2) that the 1959 Mental Health Act (MHA) represented a shift away from a legalistic approach to mental health regulation. The legalistic approach, embodied most completely in the Victorian Lunacy Act 1890, regarded the function of mental health legislation as being the protection of individual liberties, in this case the protection of the freedom of the sane against the threat of improper incarceration and treatment at the hands of psychiatrists. The legislation did not express concern for the liberties of those who were considered to have been properly hospitalised as lunatics, whose supervision and treatment was considered to be the medical profession's proper duty.

The 1959 Mental Health Act represented the culmination of a shift of policy in the direction of using mental health legislation to ensure therapeutic ends. The emphasis of the MHA was on ensuring the right to treatment, rather than the right to liberty. Power to administer psychiatric incarceration and treatment passed from the legal profession, the people traditionally concerned with the protection of liberties, to the medical profession, who were now considered the people most appropriate to make the kinds of therapeutic

decisions envisaged within the new legislation. An important aspect of this shift in perceived purpose was the expanded importance given to voluntary treatment. Paradoxically, the legislators at the time of the Lunacy Act had seen compulsory hospitalisation as a way of defending liberty. As long as the only people who could be admitted to psychiatric hospitals were there at the request and authorization of a magistrate, there could be no question of a person being held in hospital against his or her will without right of appeal. The MHA emphasized the importance of patients being allowed to receive treatment without the stigma of legal compulsion wherever possible. The negative side of this enlightened measure is that it involves the presence in psychiatric hospitals of persons who are held to be there voluntarily, and whose treatment is not therefore regulated by any kind of official body. Instances of de facto imprisonment and compulsion amongst this group of patients become problematic precisely because of the absence of regulation applying to them, and responsible bodies to enforce regulation. This is particularly problematic in a service which does allow for some use of compulsion where patients do not cooperate, and where the threat of legal coercion may be used to enlist the cooperation of patients who resist informal but de facto coercion.

Some libertarian concern had been expressed at the time of passing of the MHA (for example, see chapter 2). However, confidence in the expertise and generally benevolent function of the psychiatric profession won the day, and the MHA passed into law with the minimum of legal powers of regulation included within it, the great majority of decision making power being consigned to the hands of doctors. Subsequently, it became apparent that the MHA was not operating unproblematically, and by the early 1970s not only MIND but also the Royal College of Psychiatrists were requesting amendment.

Some of the difficulties arose not out of the principles of the MHA but out of its vagueness on certain practical points; for example, sections 25 and 29 of the 1959 MHA, which dealt with compulsory admission to hospital for observation, did not specify whether observation could include the administration of treatment without the patient's consent. This issue in particular needed to be clarified so that psychiatrists knew whether they were acting illegally and risking legal proceedings against them, and was the kind of issue with which the Royal College of Psychiatrists was chiefly concerned.

The basis of MIND's campaign was a desire to restore to the mental health legislation's therapeutic aspects a more legalistic concern for negative rights. That is to say, MIND wished to reverse the trend towards investing power in the medical profession, and reinvest it in law, the institution which ought properly to be concerned with issues of liberty and rights. As Blom-Cooper and Jefferys (1975:6-7) stated, in their foreword to A Human Condition, Larry Gostin's critique of the MHA 1959:

> In our view, the willingness to leave so much power in the hands of the medical profession was the result of a general wave of optimism about the capacity of mankind to solve most of its age-long problems of poverty, ignorance, squalor, disease and deviance. In particular, science applied to medicine was thought to be making spectacular progress in the treatment and prevention of infectious diseases; it seemed equally legitimate to expect that pharmacological advances - this was the period of the advent of tranquillizers - and discoveries in the physical treatment of mental disorders would equip psychiatrists with the means to reduce dramatically the number of disturbed individuals who had

> hitherto had to be physically restrained in padded cells or locked wards...Medicine was almost universally perceived as manifestly humane, whereas the law was seen as subordinating the individuals' welfare to the collective good...Our recent failures to achieve the most modest social welfare objectives have forced us to re-examine even those policies and practices that seemed least controversial and open to criticism. Optimism has given way to scepticism, if not pessimism. We are more aware of the complexities of human behaviour, of the unintended and unwelcome side effects of well-intentioned statutory provision, of the differences in interest and outlook that lie behind an apparent consensus of approach to the treatment of the mentally ill.

However, MIND's aim was not to reinstate the kind of legalism which was embodied in the Lunacy Act. MIND's was a 'new legalism' (Unsworth, 1987:Chapter 10). It's aim was not to defend the sane against the danger of being treated as insane. It was to support the right of the 'insane' to self-determination and non-interference even within the context of compulsory hospitalisation and treatment. It was a legalism which was less a reaction against the provisions of the MHA than a development out of them. The provision for voluntary treatment, with the consent of the patient, was seen as vitally important, and to be extended rather than reduced. And compulsory patients were also to receive as many of the benefits as possible of voluntary patients, experiencing as little restriction of liberty as could be achieved within the broad aim of administering restraint and treatment to those in need. The MHA had affirmed a growing split between the way psychiatry regarded its patients and the way the law encouraged patients to regard themselves (see chapter 2). Broadly speaking, mainstream psychiatry had

regarded all its patients as hopelessly infantilised beings who required expert guidance form the psychiatrist in all aspects of their lives. The MHA had allowed that at least some patients were competent enough to arrange for admission to hospital, and therefore by implication competent enough to determine whether they would accept treatment and which treatments they would accept.[1] The MIND campaign aimed to extend this assumption of competence to include formal, nonvoluntary patients. The fault line which the 1959 MHA had created between psychiatrists' view of their patients' competence and the view enshrined in law was finally dissolving, as all patients were coming to be perceived as exercising some level of competence in determining their own fate, at the expense of the power of psychiatrists.

> The new legalism...is part of a logic of resistance and is more authentically libertarian [than the old legalism]. The perception of the mental health services from which it flows shares with traditional legalism a common perception that they are primarily engaged in a social control function comparable to that carried out by the machinery for the management of crime, and rejects the medical preference, historically erosive of legal protection for patients, for a functional analogy with general medical services...
> The intended beneficiaries of this augmentation of patients' rights are not the sane but the mentally disordered themselves, and the injection of greater legal machinery into coercive psychiatric processes of commitment, detention, and treatment is conceived as part of an attempt to encourage patients to accept greater responsibility in decisions affecting their lives and to improve their status as citizens. (Unsworth, 1987:342-3)

The shift on the part of MIND towards an emphasis on patients' rights, over and above an interest in supporting increased levels of provision, was a phenomenon which characterised charitable approaches to welfare provision as a whole during the 1970s. As Unsworth states, this was the outcome of the development of the welfare state itself. Prior to the foundation of state based welfare provision, charities had perceived their role as being that of supplementing whatever, meagre level of state provision was available. Once the state had (in theory) accepted sole responsibility for welfare provision, charities could turn to supporting the claims of vulnerable groups vis a vis state provision. This entailed a growing interest in the rights of clients within welfare, and an emerging critique of those aspects of welfare which tended to be paternalistic or oppressive in effect.

> The concept of representing clients <u>within</u> the Welfare State, rather than merely rendering supplementary services, has highlighted the issue of 'claimants rights'. The egalitarian and paternalistic currents in the movement to create the Welfare State produced powerful bureaucratic structures charged with considerable administrative discretion and by the 1960s and 1970s its clients were increasingly organized in Claimants Unions, tenants' associations, and other self-determined structures to challenge aspects of their relationship to the authorities paying out benefits or administering services which they perceived as stigmatising and oppressive. (Unsworth, 1987:337)

This new emphasis upon clients' rights was perhaps more complicated within psychiatry than within other fields of welfare precisely because the psychiatric patient is traditionally assumed to be wholly irrational, and therefore to have nothing useful to say with respect to his or her own fate.

The psychiatrist as doctor and scientist is supposed to have some expert and objective knowledge not shared by any layperson (let alone a psychiatric patient!) which enables him to make decisions and carry out actions which ought not to be subject to legal review, but only to peer group professional review. As was described above, the 1959 MHA's provision for voluntary treatment had seriously disturbed the assumption that all psychiatric patients are by their very nature wholly incompetent. The political critiques of psychiatry dating from the 1960s were highly influential in reducing the lay person's respect for what passed for scientific knowledge within psychiatry. Thus, whilst MIND never adopted a position which was wholly hostile to psychiatry, or called for the psychiatric profession's abolition, its attempts to limit the profession's power did draw to a large extent on the body of literature which was critical of psychiatric theory and practice, and suggested that patients were usually in a better position to determine their own interests than were doctors.

Unsworth (1987:344-5) notes that MIND's campaign for legal reform did not draw upon the work of the British-based anti-psychiatrists around Laing and Cooper. These psychiatrists had been interested in theorising the relationship between psychiatry, psychiatric disorder, and Western society in a way which was open to interpretation as being libertarian, but was firmly situated within the cultural and social critique of the New Left, and had little interest in legal reform per se. Instead, the legal campaigners drew upon the American legalistic approach to mental health legislation and its foundation in the work of Thomas Szasz, labelling theorist Thomas Scheff, and sociologist Erving Goffman. All these theorists had argued that the term mental illness is, or can be, a category mistake, which has been used to legitimate pseudo-scientific discourse about simple behavioural deviance. However, the legal

campaigners tended to use these theorists not to argue for the nonexistence of mental illness, as expressed in the anti-psychiatric view that 'mental illness is a myth' (Proposition 1 of the anti-psychiatric attitudes, Chapter 1). Instead they borrowed from these theorists evidence in support of the argument that psychiatry is characteristically incompetent and potentially malign, and it ought to be subject to the law. MIND's interest was in reducing the power of medicine over mentally disordered people, rather than in arguing for the non-existence of mental illness. It shared the anti-psychiatry movement's doubts as to the benignity and competence of doctors, rather than sharing anti-psychiatry's rejection of the concept of mental illness.

This is the position expressed in an American Civil Liberties Union Handbook entitled The Rights of Mental Patients (Ennis and Emery, 1978). Ennis and Emery (1978:15-16) are explicit that for their purposes:

> it does not matter whether an individual's problem is defined as a "mental illness," a "physical illness" that causes changes in thought and behaviour, or a "problem in living." The legal rights are the same. But in order to avoid identification with implied endorsement of any particular theory, for the most part we have used the inadequate but neutral term "mental disorder." (Italics are mine.)

Ennis and Emery use studies such as those by Szasz, Scheff, Goffman and Rosenhan to demonstrate the inadequacy of medical expertise in the area of mental disorder. A similar use is made in the English context by Gostin (1975) (with the exception that Gostin does not quote the ultra-libertarian Szasz in support of his views).

The influence of anti-psychiatry was evident also in the views of many of MIND's supporters; for example, Gould (1978), criticising the 1978 White Paper, referred to the anti-psychiatric literature and artistic genre. He noted appreciatively the showing on BBC 2 in 1978 of Ken Loach and Tony Garnett's film 'Family Life', which uses a fictional case to illustrate Laing's theories about psychosis and family dynamics. Gould refers to:

> lunatics (who have only achieved this status because psychiatrists have so labelled them).

Psychiatrists he regarded as:

> a pretty shaky segment of the medical profession.

Therefore, the legal reformers based their demands for reform partially upon the liberal objections raised earlier by objectors such as Barbara Wootton, that doctors were being empowered to make decisions which were in principle non-scientific, moral judgements. But for the most part the legal reformers tacitly acknowledged the validity of ascriptions of madness or insanity or mental illness, and did not oppose all forms of mental health-justified coercion. They subscribed in principle to the value judgements which such terms imply. What they argued against was the claim of medicine to have a broad base of scientific knowledge which qualified doctors to deal with such conditions. In Friedson's (1970) terms, the legal campaigners were arguing that mental illness ought not to be the wholesale concern of doctors, not because it isn't illness, but because doctors have only limited expertise in this area. This is not to say that mental illnesses do not have physical and potentially medical aspects. It is to say that we do not as yet know to what

extent that is the case. This is what distinguishes the new legalism from the old. The old legalism was content to ensure that sane persons were not wrongfully treated by doctors. The new legalism seeks to ensure that mentally disordered persons are subjected only to treatments which the doctor is able to justify.

2. Events of the campaign

Historically, the origins of MIND's campaign can be found in the early 1970s, when both MIND and the National Council for Civil Liberties (NCCL) were becoming concerned about the operation of mental health legislation. In 1974, Tony Smythe, formerly of the NCCL, became Director of MIND. The same year, MIND established a multi-disciplinary working party to review the MHA 1959 It was decided that a full-time Legal and Welfare Rights Officer would be needed to spearhead the campaign, and American lawyer Larry Gostin was employed in this capacity. Gostin had experience of the area of mental health law reform, having been involved in projects in the United States which had used research and the courts to compel states to bring their mental hospitals into order. In 1972, whilst still a law student, Gostin had been admitted to North Carolina's institution for the criminally insane, under false papers accusing him of rape, in order to research conditions in that institution. During his time there, he compiled information upon which a number of law suits on behalf of fellow inmates were later based. The law suits were all successful, and the state requested that remaining actions be dropped in return for a commitment to a review of the legislation. Gostin himself agreed to write a statute for formal admissions and in-patient rights (Anon, 1975a:13). America tends to be considerably more accustomed to using the legal system to effect political change than is typical in Britain, having a

long tradition of upholding individuals' rights enshrined in a written constitution. There had been a number of cases in which the courts had been used to compel changes in mental health law in various states across America. Gostin's contribution was highly influential in determining the form the campaign was to take in Britain. Gostin was also familiar with the American version of anti-psychiatry, based upon the libertarian thought of Szasz, rather than the British left-wing version. (Unsworth, 1987:336). From his appointment in 1974, Gostin contributed a column to Mind Out which was devoted to legal and welfare rights issues. The reform process was assisted also by the role played by David Ennals, the Secretary of State for Health and Social Services within the Labour administration, who was personally committed to the reform of the MHA.

In 1975, MIND published the first volume of Gostin's A Human Condition, his assessment of the working of the civil measures of the MHA. A Human Condition contained far-reaching demands for reform. It proposed a narrowing of the conditions for formal admission to hospital, and an extension of the rights of hospital in-patients in the areas of rights to a driving licence, access to courts, censorship of mail, reduction of welfare benefits, qualification for jury service and, in the case of formal patients, rights to refuse treatment. The most far-reaching and radical proposals related to patients' rights to a hearing upon formal admission to hospital. A Human Condition proposed the extension of role of the Mental Health Review Tribunals to investigate the circumstances of all detained patients, whether or not the patient requested such a review. Tribunals should also operate in a far less closed and secretive manner, allowing the patient more information on which to base a case, and therefore more chance of succeeding. In addition, MIND wished to see the establishment of an independent advocacy system to ensure

the rights of all patients in mental hospitals. (Anon. 1975b; Gostin, 1975:Chapter 11)

The same year an Inter-Departmental Committee within central government was appointed to report on the civil aspects of mental health law in the light of both Gostin's work and a report which had been published by the Royal College of Psychiatrists expressing their concerns. A consultative document was published in 1976 as a result of this committee's deliberations, followed by a white paper. A period of heated discussion ensued between supporters of MIND, who thought the government proposals did not go far enough, and supporters of the 1959 MHA, who thought MIND was trying to bind psychiatric practice within a legal strait-jacket. Martin (1976) wrote of the consultative document:

> the whole tone of the document is essentially low-key, with very few positive recommendations of any significance. The real shame is that in opting broadly in favour of keeping the status quo the opportunity for a fundamental re-think about the shape of the Mental Health Act has been lost.
> Basically things will stay the same as they have for nearly 20 years. Various fundamental assumptions have gone completely unchallenged, and any resulting legislation will be the poorer for that omission. (1262)

When David Ennals revealed the contents of the white paper, Gostin commented:

> The most controversial aspect of the prospective white paper is the issue of consent to treatment...
> We view the Government's intentions on this issue with grave disappointment. Mr Ennals states that "in fairness to both to

[check] doctors and other professional staff" Parliament must clearly "authorise the professionals concerned to treat patients - who do not or cannot give consent". He states, only as an afterthought, that patients should have safeguards, but he gives no indication of their nature or effectiveness...
Parliament should not give the doctor the right to treat the unwilling patient, even if it is subject to exceptions. (Gostin, 1977:5)

Following the publication of the White Paper in 1978, MIND swiftly issued a press release condemning it.

> The White Paper is a tidying-up operation in which patients' rights are again being swept under the carpet...the White Paper reveals a myopic concern with the rights and safety of public and staff whilst making only minimal concessions to strengthen the rights and safeguard of mental patients.

Gostin was equally critical, stating:

> the White Paper on the Mental Health Act 1959 fails to alter the current use of the Act as a subtle instrument of social control and supervision.

Before the legislation was enacted, the 1979 election resulted in a change of government, the Conservatives came into power, and MIND found itself compelled to negotiate with an administration less favourably disposed to its viewpoint than the Labour Government had been. In fact, the new administration did not

act on the subject of mental health at all until 1982. In 1981, MIND was successful in having a case it had taken to the European Court of Human Rights decided in its favour (that of X v The United Kingdom), and Britain's mental health law was found to be in breach of Article 5(A) of the European Convention on Human Rights, by failing to provide patients subject to restriction orders with effective periodic judicial review. Britain was compelled to change its legislation in the light of this ruling. The Conservative administration published its intentions in 1981. In the changed and less sympathetic political climate MIND moderated its position, and expressed its welcoming of such proposals as had been made, stating:

> Patients' rights are considerably strengthened by the proposals of the long-awaited Mental Health (Amendment) Bill...but major powers of discretion are retained by the medical profession Many of the Bill's recommendations are welcomed by MIND, whose hard-fought campaign for patients; rights has often been criticised, especially by psychiatrists. Some of the new Bill's most important proposals are clearly influenced by, if not taken directly from, A Human Condition, the work of MIND's Legal Director Larry Gostin. (Anon. 1981:3)

In 1982, MIND published The Great Debate in which it laid out its proposals for further amendments to the bill. The lègislation was finally enacted in 1982 in the form of the Mental Health (Amendment) Act 1982, which was the following year consolidated with the existing provisions of the MHA 1959 to produce the Mental Health Act 1983.

3. Outcome

Unsworth (1987:334) estimates that about two thirds of the proposals enacted in the MHA 1983 derived from proposals advanced in Gostin's A Human Condition. However, MIND certainly did not achieve all it had wanted, and having lost the support of the Secretary of State, as David Ennals was replaced by a Conservative Minister, MIND probably saw fewer of its proposals enacted by the Conservatives than would have occurred under Labour. Broadly speaking, what was achieved was that:

> The MHA 1983 narrows and restricts the definition and classification of mental disorder for statutory purposes...these amendments emphasize that it is neither the mere existence of mental disequilibrium nor of deviant behaviour which activates the provisions of mental health legislations, but certain combinations of the two which justify special legal powers of psychiatric intervention. (Unsworth, 1987:317-8)

Section 3(2)(b) introduces a new test of treatability with respect to psychopathic patients, legislating that such patients should only fall within the terms of the Act when treatment was deemed necessary to produce an improvement or prevent a deterioration in the patient's condition. This measure was designed to prevent long-term detention of these patients being used solely to avoid their release from custody.

> Requirements attaching to compulsory admission and discharge under the Mental Health Act have been procedurally weighted in favour of the patient's liberty (Unsworth, 1987:319)

Social workers were to be trained and registered as Approved Social Workers before being authorised to act within the terms of the Mental Health Act. This measure was intended to prevent injustices arising from inadequate knowledge of the law. The role of the nearest relative was expanded, and the definition of nearest relative clarified. The duration of periods of detention for treatment was halved, increasing opportunities for application to a Mental Health Review Tribunal. The Tribunal's role is also no longer restricted to handling applications from patients themselves. Hospital managers are now compelled to send details of cases where a patient was entitled to make an application and did not do so to the Tribunal for automatic review.

Of enormous importance are the measures introduced to control administration of treatment. The MHA 1983 confirmed that formal admission for observation for 28 days under the Act does authorize administration of treatment. But the rules governing the nature of the treatment which was permitted under the Act were considerably elaborated. The most drastic forms of intervention, those involving psychosurgery or hormonal implants for example, can only be administered with both the consent of the patient and a second medical opinion. For less serious treatments, such as long-term medication and electro-convulsive therapy, either a second medical opinion or the consent of the patient is required. Treatments not deemed serious enough to warrant being placed in wither of these categories may be given without consent or a second medical opinion to detained patients. in practice, the psychiatrists' authority to treat compulsorily the majority of patients detained for observation was confirmed.

S.139 of the MHA 1983 makes somewhat easier the process of suing medical staff for abusive treatment. The franchise was extended to allow informal patients to vote. Finally, the Mental Health Act Commission was set up to review the functioning of the MHA in practice. The introduction of this body was the major disappointment of the legislation to MIND.

> for MIND had aligned itself with the more aggressively libertarian notion of a legally-oriented advocacy system, which would have a decentralised structure based on the situation of advocates in hospitals with regional and national support. (Unsworth, 1987:329)

4. Critiques of the campaign

The legal safeguards included in the MHA 1983 were criticised strongly by those who regarded any return to legalism as a retrogressive step which simply served to hinder psychiatrists and mental health professionals from doing their jobs by placing a complex series of legal obstacles in their way. Christopher Mayhew resigned in 1975 as President of MIND in protest at the proposals put forward by Gostin (1975) in the first volume of A Human Condition. Anthony Clare resigned from MIND's team of sympathetic practitioners in 1981, writing in an article in Mind Out that year:

> Much of the trouble, if we accept for the moment that there is trouble, relates to the fact that in recent years MIND has developed a lusty appetite for legal reform and the issue of patients' civil rights that strikes psychiatrists as excessive and potentially damaging to the many other activities for which MIND is in existence. "The need is not for increased legal formalism but for human compassion and professional skill" would

make a most apt summary for the orthodox psychiatric position on these matters. [Quoting Kathleen Jones] (Clare, 1981b:17)

MIND was sensitive to accusations of extreme legalism. In his preface to the first volume of A Human Condition, Tony Smythe wrote:

> We do not feel that a strictly legalistic approach would in itself be relevant to a human condition which is often complex and insufficiently understood and to a public service that is hard pressed for resources and adequately trained staff. Accordingly, in operating MIND's legal and welfare rights service we shall seek to integrate the different but complementary skills of lawyers, psychiatrists and social workers. (Smythe, 1975)

However, after the legislation was passed in 1982 and 1983, limited as its effects were in terms of MIND's objectives, some medical practitioners retained the view that MIND had damaged rather than promoted the interests of its user group. Bluglass (1987) commented:

> When you hear them [members of the National Schizophrenia Fellowship] commenting about the idealistic notions of the lobbyists at the time of the Bill and now the champions of community care, they have a lot to say in strong language because it is they who in practice shoulder the burden of community care. The rights of patients in terms of their right to liberty has been ideologically emphasised in all good faith at the expense of the right of treatment. We know what we want when we are

> patients. We want the right to treatment from a skilled physician and his team. (156-7)

Obviously, MIND's achievements would impress those demanding the total abolition of compulsory treatment only to a limited extent. From that point of view, the MHA 1983 would merely serve to ameliorate a problem which could have been abolished; for example, Szasz believes:

> involuntary mental hospitalization is like slavery. Refining the standards for commitment is like prettyfying the slave plantations. The problem is not how to improve commitment but how to abolish it. (Szasz, 1974:79)

But, even amongst those who would profess themselves to be radical, but not total abolitionists, there was much cynicism about the likely impact of legal changes. The patient, X, whose case MIND took to the European Court of Human Rights, was a patient of The Sheffield Professor of Psychiatry Professor Jenner, who I have interviewed as a professional critical of the psychiatric status quo, if not actively opposed to the power which medicine wields in the field of psychiatry. Jenner is well-known for his support of the Italian movement, promotion of principles of democracy, criticism of political abuses of psychiatry in the Soviet Union and acquaintance with R.D.Laing. Professor Jenner and Larry Gostin engaged in an exchange of letters to the Guardian in 1981. Jenner was highly dismissive of MIND's strategy, stating:

> I feel bound to emphasise that however great a victory Mr Larry Gostin, MIND's American lawyer, and Mr Napier, a local Sheffield lawyer, may feel they have achieved, theirs was a legalistic

point, not a human one. Even the European Court agreed with the man's recall to hospital...For those in the know, the case leaves the expensive legal games, as well as MIND's politics, open to criticism. Perhaps the expense of years of legal juggling would have been better spent helping people - even that man.'

As was made apparent in my interview with Professor Jenner, he is critical of what he perceives as the over-emphasis upon free will and responsibility which characterises the work of the American psychiatric critics such as Szasz. He is also critical of Laing to the extent that Laing derived a similar over-emphasis upon human freedom from the work of Sartre.

An example of cynicism about the likely impact of the legal reforms is found also in the work of Rose (1986b), who argues that the rights-based strategy is an irrelevancy. Rose argues that the conflict between legal regulation of mental health interventions and therapeutic regulation is more apparent than real. In fact, both liberal rights theories and psychiatry are the brain children of the Enlightenment, and exist within identical political frameworks. Legal regulations postulate the existence of a rational autonomous subject, who has both rights and duties within a liberal society. Psychiatry exists to take over control of subjectivities in cases where it has become overwhelmingly obvious that the subject in question is neither autonomous nor rational. Whilst lawyers and psychiatrists may have a vested interest in the expansion of their own professional boundaries, which may lead to the impression being given of disputes of real substance taking place, all that is in fact taking place is a negotiation of territory between two groupings which are each dependent upon the other. For Rose, this explains the failure of rights based strategies to alter substantially for the better

the situation of psychiatric patients. Rights campaigners have proceeded by positing a set of rights which they claim ought to be defended on behalf of patients. These rights have been asserted in a vacuum without proper political discussion of how resources ought to be allocated or how priorities ought to be established where different individuals' rights compete with one another. These rights are, further, expressed in the arcane and complex language of the legal profession, thus serving to provide an increased volume of employment for the lawyers required to operate them. Provision for mentally disordered people has thus not improved at all, but has actually dwindled whilst discussions in the mental health field revolved around issues of rights.

In addition, Rose believes that the rights strategy has achieved a reduction of available services without paying any attention at all to the needs of the majority of patients, the 80% or so who accept treatment voluntarily and therefore do not benefit to any great extent from an assertion of their negative rights. These patients and clients subject themselves voluntarily to psychiatrists' techniques of the self, and because the rights strategy regards this as a private decision with which the law cannot interfere, the majority of patients experience the power of psychiatry in unregulated form.

Rose's analysis is drawn from a similar reading of Foucault to that of Gordon (1986) (see also chapter 5). However, Gordon reaches somewhat different conclusions. Gordon, like Rose, situates psychiatry and liberal rights theory within the same Enlightenment born project of democracy. But Gordon is content to accept this paradigm as not inevitable, but preferable to alternatives. He wishes to assert that if psychiatry is theorised as a tool of democracy, it must itself be subject to democratic regulation and not

become a threat to democracy. Rose, on the other hand, wishes to reject democracy, at least in the Enlightenment sense. He bases his critique on a socialist vision of society, in which democracy is divorced from 'bourgeois individualism'. He proposes a number of alternative bases for ethics which do not involve rights-based discourse:

> perhaps framed in a language of duties and obligations, of social support given not because it is a right, but because it would be virtuous to give it, or politically correct to give it, or because it would make the giver a better person. (Rose, 1986b:211)

However these proposals, involving duties and obligations, are plainly inseparable from a notion of rights. If I accept that I have duties and obligations towards others, then the objects of those duties and obligations must surely be able to argue that they have certain rights with respect to me. We are back in the field of bourgeois individualistic discourse. The notions of virtue, political correctness and self-improvement are all similar in that all of them involve a view of ethics as essentially altruistic and divorced from sanction for failure to comply. They will only operate effectively if all members of a society accept that they want to be virtuous, politically correct or a better person. This immediately requires the question, 'why would anybody want any of those things?' Once it has been established that there is no reason to assume that people will ever simply want to be virtuous, politically correct or a better person, it can be assumed that it is most likely that, in the absence of a preferable ethic, many people will want to be selfish, powerful and rich. We must then accept that an element of coercion must necessarily enter into our social relations. We must work out

what limitations on freedom are necessary to prevent certain members of society becoming permanently disadvantaged in relation to everyone else, and what measures are going to be taken to enforce these limitations. And so we arrive back in the arena of individual rights, duties and obligations. This form of discourse is not preferable to others because it is true in some ultimate sense. It is preferable because experience has hitherto indicated that the most effective means of safeguarding people's well-being is to value them as individuals with rights.

This is not to detract from what is valuable in Rose's critique of the legal reform strategy. It is the case that an emphasis on individual negative rights, to the exclusion of debates on resource availability and level of provision, has produced unfortunate consequences in Britain and America. In America, 'triumphs' in the arena of negative rights were used by right-wing administrations to legitimate severe, fiscally motivated reductions in service availability. This was notoriously the case in California, where Governor Reagan used the contemporary wave of feeling against the psychiatric profession to close mental institutions without disturbing public opinion, and achieve tax cuts in the state. Civil libertarians walked straight into this outcome, as they used the notion of 'right to treatment' cynically themselves, not to attempt to compel hospitals in the States to offer real treatment, but to compel them to release patients. Similarly, in Britain also the programme of hospital closures has attracted accusations of cynical cost-cutting; for example, Scull (1984). The stress on personal liberty of the 1970s appears to have distracted attention away from the impending catastrophe which would result from underfunded 'community care' policies in the 1980s. This will be dealt with more fully in the next chapter.

The criticism of an excessive reliance upon legal strategies for reform need not deny such strategies any validity at all. Unsworth (1987:6-7) has argued that legal and medical powers in relation to mental disorder do not exist in inevitable tension, but frequently support one another. He points out that the two professions are united by as many shared interests as appear to divide them: professionalism, conservatism, paternalism, morality. He also affirms Foucault's view that both positions are dependent upon the Enlightenment world view:

> Finally, however uneasy their alliance, psychiatry and law are intimately interconnected and interdependent in the apparatuses of modern criminal justice, a relationship traceable to the emergence of a penality based upon the principles of the Enlightenment. Psychiatric medicine has been one of the principal beneficiaries of what Michel Foucault describes as a fragmentation of the legal power to punish. Law and psychiatry function as intersecting modalities of judgement and disposition in the control of crime. (Unsworth, 1987:7)

He has also criticised Rose for failing to appreciate the difference which legal interventions in medical provision have made to psychiatry, in promoting less powerful views such as those of social workers and psychologists who challenge the dominance of medicine.

It is perhaps a mistake to hold all legal rights strategies responsible for what was the unfortunate tendency for some legal rights strategists, particularly in the United States, to rely over-heavily on the arguments of the American 'anti-psychiatrists' such as Szasz. Szasz's theories, as has already been demonstrated (Chapter 4) rely on the assumption of the

universality of free will. It is simply assumed that everyone is in control of his or her own life, and therefore ought not only to be free to behave according to their wishes, but ought also to be held responsible for all their actions. This is indeed the Enlightenment ideal. However, it is because the Enlightenment thinkers also realised that for some people some of the time, and for some people all of the time, this degree of freedom is not attainable, psychiatry came into existence. There is no inherent contradiction between the promotion of individual rights and the existence of psychiatry. Some rights theorists were, during the 1970s, tending to err on the side of a Szaszian view of free will, according to which any reduction in state psychiatric provision was an unequivocally good thing. As the consequences in human terms of such a view had not yet become fully apparent, the existing imbalance between the demand for negative liberties and the demand for better service provision was yet to be fully appreciated.

It is now clear that mental health provision must be approached on fundamentally the same basis as all other health provision, at least in terms of the adequacy to which it is funded and made available. In addition, there is a good argument for affording psychiatric patients better protection of liberties than other patients, precisely because psychiatric patients are by the nature of their difficulties more handicapped in the pursuit of their own interests than other patients. They may need more assistance in defending themselves against professional error than the average physical patient, whether their treatment is administered compulsorily or voluntarily. Therefore a legalistic strategy is vindicated. However, because psychiatric patients experience real problems which require real intervention, legal rights must not only be negative rights to non-interference. They must be positive rights to proper care and appropriate facilities, as well as to such

medical treatment as is helpful. The realisation that law and psychiatry are not mutually incompatible alternative viewpoints, but exist within the same moral and political framework is invaluable in theorising the balance between liberty and therapy. Therapy ought to be working towards an increase in liberty. Liberty ought to recognise its own limits. But both liberty and therapy can equally well be theorised in terms of legally enforceable individual rights.

The example of Italy, discussed in the previous chapter, is paradoxically illustrative of the limits of both a legal strategy divorced from discussions concerning service provision, and a therapeutic strategy which underestimates the importance of legal safeguards. Law 180 is almost entirely libertarian in intention, in theory freeing patients to a great extent from the strictures of compulsory psychiatric intervention, but providing for very little provision by way of alternatives to existing services. Patients' negative rights at least ought therefore to be completely protected. This is far from the case. Southern Italy is notorious for its instances of ex-patients who are theoretically at liberty but in practice compliant prisoners in institutions which are no longer classed as hospitals. Because they are no longer classed as hospitals, they are not subject to the level of regulation which preceded Law 180. Precisely because psychiatric patients are vulnerable to coercion, even in the absence of legal structures permitting coercion, they tend to become coerced. In Britain, the 1890 Lunacy Act was not passed to institute the practice of psychiatric coercion. It was passed to regulate coercion which was already taking place. Italy now lacks any workable framework within which to police what forms of coercion are being used. Ex-patients negative rights have been effectively reduced, as in the absence of proper alternative provision they are more coerced with less regulation

outside a legal framework. Further, because no positive regulations have been instituted, stipulating what minimum level of service must be available, loss of negative liberty does not involve increase in positive right to treatment. Coercion exists purely for reasons of social control.

In the north of Italy, things are not so bad. Trieste, for example, has a highly effective level of alternative provision, and argues that adequate provision within a socialist Marxist context makes individualistic legal safeguards unnecessary. However, as chapter 6 suggests, provision which is not regulated by law can also introduce elements of unregulated de facto coercion, which are not regarded as coercion because they are not regulated by law. In conclusion, there are dangers in assuming that it is law which institutes coercion, and if the law is ended, the coercion will stop. Law frequently steps in to regulate coercion which is already taking place. The absence of proper legal provision can then serve to reduce liberties. The powers to hospitalise and treat compulsorily have tended to be theorised as exclusively negative powers in terms of civil liberties. This is not in fact the case. Civil powers of compulsion serve to protect liberties by controlling when coercion will be used, by whom, and with what ends in mind.

5. MIND's campaign platform since 1983.

Following the passage of the MHA 1983, MIND found itself in need of a new platform upon which to base its image and campaigns. It adopted the promotion of user involvement in the provision and management of mental health services as a logical next step out of its concern for individual rights. One means of ensuring that users rights are respected is to enshrine those rights in law. A further possibility is to ensure that users have direct input into the

process of planning and running services, and that their voices will therefore be heard. MIND has thus been involved in promoting user-led initiatives, such as the establishment of patient councils and frameworks for user-advocacy in psychiatric hospitals and wards. MIND has also been at the forefront of publicising in this country the work of Psichiatria Democratica in Italy (see also chapter 6). Within its own structures, the organisation has endeavoured to ensure that users are both heard and exercise real power. Since 1988, MIND's vice-chair has been a service user, Mike Lawson, whose views will be discussed in Chapter 9. More recently, in 1991, MIND has declared a commitment to promoting the right of all patients to give full and proper consent to treatment, by ensuring that they receive adequate information upon which to reach a decision.

Conclusion

MIND's campaign for reform has been valuable in clarifying and increasing the safeguards which are there to control what may be done to a person in the name of treatment. However, some opponents of MIND's strategy have argued that MIND has not always been sufficiently sensitive to the very real positive needs of psychiatric patients. In reply to this criticism, it might be pointed out that the rights strategists campaigning with MIND have been keen to promote positive rights to services as well as negative rights to liberty; for example, Gostin's (1983) account of The ideology of entitlement. MIND's approach to democracy has been fundamentally different from that of the Italian movement in emphasising negative rights over and against positive developments in provision. This has resulted in both positive and negative differences between the situation in Britain and Italy. MIND has been criticised on the grounds that legal change alone produces little material

difference in the social situation of psychiatric patients. This is true of Italy also, as the situation in the south of that country illustrates. The situation in the North of Italy is perhaps one in which it is truer to say that provision is quite adequate, but that this alone is not enough to guarantee a well-functioning psychiatric service. Legal regulation is desirable as well to prevent abuses from taking place.

Since 1983, attempts to increase the civil liberties of psychiatric patients through amendments to the mental health legislation have largely been abandoned. The legalistic approach to mental health reform has been focussed upon the use of the courts to challenge psychiatrists' interpretation of the existing legislation. The major example of this is the case of R v. Hallstrom ex p. W (No.2) [1986] 2 All E.R. 306. This case concerned the interpretation of s.3 of the MHA 1983. Some psychiatrists had been using this section to enable patients to be released on permanent 'home leave' and recalled to hospital whenever medication was due to be administered. In effect, the section was being used as a 'long leash' to secure the compliance of patients who would otherwise be likely to cease co-operation with treatment once they were released from hospital. In Hallstrom this practice was declared illegal (Cavadino, 1991:483-4).

One effect of Hallstrom was to provoke demands from the medical profession and the National Schizophrenia Fellowship for a 'Community Treatment Order' (CTO) to be legislated into existence. A CTO would be a new form of compulsion targeted at those patients living in the community who were habitually uncooperative and were considered likely to relapse if they were allowed to cease taking medication. The order would allow such patients to be removed compulsorily to hospital for purposes of treatment if they refused to co-

operate. This would constitute a major change in the philosophy underpinning mental health legislation at present, providing for some use of compulsion in respect of patients who are not under current provisions considered sufficiently disturbed to justify compulsory admission to hospital in the interests of the health and safety of themselves or others. Legalistically minded civil libertarians have most recently been concerned with resisting the introduction of CTO's into the legislative framework, rather than campaigning for legislative change in their own right (Cavadino, 1991).

Since 1983, contemporary debate has ceased to be so focused upon legalistic strategies for the preservation of negative rights, and become concerned to a greater extent with the issues of level and type of provision, from which the legal debates around the MHA 1983 distracted attention somewhat. Chapter 8 will examine the issue of provision in the context of the community care debate. Chapter 9 will include discussion of what provision ought to be available, and who ought to decide, in the context of the movement for greater user participation in running and planning of services. This will involve discussion of the problems of encouraging input into policy by a group of people whose contributions are likely to be devalued because of the very problems which have caused them to become users. In other words, professionals are liable to argue that if patients were so capable of determining their own interests, they would not be patients. Their contributions cannot simply be accepted at face value. Chapter 10 will turn to the contemporary claims of psychiatry and psychology as expert discourses, and attempt an assessment of the validity of the claims of these disciplines to have access to expert knowledge. It will then discuss what the relationship between expertise and democracy might be.

Footnotes to Chapter 7

1. It should be noted that whilst many patients who are legally informal can be properly termed voluntary, this is not true of all informal patients. A patient is admitted to hospital informally by virtue of not having resisted attempts to admit her. Informal patients will therefore include some patients who allowed themselves to be admitted, but whose mental state is such as to render it meaningless to assume that they volunteered for admission.

In addition, whilst informal patients are free to refuse any form of medical treatment which they do not wish to receive, they are not free to consent to any form of treatment at will, and are therefore included to some extent within the system of regulation established by the MHA 1983. The MHA 1983 s.57 stipulates that highly intrusive and irreversible forms of treatment, typified by brain surgery, can only be administered with the consent of the patient and the support of two doctors even when the patient's legal status is informal.

1. History of care in community

Care in the community is perceived as a relatively recent policy associated with the rapid emptying of long-term institutions during the 1980s. However, the policy originated in theory several decades before its effects began to be noticeable socially. It is also a loose term which can be used in a variety of different ways to indicate quite different sorts of intentions. This will become more apparent in the following discussion.

The roots of care in the community are to be found in the desire of psychiatrists to establish themselves as a bona fide medical specialism. At the turn of the century, psychiatry was being practised almost exclusively within large asylums built for the purpose of housing and incarcerating the insane. Whatever therapeutic optimism had once surrounded these institutions had long since evaporated, and they had degenerated into huge specialised prisons for the incurable mad. They were regarded with fear and suspicion by a large proportion of the general public, and the physicians who worked within them tended to share the stigmatised status of their patients within their own wider profession. As a renewed sense of therapeutic optimism emerged during the twentieth century, and psychiatrists began to develop a sense of their own expertise and particular contribution, the desire grew to end the stigmatised isolation of psychiatrists and their patients, and to reassert the therapeutic role of psychiatry as a medical discipline over and above the custodial function with which it had become associated. The first stage in this process of transformation was the aim of turning the asylums into proper hospitals, as expressed in the 1930 Mental Treatment Act. This act began the process of

separating psychiatry from its purely custodial function. The more sweeping changes, however, resulted from the 1959 Mental Health Act. This piece of legislation had the two fold aim of separating the therapeutic role of psychiatry as far as possible from the custodial role, and effecting the integration of psychiatry as closely as possible into the medical mainstream. This policy involved a shift from institutional care to care in the community in two senses. Firstly, it proposed a removal of the location of delivery of treatment out of the isolated specialised hospitals built for that purpose and into psychiatric wards within local general hospitals, where treatment would be delivered to in-patients on a formal and informal basis, and to out-patients who would attend clinics. Thus, care would take place in the community in the same sense that all physical health care takes place in the community: that is, inside a general hospital which is situated in the community and perceived as being itself a part of the community, as opposed to a separate isolated institution. Secondly, care would take place in the community in the sense that psychiatry would surrender its responsibility for providing straightforward custodial care divorced from treatment. People would no longer be admitted to hospitals simply because they could not care for themselves. They would only be admitted if they were perceived to be suffering from an identifiable condition amenable to treatment. They would then be discharged from hospital into whatever non-medical form of care was deemed appropriate. They would only be re-admitted to hospital as and when further medical treatment was considered necessary.

So far, the changes in policy expressed in the 1959 MHA have been presented as strategies adopted by doctors in pursuit of professional consolidation, enabling psychiatrists to separate their medical function entirely from the custodial ones which the old asylums had involved. However, there was also

a growing body of literature which suggested that the changes in policy being proposed would be of real benefit to patients also. Patients would benefit from increased freedom to request treatment, which would be available to them in less undesirable circumstances. They would also benefit from the reduced stigma which would attach to treatment within a general hospital rather than within a designated mental hospital. There was also a body of evidence suggesting that long-term custody within a mental hospital was itself responsible for the condition of many patients whose behaviour had previously been ascribed entirely to their mental illness. Barton's classic Institutional Neurosis was perhaps the best known of a growing body of literature condemning the anti-therapeutic nature of long-term institutionalisation. In the light of such studies, it began to be theorised that for patients to live in the community would itself be therapeutic. Scull (1981:8) has commented upon the extent to which 'these expectations rested upon a priori reasoning and not empirical demonstration'. This theory was presented in the form of 'normalisation approaches' (Wolfsenberger, 1972; Tyne and O'Brien, 1981). In addition, new treatments such as the major tranquillizers which were becoming available were expected to revolutionize psychiatry, enabling large numbers of patients who had previously been considered hopeless and incurable to be returned to relatively normal lives within the community. The view that care in the community was the result of revolutionary advances in treatment has, however, been disputed. Decarceration had begun before such drugs became widely available, and psychotropic medication is not now believed to be as effective as was initially hoped (Scull, 1984; Busfield, 1986; Goodwin, 1990).

Following the 1959 MHA, a fairly large number of psychiatric wards were built within the grounds of general hospitals, and the population of the long-term

custodial institutions did begin to fall steadily. As the long-term hospital population fell, however, admissions increased. It became apparent fairly quickly that what was happening was the replacement of once for a lifetime admission with the 'revolving door' phenomenon.

In 1979, the Conservatives came to power in Britain committed to a mandate of reducing public spending. The Conservative administration is now into its fourth consecutive term of government. After 1979, under the leadership of Margaret Thatcher, the policy of hospital closure continued to be pursued, in spite of increasing public and medical concern about the inadequate level of provision for patients in the community. From the late 1970s onwards, concern was being expressed in America and in Britain, about the desirability of deinstitutionalisation as an end in itself. Clarke (1979) has described how:

> Scarcely ten years ago, deinstitutionalisation was an honourable word and practice among reformers of all stripes..Reducing the populations of large, overcrowded mental hospitals was viewed in the same light as minority civil rights issues - few "right-thinking" persons could oppose it. As a result, a political movement imbued with almost religious fervour swept many state capitols and hundreds of thousands of hospitalized mental patients were "deinstitutionalised."
>
> Deinstitutionalization today carries few of these overtones. Rose (1979) and many others assess the practice as, at best, merely another ill-advised liberal political movement of the 1960s. (p461)

Gruenberg and Archer (1979) concur with Rose (1979) that the crisis which has resulted from the community care policy:

> attest[s] to an abandonment of the seriously mentally ill, and that community psychiatric services fail to meet the needs of many patients discharged from state mental hospitals. (485)

Jones (1979) suggested that the state of 'care in the community' in Britain is now more critical than that in America, in spite of the view during the 1960s that Britain was in advance of America in its provision of mental health services integrated within the National Health Service.

2. The radical political critique of community policy.

2.1 Anti-psychiatry and community care.

The early anti-psychiatric critiques of psychiatry, emerging out of the work of Laing, Cooper, Szasz and Goffman, were uncritically supportive of the community care policy. Anti-psychiatry was focused upon the critique of the old-fashioned asylum system, with its highly coercive and physically controlling use of incarceration and medical 'treatment'. Anything which reduced the numbers of patients being confined in such oppressive conditions, and restored them to freedom in the community, was regarded as progressive. There was very little concern expressed about the adequacy of arrangements for actual care in the community, although in retrospect it seems quite clear that a comprehensive range of facilities could not be provided on the small-scale privatised basis of which Kingsley Hall and the Arbours Association provided examples. The willingness of many Left wing activists to accept an extremely anti-psychiatric critique of mental health care must be regarded as at least part of the cause of the crisis in mental health provision which developed through the 1980s. The Conservative government was able to justify seriously

underfunding mental health services for several years whilst those people on the Left who expressed an interest in mental health were unable to decide whether that was actually such a bad thing.

2.2 The radical reaction against community care.

The current scenario has provoked something of a backlash against the community care policy. Andrew Scull has been a particularly fierce critic of 'care in the community'. Scull (1984) argued that the whole policy of decarceration was a cynical money-saving exercise on the part of central government. Scull has argued that the motive behind deinstitutionalisation was always fiscal. Large institutions are very expensive to run, and once the welfare state had made available 'outside relief' for the deserving poor it became cheaper to compel such people to rely on that form of relief. However, this thesis does not hold up to scrutiny. The care in the community policy predates the fiscal crisis of the state, which emerged during the 1970s, whereas the care in the community policy was beginning to emerge during the 1950s (Goodwin, 1990). Additionally, there has been some transfer of resources from the institutions to community based out-patient provision, albeit of an inadequate quantity. The argument that care in the community became a means of saving money rather than improving the circumstances of psychiatric patients during the 1970s and 1980s is more tenable (Busfield, 1986:328-9).

Scull (1989) compared the publicity campaign to free patients from the asylums to that which, during the 19th century, resulted in their incarceration within the asylum. The rhetoric is remarkably similar, albeit reversed.

> For Dix and Shaftesbury, the certain recipe for neglect and abuse was to leave the mentally disturbed to the mercies of the community. (Scull, 1989)

In Scull's opinion, the policy of decarceration has resulted in a simple failure to care for people who are vulnerable, helpless, and unable to contribute to the cost of their own care and upkeep.

A more sophisticated Marxist analysis of the care in the community policy has been proposed by Goodwin (1990). Goodwin argues that the form which psychiatric services will take under capitalism is a product of the need to reconcile three different dimensions of service provision: the service must be as cheap as possible, deliver adequate levels of control, and have prima facie legitimacy so as not to prompt reaction against its actual and ulterior purposes. The shift to care in the community took place because the asylum system of psychiatry had lost legitimacy. However, by 1975 care in the community was obviously underfunded, which resulted in a loss of legitimacy, and the legitimacy of the control functions of psychiatry were under direct attack. Goodwin sees the continued existence of the care in the community policy as threatened by its failure to reconcile the three different sorts of demands which any mental health policy must meet to satisfy the requirements of the capitalist state. He regards the strategy of exerting continuing demands on government for better funded services as doomed to failure, as it has never been likely that adequate resources would be made available for such services. His conclusion is that, whilst some individual aspects of current policy might command guarded support, we currently lack a strategy for achieving better mental health services.

Radical critiques of community care have sometimes provoked the criticism from more conservative observers that the radicals will criticise whatever is suggested, and have no positive suggestions to make at all. Jones (1982) has discussed what she refers to as Scull's dilemma, which is derived from Scull's having written historically based critiques claiming that both the building of the asylums and the emptying of the asylums are policies of capitalist oppression.

> the dilemma, which he does not make explicit, but which one can only hope will be the subject of another book, is simply this: if it is wrong to get patients out of the mental hospital, and wrong to keep tem in, what are we to do with them? (Jones, 1982:221)

Jones' criticism, however, fails to take account of more than two alternatives for radicals: either to support the asylums or to support their abolition. Jones criticisms would actually apply more directly to Goodwin (who does seem to conclude that whatever is achieved within the context of capitalism will never be sufficient to provide an alternative to capitalism's abolition) than to Scull. In fact, most radical commentators want neither the old asylums nor the current level of neglect, but rather want to see a proper commitment on the part of government to funding adequate provision to enable mentally disordered people to live as full a life as possible within the community. Indeed, Scull (1989) can evidently envisage a third alternative to both the current policy and the previous one which would involve more adequate provision of care than either. Also, David Hill, who is perhaps the professional currently best known for his continued insistence that institutional mainstream psychiatry is damaging, prioritises closing the long-

term institutions, but emphasises the need to provide their residents with satisfactory alternative accommodation.

2.3 The critique of community care as the transfer of medical control into the community.

Ramon (1985) argues against the current policy of care in the community, but does so on the grounds that a policy which merely transfers medical control of disorder into the community is bound to fail. She suggests that our current policy of care in the community is a development out of the approach which was most systematically theorised in America under the name Community Mental Health (CMH). CMH, as a comprehensive approach to mental health care, depends for its coherence on a particular conception of the nature of mental health difficulties. According to Ramon, the assumptions which must be made for the model to make sense include the view that mental illness can be caused by a range of factors, internal and external, biological psychological and social; that a person is most vulnerable to mental illness at crisis stages in life, but if the crises are successfully negotiated, the result will be personality growth; and a range of assumptions which can be related to a humanistic conceptualisation of psychiatric disorder. She concludes that this approach involves assumptions which conflict with those which are made when a straightforward clinical-somatic approach to psychiatry is used. In particular, the two models disagree about the role of social responsibility, the aetiology of mental disorder, intervention methods, the role of various professions, the role of society, and the place of non-professionals within the service system. In Britain, the CMH approach was never really considered. From the time of the 1959 MHA, it was simply assumed that care in the community meant a transfer of the clinical-somatic model, with its existing

medical services and medicalised doctor-patient relationships, into the community.

Ramon wishes to see the CMH approach introduced and developed, with an attendant shift away from the emphasis upon expert opinion and symptom removal, and onto issues of non-professionalised provision of social support, with a particular emphasis on self-help support networks:

> This development, together with feminist therapy, has been the most radical innovation to emerge since the fifties. It is radical because it marks a departure from the majority of professional models of practice and understanding of mental distress. It affirms the value of subjective and inter-subjective experiences away from the clinical model. The approach is based on the recognition of the strength of this vulnerable sector of the population, of the strength of group vs. individualistic approaches to mental distress and on the tacit acceptance that "The Community" does not exist. Therefore alternative social networks have to be created to support the mentally distressed. How far it could/should replace professional intervention is open to debate, but it has demonstrated its usefulness in conjunction with such an intervention and without it. (Ramon, 1985:300)

Ramon's thesis involves a range of assumptions about mainstream medical opinion in Britain and in the United States. With respect to the US, she is assuming that the majority of the support which community care gained there was based upon the philosophy which she associates especially with CMH. A clinical-somatic version of care in the community would thus amount to an

incoherent perversion of the original policy. With respect to Britain, she assumes that the approach which has been adopted to care in the community could be described as straightforwardly clinical-somatic. Thus, she is able to draw a qualitative contrast between the policy which she would like to see adopted, and the policy which she thinks British psychiatrists are striving to have adopted. The extent to which British psychiatry is based upon a completely clinical-somatic approach, as opposed to one which does give proper weight to social and psychological factors, will be discussed in chapter 10.

Finally in relation to Ramon's thesis, Ramon (1985) claims that she is not attempting in this book to assess the truthfulness of any particular model of mental illness, be it somatic, psychological or social. However, she also proposes that:

> a set of criteria by which to evaluate the contribution of each model will be outlined, based on what the author considers to be the essence of mental distress and its social significance. (p7-8, italics mine)

In practice, what the author considers to be the essence of mental illness is inseparable from her view of the validity of the somatic, social and psychological models. Her view would appear to be one which is fairly eclectic, but with rather more emphasis on the social and psychological than on the somatic. Again, the extent to which this view of mental disorder is qualitatively, rather than quantitatively, different from that which is official psychiatric policy, will be addressed in Chapter 10.

Ramon allies herself with anti-psychiatry in the sense of being broadly anti-medical in approach. Both the old institutions and the new policies and treatments can be criticised as medically based. The new policies can be

criticised for simply attempting to transfer the medical model into the community, where what is needed is to provide a higher level of social support and proper care. To the extent that 'community care' is based solely upon an extension of medical power into the community, it is theorised as an extension of surveillance and social control divorced from real care. Those who adopt this viewpoint point to repeated attempts on the part of some psychiatrists to have a community treatment order legislated into existence as evidence for this. Ramon, and others who adopt this approach, look typically to Italy for the model of this form of care (see also Chapter 6).

2.4 The need for a workable policy of care in the community to have considered what it means by 'community'.

A related strategy for criticising contemporary care in the community consists of accusing the community care originators as not thinking through carefully enough what is meant by 'community' and, as a result, not merely having failed to provide a policy of care in the community, but even having failed to produce deinstitutionalization in a real sense. It is pointed out that quite frequently deinstitutionalisation means transinstitutionalisation (transfer from a large public institution to a small private one). Scull (1989) notes that the board and care facilities which have sprung up in America tend to resemble wards in state mental hospitals and are often even staffed by ex-mental hospital staff. Deinstitutionalisation there has produced a new 'trade in lunacy' which resembles that which the nineteenth century reformers sought to have abolished. (It is interesting to note the extent to which the radical Scull's criticisms of America resemble the conservative Jones' criticisms of Southern Italy in this respect.) Warren (1981) offers a similar analysis of transinstitutionalisation, pointing out that the transfer from public to

private institutions usually involves also a reduction in regulation of conditions in the institutions providing care. The community around which so much rhetoric was based and which was expected to provide support at best exerts negligent tolerance, at worst negligent intolerance. Care in the community, it is argued, must involve ensuring that the patients and ex-patients now living in the community have as much right and ability to participate fully as anyone else. In terms of the principle of normalisation, this might mean that it is increasingly acknowledged that for some people 'normal life' involves acknowledging the existence of special needs exist which must be catered for in order for the individual to have any chance of being integrated into the community. Such special needs will only rarely be met by the provision of better medical treatment, but are more a matter of appropriate social provision.

This argument has been extended by feminist critics, who's concern is not solely for the patient or client, but for the carers. It has become increasingly apparent that community care generally means care by female relatives (Scull, 1989; Holland, 1988). Feminists are increasingly demanding better support for carers, and alternatives to care by relatives, whether or not such care is primarily medical.

3. Anti-psychiatry versus pro-democracy in the community care debate.

All the approaches discussed above continue to involve the implicit assumption that social and psychologically based interventions are intrinsically preferable to medically based ones. However, closer examination reveals that this is not in fact any longer the crux of the argument. The real argument is firstly that medical provision is not being sufficiently accompanied by

appropriate standards of social and psychological care. Secondly, the 'medical model' no longer refers to the provision of particular sorts of treatment, which are physiological and accompanied by organicist theories. Rather, it refers to a particular sort of relationship between users and professionals, which is characterised by a conceptualisation of problems in individualistic terms, authoritarianism on the part of professionals and the assumption that users will simply yield to expert advice. As both Ramon (1985) and Ramon (1988), her comparison of British and Italian services, reveal, Ramon is not entirely opposed to medical intervention. Indeed, as chapter 6 has discussed, service provision in Italy is not anti-medical. Ramon identifies herself not as an anti-psychiatrist, but as a 'radical reformist' (Ramon, 1988:xv).

Margen (1988) presents the issue in terms of whether services promote autonomy or dependency in patients. Holland (1988) combines a critique of medicalisation/individualisation of problems with a critique of disempowerment of users:

> there is a growing criticism of the 'psy' professions' duplicity with the welfare state in reducing public oppression to matters of private psychic despair. However, well meaning and identified with the oppressed the mental professionals are, our attempts to help will always be sabotaged by the 'recipients' humiliation and resentment at having to need help. It is only by finding a therapeutic practice which will genuinely empower the 'patient/client' that we can honestly reject the accusation that we are 'poverty-pimps' enriching ourselves out of the anguish of others. (135)

Towell and Kingsley (1988) argue that:

> Real change in psychiatric provision will only be attained where it is possible to achieve new status for people with psychiatric disabilities, new roles for staff and new public attitudes all within a single movement for reform. (171)

Hennally (1988) discusses a strategy of forming mental health resource centres where explicitly non-medical responses to mental health difficulties will be promoted. However, the fundamental basis of these centres is that:

> The experiences of power and powerlessness will be recognised as the central elements around which the theory and practice of mental health care is constructed. (209)

and:

> Almost inevitably, for ourselves the greatest tension appears to arise with medical-somatic service. The slow death of the asylum is rendering the ideological conflict between the 'medical model' and a 'sociopolitical' model of mental health distress more apparent and more widespread. (216)

Contemporary strategies for radicalised versions of care in the community, then, exhibit a continued tendency to express hostility to the 'medical model'. However, it is not explicitly apparent which aspects of the medical model are being opposed: whether it is the provision of physical, medical treatments per se, or whether it is the perceived authority of medicine in relation to its psychiatric patients. Different commenters appear to draw

upon both perspectives to varying degrees without distinguishing clearly between them.

These critiques are also of interest in their insistence that the problem with current services is that they are solely medical services which do not offer anything in terms of social or psychological assistance. Mainstream medically-oriented critics, however, regard 'care in the community' as entailing the abandonment of the most seriously ill people by medical psychiatry, as well as by social and psychological forms of service delivery; for example, Gruenberg and Archer (1979).

4. Poststructuralism and the community care debate.

Particularly interesting is the contribution of those who have been influenced by ideas of poststructuralist origin. Radical critics who regard themselves as mainly proposing extensions of anti-psychiatric thought have tended to define their radicalism in terms of a rejection of medicine and offer of alternative, non-medically based provision. As described above, this stance is still implicit in many critiques of community care, although this is no longer, perhaps, the 'real' issue. As has been illustrated, post-structuralist critiques based upon the work of Foucault reject this division into the bad medical intervention and the good non-medical, and instead address the political values and functions of all forms of intervention. Castel et al (1982) applied this kind of analysis to the American situation. They examined what had happened to medical psychiatry and alternatives to medical psychiatry since the critical hey day of the 1960s. Medical psychiatry was portrayed as already being committed to a policy of self-legitimization before the 1960s, wishing to disown its reputation for punitive

forms of 'therapy'. Alternative 'soft' approaches, such as the therapeutic community and other forms of socially and psychologically based intervention, were already being developed within psychiatry before the 1960s. The move from hospital provision to community provision was never complete. Rather, what emerged was a continuation of medical provision being delivered within hospitals and new forms of psychological and social treatment being delivered within the community. The seriously disturbed patients who now live mainly in the community are subjected to a regime which alternates between total neglect and repressive medical social control. 'Treatment' in its psychological and social forms is reserved for the less seriously disturbed middle class patients who the doctors prefer to treat and who form the bulk of the patients who attend community mental health centres in America. Basically, the community mental health centres do not cater for the same patient group which has been ejected form the institutions. This situation has been identified in Britain, also, by Busfield (1986:329-330).

During the 1960s, counter-cultural experiments were set up outside mainstream medical psychiatry. Such experiments involved the creation of free clinics and gay and feminist radical therapies. They were also characterized by a large measure of deprofessionalisation, the people who delivered the services being largely politically motivated and refusing to regard themselves as mental health experts in any sense. Castel et al (1982) note that these developments did not pose any real threat to psychiatry at all. Rather psychiatry co-opted the new ideas and integrated them into its own practices, producing a further expansion of psychiatric provision. And the trend towards deprofessionalisation turned out to be short-lived as the new non-professional workers changed political commitment into career move and trained as social workers and mental health workers. Further, an unfortunate side-effect of the

counter-culture was the burgeoning of a whole new set of psychotherapies which are deliberately divorced from notions of sickness, and which offer the chance of greater self-fulfilment and realization of potential to people who are not disturbed in any sense at all.

The combination of the continuing existence of medical approaches for the most seriously disturbed, socio-psychological approaches for the less seriously disturbed, and self-improvement therapy for everyone else who wants it results in a society which is almost entirely bound up with the psy professions. There is virtually no-one who is not surrendering some aspect of their life to professional management. In Castel et al's (1982) view, we have created a huge and subtle web of forms of discipline which will organise our social relationships for us and ensure our continuing docility within the web. Castel et al come close to preferring the honest, overtly coercive but limited function of traditional institutional based psychiatry to the well-legitimated but limitlessly expanding function of community-based psychiatry in both its orthodox mainstream and 'radical' forms.

Similar sorts of view point are found in Miller and Rose (1986), who state in their introduction that all the contributors to the book share a concern about the established radical analyses of psychiatry:

> Criticisms of psychiatry as a repressive and custodial project for the control of social deviance have been influential in the move away from the segregation of the mentally distressed, and in the proposals that carceral psychiatry be replaced by a prophylactic and therapeutic endeavour co-extensive with the community itself. Criticisms of psychiatry for its failure to

> live up to its promise of alleviating mental troubles have tended to identify this failure with excessive reliance upon medical expertise, the institution of the hospital and the notion of mental illness. Such criticism has supported proposals for the establishment of comprehensive and multidisciplinary mental-health services, and for the development of such services in the territory of daily existence - the family, the neighbourhood, the school and the workplace.
>
> Whilst the contributors to this volume have no unitary perspective - political, theoretical or practical - they nonetheless share a certain unease about such critiques and the alternatives they propose. (p1-2)

These poststructuralist accounts focus attention upon an aspect of community care which other radical critics of the policy have not always made fully explicit. This is the tendency for community services not to replace more coercive, institutional services, but rather to supplement them. Providers of radical alternatives to contemporary services need to ensure that what they are proposing will provide adequate facilities for the population served by existing services, and will not simply represent an extension of the influence of psychiatry spreading out through the community alongside institutional services which prove resistant to abolition.

Conclusion

The roots of the care in the community policy date back to the period preceding the MHA 1959. In recent years, a policy of rapid deinstitutionalisation unaccompanied by a transfer of funding to services in

the community has raised the suspicion that 'care in the community' is driven by the fiscal needs of the state rather than the needs of mental health service users. The support which anti-psychiatry lent to the policy of deinstitutionalisation, on libertarian grounds, has now faded, as radical critics have turned their attention away from the critique of institution-based psychiatry and towards the critique of community-based psychiatry. This has provoked the accusation that whatever policy is chosen, the radicals will react negatively. However, radical critics of community care have offered alternative policies. Ramon, who is also known as a supporter of the Italian reforms, has suggested that Britain should adopt explicitly the American humanistic philosophy of care which underpinned the development of Community Health Centres in that country. This would reduce, but not remove, the role of medicine in community mental health care, and emphasise more fully psychological aspects of mental health, and issues of social responsibility. Another suggestion is that the policy makers need to examine more closely the meaning of community, and pay attention to creating community rather than simply assuming it to exist.

It is interesting that although many of these critics regard it as important that the monopoly of medicine in the care of mental disorder should be reduced considerably, they are not arguing that medical services should be abolished altogether. The crux of their criticisms seems to relate more closely to the kind of relationship which mental health workers of all professions should have with their clients. This is a relationship which should be characterised by mutual respect and shared power, rather than by the authoritarianism which has been characteristic of psychiatry in the past. A final important contribution is found in the work of poststructuralist commentators influenced by the theories of Foucault. These theorists have questioned whether it is

possible for medical and institutional services to be entirely replaced by the more eclectic services which some critics have proposed. There is a danger that coercive institutional services will merely be supplemented by more socially and psychologically oriented services, which would have the effect of expanding the influence of mental health professions throughout society without improving the lot of the most vulnerable and coerced individuals.

Chapter 9 The Emerging User Movement

1. Emergence of the contemporary user movement.

In a sense, the 'user movement' in mental health has existed as long as psychiatry. Throughout the history of psychiatry there have been periodic protests by patients at the way they were treated as a result of having been identified and treated as insane; for example, the nineteenth century Alleged Lunatics Friend Society (ALFS) (Hervey, 1986). The ALFS was founded in 1845. Its initial membership was five, of whom four were themselves ex-inmates of various asylums and madhouses, and one was a relative of persons who were confined as lunatics. These five were all middle class men of influence, who were able to make their views heard to some extent in government. The most important was John Thomas Perceval, the fifth son of the assassinated prime minister and younger brother of Spencer Perceval, the Metropolitan Lunacy Commissioner. Between 1845 and 1863, the ALFS campaigned and lobbied Parliament with some success to improve the legislative provisions for the protection of civil liberties of persons identified as insane. The ALFS has frequently been regarded as narrowly legalistic in its aims, being primarily concerned to prevent the improper detention of persons in asylums and madhouses (Jones, 1960). However, this view does not reflect adequately the Society's role in seeking to influence the way in which lunatics were perceived and treated within the asylums; for example, the Society disputed the validity of the moral treatment approach, arguing that by implying that the mad needed re-education this approach perpetuated the view of lunatics as sharing the status of children (Hervey, 1986:245,254). Thus, although the ALFS was primarily concerned with the protection of civil liberties by legalistic means, it also shared the interests of anti-psychiatry and the present day user movement in questioning contemporary conceptualisations of the nature of madness and its correct treatment. Indeed, its more visionary views on the care of the insane contributed to its limited influence in terms of achieving actual change, as even people sympathetic to the campaign for legal safeguards tended to view the Society's views on the treatment of insanity as extreme and unreasonable. (Some of these views, such as the idea of patients of opposite sexes being encouraged to mix with one

another, do not strike us today as extreme or unreasonable at all!) The ALFS differed from present day user groups in that its greatest impact was upon legislation, and its membership consisted largely of middle class persons in a position to influence the legislative process. The Society did not attract the broad base of support and involvement of ordinary patients which characterises the present day user movement throughout Britain.

A further example is Johnson and Dodds' (1958) A Plea for the Silent, a collection of accounts of ordinary people's experiences at the hands of psychiatry which was published at the time of the debates preceding the MHA 1959 (see Chapter 2). Johnson, himself an ex-psychiatric patient, produced the only speech during the debates which expressed any real awareness of or sympathy for the patient's viewpoint. However, the formation of organized groups of patients and ex-patients, existing to provide mutual support and services and to campaign on issues of psychiatric patients' rights is very much a phenomenon of the last two decades.

The reasons for the recent emergence of the user movement in its different forms are multiple. Firstly, as has been discussed (Chapter 1), the MHA 1959 was the first piece of legislation since legislation began to acknowledge the capacity of psychiatric patients to exert some control over their own lives. The conflict between what the 1959 MHA regarded as the legal status of patients in relation to doctors, and the nature of the doctor-patient relationship as many patients experienced it, perhaps made it inevitable that patients' organisation should be formed in an attempt to

compel medicine and society to afford such patients the rights they deserved.

Secondly, the care in the community policy placed many patients at greater liberty than they would have experienced in earlier years, and such liberty allowed more organised resistance away from the negative control which medical staff would have exerted had their patients begun to form groups within the old authoritarian institutions. Indeed, their is ample evidence in the user movement literature of medical resistance to having organised groups of users 'meddling' with medical policy within institutions. Campbell (1986:9) has commented:

> It is one thing to lock people away and treat them badly when separated from real life. It is another to let people live among their peers and then discriminate against them.

Thirdly, recent decades have seen a general improvement in the level of education in the general population. The gulf between service users and service providers, and medically qualified and non-medically qualified service providers, is not as great as used to be the case. Some users, at least, now feel articulate and confident enough to protest at the treatment they receive at the hands of medicine.

Fourthly, the last two decades have seen a general growth of suspicion at the interventions of technological medicine and welfare, and a general interest in producing grass-roots, non-paternalistic forms of service delivery. Mayer and Timms' (1970) classic study, which revealed the perceived irrelevance on the part of social work clients of services

delivered, marked the beginning of a new interest in researching clients' own views about the degree to which the interventions to which they were subject were helpful. There is evidence of a mounting willingness on the part of welfare agencies to take client views into account; for example Sainsbury's (1983) discussion of the importance of client studies for improving social work practice. Early studies tended to focus upon the client's rating of satisfaction in respect of services received. However, it is increasingly being recognised that 'satisfaction' is an inappropriate measure to use to assess welfare clients attitudes towards services, as, realistically, clients are generally involved in welfare provision as a result of circumstances beyond their control, and whose outcome could never appropriately be termed 'satisfactory'. Fisher (1983) has argued for the replacement of the concept of 'satisfaction' with that of 'moral sanction'. Moral sanction indicates that the client, although not properly describable as 'satisfied', acknowledges that the actions of the welfare worker were reasonable and appropriate. This represents an emerging awareness amongst social workers that their client group consists of people who not only have valid opinions and information to offer, but often do so from a position of relative powerlessness. This is a theme which will be returned to below. Since the mid-1980s, MIND's platform has been based upon the promotion of user involvement in service planning and provision. In addition, the Conservative Government which has been in power since 1979 has, as part of its general free market strategy, attempted to depaternalise welfare delivery, and cast recipients in the role of consumers: a strategy which has met with a mixed response among more radical critics of service delivery, as will be discussed below.

And fifthly, the radical critiques of the 1960s and 1970s, addressed specifically towards psychiatry, have provided a theoretical rationale for the user movement's resistance of medical autocracy.

The early user groups, which emerged at the beginning of the 1970s, are characterised by a similar division to that into which anti-psychiatry had by then fallen (see Chapter 4); that is, those who wished to see widespread availability of psychotherapy, and those who aimed a political, usually Marxist critique, at the whole therapeutic enterprise. People Not Psychiatry (PNP) and the Mental Patients' Union (MPU) provide extreme examples of these alternatives.

PNP was a non-hierarchical support network, begun in London in 1969, which clearly drew its rationale from the Human Potential/Growth Movement new therapies (Barnett, 1973). Laing, Cooper and Szasz are quoted by Barnett alongside names such as Perls, Maslow, Rogers and the encounter therapists. These therapists are all perceived as having rejected the positivist 'scientism' of conventional psychiatry, psychology and social science. Anti-psychiatry is perceived as a rejection of utilitarianism, and a return to the values of wholeness and authenticity. These are expected to lead to a set of values which are 'intrinsic and eternal' (Barnett, 1973:99). PNP does, therefore, regard a non-oppressive form of psychiatry as possible, rooted in the Human Potential or Encounter Movement, which provides an alternative to 'corrective psychiatry' (Barnett, 1973:12). The advantage of these approaches is found in their not being concerned with adjustment of the individual to society as it exists, but with:

> the growth of human beings <u>continuously</u>, the release and realization of more and more potential. This will take them . .

> beyond the needs and requirements of their social existences, resulting, ultimately, in the formation of a different kind of society based on their higher values. (Barnett, 1973:152)

In short, PNP drew heavily upon the values of the counter-culture which were popular at that time. Its rationale was that individual personal development would lead to the evolution of a more caring and equal society. The group received the kind of criticism which was directed at the Growth Movement in general by more politically committed opponents of medical psychiatry. Pearson (date unknown:5) describes PNP as 'Arcadian'. It is based upon a romantic longing for a 'Golden Age when people gathered around distress as good neighbours'. The organisation will doubtless offer a limited amount of help to a small number of people, but 'it has no political significance'.

As Pearson indicates, PNP has serious limitations as a viable alternative to psychiatric care. Barnett acknowledges that the network encountered very few people who had been diagnosed schizophrenic, and that he had doubts about their capacity to provide assistance for these people (Barnett, 1973:99). He also described one occurrence when a resident at one of PNP's houses had become intolerable to his fellow residents because his behaviour was so difficult. The resident in question, Robin Farquharson, was finally picked up by police and admitted to hospital before the community had finally taken the step of excluding him. His room was then quietly relet to someone else. The impression given by Barnett is that this outcome was a source of great relief to all concerned, although it ended with Farquharson being returned to the care of positivist and corrective psychiatry (Barnett, 1973:194-6).

The MPU was a quite different kind of organisation. The MPU grew out of the Paddington Day Hospital, a radical therapeutic community in London. A pilot committee of patients and ex-patients met in December 1972 and drew up a pamphlet called 'The need for a mental patients' union'. The committee organised a meeting to be held at Paddington Day Hospital on 21 March 1973. This meeting was attended by 150 people from all over the country, of whom more than 100 were patients or ex-patients. This meeting decided that only patients or ex-patients would be accepted as members of the Union, but others could be accepted as associate members without voting rights. The MPU was to be a national organisation, but local groups should be set up which would operate autonomously. A Declaration of Intent was subsequently drawn up and passed at a second General Meeting (Durkin and Douieb, no reference available).

The MPU's stance was informed by a similar Marxist-based social control theory to that adopted by professionals described in Chapter 4 (and see Proposition 2, Chapter 1). The pamphlet drawn up by the pilot committee in late 1972:

> took the view that 'psychiatry is one of the most subtle methods of repression in advanced capitalist society'. It asserted a direct link between psychiatry and class repression - 'the heavy weapon of psychiatry, like many others, is held at the heads of the working class in order to control them.' (Durkin and Douieb, p 177)

The symptoms of 'mental illness' were theorised as both genuine distress which was the product of class based oppression, and political dissent which was medicalised in order that its real significance be mystified and disguised. The MPU's short-term aims included the abolition of compulsory

hospitalisation, the abolition of irreversible forms of treatment, rights to refuse treatment, to view case notes, to appropriate levels of privacy within hospitals etc. However, the long-term aim of the MPU was total reform of capitalist social structures, which was expected to remove the need for psychiatry in any form by removing the social oppression which is the root cause of mental disorder. That is, the MPU adhered also to Proposition 3 of those listed as anti-psychiatric in Chapter 1.

> We believe that the EVENTUAL ABOLITION OF MENTAL HOSPITALS and the institution of REPRESSIVE AND MANIPULATIVE PSYCHIATRY is possible, but ONLY IF SOCIETY IS RADICALLY CHANGED, for what is known as 'MENTAL ILLNESS' IS A SYMPTOM OF A DEFECTIVE AND SICK SOCIETY. (MPU Declaration of Intent, quoted in Durkin and Douieb)

Thus, the MPU did not see its role as being the provision of alternatives to psychiatric hospitalisation. It did acknowledge that, as long as the current social structure remains, people will continue to suffer distress, and proposed that houses should be set up to offer refuge to such people. But such houses were not intended to offer alternative forms of therapy to mainstream provision. They were to be non-hierarchically managed, run and controlled by patients without divisions into patients and professionals of any kind, including social workers and community workers, and they were intended to function as holding operations pending the socialist revolution.

A similar perspective is revealed in an interview with members of the Hackney MPU (Martin, Roberts, Roberts, and Johnson, date unknown). The members of the MPU acknowledged that there may be a need for some forms of therapy in the present, viewing it as idealistic to think in terms of

social change without addressing problems as they exist in contemporary society (Val Roberts). However, they took the view that therapy cannot solve the problems at the root of people's distress, because the true causes of distress are social factors such as uninteresting work and poor housing (Andrew Roberts).

Sedgwick (1982:228-9) has identified the problem with all the user-led organisations which emerged at his time, both in Britain and in American and Europe, as being their absence of proposals for alternative provision. He considers that, by failing to offer support to programmes being set up outside the mental hospitals, patients' groups 'condemned themselves to a permanently defensive role within the framework of the institution'. Their critiques were unable to address the changing nature of psychiatric provision. However, the patients' groups strategy does make sense if one takes into account their belief that all distress is the fault of capitalism, and will cease when capitalism ceases. Then commitment can be made to a strategy of supporting the bare minimum of care, which will itself become unnecessary in a socialist society.

The 1970s saw the development of a series of patients' rights groups, mainly centred around London, and closely related to one another. 1973 saw the foundation of COPE, the Community Organisation for Psychiatric Emergencies. COPE appears to have been less explicitly wedded to a Marxist analysis than the MPU, and less enmeshed in the Growth Movement than PNP. It regarded itself as a crisis support service which operated on a non-professional, non-hierarchical basis, and whose purpose was to prevent admissions to mental hospitals. It provided a telephone help line service, a drop-in, and alternative accommodation for people in crisis.

Members consisted of both patients and ex-patients and professionals, but those professionals who were involved were committed to COPE's non-professional principles (COPE Collective, date unknown.) In the late 1970s, COPE changed its name to EPOC. In the early 1980s, remaining members of EPOC and the MPU combined to form PROMPT (Protection of the Rights of Mental Patients in Treatment). In 1985, PROMPT became CAPO (Campaign Against Psychiatric Oppression) (Ticktin, 1991:31). CAPO is still in existence and currently providing the most strident voice in the user movement as a whole. CAPO continues to adhere to substantially the same Marxist analysis as the MPU, and borrowed parts of its manifesto directly from the MPU's earlier pamphlet and declaration of intent:

> Psychiatry is one of the most subtle methods of repression in advanced capitalist society...The "mental patient" is a sacrifice we make while we serve the gods of the Capitalist Religion.
>
> The heavy weapon of psychiatry, like many others, is held at the heads of the working-class in order to control them... Together with other oppressed groups, victims of psychiatry, through an organised Campaign Against Psychiatric Oppression must take COLLECTIVE ACTION and realise their power in the class struggle. (CAPO, date unknown)

Perhaps if the views of these descendants of the MPU have changed at all over the years, it is in so far as they are less confident of the imminence of socialist revolution, and therefore their contingency plans are expected to last for longer.

If CAPO represents the continuation of a user-led tradition of anti-psychiatry dating back to the early 1970s, then there is ample evidence of

new developments amongst users which owe less to the earlier militancy of the MPU. In 1985, the Mental Health 2000 Conference was held at Brighton. This was an event at which users from England and Wales were conspicuous by their absence, although represents were present from the Dutch patients' movement and the American patients' rights movement, including Judi Chamberlin. Subsequently, several developments were instigated in England. Nottingham patients' council was set up, based on the Dutch model. Survivors Speak Out (SSO) was set up to provide a national co-ordinating body for individuals and groups in England and Wales who were interested in self-advocacy. In 1987, SSO organised a national conference at Edale in Derbyshire. By 1988, the network had a membership of about 200, of whom more than two thirds were themselves service users and less than one third 'allies'. Currently, membership stands at approximately 300, of which rather less than a third are allies.

The contemporary user groups are larger than the groups of the 1970s and constitute a far 'broader church'. Also, their policy is to promote the user voice whatever that voice is saying, rather than to produce a universal political manifesto on which to campaign, as CAPO has done.

In addition to the user led groups, there are some examples of user-professional coalitions. A notable example was the British Network for Alternatives to Psychiatry (BNAP), the British branch of the European Network for Alternatives of Psychiatry (ENAP) which included David Cooper and Franco Basaglia amongst its members. This was primarily a discussion and campaigning group. It was an interesting group in terms of the influence of European ideas. The group ceased to exist in the mid-1980s, shortly after David Hill joined. Hill subsequently set up the London

Alliance for Mental Health Action (LAMHA), which has taken over BNAP's role.

Also of relevance in the context of user groups is the extension of the phenomena to the setting up of support and campaigning groups to represent relatives and carers of people who suffer from mental illness; for example, the National Schizophrenia Fellowship (NSF). The NSF was founded in 1972 as the result of a report in the Times of one parent's experience of attempting to gain effective support in caring for his son, who had been diagnosed schizophrenic. The initial report produced a flood of letters from relatives and carers who had had similar experiences, and the NSF was established as a support network. The NSF has been vilified by other groups, such as MIND, for its campaigning platform, which has been perceived as pro-medical model and anti-patients' rights and community care. Hostility towards the NSF reached its highest point during 1988-9, as a result of the NSF's support of Schizophrenia A National Emergency (SANE). SANE is a charity which was established in 1986 by journalist Marjorie Wallace, with the financial support of her employers, News International, and the Burton Group. The charity is committed to a disease model of schizophrenia, and exists to raise funds for biochemical and medical research. In 1989, it ran a publicity campaign which included hoardings bearing a close up photograph of an unshaven and staring-eyed man. Over the image was superimposed the caption, 'He thinks he's Jesus. You think he's a killer. They think he's fine.' MIND objected to the campaign on the grounds that it represented a stereotypically negative image of sufferers of mental illness, and was damaging to them. The Advertising Standards Authority agreed that the campaign could cause offence, and it was withdrawn. It has been reported that the NSF were as

shocked and disturbed by the emotive nature of the campaign as were other mental health organisations (Bartlett, 1989a). However, the NSF and SANE have acquired similar reputations amongst more radical commentators within MIND. Chris Heginbotham, ex-director of MIND, regarded both the NSF and SANE as promoting a view of mentally ill people as dangerous. David Hill has been outspokenly critical of both organisations (Bartlett, 1989a; Bartlett, 1989b). At times, debate between members of the NSF and members of MIND has degenerated to the point of personal abuse. However, there is some evidence that, to the extent that this predominantly negative portrayal of the NSF was ever valid, the organisation is modifying its outlook. Bartlett (1989b) reported that the NSF and MIND were attempting to work more closely together.

2. What is the theoretical underpinning of the contemporary user movement?

Theoretically, the only concern which unites users at present is the desire to make their voices heard and be taken account of when professionals and policy makers are determining their fate. It is this concern which underpins the strategies of advocacy and promoting user participation in planning and delivery of services. The emphasis upon individual personal experience, over and above theoretical or political manifestos, is reflected in the range of personal accounts of users' experiences of the services being published during the last two decades (for example, Sutherland, 1976; Millett, 1991).

Within the groups, opinions differ widely as to what innovations ought to be made in service provision. Specifically, views differ along two dimensions). Firstly, there are differences in terms of the perceived

causes of mental illnesses and most appropriate forms of intervention. In general, the user movement as a whole tends to regard mental illnesses as social and psychological in origin, and regards psycho-social interventions as most appropriate (although this view is not universally representative of all users; for example, see Sutherland, 1976). An interesting example is the promotion by a London based user group, Lambeth Link, of the work of Dr Marius Romme. Dr Romme is a Dutch psychiatrist, who has come to believe that hallucinations normally associated with a diagnosis of schizophrenia are not necessarily pathological. Indeed, he has found some evidence that there is quite a widespread experience of hearing voices within the 'normal' population, which never comes to the attention of psychiatrists. People who hear voices in this fashion, divorced form other forms of symptomatology, have usually developed their own explanatory framework, within which they can integrate the voices into their daily lives in such away that they experience no negative effects and may even regard the voices as a positive and life enhancing phenomenon. Dr Romme has hypothesized that it may be possible to use the insights and coping strategies of 'normal' voice hearers to assist 'schizophrenic' voice hearers to develop their own coping strategies, rather than adopting the traditional medical approach of using medication to control the experiences. Lambeth Link organised a conference in London at which Dr Romme presented his views. This resulted in publicity in the British media for the approach and the establishment of a support network for people who hear voices (Anonymous, 1991).

However, there is a variety of opinions amongst members of user groups about the efficacy and overall value of treatments such as psychoactive medication and ECT.

At the opposite end of the psycho-social/physiological, the NSF is highly committed to the view that schizophrenia will ultimately be revealed to result from abnormal brain function of a relatively gross nature, and is therefore properly a medical concern, albeit with psychosocial dimensions. Marjorie Wallace is sufficiently convinced of a genetic causation for schizophrenia to have suggested that if such faulty genetic material is identified, this would make possible termination of pregnancy as a preventative measure (Wallace, 1986). In accordance with its view that schizophrenia is a predominantly physical disorder, the NSF regards more effective medication, regularly administered, as the best hope for sufferers (Bartlett, 1989b). These differences of approach are a major basis for disagreement between the NSF and user groups.

The second dimension along which users' opinions vary, and a dimension which poses more difficult issues for the unity of the user movement, is the extent to which users ought to co-operate with professionals. I have identified four different 'ideal types' of attitude to the user-professional relationship, which relate to attitudes towards psychiatric expertise. Firstly, there is the attitude which is usually portrayed as the traditional 'medical model' attitude. This attitude is characterised by the view that the doctor, or other mental health professional, is the acknowledged expert who makes the decisions. The patient/client has nothing to contribute and is simply a passive recipient of professional wisdom. This attitude is the one sometimes, perhaps justifiably, believed by critics of psychiatry to characterise the average psychiatrists' outlook. The extent to which this is in fact the case will be examined in chapter 10. Here it is simply necessary to note that this attitude is not, by definition, found amongst members of user groups. It is, however, more

characteristic of the NSF. The NSF accept the current ignorance of mental health professionals in the face of schizophrenia. However, because they assume that this current ignorance will eventually be resolved in the direction of a full understanding of schizophrenia in terms of brain biochemistry, there is a tendency to approach issues of individual rights and user-control as though it was known that schizophrenia is a brain disease, which seriously limits autonomy, and, therefore sufferers merit paternalistic protection. For example, the local NSF co-ordinator emphasized the importance of research, meaning primarily medical research, which would ultimately provide the doctors with sufficient technological expertise to cure the condition.

> There needs to be more research into the workings of people's minds and how the brain functions...because if we understand exactly...some of the things that might have gone wrong with the person because of the malfunction say then that can help you to understand why the sufferer is behaving in a certain way.

Their tendency towards paternalism is also the result of their role as relatives and carers of people, and their intuition that they could perform these roles more effectively if they themselves had more power to intervene in controlling their distressed relatives' lives. The NSF co-ordinator's views were directed towards protection of the patient rather than protection of civil liberties. In fact, the implications of her position for the civil liberties of individual patients were not clearly developed; for example, she rejected the proposal that large numbers of people would be 'locked up' to protect the public, but suggested that they did need

'secure accommodation'. She was then unclear about how 'secure' such accommodation ought to be.

> [They] should be in sheltered accommodation, carefully monitored, looked after very nicely, given all the things that make people better...But I think [they] have to be monitored. Just in case [you] do maybe have one person who goes berserk occasionally...

I asked whether she thought people in such accommodation should be free to come and spend time as they wished, including engaging in behaviour in public which was disturbed and drew attention to them.

> I don't think it's nice for them to do that...What you're really saying is is it better for them to do that somewhere where they're locked up, or is it better for them to do it outside. I don't know. I don't know how to resolve that one.

In general, the NSF co-ordinator emphasized the need for relatives and carers to be assisted in caring for their dependants rather than the patients' rights to non-interference. In particular, this related to information being passed from professionals to relatives and carers. She had herself experienced periods in caring for a disturbed relative when she felt her ability to offer support was undermined by not having been kept fully informed by professionals. However, the NSF is becoming less paternalistic in its approach, and has itself recently founded a daughter organisation, Voices, to provide a forum for users within the NSF. In addition, and differing from NSF national policy, the local NSF co-

ordinator did not support plans for a Community Treatment Order, believing that this did constitute an invasion of personal liberty, although she was very concerned about the effects on individual patients and on public opinion of people who did not voluntarily continue taking their medication.

The second attitude, which is probably more widespread amongst mental health professionals, regards mental health workers as professionals, but acknowledges that to do their job effectively requires not only scientific expertise, but direct access to the needs and requirements of patients/clients. This view regards users as an invaluable resource in terms of information which will make mental health services more effective. This is the view of user involvement typically adopted by the government, in its effort to view welfare service recipients as 'consumers'. Dorrell (1990:6), summarizes the government view. Consumer involvement is portrayed as being primarily a matter of gathering opinions about what sort of provision would be acceptable to users. Provision itself is regarded as a matter for professionals, and not something in which users will be directly involved in either a day-to-day decision-making capacity or as actual providers. The differential access to power between 'user' and 'professional' is thus preserved intact. Also significant in terms of government policy is the fact that 'consumers' includes not only direct users of the services, but also carers. The inclusion of carers indicates the extent to which this approach is essentially about market research, rather than about the redistribution of power. This view is also not uncommonly found amongst social work professionals, as was discussed in section 2 above. It also characterises to some extent the outlook of the NSF, although NSF members have tended to regard themselves, rather than their user-dependents, as the most appropriate providers of information

about what kind of care is most helpful. The local NSF co-ordinator regarded medicine at present as inadequate to the problem, and relatives as the best people to advise as to the sufferer's treatment, as is illustrated by the following exchange:

> NSF Local co-ordinator: The younger generation of GP's recognise symptoms and signs but only have three months in psychiatry. At the other end, the specialists, the consultants can only go on experience and what they have perceived in the past.
>
> Ann Claytor: Do you thinks the average consultant's got more ideas what he's doing than you have?
>
> NSF LC: No. He might know the names of all the drugs but...At first I would have said that, but not now.
>
> AC: Why do you think that is?
>
> NSF LC: Because I spend more time with people. They only spend five minutes with each individual patient. You live with the patient on a 24 hour basis, so you get a far greater insight.

She also reported a series of incidents in which she felt that doctors had ignored and pathologised her viewpoint, treating it as evidence of a need to be over-protective towards her relative. This ended in her relative finally making a suicide attempt which she felt could have been prevented if her opinions had been taken seriously.

Although the NSF is perhaps changing and becoming more accepting of the importance of the view of the service user, it is likely that it will continue to be primarily an organization which exists to promote the rights of relatives and carers. The NSF local co-ordinators closing comments were:

> What I'd really like to say is that relatives and carers aren't lockers up, the only time our people are put in hospital is when we're desperate and their desperate, and we're not calling for the hospitals to be kept open just to lock people up, it's until there's something in place. And if you met a lot of our relatives, they're just ordinary people, very nice families who are not schizophrenogenic mothers and we're not over-protective and I don't believe in Bateson's double bind, none of us believe in that, just treat us in the same way they would treat the people who are being looked after, with a bit of compassion and understanding, because we all need that.

The third attitude is typified by the rights and advocacy approach to psychiatry. This approach is highly sceptical of the claims of mental health workers in general, and psychiatrists in particular, to possess any real expertise. It assumes that users are by and large the best people to determine their own self-interest, and frequently need to be protected form the interventions of the psychiatric services. The term 'consumer' is rejected, as suggesting that users are within the services out of choice, rather than necessity. This view probably typifies most user group members. An example of a group which adopts this approach is Survivors Speak Out (SSO). 'Survivors' refers to members status both as survivors of mental distress and survivors of a psychiatric system which is,

frequently, regarded as having made things worse rather than better. SSO regards itself as a self-advocacy network; that is, it exists to facilitate communication between individuals and groups involved in the promotion of self-advocacy in mental health. An SSO self-advocacy 'pack' (Survivors Speak Out, date unknown) defines self-advocacy as:

> people speaking and acting for themselves...
> Self-advocacy is about power - about people regaining power over their own lives. The psychiatric system in this country seems peculiarly designed to deny power to hose who enter it (or are sent into it) for help. (Survivors Speak Out, date unknown:1)

Clearly, there is a gulf between this awareness of traditional psychiatry as disempowering, and to be challenged, and the view that the contribution of service users is to enable the professionals to run a better service. The difference is that the SSO strategy aims at a redistribution of power, whilst the consumer involvement strategy does not. Survivors Speak Out (date unknown:3-4) acknowledges that the acceptance within the NHS of a consumerist ethic is desirable, but regards this with some cynicism, concluding that:

> Just because you are asked to address a group of social workers doesn't mean the world is at your feet. The power of the system we seek to change is immense.

However, SSO does recognise the necessity of working with professionals who share their aims. They do not adopt a separatist stance, recognising the value and necessity of professional support if a comprehensive service is to be produced and maintained (Survivors Speak Out, date unknown:15-6).

Also, SSO as an organisation has not adopted a policy on the abolition of compulsory treatment, and a charter drawn up by the SSO conference in 1987 did not include abolition of compulsory treatment amongst its needs and demands. That is, SSO as an organisation is not committed to Proposition 9 of the anti-psychiatric attitudes, Chapter 1. My interviews indicated differences of opinion amongst influential members of SSO in this respect, Peter Campbell believing in the need for some compulsion and Mike Lawson arguing for its abolition. SSO as an organisation is quite radical in its proposals in terms of its vision of the redistribution of power within services, but does not envisage a situation in which professional mental health workers could be abandoned.

Steve Ticktin (interview) thought:

> SSO is not really a campaigning group. It's more of a sort of umbrella group of survivors of the system who are coming together and trying to encourage sharing information, mutual support, and encouraging development of what they call self-advocacy groups in different parts of the country...I wouldn't call them anti-psychiatry, and I wouldn't think that they would want to be called necessarily anti-psychiatry. Certainly they're critical of psychiatry as it has existed so far. They very much want to enforce the user voice in psychiatry.

Peter Campbell is perhaps the interviewee in my group who best represents this picture of SSO. Campbell (1986:9) is highly critical of the imbalance of power which characterizes psychiatric provision, but is not uniformly opposed to psychiatric interventions. He writes of drug treatments:

> Since the drugs revolution of the 1960s and the introduction of psychotropic (mood-changing) drugs, it has become more and more possible for people with mental health problems - even those diagnosed in psychiatric terms as suffering from severe psychotic illnesses - to live most of their lives within the community. [NB He may have altered his position since then - compare interview]

Campbell (interview) is primarily associated with SSO, although he also has links with LAMHA (and before that had links with BNAP) and MINDLINK. He identified LAMHA as more politically radical than SSO. SSO tended to campaign around issues of self-advocacy rather than particular issues. The only issue upon which SSO has a policy is compulsory treatment: the organization is opposed to the introduction of Community Treatment Orders. Campbell disagrees with Szasz's views, perceiving him to be overly libertarian. However, he acknowledged the influence of Laing, dating back to the 1960s, and consisting largely of a perception that Laing appeared to be on the side of the person having the unusual experiences.

> Trying to restore some value to the experience is his major importance for me. to say perhaps the experiences these people are having are not totally negative. There's more to them than meets the eye and [you] have to listen to get inside the experience of the so-called mentally ill. That's his main contribution to me.

Campbell noted that Laing's views were not unitary, but had changed and developed substantially over the years:

> [His] supposed elevation of the experience of the so-called mentally ill to some kind of inherent spiritual value or some

> kind of superior value, really that the so-called mentally ill are actually the sane people, having wonderful valuable experiences which other people can't have - that I don't go along with really. It tends to give the impression that people are having some kind of very positive experience which is being denied them. Actually most people are in a great deal of distress and want to be part of society.

A particularly interesting aspect of Campbell's viewpoint is that he agrees with Szasz's statement that 'mental illness is a myth' (Proposition 1, Chapter 1), but:

> [I] don't think necessarily for the reasons that Szasz seems to suggest.

Campbell was familiar with Clare's (1976) discussion of the nature of mental illness in 'Psychiatry in Dissent', and also with Sedgwick's (1982) arguments.

> [Clare's] discussion about the whole question about illness - models of mental illness and physical illness - and Sedgwick too: it seems there is a very complicated argument about what exactly illnesses are, and I don't go along with what I take to be Szasz's explanation, which I think is a bit simplistic. It seems he's saying illness is something to do with the body and the mind is not an organ of the body, therefore it can't - which I think is playing with words.

However, Campbell continues to refer to 'so-called mental illness'. His explanation is that he questions the value of approaching this set of problems in terms of illness; that is, in a way which encourages a physiological, medically-based mode of treatment.

> [There is] the whole question of what are the results, consequences of saying yes, these things are illnesses. It seems to me that in a way is separate - obviously not totally separate, but in some ways a different concern because whether or not there are intellectual or scientific justifications saying these things are illnesses, in fact by saying they are illnesses therefore it seems to me that, you are saying that medical solutions are going to predominate. It seems to me that medical solutions aren't working. So I question the whole idea of mental illness and I do always say so-called mental illness or whatever. But I think mental illness exists, I mean it has a social reality. It's quite clear. But I think that part of its reality is to do with a myth. Part of its reality is not scientifically based, it's based on cultural ideas, social, all the rest of it.

In other words, Campbell acknowledges openly what is implicit in the thought of more anti-psychiatric users and professionals: handicapping psychological states are a reality, and it is not improper, in the sense that Szasz thinks it improper, to term them illnesses. The objection to the expression 'mental illness' is not that such states are themselves mythical, but that their supposedly ultimately organic nature is mythical. Campbell is identifying himself explicitly with a socio-psychological view of aetiology which is implicit in the views of many of the other people interviewed by this thesis; for example, Ticktin and Hill.

Campbell's other views corresponded with his approach to the epistemological status of mental illness. He did not believe that psychiatry was intentionally a form of social control, although it does

certainly have the effect of controlling and oppressing individuals. He also regarded institutional psychiatry as coercive even when the patient is theoretically and legally in hospital voluntarily, as for even these patients the threat of coercion remains. He was, however, aware of recent research which suggested that most voluntary patients do not experience hospitalisation as being against their will. In addition, he thought that institutional psychiatry was coercive not just because of the threat of compulsion, but because of the imbalance in perceived authority between patient and doctor and the stigmatising nature of the disorder itself.

> What I'm saying is someone who has a problem that is categorized as being a mental illness problem is going to feel in a particularly negative way about themselves, going to feel devalued, lacking in humanity, all these things. Their status as a person is called into question consciously or unconsciously because of the way we look upon that particular experience. So therefore you have a relationship with power imbalances, but also one party has fallen from the pedestal of humanness, if you like.

Campbell supported provision of alternative, non-medicalised acute services, but saw them not as an absolute alternative to medical psychiatry, but as existing alongside some kind of medical provision.

> I think I would see a kind of gradation of services. And yes, hopefully that...you would have non-medicalised acute services available, and maybe you would have to have medicalised acute services, but where those would be I'm not sure.

Plainly, Campbell would prefer even the remaining medicalised services to have as little association as possible with mainstream physical medical services. In accordance with his view that distress is primarily socio-

psychological in origin, Campbell believed much distress could be traced back to social oppression, and this was obviously so because of the particular groups in society who are most prone to distress.

Campbell did not favour abolition of particular forms of treatment, such as ECT (Propositions 7 and 8, Chapter 1), because that would restrict people's choice. Rather, he favoured greater provision of information on the basis of which people could make an informed choice. Neither did he favour abolition of compulsory admission, although notably he distinguished between admission and treatment, being less certain about the propriety of compulsory treatment. That is, he was clear that it is occasionally necessary to restrain people in their own interests, but less clear that he would reject Proposition 9, Chapter 1, which states that compulsory treatment should be abolished.

He did not share Szasz's view that people all to be held responsible for their actions at all times (Proposition 11, Chapter 1).

> In a legal sense and in an ordinary sense, I would say no to both. [That] comes from my feeling about how I would wish people to respond to things that I've done. Friends and other people when I've been in distress. [There's the] question of not wanting to deny responsibility, but I also think that I would ask friends to make allowance for some of the things that I may have said and done in regard to them when I was in distress, so I think I'm saying on a personal everyday level that I would want people to not put the full burden of responsibility on me. I think in a legal sense probably ultimately I would say the same.

Campbell had interesting views also about the involvement of doctors in treatment of distress, rejecting Proposition 4, Chapter 1:

> [I] would like to see doctors being involved. I'm not sure about psychiatrists...If you actually got rid of psychiatrists and had...doctors who dealt with the physical side of things and other groups of workers who dealt with the other side of things, and didn't have this group of people who seem to be messing around in a whole lot of things...a lot of us are very interested in things like vitamins and nutrition and herbal therapies, all this sort of thing, like Mike Lawson condemns psychiatric medication, but takes a lot of remedies of other kinds. So it's a question of not rejecting the appropriate skills of a doctor or expert or whatever.

An interview with two local members of SSO revealed them also a critical of psychiatry as it exists at present, but not pro-abolition. They described SSO as existing to enable people who've been through the system to speak out about their experiences and get things changed. SSO was said to be against ECT (Proposition 7, Chapter 1) and the introduction of a Community Treatment Order. These two members were highly suspicious of the use of drugs, believing them to be administered by trial and error, in ways which were potentially damaging. In general, they thought more psychological approaches preferable. However, they were not in favour of the total abolition of drugs (Proposition 8, Chapter 1). Broadly speaking, they protested less about the existence of particular forms of treatment than about the tendency of the existing system to administer 'blanket' approaches, not properly tailored to the needs of individual patients. Similarly, they were not opposed to the use of compulsion (Proposition 9),

provided it was used appropriately in the interests of the client. They believed it was good that people should be held responsible for their actions as far as possible, but would not adhere rigidly to such a position (Proposition 11, Chapter 1). They were aware that CAPO had separated itself from SSO because of differences in outlook.

In general these two local survivors were less clear and consistent in their views than the better known, and probably better educated, nationally known names. However, their responses were informed by extensive personal experience, and were non-ideologically and pragmatically derived.

This perspective is also that which has been adopted as MIND's official policy since its involvement in campaigns for legal reform during the early 1970s. Gostin (1990) reiterated his views on mental health and human rights for Open Mind. When Stephen Dorrell outlined the government position on consumer involvement in Open Mind (Dorrell, 1990; 6), Vivien Lindow replied offering a user-based perspective, and argued that, if it was to consist of more than window-dressing, consumer involvement must result in a pronounced change in the status of consumers within services.

> [C]ommunity Care is transplanting the hierarchy of power, with service users powerless at the bottom, straight into the community...Many of us object to the term 'consumer' because we are never given choices. (Lindow, 1990:6)

MIND has also produced guidelines to assist its own local organisations, and other groups, to promote user involvement which will empower users, rather than maintain the status quo (Wallcroft, date unknown:9; Hutchison, Linton and Lucas, 1990).

A further indication of the difference between the 'consumer' approach and the 'survivor' approach is found in the perceived benefits of participation. The main motive of the consumer-involvement approach is gathering of information; however, their may be an added assumption that participation is beneficial because it is 'therapeutic'. For example, Brotherton (1988:799) reports:

> John Hart, a speaker at the GLACHC [Greater London Association of Community Health Councils] seminar, suggested that it is therapeutic for people to be able to express their feelings about the services they use. It is even more therapeutic, he added, if suggestions are acted on.

MIND's 'user involvement pack', however, cautions against embarking upon a policy of user involvement primarily in the belief that it will prove therapeutic:

> To invite people to participate because you consider the exercise to be good for them is a patronising attitude which, at best, may not lead to action and, at worst, may alienate people. (Hutchison et al, 1990:4)

BNAP is also perhaps best placed within this category, as it consists of a user/professional alliance, albeit one which is committed to democratising services and reducing the power imbalance between users and professionals. Interestingly, the BNAP grew out of the ENAP, which was set up with the involvement of David Cooper. However, the BNAP does not properly belong in that category of groups which would abolish psychiatry. Rather, it would support a democratised, politicised and de-therapeutised approach along Italian lines. Shulamit Ramon, who has been largely responsible for the dissemination of information about the Italian reforms in Britain, was a

member of BNAP. A related development was the establishment in 1986 of <u>Asylum</u>, a magazine for democratic psychiatry, published in Sheffield to provide a forum for debate open to both users and professionals.

The fourth attitude rejects on principle any claim by mental health professionals to exercise expertise in the area of mental distress. This attitude results in a rejection of any user/professional relationship, and is thus profoundly anti-psychiatric. The British group which comes closest to embracing this view is CAPO. However, individual members of SSO and some user representatives within MIND may also be found to express it. Mike Lawson is highly opposed to professional therapeutic interventions. Lawson has been involved with the anti-psychiatry movement in London since the early 1970s, and acknowledges some influence from Laing, Cooper, Szasz and Chamberlin. Lawson lived in a Philadelphia Association house for about a year between 1983 and 1984. However, he regards even the PA approach as overly therapeutic. It was not a desirable place to be - merely less undesirable than a mainstream psychiatric hospital. He is opposed to any professional involvement in the provision of mental health services. Lawson was also a founder member of the MPU, and is currently a member of CAPO. He emphasized that his views were based largely upon his own experience, and not upon intellectual ideas. He adheres to the view that mental illness is a myth in strict form; that is, he is not proposing merely that mental disorder is psychological rather than physical in origin, but that all versions of reality are equally valid. Mental patients are society's hostages. All institutional psychiatry is coercive by definition, drugs and ECT only cause damage, and all hospitals should be closed immediately. Distress is the result of living in distressing conditions, and schizophrenic experience is a valid form of experience.

The degree of familiarity with the ideas of the original British group of anti-psychiatrists expressed by Mike Lawson is now fairly unusual. Barker and Peck (1987:2), discussing user groups' major concerns, have commented:

> These concerns are only explicitly linked to anti-psychiatry by a limited number of user groups. Many users, while raising these questions, would like to reject the proposal that they are themselves anti-psychiatry, and others would wish to support psychiatric interventions which they have found helpful.

A sizeable influence in perpetuating the anti-professional approach to user involvement has come from Judi Chamberlin, especially as expressed in her book On Our Own (Chamberlin, 1988). Chamberlin is an American user, who has attended conferences in Britain, and whose work has become highly influential since publication by MIND. Her views are worth examining in some depth, as they represent a continuation from within the user movement of the themes found in social control critiques of psychiatry (see Chapter 4). On Our Own depends heavily upon a Szaszian analysis of psychiatric disorder. Chamberlin coined the concept of 'mentalism'. Mentalism consists in assuming incompetence in a person by reason of their being psychiatrically labelled.

> 'Mentalism' or 'sane chauvinism' [is] a set of assumptions which most people seemed to hold about mental patients: that they were incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, likely to be violent or irrational, and so forth. (Chamberlin, 1987:24)

Chamberlin's development of an analysis based upon a critique of mentalism in psychiatric services soon draws her into a similar contradiction to that already associated with the ideas of Szasz (Chapter 4). She extends the critique as far as assuming that any distinction between user/patient and professional constitutes an example of mentalism. Mentalism consists not only in unfair and prejudiced assumptions of relative incompetence, but in the acknowledgement of any difference in levels of competence at all and at any time. Any professional involvement in services is therefore necessarily a bad idea. Laing is criticised for having maintained too great a professional divide between himself and his patients (Chamberlin, 1986:21). Truly alternative services must be patient controlled and resist pressures even to set up a hierarchy amongst users which might lead to mentalism developing amongst users themselves. Clearly, the objection to this stance, as to all approaches based upon Szasz's analysis, is that if people were truly capable of this level of competence all the time, there would be no need for any form of psychiatric service, alternative or otherwise. Chamberlin's insistence upon maintaining equal status results in denying the very problems for which assistance might be required.

Chamberlin's promotion of 'consciousness-raising' as a non-therapeutic and very important aspect of the user movement is discussed in Chapter 4.

Chamberlin never makes explicit the role which she sees 'alternatives' as playing within the psychiatric services as a whole. Her sweeping critique implies that she wishes to see the abolition of all traditional psychiatry and its replacement by humane, user-run alternatives such as the ones with which she has been involved, and which she describes in On Our Own. However, their are also implications within her writing that user-run

alternatives might become a supplement to existing services, and one whose position might easily become that of an elite tier within a service hierarchy. Chamberlin (1986:22) comments:

> Of course, someone going through extreme crises can be very draining and very demanding. So you need crisis centres and other similar places where people are paid. If you're getting everyone together one evening a week to help themselves through the normal crises of life, you can't take on someone who is extremely freaked out, really wanting and needing a great deal of care and attention.

A still more sinister comment appears in the same article (Chamberlin, 1986: 22):

> In our groups we expect people to put something back into the group...if we put time and energy into someone for months on end and we don't get anything back, then we start talking to the person. We say that maybe they don't want a self-help group, maybe they do want a professional relationship where it all goes one way.

There is at least an implicit threat in this quote, which says co-operate properly with our approach, or we'll send you back to the traditional services. Also, as a corollary of Chamberlin's chosen assumptions, there is no room for the suggestion that some users may be less able than others. Those who do not participate fully are perceived as having chosen to be idle, and therefore 'deserving' the fate of traditional medicine. This is quite consonant with Szasz's view that those patients who are not victims are malingerers. The extremely limited proportion of patients who might find Chamberlin's approach useful is further highlighted by her description

of projects which she identifies as genuinely 'alternative' in character, which include some which insist that users should cease to use all forms of medication upon entering the project, thus excluding immediately all those who wish to continue some level of drug use.

Also in line with Szasz's view is Chamberlin's approach to mentally disturbed offenders. She adopts Szasz's argument that criminal deviance ought to be treated as such, and offenders ought to be dealt with by the criminal justice system. That is, she agrees fully that individuals ought to be held responsible for their behaviour at all times (Proposition 11, Chapter 1).

Of these four attitudes, 2 and 3 are the most compatible. Many professionals are prepared to acknowledge their own fallibility, and proclaim themselves subject to review by bodies and individuals entrusted with protecting individual liberties to some extent. Some level of conflict over the appropriateness of actions in individual cases is, of course, inevitable. But equally, some accommodation is possible. And whilst many users may emphasize protection of their rights as a priority, they would also acknowledge the advantages of having access to a system of intervention which was to some extent designed in the light of their own wishes. Attitude 1 is incompatible with 2, 3 and 4, as it assumes that the views of the professional are necessary and sufficient, and user input can therefore only be a hindrance. NSF has been referred to in the context of both 1 and 2 because of ambiguities about the NSF members self-categorisation. Carers who categorise themselves as experts in the field of mental health fall in attitude 1, where they are professionals alongside the medical team. Carers who regard themselves as service users fall in

attitude 2, assuming that professionals need to know the opinions of users if they are to offer an adequate service, but that carers are the appropriate 'users' to ask. Attitude 4 is logically incompatible with 1, 2 and 3 as it assumes that professionals have nothing to offer, and users' own expertise is both necessary and sufficient for provision of care. However, MIND and SSO involve individual users whose personal views tend towards total anti-psychiatry, but who also work within the empowering framework of these more moderate groups. Some professionals involved in groups such as BNAP may express opinions which tend to denigrate their own status as professionals, and verge upon anti-psychiatry, but continue to offer a professional service. Therefore, the four attitudes do represent 'ideal types', and individuals might be expected to shift to some extent between them, and to be inconsistent in terms of their whole spectrum of opinions at any one time.

This dimension relates also to Gordon's (1986) conclusion, that psychiatry and democracy are, and should be, linked. Attitude 1 is plainly undemocratic, relegating moral and political power to experts. Attitude 4 corresponds to a completely laissez-faire approach to psychiatric disorder, based upon Szasz's view that 'mental illness is a myth', and is subject to the related criticisms. Attitudes 2 and 3 are compatible with the aim of setting up a democratic psychiatric service.

3. Critique of the user movement

The user movement is currently working from two rather different starting points. It is working on the one hand from the belief that mental illnesses are essentially psychosocial rather than medical, and on the other from the belief that mainstream psychiatry is autocratic and authoritarian. These are two separate, but related, issues, the first of which is empirical and the second political. The relationship between the two is either:

a) the medical/individual approach is based entirely upon a myth, and is itself solely intended to keep psychiatry authoritarian and non-democratic. The two beliefs are then directly connected.

b) the medical/individual approach has something to contribute to the understanding of psychiatric disorders, but currently operates within an undemocratic framework. What is necessary is to democratise the medical/individual form of delivery, as well as to supplement it with non-medical and social support services, provision of which need not conflict with the medical approach. It is not a case of either/or.

In Chapter 10, I shall examine the status of 'expert knowledge' within the field of psychiatry, and assess the validity of the anti-psychiatric claims that psychiatry and psychotherapy have nothing at all to offer mental health service users. Here, I shall examine the limitations of democracy within the psychiatric services. For this purpose, I shall assume that the Szaszian view (that mental illness is a myth, and all people ought to be held responsible for their conduct at all times) has been demonstrated to be flawed (see chapter 4). Therefore, theoretical viewpoints associated with this stance are also flawed; for example, Judi Chamberlin's views on

'mentalism'. Thus, I am here concerned only to address the strictly political issues of how, assuming that mental illness is not a myth, but a handicapping state, maximum democracy within service provision can be ensured. I shall be exploring how democracy may be threatened not only by professionals, but from within the user movement itself.

A. Professionally imposed limits to democracy,

(i) The nature of professions

The extent of democracy within mental health services is limited by the extent of psychiatric expertise. If psychiatrists do possess a sizeable body of expert knowledge, which allows them to offer valuable advice based upon this expert knowledge, then it is advisable for users to work within the context of that advice. Democracy is then self-limited, as users take a reasoned decision to trust professionals to offer sound advice, on the basis of perceived superior expertise. Chapter 10 presents material of some relevance here, as that chapter considers the evidence that psychiatrists and psychotherapists do have some expertise to offer.

(ii) Compulsion

Ultimately, the issue which distinguishes psychiatry from other medical disciplines is its legal authority to hospitalise and treat compulsorily patients who are perceived by professionals as requiring treatment, but who do not co-operate voluntarily. The issue of compulsory treatment is bound up with the issue of the extent of professional knowledge, and material presented in Chapter 10 is therefore relevant to this discussion. However,

the issue of compulsory detention for those patients who are considered to require supervision is not an expert judgement, but a social and political one, which it is therefore relevant to discuss here.

Firstly, it should be noted that not all user activists are entirely opposed in principle to compulsory admission to hospital. Some members of more moderate groups have come to acknowledge that if mental illness exists as a real and handicapping state, then that must impact upon our perceptions of the disordered individual's responsibility for his/her actions. For example, Peter Campbell (interview) would not always wish to be held entirely responsible for his actions.

Given that there is not total opposition to compulsion amongst users campaigning for democratised services, it is necessary to ask to what extent and by what means might a process as _prima facie_ authoritarian as compulsory admission to hospital be democratised? Part of the answer to this might be by increasing legal rights, such as right to appeal, to refuse treatment, to be represented by patients' councils etc. Also, advocacy services would go a long way towards ensuring that the individual's interests were represented at times when he/she was handicapped in pursuing them him/herself. Users might be more widely consulted as to what aspects of admission to hospital by section were found to be most distressing and could be modified. However, it must be acknowledged that compulsory treatment involves some degree of professionally imposed limitation upon the extent of democracy in service provision, in so far as it inevitably involves a reduction in the individual's freedom to choose her own interests.

B. Limitations imposed by the nature of the user movement.

The major problem which has been identified with the user movement as it exists at present is the questionable validity of its claim to represent a cross-section of users' views. Campbell (1986:9), writing from within the user movement, has identified as an issue the diversity and universality of demands which different groups are making:

> While some groups are campaigning specifically in their local area for concrete changes in provision, others are advocating the national abolition of Electric Convulsive Therapy and the provision of adequate support for people wishing to withdraw from using major tranquillizers...The position of mental health workers within existing groups is an issue which, while recognised, has not been resolved.

In addition, Campbell notes that the proportion of recipients actually involved in the user movement is quite small.

Berry (1987 Guardian) recognises that SSO's strength is that it has no agenda beyond promoting user-involvement in planning decisions. But:

> This very strength could turn out to be a weakness when awkward choices have to be made at local health meetings and the unity of patient representatives dissolves.

Mental health professionals have expressed concern not at the conflicting and inconsistent diversity of views contained within the user movement, but at the views apparently not being represented at all. Referring to the acrimonious exchanges between MIND and NSF, which were published in Community Care, Pearson and Hughes (1990) have asked:

> Why have...moderate views been overwhelmed by the larger publicity devoted to the more extreme viewpoints?...
> In this distorted debate some voices are being consistently ignored.

Pearson and Hughes identify those being marginalised as people suffering from long-term disorders and their relatives. They suggest that the user movement could become as entrenched as the psychiatric system it opposes, as a result of the undue influence of articulate users who deny the reality of mental illness by 'dabbling in semantics'.

Similar criticisms have been addressed to Asylum. Shields (1990a:31) commented:

> I wonder though whether ASYLUM appeals to a wide enough audience to make a real impact. It seems to particularly represent the anti-psychiatry lobby, the hard-done-by left-wing who are embittered and reject psychiatry altogether.

User groups have countered by emphasizing that they do not claim to be the voice of users in Great Britain, or to represent anyone except themselves. However, the demands being made are frequently ones which would influence all users if implemented, and therefore the question of representativeness must be raised. This is particularly the case when some of the most vocal and articulate voices in the user movement have tended to produce some of the most extreme demands. There is little information available about the perceptions of users as a group of the services they receive and how they could be improved, but what evidence exists suggests that users as a group are less dissatisfied and less radical than user groups might suggest. Cavadino's (1989) research on the functioning of the 1959 MHA suggested

that the majority of patients were not radically critical of their treatment in hospital. Vicente (1988) in a comparative study investigating professionals and users' perceptions of services in Sheffield, Trieste (Italy) and Concepcion (Chile) found users in all three countries on the whole very satisfied. Shields (1990b), in a comparatively small survey of just 30 subjects, concluded that services ought to be planned with greater consultation of users. However, the demands which users in Shields sample made were relatively modest, and included items such as more counselling and a client-centred service. Interestingly, these 30 users mentioned the importance of expert help/treatment 24 times, which suggests that the majority of this group of users did not share the extreme anti-psychiatric rejection of expert advice. There are problems with this kind of attitudinal research, in terms of how people's responses to questionnaires and interviews ought to be understood. As Fisher (1983:40) indicated, surveys of client satisfaction in social work tend to demonstrate consistently that two-thirds of clients are satisfied, and one fifth dissatisfied, whatever aspect of the service is being rated. Certainly, ratings of perceptions of services received need to be interpreted in the light of respondents beliefs about what extra and alternative services are and ought to be available. Vicente's research in particular needs reading from this perspective, given the high satisfaction ratings of patients in Chile, whose psychiatric services were by most British people's standards quite appalling. But more of this kind of systematic research is needed into user opinions as a whole before any firm conclusions can be reached about the representativeness of the contemporary user movement.

One important improvement might be the development of distinctions between different kinds of users; that is, a shift away from the view that 'users

of the psychiatric services' constitute a meaningful group. Intuitively, one would not expect young patients with periodic acute psychiatric difficulties to share the needs of elderly chronic psychiatric patients, and there is no reason to assume that young patients have any insight into the needs of elderly patients purely by virtue of being themselves psychiatric patients. Equally, one might predict that the needs of patients being treated primarily as out-patients for depression and self-harm would be very different from those of patients being treated for psychotic reactions. However, this approach would necessitate users acknowledging that psychiatric labels and categories do have some utility in separating patients out according to particular types of need. (This need not involve assuming that diagnostic categories have medical validity in the sense of being identifiable disease states, but would involve accepting that such categories do have social meaning in terms of indicating particular types of need).

Having offered these criticisms, I would wish to emphasize that I do not believe this invalidates in any way the practical work which user groups throughout the country are doing and the achievements which have been made. There are many examples of user-led and user-involved projects which show great awareness of the necessity, and difficulty, of involving all users, and address this issue on a day-to-day basis. I would wish merely to keep to the forefront the question of who may not be being consulted or involved in decisions which may affect their lives. This is an issue not only of the protection of users who are particularly handicapped and in need of much support, but of users who do not wish to become involved in the time-consuming and collective kinds of approach favoured by the user movement. There is a large group of users who simply do not like joining

organisations and engaging in collective action. Their needs and rights must be addressed also. Certainly, this will involve a large measure of professional input. David Brandon has suggested ways in which individual users could be more involved in actively choosing the services they receive, without needing to become involved in group activities (service brokerage). However, it is unclear how practical such approaches might be in practice. A greater danger is that this kind of approach is simply ignored because it does not correspond to the collectivist strategy of many user groups.

A further risk which the more extreme users take is that of antagonising professionals and funders by making demands which are perceived as unreasonable and impractical. User involvement is, inevitably, going to be about a process of negotiation and compromise between service users and providers. Dogmatic anti-professionalism may cause professionals and funders to close ranks and exclude any level of reform. Pearson and Hughes (1990) have suggested that:

> The radical lobby could be in danger of thrusting a damaging wedge between those in need of services and those who seek to provide them.

Certainly, there has been a feeling in recent years that MIND has to some extent lost the support of the government by promoting policies which have been perceived as impractical and hostile towards psychiatry. MIND's loss has been the NSF and SANE's gain in this respect, and the NSF has been rapidly moving to forefront in the politics of mental health, aided by large amounts of private funding and the wave of public dissatisfaction with the policy of 'care in the community'.

Conclusion

The emergence of the user movement during the 1980s and 1990s is the result of a variety of factors, including changes in legal status introduced by the MHA 1959, care in the community, shifts amongst professionals and government in approaches to delivery of welfare, higher levels of education generally, and the impact of the anti-psychiatric critique of the 1960s and 1970s. These factors have seen the increased impact upon service delivery not only of service users themselves, but also of carers and relatives of users. Groups representing carers and relatives have sometimes existed in a state of tension and hostility towards the more radical and critical abolitionist user groups. The users themselves can be placed upon a dimension according to their level of hostility towards mental health professionals. The most radical, hostile and anti-psychiatric positions, which tend to be influenced by, or at least to resemble, the ideas of Szasz, are probably not representative of the needs and views of the majority of service users and risk alienating otherwise potentially sympathetic professionals. The extent of democracy within psychiatry is to some extent limited also by the nature of psychiatric disorder, and specifically the periodic necessity for the use of compulsion, although some measures can be taken towards democratising even this aspect. The user movement as a whole does tend to adopt a psychosocial approach towards mental disorder, and to regard the extent of real medical knowledge in this area as extremely limited. The issue of the justice of this judgement will be addressed in chapter 10.

Chapter 10 Current critiques of medical treatment in psychiatry

'Anti-psychiatric' critics of psychiatry have traditionally rejected medically-based theories and forms of treatments as inappropriate to the true nature of mental disorder. Medical diagnoses have been presented as labels empty of content, and medical treatments as mystifying forms of social control, at best useless and at worst seriously damaging; for example, Hill (1983) has argued that the concept of schizophrenia is invalid, and that the major tranquillizers are the root cause of an epidemic of brain damage, and ought to be abolished. Some critics, for example Masson and Chamberlin, have taken the argument still further, and argued that psychotherapy is also dangerous and to be avoided, because it encourages people to believe that their problems can be taken to 'experts in living' to be solved, and encourages 'mentalist attitudes'. In addition, aside from criticisms of the epistemological basis of their theories and the efficacy of their treatments, psychiatrists and other mental health professionals working within the framework of positivist science have been accused of being autocratic and authoritarian in their relationships with their clients. Masson (1990) has argued that authoritarianism is inherent in the very concept of the mental health expert, who supposedly has some expert insight into how people ought to live their lives not shared by ordinary people.

This chapter will address three issues. Firstly, I shall present material suggesting that psychiatrists typically demonstrate a high level of awareness and understanding in relation to the debate around the concept of illness and mental illness. Secondly, I shall present evidence that psychiatrists do have some valid, albeit limited, medically-based understanding of serious disorders such as schizophrenia, and that medical treatments such as drugs do have some demonstrated efficacy. Thirdly, I shall present the evidence in favour of the

view that psychotherapy can be an effective means of treating some forms of psychiatric disorder.

The evidence presented in this chapter will strengthen the argument in favour of abandoning anti-psychiatry as the basis for a political critique of psychiatry, and instead adopting a critique based upon an analysis of the problem of democracy.

It should be noted that this chapter is not intended to constitute a comprehensive account or defence of contemporary psychiatric practice. This is an enormous topic beyond the scope of this thesis. My aim is limited to addressing the validity of some of the best known criticisms of some forms of psychiatric practice.

1. The concept of illness in psychiatry.

One factor which produced the emergence of anti-psychiatry during the 1960s was the predominance of positivist philosophies of science in psychiatry and general medicine (Chapter 1). Anti-psychiatry drew upon non-positivist forms of philosophy for its theoretical underpinning (Chapter 2). Critics of psychiatry tend often to assume that little has changed within psychiatry since the specialism came into being, and psychiatrists in the 1990s are every bit as positivist in outlook as they were in the 1950s. However, one important and positive effect of Szasz's (1960, 1972) critique of 'the myth of mental illness' has been to compel psychiatrists to examine their practices and question the use of the word 'illness' in relation to many of the problems which their patients bring to them. Many psychiatrists are now therefore far more sophisticated in their views about mental disorder than would have been the case forty years ago; for example, Clare (1976) considered the problem of the nature of illness in psychiatric terms, and was led to propose a view of psychiatric practice which was largely not theoretically-based at all, but driven by pragmatism, and included social and psychological factors as well as physical ones. He concluded that the concept of illness was not logically tied to organic impairment, as argued by Szasz, but could and should be extended to involve the person as a mental and bodily whole. Clare's views have been highly influential.

PAGE

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2.a. Diagnosis in medical psychiatry.

There is insufficient space in this thesis to present a comprehensive coverage of the arguments of all the people who have argued that psychiatric diagnosis has no validity at all with respect to any condition. I shall restrict myself largely to examining debate around the diagnosis which has probably been the cause of most controversy since the beginning of the anti-psychiatric debate: schizophrenia. Szasz (1976) described schizophrenia as the 'sacred symbol' of both psychiatry and anti-psychiatry. Hill (1983) has published a lengthy critique of the concept of schizophrenia, arguing that the diagnosis has no reliability or validity, and ought to cease to be the subject of research.

Adopting a classically Szaszian anti-psychiatric critique, Hill regards schizophrenia as a condition which was not discovered by Bleuler and Kraepelin so much as invented by them. He reviewed studies purporting to be researching the nature of schizophrenia, and concluded that the condition does not exist. It is no more than a 'rag-bag' of unacceptable and incomprehensible forms of social behaviour. He amassed a wealth of evidence from the research literature in support of his thesis; for example, Zubin (1967) concluded that the diagnosis of schizophrenia could be agreed upon in only 37% of cases, which represents a remarkably low level of inter-rater reliability. Copeland et al (1971) found huge differences in diagnosis between British and American psychiatrists. Hill notes that the response of psychiatrists to such findings has been to attempt to improve reliability of diagnosis. Beck et al (1962) managed to raise agreement to 54%. However, Hill criticises attempts to demonstrate improved reliability on two grounds. Firstly, the studies do not constitute realistic attempts to estimate diagnosis as it takes place in actual clinical settings. Secondly, the statistical analyses used to measure

reliability have been frequently inadequate; for example, they artificially inflate the reliability figures by failing to calculate correctly the baseline which could be predicted by chance alone. Hill offers three types of alternative explanation for the unreliability of the concept of schizophrenia to that favoured by psychiatrists:

> First, it has been suggested that application of a medical paradigm to the psychological problems of individuals who are not, for the most part, organically impaired was destined to failure from the beginning, especially in the area of categorization. Second, some have argued, in related fashion, that human behaviour is simply too complex, and individual differences too great, to be classified in the manner familiar to the natural sciences. Third, there are those who suggest that psychiatric classification is futile because it ignores such socio-political issues as deviancy and the control thereof. (Hill, 1983:181).

Next, Hill turns to the validity of the concept of schizophrenia. Reliability consists of measures of the extent to which a diagnosis of schizophrenia can be agreed upon by independent observers. Validity is the extent to which the construct actually is what its proponents claim it to be. Here, Hill argues that the concept of schizophrenia is simply a meaningless collection of various forms of social deviance, rule-breaking and incomprehensible behaviour, with no internal cohesion or theme.

Since the concept of schizophrenia is both invalid and unreliable, studies purporting to investigate its etiology are likewise meaningless; for example,

Hill has taken up opposition to studies which purport to demonstrate a genetic basis for schizophrenia. In interview, he told me he believed there to be no basis to almost all the physiological and genetic theories of schizophrenia.

> They will never find a genetic basis to schizophrenia for one very simple reason...such a heterogenous concept, it is like looking for a genetic predisposition to being a member of the Labour Party or a member of the Church of England...schizophrenia involves very nearly every broken social norm that is not covered by the law...the current research which claims to have demonstrated genetic predisposition simply does not. And the methodology of it has been demonstrated to be so inadequate so many times that I find it staggering that it's still taught in psychiatric text books as if there is some sort of credibility to a genetic predisposition. (Hill, interview)

Hill concludes that virtually all of the behaviour labelled as schizophrenia is a response to poverty and oppression which are widespread in capitalist societies. Ultimately, the only solution to the problems we describe as schizophrenia is widespread and revolutionary changes in social structures.

Hill's views have brought criticism from medical researchers in the field of schizophrenia, whose research Hill has been quick to criticise, apparently without verifying his comments before committing them to print. In 1990, The Guardian carried an item concerning research conducted by Professor Robin Murray, which indicated that schizophrenic patients had experienced changes in brain structure (Schoon, 1990). Hill (1990) responded that the research was invalid, as it had been proven that such brain changes were the product

of anti-psychotic medication, and that such research was damaging to people struggling to come to terms with their problems. Responding to Hill's comments, Hugh Freeman, editor of the British Journal of Psychiatry, wrote that:

> All research of this kind controls for extraneous factors that could affect the results; medication is the most obvious of these, and the distinguished team at the Institute of Psychiatry does not make such elementary errors. (Freeman, 1990)

The author of the study in question, Robin Murray, also responded:

> over 60 scientific studies have addressed the question of the origins of these changes, and have concluded that they are not caused by drug treatment...I would like...to invite Dr Hill to visit my research unit to see what we are doing to try to understand and alleviate this illness, and also suggest ways in which we might put any of his own ideas to the scientific test. (Murray, 1990)

Hill is also clinging to an analysis which most academic critics of psychiatry have ceased to find credible; for example, Rose (1989a; 1990) has also criticised attempts to explain behaviour genetically, and argued that the optimism surrounding recent apparent breakthroughs in the genetics of schizophrenia is premature. However, Rose is not arguing for a complete rejection of the notion of a genetic contribution to mental disorder, as Graham (1989) suggested. Rose (1989b) replied:

> It would have helped if Philip Graham...had read what I wrote before criticising me for perpetuating "the old, tired either/or myth in the roles of genes and environment in depression and schizophrenia", as my entire article was devoted to demonstrating

this was indeed a myth, despite the claims of many geneticists and the residue of the anti-psychiatry movement.

A new type of approach is suggested by Allen (1986) in her feminist contribution to Miller and Rose's collection of poststructuralist-influenced critiques of psychiatry. Allen is prepared to concede an astonishing amount of territory to psychiatry in adopting a stance which she fully acknowledges is 'a reformist politics' (Allen, 1986:111). She argues that feminists cannot continue to cling dogmatically to a position which depends on women being no more constitutionally vulnerable to disorder than men, when research evidence suggests strongly that this position is wrong. She comments of the established feminist approach to psychiatry:

> Not only has it resulted in a more-or-less overt resistance to evidence of alternative causal or contributory factors in women's pathology (*such as the embarrassingly persuasive mass of evidence for a genetic component in schizophrenia*), but also, and more importantly, has led to a near total inattention to those areas of psychiatry such as senile dementia, where social and psychodynamic explanations of the pathology have little grip. (Allen,1986:109. Italics mine)

The concept of schizophrenia has been rejected as invalid by Bentall, Jackson and Pilgrim (1988), whose critique of the reliability and validity of the concept resembles that of Hill (1983), to whose work Bentall et al refer. Bentall et al's conclusions are somewhat similar to Hill's in that they conclude that the current conceptualisation of schizophrenia serves a purpose for medical psychiatrists, in justifying them in continuing to regard schizophrenia as a disease entity, and therefore properly a concern for their

profession rather than any other. (Bentall et al are writing as clinical psychologists.) However, unlike Hill, Bentall et al do not reject the possibility of any form of diagnosis or labelling in relation to people currently diagnosed schizophrenic.

> Acceptance of this argument does not imply that psychotic behaviour cannot be understood, that biological variables are of no importance, or that disturbed individuals and their families should not be helped by psychologists and their colleagues in other professions. (Bentall et al, 1988:314-5)

They propose two alternative research strategies: firstly, that research should investigate empirically-based alternative ways of classifying abnormal behaviour which abandon the use of the schizophrenia concept, and secondly that researchers should investigate individual symptoms, such as delusions and hallucinations, rather than global disease concepts such as schizophrenia. Bentall et al evidently envisage that such a strategy will facilitate a more psychological approach to understanding the problems and deficits associated with psychosis, and reduce the current concentration upon a crudely biological approach. However, again unlike Hill, they do not suggest that their approach will prove that most disorder is ultimately socio-political in origin.

Bentall et al's proposals have been criticised by Wing (1988), largely upon the grounds that researchers are already engaged in the kinds of activities which Bentall et al envisage, and what is emerging as a result is something very like the traditional concept of schizophrenia. Further, to break the investigation of schizophrenia down into study of its individual symptom components would not clarify the situation:

> It is clear that 'delusion', 'hallucination' and 'thought disorder' are complex categories rather than discrete symptoms

and that to investigate them scientifically involves the same problems of reliability as do broader 'disorders'. (Wing, 1988:326)

Thus, although criticism of the concept of schizophrenia is widespread, the majority of this criticism does not assume that the diagnosis is entirely meaningless, only that it probably requires quite fundamental refinements. Hill (1983) is very much alone in arguing that the concept is completely lacking in reliability, validity or usefulness. The majority of psychiatrists believe that schizophrenia will continue to be a useful concept for diagnosis and research in some form for the foreseeable future. It seems that the diagnosis of schizophrenia will certainly not fall out of usage until and unless a more powerful alternative has been produced.

The material presented in this section does not, of course, prove that Hill is wrong and that schizophrenia is a proper medical diagnosis. It would be extremely difficult to prove that given the vast output of research into schizophrenia published each year which would have to be scrutinised and evaluated. However, two conclusions can be reached on the basis of this section. Firstly, Hill is very much alone amongst mental health researchers in adopting the view that schizophrenia is a construct with no merit whatsoever. Other radical critics of psychiatry, such as Allen, find themselves increasingly unable to resist the volume of research indicating that the diagnosis schizophrenia is identifying something which exists, however ill-defined and open to misperception that 'something' is. Secondly, Hill perceives schizophrenia as a term which psychiatrists attach in a dogmatic fashion to patients whose behaviour they do not understand and cannot explain. This is an oversimplification. Both researchers and practising psychiatrists are on the whole aware of the inadequacy of the diagnosis. They hope and expect that as research progresses diagnosis will become more sophisticated and useful in assisting them to treat their patients. They continue to use schizophrenia as a diagnosis in the broad and general fashion they do only because it is the best they have at present, a helpful hypothesis rather than the end-point of the debate.

2.b. Treatments in medical psychiatry.

Hill and other critics have not only argued against medical/organic explanations for psychiatric disorder, but have opposed medically-based treatments, such as drugs and ECT. It has been argued that such treatments do not exert a specific therapeutic effect, but simply dampen down aspects of general functioning. Also, they cause permanent brain damage of a degree

sufficient to justify their abolition. (Hill, 1983; Breggin, 1983, 1979) The issues surrounding evaluation of medical treatments, as opposed to medical theories, are somewhat different. Medically based theories are, in the final analysis, either true or false, and must be judged on the merits of the argument. Medical treatments are frequently used in spite of limited knowledge about their effects. There are two separate issues to be considered here. Firstly, do medical treatments produce demonstrable improvements in patients' disorder? Secondly, are the negative side effects of the treatments sufficiently severe that they ought not to be used in spite of any positive benefits they may produce?

The only three forms of treatment which are truly medical, in so far as they are necessarily authorised and prescribed by medically qualified doctors, are drug therapies, electro-convulsive therapy (ECT) and psycho-surgery. Psycho-surgery is now extremely rare, and its use is highly restricted. I will not discuss it here, as it is not a common treatment within mainstream contemporary psychiatry. [1]

(i) ECT

ECT is the most crude and drastic 'therapeutic' technique commonly in use within contemporary psychiatry. The treatment consists in passing an electric current through the brain of the patient of sufficient voltage to induce an epileptic fit. It is used as a 'last resort' treatment for depressive illnesses and related conditions, but is no longer recommended for schizophrenic patients. Early applications of ECT frequently resulted in broken bones owing to the violence of the fits. More recently, ECT has been administered under local anaesthetic and accompanied by muscle relaxants,

which have reduced the level of bodily injury associated with the patient, and to a some extent reduced the negative subjective experience also. However, the therapeutic efficacy of ECT and the side effects of the treatment both continue to be widely debated. ECT is probably the most controversial therapeutic technique commonly used by contemporary psychiatrists.

The most enthusiastic proponents of the technique hail it as a measure advance in the treatment of depression; for example, Rollin (1981):

> I regard ECT as the most important advance in treatment in our time. I fail to see, in fact, how we could carry out effective psychiatric practice, especially in the treatment of psychiatric emergencies, without it.

Research evidence suggests that such an extremely positive view of the benefits of ECT is rather optimistic; but that ECT does seem to have some value in the treatment of some depressed patients. Double-blind studies have indicated that ECT is more effective in relieving depression than a placebo; for example, Freeman et al (1978). Other studies have suggested that although ECT is of some effect, the effect is smaller than at first believed, and by one month after ending treatment, differences between patients treated with 'real' ECT and those who received a placebo treatment have disappeared (Johnstone et al., 1980). It has been suggested that ECT is particularly useful in circumstances where a patient's life is in danger through risk of suicide, and a highly effective immediate remedy to depression is therefore required. Jenner and Vlissides (1986:18) argue:

> In puerpal depression...when the mother and baby's life can be at stake, we consider it can be the treatment of choice. In the elderly, who are sometimes starving themselves and dehydrated,

and either unable or unwilling to communicate, it can be very successful.

Baldessarini (1977) regarded ECT as especially useful during the period which it takes for antidepressant drugs to take effect, and believed that it has undoubtedly saved the lives of many patients.

Opponents of ECT dispute the claim that the treatment has any therapeutic effect at all. In support of their claim, they point to instances when equipment used to administer ECT has been found to have been faulty for a number of months, and no shock has been administered, and medical staff have failed to notice any reduction in therapeutic efficacy (Lawson, 1989:18). In addition a wealth of anecdotal evidence exists provided by patients who have found ECT unhelpful (although there is also a body of evidence from patients who claim to have benefited from the treatment).

Opponents also argue that, whatever small effect ECT may exert upon the mood of some patients, its side effects are so harmful as to outweigh any claim to therapeutic usefulness. Again, the nature and extent of the side effects are controversial issues. The two most common and serious accusations made against the treatment are that it causes memory loss, and that it causes brain damage.

Evidence that ECT damages brain tissue was presented by Friedburg (1977), a neurologist and member of Network Against Psychiatric Assault. His evidence was based upon animal studies, results of human autopsies, evidence of electro-encephalogram changes following treatment with ECT, and personal accounts from patients. However, Friedburg's data has been criticised on a number of grounds (Frankel, 1977). The animal studies involved the

administration of atypically high levels of current. The human autopsy evidence was based upon the brains of patients who had not received ECT for some time before death, or who suffered from identifiable organic pathological brain conditions. Reports by patients of negative effects of ECT were acquired by advertising in the newspaper under the heading 'Shock treatment is not good for your brain'.

More recently Hill (1983) and Breggin (1979) have taken up the argument that ECT causes brain damage.

Fraser (1982:46) reviewing the evidence concluded that:

> Statistically, ECT is a 'safe' treatment. The risks of severe brain or cardiac damage, and of fractures, have become increasingly remote with the introduction of muscle relaxation and the development of anaesthesia as a speciality in its own right.

The body of evidence that ECT impairs memory is more persuasive than the evidence in favour of brain damage. Proving or disproving loss of memory is complicated by the negative effect which depression itself exerts upon memory. But it seems now clear that ECT does have some impact as well. Research has been carried out with respect to two types of memory: anterograde and retrograde. Anterograde memory refers to the capacity to store new items in memory after treatment, and retrieve them at will. Results in this area are inconsistent. Some studies show anterograde memory returning to normal quickly after a series of treatments, others suggest that problems persist several weeks after treatment has ended (Fraser, 1982:49). Retrograde memory refers to the capacity to retrieve from memory items and events stored there

before the treatment. There is clearer evidence that ECT does result in retrograde amnesia, particularly for events which occurred only a short time before the administration of the shock (Squire et al 1981). Squire et al (1981) found that television programmes viewed 1-3 years before ECT were forgotten, but ones viewed 4-17 years previously tended to be remembered as clearly as before treatment. However, research has suggested that such memory impairment is not permanent, and memory tends to be restored by 6-7 months after treatment ends (Weeks et al, 1980; Johnstone et al, 1980).

Critics of ECT believe that researchers studying amnesia amongst recipients of ECT fail to appreciate the impact which memory loss has upon patients. Bigwood and George (1986:19), replying to Jenner and Vlissides' (1986) defence of ECT, comment:

> Jenner and Vlissides say the main problem of using shock is a temporary forgetting. This is rather a bland description of an untheorised assault on a person's brain, which rather seems to turn them into temporary zombies.

In conclusion, evidence for both the therapeutic effect of ECT and the existence of serious side effects remains inconsistent. However, it seems fairly certain that ECT does exert some therapeutic effect upon depression, albeit of a short-term nature. Evidence for the existence of brain damage resulting from ECT is inadequate. Evidence for memory impairment is more clear cut, but opinions differ as to the real significance of memory loss in terms of patients lives. Some of those people who have received ECT believe themselves to have been damaged in a way which outweighed even the distress caused by their original depression. Others have found the treatment helpful at times when all else failed, and continue to request ECT when they perceive

it to be necessary. Until evidence exists which indicates that ECT is more harmful than is at present believed, and as long as some patients request the treatment, it seems that a total ban upon the treatment would not be justified. It is a separate question whether the treatment is indeed sufficiently controversial to support the view that it ought not to be prescribed under the provisions of mental health legislation for patients who have refused consent.

(ii) Drug treatments

Drug treatments in psychiatry fall into four broad categories: minor tranquillizers, major tranquillizers, anti-depressants and lithium carbonate. It is possible to object to any of these drugs, and to ECT also, on the grounds that they offer symptom relief and do not treat causes. Symptom relief and treatment of causes are not necessarily alternatives to be opposed to one another, but practices which ought to continue in parallel both within psychiatry and throughout medicine in general. However, it can be argued that drug therapies have been used to maintain functioning in untenable situations, where the situation itself has not been addressed, and this practice is open to criticism. Here I shall examine the evidence for and against the continued use of the three most controversial drug groups: minor tranquillizers, major tranqillizers, and lithium carbonate.

Minor tranquillizers

This is the group of drugs which is perhaps most open to the charge of having been used to damp down symptoms which were social in origin, rather than

addressing the causes of distress. Valium and other benzodiazepines have been used notoriously as 'housewives' drugs', offered to women trapped in domestic situations to help them cope with their role, rather than addressing the issues related to that role per se. This misuse has been compounded by the fact, of which doctors were not initially aware, that benzodiazepines are addictive. There has been a recent upsurge of support groups such as CITA (Council for Involuntary Tranquillizer Addiction) in Liverpool, which offer help to people wishing to wean themselves off minor tranquillizers. In 1990, 3,000 people were suing Roche Products Ltd and John Wyeth Laboratories Ltd, manufacturers of Valium and Ativan, on the grounds that they were not warned when the drugs were prescribed that they are addictive or that side effects include anxiety, agoraphobia, loss of memory and concentration (Neustatter, 1991). A report of the Institute for the Study of Drug Dependence (1989) identified:

> About 1,250,000 chronic benzodiazepine users in the UK, people who take tranquillisers every day. Of these, two-thirds are women, mostly aged 50 and above. Some have taken tranquillisers for 10 or 20 years.

Hill commented (interview):

> I think it is now fairly well accepted by most GP's that those drugs are fairly unhelpful in terms of the addiction that they cause. And like the major tranquillizers they do nothing to address the causes of whether it's the anxiety, or the more extreme so-called symptoms of schizophrenia. In my view all of those causes fall into a broad psychosocial [category].

The medical profession has indeed acknowledged that benzodiazepines have been grossly misused in the past. The Committee on the Review of Medicines (1980) supported by the Royal College of Psychiatrists (1988) now recommend that the drugs ought to be prescribed for a maximum of four weeks with the proviso that this be viewed only as a last resort measure of treatment. The case of minor tranquillizers does provide support for the views of those who express concern at the willingness of the medical profession to dispense substances sold to them by the pharmaceuticals industry with little real knowledge of the long-term impact of those substances.

Lithium

Lithium is prescribed specifically for patients diagnosed as suffering from a manic-depressive disorder, and is regarded by the medical profession as useful in controlling mood swings. Evidence from double-blind trials supports the view that lithium is an effective treatment for manic depressive disorder (Shopsin et al, 1975). Lithium is thought to be particularly effective used as a prophylactic, to prevent future episodes of mania and depression (Gerbino et al, 1978). The drug is commonly regarded by psychiatrists as a highly specific treatment, significantly more effective than other treatments for manic-depressive disorder and of little relevance itself in the treatment of other forms of psychiatric disorder. The specificity of the treatment has been used to bolster the view that manic-depressive disorder is clearly distinguishable from other forms of psychosis (Davidson and Neale, 1982:83).

This widely accepted view of lithium has been challenged by Breggin (1983). Breggin reports that the specificity of the action of lithium has been exaggerated. In fact, patients admitted to hospital with a diagnosis of

manic-depressive disorder are commonly treated initially with both lithium and a phenothiazine (major tranquillizer). The justification for this is that lithium does not take effect until 2-3 weeks after treatment commences. The more rapidly acting major tranquillizers are used during this period, and are highly effective in ending mania. Lithium is then given in order to maintain the stabilised mood. However, there is doubt also with relation to the efficacy of lithium as a prophylactic. Research by Prien et al (1974) found that the relapse over two years of patients on a maintenance dose of lithium was 50%. Lithium did seem to reduce relapse amongst patients with a history of infrequent attacks. But amongst those with a high frequency of past manic episodes, all patients eventually relapsed. This evidence leads Breggin to reject the view that lithium has any specificity at all in the treatment of manic-depressive disorder. Instead, he attributes the impact of the drug to its 'brain-disabling' effects. In addition to its effectiveness in the treatment of manic-depressive disorder, lithium has been greeted with enthusiasm by psychiatrists because of its apparent lack of unpleasant side effects. Breggin argues that the drug's benignity has been over-estimated, and that in fact the side effects it does produce might explain its apparent therapeutic efficacy in relation to mania.

The view that lithium has no significant side effects is based largely upon research conducted by Schou et al (1968). However, Breggin has access to data which Schou and his colleagues did not publish, including subjective reports of their own experiences after one week on lithium, which included:

> transient nausea, diarrhoea, slight tremor of the hands...A feeling of muscular weakness or heaviness was prominent in all the subjects. They had to overcome a certain resistance against rising and moving and also had a feeling that mental effort was

needed to undertake any physical task. (Schou et al, unpublished report quoted in Breggin, 1983:204)

In addition to these physical symptoms, subjects reported reduced responsiveness to environmental stimuli, a feeling of indifference and general malaise and passivity. Small (1972) studied normal volunteers' response to lithium over three weeks. The 11 subjects experienced varying degrees of toxic reaction, some quite severe. Breggin concludes that the view that lithium has no side effects is based upon comparison with the side effects of the major tranquillizers, which are far more severe. This comparison has caused researchers to neglect quite significant toxic effects.

Further evidence for the view that lithium acts by dampening down general brain function, rather than acting specifically upon the symptoms of mania is provided by the use of the drug in prisons to control aggression in prisoners (Breggin, 1983).

Therefore, evidence suggests that lithium is of some use in controlling the symptoms of manic-depressive disorder. However, the mechanism by which it achieves this effect is unknown, and its specificity is open to question. The view that lithium has no psychological effects other than upon manic symptomatology is optimistic, as evidence is emerging of quite subtle but very real changes in subjective experience associated with the drug.

Phenothiazines, or major tranquillizers

Major tranquillizers or phenothiazines, such as chlorpromazine, are currently considered the treatment of choice for schizophrenia. As a result, these are the drugs most often prescribed for administration without the patient's consent, under sections of the MHA 1983. There is some evidence that major tranquillizers have a specific effect upon the occurrence of schizophrenic symptomatology, such as delusions and hallucinations. This effect has been used to support the 'dopamine' theory of schizophrenia, which argues that psychotic symptoms are the result of dopamine over-activity. Major tranquillizers have been held to 'work' because they block dopamine receptors in the brain. However, there is no logical reason to assume that the cause of a disorder can be deduced from the actions of medication used to treat the disorder; for example, aspirin cures the symptom of a headache, but headaches are not the result of 'aspirin deficiency'.

Hill (1983) has disputed the claim that the effects of major tranquillizers are specific and has claimed that they are effective as a result of a general dampening down of brain activity. He has suggested that they produce an effect similar to that of a frontal lobotomy. Breggin (1983) has likewise classed the major tranquillizers as 'brain disabling', and argued that any 'therapeutic' impact is the result of disabled brain processes.

Recent research has cast doubt upon the usefulness of the major tranquillizers for long-term maintenance of schizophrenic patients. Crow, MacMillan, Johnson

and Johnstone (1986) found that over a two year period 42 per cent of patients taking phenothiazines and 62 percent of patients taking placebos relapsed. This suggests that only 20 percent of schizophrenic patients actually benefit from long-term use of the drugs. Actuarially corrected, the figures suggest that 58% of subjects maintained on phenothiazines relapse, compared with 70% on placebo, reducing the percentage who can be said to have benefited from medication even further to 12%. In addition, it has been suggested that patients who relapse following discontinuation of anti-psychotic medication may be suffering from withdrawal of the medication, rather than a resumption of the schizophrenic disorder. It appears that the major tranquillizers may cause patients to develop a supersensitivity to normally occurring dopamine levels within their own brains, which triggers a psychotic episode when medication is discontinued (Jenner, 1989; Chouinard and Jones, 1980; Hill, interview). Hennelly (date unknown) has pointed out that if this is the case, then the 12% of patients who 'relapsed' when their phenothiazines were withdrawn may have been suffering symptoms of drug withdrawal, rather than a genuine relapse. A methodologically valid test of the phenothiazines would have to compare patients continuing medication with patients using placebos and who had never received phenothiazine treatment. Such a study might be expected to find the difference in relapse rate between the groups to be even further reduced.

Assuming that major tranquillizers do have some beneficial effects to offer, the question must still be asked whether the drugs have negative side effects, and whether these side effects are sufficiently severe to justify the drugs' abolition. Anecdotal reports testify to the unpleasantness of the experience of these drugs. Patients taking them are generally also placed on a course of drugs to control side effects, but this is not wholly effective. The most

alarming side effect is tardive dyskinesia. This is a condition characterised by loss of voluntary muscle control comparable to that seen in Parkinsons' disease. Like Parkinson's disease, the condition is thought to result from damage to the dopaminergic system within the brain, which is the neuro-transmitter system primarily affected by major tranquillizers. 'Many patients suffer from these symptoms at some stage whilst taking major tranquillizers. For a sizeable minority the symptoms may become permanent. Hill (1985) reviewed studies investigating the prevalence of tardive dyskinesia. Studies placed the prevalence of tardive dyskinesia at between 25.7% (Jeste and Wyatt, 1981) and up to 40% (Crane and Smith, 1980) of major tranquillizer users. Hill concludes that approximately 38.5m people world-wide are currently suffering from tardive dyskinesia. Hill (interview) referred to 'a world-wide epidemic of irreversible brain damage of 40-50m people'.

Finally, a little discussed, but important, phenomenon, is neuroleptic malignant syndrome, a reaction to neuroleptic medication consisting of very high temperature, catatonic-type rigidity, and, according to Hill (interview) death in 20-30% of cases. The syndrome affects 1/2 - 11/2% of users of neuroleptic medication.

Defenders of major tranquillizers argue that, despite their problems, the major tranquillizers have produced a revolution in the treatment of schizophrenia, and until they are replaced by more effective and less harmful treatments, they are the best option psychiatry has to offer. However, evidence suggests that their impact may have been over-rated, and that they are best used with caution, in the lowest possible dosage and generally as a short-term remedy rather than as the major therapeutic tool.

Summary

This brief overview of the physical treatments commonly used by contemporary psychiatry must be cautious in its conclusions. Much is still not understood about the way in which psychiatric treatments impact upon the central nervous, and the processes by which they achieve their positive and negative effects. Conclusions can therefore be expressed only in the broadest terms, but some conclusions do seem to be indicated by the research evidence.

Firstly, there are at present no theoretically based medical treatments for psychiatric disorders; that is, none of the treatments currently on offer has been developed as a result of theoretical consideration of the likely causes of psychiatric disorders. All are the result of a pragmatic process of trial and error. If anything, rather than treatments developing out of theoretical understanding, theories and hypotheses about the nature of psychiatric disorder tend to grow out of speculation about the mechanisms which underpin the latest treatments.

However, secondly, for all their pragmatic basis there is evidence that all the treatments reviewed here have some impact upon psychiatric disorder in that all seem to alleviate the symptoms of some disorders to a (limited) extent in either the short-term or the long-term. None has lived up to the excitement with which all have been greeted upon their first introductions, but all display some merit in the control and treatment of psychiatric symptomatology.

Thirdly, all medical psychiatric treatments are effective at a price. All the treatments reviewed here involve serious side effects which must be balanced

against their therapeutic effects. ECT impairs memory, and is often experienced as very unpleasant by patients who undergo it. Minor tranquillizers are a highly addictive 'solution' to a group of problems which, of all forms of psychiatric disorder, are most plausibly psycho-social in origin. Lithium is highly toxic at only slightly above the therapeutic dose, and is no longer thought to be wholly free of side effects. The major tranquillizers are associated with the most devastating side effects of all, involving irreversible brain damage for many users.

It seems that at present it would be unwise to abolish entirely any of the major forms of psychiatric treatment, as all play some role in managing rather than curing the symptoms of serious psychiatric disorder. However, medical treatments may justifiably be approached with great caution, their benefits and drawbacks being very finely balanced. The imposition of such treatments under mental health legislation upon patients who are actively resisting is not a situation which can be endorsed lightly.

3. Psychotherapy and other non-medical professional approaches.

Sections 1 and 2 above have discussed evidence for the positive and negative effects of mainstream medical interventions on psychiatric disorder. This section will examine the efficacy of psychotherapeutic approaches.

The more extreme user viewpoints have rejected all professional input into mental health, arguing that any distinction between 'professional' and 'user' in terms of expertise or skills results in 'mentalism' (Chamberlin, 1988) or undesirable uses of power in the name of 'expertise' (Masson, 1990) (see also

Chapters 4 and 9). Masson (1990) has provided a lengthy description of the abuses which have been carried out in the name of therapy. However, his conclusion is not that abuses ought to be prevented, but that psychotherapy is itself abusive and ought to be abolished. I have already discussed the problems related to Masson's libertarian rejection of 'experts in living' in Chapter 4. My purpose here is to present the research evidence in support of the efficacy of psychotherapy.

Systematic evidence that psychotherapy is an effective treatment for some forms of psychiatric disorder has been accumulating for several decades, generally through the work of psychologists rather than psychiatrists. Two distinct types of psychotherapy have been commonly studied: cognitive-behavioural psychotherapies and psychodynamic psychotherapies.

Cognitive behavioural therapy (CBT) has been found particularly useful in the treatment of phobias and related anxiety states. In this context, therapy takes the form of systematic desensitisation by a process of controlled exposure of the patient to the feared object or situation. The exposure may be imaginary, the patient being asked to imagine various degrees of contact with the object of fear, or <u>in vivo</u>, the patient being exposed in reality. Exposure may take the form of gradually increasing the degree of exposure to the feared object, thus learning to cope gradually with higher and higher levels of anxiety, or it may take the form of immediate immersion in a highly feared situation, known as 'flooding'. Researchers have conflicting views as to the mechanism which causes this form of therapy to be so effective in treating phobic states. Some researchers emphasize the importance of actual exposure to the feared object; for example, Marshall et al (1977). Others emphasize the role of relaxation in assisting the patient to confront the

feared object in a context in which anxiety is not allowed to reach unmanageable levels; for example, Levin and Gross (1984). However, whatever explanation is preferred, the method has demonstrated efficacy in the treatment of phobic anxiety states (Rachman and Wilson, 1980).

Both cognitive-behavioural and psychodynamic forms of psychotherapy have been found effective in the treatment of disorders of mood, such as depression and generalized anxiety disorders. An advance in the evaluation of psychotherapy was made in 1977, when Smith and Glass introduced the concept of 'meta-analysis' into the field. Meta-analysis is a statistical technique which allows results from different studies to be combined so that an overall measure of effectiveness of a particular treatment can be taken. On the basis of their meta-analysis, Smith and Glass concluded that:

> the average client receiving therapy was better off than 75% of the untreated controls. (Smith and Glass, 1977:754)

Smith and Glass's technique drew criticism on the grounds that their analysis was only reliable if it was assumed that all the studies included in the analysis were methodologically sound (Eysenck, 1978). Landman and Dawes (1982) replicated Smith and Glass's analysis, having first removed from the sample of studies all those that did not meet certain methodological standards, such as the use of control groups for comparison, and preferably the use of a placebo condition. Their findings supported Smith and Glass's conclusions. The most recent meta-analysis of outcome studies in psychotherapy has been provided by Robinson et al (1990). Studies reviewed compared psychotherapy with either no treatment or another form of treatment for patients suffering from depression. The authors concluded that:

depressed clients benefit substantially from psychotherapy, and these gains appear comparable to those observed with pharmacotherapy.

Much recent research has focussed upon the task of comparing different types of psychotherapy with one another and with other forms of therapy such as drugs. Kendall and Lipman (1991) reviewed studies which compared cognitive-behavioural therapies and pharmacological therapies for the treatment of depression. They note that, in terms of swiftness of patient response, it is frequently assumed that pharmacological therapy is preferable. Research does support this view in the treatment of the more seriously depressed (Elkin et al, 1989), but Blackburn et al (1981) found that a combination of cognitive-behavioural therapy and pharmacological therapy provided more rapid and substantial improvement than either therapy used alone. Kendall and Lipman (1991) reviewed also research which examined relapse rates following the two kinds of treatment. Blackburn et al (1986) found that depressed patients treated with either cognitive-behavioural therapy or CBT combined with pharmacotherapy were less likely to have relapsed at two year follow-up than were those treated with pharmacotherapy alone. However, Kendal and Lipman recommend caution in evaluating relapse rate outcomes, as it is possible that the higher rate of relapse amongst patients reliant upon pharmacology may in fact be due to sudden withdrawal from the medication rather than 'genuine' relapse.

Elkin et al (1989) compared two brief psychotherapies, one interpersonal (psychodynamic) and one cognitive behavioural (CBT), with pharmacotherapy and a placebo. The psychotherapies proved equally effective in reducing depressive symptoms and improving functioning. Pharmacotherapy was more

effective than both forms of psychotherapy, but not significantly so. All three therapies were more effective than the placebo treatment. These differences emerged more clearly when the analysis was restricted to the most seriously depressed patients within the sample.

4. Relationship between medical psychiatry and other practitioners.

So far, this chapter has presented evidence in favour of the involvement of medically qualified practitioners in mental health care and evidence has also been presented for the efficacy of other, non-medical psychotherapeutic approaches in treating mental disorders. A final issue for discussion is what ought to be the relationship between medically qualified and non-medically qualified practitioners, such as psychotherapists, social workers and psychologists. Psychiatrists have been keen to acknowledge the value of non-somatic forms of therapy and intervention for their patients; for example, Clare (1976). There is increasing recognition that the medical practitioner is only one member of an inter-disciplinary team, and not the member who has the largest quantity of contact with the patient.

However, in spite of many psychiatrists' willingness to acknowledge their own limitations and the input of other professionals, it remains the case that overall responsibility for, and legal authority over, the patient are largely in the hands of the psychiatrist. In particular, power to treat under the Mental Health Act 1983 is vested entirely in the hands of doctors, and the medical profession also exerts a sizeable influence over decisions to detain patients under that legislation. In this sense, at least, medicine retains

a degree of influence in mental health care which is arguably not warranted by its range of expertise.

5. Implications of effectiveness of medical and psychological treatments for the politics of the user movement.

Chapter 9 discussed a number of users' views of the role of users within the service. Some users wished to end entirely the input of medicine into the treatment of psychiatric disorder. Others wished to end the input of all 'so-called experts', both medical and psychological, and set up services managed entirely be users and ex-users of the services. Others again wished to retain both medical and psychological experts, but for these experts to be more firmly held within the democratic control of the people receiving the service. This chapter has reviewed three kinds of evidence: material which challenges the view of psychiatrists as proponents of crude positivist and reductionist theories of psychiatric disorder; research which suggests that psychiatrists do have some valuable although limited knowledge relating to the causes and treatment of psychiatric disorder; and research which demonstrates that psychotherapies also have an important role to play in the treatment of psychiatric disorder. On this evidence, it seems reasonable finally to reject both the 'anti-medical' and the 'anti-expert' view of user involvement. This leaves the question of how users are to achieve a higher level of control over services which include acknowledged professional experts in the areas of medicine and clinical psychology. This issue was touched upon also at the end of Chapter 9. It is likely to remain a central issue for debate and experimentation for the foreseeable future. It is to be desired that developments in this important area are not hindered by continuing acrimonious arguments between the proponents of medicine and other forms of therapy and abolitionists.

Footnotes to Chapter 10

1. Verkaik (1991) suggests that psychosurgery may be increasing in usage, due to the work of the Brook Hospital, London's, Geoffrey Knight National Unit for Affective Disorders. This unit carries out the highest number of lobotomies in Europe. The treatment is used on patients diagnosed as suffering from severe resistant depression, obsessional neurosis, anxiety neurosis, and manic depression.

Chapter 11: Summary and Conclusion

A. Chapter Summary

Chapter 1. Introduction

The aim of this thesis has been to trace the emergence and development of that set of ideas labelled anti-psychiatry over the 30 odd years since 1960. Anti-psychiatry was assumed to be an identifiable constellation of ideas, associated with the following beliefs:

1.1 Mental illness is a mythical concept, invented by doctors as a pseudo-scientific basis for the control and coercion of deviant people.

1.2 Psychiatry is a form of social control which perpetuates the social and political status quo, and is therefore pernicious.

1.3 Mental distress is caused by social oppression, rather than by biological or psychological malfunction within the individual.

1.4 Mental distress should not be treated by doctors, because it has no physiological basis.

1.5 A schizophrenic experience can be a useful process of self-discovery, and people should be assisted through the experience rather than have their symptoms suppressed by medical forms of intervention.

1.6 All psychiatric hospitals should be closed as soon as possible, ending the compulsory hospitalisation of patients, and breaking the influence of the medical profession over the provision of mental health care.

1.7 Electro-convulsive therapy (ECT) should be abolished, because it is both harmful and fails to address the causes of distress.

1.8 Psychotropic medication should be abolished, because it is both harmful and fails to address the causes of distress.

1.9 Compulsory treatment ought to be abolished, because individuals should never be compelled to receive medical treatment against their will.

1.10 All institutional psychiatry is coercive, because until the threat of compulsion is removed from people who choose not to co-operate, no patients can be said to be in receipt of treatment as a result of genuine free choice.

1.11 Individuals should be held responsible for their actions at all times, even if they are mentally disordered, because to regard a person as not responsible for their actions is to deprive that person of a fundamental aspect of their humanity.

This constellation of 'anti-psychiatric' ideas was taken to be associated with the work of Laing, Cooper, Szasz, Scheff, Goffman and Foucault.

The thesis set out to answer two questions:

1. Why did this set of ideas emerge at this particular point in the history of psychiatry?

2. How influential are these ideas amongst mental health professionals and service users today?

Firstly, it is necessary to point out that 'anti-psychiatry' in the clear cut form presented above has, in fact never existed. The anti-psychiatrists do not form a unified or coherent group, sharing one clearly defined viewpoint. Certainly, Laing, Cooper, Szasz, Scheff, Goffman and Foucault have never shared the above constellation of views. The constellation of ideas described above emerged during the early 1970s, and were not supported in their entirety by any of the named theorists then or at any other time, although they did become identified as the core of anti-psychiatric ideas at that time.

Chapter 2 Psychiatry by the 1960s.

This chapter considered the nature of mainstream psychiatry as the specialism had developed by the 1960s. Mainstream hospital-based psychiatry was seen to be primarily organicist in outlook. However, the influence of non-organic factors upon mental health was a focus of attention for some medically oriented psychiatrists in the form of the critique of the institution. Non-medical approaches to mental health were also expanding in influence and number, particularly through the influence of psychoanalytic theory and behaviourism. The expansion of welfare services, based around an individual case work approach, was further facilitating the expansion of the 'psy professions' (Castel et al, 1982) through society, through the media of the education and penal systems and the workplace. Thus it is incorrect to view psychiatry as overwhelmingly organicist in outlook during this period. Rather than being united by medical theories, mental health professionals were during this period united to some extent by an adherence to positivism, a philosophy

of science which demands that human behaviour should be studied in the same way as the phenomena of natural science are studied. This had three unfortunate types of impact upon psychiatry:

a) The concepts of free choice and responsibility were frequently regarded as unscientific and therefore meaningless, causing the distinction between psychiatric disorder and social deviance to be neglected.

b) Because positivism dictated that science must be value-neutral, important debates about the values embodied in various concepts of mental disorder were not addressed.

c) Psychiatrists and other mental health professionals tended to treat their patients and clients as objects for scientific scrutiny, whose personal viewpoints and experiences were of no interest to science and ought to be ignored.

By the early 1960s, psychiatry was viewed by many educated lay people as a benign and scientifically based medical discipline, which no longer presented any serious threat to civil liberties. The absence of critical appraisal of the claims of psychiatrists is evidenced by contributions to the parliamentary debates preceding passing of the Mental Health Act (MHA) 1959. Concern to hear or understand the perspective of those people who would be on the receiving end of the legislative changes is noticeably absent, with the exception of the contribution of Dr Donald Johnson, himself an ex-patient. In particular, there is an absence of awareness of the tensions likely to arise between patients who viewed themselves as informal and voluntary residents in hospital, and doctors who viewed their patients as infantilised beings regardless of their legal status.

The willingness of the legislators to place great power and authority in the hands of the medical profession must be viewed within the context of the politics of the era. The MHA 1959 constituted the final building block in the welfare state reforms. The welfare state as a whole had been built around the theory that welfare provision could be rationally planned and delivered in such a way that the interests of individuals as individuals and the interests of the nation as a whole would both be served. This had resulted in a general lowering of vigilance in relation to the rights of individuals over and against the state. At the time, there was cross-party political consensus about the desirability of the welfare state reforms, which were being introduced at a time of affluence and comparative social harmony. However, the period of consensus would shortly end with the slowing of the post World War II economic boom, and psychiatry would find itself at the forefront of attacks upon the theoretical underpinnings of the welfare state and the 'affluent society' as a whole. The cultural forms upon which the youth cultures and counter-cultures of the 1960s would be based were already growing in popularity by the late 1950s.

Chapter 3. The emergence of new approaches within psychiatry.

By the early 1960s, approaches to psychiatry were emerging which did not share the positivist outlook of the approaches described in Chapter 2. Maxwell Jones' Social Psychiatry adopted an explicitly political approach to mental health based upon democratic, anti-Fascist principles. The theory of the therapeutic community (TC), for which he is best known, proposed that psychiatric hospitals ought to be organized in a democratic, non-authoritarian manner, and that these values ought to be promoted in the wider community also. However, in practice staff working in TCs retained a high level of

control over patients. Also becoming popular at this time were non-positivist approaches to psychotherapy, which were influenced by existentialism; for example, the work of the 'Growth Movement', including Rogers, Perls and Maslow. By the early 1960s, Szasz was publishing his critique of the concept of mental illness. Szasz is the main originator of the anti-psychiatric attitudes expressed in Propositions 1, 2, 9 and 11. The sociological critiques of psychiatry usually referred to as 'labelling theories', and associated with Becker, Lemert, Scheff and Goffman, were becoming well-known by the mid-1960s.

The British-based group of anti-psychiatrists began to publish during the late 1950s and early 1960s. Laing's early work is characterised by an attempt to marry psychoanalysis to existentialism, and the promotion of less controlled and more truly democratic TC's. Laing's early work is not 'anti-psychiatric' in that until the mid-1960s he appears to have been reluctant to give up entirely the notion of genuinely pathological psychological states. However, the contradictions in Laing's work between the existentialist view of the person as a free agent, and the psychoanalytic view of the person as controlled by unconscious motivations tended to be increasingly resolved in favour of the existentialist emphasis upon free will. The effect of this is to push Laing into a 'conspiratorial' theory of schizophrenia, in which the behaviour of the 'patient' is entirely rational and comprehensible, and problems only result for the patient as a result of her family's (unconscious) conspiracy against her.

After 1964, Laing and Cooper began to produce the work which is most clearly identifiable as anti-psychiatric. Laing promoted a romantic view of psychosis as a 'voyage of self discovery', which traditional psychiatry mistakes for the

symptoms of an illness and arrests (Proposition 5). Cooper viewed madness not as a route to sanity, but certainly as closer to sanity than that which passes for normality in contemporary society. At this time, Laing and Cooper were at the centre of the New Left counter-cultural political circles of the era, whose politics were based around the celebration of personal experience and subjectivity. But their romanticisation of psychosis had little of practical use to say about the organisation of mental health services, and they were not really promoting the politicisation of the mental health debate. Rather, they were supporting a libertarian view of politics, in which psychosis was the ultimate symbol of individual freedom and rebellion.

Chapter 4 Developments in British and American Anti-psychiatry, 1970 onwards.

By the early 1970s, the counter-cultural view of politics had fallen into some disrepute, and a division had re-emerged between those who wished to produce fundamental changes in the structures of society, and those who were merely interested in promoting freedom of subjectivity. By this time also, the British-based anti-psychiatrists as a group were receiving heavy criticism. Much of the criticism focused upon the contradictions within Laing and Cooper's own arguments. Specifically, they were accused of having claimed to disbelieve in mental illness, but having then invented what were, de facto, therapies for a form of mental disorder. A particularly venomous form of this attack originated from the pen of Szasz (1976). What is of particular interest is the British-based group's various responses to this attack. Laing, the remaining PA members and Berke's newly founded Arbours Association distanced themselves from Marxist critiques of the concept of mental illness. They claimed that, in stating that mental illnesses were myths, they meant only to deny that such conditions were primarily organic in origin. They were

opposed to organicist psychiatry, but not to some forms of psychotherapy. They were reserved even in criticising the use of compulsion on occasions when they felt it might be necessary. David Cooper broke with the majority of his colleagues at this time and adopted a wholly Marxist critique of psychiatry, including a rejection of psychotherapy, in which he insisted that all problems are ultimately political. Thus the British-based group evaded the contradiction, Cooper by renouncing all forms of therapy and the remaining PA members by adopting a new understanding of what it means for mental illness to be a 'myth'.

A similar split is to be found at this time amongst the broader group of mental health professionals interested in the politics of mental health. Some professionals promoted new, 'radical' forms of psychotherapy, which they argued did not share the social control functions associated with traditional forms of psychotherapy. Others denounced all forms of therapy, and reserved particular contempt for those therapists who professed to be radical. This wholly anti-therapy view has its descendants in the contemporary era. However, in recent years socialists have lost faith in the imminence of the revolution, and Marxists who argue that the only solution to the problem of mental disorder is social change tend to concede that there is a need for some psychotherapy services in the present; for example, David Hill. Anti-therapy campaigners such as Masson and Chamberlin are straightforwardly libertarian in their insistence that all therapy is simply social control. However, they also wish to see some service provision, albeit of a 'non-therapeutic' nature. Typically, such provision falls within the category of 'paratherapeutic' (Ussher, 1991); for example, 'consciousness-raising'. It seems that however the anti-therapy lobby approaches the problem of abolishing therapy, therapy tends to reappear in the new system under a different name.

This problem is associated with the reliance of anti-therapy campaigners upon Szasz's critique of the concept of mental illness. Szasz's critique is flawed on at least three grounds:

a) It fails to take account of the role of value judgements in general medicine as well as psychiatry.

b) It is dualistic.

c) It places too much emphasis on free will.

More recently, political critiques of psychiatry have begun to emerge which do not rely upon Szasz's flawed distinction between physical and mental illness. Coulter (1973) approached psychiatry from the viewpoint of questioning the source of the discipline's judgements of cultural competence and rationality. Ingleby (1981) suggested the adoption of Lacanian psychoanalysis as a tool for separating issues of meaning and rationality from issues of free will, thus remedying the stagnation of the debate in simplistic oppositions of free will and determinism.

Chapter 5 The Impact of Structuralism and post-structuralism on Anti-psychiatry.

The Lacanian psychoanalysis referred to by Ingleby (1981) is an example of structuralist thought. Structuralism and post-structuralism both emerged out of the interest of French academics in language, and the way in which language embodies and reproduces the values of particular cultures. During the early 1960s, structuralism was regarded as reactionary and pro-establishment by the French 'gauchistes', who, like the British and American counter-culture, favoured Sartrean humanistic existentialism. However, following the failure of the events of May-June 1968 to trigger a process of major socio-political

change in France, the French Left became more sympathetic towards an approach which could help them theorise the process by which societal values come to be internalised by individuals.

Lacan questions our view of ourselves as predominantly rational beings. He argues that the ego is a far weaker and more deceptive structure than we can consciously appreciate, being almost wholly at the mercy of unconscious irrational desires. He emphasizes also the importance of language as the symbolic system through which values are created and perpetuated. His work has been used by Deleuze and Guattari (1977) to present a highly romanticised view of psychotic 'pre-Oedipal' experience. However, it has also been used as the basis for critiques of the value system which underpins contemporary society and much psychiatric intervention. A notable instance is Mitchell's (1975) use of psychoanalysis to examine the meanings which have become attached to gender differences in Western societies.

Foucault also questions our standards of rationality, examining and exposing the value systems which underpin judgements of what is to be called rational and what is to be called irrational. Foucault's early work (1961, 1967) was at first regarded as supportive of anti-psychiatry, calling for the closing of the asylums. However, his interests developed in a quite different direction, as he became increasingly concerned to demonstrate the ways in which deviance and pathology are identified and separated from 'normality' according to standards which contemporary society creates and enforces. His major contribution was to demonstrate that power is not merely repressive. Medicine does not operate solely by preventing its patients from experiencing the 'true selves' which are suppressed by medication, ECT and incarceration. Rather, medicine is active in a positive way throughout the whole of society,

using its power to produce the individuals which the values of contemporary society demands. Thus, this critique can be used to address the questions 'what values does psychiatry enforce?' and 'what values should psychiatry enforce?' A beginning has been made by Castel et al (1982), who question the desirability of the spread of the 'psy' professions throughout American society, and Miller and Rose (1986) who question the wisdom of anti-psychiatry's focus upon opposing medicine and the mental hospital in Britain. Of particular interest is Gordon (1986), who argues that the invention of psychiatry and the rise of democracy are inextricably linked. Psychiatry ought to be subject to the interests of democracy, and look to democracy for its values. Democracy ought not to become subject to psychiatry.

Chapter 6 The Italian Experience

Critics of psychiatry looking for alternatives to anti-psychiatry have also been influenced by the Democratic Psychiatry approach of Italy, inspired by the work of Franco Basaglia. Basaglia's main influence was the democratic philosophy of the therapeutic community, as created by Maxwell Jones. Basaglia was not influenced at all by the work of Szasz. He did not adopt the argument that psychiatric patients ought to be released because mental illness was a myth. He was, however, influenced by Foucault's structuralist critique of the separation of Reason and Unreason at the time of the Enlightenment. This led him to argue that psychiatric patients ought to be released because madness ought to be returned to the societies to which it belonged, and dealt with by those societies as communities. Like Szasz, Basaglia opposed compulsory hospitalization and treatment. However, his reasons for doing so were quite different. Basaglia believed that in psychiatry a therapeutic

endeavour and a policing function had become confused. He merely wished to see them separated. He did not oppose the provision of psychiatric care within the prisons, he merely opposed incarceration within the hospitals. His aims were not libertarian, but Marxist structuralist. He wished to return the suffering people whom he regarded as the products and rejects of capitalism to the society from which they had come, and which would have to find new ways to care for them.

Basaglia was largely responsible for the drafting of Law 180, which limited to a great extent the level of compulsion which Italian psychiatrists were able to use. The effects of the legislation have been the subject of intense controversy, both in Italy and in Britain. Those who support the Italian reforms point to the services in the North of Italy, particularly Trieste, as models of good modern psychiatric care. However, Jones and Poletti (1984, 1985, 1986) have pointed out that provision in the South of the country, where professionals and local government do not share Basaglia's enthusiasm and commitment or his Marxist analysis, is far from adequate. In the South, many patients' legal status has changed in name only, and their living conditions have changed only in that they have become more squalid and less well-regulated. In both the North and the South it is impossible to estimate how much de facto coercion occurs without regulation. Miller (1986) has criticised Basaglia for sharing the uncritical faith in the power of community which has resulted in poorly planned and disastrous shifts to care in the community in other countries in Europe and America.

Chapter 7 MIND's Policy and Campaigns from the 1970s to the present day.

The Italian Law 180 was passed in 1978. During the 1970s, MIND embarked upon a concerted campaign to persuade Government to revise the British mental health legislation to offer greater protection to the rights of mental patients. MIND's stance was never overtly anti-psychiatric, but the organisation was influenced by the growing body of literature criticising the quality of psychiatric theory and practice, and drew upon it to give its arguments strength. The MIND campaign was based upon the argument that psychiatry is far too primitive and uncertain a science to be allowed to wield so much power in respect of individuals' lives and persons. The MHA 1959 was the result of an over-optimistic estimation of the amount of progress psychiatry had made during the twentieth century, and did not offer adequate protection of civil liberties to those who found themselves being treated compulsorily under its powers. Legal reform finally took place in 1982 under the Conservative administration. Many changes which were made did derive from MIND's report and recommendations, A Human Condition (Gostin, 1975), but the changes were comparatively limited compared with the demands which MIND had made.

The British legal changes differed from the Italian reforms, in that MIND aimed to strengthen the rights of patients through use of the law. Basaglia had hoped to remove mental health from the legal framework entirely, and base provision upon Marxist collectivist principles. This reflects a difference in the conceptualisation of democracy between Italy and England and Wales. The Italian reformers hoped that democratic psychiatry would be achieved by removing legal restraint, and hoping that adequate service provision would result in the needs of all people being met. The MIND campaign assumed that

democracy would best be achieved by enshrining negative rights to civil liberty in law. The experience of both countries suggests that these two strategies need to be pursued in tandem to ensure a genuinely democratic service. Positive provision of services is vital, but it is also important that positive provision should be balanced by guarantees of individual liberties.

Since 1982, MIND has based its campaigning platform around the issue of user involvement and empowerment in management and delivery of services. Most recently, the organisation has been campaigning around the issue of properly informed consent to treatment by patients within psychiatry.

Chapter 8 Care in the Community in Britain.

The care in the community policy originated during the 1950s in response to the critique of the institution which reached its apex at that time. Since the early 1980s, Conservative governments in America and Britain have been seen to be using the policy of care in the community for fiscal convenience, regarding hospital closures as opportunities to reduce public spending. Rapid deinstitutionalisation in the absence of provision of alternative care has produced a crisis for both psychiatry and anti-psychiatry. As Miller and Rose have pointed out, both psychiatry and anti-psychiatry placed their faith in the community. Psychiatry believed that closing the institutions would liberate the curative power of psychiatry. Anti-psychiatry believed that closure would liberate the patients. Neither of these scenarios has occurred. Radical critics of psychiatry have had to find ways of coping with this outcome. This has been a factor of immense importance in the declining support for anti-psychiatry.

Radicals have argued that care in the community is failing because the policy makers have sought merely to transpose a medically-based model of service delivery into the community, when what is needed is to produce an entirely new model of mental health care, which allows proper weight to social and psychological factors as well as medical ones. Ramon (1985) has argued that Britain should have adopted the philosophy which accompanied the setting up of community mental health centres in the United States. Ramon (1988) is also a proponent of the Italian model of democratic psychiatry. Others have argued that the problem is that policy makers have failed to theorise adequately what they mean by 'the community', simply assuming that the community into which patients are to be moved actually exists. Because this community does not exist, but needs to be created, 'deinstitutionalisation' has frequently meant 'transinstitutionalisation', patients being moved from large unpleasant state-managed institutions into small unpleasant privately managed institutions.

Miller and Rose (1986), writing from a post-structuralist perspective, suggest that the Italian reforms are based upon the same rhetoric as that which has accompanied the British care in the community policy. Immense faith is being placed in the community as a panacea, but the community will never be adequate to the demands placed upon it. Carefully planned provision of care will always be necessary. Here, Miller and Rose provide an instance of the use of post-structuralism to question the values underpinning the rhetoric which accompanies the introduction of 'progressive' new policies.

Chapter 9 The Emerging User Movement

A major contribution to the mental health debate at present is being provided by the various elements of the user movement. As was noted in chapter 2, the

MHA 1959 created a conflict between the expectations of an voluntary, informal patient as to how they should be treated by hospital staff, and the expectation of the staff as to what qualifies as appropriate patient behaviour in a psychiatric hospital. By the early 1970s, this conflict had resulted in the formation of groups of patients and ex-patients demanding that their views be heard. The early user groups were especially very much influenced by the anti-psychiatrists. PNP reflects a radical therapy, counter-cultural viewpoint which is not currently very popular. The MPU represents a more Marxist, anti-therapy approach. The MPU no longer exists, but its descendant, CAPO, continues to represent this form of critique amongst users.

More recently formed groups have presented a pragmatic approach to mental health, based less upon knowledge of the anti-psychiatric literature and more upon their own experience. Attitudes of contemporary user groups towards psychiatry can be placed upon two dimensions:

a) The first dimension indicates the extent to which psychiatric disorder is treated as a medical versus a psychosocial matter. Traditionally, anti-psychiatry has rejected the medical model in favour of some form of psychosocial paradigm.

b) However, groups can also be categorised on a second dimension, which indicates the extent to which it is believed that psychiatric decisions ought to be made by experts, versus the extent to which they ought to be made by users. Anti-psychiatric groups have tended increasingly to reject any form of expertise alongside the medical model. More recently a pragmatic strategy has emerged of wishing to retain experts, with all the benefits that expertise can bring, whilst wishing to democratise the way in which professionals work, so that their expertise can be used without users becoming subject to their power. In the words of Peter Campbell, 'We want professionals to be on tap,

not on top'. Groups such as Survivors Speak Out recognise both the need for services to be provided with whatever professional support is necessary, but also for users to have an input into these services, how they are delivered and whether they are delivered. A workable relationship is being forged between mental health expertise and users' demands to be properly involved. Concepts such as advocacy and self-advocacy are being explored as ways of promoting the user viewpoint and empowering users. MIND has pursued a policy of involving users both in executive decisions as national level, and by forming its own user network within the main organisation.

The post-structuralist critiques of psychiatry are complex and highly academic and not understood or read by the majority of the user movement. However, the more moderate groups within the user movement are evolving strategies not inconsistent with the poststructuralist form of critique, in that they are addressing themselves less towards the truth about psychiatric disorder, and more towards issues of democracy and power within services.

The increased confidence and influence of service users has been matched by an increase in influence of groups representing relatives and carers of service users. Groups such as the NSF have promoted the view that the serious forms of disorder which are categorised schizophrenia are in fact biochemical brain disorders. Paradoxically, they promote the view that service users are in need of expert medical assistance, and sometimes expert medical control, whilst proclaiming themselves the true experts in serious psychiatric disorder. The NSF has frequently found itself in public conflict with the more radical and anti-psychiatric user groups and individual users. There is room for concern that the views of the most handicapped and needy users are excluded from this debate between extreme ideological viewpoints. If the user

viewpoint is to increase, rather than reduce, democracy in mental health service delivery, then it is vital that the views of all users are represented.

Chapter 10 The nature and extent of psychiatric expertise.

The final chapter of the thesis examined the claims of mental health professionals to possess a substantial body of real knowledge and therapeutic expertise in relation to psychiatric disorder. The adherence of psychiatrists to positivist methodologies was examined. It was suggested that contemporary psychiatrists are far more sophisticated in their awareness of the problematic nature of the concept of illness than anti-psychiatric critics have given them credit for. (And perhaps rather more sophisticated in their treatment of some of the issues than the anti-psychiatrists themselves, most psychiatrists having identified the flaws in the views of Szasz.) In relation to issues of diagnosis and labelling, the epistemological basis of the diagnosis of schizophrenia was examined by reference to Hill's (1983) critique. It was acknowledged that the concept does have flaws, and many psychiatrists hope and believe that it will be replaced eventually by a more sophisticated system of classification. Researchers such as Bentall et al (1988) are already proposing possible bases for new forms of categorisation. However, Hill was found to be completely isolated amongst academic researchers in believing that the concept of schizophrenia would be abandoned in the absence of a more viable replacement. The overwhelming opinion is that the diagnosis of schizophrenia is indeed crude and imprecise. But should it fall into disuse this will be because it has been superseded by something better, not because researchers have finally acknowledged that the object of their research does not exist.

In relation to medical treatments for psychiatric disorder, it must be acknowledged that the expertise of psychiatrists is extremely limited. There are no theoretically based forms of psychiatric treatment. All treatments currently in use have evolved through a pragmatic process of persevering with whatever seems to produce results. Research suggests that medical treatments currently in use, such as ECT and the various types of medication commonly prescribed, do have some impact on the symptoms of psychiatric disorder. However, this impact is quite limited, and such positive benefits as are endowed have to be evaluated with reference to the traumatic physical and psychological side effects which also result from treatment. Psychiatrists have frequently been slow to acknowledge the negative effects of their treatments; for example, the problem of dependency which is posed by the use of benzodiazepines. With respect to non-medical forms of treatment, research into psychotherapy has consistently shown this form of treatment to be of benefit to a range of patients, both used alone and in tandem with medical forms of treatment.

In light of this evidence, it was concluded that medicine does have some useful expertise in relation to the understanding and treatment of psychiatric disorder. However, this knowledge and expertise is limited, and the input of non-medical psychosocial forms of therapy and management is essential. It is most probably true that the medical profession exerts more power and control

in the area of mental health than is warranted by the profession's level of knowledge and expertise.

B. Conclusions.

This thesis set out to answer two questions:

a. Why did anti-psychiatry emerge during the late 1960s and early 1970s?

The thesis has demonstrated that 'anti-psychiatry' as a single, wholly coherent set of ideas did not emerge at all. Rather, from the 1960s onwards, a series of critiques of psychiatry emerged which shared a basic attitude of mistrust towards mainstream medical organicist psychiatry, but diverged greatly beyond that. The earliest critiques were principally reactions against positivism in psychiatry and social science. The labelling theorists, including Scheff and Goffman, did not place themselves in direct opposition to all physiological theories of mental illness, but argued that psychiatry was quite possibly creating a large proportion of the distress which it claimed to 'discover' and treat. These theorists questioned the objectivity of the concepts with which psychiatry worked. Szasz represents a reaction against the Progressive Liberalism of welfare state politics and the belief in a perfectly planned and harmonious social environment. Laing's early work aimed to demonstrate that much of the symptomatology which psychiatry sought to explain in causal terms could be regarded as meaningful behaviour if placed in proper social context. All these theorists can be regarded as attempting to restore some degree of agency to the individual, where positivist social scientists and psychiatrists had tended to adopt a 'faulty machine' view of humanity.

Laing and Cooper's later and more truly 'anti-psychiatric' thought emerged in parallel with the counter-cultural politics of subjectivity of the late 1960s. Their work at this time shows an unfortunate tendency to romanticize psychotic experience, portraying it as a form of mystical experience, in the case of Laing, or a form of political activism, in the case of Cooper. The disillusionment of the New Left with the counter-culture, which took place during the early 1970s, led to a definitive split amongst critics of psychiatry at that time. Laing and the majority of his colleagues in the Philadelphia Association adopted a 'radical therapy' position, and from then onwards devoted themselves to the provision of fringe forms of psychotherapy. They continued to argue that 'mental illness is a myth' (Proposition 1), but only in the weak form which asserts that pathological mental states do not have an organic basis. Cooper became more overtly and uncompromisingly Marxist, promoting mass socio-political change as the only way to alleviate distress, and denouncing psychiatric diagnosis and treatment as mystifying forms of social control operating in the interests of the capitalist status quo. He continued to regard mental illness as a myth in the strong sense of asserting that pathological mental states are themselves mythical concepts created for socio-political purposes.

b. How influential has anti-psychiatry been during the 1980s and 1990s?

The Marxist anti-psychiatry which became fairly popular during the 1970s still exists and is visible in the views of David Hill. A non-Marxist, libertarian view is found in the work of Masson and Chamberlin. All these theorists claim to be essentially opposed to all therapeutic approaches to mental disorder. However, as the possibility of a socialist Britain looks increasingly distant, Hill is compelled to offer some assistance to those people he regards as

victims of capitalism in the present, and justifies provision of psychotherapy services on that basis. Masson and Chamberlin purport to have rejected all forms of therapy, but continue to promote alternatives to psychiatry which might be termed 'paratherapeutic'. Thus, those who continue to argue in favour of the abolition of psychiatry invariably find themselves in the position of having to propose a preferable alternative for the large number of seriously disordered people. The expression 'mental illness' can be abolished by fiat, but the problem, unfortunately, cannot.

Anti-psychiatric critiques of psychiatry continue to carry some sway in the user movement, particularly amongst its most influential and articulate speakers. Chamberlin is a leading voice in the American user movement, and her views have been widely publicised in Britain (Chamberlin, 1988). Lawson, MIND's vice-chair, adopts a straightforwardly anti-psychiatric critique. The user group Campaign Against Psychiatric Oppression bases its platform upon a form of anti-psychiatry which resembles very closely that adopted by the Mental Patients' Union during the early 1970s.

However, for a variety of reasons, anti-psychiatry has largely ceased to be viewed as a credible critique of psychiatry. Academic criticism of the content and internal contradictions of anti-psychiatry, particularly the views of Szasz, has reduced the stance's credibility. The reality of care in the community as the policy has been implemented by right wing governments in America and Britain has largely silenced demands that mental health services be reduced, and focused attention upon the problem of lack of provision for both chronically and acutely disturbed patients. In the present climate, radical critics of psychiatry have begun to seek alternative political views to those provided by anti-psychiatry. The work of Basaglia and Psichiatria

Democratica in Italy has been identified as a useful model for emulation. MIND has shown great interest in the Italian reforms. However, the Italian Law 180 has also received criticism from those who have argued that, throughout the country as a whole, provision in Italy is certainly no better than that in Britain or America. Miller (1986) views Italy as simply one more instance of the belief in 'community as panacea' which has characterised psychiatry during the second half of the twentieth century.

However the Italian model does illustrate the new basis for political critique which is overtaking anti-psychiatry. This is a critique rooted in the theory of democracy. Gordon (1976) argued that psychiatry and democracy are intimately related, both being products of the Enlightenment. The two are conceptually related also. Democracy demands high levels of rationality and autonomy in its subjects. Psychiatry exists to promote the development of rationality and autonomy where they are absent. Psychiatry is the servant of democracy. The basis for a political critique of psychiatry is to be found in ensuring that psychiatry remains the tool of democracy, and does not become its ruler. Basaglia attempted to promote democracy in psychiatry by emphasizing the subjective needs of psychiatric patients, and attempting tor restore them to the communities from which they have been excluded. His attempt was only very partially successful, as he failed to guarantee both positive rights to provision, enshrined in law, and negative rights to civil liberty adequately enshrined in law.

In this country, democracy is also the basis of MIND's policies. During the 1970s, MIND devoted its energies to improving the civil liberties available to patients under mental health legislation. Since then, it has been primarily concerned to promote the voice of both formal and informal

psychiatric patients throughout the mental health services. Its campaign for consent to treatment is the latest instance of its promotion of the principles of democracy. Amongst the user groups, Survivors Speak Out does not campaign for the abolition of psychiatry, but promotes the users' own viewpoints through the provision of advocacy. The views of Peter Campbell reflect a concern for democracy and empowerment, rather than a simplistic demand for the abolition of psychiatry.

Democratic psychiatry has largely overtaken anti-psychiatry as the radical campaigning platform in the area of mental health. Anti-psychiatry was perhaps helpful in raising and publicising important questions during the 1960s and 1970s, particularly in relation to the meaning of 'illness' in psychiatry, and the role of medicine in the treatment of 'mental illness'. However, the answers which anti-psychiatry offered to these questions were not adequate to the problem of mental disorder. The emerging campaigns for democracy in psychiatry are more likely to provide some solutions. However, the promotion of democracy in psychiatry is fraught with difficulties because of the nature of the problem which mental health services exist to serve. Democratisation is likely to be frustrated by factors within psychiatry itself, including psychiatrists' status as professionals, and the continuing operation of the sections of the MHA 1983 which permit some compulsory treatment. In addition, the user movement may itself become a threat to democracy, if it fails to promote the views of the most vulnerable and handicapped users, and over-emphasises the more articulate and strident voices of those who continue to oppose outright the provision of psychiatric services. However, the issue of democracy within mental health service provision is likely to remain an issue for the foreseeable future.

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Appendix 1 Interview Schedules

1. Interview Schedule for Interviews with 'Radical' service Users and Professionals.

1.1 Are you familiar with Laing and Cooper's work?

1.2 Would you say that you are influenced by the ideas of any other authors; for example, Szasz?

1.3 Do you agree with Szasz's opinion that mental illness is a myth?

1.4 Do you think that psychiatry is just a form of social control?

1.5 Do you think that all institutional psychiatry is coercive?

1.6 Do you think that compulsory treatment should be abolished?

1.7 Do you think that all psychiatric hospitals should be closed as soon as possible?

1.8 Do you think that mental distress should not be treated by doctors?

1.9 Do you think that a schizophrenic experience can be a useful process of self-discovery?

1.10 Do you think that mental distress is caused by social oppression?

1.11 Do you think electro-convulsive therapy should be abolished?

1.12 Do you think psychotropic medication should be abolished?

1.13 Do you think users should run their own services?

1.14 Do you think people should be regarded as fully responsible for their actions, even if they are mentally distressed?

2. Interview Schedule for Interviews with 'Mainstream Psychiatrists'.

2.1 Do you think that doctors are the best people to treat people who suffer from serious mental illnesses; for example, schizophrenia?

2.2 Do you think that serious mental illnesses such as schizophrenia are actually brain diseases?

2.3 Do you think that researchers are close to finding an organic or biochemical explanation for serious mental illnesses such as schizophrenia?

2.4 Do you think the category 'schizophrenic' will continue to be meaningful for psychiatrists in the future?

2.5 Do you think the major tranquillizers work by correcting identifiable biochemical imbalances?

2.6 Do you think that serious mental illnesses such as schizophrenia are entirely or mainly genetically predetermined?

2.7 Do you think that social factors play any part in the onset of serious mental illnesses such as schizophrenia?

2.8 What is the relationship between social causes and organic causes?

2.9 Do you feel confident that you can recognize serious mental illnesses such as schizophrenia in patients of different cultural backgrounds to you own?

2.10 Do you distinguish between serious mental illnesses which you feel sure are mainly physiological in origin and less serious ones you feel sure are psychological in origin?

2.11 How do you make this distinction?

2.12 Does it make a difference to how you treat the patient?

2.13 Do you think doctors are the best people to treat people who suffer from less serious mental illnesses?

2.14 Do you think that you views are typical of most psychiatrists?

2.15 How many psychiatrists do you think believe that serious mental illnesses do not have organic causes?

2.16 Why do you think that some psychiatrists think this?

2.17 Do you think their views are reasonable?

2.18 Do you think anti-psychiatry has been helpful to psychiatrists and their patients at all?