Asylum

a magazine for democratic psychiatry

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EXCLUSIVE INTERVIEW: R D LAING

Psychiatric Democracy in Italy

The Politics of Mental Health

news views reports

FIRST ISSUE

Editorial

At the end of 1984 a conference was held at Wakefield, concerning the plans to close the mental hospitals. The day was dominated by reports and discussions of the Italian experience of just such a policy. Many were impressed with the work of the radical reforming group, Psichiatria Democratica, which had cut across the crippling disciplinary boundaries of mental health care in Italy, and had produced very significant results.

It became apparent at that time that a number of mental health workers and ex-patients in the region thought that a forum for debate was sorely needed. A forum that was non-aligned politically, professionally or by trade union. A forum in which all views could find expression.

A group came together and decided that the first objective in a campaign for a more democratic psychiatry - to address all issues in the field, not just hospital closure - was to establish a magazine.

This is the first issue.

ASYLUM is to be published quarterly by this Yorkshire-based group of mental health workers, ex-patients and interested parties. We intend the magazine to be THE FREEST POSSIBLE NON-PARTISAN FORUM FOR DEBATE FOR ANYONE IN ANY WAY INVOLVED IN MENTAL HEALTH WORK. WE WISH TO SEE A MORE DEMOCRATIC AND HUMANE MENTAL HEALTH SERVICE. WE KNOW THAT EFFECTIVE ACTION CAN ONLY EMERGE FROM HEALTHY, DEMOCRATIC DEBATE, IN WHICH ALL SIDES CAN PARTICIPATE AND BE HEARD.

Those in charge are fully aware of the value of unity in action. ASYLUM is offered as a vehicle for unity amongst those at the sharp end of psychiatry. This is yours, the readers' magazine. We welcome all contributions.

We intend to edit minimally and in full consultation with contributors. If you have to contribute anonymously, that doesn't matter.

Within the editorial group there is an admiration for the work of Psichiatria Democratica. We are agreed amongst ourselves that the use of coercion, locked doors, violence, drugs and ECT is, at the very least, regrettable. But exactly how to organise therapy remains the fundamental problem. And so this issue continues with the theme of Italian reform, including an article about the founder of Psichiatria Democratica and one by a nurse who lived through the experience of closing a hospital down and moving out into the community. We also include articles on other issues of mental health care and reform that we feel are very important today and for the future.

This is what we think. What do you think? The editors of ASYLUM invite your contributions as readers and participants in a movement to make psychiatry more responsive to the real needs of patients and of those employed to relieve their distress.

Asylum is a nonprofit-making quarterly magazine for democratic psychiatry.

The views expressed in ASYLUM are those of the individual contributor, unless otherwise stated.

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Italian mental health reform

In 1978 the Italian Parliament passed a radically new Mental Health Act, Law 180. It barred the admission and readmission of psychiatric patients to large public hospitals. It also prohibited the construction of new psychiatric wards, and set a limit to the number of in-patient beds at 15 per 200,000 population. Existing hospitals were to be closed or run-down, and patients were to be rehoused in a variety of settings - flats, group homes, community hostels - or invited to remain as guests in the existing hospital accommodation. Community-based mental health centres were established, operating on an informal, drop-in basis, thereby avoiding bureaucratic referral systems. The Law specifically prohibited the redundancy of staff resulting from these changes. They were to be redeployed within the new community-based service.

In Britain in the 1960's psychiatric hospitals began to discharge large numbers of long-term psychiatric patients. For many the idea of 'community care', in the absence of any clearly formulated principles and policy, has meant living in institutionalised hostels, private lodging houses, lonely bedsits, or sleeping rough on the streets. Far from creating any realistic new ideas or understanding and caring for emotionally distressed people, the medical model has merely been reproduced outside of the hospitals with people 'maintained' on long-term drug therapy, the occassional visit from a community nurse, and a ten-minute out-patient appointment.

There is now, coming ever stronger from the Government, a national policy to close down all psychiatric and mental-handicap hospitals. In many areas the closure dates have already been announced. Sometimes the dates just appear in the local press, and take by surprise those who live and work in the hospitals concerned. In Italy the staff, patients and local residents were involved from the beginning, in a gradual process leading towards the creation of genuinely community-based services, the cooperative redeployment of staff, and the education of the local communities - in the more honest and compassionate localities. Other localities resisted and obstructed the new Law. Unless we in Britain are prepared to confront the issues, we are in danger of creating a situation whereby hospital closures will only mean a lack of services, redundancies, lower-paid workforce, and the over-burdening of families and local residents.

F Basaglia - democratic psychiatrist

Franco Basaglia was a Venetian of upper class origins, but with radical, anti-fascist views. He spent several months in prison for his underground activites, and certainly read and was influenced by the communist theorist Gramsci and his similar experiences. Prison was his experience of a total institution, and he struggled for the rest of his life to counter just that.

After qualifying medically, Franco became a university lecturer in Psychiatry at Padua. In the early '60s he came to London and met Maxwell Jones, Ronnie Laing and David Cooper. Subsequently he decided to try to take-over the mental health services of a small town, Gorizia, on the Yugoslav border. Before going he negotiated with the administrators for a free hand, and for the simultaneous appointment of ideologically compatible psychiatrists and social workers.

The life of the hospital became centred around the debate between patients and staff, and others who wished to be involved, on what to do with the hospital and its services. Apathetic patients became active, and in some cases became chairpersons of the policy-making committees, and soon produced their own newspaper. They also began to take jobs in the hospital at ordinary trade union wages. The whole hospital became open and unlocked, day and night, and the local population were encouraged to join in its activities, while groups of patients who had begun to work in the hospital moved out as commercially viable co-operatives.

In the late '60s student protests in Italy, as elsewhere, coincided with factory and trade union protests and the founding of the feminist movement. Basaglia's work attracted the protestors, and volunteer students came to work in Gorizia.

In 1970 Basaglia moved to Trieste and there he led the creation of mental health centres. These were walk-in centres, to replace hospitals, some having overnight accommodation for up to eight people. Psichiatria Democratica was founded by Basaglia and colleagues as a loose association of professionals fighting for radical changes in Italian psychiatry. In 1978 they induced the Parliament to pass Law 180, which

declared the desirability of the closure of psychiatric hospitals and steps to implement this.

In 1980 Franco and some of his team moved to Rome, but he died from a cerebral tumour in 1981, making the now famous comment: "This is a good moment in which to die."

His great companion was his wife, Franca, the first Italian Member of Parliament to represent mental patients, and a joint author or contributor to most of his works. They were a brave, determined, compassionate, cultured and brilliant couple. They saw the need to transcend the existential phenomenology of Sartre and Laing, and to be practical in a social context, which they interpreted along Marxist lines. Basaglia's work The Death of a Class expressed their view of the relationship between mental illness and society. The Deviant Majority was concerned with the majority's interest in marginalising or excluding minorities. The Criminals of Peace explores the violence in peacetime, not least that towards psychiatric patients. The most famous book was The Negation of the Institution - but little of their work is in English.

The central idea is expressed in Franco's statement: "The production of a new culture cannot be born without a new social practice".

Dr F A Jenner, Dept of Psychiatry., University of Sheffield.

ITALY and the legitimation of psychiatry

BY DR ALEC JENNER

The visit to Sheffield in April 1984 of four Italian mental health workers, members of Psichiatria Democratica, and my own subsequent visit to Trieste in August 1985 have inflamed my preoccupation with the legitimation of psychiatry. The current Italian scene, which that group praised, is the most obvious remnant of the turbulent 1960s. Many students and workers were then causing untold concern to all authorities, from university and factory administrators to the French Government itself. The fervent passion and original thought associated with some chaos and insecurity was exciting as well as frightening. The responses were also varied: many closed their eyes and others reacted as if youth had gone mad. In return it was declared that no-one over 30 could be trusted, and the enigmatic advice was given: "Don't change your mind, there's a fault in reality".

Franco Basaglia was the Italian Laing of that period, and in fact more influential in actually changing institutional life. Unfortunately little of his writing is available in English. He argued essentially that the fault in reality was the concretised thought which an industrial society like ours produces, and in which it is abnormal to be miserable with the lot assigned us in the family, factory, etc.

That, added to the conviction that society can't really be changed, and that doctors must deal with abnormal individuals, leads, if not to the legitimation of psychiatry, at least to its birth and childhood.

This legitimation is the faith that the doctor cares and knows best: Basaglia questioned both assumptions. Of course the doctor cares - most are humane - but the way he cares depends on his ideology. For Basaglia, that depends on what and how he thinks and knows things. Or, put another way, it depends on the realities which he accepts unquestioningly. Basaglia argued that that depends heavily on the common sense of the period, which a wealthy and priveleged group will usually blindly support and help to fit all others to. The title of his book - The Deviant Majority - underlines this view.

It was Basaglia who was the major architect of the Italian Law 180, radically altering the concept and practice of psychiatry.

But the democracy in Psichiatria Democratica does not depend on anything like that which Mrs Thatcher calls her "mandate" from the polls. It is the insistence that the degree to which people care, are democratic, is to be measured by what they do in relation to obvious human needs, despite profession and rank. The doctor doesn't have to call the nurse to wipe the old man's bottom, if that is what is needed and he is there. In addition, the doctor's claim to be more able to treat psychiatric disorders than the paramedical is fairly suspect, even without asking what is best and accepting the common sense view of health: ie, fitting in and not complaining, being happy with your lot.

The doctor's case in the higher level debate is even less valid: his potency when in fact the patient wants to see the top man arises itself from the hierarchical structure the top doctor enjoys and will obviously be bent on preserving, like any other professional.

Basaglia would not have denied the way in which the term 'madness' is used, or a near synonym. Presumably madness is recognised in all societies. However, all classical scholars know of the howlers caused when concretised concepts of the meanings of words used in one time and place are applied to another. 'Idiot', for example, in Classical Greece, referred to the private individual who thought for himself. Bearing these sorts of considerations in mind, and not denying that misery and madness antedate 19th century Europe, Basaglia still points out that our modern debates on the definitions of madness, our institutions and professions and modern laws on psychiatric treatment, emerge with industrial society.

Basaglia would claim that too much human wretchedness had to be fitted into the new means of production. The prevailing idea was that society was rational in its development, its production of great new wealth and possibilities. It was, or is, unreasonable to be unable or unwilling to join in the great adventure. Such people must be somehow wrong. People should want to live and to work, and ought not to be angry or depressed about the nature of things, nor even very anxious. To be paranoid is to be ill, to be unaware of being a pawn in a game is healthy.

Having defined who is to be called "mentally ill", the great ally of industrialism, "objective scientific thought", which made the factory itself possible, must be given cash to help classify and treat the "illness". "Science" is clearly the only road to knowledge. The healing of the mentally afflicted, too, must become both a science and an industry to "improve" life and society.

The asylum was as generous to the idle as the slum and early factories were to the productive, and medicalisation removed the problem from the issue of justice. Certainly, he who doesn't work can't expect the rewards of others' efforts, unless he is an owner, or ill. The law could have engaged itself with the problem of those who are "a danger to themselves and to others", instead of producing the glaring conflict in psych-

iatry between healing and policing.

The current Italian system does favour the law responding to violence, but the mental health worker maintains regular contact with his clients in prison, as he would in their homes. The major hope of the mental health worker, according to Basaglia, depends on really convincing the patient that care rather than control is his concern. Basaglia would certainly have felt the fact that modern psychiatry is born out of the French Revolution, via Pinel, as a central insight into its nature. The new, rational, productive and caring society needed to be able to cope with these people. The Soviets hospitalised dissidents as schizoid only after Khrushchev had denounced Stalin's misuse of the law: then the law couldn't cope and the Soviet establishment became afraid of what might be revealed. Freedom couldn't go too far. The justice of the structure of daily life couldn't be discussed publicly in the courts!

Perhaps it is true that, to some extent, Italy's backwardness, and the legacy of Fascist laws made Basaglia's task and revolution easier, just as the English had their revolution in politics before the French, and so had an earlier development of industry and free trade. We also began to improve our asylums before Italy, and much of what Basaglia portrays is of a bygone age in England. It is important, however, not to let the difference in context allow us to miss the impact of what is left of Basaglia's message in our own too easily complacent complicities.

Basaglia's reforms began with a conventional attraction to Maxwell Jones' concepts of therapeutic communities. These were isolated enclaves in which people's outlooks and behaviour were adjusted by themselves. This exonerated the professional from the charge of "brainwashing to fit them in". However, the adjustment was still made outside the real community itself, and despite all its virtues, 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. The modern craze for family therapy can be considered in the same light.

Basaglia recognised the differences between post-war Italy, France, Britain and the USA, but insisted that certain constants remain: the conceptualisation of illness, failures to explore the meaning of suffering involved, the failure to see that individuals, especially psychotics, have a potential for real life and development, but not necessarily to fit our moulds.

The horrors of the asylum in England led to experts taking control in the community. Basaglia does not want to argue for that. He is anxious to express the eternal need for revolution in thought, for reflection on our own professional behaviour and motives, for recurrently creative criticism of our social mores, and a persistent vigilance against the recurrence of institutions. The most widely read of his books - L'Instituzione Negata - is about the unsuitability for people of the institutions. He campaigns against creeds, against an organisation that becomes reified and takes over from men who feel they cannot change it, against our own need for domination, and for an increased consciousness of ourselves and our own tendencies. Honesty about them will make us more sympathetic and understanding, less organised and efficient, but much less alienated and alienating and necessarily more human.

According to Italian Democratic Psychiatrists, when the professionals are seen to be fighting against the institutionalised power structures, and when they themselves close the mental hospitals, then the symptoms of the patients change. The so-called Socialist Patients' Collective, in Heildelberg, Germany, took over the hospital for a period, and it was similarly claimed that chronically apathetic and irrational people became verbally able and competent. There, however, it is claimed, the protestors were about to resort to gross violence, recommending the use of guns in the patients' struggle for real power. Hence the police took over, and Huber, the psychiatrist and leader, was imprisoned. It is, however, remarkable how little British psychiatry knows about these experiments. Irrespective of whether one would wish to copy them, surely we should be clear about whether some "schizophrenics" did and do change in such an enlightening way.

I confess I am not sure how successful copying Psichiatria Democratica could be here, nor how long it can survive in Italy. I also lack the courage and utter conviction to struggle as Basaglia did. My own position is too comfortable and I can use the institutions, outpatients, professionals, etc, in a fairly adult way for my own ends and good income. But does that legitimate them or me?

I think in part it does, as an enormous element in mental health, in the language game we play, involves complicity with social structures. Inability to beat them, and a profound unwillingness to join them because of emotional hang-ups, spite, lack of trust or opportunity simply won't work. The art of politics is the art of the possible, and the aim is success without totally losing sight of the cause, or losing too many troops. It is all necessarily complicated and somewhat contradictory. The first step is to notice. Then the possible quality of the debate and of reforms can be improved.

In Italy nurses grow and mental hospitals fade away

BY GIVOANNA BATTAGLIA – PSYCHIATRIC NURSE, TRIESTE

Fifteen years ago Trieste had a psychiatric hospital with more than 1200 beds. There were plans to build another.

Today, instead of the hospital, we find seven community health centres, with 40 beds in all, for a general population of 300,000, and a client population of about 3,000 yearly. There is an emergency service, 22 group homes, and some work co-operatives. 280 ex-patients live in the converted buildings of the old hospital. There they live as free citizens, with support. A team providing psychiatric support in the local prison finishes the setting.

To tell the story of these 15 years, as we have lived it as nurses and protagonists, is not easy.

I must emphasise first of all that of the nurses working today in the new structures, 80% have worked in the old hospital. Only 20% are new nurses, replacing those who retired.

And so the transformation from a hospital-based model to one of providing health and social support in the community has taken place in Trieste via the everyday practice of the 300 nurses who worked in the old psychiatric hospital.

We believe that the fact that the psychiatric experience of Trieste is special, even in Italy, is related to the fact that the nurses participated in it, at times in a contradictory way, but always as active participants.

I would not like you to think it was all that simple, without conflict among us. Sometimes practical situations led to open conflicts between us or between us and the union, as well as between nurses, doctors and administrators. Even today there are still unresolved problems, not because of the closing of the hospitals, but because of the slowness of the administrative, legal and union systems, which have not kept up with the changes in our daily work.

With the problems, the feelings, the conflicts we have gone through, when it seemed impossible that a city this size would be able to survive without a psychiatric hospital, it is not easy to reconstruct such a long story.

It seemed impossible that we nurses could radically change our work; that those chronic patients who had lived for years in the hospital might be able to move out, to dress, to live in normal conditions. It was difficult to imagine that those young people familiar to our admission wards, with us knowing that they would become long-term patients, could have a different career to pursue. It seemed impossible to think that there existed other places in which to confront a serious and violent crisis which we witnessed in people brought in by the police; and yet that it just might be possible that the episodes of violence which we considered normal in our work might become an exception, abnormal.

I know there exists a debate in psychiatry around the work initiated by Professor Franco Basaglia. It might take a long time to explain it all, but I would like to say clearly that it is possible to confront psychiatric suffering outside of mental hospitals.

When Basaglia and his group of doctors arrived in 1971, we, the nurses, moved out of a phase in which more than 1/3rd of us were in temporary posts, and very much dependent upon the goodwill of the matron and director, and the wards of the long-term patients had a doctor visiting for one hour a day.

The hospital was a very strong hierarchical system, based on personal and political favours, with us nurses busy maintaining the system.

Many of the long-term wards had nurses abandoned on them, weilding enormous power over the patients - the symbol of which was the bunch of keys.

Several admission wards with those "at risk" and "violent" had nurses especially chosen for their physical strength, and had to be preoccupied only with the possibility of violence.

In the first few years the changes with regard to the internal life of the hospital and the contradictions that developed remained dormant. They were rarely so simple as a conflict between nurses and doctors, or the "reactionary" vs the "progressive".

Often our discussions were confused, and nurses could easily take contradictory positions. For example, while the rigid hierarchy was being destroyed many were glad to no longer be victimised by it, but also strongly opposed to being stripped of their own power.

The intervention concerning the rehabilitation of long-term patients managed to bring a radical change in the way we worked. For many this was accompanied by a sense of liberation, yet it entailed problems at the level of the union's definition of our role, and at the personal level of role definition. We lived this new possibility as an insecure opportunity which depended solely on the goodwill of the hospital director.

The open doors have curtailed some of the anxieties, but there were patients who could not even go out of an open door. This generated tension and a new awareness of how people may be controlled. Many patients did not want to go out for more than a few minutes. They seemed to be indicating a fear that this new freedom was an illusion, and needed to be supported in that first move towards an unknown and unsafe world.

One of the most explosive conflicts developed around the creation of a work co-operative by ex-patients carrying out cleaning jobs. Initially, the nurses cleaned, and patients helped, including those doing occupational therapy. Patients were paid with cigarettes and money. In 1973 the administration decided to create the co-operative, whose members were paid a proper rate. This liberated the nurses from unpleasant jobs, but initiated strong reactions from those who claimed the patients could not be trusted to clean properly. The fear of the nurses being forced to change their role into one free to focus on relationships with the patients was lurking behind this issue.

Today that co-operative has over 100 members, a mixture of old patients and new clients, has a turnover of over £60,000 annually and gets contracts from outside the health system.

In general we were confronted with two major questions: What would our future be without a hospital? and: What about the patients? - what will they do on the outside? who will look after them? what will happen if they go into a crisis?

It was decided that there was no need for a total confrontation, but that constant meetings, discussions, everyday small changes in work and relations of the personnel and patients, would all lead to a better future both in terms of the patients' well being and in terms of the nurses' professional identity.

Our national union oscillated for a long time between political support for the change and an attempt to resist it in practice. We got orders such as: be wary, don't do certain jobs, don't leave the hospital with the patients, don't make home visits. As the union was not in touch with our changing reality it lost its hold over the nurses who opposed the changes as well as those who were all for them.

In 1976-77 the confusion suddenly stopped for a moment. Each side declared its position. Already there were 100 nurses working outside the hospital, the rest remained inside. Community mental health centres had been created to provide support for those who had left hospital, either for group homes or for their families, and to prevent the hospitalisation of new clients. The team of doctors, social workers and nurses was invested with tasks which were completely new - home visits, rehabilitation, introducing people to jobs, preventions, etc. But at times this new mode of operating did not work out and an admission became necessary. To meet this need some admission wards were kept. Although the atmosphere changed, the roles did not. Apart from this, several wards with long-term patients remained because of the patients' old age, the lack of suitable accommodation, etc.

The nurses working in the centres tended to value their work as an alternative and a superior sort of professionalism to that inside the hospital. The nurses on the admission wards emphasised the limits of the work done in the centres, and the latters' dependency on the traditional type of professionalism. The new type of work was not recognised by the unions for some time and did not lead to a higher salary.

Those two camps remained separate because the settings for prevention and rehabilitation were physically apart from those in which crisis management took place. In the latter, the culture of the "madhouse" continued to exist and the disagreements between the two types of nurses deepened.

In 1978 this particular conflict was altered by four factors, and a new phase began:

The new Italian Mental Health Law was enacted. It legislated the gradual closure of psychiatric hospitals, to be replaced with psychiatric wards in general hospitals - but only 15 beds per 200,000 population - and a network of community health centres.

A battle started without the support of the trade unions for a new contract and professional recognition for the new type of work of all of the nurses. This battle was won by the nurses, and it reunited the group.

The decision at the level of the directorate not to establish a psychiatric ward in the general hospital, but to develop the centres so they could accommodate people in acute crisis. The closing of the admission wards led to all nurses moving out, and this let the centres operate a night shift.

More work was put into either closing down the rest of the hospital or converting some wards into group homes.

We have discovered that it is possible to be a psychiatric nurse outside of a hospital. It is also possible to have a therapeutic relationship with a patient when he or she is going through a crisis, without an admission ward, and to help them to build up a normal way of life regardless of their illness. We have also seen the transformation of the forms of mental illness.

Today we nurses have a different relationship with these people who were in hospital, and who look on us today with confidence because they have seen that we have helped them to construct a different way of life. Also, we can see the slow process of cultural change of the whole city around the issue of psychiatric problems. Today we have young people coming to the centres from a generation that does not know what a psychiatric hospital means, and who have a very different attitude towards us than the people we used to work with fifteen years ago, the service we offer and their illness.

It might be said that they are less afraid of us and of their psychiatric problems. We believe it is no accident that the number of episodes of violence has decreased significantly compared to what used to happen in the old hospital and that the number of compulsory admissions is only 1% of the total interventions in the centres.

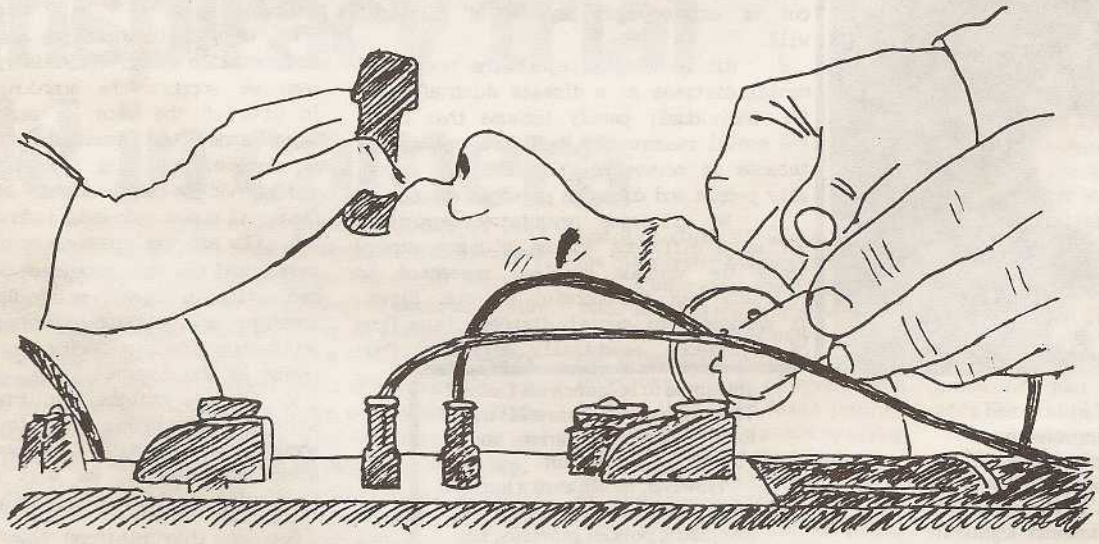
In each centre there are 4 doctors, 2 social workers, and about 25 nurses. We try to work as a team because we wish to secure the continuity between psychiatric and social support, between crisis intervention and rehabilitation, between an interview and social support. Above all, because we were able to work together in these moments, we could participate actively and acquire a new type of professional identity.

Not all problems are resolved, nor was the process of change without its pain, but it was a beautiful change. We can verify that our request to work with patients outside of the hospital has met a good response.

"Where will they go when they are unwell?" They always come to us. Even though we are not all together in one big place. We exclude no-one ands work without violence, against the mentally disturbed person's marginalisation, and for their health. It is important for us to remember that without a psychiatric hospital they can lead a dignified life. They are feeding themselves, washing themselves, dressing. These simple facts of life are important to us because we know that we, too, could well become, under greater stress and strain in our lives, mentally ill ourselves.

RESISTING DOCTORS' POWER : 1

ECT – the conscience clause



In 1982 a student nurse was sacked for refusing to participate in giving ECT. The training rules were rigged, after the event, in order to sack the student - a point which his lawyer, MIND's Larry Gostin, made nothing of, but instead argued a pathetic liberal case for the student's right to refuse on the grounds of conscience. All very well, but not likely to stand up in a court of law, which deals with contractual technicalities, not appeals to humanitarianism.

The student nurse lost his case, but was invited to speak about ECT and the right to refuse to participate, at COHSE's national conference, that year. At a well-attended fringe meeting, delegates were urged to raise the matter at their own branches in order to push for a national policy supporting nurses refusing to participate in ECT on the grounds of conscience.

In May 1984 COHSE issued a policy statement: ECT, Conscientious Objection. This was brought about by union members raising the matter at branch level, instructing delegates to take it to regional level, and forcing the National Executive to consider the issue.

These are the two most important recommendations of the National Executive:

The Confederation upholds the nurse's right to hold ethical and professional objections to participating in ECT. Whilst recognising this is a minority viewpoint, the Panel believe it is a growing body of opinion.

The Confederation should support those members who ascribe to the belief that to participate in ECT is wrong.

Though this is a first step, it is a very important one. What is needed now is further union branch activity to push for a stronger, explicitly supportive policy. As an isolated individual, no health worker could resist management victimisation, and that is what one must expect if one tries to resist the imposition of arbitrary power. Health workers owe it to their patients and to themselves to organise collectively to bring about democracy in psychiatry. That is what the right to refuse to participate in shock treatment is all about.

And why stop there? Drug therapy and

behaviour therapy are also inhumane. Unions in the Health Service should be promoting positively therapeutic programmes, instead of always reacting, defensively, to the hard sell of the drug companies and the entrepreneurs of smooth-talking faddish pseudo-therapies, and to the no-questions dictates of bureaucratic-minded managements.

Initially this needs an educational approach to expose the ideological nature of normal psychiatry - the motivated, interested untruths which govern what passes for ideas in psychiatry, and hence what happens in practice. If health workers are going to refuse to participate in administering shock treatment they must be able to offer genuine and practical alternative therapies. There should be an active campaign to get better staffing levels in order to practice the proper therapy of decent human contact rather than containment (drugs) and coercion (behaviour therapy).
Lyn Bigwood.

RESISTANCE: 2 THE British Network For Alternatives To Psychiatry

The British Network is part of the International Network for Alternatives to Psychiatry. It is an umbrella organisation for groups from all over Europe and North America, aiming at a fundamental debate on psychiatry and the promotion of alternatives to the existing system.

The Network takes different forms in different countries. Here, its members are consumers of the psychiatric services and professionals from the different helping professions, as well as interested lay people. People join as individuals, not as representatives of a discipline or group.

Purposely, the structure is not rigid. There are only a few rules, and duties are undertaken on an ad hoc basis. So far there is no system of funding.

The Network meets monthly for discussion and decision-making. Working parties are formed according to need.

The meetings are run democratically. The common denominator uniting the members is the deep dissatisfaction with the current psychiatric system.

The British Network has existed for just over two years and so far operates only in London.

As members of the Network we affirm the following principles as the basis for the discussion of fundamental changes in the essence of the psychiatric system:

1. That mental distress does exist. Psychiatric problems cannot be defined out of existence by an act of political will.

2. But we firmly reject the notion of mental distress as a disease which afflicts the individual; partly because that masks the social reasons for such distress, partly because it serves to stigmatise and segregate people and diminish personal autonomy.

3. We criticise psychiatry separating off as a different sphere of human experience the various problems presented to it. This has two harmful effects. First, it assumes that mental distress is a form of experience essentially different from the range of other personal experiences. Secondly, it assumes that psychiatry is the most appropriate way of dealing with such distress. Along with this goes the power and responsibility accorded to psychiatrists. We do not regard it as desirable or realistic to reject professional knowledge and expertise out of hand, but we do call in question the exclusive social authority and power that goes with the professional role.

4. We hope to see the rapid dissolution of mental hospitals; but not for the economic/technocratic reasons currently promoted. Total institutions disconnect people from ordinary life. This, however, is not to deny people's right to a temporary and open refuge - the original meaning of the term "asylum".

5. We are concerned that community psychiatry can result merely in a shift of the site of psychiatric ideology and practice from the hospital to the community. But this is not inevitable, provided a reorientation of the entire system can be brought about.

6. It is essential that any discussion concerning institutional changes must involve the psychiatrised fully in the decision-making process. It is crucial that this is actively encouraged and supported by all groups currently involved in decision-making.

7. We wish to emphasise that a critical confrontation with psychiatry does not mean we support the abandoning of care. In view of the cuts in services already being made, we demand an adequate level of service. Reforming psychiatric services should not be used as an excuse to cut financial support or make redundancies.

8. GPs are the gatekeepers to psychiatrisation and the main providers of psychiatric medication in this country. Therefore their training and attitudes are of paramount importance in considering any fundamental change of the system.

9. We are against involuntary incarceration of psychiatric patients. Individuals should have the right to refuse any psychiatric intervention, as well as the right to receive the best help possible.

Out of this platform have emerged the following main objectives:
1. to make the general public more aware of the issues involved in mental distress.
2. To lead to change in the policies related to mental distress.
3. To promote a direct support project.

So far our activities have included:
a clarification and an arrival at a consensus amongst the Network's heterogeneous membership as to what the Network stands for;
the formation of several working parties focussing on:
our platform,
the closure of the psychiatric hospitals,
how to promote the abolition of the use of ECT,

Kenneth Wood

Ken Wood died in July, and a bright star disappeared from psychiatry's night sky. He did not belong to MIND, but for over ten years he was an active campaigner for psychiatric inmates' rights. He was not a mental patient himself, but he knew people who were.

Around 1974, he launched a Mental Patients' Union and ran it with the help of ex-patients. When their problems recurred, he often had to organise the Union's activities single-handed.

He received help from the controversial Scientologists; they had their own campaign for mental patients' rights, the Citizens's Commission for Human Rights. Ken joined forces with them, as running the Union by himself had proved too difficult. Never a Scientologist himself, he eventually parted company with them, feeling uneasy about Scientology. He attempted to re-launch his Union. The problem was money. He tried to get funding from various bodies but nothing worked out.

However, he achieved a lot; not, perhaps, in revising the country's psychiatric policies generally, but certainly in helping individuals. He had built up a number of contacts in the political and psychiatric fields. He had learnt which hospitals were bad and which were not-so-bad, which psychiatrists you could trust with your life and which ones you could not trust with an old boot.

His contacts helped him get things done. One example: he once had four hours to prevent someone being sent to Broadmoor. He succeeded. Can MIND match that? MIND, apparently, was not particularly receptive to Ken. Shame on MIND! **Robert Dando.**

FROM: OPENMIND No. 17, 1985

the possibility of establishing a drop-in centre,
how to support those wishing to come off major tranquilisers.

Usually the working parties report to the general meeting and come up with concrete proposals for a Network project;
a study day in which we looked at the processes and objectives of the current plans about the closing of large psychiatric institutions. The study day successfully disseminated information about closures and about the Network itself.
participation in the annual International Network meetings.

The present period is critical for the development of British psychiatry. Is it going to move towards a genuinely radical alternative, or will "change" be merely window-dressing?

The Bristish Network will do its utmost to promote a radically alternative psychiatry.

For further information contact:
The British Network
158 Rivermead Court
Hurlingham
LONDON SW 6

RESISTANCE:3

Campaign Against Psychiatric Oppression

If someone is having their arm twisted it does not mean that they are ill if they feel pain - there would be something wrong with them if they didn't! And the remedy is not to insist that they take pain-killing pills, that they are really imagining it all, or in fact torturing themselves. No! The answer is so simple a child might see it - though not a shrink, who is trained to not see what is in front of his face, anyway. The answer is, quite simply, to stop the twisting. It is the same with someone caught in the torments of an untenable and contradictory social situation.

Even psychiatrists who admit the dangers and disadvantages of their "treatments" attempt to justify them on the grounds that it is better for the "patient" to submit to these measures rather than suffer from crippling anxiety, crippling depression, or crippling confusion.

We deny this. And assert that "patients" are not crippled by anxiety or depression or confusion, but, on the contrary, they are anxious, depressed and confused because they are crippled - by circumstances over which they have little or no control, circumstances which thwart, threaten and confuse. When a person's behaviour is intolerable to his/her fellow humans, it is usually because his or her situation is intolerable to him or her. And such a person may need help to change the situation they are in.

Psychiatry and its institutions do nothing to change this situation, but rather perpetuate it by forcing the person to accept and adjust to it. We reject the idea that "being well" is the same as "being normal" or as "being good" - ie, behaving as you are expected to.

The situations into which the victims of psychiatry return is then made worse because of the label given them - which continues throughout life. This label, such as "schizophrenia","personality disorder" (and many others), makes discrimination almost inevitable in getting jobs, etc.

Psychiatry is a very subtle method of repression in advanced capitalist society. Because of the subtlety few recognise the dangers shrouded by the mystification of "modern medicine". The pschiatrist has become the High Priest of technological society, exorcising the "devils" of social distress by means of:

psychosurgery -butchery of the brain,
electric shock "treatment" - plugging brains into the mains,
and the heavy use of drugs - poisons that deform the central nervous system and create passive addicts.

The "mental patient" is a sacrifice we make while we serve the gods of Capitalist Religion.

The big guns of psychiatry are held to the heads of the working class in order to control them. Statistics show the disproportionate admissions to psychiatric institutions from areas of poverty, bad housing, high unemployment and heavy industry - in short, working class areas. The suffering inflicted on working people, and particularly on women, through poverty, repression, frustration at home and at work, etc, obviously tends to result in anxiety, depression, and, when extreme and unrelieved, sometimes in delusions. Although it must be recognised that what a doctor calls "delusions" are often accurate perceptions of a working person's oppressive reality.

In this way the oppressed become the scapegoats for the economics of capitalism, which has deliberately created a pool of unemployment, in which people can become depressed, disillusioned, and lose confidence in themselves.

THE PSYCHIATRIST DOES THE REST!

The middle class is not exempt from falling foul of the system. As the managers, administrators and apologists for capitalism, the middle class is obliged to defer to the ideology of its masters, the ruling class of money-barons. In order to preserve its status and security of privelege, the tenuous distinction between the middle and the working class, middle class people who offend against, reject, or unable to cope with the values of alienated individualism (a squalid, private mentality), competitiveness, and "striving for success" are seen as a threat to the class values and therefore the class position. "Deviants" expressing their escape from, or attack on, the class values, through "depression", "psychosis", or "character disorder", having thus been labelled, add to the numbers conveniently dealt with by psychiatry.

Confronted by psychiatry, the "patients", from whichever class, are thrown into the relationship of workers vs ruling class. The psychiatrists, agents of the capitalists, enemies of change, proceed to con the "patients" into the belief that it is they who need changing!

Just as the poor are blamed for their poverty, the unemployed for their idleness, slum tenants for bad housing conditions, and "backward" schoolchildren for their "deficiency", psychiatric "patients" are blamed for their "illness".

IT IS TIME WE FOUGHT BACK

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 - alongside trade unions, claimants unions, prisoners' rights groups, feminists, ethnic minorities, gay liberation, etc.

Copies of CAPO's manifesto, (50p per copy), and further information can be obtained from: CAPO, c/o 18 Seymour Buildings Seymour Place, LONDON W1H 5TQ

MRS JONES by MIKE LAWSON

You look a little angry now,
You keep pacing up and down.
You're not smiling now,
You wear a frown.
We will increase the dose to make you better,
Was it you who wrote this letter?!
We have to find out what is wrong with you,
There are so many things we can do.
Modern medicine is wonderful,
Look at Mrs Jones.
I say, look at Mrs Jones!

You must cooperate, science will take a hand.
There is a nuclear serum to inject into your gland.
First we'll take your clothes away
And you'll be under observation.
That will help us decide the treatment you need.
Look at Mrs Jones.
I say, look at Mrs Jones!

You've been here a month now, and it's hospital policy
To advocate the use of ECT.
We insist you sign here.
Don't interfere with your treatment.
Doctor knows what's best for you.
Look at Mrs Jones,
I say, look at Mrs Jones.

You're not cooperating, we've tried to make you better.
If you won't sign, there are other ways.
Come on, wipe that tear away.
We are trained to reassure.
Look at Mrs Jones,
I say, look at Mrs Jones.

If you insist on not helping yourself
You will get heavy drug therapy, and sent to a back ward.
Be sensible. Look at Mrs Jones.
I say, look at Mrs Jones.

Your mother has been told you are a schizophrenic.
Now, no need to panic. We can help you.
Look at Mrs Jones, Mrs Jones, Mrs Jones!

RESISTANCE:4 Patient Power

A salutory story from a lucky and plucky young lady who found herself sectioned in Scotland recently:

Experiencing visions to accompany her distress at the breakup of a long-standing relationship, she allowed her mother to call a doctor, and went voluntarily to hospital. There she was immediately put on a three-day section. The next day she got the formal letter: YOUR RIGHTS UNDER THE MENTAL HEALTH ACT. It does spell out the patient's rights, but is also quite intimidatingly honest about her lack of rights. At the time, the letter just made her more scared.

After the three days, she was put on the 28-day section. After three weeks of that she managed to persuade the doctor that she was well enough to leave, without her mother's consent.

Ten days later she went back to see her parents, and they drove her straight back to the hospital. Again she was put on a three-day and then a 28-day section. This time she got no letter about her rights for four or five days, and the letter referred to their 28-day holding and treatment powers.

This time she went carefully through the letter, particularly noting that (1) she was not told when she entered that she might be kept for more than 3 days, and (2) that she had no easy access to the doctor to argue her case, and when she did finally get to see him he didn't appear to listen.

Having written comments over the letter she took it, and argued it to a nurse, a charge nurse, a nursing officer, and various others including the doctor, at the ward meeting. She talked of her own sanity and of the hospital's own failure to follow proper form when they sectioned her. She said she would contact her solicitor and approach either the Health Board or the Mental Welfare Commission, as the hospital letter indeed advised her if she was not satisfied.

It was decided to take her off the section. The next day she told her doctor she wanted to go, and did so.

Now she doesn't feel particularly happy - but who, except parents and psychiatrists can manage to keep on a completely even keel and a stiff upper lip when their love affair ends? Considering the rights the hospital had over her, to constrain, drug and shock her, she is glad to be out.

RESISTANCE:5 NEEDED Some Everyday Horror Stories, and a Recommendation

"WHILE THERE IS INVOLUNTARY INCARCERATION, THERE ARE NO VOLUNTARY PSYCHIATRIC PATIENTS IN BRITAIN" Thomas Szasz, on tv, 1986.

from the Yorkshire region.

A female graduate, in her mid-thirties, once the pride and joy of her bible-thumping vicar father, had been admitted to an admission ward for the third time. In the late '60s she had won a scholarship to California, and come home having moved somewhat towards a hippy way of life - but nothing very daring. Her brother, who had left home at 15 in order "to get away from the family", recalled that the father had been very disapproving of the change in her, and used to hit the daughter. Over about ten years she gradually withdrew from social life, alternating between a bedsit and home, and always in conflict with her parents.

Then she was brought into hospital from home, on an Emergency Section initiated by her father. She was completely unkempt, with layers of filth and grease on her face. It took several days to unmat her hair. She was almost mute, walked like a zombie and wished only to stay in bed. She had spent sveral months like that, ever-worsening. In that state her mother, on a visit, called her "serene".

She was nursed under conditions of quite strict security, due to what were described by her family and the hospital staff as "previous suicide attempts". On her previous admission, also initiated by her father, she is said to have tried to jump from the roof of the hospital. To the nurse in whom she could confide, however, she said she had at that time been trying to escape from the hospital, very much upset at her father calling the police in to get her put away. On another occassion she had fallen forty feet from an attic window of her parents' home. They said she jumped. She said she fell. Her brother said it was hard to see how she could have fallen through such a small window (perhaps she was pushed). Her face had been somewhat disfigured by that fall.

Her father, seen on visits, was clearly a bigot and a bully, who saw his daughter as "wicked",and a threat to his reputation. Her mother was "ethereal" - quite passive and unrealistic, and she thought well of her daughter, as "other-worldly", as if her daughter's distress was a gift. The daughter, meanwhile, could quite cogently tell the nurse that her father "had her just where he wanted her", and that he wanted her locked away. Receiving sympathy from the nurse she exclaimed: "At last I have a friend."

Shortly, management moved all the staff off the ward. No reason was given, except the old one that staff need experience of other wards. The real reason was that the ward's Charge Nurse had resisted bad management policy for too long, and had got a happy team together. By then the patient had begun to communicate, and to get up and about of her own acord. Not long after the arrival of the new staff the patient was put, on the doctor's orders, on a high dose of anti-depressant drugs. She began to walk around, as high as a kite, smiling like a robot. In this condition she was allowed home on weekend leave. Had the old staff been there both the drugging and the leave would have been strenuously resisted. The patient died in her parents' home that weekend.

The coroner's report said that she committed suicide, in bed, by suffocation. But how does one sufficate one's self to death with a pillow? As soon as you black out, your grip relaxes and you can breathe again.

A female patient, about 30 years old, tells a nurse that her consultant had had sexual relations with her for two years, and then had terminated them several years ago. But he remained her doctor. She had told two senior nurses this, on two separate occassions in the past. Once this had led to her being privately threatened by the consultant concerned, and she had been made to retract her story. The fact that she was still under his care was a continuing source of anxiety to her, and now a basic element in her emotional, psychiatric problems.

The nurse who heard this forwarded the information to her Nursing Officer. This led to three responses: management set up a meeting between the consultant and the patient, which meeting the nurse could not prevent, and after which a written denial was extracted from the patient; the patient was soon after discharged;

the nurse was accused of non-specific incompetence, put on probation and moved from an admission to a geriatric ward, and slanderous allegations recorded on her file.

The nurse then brought her union in. This led to the patient being pursued into her home, by an unknown figure from management, and another written denial being extracted from the woman. It also led to the nurse being interrogated by senior management in an attempt to find some, any fault in her conduct. The nurse was also threatened with the sack by another consultant. Management claimed the affair was closed after an "investigation" had been concocted,

which found nothing wrong, except on the part of the Nursing Officer, who was "reprimanded".

Elsewhere in the region, a man recently died having held the dubious honour of the local record for the number of ECT administrations: 600 - 800. Naturally, he existed on a back ward. He was also renowned for attacking people, mainly staff.

When he died he was emaciated, and had, for a long time, been spitting up about a pint and a half of sputum a day.

A sympathetic junior doctor managed to get his confidence about three weks before he died. He found massive bruising of the man's legs, top and bottom, on his groin, and with an actual footprint-shaped bruise on his backside. He was, despite his emaciation, extraordinarily active and agile. His case notes, 2½ years before that examination, included notes about a struggle between the man and a member of staff who had tried to get a conker out of his mouth.

The inquest found that the man's stomach and intestines were completely clean. There was a conker lodged in his foodpipe. A cavity had formed above the conker and food had backed-up and overflowed into his lungs. For 2½ years he had been absorbing nutriment through his lungs and coughing up the rest. No doctor had noticed this.

The junior doctor reported his findings to the consultant concerned, at the time of his own examination, three weeks before the man's death. The bruising would have been clearly visible at the time of death, but no mention appeared in the coroner's report.

Everybody working in mental health will know a host of such stories. What is disturbing about such events is not so much that the world, including hospitals and coroners' courts, is corrupt. It is that those who do all the dirty work of the system don't contest the corruption. It is, for example, a nurse's duty, not some sort of optional extra, to be responsible for patients' welfare. Of course, if you report any corruption you cannot expect the vested interests to lie down and accept their responsibilities. Of course you must expect an extension of the corruption into the victimisation of you, the one who is trying to do the job properly.

So, when dealing with controversial matters, for the sake of your own protection and for the sake of ever helping those patients undergoing maltreatment, health workers must think and act collectively.

The union is not just an insurance policy against job-loss, or the hope for better pay. It must be used as an agency for enforcing decent, humane treatment, which, as a significant by-product, will make for better working conditions all round.

If you have a problem which might lead you into conflict with management, or already has done so, mobilise your union. If the rep can't or won't handle it, tell the branch members at the regular meeting.

As a first step, workers would do well to compile dossiers on abuses, even if they feel they cannot pursue them. What a change of atmsophere there would be if each union branch published what it knew about minor and major abuses and corruptions at their workplaces, and if information was pooled and the scope of abuse became public knowledge. Mismanagement can only thrive on secrecy and the isolation of the staff and patients they harrass and victimise. Publicity could lead towards the emergence of policy to deal with bad management.

As things stand today there is usually an air of resignation and acceptance, of isolated, apathetic cynicism, in which, at best, the union prosecutes the odd case, on the quiet, without mobilising any collective energy against the abuses that those public servants, hospital managements, seem to routinely get away with.

Systematic publicity and the law: While there is still law and legal recourse, unions should be mandated, instructed by their memberships, to prosecute strong cases. Look at all the energy lost in apathy and people just moaning about bad management. Because, meanwhile, however loud you moan, management, the political tyrants of the people's Health Service, laughs all the way to their fat pensions. While conditions get ever worse for the staff, and patients continue to suffer from arbitrary violence and abuse.

Philip George.

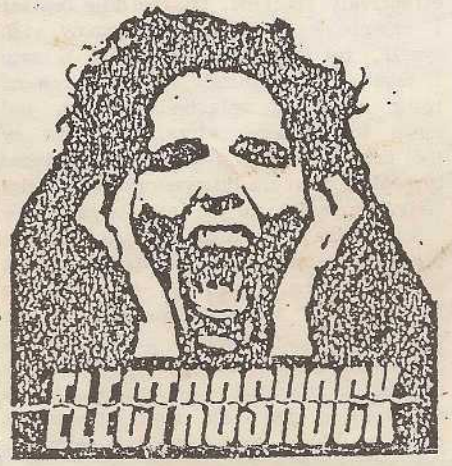
THE POLITICS OF MADNESS OR BRITAIN'S SECRET POLICE FORCE

FROM: LABOUR BRIEFING OCTOBER, 1985

There exist , in capitalist Britain, two types of law. Each has its own set of labels and punishments, and a personnel of paid enforcers. The political function of one is increasingly obvious. The Political function of the other remains well disguised. When an angry miner is locked up as a "criminal", we feel angry too. When an angry black person is locked up as a "rioter", we feel angry too. When someone is locked up as a "psycho", "nutter" or "mental case", however, our reaction is either indifference or pity. We swallow the propaganda that this is a medical event, for the good of the recipient. We fail to understand that the mental health system operates as a second police force, enforcing capitalist rules not covered by the legal system. This, we convince ourselves, only happens in the U.S.S.R.

Dr David Hill

Clinical Psychologist, author of "The Politics of Schizophrenia".



As with the legal system, the first step is to brand us with discrediting labels. Terms like "psychotic" and "mentally ill" are extremely damaging. Capitalists try to convince us that only certain types of thoughts, feelings and actions are "natural". Psychiatric labels are designed to persuade us that anyone not conforming to this official version of reality is deserving of pity and needs help to "adjust". They conceal the fact that it is the alienation of a capitalist system that causes so many of us to feel depressed, scared or confused. Every time you hear, or use, terms like "mental" or "insane" you are missing the point. The point is a political one, and a point which many socialists are only just beginning to grasp. We must no longer allow those sisters and brothers who are either in extreme distress or who simply choose to be different, to be dismissed as "sick" and punished with incarceration, poisonous chemicals and electrocutions. We must no longer believe the lie that there is some mysterious biochemical process (which would be discovered if only psychiatrists were given more money) that explains why thousands refuse to conform to capitalist social norms.

"Schizophrenia"

When the "illness" of "schizophrenia" was invented, at the turn of the century, literally hundreds of behaviours considered unacceptable to those in power were lumped together, and called "symptoms" of some unseen, genetically transmitted, biochemical abnormality. These included being very artisite, very religious, very political, very kind, very cruel, very talkative, very quiet, very angry, very sad, very unemotional, very much like the opposite sex and slightly homosexual.

The value of this myth was well understood by the ruling class of rich white males. The first grants ever made by the Rockerfeller Foundation to "research" in

Europe were to the German psychiatrists who invented "schizophrenia". Eugenic sterilizations were soon followed by the murder of over a quarter of a million "psychiatric patients", who were given the medical diagnosis "Life Devoid of Value". These murders *preceded*, and served as a model for, the attempted genocide of the Jews.

In the 1980s, psychiatry still singles out particular groups for "treatment". The poorest sections of society are about eight times as likely as the wealthiest to be diagnosed "schizophrenic". Ethnic minorities tend to be admitted to hospitals at higher rates than the general population. Lesbians and gays are still offered various forms of "therapy" to help them "adjust" to "normal" sexuality — including being administered electric shocks while looking at pictures of the same sex.

Women are labelled "mentally ill" more frequently than men. The average rates of admissions to British psychiatric hospitals per 100,000 of the population (1977-1982) were 318 men and 442 women. Women are labelled "neurotic" and "manic-depressive" at more than twice the frequency of men. Women receive particularly severe diagnoses if they are assertive, "unattractive" or hold feminist or socialist principles. My particular favourite research study is the one which demonstrates that feminist and socialist women who have plans to act on their beliefs tend to be diagnosed more severely than those who do not.

The total figures are frightening. Every year there are nearly 200,000 admissions to British psychiatric hospitals (increasing, as always, with the unemployment rate — disguising depression as sickness), and over a million and a half visits to outpatient clinics. In 1983, there were 28½ million prescriptions of the powerfully addictive minor tranquillizers (valium, librium, etc.) predominantly to women.

Tranquillizers

Three major tranquillizers (modecate, depixol, haldol, etc.) routinely injected into so-called "schizophrenics" cause uncontrollable shaking ("tardive dyskinesia") in about a quarter of cases. This is usually a *permanent* form of brain damage. One of the largest drug pushers, Hoffman LaRoche, proudly claim that about 150 million people world-wide currently receive these drugs and admit that "five to ten million people may have tardive dyskinesia".

In 1982, on 139,307 separate occasions, people in Britain had their brains electrocuted, with enough voltage to cause convulsions. The devastating effects of so-called "Electro-Convulsive Therapy", most easily seen in the form of permanent memory loss, are best summed up by a leading U.S. neurologist: "I'd rather have a small lobotomy. I know what the brain looks like after a series of shock — it's not very pleasant to look at."

We are slowly learning, from feminists, that solutions to problems must take place at both the personal and political levels. We must talk to one another more about how depressed and confused we all sometimes feel as a result of living in a totally alienating society We must take care of one another better and not hand over our friends, lovers and relatives to this second police force, armed with pills, needles and electricity. We must stop using terms like "nutter" and "mental" which are just as valuable to capitalists as terms like "queer" and "nigger".

We must demand that Party policy include a planned but *rapid* closure of psychiatric hospitals.

There are, however, four dangers in current plans for community care. The first is inadequate funding. The second is the tendency to expect the "family" — i.e. unpaid female labour — to pick up the pieces. The third is outlined in the platform of the Network for Alternatives to Psychiatry (British Branch): "Community psychiatry can result in a simple shift of the site of psychiatric ideology and practice from the hospital to the community. This is not inevitable. provided a reorientation of the entire system can be brought about." And we must insist that this reorientation exclude ineffective and harmful medical procedures, and include the meeting of basic human needs: housing, income and a fair share of understanding and love.

The fourth problem is that of professionalism. Communities, not professionals, must decide what services they need. Be warned that the development of community mental health in the U.S. has led to the existence of more mental health professionals than police officers!

Finally, a quote from the manifesto of a London based group, Campaign Against Psychiatric Oppression:

"The heavy weapon of psychiatry is held at the heads of the working class in order to control them. The suffering inflicted on the working class, and particularly on women, through extreme material poverty, social repression, home and work frustration, etc., obviously has a tendency to result in anxiety, depression and sometimes 'delusions' as a form of escapism — though it should be recognised that what a psychiatrist calls 'delusions' are often accurate perceptions of the worker's oppressed reality."

POST-PSYCHOTIC SANITY by Jim Sheen

I have suffered severly from psychosis, so I have the experience to give some sort of an account of this condition.

In the first instance, sanity should quite simply be considered as some form of natural balance that, as with all natural balances, is best maintained by means of good health. The Greek scholars viewed the person as a tripartite being, consisting of mind, body and soul. The best basis for sanity is when the health of all three is well maintained.

It is my belief that the place of man is with the very life-force. That man is, or rather should be, just as much a harmonious part of nature as all other living things. At this point I would like to say that I am certain that natural cures and natural healing should be the first resort of doctors when dealing with mental health, and, indeed, with health in general. Let it be understood that true health is in fact a harmony with nature, and that the basis for sanity is a true perception of the living.

Balance is maintained by harmony. For example, if a treatment of a patient were too drastic, then natural disharmony would pervade the person's mind, and it would be unlikely that a natural balance could effectively function. On the drug Depixol I experience a feeling of harmony with myself, but the resulting mental balance I have is not natural. My experience of being alive is relatively dimmed, and since the balance maintained in me by the drug is not a natural one fostered by health, then the drug-maintained balance cannot be said to be the best for me.

But, without medication, my balance is rapidly changed and is apparently not self-containing. This, to my mind, is the result of treatment that was, in the first place, too drastic. If a treatment is in harmony with nature a natural balance becomes a possibility. Otherwise, it is not possible. There are natural treatments that should be given more consideration, such as personal therapy, physical fitness, and a careful regulation of what the body takes in.

But, of course, above all, the emotional needs of the distressed should be catered for sympathetically. Reliance on artificial drug therapy should be kept to a minimum.

Dr R D Laing has been, for more than 25 years, Britain's leading voice of dissent within psychiatry. His books, The Divided Self and Sanity,Madness and the Family, amongst many others, proposed a humanistic theory of communication crisis as the basis of emotional and intellectual breakdown, in opposition to the atheoretical, blind technicism of establishment, medical psychiatry.

In the 1960's he set up the Philadelphia Association of therapeutic homes in the community, but today he is engaged in private practice.

For those who are unfamiliar with his work, perhaps the best quick introduction is the second chapter, pps 19 - 38 of The Politics of the Family (Penguin, 1971).

In the interview Dr Laing begins rather reticently - a bad omen for an interview. But he warms into it, tending to give considered replies in the rich brogue of an old Glaswegian hipster. We have translated his affirmative as "Yeah", but there's no American or cockney in it, it's more of a rolling "yuh".

LYN BIGWOOD, RMN TALKS TO R.D. LAING

- SANITY, MADNESS AND THE PSYCHIATRIC PROFESSION

(Testing the taperecorder) The time has come to talk of many things/ Of shoes and ships and sealing wax/ And cabbages and kings.

First of all I'd just like to thank you for granting us this interview, I appreciate it very much. And, without wishing to hero-worship you, I would like to say now that your work has had a very great influence on me. I started psychiatric nursing when I was seventeen, and I read The Politics of Experience, and then Sanity, Madness and the Family, when I was beginning. I'd just like to get that out of the way before we start, really, by saying that I've always borne your work in mind, and it's been very useful to me throughout my work.

So can I ask you a very general sort of question? After 40 or so years of psychiatry, I wonder how optimistic you are? Do you feel that any sort of organised help for people that are emotionally disturbed is genuinely possible, or do you feel that inevitably it will degenerate into what might best be described as policing people?

I'm neither optimistic nor pessimistic about that sort of thing. I'm not optimistic nor pessimistic in the sense that I don't expect the future to suddenly become worse or better than the present, or past. The different trends or currents that currently compose the mental health professions are not going to suddenly go into a waterfall, as it were. I don't think everything is suddenly going to change, one way or the other. In other words, there's not going to be a greater concentration of compassion or a greater concentration of callousness, suddenly, or a greater component of understanding or forbearance, or the opposite of that.

What has happened, the last not quite 40 years that I've been involved - I'm 58, so, oh, it's almost 40 years that I've been involved in the medical profession..Technology is really biting into this field. I don't think that makes a fundamental difference,so...

So, more of the same, basically, the same kind of struggles?

The same sort of stuff, I imagine, is going to go on,with certain variations on the format, is going to take place.

OK. You've written quite a lot in your books about your own medical training, and in general about the training of doctors. I wonder if you could say something about how you think doctors should be trained, and how psychiatrists should be trained? You've been very critical of the medically oriented...

Yeah, you see, I think that in our society the policing of people, in more ways than narrowly regarded as criminal... there's different ways in which society, our sort of society - we're not stepping into utopia - the sort of society we have, couldn't exist without monitoring and picking people out who get out of step. And the way it is done, they can either be called "criminal" - there's no problem with the so-called terrorist people, with hand-grenades and stuff like that, at airports, and things like this - but people who walk off the pavement at the wrong time. It's got to be kept tidy.

Various things incite quite a lot of people to very violent, passionate responses. For instance, in the United States at the moment, in the mental health field, there's tremendous agitation about child abuse, incest. I don't think this is nearly so.. I mean it's stirred up there. Now, I don't think it fundamentally depends on the medical profession what society wants, what services different groups are expected to fulfill and perform in relationship to the overall maintainance of stabilisation of the human element of this human material complex of stuff that makes up our

global civilisation. So what sort of training psychiatrists should have really depends on what function society wants to accord psychiatry.

The simplest training for psychiatrists would be simply training in neurology. That would appear to be, at any rate, a simple response. But if psychiatrists are simply trained as neuropsychiatrists or neurologists, then of course it means they have got no special competence whatever in the field of communication, human communication, interpersonal relationships, microsystems like families, and in between systems, like families whose children, men and women, the relationships between generations, relationships between the sexes, and all the rest of it, etc,etc. Medical students in psychiatry, at the moment, in their training, get absolutely no training in relationship to all these things. If you become a psychiatrist later you're expected suddenly to exercise some sort of decisionmaking and authority about this. You know absolutely nothing about it. You know nothing about sociology, nothing about anthropology, not the slightest mention in the training about the nature of human sexuality.

And you see this as a bad thing?

No, it's probably a good thing to remain ignorant about this. It depends who is going to train psychiatrists. The point is this: if psychiatrists would admit to themselves when society placed them in the capacity of being simply people who examine people's bodies, or get their bodies scanned, particularly specialising in the nervous system, nerve tissue, etc, scanned and examined in this way and that way, and to pick out whether anything is the matter with people, physically, biologically, biochemically, and that sort of thing - if that is what psychiatrists are about, then they should confine themselves to that. But psychiatrists are accorded vast powers that have got nothing to do with that at all. But to do with how people conduct themselves, in relationship to other people, and how people feel and experience themselves, what they say, etc,etc, the psychiatrists have got no training of any kind, right up to the MRCP, their higher examinations in this. No undergraduate training, no postgraduate training, etc, etc. No competence in what society expects psychiatrists to know about.

Say, give you an example of this - you'll have to be careful what you edit out - a professor of Psychiatry in Athens, a tremendously powerful position, last year invited me and several other people over to Athens to debate, in front of him and an assembly of senior Greek psychiatrists, the 'DSM 3', Diagnostic & Statistical Manual edition 3 of the American Psychiatric Association. It's the most powerful psychiatric bible in the world. It links multinational drug companies' classifications, insurance, wee morsels about divorce, custody of children, and all the rest of this. It's a very important classification of mental disorders. It's the most globally standardised in the world. And he said that he had been - I think he was about maybe 40 or something - he had been all his life a neurologist. He said:"I knew nothing about psychiatry until I was appointed Professor of Psychiatry at Athens". Didn't know a thing about psychiatry. He said "I started to read psychiatric papers and tests, but," he said," it's totally mad!" He's perfectly innocent and naive..He never really had any idea what psychiatry was about. He said he realised this, so now he's in this position that the functions he's supposed to perform as a psychiatrist, strategically, and in training, and in relationship to politics in Greek society, families, planning, the way everything goes has got nothing to do with what he thought medicine was about. And it hasn't got anything to do with that. So he's taken that on board and he's sort of doing his best. But he's certainly no background training.

For background training has got nothing to do with , or very little to do with remembering the chemical formulae for this and that neurotransmitter and so on. Which is all rhetoric for psychiatrists, anyway. They're not biochemists. Dr X has actual training. I mean he started off as a biochemist, in the first place. So he's not one of those psychiatric rhetoricians who sort of learn to say "imipramine", or something like that, and remember the paper formula of something. I mean, you can memorise that sort of thing in about half an hour, which gives you an edge on people - you've got a vocabulary of about twenty or thirty words. You know absolutely nothing about chemistry. You've never actually done anything in a biochemical laboratory, you never enter a biochemical laboratory, except in the second year as a medical student you get a glimpse of what's going on there.

So what you seem to be saying is that the training that psychiatrists get bears very little relationship to the work that they're expected to do.

No relationship at all. A psychiatrist is not trained to have anything to do with,say,what a psychiatric nurse has got to deal with from morning to night, in a ward relating to other people who no-one wants - that's why they're there - very strange people as far as society is concerned, otherwise they wouldn't have got there or been put there. A lot of them are very crazy and a lot of them are very miserable and don't know what to do with themselves. In a context that is miserable for the staff and the patients, in most places. I mean, if you want to hang out with people the last place you do so is in a psychiatric clinic or unit, as far as the staff and the patients are concerned.

So the whole thing becomes..psychiatrists come round in the morning, do their round - or at least the style varies - get reports, write out this, come round and so forth, interview a few people, but haven't got the slightest clue about what the real stuff is on about.

No. You said earlier that psychiatrists seem to be going beyond their capacity in commenting on human relationships and sociological matters and so on, that they're not trained to do that, they're only trained in the neurological science. In my experience there were very few psychiatrists that actually concerned themselves with the nitty gritty of human relationships and sociological matters and so on. They seemed only to happy to concentrate on neurological issues.

Yeah, well, I'm saying that's decent.

You think that's decent?

Yeah, if they keep away from that, because they've got no special competence in human relationships.

But do you think the neurological issues bear any relationship to the real problems of the people in the hospital?

No!

No! So what function are they performing?

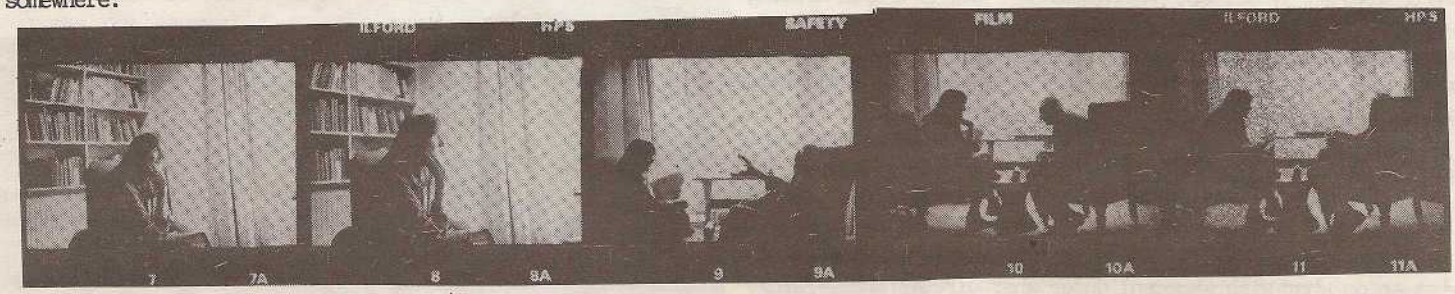
Well, they're monitoring to check out if there's anything physically the matter with them, and as far as 99%, the bulk of people who are dumped into psychiatric wards , they're scanned in every way, and there's nothing the matter with them. So they've got it, as it were, clear about that. So there's nothing the matter.

The whole of psychiatric literature pours out, all over the world, there's endless papers telling us, every week, every day of every week, from every country in the world, all over the place, how these people have got something the matter with them, which they're continually discovering. And I think about 0.3% of psychiatric papers are read, by anyone else other than those who write them. Psychiatrists don't read them any more because they know it's all nonsense. The only reason for writing them is to get some status - you've got a name with a date and you've got 2 or 3 papers plus an MD, and so forth. etc, and that's good for getting a consultant job or something like that. They know that what they're talking is total nonsense, between themselves, so they never read their own rubbish.

But, I'm saying, if society needs - this is an American expression:"needs", you've got a "need" - if society, as it were, needs places to put people, then it's got to find people who will be. the officers and non-commissioned officers, you know, everywhere up from privates and sergeants to captains, you know, a sort of hierarchical thing that will do that policing service. If it's not going to be a special branch of the medical profession, who else is it going to be? Is it going to be priests? Is it going to be a new type of mental health officer? This is what is happening in America, for instance. There are now more mental health professionals in the United States of America than there are uniformed policemen. Dealing with the flakey side of society - people that the police don't want to have anything to do with. They are not stealing cars or anything, they are going to sleep underneath that car, or on top of a car in the middle of the night, and so on. They are the so-called street people. They are people who run away from home and sort of pile into Phoenix, Arizona, and places; sort of thousands of them from all over America. They've got to be rounded up and wiped off the street, because people don't want to see too much of them. They've got to be put somewhere.

cine. That can be addressed within the psychiatric profession, of course. But it's difficult to address themselves to that within the context of the function such of the psychiatric profession. And it is very difficult - in fact it's impossible - for anyone who isn't actually a psychiatric nurse or a psychiatrist to have access to this sort of human misery. In other words, it's boring, and to a large extent futile to talk to so-called lay people about this sort of thing because they don't know anything about it. They've no experience of day-in, day-out, round the clock, what it comes down to when someone is completely out of it, say, or really, if you let them out of the door, they wouldn't last five minutes. They really wouldn't last five minutes.

So, what the Italians did..Basaglia had never been in a mental hospital in his life, and he's Professor of Psychiatry at Rome, academic, teaching sort of thing. Then he was appointed as a superintendant of a mental hospital. A decent doctor. Suddenly realises what he's..all these deeply shocked and bewildered..all these people that, as a doctor, he knows have nothing the matter with them in an ordinary medical sense, all being locked up. Why are they there? What had happened? So he and his pals,with no depth of years of experience. being imbued with a Marxist ideology of a rather sentimental kind, sort of suddenly sneak in, without other people realising what they are doing, even the majority of psychiatrists,sneak in a Law: they are going to close the front doors of mental hospitals and open the back doors. And it produced chaos in Italy. This year there's a backlash on this. As epitomised, for instance, by a case: a backward catatonic schizophrenic is not just let out the door, is given a push, kicked out the door, back to his mum. So he gets, from the backward, curls up in the back room. Doesn't eat, pissing and shitting, etc. And his mum hasn't the faintest idea. What can she do? She can't do anything. Now, the police won't take him, the psychiatrists won't take him, no-one will take him, there he is. So he dies. She is brought before the courts accused of murder. That's no solution



Now, who are going to be the officer class that directs this kind of operation? The police don't want to do it. The churches are not taking this on. They refuse to take it on. So I think it could be transferred between the medical profession to do this dirty work, or a new type of functionary of religious institutions. But religious institutions haven't got the credibility with so many people. Anthropologists,sociologists? You know, who will it be? So , under the circumstances, maybe it's just as well to keep it as a function given to the medical profession.

So you're quite clear that the prime function of psychiatrists and related mental health professionals is a policing function?

I wish it wasn't. There are a tremendous number of people who are absolutely miserable and desparate, confused and bewildered,etc,etc,etc,etc within this policing function.

But psychiatry doesn't ask for this function, actually. Psychiatry hasn't invented it. It's a societal function, which unsuspecting doctors actually find themselves in. A lot of them don't realise that that's what their function is, themselves. There is a function of addressing one's self to human suffering, in the ancient tradition of medi-

to the.. What can she do about a grown, withdrawn, regressed, doubly incontinent catatonic schizophrenic? Of, you know, forty year's old. So she's accused of murder because he dies in her house. Well, that is no psychiatric revolution. That is no progress. I disassociate myself from that Italian experiment, in that sense, totally.

I'm glad you mentioned the Italian experiment, because it's something I wanted to ask you about. In your address to the Richmond Fellowship Silver Jubilee Conference you did seem quite scathing about what's happening in Italy, but in your most recent book, Wisdom, Madness and Folly, I got the impression that you were quite sympathetic to some of the ideas..

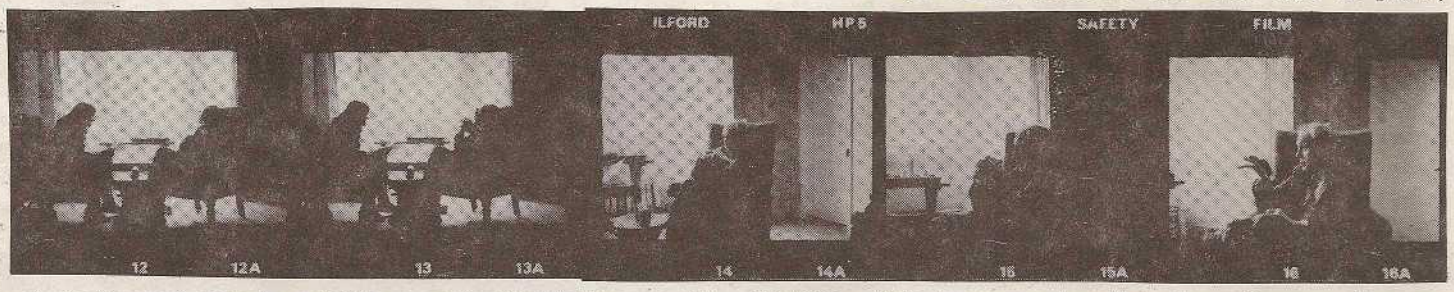
Oh, yeah, I'm very sympathetic to the intention. But it has blocked the Italian experiment because they polarised it into an alliance with the Italian Communist Party, socially, and so forth, has given it a very bad name, everywhere else, by polarising it politically that way. I don't think it is a polarised poltical issue. It's not the oppression of capitalist right-wing Government on..I mean, we know that several times more people in the working class are diagnosed schizophrenic than people who are wealthier. More women are diagnosed than men. More women get electric shock

than men. In America I think the rate of lobotomies or some version of brain operation is 3:1 of women over men. Anyone would be out of their mind to think that women are genetically three times as likely to be psychotic as men. The operation of this diagnostic and prescriptive and treatment system in relation to different classes in society is very differential indeed. And anyone who argues: "Oh, that's a matter of biological, genetic stuff, etc" is either naive or sort of deeply lying if they believe that.

I can think better where I am. /stands away from the mike, over by the window/

/paraphrases/ "Open violence only breaks out when the concealed violence of society breaks down..

Of power. When everybody is in their place, between master and slave, in our system, polarised sexually, or polarised racially, or by colour of skin, you know, or whatever, when that breaks down, then violence breaks out. Now the violence that breaks out there is a sort of leak from the..If everyone would obey the orders given by the people in control it would all be perfectly peaceful. Now that type of peace, however, that keeps on breaking down. Because that peace is only in the interests of the minority of people who are issuing the orders who everyone else is in play /sic/. Psychiatry comes into this because it's a breakdown in that system Our system is very flakey all over the place.



I don't want you to publish a sort of put-down on the Italian thing. But the Italian thing has discredited an attempt in that direction in this country because it's been linked unnecessarily, and I think.. I mean, I objected to - and I was sort of friends with some of them at the time - I thought it was a disaster to go into an alliance with either right-wing or left-wing politicians to get this sort of thing through. Because they would then be trapped in this whole other world of political debate. That this issue ought to becompletely apolitical. I mean, psychiatry is used as a repressive instrument in Russia. The Chinese, who will catch up very quickly, are about thirty years behind us. They are into insulin deep comas. It'll take them a few years to sort of discover what we discovered thirty years ago: that it doesn't work. But they've got to learn that. They'll catch up, very quickly. So it's got nothing to do with left-wing or right-wing, capitalism or socialism, or communism and so forth. This kind of thing, I think, operates, transects one or other type of organisation of society at large.

Are you saying then, that apart from specific situations such as Russia, that psychiatry is not a political issue?

I'm saying it's a deeply political issue.

Deeply political. Beyond party politics?

Yeah, right. It's the essence of power: of who allows what to do whom with whom and under what circumstances /sic/. That's power. Between the young and the old, and between women and men, between parents and children..

And between classes, would you say?

Oh, yes, between classes. But in this country people are not locked up or given psychiatric treatment for reason of class politics, explicitly. Explicitly. Although it was proposed, in the early '50s, in America in the McCarthy era, it was seriously discussed whether communism ought not to be diagnosed as a form of paranoia. And communists who would then be diagnosed as suffering from a form of paranoia called "Communism", like, say, "Schizophrenia". And treatment for it, the best treatment for it would be lobotomy. So you would lobotomise people suffering from the paranoid condition of feeling society as persecutory, a branch of Paranoia, and give them lobotomy. Which would enable them to not be kept in prison or in a mental hospital at vast expense for years on the taxpayers' money. They would be sort of let out again, harmless.

/the photographer arrives/

Well, let's have a break for coffee..

/a bit later/

...concealed,silent violence of the power-system breaks down, so some people are out of control.

Sit here and say that.

Yeah. Of course. In every respect. But you ask me whether I'm pessimistic or optimistic about it. Tremendous changes are happening just now. I mean, you can talk about astrologically, or this way and that way, the Aquarian Age, the New Age, we're certainly moving out of an old industrial capitalism into another type of global electronic world in which a great number of things we took for granted are going to go. In which, particularly, it's something I haven't written about, but the whole sexual thing is changing. Not because of feminist propaganda, just because men are not worth the money.

Men are not men any more?

They're not worth their money, for their function in society.

What do you mean?

You've got to pay, now, women more money. It's a neuter gender.

You mean the old sex roles are breaking down?

Men are not worth the money. That they can't replace themselves with their money that they used to have, in terms of their possession of property. So they're going to have to more and more have to take their chances. It's got nothing to do with ideology. It's just pragmatic.

That's one of the things, you see, that I like about Mrs Thatcher. It's extraordinary. She's the Chairman of the Board. Not because she's a woman or because she's a man, just because she's very good at it. She's very good at that, what she does she does very well, and businessmen and businesswomen are not interested in whether she's got a penis or a vagina, for that function.

Well, what is her function, do you think?

She operates a local branch of territory, mainly in terms of software population pool, here, and land territory. She's the Chairman of the Board, of the local operators, for that.

Would you agree with Marx's statement that the State, or Government, is primarily the executive committee of the ruling class?

Yeah. Of course. Oh, you don't have to be a Marxist, er, Roger Scruton would agree about that. He's the sort of right-wing intellectual, philosopher, behind the type of so-called Conservative thinking. You see, I'd like that statement to be taken out of..you see, most right-wing, reactionary French thinkers make that sort of statement. They're all