

THE RADICAL THERAPIST

The Radical Therapist Collective
Produced by Jerome Agel

therapy means
CHANGE
not adjustment

THE

RADICAL

THERAPIST

The Radical
Therapist
Collective

Produced by
Jerome Agel

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How To Be a Radical Therapist by Richard Kunnes,
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Stealing Mental Health: Theory and Practice
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**therapy means political change . . .
not peanut butter**

Introduction

Radical therapy is just beginning. It's being developed all across the country. It can't be described in six easy rules or five techniques—that's good, because RT is a way of living, not another "new kind" of therapy that can take its place in the psychotherapy spectrum. RT starts from the awareness that therapy is a social and political event, and moves to the conviction that therapy systems—like many of this country's institutions—must be changed.

RT groups have begun in Berkeley, Cambridge, Chicago, New York, New Haven, and elsewhere. People have identified themselves as "radical therapists" and are working for change where they can. Some are working within the system—in community mental health centers, neighborhood clinics, hospitals, and training programs; others are starting alternatives outside the system—in rap centers, therapy collectives, communes and radical psychiatry groups. Many colleges now give at least one course in radical psychology.

People are determined to stop therapy's perpetuating and legitimizing oppression. We're developing a therapy that serves the people.

Wherever you look, therapy has failed. The only persons consistently helped are the therapists, whose lives are comfortable. State hospitals are collecting bins and processing plants; psychoanalysis serves a fancy elite group, and it's debatable if it helps even them. Other forms of therapy are hit-and-miss—the field is swollen with people selling their wares, but the wares are often shoddy and the marketplace is corrupt. Most therapists are men; most patients, women. Therapy, thus, reinforces and exemplifies the sexist practices of this society, making it hard for a woman to get real help. Most therapists are white and middle-class, thus making it hard for lower-class, black, brown, and red people to get counseling in a nonoppressive way. Family or group therapy may deal well with interpersonal dynamics, but it grapples less fully with the real social conditions under which people live. New touchy-feely encounter therapy helps people become freer in themselves, but ignores social or political change. A third of all therapy is commissioned by someone else—government, military, business, school; the therapists' main allegiance is to their bosses. (Thomas Szasz has written eloquently about this for years.) And all this in a society that, as R. D. Laing points out, systematically drives people out of their minds from childhood on, a society that regards as "normal" a meshwork of dehumanized, mechanical, and rigid patterns of destructive behavior. Nero (therapist) fiddles while Rome (Amerika) burns.

The therapist touts himself as a magician. But he doesn't follow through. Instead of allying himself to the tradition of soul healing (witch, witch doctor, GP, priest), he allies himself to the status quo—and bolsters it. He sells his skill like a vendor of fried chicken. He uses his prestige to

discredit and slur social protest, youth, women's liberation, homosexuality, and any other different kind of behavior. Therapists' rewards come from helping the system creak on.

Claiming to be "detached and clinical," therapists never are. They can't be. Their words and acts demonstrate their bias. Current therapy's emphasis on the individual cools people out and/or puts them down. It cools them out by turning their focus from society that fucks them over to their own "hang-ups." It puts them down by making them "sick" people who need "treatment" rather than oppressed people who must be liberated.

Therapy is change, not adjustment. This *means* change—social, personal, and political. When people are fucked over, people should help them fight it, and then deal with their feelings. A "struggle for mental health" is bullshit unless it involves changing this society which turns us into machines, alienates us from one another and our work, and binds us into racist, sexist, and imperialist practices. To do good work, radical therapists will have to take risks—to *organize* therapists, clients, and hospital workers, and to *attack* precious, oppressive institutions: the nuclear family, the forty-hour work week, fee-for-service care, mental hospitals as they now are, treatment of children as parents' property, professionalism, and so on. This will be done.

Some people say radicals are against culture. That's nonsense. Yes, we want to root out the aspects of this culture that oppress us. But we want to preserve the rest—art, science, history—and make it freely available to everyone. Therapy, today, is treated like a dark secret—patients are kept mystified, they're not told what the therapist knows. We want to stop the mystification that

sets therapists up as gods—words that confuse, medications that aren't discussed, theories that are bullshit, silences when people are asking questions. If there are ways of helping people with problems, let's say what they are and teach them to people.

There's a difference between *skill* and *role*. Therapy skills that have been developed are useful; so is the understanding of human behavior we've built up. These can be made available to everyone. On the other hand, therapist roles, which have made therapists privileged and unaccountable, can be abandoned. Roles oppress us; skills serve us. Abolishing mystification and professionalism is part of our task.

Not all therapists are pigs. Many are well-intentioned people who have been trapped, like the rest of us, in a lousy system, though in a less deadly way since they benefit materially from their "oppression." Those who still want to do valuable work can join us in the struggle for change. The others will fight us tooth and nail, calling us names, reading us out of their "professional" organizations, and so on. That kind of politics is nothing new.

Therapy today is a power relationship between people—one up, one down; helper and helped. In a society built on individualism and competition, it embodies the *problem*, and thus can scarcely be seen as a *solution* for people who are fucked up. Current therapy offers "solutions" only to people who buy the system and want to maintain their place in it. Which is another way of saying current therapy serves the system.

That's why we need to develop alternatives. Two, three, many alternatives. Therapists and clients and people, joining together in a common effort.

This anthology is a beginning. It offers articles

from *The Radical Therapist*, and, hopefully, provides people with a place to take off from.

A word about *The Radical Therapist*

The Radical Therapist began as an idea in a cold North Dakota winter. Therapy, like other professional fields, had spawned several radical groups and caucuses in recent years, but no journal had emerged as a rallying ground for all the people involved. That's why we began *The Radical Therapist*. If we hadn't started it, others would have. It was in the air.

The response to our first issue confirmed our feeling that many people were ready to help develop radical therapy. Every day now, more people realize they're part of the network, too. *The Radical Therapist* speaks to many people—not just to “professionals,” but also to clients, patients, students, workers, young people, women, and others concerned with changing therapy as part of changing society.

Our first year was chaotic. Some of us were in the Air Force (against our will), and were being watched closely. The women were involved in organizing women's liberation groups in this area, which was difficult and exciting. We helped start a rap center in town, and went through a classic witch-hunting scenario, and we were charged as dangerously subversive. Things managed to work out.

Many people have helped us—subscribing, finding us bookstores, sending in articles, writing us letters, sharing ideas. Their help has made *The Radical Therapist* possible, and we appreciate it very much. (Subscriptions are only \$6.00 per year; we start you with the latest issue that's still available.)

A word about this book

This anthology raises the question of co-optation. Reaching more people than *The Radical Therapist*, it still plays the publishing game, and generates money for booksellers, publishers, etc. Our choice was simple: 1) we could claim ideological purity and not publish, thus failing to reach the general public, or 2) we could publish this book and reach more people, accepting the economics of book publishing. We couldn't publish this anthology ourselves at this time. We felt it was more important to give people across the country a chance to read these articles. We chose to publish. We'll share our royalties with the authors whose articles are here. Their articles—with their split infinitives and sometimes peculiar punctuation—appear here exactly as they were submitted to, and were published in, *The Radical Therapist*. No effort was made to edit for consistent style. Each voice remains original.

We're thinking about next year now—pursuing ways of getting our ideas to people who don't read books, finding out what others think and feel about therapy. This means work with new formats and new media. It means speaking and listening to people. It means trying more things out.

We'd be interested in hearing your comments and suggestions.

In the struggle,

MICHAEL GLENN

for *The Radical Therapist*

R.D. # 1

Hillsdale, N. Y. 12529

July 1, 1971

The RT Collective: David Bryan, Linda Bryan,
Michael Galan, Michael Glenn, Sara Glenn.

Manifesto

Why have we begun another journal? No other publication meets the need we feel exists: to unite all people concerned with the radical analysis of therapy in this society. It is time we grouped together and made common cause. We need to exchange experience and ideas, and join others working toward change. The other "professional" journals are essentially establishment organs which back the status quo on most controversial issues. They support the anti-youth hysteria so prevalent today and stifle efforts for change. We need a new forum for our views.

In the midst of a society tormented by war, racism, and social turmoil, therapy goes on with business as usual. In fact, therapists often look suspiciously at social change and label as "disturbed" those who press toward it. Concerned with maintaining and justifying current practices, therapy avoids moving toward making life more meaningful for all people. All this is no secret. Many people in and out of therapy fields agree the situation is intolerable. Why then does it persist?

Therapists by training, what we have been taught is increasingly irrelevant, and even destructive. Our notions of therapy are obsolete: elitist, male-centered, and obsessional. Our modes of practice are often racist and exploitive. Clinging to concepts often outmoded and rarely questioned, we insulate ourselves from the society around us and support the status quo. And we can do this very

successfully. The therapist in this society is safe: he lives near the top of the heap, pursuing moneyed comforts, influence, and prestige, while the rest of society is racked by violence and war. He buys land and boats while others die in the streets. Often he even seems unaware of the bias he perpetuates or of the oppression he enacts in the name of "liberation." Expert as he may be at analyzing intrapersonal forces, he is often ignorant about forces controlling the larger society in which he lives. This must be exposed and clarified.

Therapy today has become a commodity, a means of social control. We reject such an approach to people's distress. We reject the pleasant careers with which the system rewards its adherents. The social system must change, and we will be workers toward such change. But to be true instruments of change, therapy and therapists must be liberated from their own forms of oppression.

The Radical Therapist will be a rallying ground for all people concerned with this task. Therapy to us broadly encompasses all factors affecting the psychic well-being of individuals, families, and social groups. We open our pages to all people with pertinent ideas about therapy today: to clients of therapy systems, therapists, and people in related fields.

We shall pursue the following points:

Providing a needed forum

Therapy in latter 20th-century America must be redefined and altered. Many people across the country are willing to help in such a task. All that is currently lacking is a forum. *The Radical Therapist* will be that forum.

Therapy has political as well as professional aspects. Radical insights within the therapy fields can alter the way we define and carry out our work. Radical insights into the larger social order can show therapy's place within that order, and suggest how it can be a more effective force for change. At the outset, we acknowledge the uneasy tension between the words "radical" and "therapist" in our

title. Yet many of us live daily with this tension and know only too well that it must be clarified.

Just as all people are potentially patients, so all are potentially therapists. All can attack the roots of emotional distress. We invite support from all concerned people, not just from a professional elite. We repudiate divisions among ourselves on the basis of sex, class, training, and status: we are more alike than different. Our common task is transforming therapy into a more effective popular system which can free those in distress instead of oppressing them.

Liberating therapy, therapists, and others

Therapy is dominated by gradualist models which bolster the status quo. Even well-meaning people today find themselves trapped in a frustrating, dehumanizing system, from which they see no way out. The revolutionary spirit of the founders of therapy—Pinel, Freud, Reich—has been weeded out. Intending to liberate people from their neuroses, therapists today further “adjustment,” social control, and the commercialized society. In spite of evidence from therapists themselves, the system remains unresponsive, bulky, privileged, and stiff. Therapy notions are a tangle of midwife myths, fantasy, and outright bias. Therapy practices serve the free enterprise system. But contemporary therapy demands contemporary ideas. Sensitive to notions of “countertransference,” therapists can be amazingly blind to their own class, race, and sex bias; and to the historical moment in which they live.

Therapy's goals need clarification. Many today are in emotional distress and seek help. What kind of “help” will they get? From whom? Toward what end? At what fee? Under what system? With what orientation? And who will guarantee the competent concern of their “therapists”?

Therapy today is a class phenomenon: a luxury for the well-to-do. Most people receive no such help, or are consigned to hurried, inexperienced therapists who rely mainly on drugs. At home with the affluent, therapy extends itself

with suspicion to other social groups, and often tries only to regulate or determine their development. Therapists universally retreat behind the safety of a one-up "impartial" stance. The situation is unsatisfactory.

Therapy's insights must be reevaluated and altered, and then made available to people in ways which serve their goals. As a commodity on an open marketplace, though, therapy is ultimately degrading.

Nor is it enough to pursue a medical model and try to develop popular programs to "treat the masses." Therapists must understand their place in the changing social and political reality: thus therapy must become more politically aware. No therapist, no person, can claim detachment from his social context. Each human act is a social and moral statement: a political fact. It then becomes important which values we hold and which of them comes first. This awareness must structure all radical therapy today; for liberation from within has to be accompanied by liberation from without.

Developing new training programs

Therapists are groomed for elitist, frequently escapist and exploitive careers. Professional associations and journals legitimize such training, and the mass media tout its necessity. Yet current training perpetuates outmoded systems. In an age when everything is under question, therapy training bears down all the harder on those it teaches, as if this will abolish doubt. Hierarchical systems obviate change; and training programs, like practice, tend to stultify and wound many people. The system is slow to respond to popular needs.

Artificial barriers are created everywhere: between senior and junior staff, between therapists from various disciplines, between "professionals" and laymen. Institutional rigidity represses the need for alteration, and men of good will are lost year after year within their labyrinthine tangles.

Training programs keep therapists apart and encourage

false professionalism. Course work in other relevant fields is lacking in every discipline. Psychiatrists lack training in psychology; social workers lack training in simple drug use; psychologists lack training in sociology. All therapists lack training in politics, art, history, and economics, which they vitally need today. Therapy is not a medical specialty, nor is it a branch of the social sciences. It is a field all its own, dealing with relationships between people; and as such it demands its own orientation and its own training programs which draw on the experience of all pertinent disciplines.

We need new training programs, not amended or expanded versions of what we already have. We need ten times as many therapy workers. We need to make better use of community resources and extend to more people the insights now available to the few. We need, not more of the same, but a wholly new approach. Finally, we need to examine the free system which allows some therapists to obtain excessive wealth at people's expense.

Training must be demystified and made more open, more responsive, and more creative. New experiments are already beginning to challenge and redefine our notion of therapy. We encourage them and look forward to their results.

Elaborating a new psychology of men and women, and new concepts of family and community life

The ways we live intimately with one another are changing. Yet much of this is poorly understood. We must look into ways in which unquestioned male-dominant ideas have influenced therapy, especially therapy of women. Men and women must both be liberated from rigid sex stereotypes in order to develop their own potential. Deviance as a social diagnosis must not be confused with neurotic behavior.

We need to know much more about all this, for our old ideas are no longer appropriate. The nuclear family, so long revered and unchallenged, now appears as simply the

most common alternative for achieving needs for intimacy and raising children. We need to evaluate the other alternatives. Similarly, we need to investigate the changing notions of men and women, as well as alternate modes of living. But unless we ourselves are freed from dogma and bias, we will never understand others who experiment with new ways. Instead, we will see dangerous "sickness" everywhere.

Encouraging the development of more responsive therapy programs under client control

Despite all the talk about "community mental health," therapists have done little toward considering the real health needs of communities. The community mental health movement is a fraud. It has never been in popular hands. Affording a crucible of power to ambitious professionals, it often offers but another form of oppression to the people. Professionals' needs for wealth, prestige, and influence are satisfied, while distress in the community goes on as before. Yet the therapist's money comes from the community. Bringing a skill in understanding human feelings to the community, he must learn to offer it as his clients need it, not as he would give it. More sensible forms of therapy, controlled by and responsive to community needs, must be devised and offered.

The community is its people: not the therapists, or the university, or the research teams, or big business, or the government. Therapists who enter the community may consider themselves part of it: but they cannot claim to know what is best for it. They cannot shape its needs. As radical therapists, our task is exposing the nature of current practices and pursuing new innovations in therapy services: decentralized, democratic, noninstitutional, and popular. We can identify and channel grievances, and help stimulate action. This way we join the search for new ways of serving the community's needs.

More than communities are being violated. Therapists define what is appropriate and what is not, even while

claiming to be "disinterested." They operate as forces for social control, weeding out deviance with the label of "mentally ill." Wherever it functions as an agent of the system, encouraging conformity, helping people "adjust" to the realities of exploitation, antiquated roles, and a casual dehumanizing ethic, therapy is an instrument of oppression. Such "therapy" institutionalizes and stigmatizes those whom society will not tolerate, numbs minds, tranquilizes and antidepresses, electroshocks, disenfranchises, diagnoses, ostracizes, psychologizes, and treats people as commodities and things. We oppose this from the core of our being. We denounce all "therapy" which dehumanizes and violates our brothers and sisters.

Encouraging new techniques

We encourage the search for self-realization, singly and in groups, with the eventual goal of growth within communities. Growth can be individual as well as collective. We support new techniques and innovations in therapy, but we decry their use as middle-class escapist outlets or as vehicles for profiteering by some in our field. Effective techniques should be popularly available.

New forms of therapy are important in our move toward liberation. They deserve sympathetic and critical evaluation, freed from insistence that whatever exists now is best. So long as innovations are honest and open and are not used to exploit people, we are interested in them. Moves toward group and communal experience, as well as individual growth, can help free us from inner as well as outer forms of repression.

At the same time, we are alarmed by the use of insights from therapy fields to extend institutional and governmental control, through required psychological tests for employee applicants, inappropriate in-depth interviews, and the use of therapists as consultant engineers for third parties such as corporations, the military, and universities. Psychological innuendo in advertising is also questionable on moral grounds, and must be reexamined. Therapy can-

not escape responsibility for the oversexualization of every commodity on the market; and for the undersexualization of sex itself.

Confronting the way our society functions

We are concerned with the social milieu in which we all live, and with its effect on psychological well-being. Thus we join the crusade against violation of our natural resources, whether through encroachment on our minds by advertising, the mass media, stereotyped education, and outdated cultural myths; or through the blatant destruction of our environment's wholesomeness through air and water pollution, overpopulation, chemical and industrial waste, and unlivable cities. Our technology might create an environment free from scarcity and want, clean and aesthetically pleasing. Instead, it destroys whatever it touches.

Just as the rivers and lakes are destroyed by an arrogant, unfeeling technology, so our sense of humanness is barged daily by the mass media. Advertising and the consumer economy make every person a thing. The measure of success becomes accumulated objects, wealth, and notoriety; not the well-being of one's family and self, community, and world. We must realize that many people called "mentally ill" have been socially traumatized by our society, which creates and exacerbates emotional suffering. While we do not pretend that all mental suffering is socially caused, we are alert to the social and political roots of much of it. Failing to pursue this would be negligence and complicity.

Beyond the environmental ruin and the consumer economy lies the constant presence of war. Breaking out now on many fronts at once, war's results are always the same: destruction of people, killing and maiming, disruption of family and community life, violence, brutality, senseless suffering. The internal ills our society now experiences have already "brought the war home." What we practice internationally, we now suffer nationally and

locally. We are all affected by such brutality, and by the ultimate madness of our nuclear weapons. Unless we as therapists and people can look beyond "professional" issues and approach the social and political roots of suffering, we act as unknowing agents for the established order.

In the midst of social upheaval *The Radical Therapist* allies itself with those working for needed change.

Essentially, *The Radical Therapist* seeks to bring together all people concerned with looking at therapy in today's society. While drawing on therapeutic tradition, we should deprofessionalize and demystify therapy work. Our view of existing institutions is radically critical: but then it is no secret how bad things have become. We will make people aware of the situation, and pursue programs for change. In this exciting venture, we invite support and participation from all who help us redefine therapy and make it a more responsive, meaningful human pursuit.

**THE RADICAL
THERAPIST**

I. Toward a Theory of
Radical Therapy

Radical Psychiatry: Principles

Claude Steiner

Claude Steiner is at the Radical Psychiatry Center in Berkeley.

Psychiatry is the art of soul healing. Anyone who practices the art is a psychiatrist. The practice of psychiatry, usurped by the medical profession, is in a sad state of disarray. Medicine has done nothing to improve it; as practiced today, medical psychiatry is a step sideways, into pseudoscience, from the state of the art in the middle ages when it was the province of elders and priests as well as physicians.

Psychiatry as it is predominantly practiced today needs to be changed radically, that is "at the root."

Psychiatry is a political activity. Persons who avail themselves of psychiatric aid are invariably in the midst of power-structured relationships with one or more other human beings. The psychiatrist has an influence in the power arrangements of these relationships. Psychiatrists pride themselves on being "neutral" in their professional dealings. However, when one person dominates or oppresses another, a neutral participant, especially when he is seen as an authority, becomes an enforcer of the domination and his lack of activity becomes essentially political and oppressive.

The classic and prime example of this fact is found in psychiatry's usual role in relation to women where, at worst, psychiatrists promote oppressive sex roles and at best remain neutral, therefore supportive of them. The same is true of psychiatry's traditional role in relation to the young, black, and poor; in every case psychiatry's "neutrality" represents tacit support of the oppressive status quo.

There are four types of psychiatrists. Alpha psychiatrists are conservative or liberal in their political consciousness and in their practice and methods of psychiatry; the largest majority of medical psychiatrists fall into this category. Beta psychiatrists are conservative or liberal in their politics and radical in their methods. Examples of this type are men like Fritz Perls and Eric Berne and the human potentialities psychiatrists, usually not physicians, who expand the boundaries of psychiatric practice, but tend to be unaware of the manner in which oppression is a factor in psychic suffering and ignore the political nature of their work. Gamma psychiatrists are radical in their politics but conservative in their practice. Examples of this are Laing and others (as a special case, Szasz, whose awareness of the politics of psychiatry is quite heightened) who practice old, outmoded methods of therapy based on Freudian or neo-Freudian theory with emphasis on individual psychotherapy, "depth," and "insight." The fourth kind of psychiatrist is the radical psychiatrist, who is radical both politically and in his psychiatric methods.

The first principle of radical psychiatry is that in the absence of oppression, human beings will, due to their basic nature or soul, which is preservative of themselves and their species, live in harmony with nature and each other. Oppression is the coercion of human beings by force or threats of force, and is the source of all human alienation.

The condition of the human soul which makes soul healing necessary is alienation. Alienation is a feeling within a person that he is not part of the human species, that she is dead or that everyone is dead that he does not deserve to

live, or that someone wishes her to die. It may be helpful, in this connection, to remember that psychiatrists were originally known as alienists, a fact that seems to validate the notion that our forefathers knew more about psychiatry than we. *Alienation is the essence of all psychiatric conditions. This is the second principle of radical psychiatry.* Everything diagnosed psychiatrically, unless clearly organic in origin, is a form of alienation.

The third principle of radical psychiatry is that all alienation is the result of oppression about which the oppressed has been mystified or deceived.

By deception is meant the mystification of the oppressed into believing that she is not oppressed or that there are good reasons for her oppression. The result is that the person instead of sensing his oppression and being angered by it decides that his ill feelings are his own fault and his own responsibility. The result of the acceptance of deception is that the person will feel alienated. A good example of this is the depressed youth who does not wish to participate in a war, but is forced to do so and told that he's doing it for the benefit of his country, the benefit of his brothers and sisters, or even for his own benefit. If he neglects to see that he is oppressed in this situation and comes to believe the mystifications about it, he will then turn from someone who is angry at his oppression to someone who is alienated and believes that he is a coward. Another example is the woman who, angered by her husband's domination, ceases to enjoy sex with him. Again, if she fails to recognize her oppression she will conclude that she is at fault; that she is "frigid," while if she becomes aware of the source of her anger she will recognize that her loving nature is intact.

Thus, the difference between alienation and anger about one's oppression is unawareness of deception. Psychiatry has a great deal to do with the deception of human beings about their oppression.

$$\begin{aligned} \text{Oppression} + \text{Deception} &= \text{Alienation} \\ \text{Oppression} + \text{Awareness} &= \text{Anger} \end{aligned}$$

What, then, are the methods of radical psychiatry? *The radical psychiatrist sees anyone who presents himself with a psychiatric problem as being alienated, that is being oppressed and deceived about his oppression, for otherwise he would not seek psychiatric succor.* All other theoretical considerations are secondary to this one.

The basic formula of radical psychiatry is:

Liberation = Awareness + Contact

The formula implies that for liberation two factors are necessary. On the one hand, awareness. That is, awareness of oppression and the sources of it. This type of awareness is amply illustrated by the writings of Laing and the writings by radical feminists and blacks, and so on. However, this formula also implies that pure awareness of oppression does not lead to liberation. Awareness of oppression leads to anger and a wish to do something about one's oppression so that a person who becomes so aware changes from one who is alienated to one who is angry in the manner in which some black people and women have become angry. Anger, therefore, is a healthy first step in the process of liberation rather than an "irrational," "neurotic," or otherwise undesirable reaction. But liberation requires contact as well as awareness. That is to say, contact with other human beings who, united, will move against the oppression. This is why it is not possible to practice radical psychiatry in an individual psychotherapy context. An individual cannot move against his oppression as an individual; he can only do so with the support of a group of other human beings.

Thus it appears *radical psychiatry is best practiced in groups* because contact is necessary. Because people seeking psychiatric help are alienated and therefore in need of awareness *a radical psychiatry group seems to require a leader or leaders* who will undertake to guide the liberation process. To avoid the leader's oppression of group members *each individual member should propose a contract with the group* that indicates his wish to work on a specific problem. Liberation from the leader's guidance is the

ultimate goal of radical psychiatry and is indicated by the person's exit from the group.

Contact occurs between people in a number of different forms. Basically contact is human touch, or strokes, as defined by Berne. But contact includes also when people become aware of their oppression, permission, and protection. Permission is just what the word implies, a safe-conduct for a person to move against his oppressor and to "take care of business." This permission needs to come from a person or persons who at the moment feel stronger than the one who is oppressed, usually the leader. Along with the permission, the person who is to move against the oppression needs to know that he will be protected against the likely retaliation of the oppressor.

This, then, is the vital combination of elements in radical psychiatry: awareness to act against deception and contact to act against alienation. It should be reemphasized that *neither awareness by itself nor contact by itself will produce liberation*. As an example, it is very clear that contact without awareness is the essence of the therapeutic encounters of the "human potentialities" movement. The potency of human contact and its immediate production of well-being, as found at Esalen and the present RAP Center, is rightfully eyed with suspicion by therapists in the Movement because without awareness human contact has a capacity to pacify and reinforce the mystification of the oppressed. It is equally clear that pure awareness, whether it be psychoanalytic or political, does not aid the individual in overcoming oppression since the overcoming of oppression requires the banding together of the oppressed.

On Training Therapists

Michael Glenn

Michael Glenn is on The Radical Therapist Minot staff. While much of what follows describes a psychiatrist's experience, it is also true of other "professional" therapists' training. The suggestions at the end speak to all therapists.

The psychiatrist in training is embedded in a medically oriented matrix with a closed-guild tradition, whose model is master and apprentice. He is assumed to be inexperienced and naive, a stumbling creature whose every step must be watched and checked. The model of supervision approximates that of therapist/patient, and the supervision constantly resorts to unbeatable ploys, like commenting on the trainee's psychological hang-ups. Mathematicians, businessmen, artists, actors, teachers, historians: all are acknowledged to have some sense of the world and of their place in it by the time they are thirty: yet the therapist in training is encouraged to see himself as grossly inadequate, ill informed, and bumbling.

The professionalism of the medical model, with its aura and mystique, permeates psychiatric training. One is constantly mystified and perplexed. The completion of train-

ing allows the now-professional psychiatrist to begin mystifying others, even though he usually has no idea how he does it. He seems to become mature, capable, and a member of the guild in good standing the moment the diploma enters his hand.

Its model makes psychiatry invincible. Attempts to change are readily discredited as psychopathology, delayed adolescence, and acting out. The trainer rarely encounters the trainee as another person, a brother or sister. Training is marked by psychological put-down, intimidation, and guilt-invoking techniques. Its graduates then repeat their experience with their clients. Such a dehumanizing, destructive system must be changed.

Szasz, Laing, and others have shown how psychotherapy dehumanizes both patient and therapist. Goffman has shown this in asylums. The same is true for therapist training, which effects the professional annihilation of trainees by incorporating them into a corrupting structure, which they must accept to succeed.

They must play the game correctly. But learning to play the game correctly often ties them to its rules for life. It is a Medean shirt which cannot easily be removed once it is put on.

There are several features to this:

Professional mystification and the psychiatrist's role

Psychiatrists, being physicians, have endured years of psychological brainwashing called education. They have learned that, to be able to make an exorbitant income, they must assume a social mask of Responsibility and Omniscient Doctor. They are our society's shamans, though lacking in the latter's sense of true drama.

Medical training has certain values: 1) It lets the young psychiatrist see the system as it really is; 2) It helps him learn to act decisively in emergencies; 3) It gives him experience with ultimate, profound situations; 4) It provides him with a range of human experience—albeit as

observer—usually forbidden others not in the guild; 5) It gives him status in the system.

In return, however, medical training tyrannizes the young psychiatrist in several ways: 1) It foists an image of the physician on him; 2) It keeps him an observer, not a participant; 3) It makes him seem/feel infallible; 4) It inculcates in him values of sacrifice and responsibility, while at the same time insisting he owes himself all the luxury he can later obtain, thus encouraging him to accept materialistic values as the true measure of his worth; 5) It estranges him from others.

Medical training supports the conventional values in this society: the status quo, traditional sex roles, the search for profit. The physician becomes a petit entrepreneur. He has to behave the correct way. He becomes a defender of the church, the family, the community, the nation. His role today is a far cry from what it was in the 19th century, when physicians were often, as skeptics and scientists, in the vanguard of social change. Now, comfortable and fat, they challenge little and accept much. They hang on to what they've got.

In addition, medicine is mystifying. Doctors have kept their numbers down. They conceal facts from patients. They hide behind the garb of their professionalism, as if they possess arcane secrets. The public goes along with them and attributes all kinds of knowledge and power to them which they do not possess. Use of drugs, treatment of illness, prognosis of common maladies: all these are kept as secrets for the medical profession only. Mystification augments their status. But, based on a lie—that only they are capable of holding the secrets—it makes the "profession" ever paranoid, ever watchful, ever more secretive. Of course physicians resent pressure "from below" to demystify.

The doctor's morality is conventional: thus oppressive. Physicians act to heal and patch up: not to challenge the fabric of the system which sustains them. Psychiatrists, at the top of the "mental health" heap, may indulge in liberal causes without fear, especially in a liberal university or

town setting; but they run into trouble if they become politically concerned beyond that. (I can cite five known instances of therapists being dismissed after becoming involved in community politics.)

The psychiatrist in training learns to treasure his elite identity, to pull rank on "ancillary" and "paraprofessional" personnel. His lengthy training lets him charge higher fees in private practice. He is a ubiquitous authority, assured prestige if he only behaves right.

The same is true of other therapist professionals. Each pecks on those beneath him; and all peck on the clients. Mystification of their skill maintains their invincibility.

Who needs medical training?

What is the rationale for psychiatrists—or any therapists—being physicians? How relevant is medical training?

Four years of medical school followed by an internship give the young psychiatrist the following: months of anatomy and biochemistry, histology, pathology, urology, surgery, cardiology. But he receives NO sociology, psychology, anthropology, politics, or notions of human interaction. To be a physician, he endures all kinds of special training, which he only forgets later. Indeed, he has to *unlearn* his taught bias later on.

If the medical model is really important, all therapists could receive training in it. Certainly notions of public health, emergency care, and common maladies are useful to everyone who works with people. But the bulk of medical school's professionalism, formality, and specialization is irrelevant to the therapist's work.

The usual arguments for psychiatrists having to be physicians—thus distinguishing them from psychologists, nurses, social workers, etc.—are rationalizations for historical accident and caste privilege. Emotional difficulty was defined by physicians as a *medical* illness: thus it had to be treated by a physician specialist in emotional illness. The medical model makes psychiatry oppressive: people are defined as "patients;" they are told they have "dis-

eases;" they are locked up, shocked, socially denigrated, and ostracized because they are "sick." The psychiatrist becomes society's cop.

Do people with problems in living really have an "illness"?

The medical model makes psychiatrists a healthy elite. It makes the patients an oppressed class. Other therapies too, insofar as they participate in the one-up, one-down relationship, join psychiatry as oppressive.

The issue of prescribing drugs is a red herring. Because only physicians can prescribe the drugs needed to treat emotional "illness," they maintain a monopoly on their role. This issue is so contaminated with drug-company commercialism, "diagnostics," and mystifying guild elitism that any sensible discussion of it is impossible. The simple fact is, if drug use is important, most people can learn about it in a rather brief time.

Others argue that psychiatrists need medical training to "catch" brain tumors and other "organic" diseases which might masquerade as depression, conversion reactions, etc. The argument is weak. If such training is important for a therapist to have, it can be taught most therapists in a rather brief time. It doesn't take five years of medical training to recognize organic disease.

Medical school is about 80 percent a waste of time for the young psychiatrist. It should be scrapped.

Repression of trainees

In most psychiatric training centers, the residents, young adults, are powerless. Their curriculum is not theirs to make; their routine is set up for them to follow. "Others wiser than they" determine what they shall and shall not do. Resident advisory councils are false fronts.

The ideal therapist in training is intelligent and afraid: indecisive and obsessional, he can be made to feel inadequate and guilty with ease. Over and over again, in my own training, administrators and supervisors would push residents down, dismissing their grievances as adoles-

cent psychopathology, criticizing their efforts at assuming responsibility for their own education. The amazing thing is how readily the residents accepted this image of themselves. They got themselves into therapy. They forswore social activism to uncover the "causes" of their rebelliousness within themselves. A more thorough job of mystification and brainwashing was never achieved!

Here, at random, are some incidents from my own experience:

1) An activist resident who organized the community against the university's "mental health center"—an imperialistic fraud—was fired for "clinical incompetence." The other residents refused to create a stir to defend him.

2) The director of the emergency room service decided that third-year residents would have to see every patient the first-year resident saw. This rule had not been observed for years. Rather than discuss the situation, the director insisted his will would be followed. Residents' arguments could not move him. Yet the residents would not consider a strike or collective action to dramatize their opposition. Their attitude was: Why make waves; we'll soon be out.

3) A resident rotating through a state hospital criticized its program to its director. The latter complained to a supervisor, and the resident was severely upbraided for "unprofessional behavior."

4) A paper written about the state hospital system was bottled up by the administration and refused imprimatur.

5) An anonymous letter circulated among the supervisory staff which demanded higher salaries for residents and threatened to call the press unless its demand was met. The letter was angrily denounced by several of the staff at a residents' meeting. The unknown author—it was unclear to the residents if any of their number had ever written it—was called "seriously disturbed" and told to get himself into therapy. The issue of salaries was not discussed, except when the director advised any resident who wanted more money that he could go elsewhere. The anger and fear of the staff was incredible.

6) The grapevine in the program proclaimed that, so

long as a resident didn't rock the boat, he could leave the program and make \$40,000 a year. Most of the residents swallowed the bait. What earthly incentive could they then have for challenging the system!

Our program emphasized one-to-one treatment, psychoanalytic insight, and hospital care. Family and group work was almost nonexistent; and the "community program" existed in a vacuum, whose instructors never discussed what was going on in the actual community outside but instead prepared the residents for administrative posts.

It was frightening how few residents saw any value in opposing a system which they all agreed was oppressing them. Their attitude was to wait until they were out and on top themselves. Their salvation, in other words, lay in their future capacity to bilk, brainwash, co-opt and alienate others. They preserved the illusion that, so long as they disagreed inwardly, they could go along with the outward demand and still preserve their integrity.

Unless training programs are changed, therapists will continue to serve their own interests, not that of the people. They will be men of good will in an oppressive structure.

Therapy and politics

Therapists are politically naive. They come through a professional education which gives them little understanding of social and political issues. Psychiatrists probably suffer the most through their long isolation in medical school, where they remove themselves from their society and give themselves the illusion they are gods. They are ignorant of their place in society; they are ignorant of what is going on in the real world; they are victims of a narrow horizon.

Many therapists go into debt to complete training. Making money to them is important. Staying within the system they can rise out of debt and become affluent in a matter of years. It is no wonder they guard their possessions

jealously and are angry at those who "impatiently" press for change.

The life-style of the therapist—certainly the psychiatrist—proclaims his place in the status quo. He lives comfortably off in the suburbs, or in a town house. His children are in private school. He has a maid to free his wife. He owns color TV sets, cars, boats, land in the country, stereos, tailor-made clothes, season opera tickets, a fine portfolio of stocks; and takes vacations around the world. **HOW CAN HE EVER BE AN INSTRUMENT OF CHANGE, THEN?** He owes allegiance to the system in which he prospers.

Thus it is that he becomes an oppressor, an enemy of the people. While he eats high off the hog, others starve. Even when he is "liberal" he rarely risks his security for his ideas. Within the present system, it seems, he has no choice. That is why the system must change.

Therapy is not a branch of medicine, nor is it a social science

Therapy is a discipline in its own right, dealing with human feelings and human relationships in a human society. It was a historical accident that therapy became incorporated under its various disciplines.

If we accept this, it then becomes clear how unfortunate and divisive are the distinctions between the various therapy fields. For some therapists to have medical training and others social work training and others experimental psychology training, etc., means that the field of therapy is being partitioned like Poland in the 18th century. Therapy demands its own institutions, its own training programs, its own practice. The therapy fields belong together, brothers and sisters under one roof.

Current training programs prepare young therapists for roles which already exist in the system: institutional roles, private practice roles, research and teaching roles. But they don't prepare them for reexamining and challenging the system itself.

The young therapist may see this, but he isn't sure how to deal with it. Staying clean has its advantages. Going outside the system is a hardship. Only a few will take the risk, and they can be easily isolated.

New training programs are needed if any change is to occur.

Alternative training programs

Alternative institutions have risen dramatically in recent years. Spurred on by Goodman and others, free universities, free clinics, and new life-styles have emerged. Roszak documents the movement's strength. Berke presents its rationale. Domhoff underscores its political importance.

Rather than confront the present system head on and be massacred by its flunkies, many today are working "to let grass push through cracks in the concrete": putting energies into new forms and new ways and letting the system collapse of its own dead weight. Some attempts have already been begun. Others will soon arise and solidify. The following is a sketch of what they will involve:

- 1) Training will not divide people into categories such as "psychiatrist" and "social worker." All people in the program will be therapists. They will be trained as such. Further skills can be obtained elsewhere.

- 2) Training will be open to all people, not made a class privilege. Those from poorer communities and minority groups will have ready access to the training their communities need. There will be an end to honky experts who come as colonialists to tell people how to live.

- 3) Training will be funded by local communities.

- 4) Training will be demystified and deprofessionalized. What is necessary to know will be taught, straight out. What is unnecessary will be trashed. Therapists will be workers in their communities, like any other worker. Their skills are needed for the common good. But their skills will not make them a "professional" elite.

- 5) Training programs will be interdisciplinary, dealing

with psychology and politics, sociology and art, the mass media, the analysis of power, theories of interaction, and contemporary history.

6) The model of training will change from hierarchical, obsessional, master/pupil interaction to a more open, popular, democratic form. All whose ideas and insights are valid will be heard. Age itself will carry no guarantee of wisdom.

7) New techniques will be evaluated openly, without fear of change. Therapy training centers will be like free universities, not trade schools. Free inquiry and dissent will be encouraged, not put down as "pathology." Therapists will become politically involved in the overall struggle against oppression.

8) The number of therapists trained will increase, thus benefiting the people by more available, more adequate, more relevant care.

9) Incomes for practicing therapists will be appropriate to their work. No one will grow wealthy from the people's suffering.

10) Modes of collective practice and communal living will be tried, in the belief that the therapist's life-style strongly affects his work. Therapists will not live aloof from their clients, distanced by class and interest, elite oppressors helping only from "above." They will be part of their community.

11) Therapy will be available to all, not sold to those who can afford it like fried chicken or any other commodity. It will be geared to the needs of communities, not the needs of professionals.

Let us push ahead, toward a radical therapy.

Radical Psychiatry and Movement Groups

Claude Steiner

Radical psychiatry's main goal is to help human beings overcome alienation. Because alienation requires contact with other human beings in groups it is important that radical psychiatry provide guidelines for the healthy functioning and survival of groups. When people who are interested in radical changes organize groups they quite naturally wish to organize them along lines which differ from the authoritarian and alienating basis on which oppressive, establishment groups are usually organized. As a consequence the structure of such groups is usually uncertain and indeterminate, and the cohesiveness of such groups against external attack is weak. There are two types of attacks upon movement groups which have become classic examples: one of them is the leveling of hierarchies; the other is the game "Lefter Than Thou."

Lefter Than Thou

It is a phenomenon completely familiar to everyone who has worked in a radical organization that in the course of events it happens that one or more people will attack

the leadership by professing to be more revolutionary or more radical than the leadership. Since it is always possible that this is the actual state of affairs, namely that the leadership of the group has become counterrevolutionary, many an organization has been totally torn apart by this kind of argument; in many cases organizations that were doing true and valuable revolutionary work.

How is one to distinguish a situation in which a splinter group is for one reason or another simply attacking the leadership illegitimately, or whether such a group is in fact justified in its attacks?

I would like to cast the illegitimate attack of the leadership of a group by a splinter group in the mold of a Bernean game. The game is called "Lefter Than Thou." The thesis of the game is that a group of people doing revolutionary work which has a certain amount of momentum always includes a subgroup of people with revolutionary aspirations but who are incapable of mustering either the energy or the courage to actually engage in such activities.

"Lefter Than Thou" players are persons who are dominated by an extremely intolerant and demanding conscience (or Parent) on the one hand and are not able to mobilize their scared Child to do any work on the other. Criticism of the activities of the group and the decisions of the leaders becomes a substitute for revolutionary work. This criticism occurs, usually, at meetings where work would ordinarily be discussed, and it always replaces effective action. "Lefter Than Thou" players are either effective in dismembering the organization and wind up without a context in which to work, or they are expelled from the organization by the effective leadership of it and find themselves again in a situation in which no work can be done. In both cases they have a clear-cut justification for their lack of activity, and this is the payoff of the game.

It is a hallmark of "Lefter Than Thou" players that they are angry, often "Angrier Than Thou"; it is quite possible, however, to distinguish the anger of a "Lefter Than

Thou" player from the anger of a person who is effectively reacting to his oppression.

"Lefter Than Thou" players are most always children of the middle class. On this basis it is easy to see why a group of black militants can hardly be accused of playing "Lefter Than Thou" while a group of white college students who accuse these black militants of not being radical enough is suspect.

Whether a person plays "Lefter Than Thou" or not can be determined by making a simple assessment of how much revolutionary action he takes other than at meetings over, say, a period of a week. It will be seen that if observed closely, the activity of a "Lefter Than Thou" player occurs mostly in the form of an intellectual "head trip" at meetings and hardly ever in the real world. "Lefter Than Thou" players will excel in destructive arguments or sporadic destructive action when sparked or impelled by others. But it will be seen that they lack the capacity to gather momentum in creative or building work and that they lack the capacity to work alone due to the extreme intransigence of the Pig Parent in their head which will defeat, before it is born, every positive, life-giving effort.

It appears, therefore, as if that extraordinarily divisive game "Lefter Than Thou" is played by persons whose oppression has been largely oppression of the mind. This form of intellectual oppression, a Calvinist "morality of the intellect," is usually accomplished in a liberal context in the absence of societal or familial application of force, a context in which action or force is actually disavowed so that the chains that bind the person are strictly psychological or within the head, yet most paralyzing indeed. When anger is felt it is not expressed physically but in the form of destructive talk.

Movement groups are especially vulnerable to destructive talk as their leaders are often in awe of and mystified by intellectual accomplishment. It must be remembered that a game has to be played by the Victim as well as the Persecutor. The Victim in this case being the lead-

ers of the group under attack who, ordinarily, are more than willing to submit to the persecution of the "Lefter Than Thou" player. This willingness to respond to "head trips" and intellectual arguments is a characteristic of certain cultural subgroups, so that while a "Lefter Than Thou" player would be scoffed at and ignored in a very clearly action-oriented movement group, "Lefter Than Thou" players have a capacity to affect the decisiveness of the guilt-ridden intelligentsia.

This game is a liberal, intellectualized form of the aggressiveness that has been observed among the oppressed poor and the black. It is a well-documented fact that crimes against persons occur mostly between members of oppressed subcultures. Fanon in *Wretched of the Earth* illustrates how the savage, homicidal, and capricious criminality that has been observed among Algerians dissolved when the war of liberation became established. The supposed fact that Algerians are born criminals, taught even to Algerians by the faculty of Algiers, was not only not a fact but a mystification of their oppression. The actual fact of the matter is that the oppressed, when they have no access to their oppressors, either because their oppression is mystified or because their oppressors are not within reach, are likely to wind up at each other's throats. "Lefter Than Thou" is a case of the frustrated and mystified oppressed seizing the throats of their brothers and sisters because of an incapacity to engage in positive, creative revolutionary action.

The measure of a revolutionary's worth is the work that she or he does. When a person questions the effectiveness of the leadership of a group or the work of a group, the first question to that person should be, "What work are you doing?" It will be found that in most cases the critic is a person who is doing very little or no work. If that person is, in fact, contributing a great deal of work outside of the discussions at meetings, then the challenge of the validity of the leadership's goals and methods is again open to question. Thus, the demystification of a

critic's actual work output is a very important tool in the maintenance of a cohesive movement group.

Another usual attack upon movement groups which is also quite effective is "leveling."

Leveling, hierarchies, and leadership

The greatest single evil in mankind is the oppression of human being by human being. Oppression ordinarily expresses itself in the form of hierarchical situations in which one person makes decisions for others. It has been the wish of many to eradicate this greatest of all evils from their lives. In order to do so some people have completely leveled hierarchical situations and have attempted to function socially in the total absence of leadership, in the hope of building a society without hierarchies in which the greatest evil—oppression—cannot find a breeding ground.

With the specter of the worst pig, authorization hierarchy haunting them, people have attempted to work in organizations which have been leveled of all hierarchies. In my opinion such organizations, when they involve more than about eight persons, have an extremely low chance of survival. When "levelers" enter an organization and impose willy-nilly a no-hierarchies principle they usually bring about the ultimate destruction of the group.

I will attempt to demonstrate the fallacy of leveling of hierarchies, and will attempt to present an alternative to leveling which I believe is capable of making rational use of the valuable qualities of leadership in people while preventing that extension of leadership into oppression which is such a scourge upon humankind.

First let me define some terms:

I will call oppression the domination by force or threats of force of one person by another.

I will call leveling a situation in which, at least publicly, no leader is recognized and no hierarchy is allowed in a

group, even though leadership and hierarchy may in fact exist.

I will call a hierarchy a situation in which one human being makes decisions for other human beings.

I will call a leader a person in a group who is seen as possessing a skill or quality which causes others to wish to learn or profit from that quality.

Hierarchies come in a great variety of forms, from the murderous hierarchies in a capricious war to the mother-child hierarchy, including the hierarchies between teacher and student, man and woman, black and white, master and slave, factory owner and exploited worker, foreman and journeyman, craftsman and apprentice. Some of these hierarchies are alienating and dehumanizing. Others are not. To relate to all hierarchies as if they were all dehumanizing and evil is a great error, bordering on mindlessness. Hierarchies should be analyzed in terms of whether they affect human beings well or badly.

There are at least three human hierarchies which are of obvious value to humankind and which clearly would not profit from being leveled.

The first and most basic hierarchy is the hierarchy between mother and child. Here one person makes decisions for another person and it is difficult to see how leveling this hierarchy would be of any advantage to humankind. When this mother-child or parent-child hierarchy is extended beyond its fruitful and natural reach, namely when it is imposed by force or threats of force and beyond the period in which the child needs parental protection and when it is extended to large aggregations of people, then this parent-child hierarchy becomes the model for the military, the great corporations and so on.

Another such is the hierarchy between a human being who is in great physical pain or need (the sick, the hungry, the wounded, the deranged) and another human being who has the means to fulfill that need. When a person is in dire physical need he may wish that another human being will make decisions for him. Again, this natural hierarchy which is conducive to well-being can be ex-

tended into one that is damaging as has been the case with the hierarchy that has been created by the medical profession and the attending psychiatric and other mental health professions. Again, the continuation of the need beyond necessity, the continuation of ministrations beyond necessity, the encouragement of the preservation of the hierarchy even in the absence of physical need, have resulted in a hierarchical medical establishment which at this point may be doing more against human health than for it. This may sound startling but if one separates medical knowledge which is vast and potentially helpful from medical activity which is self-serving and oppressive one can see that the medical establishment is not only not fully serving humanity but holding back potential help from it.

A third hierarchy is based on differences of skill between human beings in which one person who can be considered a craftsman is sought out by another person who wishes to learn her craft. This hierarchy in which one person places himself below the other in knowledge is desirable to both. The apprentice, by recognizing his need to learn and by riveting his attention to his master, is likely to acquire a skill more quickly and more thoroughly than a student who questions the master's knowledge. On the other hand a teacher who is given the attention and recognition of an apprentice finds his teachings the greatest rewards for his life effort. Both the craftsman and the apprentice profit from this process, and it is hard to see how either of them, especially the student, is damaged by it. Again, this natural hierarchical situation can be extended beyond its necessity so that certain persons are forever kept in an inferior position to others with respect to their skill. This, of course, is the basis for most universities and professional schools and is again an example of where a natural hierarchy can be extended into an oppressive and evil one.

It is characteristic of humanizing hierarchies that they are first, voluntary; second, bent upon their own destruction or self-dissolving.

All three of the above mentioned beneficial hierarchies can be extended into oppressive ones. The tendency toward dehumanizing hierarchies that may exist in human beings can be overcome by human beings who decide that they wish to do so. That very same tendency can be empowered by the human intelligence as has been done, to the point of building monstrous hierarchies which may now consume us. As human beings we have the choice between mindlessly extending natural hierarchies to the point where they will devour us, or equally as mindlessly leveling and abolishing them, or using our intelligence, wherever it suits us, to create groups with humanizing, beneficial hierarchies when needed.

I wish to postulate an intelligent principle of authority which discriminates between hierarchy and oppression and which I hope will be useful to people working in movement organizations.

The first principle of human hierarchies is that they be voluntary and that they be self-dissolving, that is that the eventual historical outcome of the group's work be to make the hierarchy unnecessary.

The second principle of human hierarchies is that leaders shall be responsive and responsible.

In order for a hierarchy to be voluntary it cannot involve oppression or coercion by force or threats of force. As a consequence, no one shall use force or threats of force in any situation relating to human beings within a movement or an organization of which he's a member. Intimidation of group members by psychological means (pigging) must be avoided by developing an atmosphere of mutual protection between group members.

Responsive leaders are leaders that are available for criticism by group members. Thus leadership can be extended only as far as it remains possible for all group members to make extended face-to-face contact with the leaders.

Finally, a responsible leader is one who feels the impact of his or her actions and takes responsibility for them. This is a human quality which can only be assessed by ob-

ervation. Responsibility is judged from the leader's previous actions and can only be ascertained over a period of time during which his or her work is open to scrutiny and during which the important quality of responsibility is observed.

The same kind of guilt that operates in the leadership when faced with "Lifter Than Thou" players comes into effect when confronted with a leveler.

The self-doubt of a leader is the greatest aid to the leveler. Oppressors don't respond to such attacks at all, but good leaders are prone, because of their basic wish to be responsive and responsible, to allow the attacks of a few to vitiate their useful work for the many. Thus when faced with such attacks leaders should responsibly investigate their work and responsively obtain feedback from all the group's members before abdicating their leadership. Only if this analysis reinforces the levelers' argument should a leader allow that most precarious process, leveling, to occur in the group.

How To Be a Radical Therapist

Richard Kunnes, M. D.

Rick Kunnes is an activist affiliated with the Albert Einstein College of Medicine department of psychiatry. © Richard Kunnes, M.D. All rights reserved.

I

The word "radical" comes from the Latin *radix*, meaning "root." The radical therapist, therefore, gets to the root or cause of the issues before her(him) and does something about it. A recent cover of *The Radical Therapist* said: "Therapy means political change . . . not peanut butter." This implies that the root issues the radical therapist deals with are political.

This article is about how one attempts to be a radical therapist, and more importantly, a political person. The tactics described below are by no means limited to therapists. The fact that they are not limited to therapists is an example of the breakdown of the artificial barrier which separates "therapist" from "patient." I have nothing to say that hasn't been said and done in numerous other circumstances. This article is simply a review of a number of

known political tactics (practices) and the theory and strategy relevant to them. The article is particularly aimed at those working in "professional" settings, especially in institutions.

To state the obvious, all the tactics are public, i.e., they're geared to be seen and felt by more than one or two people. The tactics are aimed at placing oppressive institutions in a bad light; they hopefully change people's heads in a political way. Many of the tactics are incredibly primitive and simpleminded; however, we don't always think of them and/or do them because of the oppressive mind-fuck that Amerika has become.

As an example of primitiveness, note the second sentence of the first paragraph where ". . . her (him)" is used in place of just "him," hopefully providing a small jolt to our conventional sexism. Another syntactical jolt is when writing about the lower half of Vietnam, write south Vietnam (small *s*) to signify that there is no such country as "South Vietnam" and that the division of Vietnam is an illegitimate one. All therapists' language, papers, and lifestyle should be full of similar jolts. To the degree possible, every word should be a guerrilla theater in miniature.

Wear a political pin to work, put a political poster in your office. The more outrageous, the better. People ask questions about pins and posters, rap with those people. Hospital administrators and other institutional types get pissed off and attempt to suppress such overt political behavior—simple as it is. In 1968, in the department of psychiatry of Columbia University, young psychiatry residents were forbidden to wear "McCarthy for President" buttons. While there was no successful organizing around this issue, the politics of the institution were widely exposed—and just with a political button.

Along the same path, women at work can challenge sexism by wearing slacks, men can challenge professionalism by refusing to wear a tie and always wearing jeans.

One's politics should be "up front" where they can be seen and talked about, that's what makes them political. All institutional and professional meetings and conferences

should be politically confronted—doing anything from raising your hand to make a politically relevant point, to depositing a stink bomb (isobutyric acid) at a particularly piggish meeting. Do anything to make an administration uptight. Demand to have radical speakers, radical seminars. Demand that nonprofessionals and “patients” be featured speakers and demand that they be paid what the “professional” speakers get. Demand day-care centers. Demand that all professional and administrative meetings be open, not only to lower echelon professionals and workers, but to the community. Talk to your fellow workers about this *and* to the administration—stir them up by giving them advance notice of what you intend to do; that way they’ll be sure to overrespond.

Publicize your demands with leaflets inside and outside the institution, especially in the most public areas, e.g., entrances, cafeterias during lunch time, the boss’s office. Do a sit-in in a director’s office; call the press (ask for city desk and definitely call the wire services). Just threatening to do this is often enough to get a response, and the administration’s response is always an advertisement for your politics. Five people with large, visible, politically appropriate picket signs marching inside and/or outside creates a tremendous political presence. Some of the recent convention conferences were disrupted by only three or four people—enough to make the European newspapers.

Set up a radical literature table adjacent to or on the inside of your place of work and/or your waiting room.

Do a power structure analysis of your institution and distribute it. *Every single hospital* in this country has on its board of directors somebody making millions on the war and/or pollution and/or slum landlordism. Expose them. Fight to get rid of them, not that that in itself will solve the problem, but it will educate people politically. Attempt to delineate publicly their relationship to institutional expansionism, dual and racist systems of service, racist and sexist admissions policy. Virtually every single hospital and educational institution has investments and stocks in war

industries and/or pollution makers. Expose these contradictions.

Demand power decentralization, community control of services, student control of education, worker control of the work setting, open admissions and career ladder programs that are open-ended at the top.

Radical staff *and* radical patients should write and distribute a radical newsletter. The newsletter staff should have an office and a phone extension where contact with newcomers and recruits can be made. Ask the boss or a board director for interviews.

Yes, there is the danger of being fired and each person must judge the risks accordingly. However, if it's any consolation, it's a great issue to organize support for people who are fired and/or striking. Expose the benevolent neutrality and "value-free" science of your local institution.

For those of you who are a little more clandestinely oriented, have a few thousand 11-by-3-inch stickers saying "Free Angela" or "Community control of—" (fill in name of appropriate institution) or "Vietcong have won" or whatever. Place the stickers on inside and outside walls. Or glue on large posters. Powdered milk with a little water makes fantastic paste.

Look for potential allies in people doing union organizing, young students, the community allegedly served, and alienated professionals.

Do two, three, many actions. Organize different levels of political entry. For example, "consciousness-raising" groups for men or women might be an easier point of entry than sitting-in or picketing. Or start with a radical study caucus. Present a patient's case history emphasizing politically relevant points, concluding with a political analysis, not a psychoanalysis.

If you decide to have any meeting that has some political potential, advertise for it heavily, making sure the boss knows about it so that, hopefully, he (bosses are almost always "he") will respond. If a meeting room isn't available, demand and fight for one. Always try to draw lines to separate you and your people from the boss.

Demand changes in services and expose their deficiencies. Fight to change teaching and research priorities to service priorities. In state hospitals and institutions of similar quality, try to move staff and "patients"—an Insane Liberation Front, if you will. For example, at most state hospitals at least some patients lie in urine-soaked sheets all day. Complain to the administration, leaflet patients and staff, hold meetings in hallways and administrative offices, and even finally call in the media for a urine-dumping ceremony on the boss's desk.

Demand innovative services, e.g., home care, outreach, and preventive services. To see real alternative and innovative services, encourage people to go to Cuba, especially on the Venceremos brigade.

Fight involuntary commitment without a *trial*. Be part of a patients' rights movement:

Expose failure to properly and legally inform patients (so-called "informed consent"). For example, most patients receiving research drugs or on research wards have no serious understanding of what's going on or why they are on a research ward, as opposed to a standard ward or even in the hospital. If patients are research subjects they should be paid accordingly.

When you do "therapy" always suggest various political settings to help "patients" deal with their alienation and oppression. Always attempt to help patients understand the political causes of their "symptoms." Suggest to your patients that they work with existing political organizations, e.g., women with Women's Lib; anybody with a Panther Defense Committee.

Support in any way all segments of the population particularly oppressed by psychiatry, namely blacks, Latins, women, homosexuals, youth, prison inmates, and anyone doing something politically relevant. Help raise bail for any political prisoner, especially if she or he is a member of the same oppressed group that you are, e.g., blacks, women, homosexuals. At your next regular conference, rather than somebody presenting a paper, do a guerrilla theater demonstrating what sexism is like in the "thera-

peutic" setting. If you're a therapy student and written tests are given, distribute your own counter-test, a test that asks real questions, especially about the institution you're at and about the institutions of psychiatry and psychology.

Encourage patients to talk to one another, to help themselves understand the *collective* nature of their symptoms. Encourage patients to take any of the above-mentioned actions and any other political actions, even if it is simply getting a group of patients to get themselves together to go down to the local radical "coffeehouse" or rap center to help discuss political issues.

Since even the most "private" hospitals and institutions have the major portion of their funds coming from public sources, demand that board of directors meetings be always open to the public. Demand that budgets and contracts be available for review. Work with community groups fighting for community control.

Embarrass and expose institutional failures by providing services it doesn't, but should provide. For example:

1. Lead poisoning is a major cause of mental illness and mental retardation in children in metropolitan areas. Go to your local health department, get lead-screening kits and go door-to-door in poorer neighborhoods, especially accompanied by such groups as the Black Panthers. Any child with a positive test for lead should be brought to the hospital. Explain to each family seen why you're going door-to-door, the politics of slum landlordism, and how it is a direct cause of lead poisoning and mental illness.

2. Malnutrition is also a major cause of mental illness in poor children. Do a nutritional survey. Rip off a micro-hematocrit centrifuge to do iron-deficiency anemia studies as a screening test for malnutrition. Malnourished children should be sent to a Black Panther breakfast program or its equivalent. Mothers should be pushed to work with the local welfare rights organization. The politics of expensive ghetto groceries, the welfare system, and racism should be discussed more than psychiatric symptoms. Push welfare and/or Medicaid doctors to write prescriptions for food.

When institutional failings are noted, publicly expose

them; literally petition for change. Petitions themselves won't produce any results, but asking people to sign a petition at your centrally located petition table is a great way to start a politically relevant conversation. Use your professional prerogatives and privileges to infiltrate and educate.

II

Many people complain about the disruptive nature of many of these tactics, particularly in regard to conventions. The argument is advanced that a disruption violates freedom of speech and press. It's our feeling that things such as freedom of the press belong only to those who own one. The same applies to freedom of speech; if you don't have access to the media, all you can do is speak to yourself. Therefore it's important to schedule your disruption before 1:00 P.M. in order to insure adequate preparation by the media for the six o'clock news. As Jerry Rubin says, if you didn't see it on TV, it didn't happen. Make sure you bring your own bullhorn when the microphone electricity is cut. Also bring a prepared press release signed by an organization with a telephone number next to it. You or your organization may then be invited to radio and TV talk shows, as well as interviewed by the press for further clarification of the disruption.

If you seize control of a convention meeting you can run your own meeting, open up a real dialogue and truly have freedom of speech. *Genuine and meaningful discussion cannot occur at a convention in Amerika without disrupting it.* Turn the convention into a political education meeting. The disruption is also a protest against the elitism, racism, and sexism which abounds at any professional convention, simply by virtue of its being a convention of professionals.

And what about those conventions and seminars which discuss the war and racism. It's repressively tolerant to have a "debate" about or a "vote" on the war or racism. White Americans have no right to discuss the fate of the

Vietnamese or of black people, except to get off their backs.

There are some other reasons why mental health conventions and seminars should be rightfully disrupted:

1. To protest the fact that conventions and seminars are a showpiece, a facade. They pretend that the mental health professions are open, responsive, and accountable. By definition, a profession is accountable only to itself and for that reason alone should be attacked.

2. To protest the repressive ideology of psychiatry and psychology which is both individualizing and alienating.

3. To produce a laboratory of reality to really deal with mental health and mental illness. For example, many people in the audience will be far more enraged about a disruption than they will be about the war. The fact that one can respond more strongly to disruption than to genocide is a measure of the crazed oppression of our society.

4. To de-legitimize, demystify, and deprofessionalize mental health institutions. After all, anybody can take part in a disruption.

5. Lastly, and in some ways most importantly, is the role of exemplary action. With all our white-skin privileges, the least we can do is to be an example of white people in revolt.

Radical Therapy Needs Revolutionary Theory

Terry Kupers

Terry Kupers is a psychiatry resident at UCLA, and a physician for the Black Panther Party's Alprentice "Bunchy" Carter Clinic.

A patient once objected to Freud: "Why, you tell me yourself that my illness is probably connected with my circumstances and the events of my life. You cannot alter these in any way. How do you propose to help me, then?" He received this response: ". . . much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health you will be better armed against that unhappiness."¹ The tendency of psychiatry to remain aloof from social realities and concentrate on merely "transforming hysterical misery" is being challenged by a growing number of radical therapists whose aim is to also change those "circumstances" by revolutionary practice.

Unfortunately, many such attempts develop into a compartmentalization where social struggles are entered and experiments with therapeutic modalities occur but no synthesizing theory gives meaning or clarity to either

endeavor. The purpose of this paper will be to examine possibilities of viewing the individual mental illness and therapy from a Marxist perspective in seeking a unified and revolutionary praxis for radical therapists. This will include a criticism of approaches of many revisers and rejecters of Freud, an overview and methodology for criticizing, learning from, and replacing bourgeois psychiatry and an attempt to use some clinical observations to enhance and direct such an approach.

There have been many attempts to revise Freud's essentially individual-oriented theory of neurosis so that understanding and solutions for pressing social problems can be included. Often, these revisions see Freud's biologism/psychologism as inadequate but go on to merely add reality variables and social factors without confronting basic fallacies in Freud's model (Erikson, Horney, etc.). Unfortunately, the attempts of many radical therapists have led to just as fragmented a theory because they attempt to bring their view of the individual into line with their revolutionary analysis of society and end in fractionation rather than integration.

Herbert Marcuse points out some notable fallacies in the attempts of Fromm, Horney, Sullivan, and others to revise Freud.² He shows how their theories, while attempting to place the human individual in control of the environment, actually end in a view of a too malleable personality more the victim of social forces than their molders. Marcuse's criticism of the fallacies and superficialities of the neo-Freudians is fine, but he himself never criticizes the more basic distorted assumptions of Freud, such as the instinct theory that Freud articulated to explain and excuse a static status quo of class domination. Marcuse seems to accept Freud's bourgeois illusions without real development of evidence, perhaps for fear that criticizing them might end in less of a "depth analysis." Whether Freud is accepted as revised or entirely rejected and replaced, most attempts at radical therapy fall short of developing a model to integrate therapy with revolutionary struggle.

Roger Garaudy, in discussing a methodology with which

a Marxist must examine reality, says, "In our scientific representation of the world it is becoming, we find, more and more difficult, and will be ultimately impossible, radically to separate in the object what the thing would be 'in itself' without us, and the knowledge we have of it. . . . Scientific laws are not a copy of anything; they are constructions of our mind, always approximate and provisional, which allow us to take hold of a reality which we have not created, and of which only practice, methodical experiment, can guarantee us that our models correspond in some degree to its structure, that from a certain point of view they are at least 'isomorphous.'"³

Freud certainly built an "approximate and provisional" model of the individual, but questions arise about his "certain point of view" (that of the Viennese bourgeoisie). This is because Freud was both influenced by and contributed to "bourgeois ideology." Marx described ideology as "false consciousness" (since then, ideology has lost its specific meaning and been defined in common usage as a system of ideas). The capitalist class uses such false consciousness, as well as force, to prevent its own overthrow. As long as the masses view reality in a distorted fashion, they will not see how their real interests can be served only by a revolution. Television, radio, and advertising display this false consciousness as they develop in the minds of the the public ideas like "conspicuous consumption [color TV, new cars, etc.] is virtuous" or "cowboys and white soldiers are good while Indians [read: third world peoples] are savages and should be slaughtered." This ruling ideology has been imploded into all of us for all of our lives. It is the distortion of reality necessary for large numbers in this country to accept the reality of war against "them" in Vietnam or genocidal police attacks against "them" in our ghettos and barrios and to feel that this is "best for democracy."

There has been no real problem for the capitalist system in accepting Freud's contributions as part of the "ruling ideology." Freud's effect in causing people to see their problems as emanating mostly from internal conflicts rather

than from an oppressive and exploitative society is just one example of how this "false consciousness" can deter threats to the social status quo. In fact, Freud's treatment of women is a perfect example of how a distortion or illusion that is necessary in order to maintain a system of domination of the majority by the minority is built into that system's ideology. The illusion is that the state of affairs we see now is natural, inevitable, and unchanging. Such an illusion is needed in order to keep the majority from moving to change the system. Freud builds this illusion into his theory. When he observes that women occupy an inferior, dominated position in society, he assumes this is natural and will always be the case, so he looks to concepts such as "penis envy" to explain the inevitability of this inferiority.

It is very easy, then, to reject Freud's contributions mechanically, as many on the left do, as an "apology for the ruling class." This approach, however, fails to recognize that ideologies both distort *and* reflect reality. There is a kernel of truth in the "scientific representation of the world" by a bourgeois ideologist in spite of his "certain point of view" and distortions. It would be a great waste if all of the observations and contributions of eighty years of psychiatry were rejected without being thoroughly evaluated to determine which experiences and accurate reflections of reality can be incorporated into a Marxist or radical therapy model.

To do this, Freud's model must be viewed and criticized on several levels: on the sociological level (e.g., who is treated, how much charged), the technical level (e.g., psychoanalysis as a therapy), the ideological level, and the theoretical level. Examples of critiques of Freud's model at each of these levels include: on the sociological level, analysis can be a time-consuming interaction of a few privileged professionals with a few moneyed clients; on the technical level, it can foster introspection and excessive soul-searching as an alternative to expression of anger and action to change the environment; on the ideological level, it can play down the social conditions which foster

unrest by attributing cause for revolutionary movements to "regression to the temper tantrum stage" (Bettelheim) or Oedipal rebellion; on the theoretical level, its static, a historical view sees the inferior status of women or violence or the nuclear family as inherent in the human species rather than as products of a particular period and particular social relations which can be consciously changed. In addition to raising these and other criticisms of each level, it must be seen that the levels are inter-related. The fact that analysis is practiced mainly in places like Beverly Hills (sociological level) is not unrelated to the fact that the analytic model sees human nature as static (theoretical level: i. e., since it is static, there is no need trying to change specific oppressing conditions). Both of these levels serve the purpose of continuing the status quo and fit nicely into the ruling ideology. Thus, practicing analysis in a ghetto would not change the basic distortions in the theory.

Just as Freud's model must be examined on all of these levels, so must its replacement. A radical therapy cannot be substituted as practice without developing an alternative theory. A tendency to do so is seen in replacing the practice of "Freudian analysis" by the practice of "transactional analysis" and calling the result "radical therapy." This is not to say that transactional analysis may not turn out to offer some hopeful alternatives. Rather, shifting of practice without due consideration of the underlying theory often results in a superficial analysis or "pragmatism." Pragmatism has long been a methodological prop of capitalism because, by its positivist explanation of reality, it tends to preclude understanding phenomena "by the root." Another problem is that even radical therapists, especially those with middle-class backgrounds, cannot be entirely free from bourgeois distortions emanating from the "certain point of view" or embedded ideology that they grew up with and live with. These distortions cannot be entirely overcome by a recent and conscious choice to accept a revolutionary or proletarian world view.

How can that elusive reality be viewed as accurately as

possible in order that the best "isomorph" be developed leading to the best understanding of priorities for change? It might help to review an old fable that goes something like this: Three blind men "discover" the elephant. One puts his arms around a leg and describes the elephant as a large "trunk like a tree." Another feels the side of the animal and describes it as a warm solid wall. The third pulls the trunk and gets sprayed by the irritated elephant, describing it as some kind of shower mechanism. If we for a moment compare the elephant with reality, it is as though we all see problems in the real world that need altering, but we all view the reality differently because of our different vantage points. Our class backgrounds, finite experiences, and the overwhelming complexity of reality itself prevent us from seeing the "total elephant," and thus from establishing efficacious priorities for meaningful change. Thus, as radical therapists, we "come out swinging," developing new twists to therapy and sporadic forms of participation in mass struggle, recognizing that social ills effect mental health but never completely clarifying how and why.

Karl Marx developed the methodology to eventually grasp the "total elephant" and understand the individual and his or her relationship to society—dialectical and historical materialism. According to him: "In the social production which men carry on they enter into definite relations that are indispensable and independent of their will; these relations of production correspond to a definite stage of development of their material powers of production. The sum total of these relations of production constitute the economic structure of society—the real foundation, on which rise legal and political superstructures and to which correspond definite forms of social consciousness. . . ." By viewing the mental health institutions and therapies as superstructural ramifications of the economic base, changes can be actuated without distorted expectations of the revolutionary implications of such change. They do have some effect, as Engels pointed out: "The political, legal, philosophical, religious, literary, and artistic

[and we might add psychiatric] development rests upon the economic. But they all react upon one another and upon the economic base. It is not the case that the economic situation is the sole active cause and everything else only a passive effect. There is a reciprocal interaction within a fundamental economic necessity which in the last instance always asserts itself."⁵

As long as we are aware, then, of the illusions and distortions of psychiatry and how it relates to a total view of society and revolution, we can learn much from its observations. The concept of psychic determinism is an important reflection of reality—that all behavior is ordered and follows understandable laws instead of being random and accidental. The concept of the transference distortion is similarly important—that present perceptions are distorted by memories of past experiences. The use of psychiatric concepts such as these has led to profound insights about the workings of the mind in health and disease. As examples, three observations about psychosis follow:

1) It is well known that a subject in an experiment who undergoes nearly complete sensory deprivation soon experiences hallucinations and delusions.⁶

2) Similarly, often a severely burned person who is completely immobilized and strapped to an automatic bed with all needs attended by hospital staff subsequently develops a psychotic episode.

3) Interpretations and feedback compiled while examining transference distortions of paranoid individuals result in understanding as best as possible their experience and paranoid stance toward their environment something as follows: "I am the center of something that is going on. I do not understand what is going on. Others out there not only understand what is going on but are in control and the cause of it. They must be in control since I cannot control what happens to me. They are punishing me for some unknown reason. I am powerless. I can only guess what is expected of me and hope to discover it in time to avoid more punishment." This selection of some of the fantasies of people with paranoid distortions has obvious

dynamic and genetic meaning and derivation. Here it will only be considered as it aids in developing the methodology under study.

All three of these observations of "psychotic" experience share certain common elements. There is a failure or dissociation in getting accurate feedback from the environment, deficient ability to act upon and interact with that environment, and probably a related sense of powerlessness and control by external and variously unknown forces. Thus, feedback and control of the environment seem to be related to healthy versus psychotic mental functioning. These three concrete examples not only demonstrate the important reflections of reality which accompany the distortions of a bourgeois ideology, but they coincide strikingly with some of Marx's and Engels's statements.

Marx did not develop as complete a theory of the individual as we might have liked because of the exigencies of the revolutionary struggle which required his focusing on social phenomena. This does not mean the methodology he developed cannot be used by others to advance our understanding of the individual and mental functioning. Marx pointed out that knowledge of nature or the environment can only come through man's acting upon it and in Engel's words, "it is only through the activity of man that the test of causality can be made."⁷ Then, in his work on alienation, Marx showed how man has been deprived of being able to mediate his own existence under capitalism. Where man as independent producer once mediated his struggle to transcend nature via his labor, capitalism results in his alienation from the product of his labor, then from the labor process, then from his species being, and finally from other men (and women—Marx always talked of man in the generic). Since man no longer owns the product of his labor but it confronts him as an alien and reified object, we see "the relation of the worker to the product of labor as an alien object exercising power over him. This relation is at the same time the relation to the sensuous external world, to the objects of nature, as an alien world inimically opposed to him."⁸ Although this

sketchy statement about Marx's concept of alienation is all space allows, it is apparent that Marx related the subjective feelings of depersonalization, despair, and powerlessness to the exploitation of the worker for profit in a capitalist society. Marx thus captured each individual's feelings of depersonalization and estrangement and rather than seeing them as an inevitable "human condition" to be battled "all alone," he gave social meaning and collective hope for a historical transcendence of what bourgeois ideology (i.e., existentialism) sees as man's fate. Perhaps mental illness can be viewed in the same light.

Marx's concept of needing to interact with to know the environment seems to parallel the incapacitated and immobile burn patient's or sensory deprived subject's probable wish to know and interact rather than to become a psychotic. Marx's development of the alienation of workers seems also to parallel the subjective "helpless—controlled—manipulated" feeling of the paranoid individual. What do these parallels mean? They are not due to coincidence. The individual qua individual and the individual as part of society experience the same real world. Any phenomena occurring in the social realm will have an effect on the individual realm and vice versa. Marx described one side of this complex interrelationship when he said "the human essence . . . is the ensemble of the social relations." He described another side when he said, "The materialist doctrine that men are products of circumstances and upbringing and that, therefore, changed men are products of other circumstances and changed upbringing forgets that circumstances are changed precisely by men and that the educator must himself be educated."⁹ The former side is used mechanically by some who say "capitalism causes mental illness and socialism will cure it." The latter side is stressed out of proportion by Freud as he views the evolution of civilization as the struggle "between the instinct of life and the instinct of death as it works itself out in the human species."¹⁰ Freud's one-sided distortion of this relationship must result from his bourgeois vantage point from which he develops only

fragments of a total isomorph of reality. Marx's dialectical method should result in a less distorted understanding of the relationship between society and the individual in the case of psychosis. More work needs to be done to elucidate a microscopic understanding of such relationships but it seems clear that it would be exceedingly difficult to end paranoia in a social system which ensures "alien objects exercising power over" the worker (alienation). Thus, a meaningful solution to mental health problems can potentially occur only after the revolution when, as Marx says, "freedom cannot consist of anything else but the fact that socialized man, the associated producers, regulate their interchange with nature rationally, bring it under their human control; instead of being ruled by it as some blind power."¹¹ (See Adam Schaff's *Marxism and the Human Individual* for a discussion of postrevolution alienation.)

The task for radical therapists is immense. A unified theory of society and the individual must not suffer loss of depth or profundity in studying each and yet must not compartmentalize the two studies. The radical therapist must try to understand the bourgeois illusions and distortions in the field while he or she probably comes out of the same class experience that creates the illusions. The relationship of society and class domination to mental illness must be understood without hindering the best effort at alleviating mental suffering at each moment and within the perspective of revolutionary change for society. Radical therapists must develop a theory of man and practice of therapy while integrating these into priorities and praxis for revolution. Only a radical therapy based on the Marxist *weltanschauung* can accomplish all these tasks. Freud's limited view of man's fated "unhappiness" must be replaced by Marx's thesis, "Philosophers [and psychiatry?] have interpreted the world in various ways; the point however is to change it."¹²

Notes

to Mr. Kuper's Article

1. S. Freud and J. Breuer, *Studies on Hysteria*, New York: Avon Books, 1966, p. 351.

2. H. Marcuse, *Eros and Civilization*, New York: Vintage Books, 1955, Epilogue.

3. R. Garaudy, *Marxism in the Twentieth Century*, New York: Charles Scribner's Sons, 1970, p. 62.

4. K. Marx, Preface to *Critique of Political Economy*, 1859.

5. F. Engels, "Letter to Starckenberg, January 25, 1894," *Marx-Engels Selected Correspondence*, New York: International Publishers, 1936, p. 516.

6. S. Freedman, "Sensory Deprivation: Facts in Search of a Theory," *Journals of Nervous and Mental Disease*, Vol. 132, January 1961, pp. 17-21.

7. F. Engels, *Dialectics of Nature*, New York: International Publishers, 1940, p. 171.

8. K. Marx, *Economic and Philosophic Manuscripts of 1844*, New York: International Publishers, 1964, p. 111.

9. K. Marx, "Theses on Feuerbach," in *Ludwig*

Feuerbach, by Engels, New York: International Publishers, 1941, p. 83.

10. S. Freud, *Civilization and Its Discontents*, New York: Norton & Company, 1961, p. 69.

11. K. Marx, *Capital*, New York: International Publishers, 1967, Vol. 3, p. 954.

12. K. Marx, "Theses on Feuerbach," *ibid.*

II. "Mental Illness"
Old and New

Letter

C. B.

C. B. spent several years in mental hospitals and is now out.

Dear———,

Today I am feeling broken as a human being and your letter which we received today made me think twice about the reason for this. Is it my illness creeping back again, as it often does, or is it a result of the system which purports to "help" those who are ill? I feel less able to cope with the world than ever before.

To be snatched from a world in which you feel you have a place (no matter how small) and purpose (no matter how insignificant) to a hospital is a most jarring experience. People need to feel they are contributing to the environment in which they live. You are in the hospital to "get better" and that's the only purpose. It would be sufficient if the patients were given some responsibility to this end. In the hospital you must 1) get up in the morning (in some places even this is not required); 2) eat, if you want to, at specified times, the food that is planned and prepared by others; 3) take your medicine which is handed out at specified times by a uniformed nurse; 4) attend

activities, if indeed there are any, that have no purpose other than to keep you "occupied"; 5) go to bed.

It's a pretty dull existence in which everything you need is handed out in neat little packages—even the therapy—not when you may need it most, but again at specified times. I guess any institution needs to keep a schedule, but, God, it's deadly for the patient. Pretty soon the patient begins to look around for some way of changing the careful orderliness of the routine and soon finds out that if you cause enough ruckus you can get 1) a needle; 2) in some places a straitjacket; 3) an isolation room; or 4) if the place is well staffed, someone to stay not less than three feet from you; or 5) sodium amytal which sort of puts you out of it in a high which makes the place more bearable. Not all outcries are made out of boredom and this wish to break the terrible efficient orderliness of the place, but I think a good deal of them are. What patients want is some recognition of themselves as individuals—even the routine of making a ruckus doesn't satisfy the need for being recognized and appreciated as an individual who may have something positive to contribute. Instead they are reduced to making a fuss to change the routine. And even this is unsatisfying after a while . . .

Some people think that the means of dealing with upset patients is cruel. Really, it isn't so—they are to the upset patient a means of getting a response that means his problem (even if not the real one) is recognized and dealt with. To the sick patient it is a form of love—the only kind he can extract from his environment.

In the hospital you learn that there are a very minimum number of things you must do to exist. This is the terrible message of the hospital. You don't even need to wash or brush your teeth to get along. All motivation is drained, for your very minimum needs will be taken care of for you. This attitude is carried with you when you leave. It doesn't really matter what you do or don't do.

On leaving the hospital there is the added problem of feeling guilty for not doing more than the minimum, but it is already engrained in you that nothing is really essential.

I guess what I am talking about is the fostering of dependencies of already dependent people—the taking away of all motivation to do for yourself. Even taking medicine (although I admit it's sometimes necessary) means to the patient that he is sick and can't control his own behavior. In the hospital the rewards for being "sick" are so much greater than the ones for being "healthy."

G——: The first hospital I entered. Essentially it was a drying-out place for alcoholics and a waiting station for those going on to other hospitals. I suppose its function was diagnostic. Therapy—if any—was provided by the patient's own doctor. Most of my time there was spent pacing the floors. Most of the anxiety there was not knowing what to do to help myself get better. I was still under the illusion, which Dr. B—— had led me to believe, that I would only be in the hospital a few weeks. I was anxious to get help so that I could return to the outside as soon as possible. There was no help. Only endless conferences about where I would next be sent. The weeks dragged into a whole month—a long time for someone to just wait to get help.

P——: I would characterize this place as the one, which in my experience, gave the greatest rewards for being sick—especially for acting out. I entered on a fairly "well" ward. For some reason I still don't know, I was sent up to the ——th floor, which had patients who were more obviously sick. There was more staff, more medicine, more things you couldn't take with you on the ward. Oh yes, every time you changed wards your belongings were gone through with a fine-tooth comb to see if you had any forbidden items. And you yourself were looked over. It seemed almost a challenge to smuggle in certain items. There was the feeling that you were a dangerous person, not to be trusted in the least bit. This certainly makes you want to give them what they expect—a wild unmanageable patient. And there were other rewards for being cuckoo too. You got much more attention in all sorts of ways. There was the pulse chart—you had your pulse taken twenty million times a day and the yes, no chart for your

BM's. Every detail of your life was down on paper and what's more you couldn't see what was written about you, nor could you know your "diagnosis." I have said that these things are rewards, but in the end they are really not helpful in getting you better and out of the hospital. These things cater to the already sick person and his feelings about himself. For instance, the person who feels impulses to harm himself will feel more inclined to carry out these ideas if he feels that other people are afraid that he will not be capable of stopping himself. He will carry out the expectations of others. There were other floors, too, each with different rules, and so I spent two years shuttling between the unrestricted and restricted floors. P—— is a private hospital and I gather runs on private funds from the families of the patients there. It is exorbitantly expensive. My uncle stopped paying them because he no longer wanted me to stay there. It took them six months to get me into a state hospital and during that time my bills mushroomed. The final bill was \$40,000 which my uncle refused to pay. They later tried to sue my mother but settled it out of court. I don't know what the final settlement was. My feeling is that no hospital, no matter how wealthy the patients, should charge such exorbitant prices. My illness was only fostered: why should I pay high prices for that? It was physically comfortable with private rooms, and the food was edible (and fattening). That was all.

M—— State Hospital: I first entered on the admissions ward. It was a huge place, less physically comfortable than the two previous ones, but in some ways better. At first I had to wear a state gown. I had not one thing of my own. Everything that was personally mine was taken away. I had a bed in the infirmary of the admissions ward—one of those high hospital beds with the rails on it. I felt it was the end of the line. I felt so hopeless that I lay in bed for months getting up only to smoke four cigarettes a day and to have shock treatments three times a week. I didn't even have enough will to live to feed myself. So I was fed by someone on the staff. Not even one thing was

expected of me—not even to feed myself. There wasn't enough staff and what there was I wouldn't speak to, so they didn't bother to talk to me, though that might have helped eventually. After all I was still alive and could hear most of the time. They didn't even respect my feelings enough to tell me that I was to start ECT. The morning after I arrived they herded me off with all the other patients to another building. I didn't even know where I was going. We waited (about fifteen or twenty of us) while we went in one by one. As you entered the room the ones who had already had their treatments were out on the beds. It was only then that I knew I was to have ECT. Quite a shock—literally and otherwise. This went on, I later figured out, for ten weeks or more. Even after the shock treatments (it felt like the punishment I deserved) there was more lying around in bed with no one to speak to. Finally I came to one day and decided that (felt that) I wanted to right all this. The only fight I knew was against myself and, there being a limited number of night staff, I was put into a straitjacket more politely called a camisole. That was after the usual needle of Thorazine—three of them in one night—which further fulfilled my wish for self-punishment.

The next morning I was carted off to the chronic ward. So far I had received no therapy other than the ECT. I really did feel that this was what I deserved. It's a punishment in that it dehumanizes you, but also a reward in that at least you are getting some sort of reaction out of the people around you. Again my things were combed over. I was stripped naked, notes were taken on scars and other identifying features, and I was again placed in a state gown. The ugliest things—worse than potato sacks. Finally I got my clothes back and a therapist. He was a resident—so that didn't last long. Things hadn't been going well. It was at that point I think that they gave up on me, for after the resident left I was not assigned another therapist. I had given up too! I was shuffled from one meaningless activity to the next. One of the activities I remember as a child—a rhythm band. We pounded on sticks or clappers for an hour each week. For most of us it was a

most degrading experience—to have someone stand up in front of you and tell you to beat the sticks in time to some horrible march music or other.

Without further treatment, someone decided that I needed to be rehabilitated so I was sent to the bag factory. For someone with a college background to be sent to fold bags (we got paid for it) was degrading enough. Everyone around you hallucinating . . . but for all this we were paid (if you worked hard enough) \$5 a month. I felt after a month or so working there that if that was all I was good for the rest of my life I'd rather not live, so for the second time in that hospital I rebelled in the only way I knew how—against myself—and ended up in the infirmary on ECT again. I don't know how long I was on them that time. I expect not as long as before. The one good thing about M—— is that if you were well enough you could at least wander around the grounds with another person. This brought me into contact with the thousands of the world's forgotten people at M——. Most of them were obviously out of their minds and had spent years at the place and were fully institutionalized. I identified with them and at times felt that theirs was my fate also. Everything was provided them by the state. All their social activities were planned out and everywhere we went we were herded like cattle except in our "free" time on the grounds.

I was lucky I was still wearing the clothes that had been mine before I went into the hospital. They were old and out of date, but at least they were mine. I was also lucky in that I had an allowance. There was a store on the grounds where we could get snacks and even meals. Our only pleasure then became the very primitive one of eating.

About the staff—I was lucky in that the staff on my ward was pretty good. My group leader was a very decent and humane sort of person as was the head nurse. The rest were mostly condescending but at least they weren't physically abusive as they were on some wards. As I got better I was given the privilege of sometimes having coffee with the staff and I used to listen to their problems,

which was a switch from anywhere else I had been. It had the effect of making me feel worthwhile in some sort of way. It bridged the gap between patient and staff and we became friends, sort of on an equal footing. The two of them were decent, though simple people, with real human concern. Mrs. S—— I remember did administer those thirty or so needles I got one week. Boy was I sore. I had done some acting out and the doctor who didn't know me very well thought that maybe I should have more shock treatments, go to the violent ward, or have the four shots a day. He decided on the latter. That was real punishment! But being sick I thought it was what I deserved again.

I was beyond pain. It seemed I could endure any kind of physical pain without even wincing or saying ouch! I even had some stitches put in without a local anesthetic, and it didn't seem to hurt. I guess I had cut the nerves.

Being in a state hospital where the length of your stay is limited only by your lifespan is a very depressing feeling, but even more depressing than that is getting so acclimated to being dependent and taken care of that you begin to look forward to the few activities that are available to you without a thought to the outside. Indeed it's rather frightening after being dependent for so long to think of making it on your own in the outside world. M—— is particularly removed. It's a community unto itself—even has its own electric power plant, laundry, etc., etc. The atmosphere is depressing—nobody leaves unless they run away. This is almost always true once you get beyond the admissions ward. I only know of one or two persons who have left my ward and only one other besides myself have stayed out. People have left, but only to return in a week or month in worse condition than when they left. Something must be wrong with the system somewhere.

Eventually I felt I was well enough to look for a job in town. Like most hospital towns, the townspeople are very much afraid of the hospital and of the patients it houses. This is another aspect of mental health in which work needs to be done—public education. Needless to say no one would give me a job in M—— and I spent long

hours answering every ad and going to places where there is a frequent turnover. It was disheartening to finally make the decision to return to the world only to be turned away.

I finally entered a sculpture course at the community college. One of the aides used to pick me up—she was a student there—and the teacher found out somehow that I was a patient at the hospital. She made things difficult for me after that in subtle ways, criticizing my work, etc. One day the local newspaper came to get a story about the class and the photographer wanted to take a picture of me and my sculpture. She kept saying, “No, not that one. This one is really a better one,” etc. The photographer ignored her and took my picture anyway—and ran the picture of me and the story in the newspaper. That was a good one on her! But it just goes to show the prejudice that does exist . . .

B——: The most frightening thing I found about B—— was that there was no one to introduce you to the routines of the ward. It took me three days of questioning to find out where and when to wash out my underwear! The aides had no patience with explaining things to you. You are plopped on the ward and that’s it. If you don’t do things that you should you are in for verbal and physical abuse by the aides. Needless to say, the place is a real snakepit—with mice and no doubt rats (though I never saw any rats). My glasses and all personal belongings were confiscated. You have to protect yourself against the other patients. I was attacked twice—I think because I looked so scared. Stealing was rampant. You had to carry all your things with you including toothpaste, comb, cigarettes, etc., and sleep with them under your bed at night!

The admissions procedure was horrifying. Some aide, who should have been on the ward herself, stripped me of all my clothes but my pants—with men walking around—it was most humiliating. She kept yelling at me to hurry and when I wasn’t fast enough to suit her she started pushing me around. I had my temp taken—101. It was noted in the chart but nothing was done about it.

We had to sleep in the hall. The only way I got a bed the first night was having another patient fix one up for me—again I didn’t know the procedure. She was the only kind person there. She sort of had a deal with the staff for doing those extra things, I guess, in return for some kind of special treatment.

B—— was the most dehumanizing place of all. Apparently I was on the worst ward there. I have heard since that all the wards are not as bad as that one—the patients not so wild, the staff not so abusive—but it’s still B—— and I think the place lives up to its reputation. I went to B—— in a paddy wagon with the little men in white coats (I never really thought they existed) and a police escort. It really made me mad because as upset as I was I think I could have gone with a friend and admitted myself instead of being committed. That really is a rotten feeling to feel that you have been put in an institution against your will without being able to get out. I was fortunate in being there only three days. Even those three days have left their imprint on me.

The K—— Day Care Center: This place is going in the right direction it seems to me. The program is run by the democratic process . . . It’s very frustrating having to make decisions all the time and even harder to stick by them . . .

The staff is there to point out ways of looking at problems through questions. The emphasis is always on feelings. It gets to be a little wearing after a while . . . Gradually though things do happen. At first it was a shock to know my own diagnosis, but after all it’s just a label for what I have been going through for years. We make our own decisions, we are responsible for being there, we take our own medicine, we make our own lunches, plan them, clean up after ourselves. In other words we are given more responsibility for our own lives. We are not treated as dangerous or helpless individuals . . .

Therapy is change not adjustment. This I think is the basic idea of the clinic. The idea is not to quickly patch up an individual so that he may return to a job or whatever,

but to make an individual content with himself and free to express himself creatively . . .

P.S. The night I wrote this H—— and I stayed up all night—I had no emotion while writing this until the next morning when H—— had left for class. Then I became upset and was urged to go to the clinic. I showed them there what I had written. My doctor believed that it was good and that copies should be made to give to the administrators of the clinic. Dr. R——, one of the administrators, read it the next day. His reaction was completely different. He was defensive and thought that the feelings I expressed were just written by a sick individual. He kept asking, in a very “professional” noninvolved tone, what I had done to make myself more independent. It was a real put-down. I felt very angry and depressed until I started to realize that it was his problem not mine . . . Dr. R——’s reaction to me is just what I have been talking about—the condescending attitude of professional workers.

I’d be interested to have your reaction.

Flection / Reflection

Mary Barnes

Of her particular experience at Kingsley Hall; Mary Barnes has written a book with Joe—Dr. Joseph Berke, who guided her through madness, Mary Barnes: Two Accounts of A Journey Through Madness, to be published early in 1972 by Harcourt Brace Jovanovich.

Flection

Flection: the act of bending or the state of being bent. That's how I was at Kingsley Hall, bent back into a womb of rebirth. From this cocoon I emerged, changed to the self I had almost lost. The buried me, entangled in guilt and choked with anger as a plant matted in weed, grew anew, freed from the knots of my past.

That was Kingsley Hall to me, a backward somersault, a breakdown, a purification, a renewal. It was a place of rest, of utter stillness, of terrible turmoil, of the most shattering violence, of panic and of peace, of safety and security, and of risk and reckless joy. It was the essence of life. The world, caught, held, contained, in space and time. Five years as five seconds; five seconds as five hundred years.

Kingsley Hall, my "second" life, my "second" family, may it ever live within me. My life, within a life. It was a seed, a kernel of the time to come. How can I know what will come. As I write, as I paint, the words, the colors they emerge, grow, take shape, blend, and part; a sharp line, darkness; light. The canvas, a paper, a life, is full; complete, whole. We are at one with God. Through the half-light, the blessed blur of life, we stumble to the God we sense within.

Knowing, yet unknowing. Seeing, yet blind. Striving yet yielding; we reach out, from our own depth to the height of heaven, and in our stretch all life is held, bubbling and breaking with joy; still as deep water, moving as the clouds. Thousands, millions of lives. A word, a color, alone yet a part. One life seeking to live, expanded consciousness, participation in the "sight of God." How would I be in a new place? God knows.

I would let everything "be"; all the "Johns" and "Janets" and "Peters" and "Pamelas" I would let "be." We should be alone, yet in communion, in communication, with each other. In order to come to the light we have to germinate in the dark.

We must go the way we are made, an oak cannot be bent as a willow.

To lay down, to pray, to draw in to the core of one's being, is to "start a place." What place? A house, a community, a group of people? You have to wait and see what will happen, and let it happen.

The place that you start is there already, inside the people that will come. It's as white as heaven and black as hell and the background is gray, because that's the mixture we mainly are. How to build heaven on earth, how to save souls. That's what it's all about.

"Don't be too 'spiritual,'" says Joe. "No," I replied, "I'll try to express it in psychological terms."

"Dark night of the soul," deep despair, desperate depression; schizophrenia, split mind, tormented with distractions; cut off from God; division of the self; "to die to the self to live in God"; to get free from the self in the mother

to live in God within the self; "our life as a bird has escaped from the snare," from the bonds, or rather the emotional ties, of the past have I through psychotherapy been released.

Different ages, different terms, the world moves, in the eternal breath of God.

Reflection

Ronnie (Dr. R. D. Laing) told me "What you need is analysis twenty-four hours out of twenty-four." I was one of those people who just cannot be healed through spasmodic help, whilst living in an ordinary situation. I just had to be in a special place, a house for madness.

It's the inner state that matters. But it's less sick people than I was who can get free, whole, through the ordinary course of life. Extreme states help to "bring it up," to uncover the real self, but to go further in extreme conditions is very rare. How many, in a prison, physically living with the family one was born into, or in a contemplative convent, reach through to integration, wholeness, sanctity? It's what we are all made for, given time in this life to achieve.

Yet, never, for one moment, do we "make it" of ourselves. God, through other people reaches out to us and draws us on. It's a question of suffering but the suffering for many of us means madness before sanity—sanctity—wholeness. We go from false self, to madness, to sanity.

Mother Mary of Jesus early in this century spent two years alone in her cell, in a sense sick, yet not physically ill, before she was able to participate in the life of her community. Many years later she founded thirty-three Carmelite convents in England, Scotland, and Wales before she died in 1942.

A convent day school in London is boarding one of their older pupils, because she is in mental distress. But it is rare for an established community to accommodate itself to the needs of such people, and if these people were in psychotherapy as such, with all the tremendous emotional upheaval that entails, it would probably be well nigh im-

possible to accommodate them within "so-called" sane living conditions.

A very twisted-up person cannot get free without being allowed extremes of behavior. Regression is a safety valve. Playing, bashing about, screaming, sucking, messing with shit, lying naked, wetting the bed, are all ways of getting the anger into the body without hurting the body.

Lying in a painful position, being alone for a day, will resolve anger. But resolution through bodily pain, fasting, and isolation as all religious orders of all religions through all ages practice is *not* possible, at least at *first*, for people who are very twisted up, as I was. They have to be allowed, encouraged, to *be* as "baby" as they feel and emotionally regrown until they can participate in what might be termed a more "spiritual" level of development

Just as one doesn't give a one-year-old baby tranquilizers or kneel him down to meditate, so must one *not* have expectations of a person in madness utterly beyond his state. Otherwise, there is danger of just shaking him (a modern way of doing this is electric shocks) or shutting him away in a cupboard (the chronic ward of a mental hospital).

The person must be seen and understood as the baby he is—and allowed to live that way, through it.

He is dying to be loved, to be wanted, to be accepted. He has within himself to emotionally accept, to feel, all the anger, the anguish of the past, to go through periods of deadness when nothing at all can be felt, to be green with envy and hating with jealousy. Still, he must be loved, totally, for what he is, as a baby needs love.

Important as understanding is, it is love and trust that matter most. As a mother knows her baby, so can one "know" another person. Immediate response of feeling is not in the head. It's the heart, the feeling that counts. Intellect and feeling come together later. Madness is the nursery, not the library. Babies suck and mothers love. Let therapists beware of too much thought and lettered words. (Madness and the understanding of it is more akin to contemplation than intellectual activity, as such.)

As a "little baby" with eyes tight shut I lay together "whole" on the floor. Anything more was "too much." Too much for my "wholeness." It was better to be "very baby" and whole than pretending and talking or walking and split.

Truth wells up from within, and living growing life brings changing forms and structures to suit the needs on one's being. (After psychotherapists the people I seemed most able to "meet" in madness, or "felt" nearest to, were contemplative nuns.)

The fear of coming out of a straitjacketed, stereotyped existence to a consciously unknown, long-forgotten life, is very great. Not iron bars or padded cells, not injections or tablets, but *people*, who love and accept, and know how and when to leave you alone, are what's needed. Given the soil, a plant will grow.

How to let go, lie down, break, be held, be beyond words, float, is a matter of trust. It's trusting God, through another person and no matter if so-called "mistakes" are made, God doesn't "drop us." Through every shattering, smashing explosion our life is still there, more whole than before. Our will submitted we are yet free, and every happening is a growing step. When in a mad state one is "without words," in touch with the "hidden underneath" of another person. Very sensitive and fragile you respond or withdraw as a snail with a shell. The other person may have no idea what he is hiding, but you pick it up—like a magnet.

Madness is purification. To go through it needs a guide, in the terms of our world today, a psychotherapist. It has to be gone *through*, not round, and only someone else can keep us there. "You're a slippery eel; the more you suffer, the more free you get." So Joe (Dr. Joseph Berke) would tell me.

When of ourselves we would give all, we must take half, and when of ourselves we would take half, we must give all.

Joe taught me a lot about this through food. If in the course of going through madness, the baby regressed state

is at times "leapt above," the baby as it were sensing, seeing, as a "wise old man," and what might be termed mystical experience is encountered, this should not be "wallowed in." It's a drink, a refreshment, a shady tree, a magnificent view, before again going down through the woods.

Going through madness is a matter of right *discipline* and *control*. So *feeling frees* and *serves* us, instead of *binding* and *killing*. A saint feels evil as fire on flesh. Many of us feel much that is not evil as if it was. Something is amiss, we are astray, off track.

The feeling of shame, guilt, that brings us to a dead stillness, makes all giving and receiving of love impossible, is a barrier to all creativity, causes us to feel as ghosts and bury our souls and bodies in "living death," is a very great sickness.

When very twisted up so the feelings, the emotions, are not true, the impulse of the being is to break down.

To resist is "screaming agony" or "living death."

To be helped, to make the break, to go *through* madness, is salvation.

Madness and Morals

Morton Schatzman

Morty Schatzman is an expatriate who has worked in England the past half-dozen years developing a theory of antipsychiatry with Laing, Cooper, and others. Adapted from an article published in Counter Culture, edited by Joseph Berke (London: Peter Owen).

Thou lovest Truth and Beauty and Righteousness: and I for thy sake say it is well and seemly to love these things. But in my heart I laugh at thy love. Yet I would not have thee see my laughter. I would laugh alone.

My friend, thou art good and cautious and wise: nay, thou art perfect—and I, too, speak with thee wisely and cautiously. And yet I am mad. But I mask my madness. I would be mad alone.

My friend, thou art not my friend, but how shall I make thee understand? My path is not thy path, yet together we walk, hand in hand.

—Kahlil Gibran,
The Madman

There is reason to believe that a society which sees people as "mentally ill," calls them "mentally ill," and treats them as "mentally ill" aggravates *by* those acts the condition which it calls "mental illness."

People in a group label behavior which breaks rules of the group as bad, criminal, malicious, sinful, selfish, immature, foolish, idiotic, ignorant, and so on. They develop criteria to judge which behavior breaks rules and how to label it. They cannot apply any of these labels to the behavior of some individuals who persistently break rules. Men in other times and places ascribed this behavior to witchcraft, spirit possession, or demons. Today, men in the industrialized nations of the world see the same behavior as "symptoms" of "mental illness."

Men in western society have created norms to define which items in the cosmos must be seen as real or unreal and as inner or outer. If a man sees as real what they say he should see as unreal, or vice versa, or as inner what they say he should see as outer, or vice versa, and if he argues the validity of this view by a style of argument which they consider abnormal or does not argue it at all, they are likely to see him as "mentally ill." Western society appoints psychiatrists as experts to examine some of its members who break rules to discern if they break those rules for which they can be called "mentally ill."

The tradition of scientific medicine teaches a doctor to keep distinct his moral attitude towards diseased persons from his nonmoral objective attitude toward their diseases. But the *moral* views of Western society define for a psychiatrist what persons he may diagnose as "mentally ill" and whom he may treat. A psychiatrist, especially if he works in a mental hospital, is concerned with surveying morals and mediating rules. He must deny this if he wishes to believe that he adheres to the principles of scientific medicine. Although he sees "pathology" in behavior which breaks rules, *because* it breaks rules, he does not say so, and usually does not even say that he considers it to break rules. If he works in a mental hospital he imposes rules on "patients," rewards obedience and

punishes disobedience, and calls these activities "treatment." In the more advanced mental hospitals he tutors "patients" to think, feel, and act "appropriately," and calls this "therapy." These maneuvers confuse many patients and induce them to respond in "abnormal" ways which the psychiatrist may see as more evidence of their "mental illness."

Many "mental patients" have always understood this situation; now some social scientists, psychologists, and psychiatrists do. Drs. Ronald D. Laing, Aaron Esterson, and David Cooper are psychiatrists in England who saw the need to create alternatives to the traditional mental hospital ward. David Cooper led people on a ward in a mental hospital near London to question their premises and to change many customary practices. The Philadelphia Association, Ltd., of which Laing, Esterson, and Cooper were founder-members, has affiliated itself with several self-governing households in London in which people, most of whom have previously been diagnosed as "mentally ill," live outside the mental hospital system. They are more like hippie communes than like the most liberal mental-hospital wards. I shall describe Kingsley Hall, the largest of them, after explaining the rationale for their existence.

Mental hospitals

Present-day Western men presume that their cultural forbears became enlightened around the end of the 18th century to a truth to which men had been blind for too long: that madmen are sick men. The modern experience of madness has been governed by the conviction of "sane" people that madness is really an illness and by their belief that this truth has been firmly proven by advances in scientific knowledge. They have converted the asylums into medical spaces where doctors have assumed the dominant roles. The doctors have based their powers on the presumption that they have scientific understanding of the inmates. This has been a disguise and a pretension, says

Michel Foucault, a French philosopher and psychologist. Psychiatric practice in the mental hospitals has been a *moral* tactic, cloaked with the dignity of scientific truth. The asylum, as set up by the doctors, has been from the beginning, Foucault says:

. . . a structure that formed a kind of microcosm in which were symbolized the massive structures of bourgeois society and its values: Family-Child relations, centered on the theme of paternal authority; Transgression-Punishment relations, centered on the theme of immediate justice; Madness-Disorder relations, centered on the theme of social and moral order. It is from these that the doctor derives his power to cure . . .

Philippe Pinel was a doctor whom historians of psychiatry regard as the "father" of the modern mental hospital, and whom apologists for the status quo call the "liberator of the insane." In *A Treatise on Insanity* he suggested how to "treat" the "maniac, who under the influence of the most extravagant fury shall be guilty of every extravagance, both of language and action."

. . . no more coercion is employed than what is dictated by attention to personal safety. For this purpose the strait-waistcoat will be generally found amply sufficient. Every case of irritation, real or imaginary, is to be carefully avoided. *Improper application for personal liberty, or any other favor* must be received with acquiescence, taken graciously into consideration, and withheld under some plausible pretext, or postponed to a more convenient opportunity. The utmost vigilance of the *domestic police* will be necessary to engage the exertions of every maniac, especially during his lucid intervals, in some employment, laborious or otherwise, calculated to employ his thoughts and attention.

Although he recommended the use of baths and “pharmaceutical formulæ” like “antispasmodics” to calm the “tumult” of mental patients, he said that the fundamental “treatment” is “*exclusively moral.*”

The extreme importance which I attach to the maintenance of *order* and *moderation* in lunatic institutions, and consequently to the physical and moral qualities requisite to be possessed by their governors, is by no means to be wondered at, since it is fundamental principle in the treatment of mania to watch over the impetuosities of passion, and to order such arrangements of police and moral treatment as are favorable to that degree of excitement which experience approves as conducive to recovery.

He said:

The doctrine in ethics of balancing the passions of men by others of equal or superior force, is not less applicable to the practice of medicine, than to the science of *politics*, and is probably not the only point of resemblance between the art of *governing* mankind and that of healing their diseases.

“The Importance of an Enlightened System of Police for the Internal Management of Lunatic Asylums” is the title of one of the six sections of this book.

The principles of “treatment” have not changed since Pinel, but the techniques have become more sophisticated. Tranquilizing drugs, electroconvulsive shock, and insulin coma maintain “order” and “moderation” more effectively than the straitjackets and antispasmodics did, and psychotherapy and therapeutic community meetings are more likely to persuade “patients” to conform than was the moral instruction of the governors of lunatic asylums. The “treatment” which hospital psychiatrists give is still exclusively moral. Unlike Pinel, they do not say that it is.

Mental hospitals like prisons confine deviant persons, but they confuse their inmates more, since they do not tell them what rules they have broken, nor even that they have broken rules. The psychiatrist in the mental hospital tries to persuade *himself*, his colleagues in the medical profession, the staff, the "patients," the "patients'" families and friends, and society that he practices medicine, and denies to himself and all others that any persuasion occurs or is even necessary. To frame his activities within a medical model he calls a trial, "examination"; a judgment, "diagnosis"; a sentence, "disposition"; and correction, "treatment." If his "patients" claim they are not ill they challenge his pretensions.

One must admire the ingenuity with which he copes with this contingency. He presumes that a basic "symptom" of the "mentally ill patient" is his failure to know that he is "ill." When the "patient" disagrees with the doctor who says he is "ill," the doctor does not tell him that he should not disagree, but that he does not *know* what he is saying, and that he does not, *because* he is "ill." He hears the "patient's" statement that he is not ill as evidence that he is "too ill" to realize that he is "ill," and he tells him so. If a "patient" feels healthy despite being told by his doctor that he is not, and says so, the doctor may tell him that he is not motivated to regain his health.

The psychiatrist outwits by another twist a person who pretends that he is mentally ill to maneuver a social situation for personal gain. The psychiatrist who suspects a person of this "diagnoses" him to suffer from the "syndrome" of feigning illness which he considers to be a sickness with a poor prognosis (Ganser's Syndrome). If a man knows what is going on, but pretends that he does not, and knows that he is pretending, the psychiatrist may see him as a man who thinks he knows he is pretending, but as really not pretending, and as pretending to pretend.

Kaplan, an American psychologist, says in his introduction to *The Inner World of Mental Illness*, "a series of first-person accounts of what it was like" to be "mentally ill,"

One of the salient features of the psychopathologies that are described in this book is that they are opposed to a normality which is intimately related to the major value orientations of western society. It may be asserted therefore that abnormality [psychosis] involves a negative relationship to prevailing social normative prescriptions—perhaps the most extreme and complete form of negation that is possible. This is more than an abstract and logical conclusion. In the jargon of the moment we may call this “alienation.” In this association of abnormality with a refusal to be bound by things as they are and with the striving to be different, we have what is at bottom a concern with the category of change and transcendence.

The same is so for many of the “mentally ill” who have not published their ideas. The disease spins off a runaway feedback loop: those who negate the prevailing social norms are negated by those who uphold them, and the upholders are negated in their negations of the negators by the negators . . . not *ad infinitum* but *ad* the ascription of “mental illness” by the upholders upon the opposers.

When Jeremiah broke an earthen vessel in the temple courtyard to pronounce and predict the destruction of Jerusalem, the temple police seized him, beat him, and punished him publicly by putting him in the stocks. They did not, as far as we know, suspect him of “mental illness.” Recently, a young man in the NATO military forces, with a position in a chain of command to push a nuclear-missile “button,” decided to refuse to obey orders related to his job. He told his superiors they should not command any man to do such a job. He was diagnosed as “schizophrenic” and was hospitalized.

All that is certain about “mental illness” is that some people assert that other people have it. Epistemologically, “mental illness” has the status of an explanatory concept or a working hypothesis. No one has proven it to exist

as a thing nor has anyone described its attributes with scientific precision and reliability.

Since mental hospitals regulate the behavior and the biochemistry of their inmates to a degree unequaled elsewhere in the "free world," "patients" rebel and resist. Official psychiatry trains the young psychiatrist not to see what is in front of his face when it teaches him to class "patients" attempts to protest against their situation as "signs" and "symptoms" of "illness." He learns to label "patients" as "ill" with "personality disorders" if they make problems for *others* by defying the authority of the hospital or of society. He is taught to see those who openly challenge the rules of others as "sick" with an "illness" called "psychopathy" or "sociopathy," and those who inhibit their challenge due to a fear of the consequences as "sick" with "passive-aggressive personality disorders." He treats the "victims" of these "diseases" with drugs and may insist on bed rest too. He learns to see "acting out," "agitation," "excitement," and "withdrawal" as symptoms which disturb his "patients" and not to see that they may be saying by this behavior that *he* is disturbing them.

Some doctors in their first year of psychiatric training argue at staff meetings that their "patients'" responses to their situation in the hospital are valid. I have heard their teachers tell them that they have not yet "worked through" their own "adolescent personality crises."

What I describe here is a special case of what Wittgenstein called the "bewitchment of our intelligence by means of language." "A picture held us captive and we could not get outside it, for it lay in our language and language seemed to repeat it to us inexorably."

Laing says:

The concept of schizophrenia is a kind of conceptual straitjacket that severely restricts the possibilities both of psychiatrists and patients. By taking off this straitjacket we can see what happens. It has been abundantly shown in the field of ethology, that observations on the

behavior of animals in captivity tells us *nothing reliable* about their behavior in their own natural setting. The whole of our present civilization may be a captivity that man has somehow imposed on himself. But, the observations upon which psychiatrists and psychologists have drawn in order to build up the prevailing picture of schizophrenia, have, almost entirely, been made on human beings in a double or even treble captivity.

The power to confine people in mental hospitals, involuntarily if necessary, deprive them of civil liberties, define their limits of legal redress, and award to their medical governors license to formulate and execute rules to regulate their management and treatment derives from the state and is guaranteed by the law. The confinement of the “mentally ill” must serve a basic homeostatic function to sustain the social and political order in Western society since so many people are confined and so many work to confine them.

Here is a schematic version of an actual story. Matthew, aged twenty-three, is from a devout Christian family. When he was twelve his father died; since thirteen he has slept in the same bed as his mother, at her request, because she has feared to sleep alone. He meets a woman of his own age whom he likes and whom he kisses one evening. That night “vampires” attack him in his sleep. When the nightmares continue, his mother takes him to a GP who tells her he shows early signs of “mental illness” and suggests he go into a hospital before his “disease” progresses further.

He enters a mental hospital as an in-patient. He says to his psychiatrist the next day, “Please help me. You are a messenger from God. You will decide my fate: whether I will go to heaven or hell. Do I have any power to influence you? If I confess that I have masturbated, will I help my chances with God or hurt them?” The psychiatrist thinks Matthew is being “grandiose” and “overrideational,” and *therefore* diagnoses him as a “para-

noid schizophrenic"—"grandiosity" and "overideation" are "symptoms" of "paranoid schizophrenia." The staff think the "disease" is due mainly to an inherited constitutional biochemical defect. They believe the "illness" appears now because the sexual excitement stressed his delicate state. They do not implicate his mother's feelings and behavior toward him, or his toward her, as pertinent to the understanding of his "illness." They see his mother as "nervous" about his health but they dismiss this observation as irrelevant. Besides, how can they blame her for her concern, especially since her husband has died from an illness? The hospital is a good place for Matthew: he will have a chance to rest because the rules forbid all sexual contact.

The psychiatrist treats him with a common tranquilizing drug which is thought to have an "antischizophrenic" action. As the dose is raised progressively he develops a new "symptom": he says he is "being poisoned." The common side effects of this drug occur at the same time: dry mouth, nasal congestion, blurred vision, constipation, drowsiness, stiffness of the muscles of the mouth, and occasional dizziness. The staff realize that the drug is responsible for these effects. Since the doctor has diagnosed him as a "paranoid schizophrenic" they see his belief that he is being poisoned as a "progression" of his "disease" which is occurring *despite* the efficacy of the drug.

The doctor raises the dosage of the drug. Matthew now shows the effects of high dosage: a pill-rolling tremor of both hands, masklike rigidity of his facial muscles, a stooped posture, and short quick steps when he walks. He reveals to an attendant on the ward that he has phoned the municipal health department to complain that the hospital poisons its inmates, and that he has done this to protect others. He frequently says that he is frightened. The staff now believe his "disease process" is worsening.

The doctor adds a second tranquilizing drug, administered by injection. Matthew develops a rash over a large part of his body. He says that the doctors are "in league

with the devil" to arrange that he burns in hell for his sins, and that he would "rather die than suffer eternal damnation."

The staff see him as "deteriorating" rapidly despite the best modern "treatment." They see his "illness" as "*unresponsive*" to drug therapy. The doctor orders electroconvulsive shock therapy. "Patients" often experience this therapy as an assault and they always suffer some memory loss after it. The doctor knows this but he wishes to help Matthew before it is too late.

The staff do not see his behavior as a consequence of his experience of *their* behavior toward him. Here is an outline of some transactions between him and them in which I infer his experience of his situation, and interpret his behavior as an attempt to cope with *their* behavior.

- 1) He sees from the posture which his psychiatrist adopts toward him and from what other "patients" tell him that the psychiatrist can assume much control over him if he wishes to. He hopes that the psychiatrist will not, but fears that he may.
- 2) He sees that the psychiatrist does not see himself as a powerful master who controls his charges, but as a doctor who treats "sick patients." He fears that if he tells the doctor he fears his power he may offend him.
- 3) A nurse tells him that "patients" help themselves when they reveal their innermost thoughts to their doctor and the staff.
- 4) A nurse tells him he is "ill" and belongs in the hospital. A nurse's aide tells him that although he entered the hospital voluntarily, the psychiatrist can sign a form to confine him against his will.
- 5) He cannot obey the claims of both 1) and 3) unless he disobeys his consideration in 2). He cannot obey 2) unless he disobeys the demands of either 1) or 3), and if he makes a move to leave the situation he will disobey the advice of the staff and risk being confined involuntarily. He decides upon 6).
- 6) He tells the doctor, "Please help me. You

are a messenger from God. You will decide what my ultimate fate will be . . ." etc. His religious upbringing colors the content of what he says. His dilemma imposes the *necessity* to speak in metaphor. 7) He does not realize that these statements lead his doctor to diagnose him as a "paranoid schizophrenic."

Although staff "treat" a "patient" by frequently telling him that he is "sick," they usually do not tell him his "diagnosis." Nor do the staff tell a "patient" which data his doctor thinks are pertinent to the "diagnosis," or how, or why he thinks the data are pertinent. If a "patient" asks to know this information, to which all the staff have access, they generally reply evasively.

8) He is not sure why his doctor has ordered a drug for him. When he asks a nurse why, she tells him he is "ill" and that the drug will make him "feel better." 9) He tells the staff that this cannot be the right drug for him since he had felt well before he took it and now feels ill. 10) His doctor says that the fact that he had felt well before he was given the drug does not prove that he had not been ill then since "mentally ill patients" often do not realize they are "ill." The nurses tell him at a ward meeting that he should trust his doctor since the doctor is trained in this field and he is not, and that "mistrust" is a "symptom" of "mental illness." 11) He feels confused. He mistrusts those who tell him he was ill when he felt well and that the drug they give him can help him to "feel better" when it makes him feel ill. He mistrusts them more when they tell him he is ill if he mistrusts them. How can he influence the doctor to change his "treatment" and conceal that he mistrusts the "treatment"? 12) He says he is being "poisoned."

In this way he both conceals and reveals his mistrust. Since he does not know the doctor has diagnosed him as a "paranoid schizo-

phrenic" and has ordered the drug to "treat" this "disease," he does not realize that by saying he is "being poisoned" he brings about what he most fears: an increase in drug dosage.

I leave it to the reader to complete the analysis of the story from here to the doctor's decision to administer electroshock therapy.

I have heard many ex-mental patients tell me of experiences in mental hospitals similar in *structure* to my inferences about this man's experience. I read this story to seven of them and they all confirmed that they had found themselves in predicaments like this one, with which they had found it difficult to cope in a sane way. Mental hospitals entangle all their "patients" in knots which are so constructed that the "patients'" struggles to untie them tighten the knots.

The staff's practice of translating interpersonal events within the hospital into terms of a medical model bewilders the inmates, many of whom are befuddled already before coming to the hospital. Goffman, a sociologist who studied the social world inside a large American hospital, says:

. . . whatever else these institutions do, one of their central effects is to sustain the self-conception of the professional staff employed there. Inmates and lower staff levels are involved in a vast supportive action—an elaborate dramatized tribute—that has the effect, if not the purpose, of affirming that a medical-like service is in progress here and that the psychiatric staff is providing it. Something about the weakness of this claim is suggested by the industry required to support it . . .

Mental patients can find themselves in a special bind. To get out of the hospital, or to ease their life within it. They must show acceptance of the place accorded them, and the place accorded them is to support the occupational role of those who appear to force

this bargain. This *self-alienating moral servitude*, which perhaps helps to account for some inmates becoming *mentally confused*, is achieved by invoking the great tradition of the expert servicing relation, especially its medical variety.

The mental hospital confronts hapless wayfarers, gives them conundrums to solve, and punishes them dreadfully if they fail. Shall we not find an alternative to this modern sphinx before it destroys the unwary among *us* too?

The anti-psychiatry ward

Dr. David Cooper in 1962 began to dehierarchize one ward within a large mental hospital near London. He wished to "allow a greater degree of freedom of movement out of the highly artificial staff and patient roles imposed on people by conventional psychiatry." He called his project an "experiment in anti-psychiatry."

The staff abolished role-bound behavior such as organizing "patients" into activity, supervising their domestic work on the ward, and "treating" them. An "antirule" was set up that "patients" decide their own leave period, attendance at meetings, and getting out of bed. In response to external administrative pressure the ward staff partially restored their own role-bound behavior.

David Cooper sees the result of his "experiment" to be that "the limits of institutional change are found to be very closely drawn indeed—even in a progressive mental hospital." He suggests that "a step forward means ultimately a step out of the mental hospital into the community."

Kingsley Hall

Kingsley Hall is the name of a building in the East End of London. It was built about sixty years ago. It is three floors in height. About thirteen people can live there

comfortably, each with his own room. A large ground-floor hall, a "games room," a dining room, a meeting room, two kitchens, and three other rooms—used by the occupants now as a meditation room, a chapel, and a darkroom for photography—comprise the "common rooms." The roof is open and has a garden.

The building has been used in the past as a community center for meetings of various kinds, and as a settlement house. It has also served as a place of worship. Mahatma Gandhi stayed at Kingsley Hall when he visited London in 1931.

The Philadelphia Association, Ltd., leased the building from the Kingsley Hall Board of Trustees in June 1965. The community which I describe here began then and has included over one hundred individuals. The PA also has affiliated itself with several other small communities similar in aim to Kingsley Hall. The people in each household make the rules which govern their life together. These households comprise a major social experiment.

Several members of the PA lived at Kingsley Hall in the year 1965–66. The residents are free to ask them for advice or help whenever they wish. The PA has sponsored lectures in psychiatry, anti-psychiatry and phenomenology at Kingsley Hall, and has arranged seminars and meetings there with professional people in many fields.

The community has been a link in a chain of counter-culture centers. Experimental drama groups, social scientists of the new left, classes from the Antiuniversity of London, leaders of the commune movement, and avant-garde poets, artists, musicians, dancers, and photographers have met at Kingsley Hall with the residents in the last three and a half years. The Free School of London met there for the first time.

The founder-members of Kingsley Hall hoped to fulfill in the community their seed idea that lost souls may be cured by going mad among people who see madness as a chance to die and be reborn. Laing says in *The Politics of Experience*:

No age in the history of humanity has perhaps so lost touch with this natural *healing* process, that implicates *some* of the people whom we label schizophrenic. No age has so devalued it, no age has imposed such prohibitions and deterrents against it, as our own. Instead of the mental hospital, a sort of resericing factory for human breakdowns, we need a place where people who have travelled further, and consequently, may be more lost than psychiatrists and other sane people, can find their way *further* into inner space and time, and back again. Instead of the *degradation* ceremonial of psychiatric examination, diagnosis and prognostication, we need, for those who are ready for it (in psychiatric terminology often those who are about to go into a schizophrenic breakdown), an initiation ceremonial, through which the person will be guided with full social encouragement and sanction into inner space and time. Psychiatrically, this would appear as ex-patients helping future patients to go mad.

When Freud returned to his patients' earliest memories (and his own) he found traumas which he saw had led them (and him) to repress regions of their (and his) being. He revealed feelings and energy which had been buried and "bound" together with the forgotten memories of events which had occurred in childhood and infancy. Freud urged his patients to remember their pasts, and to recover their lost feelings, in order to make themselves whole again. He also said he knew of acts of men who had lived before recorded history which survived as "unconscious" memories in the minds of all living human beings and influenced their behavior. He did not urge his patients to go back to that time, long before their births, to cure themselves.

Human societies in diverse times and places have relied upon a method of "psychotherapy" which Western man has forgotten and suppressed: the return to chaos. To cure himself "archaic" and "primitive" man goes back beyond