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MENTAL HEALTH

Editorial Perspective

Mental Health and Society

Nowadays, men often feel that their private lives are a series of traps. They sense that within their everyday worlds, they cannot overcome their troubles, and in this feeling, they are often quite correct: what ordinary men are directly aware of and what they try to do are bound by the private orbits in which they live; their visions and their powers are limited to the close-up scenes of job, family, neighbourhood; in other milieux, they move vicariously and remain spectators. And the more aware they become, however vaguely, of ambitions and of threats which transcend their immediate locales, the more trapped they seem to feel—C.Wright Mills in "The Sociological Imagination."

THIS is the condition of modern man. In order to understand mental health and illness it is very important to know the concept or nature of man within a given social milieu; for on this depends the definition of what is mental health and illness, the normal and the pathological. The human situation or human existence in a social milieu thus becomes the key to understanding mental health.

It is not necessary to go into the various conceptions held historically but it should suffice to state that the definition of mental health in a society is intimately related to the concept of human in that society. These conceptions are the result of the relations of production prevailing within a given society. They have a direct bearing on the human situation and determine mental health of individuals as well as classes. Marx described this aptly in the 'German Ideology': "The production of ideas, of conceptions, of consciousness, is at first directly interwoven with the material activity and the material intercourse of men, the language of real life. Conceiving, thinking, the mental intercourse of men, appear at this stage as the direct afflux from their material behaviour. The same applies to mental production as expressed in the language of the politics, laws, morality, religion, metaphysics of a people. Men are the producers of their conceptions, ideas, etc. real, active men, as they are conditioned by the definite development of their productive forces and of the intercourse corresponding to these, upto its furthest forms. Consciousness can never be anything else than conscious existence, and the existence of men in their actual life-process." (Marx, 1956)

Thus, pathology stems from society itself and no amount of cure of an individual who manifests symptoms of being mentlaly ill, will provide a complete solution to this sickness. Mental helath is not a question "of the 'adjustment' of the individual to his society, but, on the contrary it (requires) the adjustment of society to the needs of man . . . whether or not the individual is healthy, is primarily not an individual matter but depends on the structure of his society. A healthy society furthers man's capacity to love his fellow men, to work creatively, to develop his reason and objectivity, to have a sense of self which is based on the experience of his own productive powers. An unhealthy society is one which creates mutual hostility, distrust, which transforms man into an instrument of use and exploitation for others, which deprives him of a sense of self, except inasmuch as he submits to others or becomes an automaton" (Fromm, 1956). It is therefore clear that the understanding of man's psyche "must be based on the analysis of man's needs stemming from the conditions of his existence" (ibid).

Historical Background

In the past mental illness was generally the equivalent of lunacy or madness but in post-industrial societies things are different. Understanding of mental health was earlier dichotomised into being mad or being sane. Now the situation has changed.

A change in the social formation cuts across the length and breadth of a social structure and leaves none untouched. The sphere of the human psyche too is affected. Traditional societies are close-knit and therefore have a greater capacity for absorption of distress, frustrations and conflicts that impinge upon individuals because of prevailing class-relations. Family, clan and community ties cushion members against them temporarily releasing them (individuals) from the traps of daily living.

With the industrial and French revolutions the old order received its death blow. Individuals, uprooted from their traditional ties, had to face new realities of changed production relations, but this time with little or no support from their family, clan or community. The new production relations under capitalism made alienation of man complete and mental health acquired additional dimensions. It was no longer confined to "madness" but smaller deviations from accepted norms became equally important, because a mass society that was emerging required stronger measures and mechanisms for social control if the status quo had to stay undisturbed.

The first break came during the "Paris Commune" when Philippe Pinel, a French physician, obtained permission of the commune to treat inmates of asylums with kindness and sympathy: instead of incurable lunatics they were now considered as "sick" persons who were in need of treatment rather than being evil and deserving punishment. Pinel's therapeutic intervention advocated a moral treatment—treating afflicted persons with care and concern and at the same time improving their environment; patients were taught the value of work, recreation, religion, social activities and self-control (Bockoven, 1963).

Thus for the first time the theory of unadjustment to society was put to practice and mental health henceforth became a matter of adjusting the unadjusted through a process of correction.

With further advancement of industrial society and strengthening of capitalism, issues of mental health were no longer confined to the lunatics, but increasingly neuroses began to acquire a central focus. This was thanks to the weakening of human ties and the process of alienation. Karl Marx described this as the negation of productivity in that man (the worker) can no longer "fulfill himself in his work but denies himself, has a feeling of misery rather than wellbeing, does not develop freely his mental and physical energies but is physically exhausted and mentally debased" (Marx, 1967). The man who has thus become subject to his alienated needs is "a mentally and physically dehumanized being . . . the self-conscious and self-acting commodity" (ibid).

Through Marx's writing it became clear that pathology resided not in the individual but within the social system itself. Mental illness originated in the pathological society and it was society that needed a total transformation; man's mental state depended upon the nature of the social system.

However, this explanation was set aside as it was a challenge that suggested the destruction of the existing system. Soon after Marx, Max Weber's verstehen approach came to the rescue of capitalism. Weber upturned Marx and provided a foundation for a new explanation to emerge about man's mentality. This new break was that by Sigmund Freud who directed attention to the intrapsychic life and emphasised the importance of the

unconscious. This psychology of the unconscious was indeed "revolutionary" and path-breaking because until Freud philosophers had always equated the mind with consciousness. Freud's now famous "ice-berg" theory revealed that "only a very small part of what is mental is conscious; the rest is unconscious made up of inadmissible and involuntary ideas which motivate behaviour" (Appignanesi and Zarate, 1979).

Sigmund Freud

"Where id was, there shall ego be" was Freud's way of describing mental health. Id is the unconscious, governed by the pleasure principle, and ego is the preconscious that emerges because of the reality principle. These ideas of the unconscious revolved around the oedipus complex which has generally acquired the expression 'father ... murder, mother ... incest'." In Freudism 'libido' plays the part of the mythical 'caloric' of eighteenth century health mechanics, or of the 'gravity' of Newtonian physics (Caudwell, 1971).

As a consequence, Freud's obsession with sexuality prevented him from using to advantage the contributions of Marx to the understanding of human behaviour.

Freud's sexual determinism is unrealistic. A child's desire for his mother's breast and subsequently for her love is not an incestuous response but that of hunger and emotional support; for the child it is the mother who provides social, economic and emotional security. Nor does the child see the father as a rival or, in his unconscious, desire to murder him. The father's role as a patriarch bestowed by society is interpreted by the child as a stranglehold on his freedom, creativity and object of security (the mother), and therefore in his unconscious he seeks to challenge it. A review of anthroplogical studies of matriarchal societies may indicate possibilities to further substantiate and support this critique of Freud's conception.

Freud's insight of the human psyche was based on an understanding of the individual, and as a consequence his interpretations of mental manifestations suffered severely. He did not see the individual's psyche in the context of the social milieu and therefore got trapped in the confines of the libido instinct.

Caudwell (1971) writes: "We must establish sociology (Marxist) before we can establish psychology, just as we must establish the laws of time and space before we can treat satisfactorily of a single particle ..." This Freud has failed to see. To him all mental phenomena are simply the interaction and mutual distortion of the instincts, of which culture and social organisations are a projection, and yet this social environment, produced by the instincts, is just what tortures and inhibits the instincts.

However, Freud's influence on the various disciplines of the human psyche is still very substantial. Freud's contributions have greatly been responsible for the extensive attention that mental health receives, especially in western countries. It was largely due to the emergence of Freudian psychoanalysis that the mental health movement became popular in the USA. The professions of psychiatry and psychoanalysis subsequently acquired a new importance in the field of medicine—they became big business; a new technology developed around them—psychotropic drugs, psychosurgery, electrotherapy and the like. Until the late sixties, this individualistic approach to mental illness remained predominant.

Community Mental Health

At the turn of the seventies, by when the futility of the individualist approach was proved beyond doubt, things began to change. The community basis of mental health was recognised in the USA, but still the problem continued to be seen as one of adjustment and unadjustment to society. The difference was that it was not the individual that required to be adjusted, but the entire community in which he lived. Thus, if the mentally disturbed person came from a ghetto then psychiatric social workers and other paramedics were to be used for resocialisation of the immediate community of the mentally ill person; these paramedic workers thus became a new arsenal in the forces of social control.

It would be of interest to list out the characteristics of this community mental health movement (Bloom, 1973): a) emphasis on practice within the community rather than in institutional settings such as mental hospitals; b) effort to provide services and programmes directed at the total community rather than individual patients; c) prevention services given higher priority than therapeutic services; d) clinician offering indirect services—consultation, mental health education, training of community care givers (teachers, clergy, public health nurses, etc.)—rather than working directly with patients, thus reaching larger number of persons; e) innovative clinical strategies developed that more promptly meet the mental health needs of larger number of people (eg: crisis intervention) than was possible before; f) more rational basis for developing specific programmes, based upon a demographic analysis of the community being served, its unmet mental health needs, identification of those persons who are at special high risk for developing disordered behaviour; g) use of new personnel—para-professionals—to supplement services delivered by psychiatry, clinical psychology, psychiatric social work and psychiatric nursing; h) committment to "community control" dealing with community representatives in establishing programmes; and i) identifying sources of stress within the community and not simply within a sick person.

From the above listing it becomes clear that the community mental health movement is no different from the community health movement which aimed at developing resources in a decentralized manner (at the community level) so that through a new category of resource persons (such as paramedics, "voluntary" agencies or NGOs, etc.) the ruling class could strengthen mechanisms of social control, making them appear as self (or community) regulatory and democratic; thus, preserving the status quo. This fits in with the 'circulation of elite' framework of Vilfred Pareto which is regarded as a weapon of the ruling class (elites) to protect its own decadence "by introducing the idea of new 'social forces' among the masses" (Bottomore, 1966).

Dimensions of Mental Health

In spite of the understanding that the social structure of capitalism is in itself responsible for mental illness an overwhelming proportion of psychiatrists and psychoanalysts continue to treat mental illness as a primarily biological and behavioural problem. Therapeutic systems that have been evolved in recent years are therefore based on these assumptions and hence inadequate.

The problem of mental health, though having its own peculiarities, is no different from that of health in general or other social problems such as poverty, communalism, racism, sexism, arms race, etc. All these problems, both under capitalism and totalitarian socialism, are dealt with by society from the perspective of commanding social control. In the case of mental illness those afflicted, i.e. those not conforming to the norm, are subjected to degradation, segregation and isolation (in asylums) and more recently to incarceration, surgery, various chemical treatment procedures and inhuman psychological therapies, all directed towards driving home the point (to the patient as well as the population at large) that norms of society are sacred and unquestionable and must be followed at all cost.

Those whose behaviour is not accounted for by the rule-following model face not only the above stated consequences but are also labelled (eg: schizophrenic, hysterical, manic-depressive, catatonic) and stigmatised.

Erving Goffman calls this process 'mortification'. He writes (Goffman, 1984): "On admission to an asylum the 'patient' is stripped of his identity and any social support he enjoys. He begins with a series of abasements, degradations, humiliations and profanations of self. His self is systematically, if often unintentionally, mortified. The staff employs procedures on admission that complete this process of mortification—taking of life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage, undressing, bathing, disinfecting, haircutting, issuing institutional clothing, instructing as to rules, and assigning to quarters."

Mental asylums are thus not very different from penal institutions having as their main function the correction of unadjusted behaviour; a process one may call resocialisation, which at times may go to the extent of disculturation (rendering temporary incapacity of managing normal day to day life processes when one gets out of the asylum).

It has been proved adequately that the therapeutic effects of currently practised psychotherapy "are small or non-existent and do not in any demonstrable way increase the rate of recovery over that of a comparable group which receives no treatment at all" (Eysenck, 1965). Thus, concludes John Ehrenreich that psychiatry "is the branch of medicine which openly specialises in the social control of deviant behaviour" (Ehrenreich, 1978); and Thomas Szasz adds, "therapeutic interventions have two faces; one is to heal the sick, the other is to control the wicked ... contemporary medical practices—in all countries regardless of their political make-up—often consist of complicated combinations of treatment and social control ... psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behaviour annoys or offends others" (Szasz, 1974).

Beyond the asylums, in daily life, such interventions are increasingly manifesting themselves, becauses problems which are essentially social are being further appropriated by the medical professions.

Mental illness is today generally classified into two categories—*psychoses* and *neuroses*. "What most patients of the first group suffer from is anxiety or depression, which if it exists in a mild form, may only be neurosis. When it reaches a severe stage, the person becomes totally abnormal. the opposite extreme of depression is excitement or elation; when depression and elation are manifest in a cycle, it is known as manic-depressive psychosis ... (Among neuroses) the commonest is the anxiety neurosis, followed by obsessional neurosis, the compulsive urge to wash your hands, a fetish for cleanliness, an abnormal concern about pollution. All the phobias too come under this classification" (Chakraborty, 1985).

In a survey conducted recently in Greater Calcutta it was found that 140 per 1000 persons suffer from some mental illness or the other. Neuroses affect one in ten of the population. The psychotic group is smaller, 16 per 1000 persons and half of these are acute cases, incapable of functioning socially; this is a very low figure in the international context, surprisingly so in a city like Calcutta where one expects more psychotic problems since the major factor, stress, is so overwhelmingly present (ibid).

Poverty and inhuman living conditions, especially in the third world, play a significant role in determining mental health. The working classes trapped in unfavourable work situations and unhygienic conditions are probably the worst off due to their alienated state. These cases of mental disturbances may not be recorded as neuroses or psychoses but the fact remains that their mental health is poor because even obtaining two square meals is a struggle: which means a lot of insecurity and mental trauma.

Minority communities and underprivileged castes in India, blacks in South Africa and a few western countries also live under a fear psychoses that adversely affects their mental well-being. Women as a group have historically faced and continue to experience mental trauma as a consequence of their placement in a patriarchal society. Males have throughout history enjoyed the privilege of double values whereas females have always been suppressed, their entire life-cycle being explained in terms of their uterus and sexual function, especially from the medical perspective (Ehrenreich and English, 1978). This results in differences of interpretation of the same qualities held by men and women. This is explained very well in a paper by Vibha Parthasarathi (quoted by Kalpana Sharma in the Indian Express Magazine, 27th October 1985). She writes that the quality of being "open" is interpreted as "flexible" for men and "fickle" for women; the quality of being "forthright" is interpreted as "frank" in the case of men and "rude" in women; "resoluteness" as "firm" for men and "rigid" for women; "unflinching" as "strong-willed" for men and "stubborn" for women; and so on. As a consequence these biased interpretations are in a large measure responsible for the neuroses or psychoses in women.

The modern world of advertising in capitalist societies and propaganda under both political systems promote values of the status quo, numbing creativity of the human species, inculcating a consumerism that drives man into becoming an automaton; he either becomes obsessed with the advertised or propagated norms and is labelled as an obedient or good citizen or he rejects these norms and is classified as a deviant, and if the deviance goes beyond the acceptable limits the person is labelled mentally ill, thus becoming a prey to the therapies of psychiatrists and psychoanalysts.

And finally patriarchy, which manifests itself through exploitative production relations, also contributes to mental pathology. Patriarchy, besides promoting sexism and suppressing women, promotes the idolatory of the clan, the race and the nation; it is in Freudian terms an incestuous fixation. It is manifested in our times in totalitarian regimes, bureaucratisation and monopoly control of productive forces, among other things. Fromm puts this point forcefully when he points out that "nationalism is our form of incest, is our idolatory, is our insanity; 'patriotism' is its cult" (Fromm, 1956). He furthers this argument by indicating the similarities between capitalism and totalitarian socialism. "Both systems are based on industrialisation, their goal is ever-increasing economic efficiency and wealth. They are societies run by a managerial class, and by professional politicians. They both are thoroughly materialistic in their outlook regardless of Christian ideology in the west and secular messianism in the east. They organise man in a centralised system, in large factories, political mass parties. Everybody is a cog in the machine, and has to function smoothly. In the west, this is achieved by methods of psychological conditioning, mass suggestions, monetary rewards. In the east by all this, plus the use of terror (or course, the west also uses terror—the 'spectre of Communism'). It is to be assumed that the more the Soviet system develops economically, the less severely will it have to exploit the majority of the population, hence the more can terror be replaced by methods of psychological manipulation. The west develops rapidly in the direction of Huxley's 'Brave New World', the east is today Orwell's '1984'. But both systems tend to converge" (ibid).

Conclusions

Medicalisation of human mental situation, the social control that goes with it, the alienation that class-relations generate

and the general drugging of the human mind through the modern information systems have made an obedient cog of him/her. Then, if the currently prevailing social formations are largely responsible for mental distress and frustrations, what does the common man look towards?

It is a difficult question to answer. Psychoanalysis, like psychiatry, has failed in its purpose. In the west, as well as east bloc nations, the former has become only an appendage of the latter—which is highly medicalised. In the underdeveloped countries, especially of Asia and Africa, both psychoanalysis and psychiatry have not found any significant roots, but in most of these countries traditional ties are still strong enough to provide comfort from the trappings of the social system.

Isn't this itself an indicator that a community-life that is *free* from exploitative class relations, patriarchy and a centralised and bureaucratised social control system will lead us towards a mentally and socially healthier life?

It has indeed been a difficult theme to compile. All the articles, except David Ingleby's which has been reproduced from a collection of the Radical Science Collective, are on psychiatry. We begin with Dilip Joshi's Psychiatry: State of the Art, which takes a look at present day psychiatry and its medicalisation.

Next we have Annie George's article which reviews the training programmes for medical and psychiatric social work and the role social workers play in psychotherapy. Psychoanalysis, that is extremely popular in west, is of little consequence (in practice) in our country—we present Ingleby's article that deals with ambivalence of psychoanalysis. This is followed by a short piece on a psychiatrist, Anand Nadkarni's experience in becoming one. We have two review articles, one on psychosurgery by Bindu Desai and the other on gender differences by Nalini. In addition we have a long non-theme article on experiences of a participatory research project on women and health by Gabriele Dietrich.

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Psychiatry: State of the Art

dilip joshi

Psychiatry, over the years, has been thoroughly medicalised—it views mental illness as a purely biological problem. The author presents a critique of the prevailing worldview of psychiatry and its practice. He argues in favour of a discounted alliance between psychiatry and medicine so that a more human psychiatry may be evolved.

MENTAL illness seems to be the major problem of our time. In the United States doctors write 200 million prescriptions each year for psychoactive drugs. Half to one million people are treated for 'schizophrenia'. In Britain, on the other hand, 25 per cent of all hospital beds are occupied by the mentally ill. One in nine men and one in six women can be expected to enter a mental institution in their lifetime (Ingleby 1980).

Psychotherapy—Current Perspectives, a book written by a group of psychotherapists, reveals an astounding scenario. The child consults a school-counsellor, mother of the child attends consciousness-raising groups for women, father attends 'T' sessions at factory and the grand-parents participate in a workshop conducted by a professional on 'pains of ageing'. Psychiatry today permeates and encompasses all significant events in human life. (Cottle and Whitten, 1980). On the other hand within psychiatry there is no consensus about:
(a) What are mental illnesses? (b) Who should treat them? (c) What are the means (how to?) and what are the ends? (What is cure?)

We have a vast amount of literature on mental illness compared to our inadequate understanding about it. Is there something fundamentally wrong? This article takes up these issues and examines them critically.

Mental Illness Not a Disease of the Body (Brain)

One is often told during training that 'schizophrenia' is a disease of body (brain) like diabetes, hypertension (high blood pressure). One is also told that we are ignorant about the cause of 'schizophrenia' but is it also not true of a bodily disease like cancer? 'Schizophrenia' is presented as a disease of body (brain) with a fixed cause which is being found out. One is reassured that with the advance in medical technology, psychiatry will be able to solve the riddle of 'schizophrenia'.

The present day trend in psychiatry is towards explaining mental illnesses as disorders of brain chemistry. It is speculated that tomorrow we will possess such powerful drugs to cure mental illnesses that psychiatry will not exist as a separate discipline but will be incorporated in clinical medicine and even general practitioners will be able to tackle these problems.

But let us look for evidence. Seymour S. Kety has done the most extensive work on 'Bio-chemistry of Schizophrenia'. He says that his work is inconclusive about 'schizophrenia' being a bodily illness (Avieti).

One does not deny that physical illnesses and drug-induced states produce a picture resembling mental illness. But Seiger, Osmond and Mann (1969) disagree about closeness of drug induced states with real illness. Dr. Joseph Berke argues that in 'schizophrenia' hallucinations are mainly auditory. While under the influence of psychedelic drugs people rarely have hallucinations of any kind. Most of the experiences of false perceptions (illusions) are visual in nature (Berke).

One of the main theories about 'schizophrenia' is the dopamine theory. It states that the specific behavioural symptoms are produced by excess of dopamine in the brain (Kaplan and Saddock, 1980). If one finds that an abnormal behaviour (inability to work consistently, inability to relate to people, etc.) or an abnormal experience (inability to experience pleasure, feeling that whole world is against you, etc.) is accompanied by a change in body chemistry (excess of dopamine in brain) one cannot conclude that excess of dopamine is the cause of this behaviour or experience because:
(a) One considers excess of dopamine as abnormal only because one took the behaviour or experience as abnormal in the first place.
(b) One is correlating an entity in the natural domain (excess of dopamine) with a phenomenon in experimental domain which one cannot correlate scientifically.
(c) The excess of dopamine can be subsequent to the experience.

Let us further clarify the difference between a physical illness and a mental illness by taking the example of hypertension and 'schizophrenia'.

When as a doctor I find that the blood pressure of the person sitting next to me is more than 120 over 80 millimeters of mercury, I tell him that he is suffering from hypertension. Whatever my values, my beliefs they do not influence what I see or observe, hypertension remaining a similar entity all over the world.

On the other hand when a psychiatrist makes a diagnosis of 'schizophrenia' he is judging the behaviour or experience of the person sitting next to him according to certain prevalent (cultural) beliefs about human nature and what he sees is influenced by what he believes.

The findings of United States-United Kingdom Joint Schizophrenia project reveal that American psychiatrists tend to diagnose 'schizophrenia' much more frequently than their British counterparts. For a similar case an American psychiatrist will diagnose the person as 'schizophrenic' while the Britisher would not. (ibid).

Objectivity of Diagnosis in Psychiatry

"The diagnosis of schizophrenia should rest on whether a normal person understands the person concerned's behaviour"—Manfred Bleuler, a leading psychiatrist (Laing, 1982).

So how are psychiatrists different from lay people? A lay person also understands that a person is behaving in an unorthodox way, the psychiatrists call it 'schizophrenia'. But what have they gained in the process? Has calling the person 'schizophrenic' rendered his situation, his response, more intelligible? No. One feels that the exercise of diagnosis is for screening normal, good, conforming behaviour or experience from an abnormal, bad, nonconforming one; rather than to really understand the *genesis* of that behaviour or experience. This distinction is made by the psychiatrist on the basis of certain prevalent beliefs about human nature and hence in the psychiatric interview a fact never remains a fact, it already becomes an interpretation, a value judgement (Goldmann).

A-priori Assumptions About Human Nature in Psychiatry

These assumptions are based on an image of the human being as a sociable, non-violent, hardworking, rationally profit making organism. These assumptions are revealed when one sits in the psychiatry out-patient department and makes a list of most

frequently asked questions. These questions are:
(a) whether the person works regularly? (b) whether he/she mixes with others? (c) if in business, is there adequate profit making? (d) whether he/she is violent towards self or others? (Thines)

This human nature is supposed to be all pervasive and universal, according to the psychiatrist. But let us look around, let us go into the past to find out whether this is true.

Can one say that human nature is essentially peace loving, non-violent when one looks back at Nazi concentration camps, the bombing of Hiroshima and Nagasaki? Where is the sociable human nature when two communities exist side by side in the world with evergrowing paranoia about each other?

Can one find a hardworking human being amongst those few who rule the world today and enjoy at the cost of toiling masses? Isn't the wealth of many European countries smeared with sweat and blood of the colonised people?

Man is yet to be born. On the totality of images that we create by our praxis in the world depends the future image of man. As of today, this is a period of inhuman exploitation of men and women and a narrative of violence to maintain and perpetuate that oppression. It is surprising then that those who are most frequently diagnosed as mentally ill belong to the category of defenceless (poor, children, women, aged) or those whom the middle-class, superior caste/race psychiatrist cannot understand—the ethnic minorities, people who live on fringes of cities. Half a million children in the United States receive treatment with powerful psychoactive drugs for being 'hyperkinetic' (Ingleby, 1980). The incidence of 'schizophrenia' is more in the lower socio-economic strata (Lidz).

Practice of Psychiatry

"Cure is accomplished when the former person becomes an obedient robot moving around either in the chronic backwards of mental institution or without any human sense in the outside society . . ." (Cooper, 1974).

Antonin Artaud, a great poet, wrote with anguish after being given electroshocks in a hospital at Rodez "I died at Rodez under electroshocks. I say dead, legally and medically dead" (Greene).

Ernst Hemingway describing his experience of shocks to his friend said, "it was a brilliant cure, but we lost the patient. It killed both my soul as well as my mind." He committed suicide a few months later (Madness Network News, Fall 1984). A violonist who was given shocks for depression in a Glasgow hospital, could not later on give her performance as she lost her violin repertoire (Laing, 1976). Most of the groups working for a ban on electroshocks in different countries of the world claim that not only do shocks cause memory loss, disorientation wild excitement or terror, but shocks can also kill. Shock is not only a procedure wherein electric current is passed through the brain of a person but also the dehumanising ritual of being forcibly held by people, being forced to lie down, etc. which a person has to go through. Why are people not told about the after-effects of shocks? Why are they not told about the procedure? I am sure if the procedure is described to the person, he will never like to undergo such a dehumanizing experience. Shocks are either mystified—'Its only an injection', 'You will be cured', or they are offered as an alternative to long term hospitalisation. In a similar situation a group of prisoners agreed to participate in an experiment which they knew would damage their health, so as to get their prison stay reduced.

Dr Caligari's *Psychiatric Drugs*, a book published from Berkeley, informs us that psychiatric pills neither tranquillise nor elevate our mood, they actually deaden our feelings and our bodies. Drugs like thovagine, steliazine, nlehavil, haldot (all anti-

Towards a Human Psychiatry

Present day psychiatry considers the person as a passive object, who reacts in a determinate way to his situation. It shows complete disregard for human subjectivity. Between our interiorisation of exteriority (family, class experience) and our re-exteriorisation of this interiority, i.e. in the passage from exteriority to exteriority (objective to objective) there is a moment of human subjectivity. We do not necessarily reproduce in the same exact fashion the exteriority which we interiorise. In other words we can always make something of what is made of us. This is the realm of human freedom. This is ignored in the constitution of the person as passive object.

psychotics), tofanil, elavil (antidepressants) have a damaging effect on the brain.

Tandive dyskinesia is a syndrome charecterised by involuntary movements of tongue, face, neck, developing after long term antipsychotic medication. It is difficult to cure. The addiction potential of diazepam (valium, calmpose) is also mentioned in the book. A separate chapter instructs the readers on how to safely and gradually withdraw from psychiatric pills. But people coming to psychiatry departments are hardly told about the after effects of pills. Why?

Critique of Medicalised Psychiatry

In his postscript to 'Discussion of Lay Analysis' Sigmund Freud emphasised that psychoanalysis is not a branch of medicine but comes under the head of psychology and the training for psychoanalysis differs from that imparted to physicians. More important than whether the trainee is a medical graduate or not, is the specialised training for psychoanalysis. He also stressed that the trainee will have not only to study psychology but also sociology, history of civilisation, Darwin's theory of evolution, etc. But has psychiatry paid any heed to Freud's advice? No. Even to pay heed to it, it will have to read, remember his work and not repress it.

Today the alliance between psychiatry and medicine is complete with incorporation of psychiatry into general hospitals. Those who train in psychiatry are medical graduates who take up psychiatry as a postgraduate discipline, while in his days Freud defended 'lay analysis' (McGuire).

The present day psychiatry is medicalised psychiatry with its belief that mental illnesses are due to disorders of brain chemistry, with its emphasis on diagnosis and classification (labelling) and its promise of instant cures with pills and shocks.

By proclaiming that mental illness is a physical illness, it situates the problem inter-individually, allowing family and society to wash its hands of the person and hence it remains essentially status-quoist. By giving more emphasis on diagnosis and classification than understanding, intelligibility, which requires empathy, it is basically screening people who cannot fulfil the expectations the society has of them, on behalf of the ruling class.

By its reliance on pills and shocks it ends up by medicalising human problems and hence psychiatric therapy has on the contrary damaging effects.

For lay people psychiatrists wearing white coats, dispensing medicines appear scientific, objective. But if there is no consensus on fundamental issues in psychiatry, if there is more emphasis on labelling than understanding, and if the therapy is arbitrary and damaging, any amount of scientificity that psychiatry will try to bring in from outside, from its white coats, its pills, its sophisticated research on the body of 'schizophrenics', its alliance with medicine, will be futile.

On the other hand the present day psychiatry believes that the psychiatrist is a passive observer. He does not influence the situation, he does not see what he wants to see. By constituting the person as an object, an ensemble of physico-chemical entities, which is only worth effort of labelling and classifying, the psychiatrist remains totally external to the lived experience of mental illness.

Mental illness is nothing but a response of the person to his situation. We will be able to comprehend it only when we grasp the situation to which it is the response. It is also essential to understand the lived experience of mental illness with the help of mediations like family and class.

Instead of being a discipline which of necessity must give respect to the dignity and freedom of the individual, present day psychiatry is repressive. It should be our common endeavour to reinstate this respect for human dignity and freedom in psychiatry so that it will really be a human psychiatry.

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Dilip Joshi
through SHR

The Helping Profession: Is It Really Helpful?

annie george

The role of medical and psychiatric social work in dealing with the mentally ill has been considerably enhanced due to the community mental health movement. What is the role of the social worker? How adequately are they trained for handling their task? In this article the author, herself a trained social worker, addresses these questions and presents a critique of psychiatric social work programmes as they exist today in the context of the Indian situation.

IT is generally accepted today that the causative factors for mental ill health are multifarious and interlinked and so their handling on many fronts—curative, preventive and promotive—is done by a multidisciplinary team. Traditionally, and till today, mental ill health has been seen as an illness in a clinical sense, and so the doctor is the person with whom the mentally ill person comes in contact for treatment. But increasingly, and cardinally, through the influence of developments in this field in the west, other professions have been roped into the field of mental health. Psychiatric social work is one such profession.

Who is helped through the intervention of social work, the "helping" profession, in the field of mental health? What were the roles assigned to it historically, and how have they changed to fit the mental health situation in India today?

Evolution and Contributions of Psychiatric Social Work

The concept of what constitutes mental health and ill health has always varied, and with it has changed the role of the social worker. The western practice upto late 19th century was to segregate the mentally ill persons in asylums, away from the mainstream of society. Since such persons were considered incurable, no psychiatric attention was given to them; social work intervention was also non-existent. By the end of the 19th century the understanding of mental illness in western society had changed considerably: mentally ill persons were now considered "sick" and various physical and psychological therapies were tried on them. The underlying assumption of such an approach was that people became mentally ill because of their inability to adjust to the pace and demand of urban industrialised life. Various theories citing psychological factors intrinsic in the "sick" individuals were put forward as the cause of their maladjustment; but whatever the understanding and the line of treatment, the end goal of the process was definite—the mentally ill person had to be treated such that he/she would be able to adjust back to society.

In the practical application of this conceptual framework there was tremendous scope for social work. Medical and psychiatric social work emerged in the USA and Great Britain in late 19th century because doctors there felt the need for a person who would supplement the service of medical care provided through hospitals. Social workers were used by them to get a more complete picture of the patient's background by providing psycho-social data about the patient. In India psychiatric social work started because Indian doctors had gone abroad and had seen psychiatric social workers and wanted them to act as "acolyte" to the high priest, the doctor. (Marulasiddaiah and Sharriff, 1981).

Right through the sixties, in the west, the treatment of the mentally ill was predominantly individualistic, institution-based and curative; this is the approach which is prevalent in India today. The role of the social worker was to understand the behaviour of people when they are (mentally) ill, the potentialities within individuals and their families, the resources in the community, the environmental effects associated with the disease, creation of insight into their problems, to bring out a social diagnosis and to suggest means of treatment together with physical and other psychological methods which would help them *revive their strengths and become active citizens* (emphasis mine) (Marulasiddaiah and Sharriff, 1981). In other words the social worker used all possible means and resources to help the person adjust to the very conditions which caused the problem. Through experience, social workers realised that other social groups to which the mentally ill person belonged, like the family and the work group, could also be used in the process of getting the person readjusted. Thus emerged treatment methods like family centered therapy and milieu therapy.

By the seventies there was a growing disillusionment with the person-centered, curative approach. Individual care in helping the mentally ill person to adjust was time consuming, expensive, and its results were seen only after a long period of intervention. Community based mental health services were seen as an alternative. In this approach like the earlier individual-centered one, the basic understanding of mental health had not changed; the contributions of social conditions—growing alienation, pressures of urban competitive life, erosion of traditional community support systems—to mental ill health were not acknowledged. Mentally ill persons, those who deviated from the norms determined by society, still had to be adjusted to fit into that society. The difference was that the adjustment would start with the community, would focus on preventive measures and would reach out to more people by training people from the community as frontline mental health workers. For the social worker the essential difference was that instead of treating the individual as an unit of work, the community became the work unit. Her major role would now be to provide psycho-social data about the community, and to plan programmes to prevent mental illness, programmes which includes recreation facilities for adolescents, family life education, and so on. Since the community health movement has not gained much ground in India, there are not many community based mental health programmes. Activities like organised recreation activities for children, fun fairs and sports days which are organised by social work agencies for disadvantaged groups usually go under the garb of community mental health programmes. These programmes may temporarily divert the attention of the people from their problems of daily living but they do nothing to alleviate them.

Though the role of the psychiatric social worker has changed through various approaches to the treatment of mental ill health, her contribution to society has remained the same: to identify mentally ill persons, to treat them in a congenial manner through social work techniques, to resocialise the person to the requirements of society, and if such resocialisation is not possible, to segregate the person from society so that other normal people are not disturbed in their daily functioning. In fact, the social control aspects of the job generally remain in the background, and what emerges for the mentally ill person and the public at large to behold is a gentle, caring woman (psychiatric social worker) whose entire function is to be at their service and to look after their problems. Most medical and psychiatric social workers are women; other specialisations of social work like community development or criminology are considered the male domain. Medical and psychiatric social work

is probably seen by most people as an extension of the traditional role assigned to women as the caretakers of the sick and helpless members of the family. Moreover, traditionally, the woman bears the responsibility of socialising the child and psychiatric social workers, as an extension of this traditional role, resocialise the mentally ill person who has lost the social skills which are necessary to survive in an industrial, competitive world. Thus through their legitimately assigned task of labelling (diagnosis), treating and/or confining persons with deviant behaviour, the psychiatric social workers perform a subtle and sophisticated form of social control. Her efforts to identify and change the stress inducing elements inherent in the way society has been organised are negligible. The present day social work education programmes are partly responsible for this state of affairs.

Psychiatric Social Work Training Programmes

Entrants to the field of psychiatric social work are trained for the profession through a two year course, generally conducted at the post-graduate level. Some schools of social work in India offer specialised training in medical/psychiatric social work. At such schools, in the first year students are taught basic courses in the methods of social work, human behaviour, man and society, and some electives. It is in the second year generally that courses related to the specialisation are taught. These usually include courses on psychiatric information for social workers, courses on methods of social work used by psychiatric social workers—mainly casework, or working with an individual and his family—and concepts from different schools of thought, like Freud, Rank and Parsons which have practical use in casework. Much of the theoretical base and action of medical and psychiatric social work is derived from Talcott Parsons' model of the sick role, in which, sociologically, illness was seen as a form of social deviance where an individual adopts a specific role. The sick role was characterised by the patient's temporary exemption from social responsibilities, and freedom from blame for being sick. However, since the role was considered undesirable and socially not approved, the sick person was expected to seek professional help to get well, and to comply with the treatment prescribed by the medical personnel. Though Parsons' model of the sick role provides the basis of work for the psychiatric social worker, in terms of treating mentally ill persons and getting them back to perform their socially defined roles, it also is a legitimisation of the power of mental health personnel over mentally ill persons who have to comply with the treatment of the professionals in order to have the label of social deviant removed. In the theoretical part of the training most emphasis is given to casework than on any other method of social work. In casework the focus of content is on various theories which explain human behaviour and which therefore help the psychiatric social worker understand, arrive at a social diagnosis and plan out the treatment of mentally ill clients. Thus these courses tend to stress psychiatric analysis of individual problems rather than skills in dealing with the core of the problem situation itself. They are also institution centres and stress the remedial aspects in mental health (Miranda, 1985). At the level of theoretical training mental health is not seen in its wider sense with contributions from other courses on social work methods. Specialisation courses are so compartmentalised that students of psychiatric social work generally cannot take courses offered by other specialisations like community development or family welfare, even though the information content of these courses may be very relevant for the psychiatric social work student to develop a holistic understanding of her field of training.

Field work is the practical component in the training to become a psychiatric social worker. Field work experience, in which the student is attached to various social work agencies for two or three days per week for the entire period of the training, is largely limited to institutional urban settings like child guidance clinics, mental health day care centres, and psychiatric departments in wards of urban hospitals. Here the student gains maximum experience in casework or in working with individuals who are diagnosed as mentally sick. Any experience in community mental health is usually unplanned and incidental. It is expected that when students become practitioners they will be able to transfer their skills to other settings. This never really happens. In field work students spend more time learning about the "what" and the "how" in field work tasks than in engaging in the "why" or analytical and conceptual learning (Miranda, 1985). Hence, students are more bothered about what are the symptoms and how to counsel a mentally ill person than in understanding why he has been labelled as sick, and what were the forces in his immediate and extended environment which caused him to behave in a different way than is normally expected.

Field work is critical learning experience for the social work student because this is the period when her concepts about the practice of the profession are being formed, based on her practical experiences; she is also trying to work out her professional role as a social worker. Relating theory to practice becomes the major learning activity in field work. When theory and practice focus exclusively on the mentally-ill person and on his treatment so as to get him resocialised and readjusted to the demands of society, it is inevitable that by the end of the training period the student social worker has equated working on treatment and rehabilitation of mentally ill persons as the main role assigned to her. She in turn becomes a practitioner and carries on this tradition.

Relevance of Training

Observing the practice of psychiatric social work today, it would appear that the effectiveness of the training is limited to the time tested casework method. However, as Desai (1981) says, the effectiveness of a profession depends on the quality of preparation of the practitioners. The objectives of the curriculum in social work training are to prepare the type and quality of manpower capable of performing tasks and functions which ultimately achieve the goal the profession has set for itself in the context of the society in which it seeks to serve. Desai analyses and lists the social realities of India as poverty, population and its interface with problems of housing, water supply, sanitation, accessibility to services; unemployment, disability resulting from social and economic inequity, and the exploitation of the vulnerable and weaker sections of society. Constant coping with these problems could lead to a breakdown in an individual's mental health functioning. Therefore the tasks of the (psychiatric) social worker would be to identify policies and socio-economic structures which are exploitative of the majority and which are not designed to achieve social goals for all. A second major role would be to develop and/or modify services and/or institutional structures for educating people to recognise their inherent capacity for action. By and large psychiatric social workers do not perform these roles because neither at the training level nor at the practice level has it been consciously realised and acknowledged that it is these societal problems of daily living which are contributing to the mental ill health situation in India.

The present day training programmes do not address these tasks. The training curricula are basically borrowed from the west, mainly the USA. They aim at helping people adjust to an urban, industrial and metropolis dominated social milieu—because Indian social scientists accept the western model of

development for the elimination of poverty. Social work was established to help the deviants of the system to adjust to it and to provide remedial services to those who are victims of new social systems (Desai, 1981).

The training and practical efforts of psychiatric social work is relevant; to whom it is so is the question. If serving the needs of the majority of the population in order to bring them into the mainstream of development is the goal of social work, then the training for psychiatric social work, particularly the knowledge about what constitutes mental health and mental ill health, the skills in treating mentally ill persons based on the understanding of what constitutes mental health, and the values embedded in such an interpretation are not relevant to the majority of the people, not even particularly to the mentally ill. Social workers have not been able, in any significant way, to work out strategies to deal with the daily problems of living of the majority—problems which take their toll in terms of familial tensions, and mental ill health. What the professions involved in mental health have successfully done is to medicalise social problems, to make it appear that problems stemming from social causes are actually due to individual deviance, solvable or at least controllable by the individual's doctor (and others involved in the therapeutic process) (Ehreinreich, 1978). Psychiatric social work, in this sense, is very relevant to the powers that be; through the semblance of a profession based on scientific knowledge, which helps deviant people adjust, it ensures that the way society is presently organised is maintained.

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UN List of Banned Products

LAST June, the UN decided to delete all trade information from future editions of the "UN Consolidated List of Banned and Severely Restricted Products", an international directory of trade and regulatory data on over 500 products contributed by 60 countries. Just this week, the UN announced its intention to reverse that decision. The reversal came after months of lengthy debates on the issue within the UN in a highly politicised atmosphere. Ultimately, reason pre-vailed over pure politics and the public interest perspective—including trade data—emerged as the only rational solution to the debate. The 1986 edition will include trade data and the unique trade name index for pesticide and pharmaceutical products.

Hundreds of very thoughtful letters from the NGO community were in a large part responsible for allowing the debate to occur at all and for eventually helping to turn the decision in the direction of including trade data. While opposition to the mere existence of the 'List' has clearly diminished over the past several years, it has not disappeared. At the present, claims are being made that the 'List' is not really useful to governments, but is only a duplication of other efforts at information sharing laready in place in other UN agencies.

The United Nations is currently preparing its report on the Consolidated List Project for the Economic and Social Council (ECOSOC) meetings to be held in July. The office preparing the report would like to include examples of instances where the List has been useful to governments. The UN has recently written letters to countries in order to collect that information from them.

NGOs could be helpful in supporting the UN effort to collect data on the List's usefulness in a number of ways:

1 Encourage your government to reply to the UN's request for information. The UN has sent requests for information on the 'Lists' usefulness to World Health Organisation correspondents, United Nations Environment Programme correspondents, and the United Nations Development Programme's Resident Representative in all countries, and have asked those Reps to contact government officials for that type of informaton.

2 Contribute your own examples of how your organisation has used the List to bring about positive changes in laws or practices in your country. Brazilian groups, for instance, have used the UN Consolidated List in their efforts to persuade their government to severely restrict certain very dangerous pesticide products. A British organisation has reported that it has found the List very useful in its work with the United Kingdom's Food and Environmental Protection bill.

If you do send data on positive contributions of the 'List', please try to make your descriptions as specific and as well documented as possible. For example, it would be helpful to include the date of any legal or administrative action taken and a copy of the actual taxt of the law with your description of the action. If it is impossible for you to collect background documents, but you know of an action that has been taken as a result of the UN 'List', please report it anyway. Background can be collected later, if needed. All information must be received by May 15, 1986, it is to be included in the UN's format report for the Economic and Social Council. The UN address is: Assistant Secretary General, United Nations, DIESA-PPCO, 18th floor, New York, New York 10017; USA. Also, please send a copy of all correspondence to us for our information.

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The Ambivalence of Psychoanalysis

david ingleby

Almost since the beginning of the century, psychoanalysis has sat like an undigested meal in the collective stomach. Unable finally either to assimilate or eliminate it writers have endlessly churned over its merits and demerits. The list of books on psychoanalysis which are offered to the public year after year never ceases to amaze. For, as well as being one of the most daring and radical ideas ever put forward, psychoanalysis is also part of a deadening and conformist apparatus. This paradox, which underlies the permanently troubled relationship between psychoanalysis and the Left is the subject of the article, condensed from "Psychoanalysis Groups Politics Culture" edited by the Radical Science Collective Free Association, 1984.

The Essential Ambivalence

WITHOUT doubt it is the ambiguous political message of psychoanalysis which has kept the discussion open so long. If it were possible to classify it once and for all as 'progressive' or 'reactionary', the issue would long since have been dropped. Writing a political character reference for psychoanalysis is no easy matter. So deep are the contradictions involved that one comes to mistrust anybody who has arrived at a simple conclusion 'for' or 'against'.

The political arguments against are well known. As a therapy, psychoanalysis can be authoritarian to the point of 'brainwashing' its patients; and concerned both with 'inner' factors to the exclusion of 'outer' ones, and with adjusting the individual to the *status quo*, rather than society to its inhabitants. As a theory, it is reductionistic, ignoring social factors and obscuring political tensions, and embodies many conservative and socially pessimistic assumptions. When this theory becomes disseminated as a popular world-view, we are in the grip of an ideology which stifles political action even before it can be expressed.

Yet as often as it is vilified, psychoanalysis is redeemed by leftist (and feminist) enthusiasts who come to its rescue. In the Frankfurt School tradition, it offers, first, a critique of the collective psychoanalysis which makes capitalism tick (Reich, Adorno, Marcuse); and, second, a mode of analysis—'critical self-reflection'—which provides a paradigm for 'emancipatory' thought (Habermas). In French structuralism (Lacan, Althusser), it decentres human subjectivity away from the Cartesian ego, in a paradigm shift as radical as that achieved by Copernicus four centuries before. For those seeking to give content to the slogan, 'the personal is political', it reaches beneath the banality of everyday consciousness to grasp the processes which underly the power-structure of relationships. Lacking any serious competitors on this terrain, psychoanalysis is likely to survive any denunciation its critics heap upon it.

We are not likely to find which side psychoanalysis is 'really' on by scrutiny of Freud's own political views. Aside from the fact that quotations can be dredged from his writings which show him in any light one pleases, the assumption on which such a search is based is a faulty one; there may be little correspondence between an individual's conscious attitudes to society and the message which speaks through their writings and actions.

The truth is, as I shall attempt to show in this essay, that the political character of psychoanalysis is *inherently* ambivalent; this is due, not only to the fact that different readings of it can be produced which argue in different directions, but also to certain contradictions built into its practice and theory.

Psychoanalysis As Therapy

The strongest criticisms of psychoanalysis as a set of practices arise from the fact that these practices are part of a system, labelled by Kovel (1980) the 'mental health industry', which basically exists because of its effectiveness in maintaining social order. Psychoanalysis shares with other types of 'mental welfare' concern to adapt or adjust individuals to their allotted place in society, by reference to an hypostasised set of norms of 'mature' human behaviour. Like them, it 'blames the victim' for his or her breakdown, leaving unscathed the larger social framework within which breakdowns occur. Seeing itself as a technology, it dehumanises its patients by submitting them to a rigid set of rules and modes of understanding; it infantilises them, the better to be able to control their development.

The same criticisms can be made of virtually any other aspect of the mental welfare system. It is a convenient oversimplification to say that this is because the system is based on psychoanalysis; in reality, the system is formed out of many different theories and practices, and what is visible of psychoanalysis within it is only the lowest common denominator which it shares with these other approaches. Berger (1955) may be right in claiming that, if Freud had not existed, American society would have had to invent him, but what this means in fact is that the success of psychoanalysis within the mental health system was (to use a favourite term of Freud's) overdetermined. Some of the determinants had little to do with Freud, and much more with the demands of the system.

That system, to a large extent, can be identified with psychiatry, but we must not overlook the dialectical change which psychiatry and psychoanalysis wrought upon each other. Unfortunately, most of the political critiques of psychiatry are focussed on precisely those parts of it which resisted this transformation; anti-psychiatry, and accounts of 'the medicalisation of deviance', have as their point of departure State-run, asylum-based, and physically oriented methods of treatment. Psychoanalysis, on the other hand, normally takes place with a private contractual relationship between client and professional; it is seldom institutional; and its method is purely verbal. Moreover, far from being something that can be imposed on people, it in fact demands from them a level of motivation which leaves many patients emotionally and financially exhausted. The continuity with nineteenth-century asylum psychiatry is an illusion; in reality, psychoanalysis resolved a profound crisis in mental welfare, by providing the *savoir* for new forms of intervention aimed at the population *outside* the asylum. Freud, of course, was not a psychiatrist but a neurologist, and from his out-patient practice he brought into psychiatry a method of dissecting everyday lives which the asylum doctors, with their largely cadaverous population of subjects, could never have developed.

A critique which can encompass psychoanalytic practice has to take as its starting-point a whole system for the management and surveillance of social life, the 'psy complex', of which traditional psychiatry forms only the backstop. The psy complex is an ensemble of agencies, including clinical, educational, developmental and industrial psychology, psychotherapy, and social work, whose discourses are not confined to particular sites of professional intervention, but which traverse the family, school

and work-place—indeed, 'the social' itself. The most effective ways of analysing this system have come not from anti-psychiatry, but from the 'post-structuralist' writers surrounding Foucault: Castel, Donzelot, Deleuze and Guattari.

Apart from the fact that these writers adopt a much broader definition of the mental health system than the anti-psychiatrists did, they diverge from the latter on three fundamental issues. The first concerns the relation between professionals and the State: whereas anti-psychiatry saw the former as agents of the latter – a kind of mental police force — writers on the psy complex emphasise its disorganised nature and its tendency to create its own goals. The second difference concerns the nature of the power exercised: for anti-psychiatry, this was essentially repressive, being concerned to stop people doing things they weren't supposed to. Post-structuralists, however, stress 'productive power' – the dissemination of discourses among a receptive population, discourses which shape and structure new forms of subjectivity. Lastly, whereas, for anti-psychiatry, the medical model and positivism played key roles in the legitimation of psychiatric interventions, the post-structuralists treat with contempt the notion of ideology and ideology-critique.

At least on the first two points, the post-structuralists' approach to the psy complex seems far more relevant for understanding psychoanalysis. (This is hardly surprising, for these authors to a great extent approached the subject by way of psychoanalysis.) For them, the growth of interventions in mental welfare has to be seen in the context of a gradual transfer of power from the family to other agencies.

With the decline of patriarchal power under capitalism, many of the traditional functions of the family in controlling and caring for individuals could no longer be exercised. The welfare state came into being through the piecemeal replacement of these functions by public agencies. Important among these, of course, was asylum psychiatry; but this came to be seen as not only an ineffective response to social ills, but one which came too late. Just as good drainage and physical hygiene had improved the physical health of the population, so analogous measures would guarantee its mental (and moral) health. The breeding-ground of all disorders came to be seen as the family, and it was on this site that measures were concentrated.

As Donzelot shows, a large apparatus was set up to monitor and deal with the 'failures' of family life, opening up in the process new avenues of intervention into the family itself. The achievement of psychoanalysis was to provide a systematic theory, a set of norms and a technology for regulating private lives. Some of its major advances were in fact made in the context of the two World Wars, when new opportunities arose to develop psychological remedies for military problems. Psychoanalysis achieved its dominant position within American psychiatry, however, by riding in on the wave of the Mental Hygiene Movement, which sought a radical reform and broadening of mental welfare services. This approach, with its emphasis on detection and prevention of mental disorder at an early stage, called into being a system as much concerned with socialisation as with care and relief.

The precise role of psychoanalysis within this system is perhaps the key issue that most sharply divides its supporters and detractors on the Left. According to Althusser (1971, p.178), the French Communist Party's rejection of psychoanalysis was based on a failure to recognise the travesty which American psychiatry had made of it: 'the "dominant" ideas, in this case, were playing their "dominating" role to perfection, ruling unrecognised over the very minds that were trying to fight them!' Lacan's more authentic reading would show that the biological and medical interpretation of psychoanalysis was, in fact, a heretical departure. Jacoby (1975) repeated what the Frankfurt School had argued all along, that psychoanalysis was not about 'nature' so much as 'second nature', quoting Marcuse (1962) as follows: "Freud's theory is in its very substance 'sociological', and no new cultural or sociological orientation is needed to reveal this substance." According to Jacoby, the authentic gloom of Freud's analysis of modern life had been excised for the American market, and replaced by a view in which achieving harmony between individual and society was merely a technical problem.

It is indeed true, as Paul Hirst points out (1981), that psychoanalysis has been by no means as universally influential in the formation of the psy complex as Donzelot and others assume. However, the mere fact that analysis remains a minority treatment should not blind us to the enormous influence that Freudian ideas have had on a wide range of forms of intervention. Even where an approach was adopted (such as learning theory) which nominally opposed psychoanalysis, such alternatives were fashioned in debate with psychoanalysis – a debate conducted in its own terms. And to complain that psychoanalysis was unwillingly co-opted into the mental welfare system is to ignore the prodigious efforts made by Freud himself to gain a foothold for it in the USA (see Castel, 1982, p.324).

This widespread dissemination of psychoanalysis, however, was indeed accompanied by a transformation of its original principles. Freud's ideas were only taken up in so far as they suited the aims of the psy complex; it would be as misleading to read off his views from the practices which purport to be based on them, as to try and infer Piaget's thought from the 'child-centred pedagogy' which claims him as its mascot (Walkerdine, 1984). In both cases, the take-up was selective, and one can imagine other uses to which the theories could have been put. To decide what psychoanalysis 'really' is, is like speculating about what Jill would be like if she hadn't married Jack twenty years ago; Jill may have had characteristics before the marriage which seem to have disappeared now, but on what grounds can we claim that this was the 'real' Jill? Nevertheless, in concentrating on the lowest common denominator which psychoanalysis shares with the rest of the psy complex, we may miss more essential features which set it apart.

The very lowest of these common denominators is something so obvious that one may easily overlook it – the *individualism* of psychoanalysis; the fact that it treats problems arising on social life in terms of the properties of individual subjects. It is the defining feature of all psychology that it takes the individual as the unit of analysis; Henriques et al. (1984) see this as intrinsically connected with psychology's functions of surveillance and regulation.

At the next level of specificity, which sets psychoanalysis apart from organic or genetic theories of personality, but leaves it undifferentiated from other environmentalist approaches, is the conviction that the determinants of individual dispositions are to be found in childhood, and that treatment can modify these dispositions. This, it will be noted, says nothing about the unconscious, or about sexuality, therapeutic technique, or the discontents of civilisation. To that extent it overlaps with the principles of behaviourist learning theory: Castel (1982, p.51) points out that, so far from being sworn enemies, psychoanalysis and behaviourism in the USA have often made a fruitful partnership. (It was J.B. Watson himself who suggested that 'any man in a position to serve in high public office should be obliged to submit to psychoanalysis'.) But only a superficial acquaintance with the content of the two theories is required to see how much of Freud's thought must be set aside to make such a partnership possible.

Whereas the focus of intervention for the asylum system had been insanity, twentieth-century forms of mental welfare

concerned themselves with malfunctioning in everyday settings – 'failure to cope' (Armstrong, 1980). Such failures were encoded via the theoretical construct, 'neurosis', which – in the new sense which he gave to it – was Freud's chief gift to the psy complex. The concept of the unconscious, on the other hand, was taken up somewhat selectively by American psychiatrists. Rather than furnishing them with a critical perspective on bourgeois society, or a 'decentering of the human subject', it mainly served to reassure them that they could safely adopt a psychological approach without giving up their traditional claim, as doctors, to know better than the patient what was wrong with them. The notion of the unconscious thus played a central part in building a professional ideology for the psy complex (Scull, 1979). A theory which relegated the patient's own views about what was going on to the status of fantasy, and which took disagreement, or 'resistance', as a sure sign that the professional was in the right, did wonders for professionals anxious to secure their cognitive authority as experts on the field of human subjectivity.

As I have remarked above, classical Freudian therapy was by no means the main contribution of psychoanalysis to the psy complex. Such treatment was too expensive and time-consuming to be suited to more than a tiny minority of cases: for other patients, and other fields of intervention, new 'psychodynamic' methods had to be evolved. The most obviously recognisable are the post-Freudian, neo-Freudian, and even anti-Freudian forms of individual therapy, which sprouted prolifically in the fertile soil of the American market. In addition, Freudian principles were extrapolated to the construction of institutional regimes, of which group therapy was the mainstay; in this case, the object of transference became the group, rather than the doctor running it. When such methods were employed in the construction of therapeutic communities, we see a remarkable revival of the moral treatment pioneered over a century before by Tuke and Pinel. The aim of both treatments was to recreate the family environment in which disorders had supposedly arisen, this time under strict technical control, so that the deep-seated problems could be 'worked through' in a new context.

Other forms of intervention did not use Freud's prescriptions regarding therapy, but instead took his notions about development and family life as their guiding principles. Social workers, for example, did not ask their clients to free-associate or produce dreams, but they commonly understood the client's attitude to them in terms of 'transference', and attributed their problems to the insidious workings of unconscious fantasy – rather than to real social difficulties, which they had no mandate to remove. Agencies concerned with the promotion of norms of family life (such as family or juvenile courts) looked to psychoanalysis for the normative principles which defined a 'healthy' upbringing (e.g. the notion that boys need a father in order to grow into men). The wide range of services designed to monitor and regulate the environment of early socialisation (child guidance clinics, parent education courses, early detection schemes) was founded on the Freudian dogma of the infantile origins of neurosis – even though actual psychoanalytic theory was from time to time deemed unfashionable. John Bowlby's 'attachment theory', for example, is a set of ideas which have been highly influential in forming pedagogic attitudes and public policy, based on a bowdlerised – or should one say Bowlbyised? – version of analytic theory.

Wider afield, we may note the influence of psychoanalysis on marketing, on industrial organisation, and educational practices. Finally, there is the dissemination of Freudian ideas into popular culture. This process, which by-passes the professional nexus, is an aspect of what Brinkgreve et al. (1979) term 'proto-professionalisation', and is perhaps the most far-reaching of the effects of psychoanalysis. In the USA, it has not merely restructured people's ideas about what would constitute an adequate response to personal difficulties; it has become a world-view. As Castel (1982, p.261) puts it, 'Psychoanalysis was the main instrument for the reduction of social issues in general to questions of psychology.'

To describe the political character of psychoanalysis, however, it is not simply to list the types of intervention which it informed, without describing the content of the interventions. What sort of values and social ideology were associated with the name of psychoanalysis?

Here we reach the kernel of the contradiction which forms the topic of this essay. For to characterise psychoanalysis simply as 'conformist' or 'libertarian', 'progressive' or 'reactionary', 'pro-family' or 'anti-family', is impossible; in reality, it is all of these things. This ambivalence can be traced to the essential paradox of the welfare system of which psychoanalysis forms a part. For at the same time as it maintains and reinforces traditional forms of social life – in particular, the family—the psy complex undermines their very basis, by taking away their rights to self-determination. To adopt a global metaphor, it props up the ailing regime of the family, by turning it into a puppet dictatorship or client state with no real autonomy. Thus, the psy complex does not simply reinforce the family, nor simply undermine it. In a subtle holding operation, it manages to do *both*.

This point is made most effectively by Donzelot (1979), who compares Freud's role in the social realm to that of Keynes in the economic. Just as Keynesian economics maintained the mainspring of capitalism—the profit motive—but brought it under political control with a system of checks and balances, so Freud devised a technology which enhanced individual autonomy in some respects, yet retained the family as 'the horizon of all individual paths' (op. cit., p.232). In doing so, he struck the necessary balance between 'the necessity of imposing social norms of health and education, and that of maintaining the autonomy of individuals and the ambition of families as a principle of free enterprise' (ibid.). (There is a further parallel between Freud and Keynes, which Donzelot does not remark, but which is pointed out by Hirst (1981): that the doctrines of both were significantly distorted by the agencies which took them up.)

Though Marxists have long emphasised the role of the family in physically reproducing and servicing producers and consumers, Donzelot's emphasis on the family as a generator of 'ambition' (what we might call 'the Dallas principle') points to individual identity and motivation. Ambition, in fact, is not quite an adequate term to describe the scenarios and compulsions which the family bequeathes to its offspring. We must also take into account the mechanisms described by Chodorow (1979), through which the urge to mother reproduces itself, and also the general process of appropriation of cultural resources posited by Vygotsky and elaborated by the Berlin school of 'critical psychology' (see Elbers). The more we study these processes, the more illusory becomes the opposition of individual autonomy and family structure; the two are, in fact, mutually constitutive.

The ambivalence of psychoanalysis in relation to the family lies in the fact that it can unmask, and potentially dismantle, the mechanisms which hold the family together; it can untie the sacred bonds which hold fast man and woman, parent and child, in its stifling embrace. Yet it can also use this knowledge to tie the bonds even tighter, if it chooses. The wealthy intelligentsia who were the first clients of psychoanalysis (and will probably be its last) sought an escape from conventions of family life and sexual morality which were seen as no longer functional (what would nowadays be called 'getting rid of your hang-ups'). Castel (1982, p.32) claims that the first adherents of psychoanalysis in the USA were 'in rebellion against New England puritanism and

moral conformity', and no doubt Freud served them well. Yet the extent to which such an escape was permitted was circumscribed by psychoanalysis itself; and there is little doubt that, especially in the versions produced for consumption lower down the market, psychoanalysis defended more traditional values than it opposed.

It did so chiefly by reducing the elements of human existence to the nuclear family (what Deleuze and Guattari (1977) term the 'mama-papa matrix'), and by insisting on the inevitability and universality of certain emotional patterns, notably the Oedipus Complex. (If you were unfortunate enough not to have an Oedipus Complex to start with, Deleuze and Guattari wryly note, the analyst would start by installing one for you.) In addition, the dominant American version of psychoanalysis (ego psychology) emphasised the reinforcement of the ego, that is, of the 'reality principle', which is as much concerned with social realities as with physical ones. By conflating the two sorts into one absolute and unquestioned principle, psychoanalysis reified the social order into a timeless law. Thus, the conservative effects of psychoanalysis were closely bound up with the theory underlying it—a topic we shall deal with in the next section.

We may analyse the political stance of psychoanalysis, not only in its attitude to family structure, but also through its dealings with the individual subject. Here, criticisms relate to the power-relationship between analyst and patient, and the picture (once again) is by no means straightforward.

The commonest criticism, from a liberal standpoint, is that psychoanalytic technique is authoritarian and manipulative; it exercises a kind of totalitarian power that treats the patient as an object, or at best a sort of child. Castel (1972) stresses that, despite the liberal connotations of 'free association', the power-relationship between analyst and patient is highly asymmetrical; the analyst, in the name of 'technique', banishes certain topics by treating them only as masks for other topics. Any questioning of the way the analyst exercises his or her powers, for example, is treated as material for interpretation only. This one-sided relationship parallels that to be found between professionals and clients throughout the rest of psy complex. Elsewhere (Ingleby, in press) I have argued that the power of these professions is very largely based on the parental nature of the relationship which is on offer. (To this it shoud be added parenthetically that the *style* of parenting offered has changed in recent years, away from an autocratic and omniscient posture towards a more democratic and 'client-centred' one.)

Yet it is too simple to regard psychoanalysts as paternalistic in the same sense as priests, doctors or social workers. What is unique in analysis is the fact that this 'transference' is quite explicit and becomes, indeed, the main vehicle and topic of the therapy. Though it looks as if the analysts are merely aiming to install themselves in the parent's place, the better to control their patients, it is paradoxically the aim of analysis to destroy the very scenario on which it is built. Analysts are supposed to act as a 'blink screen', in order to reveal the images being projected on to them. They are, in effect, playing at not being there, in order to demonstrate that the patient's attitude to them is not based on reality, and must therefore be given up. So, far from telling patients what to think or do, much of their efforts go into sidestepping the patients' attempts to get them to do just this.

In psychoanalysis, then, transference is like a ladder which is thrown away when the goal is reached; not to have 'worked through' it thoroughly is the tell-tale sign of an 'incomplete' analysis. The aim of analysis is a relationship thoroughly cleansed of all parental undertones, which enables the patient to dismantle the familial scenarios which have previously structured and dominated his or her life. Doesn't this sound like emancipation?

The critics, however, are not attacking the ideal outcomes of analysis, but what goes on within it, which is rather like a game of football played on a sloping pitch. What is constitutive of dialogue is the equality of the speakers—the fact that both sides respond to each other's utterances according to the same rules, and accept a commitment to respect each other's communicative intentions. A situation in which everything one partner says is routinely reduced by the other to the status of material for interpretation is clearly incompatible with this ideal. Indeed, as Lomas (1982) points out, it is probably rather bad for people—especially if they find relationships problematic in the first place. The lack of reciprocity between analyst and patient makes the relationship less than a human one: Freud's 'rule of abstinence' specifically forbids analysts from presenting themselves to their patients as *persons*.

Psychoanalysis, however, never set out to be a humanistic or phenomenological method. It is true that understanding another's point of view requires treating them as an equal in the dialogue; but if you want such a therapy, the analysts would say, you are free to choose another variety such as client-centered therapy or (better still) co-counselling. Psychoanalysis, as Ricoeur (1970) pointed out, is not a species of phenomenology, and its method can never be purely hermeneutical; its systematic mistrust of the patient's viewpoint is required in order to gain a leverage on resistance and to reveal the patient's compulsion to lie about certain topics. One dosen't enter into negotiations with the Unconscious. To be liberated from one's own self-deceptions, which is the sort of emancipation Habermas (1972) sees in psychoanalysis, one has therefore to forego the 'unconditional positive regard' enjoined on therapists by Carl Rogers.

But the problem with this ideal of critical self-reflection is: where do the criticisms come from? If they come from an authority regarded as absolute, the so-called emancipation leads straight back into domination. (This, in fact, is the basic criticism of 'critical theory'). Now insofar as the criticism of one's self-perceptions comes from the analyst in person, we have seen that the authority ascribed to this figure is but a symptom of immaturity, which is fostered only in order to eradicate it. The 'full analysed' patient is free to treat the analyst as a cognitive equal, whose interpretations may reasonably be rejected if one can come up with better ones.

To see the analyst in *person* as the locus of authority, however, is a basic error. As we have seen, technique requires that the analyst's person should be kept totally hidden (witness the placing of the chair behind the patient's head); the interpretations come, in fact, from the doctrines of psychoanalysis, which the analyst represents in much the same way that the priest represents the doctrines of the Church, ('Not I, but Freud within me. . .') Thus it comes as no surprise that the patient's interpretations can stand on equal terms with the analyst's; the acceptability of *both* depends on their conformity with the framework of psychoanalysis. What the patient submits to, is not the rule of the analyst, but the rule of *analysis*, to which the analyst is every bit as subject. The real authoritarianism of psychoanalysis lies, not in the domination of patient by analyst, but in the domination of both by a analytic doctrine.

This is not mere hair-splitting: it is the resolution of the paradox that 'working through the transference' abolishes the analyst's authority, while building up that of psychoanalysis itself. I would submit further that the relationship to psychoanalysis itself is also ruled by irrational, unconscious processes, and that *this* form of transference is never worked through, since the analyst is likely to be as thoroughly immersed in it as the patient. That psychoanalysis is a supernatural

authority of analysts, as well as for patients, is betrayed by the curious behaviour of its practitioners towards their profession. To some extent their protectiveness is justified by the necessity of defending it from the real enemies that surround it; but their belief in its intellectual omnipotence, their obsessional preservation of its rituals (see Lacan, 1973), their scornful attitude to outside criticism and internal heresy—all these are more the hallmark of religion, than of a practice that claims to be the quintessence of rationalism. What the analytic community fails to understand is that it is not the truth of its beliefs which needs defending, but the grounds on which they are arrived at. Psychoanalysis can never claim legitimate authority if it is presented as a divine revelation.

We thus arrive at the conclusion that, although psychoanalysis is concerned with raising consciousness, and thus with raising certain powers of the self, it does so by attenuating certain other powers. Though productive, in Foucault's sense, it is also repressive; it demonstrates how wrong it is to regard productive power as *replacing* the repressive sort.

The way in which psychoanalysis 'produces' new forms of subjectivity, both for patients and in the culture generally, is the same as the process by which those around the child create his or her subjectivity in the first place. To understand this process, it is necessary to introduce the ideas of Vygotsky or Mead rather than Freud himself. The disclosure of psychoanalysis provides a framework of interpretations and implicit responses, in terms of which individuals may orient and articulate themselves; it thus gives them a 'position' within a discourse, in which to exist as subjects. Autonomy and awareness come into being in the space between analyst and patient (Ingleby, 1983).

This process also describes the productive effects of psychoanalysis within the culture generally. According to Foucault (1978), sexuality was not 'repressed' in the Victorian era, but endlessly talked about at a professional level; Freud did not shatter a silence, but merely transformed one discourse into another one. The discourse about sexuality (which had its ultimate origin in the religious confessional) embodies the codes which structure and regulate social life. Though these codes function 'productively', they are nevertheless imposed in a thoroughly 'repressive' way—as is also true, incidentally, of the codes within which subjectivity originates in childhood. Every discourse has a non-negotiable foundation which must be accepted as a condition of participating in it. As English people know from birth, there are things one simply doesn't talk about, and things one simply doesn't do: the child soon discovers that to certain 'why?' questions, the only answer is 'because'. It is in the parts of itself that the discourse does not allow to be questioned that its repressive power is concealed. In psychoanalysis, these parts are rather extensive. As Donzelot puts it (1979, p.230), 'the discourse of the psy professions credits the family with being both the only model for socialisation and the source of all dissatisfaction: it enables them to circumscribe the position of their clients, to mark out its circuits and block it exists.'

Psychoanalysis As a World-View

To bring in psychoanalytic theory at this point is not to change the subject: rather, to try to analyse the discourse of psychoanalysis as if it did not have an explicit and elaborate theoretical basis would be absurd. The theoretical counterpart of the 'familialism' embodied in psychoanalytic practice is the Freudian insistence on the elemental nature of certain types of family relation as the cradle of subjectivity. In this gaze, every influence on socialisation except that of the family is rendered invisible.

Not only does the family become 'the horizon of all individual paths', but it is a family frozen into the particular historical form in which Freud happened to find it. Marcuse may be right to argue that Freud's theory 'does not require the addition of a sociological dimension', in the sense that it places development firmly within the parameters of a basic social institution; but these parameters function exactly like constants in a physical law—they do not explain anything since they can never vary.

One might argue that Freud treated the social order of his time as a constant out of conscious conservatism, because he did not think there could be a better one; but in fact the theory that he wrought gave him very little choice, since it insists that this social order is the only possible one, given the 'human nature' out of which it has to be constructed. Freud did not see political ideals such as equality between the sexes, solidarity among mankind, or fulfilment in work as either practicable or desirable, save in miniscule amounts. This is because, on his view of human nature, alienation in all of its forms is inescapable. American psychiatry thus did not suppress the 'radical vision' of psychoanalysis, as Jacoby or Althusser would have us believe: there was no such vision to suppress.

The Inevitability of Alienation

For Freud, civilised man was inescapably at loggerheads with himself and with other men—and increasingly so as civilisation progressed. Both intelligent behaviour and social organisation entailed conflicts with human nature which made frustration inevitable: in Freud's metapsychology, the relationship between Ego and Id was essentially one of colonisation. This set severe limits on what could be achieved by therapy, and the optimistic project of using psychoanalysis to produce a happy reconciliation between individual and society—as American Freudianism sought, by and large, to do—was a hollow travesty of Freud's own philosophy. 'Transforming hysterical misery into common unhappiness' was the most that Freud claimed to do for *his* patients (1984/1954). Neither, of course, could Marxism free us from our chains, for the chains were part of our humanity itself.

To mitigate the severity of Freud's diagnosis, Marcuse (1962) introduced a distinction between 'basic' and 'surplus' repression—the former being that which was required to maintain civilised behaviour generally, the latter being added to this by forms of social domination. As far as Freud was concerned, however, the removal of 'surplus' repression would make hardly a dent in the sum of human misery. In the following sections I shall examine the different ways in which psychoanalysis can be thought to imply the inevitability of conflict. Freud's belief in this inevitability was, as he would say, 'overdetermined'; several different lines of reasoning led him to the same conclusion.

The Axiomatic Approach

Occasionally Freud makes it clear that for him, the opposition between 'reason' and 'instinct' is axiomatic, inherent in the concepts themselves. In accepting this presupposition, he was merely subscribing to the dominant conceptual framework of his time; that 'natural' desires were inherently 'unreasonable' ones was, for the average citizen of the nineteenth century, an unquestionable piece of wisdom, and we will be committing a pardonable solecism if we regard Freud as a typical Victorian in this respect. The dualism can of course be traced back to Descartes, and still further—although it was not without its critics, such as Rousseau, in the romantic epoch.

We see Freud elaborating this idea in his discussion of aggression in the case of Little Hans (1909/1956): Here, he refers to:

> . . . a universal and indispensable attribute of all instincts and impulses—their 'impulsive' and dynamic character, what might be termed as their capacity for initiating motion (p. 28).

The attribute, Freud goes on to suggest, lends to all conduct an aggressive (and, by implication, anti-social) character.

Horowitz (1977) demonstrates the same sort of preconception in his assertion that human drives are inherently 'distant from reality' (p. 9). Having accepted this idea, of course, Horowitz commits himself to a form of 'basic repression' that effectively pre-empts much of his subsequent discussion. A little conceptual analysis, however, soon shows that this notion is not a logically necessary one. For if what we mean by 'instinct' is simply an end which the organism innately seeks, then instincts have to be controlled merely because they lack form—not because they have the *wrong* form. In this sense it is a category-mistake to see an opposition between reason and instinct, because they are logically not the kinds of entities that can be in conflict. Rationality is concerned with means, instinct with ends, and insofar as rationality provides the means of gratification of instinctual needs, it removes a conflict rather than creating one.

Clearly, there are no grounds here for regarding the relationship between Ego and Id as one of repression; the relationship between cognitive and motivational mechanisms is essentially one of cooperation, not competition. Opposition can only arise because instincts themselves conflict with one another, or because the human mind inherits irrational modes of thought in addition to instincts themselves. However, making this elementary point does not go very far towards refuting Freud's pessimism; precisely such postulates form the basis of his whole theoretical system.

Elsewhere (Ingleby, 1983) I have tried to show that Freud's failure to explain the origins of rationality and consciousness comes from looking in the wrong place—in the individual, instead of 'the ensemble of social relations', and that this reflects a contrast between two world-views, 'Enlightenment' and 'Romantic', in terms of which most psychology remains rooted in the former camp. A theory of the social construction of the ego is implicit in the *practice* of psychoanalysis, and can be articulated in theory with the help of constructs borrowed from Mead, Vygotsky, and recent developmental psychology inspired by these two.

The Competitive Paradigm

I hope to have shown in the above that Freud approached the field of psychology with strong preconceptions about the inevitability of conflict between man and other men, nature and himself. (The conflict between man and woman is another part of the story, too, but one to which I have not been able to do much justice here. See however, Chodorow (1979, Ch.9).) In the case of libido, it is primarily because Freud assumes that the patriarchal nuclear family is inevitable that he sees frustration as necessary; primary process, however, constitutes an apparently innate mode of unreasonableness which militates against adaptation to *any* form of society. I have argued that it is the latter, cognitive postulate of Freud's which most seriously undermines a belief in social progress.

Though I am thus proposing that part of Freud's pessimism should be regarded as warranted, I have argued that most of it is not and it is therefore interesting to consider where his beliefs about human nature might have come from.

Chiefly, it would appear that it is Freud's tendency to ignore the social context of his observations that leads him to make the inferences he does. Freud's method was essentially ahistorical, in that he attempted to infer the nature of what had been repressed from its (unconscious) form after repression—without taking into account the possibility that whatever led to its being repressed in the first place might also have affected its form. Had he done so, the act of repression would have lost its self-justifying appearance, and Freud would have had to seek elsewhere the reasons for man's self-alienation.

For Freud characterises the Id in the same way that white Americans characterised the Red Indian, and colonial peoples generally have characterised the victims of their exploitation. The Indian had to be brutally repressed, so the myth ran, because his behaviour was lawless and wanton; likewise with the 'criminal violence' of the Algerians under the French—so coolly demythologised by Fanon(1967)—and so too with the lawlessness of children, mental patients, the working class . . . and the Id.

But these myths can only be sustained by leaving out of view the political facts of the case; the restoration of historical perspective brings back the justice and intelligibility of what has been repressed. We see that the domination and exploitation of the colonised person *produces* the characteristics which are supposed, by entirely circular logic, to justify it. Thus, the behaviour of the Indians does not reflect the intrinsic character of their culture, but that of the oppression they experienced; likewise, the 'seething chaos' of the Unconscious does not reflect man's biological predispositions so much as the savage force by which they are suppressed.

In order to understand what Freud found in the Unconscious, then, we must bear in mind the violence with which nineteenth-century Europe exploited its citizens—something to which Freud was remarkably insensitive, as his discussion of the case of Schreber demonstrates (Shatzmann, 1973). (For all this, we must hastily disavow the attitude that Freud's observations were somehow unrepresentative of civilisation before and after.)

Thus, we can see that the myth of inherent opposition between nature and culture was congruent with Freud's own conventionally conservative politics; precisely because this myth renders invisible the objective contradictions in society. Viewed in this light, Freud's theories seem not so much a challenge to the received ideology of his time, as a new and sophisticated reformulation of it.

What is this ideology? I have called it the 'competitive paradigm', because it sees any gain to one individual as entailing a corresponding loss to another. This, of course, is also the ideology of 'possessive individualism' (see Macpherson, 1962); although this view of society has its roots in the eighteenth century, it has enjoyed a sudden and spectacular revival in recent years, as part of the philosophy of monetarism. The concept of 'free enterprise' embodies an implicit assumption that enterprise which is free is competitive, because human nature is such that people would never of their own accord enter into cooperative arrangements. (The fact that even under capitalism, they persist in doing so, is always conveniently overlooked.) 'Laissez-faire' economies, instead of being seen as the forced contrivances which they are, are implied by their very name to be the outcome of letting things happen 'naturally'.

The assumption that 'free' enterprise is competitive entails, in turn, that cooperation in the common interest must be coerced; thus, socialism is identified *a priori* with iron rule and the end of liberty. Christianity is regarded in much the same light: for Freud, 'love thy neighbour as thyself' was a ridiculous and repressive injunction. 'The commandment is impossible to fulfil; such an enormous inflation of love can only lower its value, not get rid of the difficulty' (Freud, 1930/1961, p. 80). In short, therefore, we do not need to seek the origins of Freud's beliefs in his discoveries, his private political views, or his personal state of mind; they were very much a part of his time, and of ours as well.

The Necessity of 'Revisionism'

It should be clear by now that Freud's theories, in the form in which he left them, are not compatible with Marxism, or even with a liberal belief in progress. This raises problems for the 'new Freudians', who maintain that it is only subsequent 'misreadings' of Freud that have given rise to the impression of reactionary ideology. Jacoby (1975) sees Marcuse as 'unfolding' Freud's concepts into a revolutionary vision of history; but this 'unfolding' turns out to be of precisely the same kind as that of the conjuror who unfolds a handkerchief to reveal a flight of pigeons or a white rabbit. Jacoby is scathing in his attack on 'revisionist' versions of psychoanalysis—but without a substantial amount of revision, Freudian theory cannot legitimately be used for any but its traditional conservative purposes.

Of course, it may be the belief in progress which ought to be revised in the light of Freud; but in view of the foregoing discussion, I do not think Freud's arguments for the permanence of the existing order can be sustained—with the possible exception of 'primary process', to which I shall return below.

What would Freudian theory look like, then, if its more obviously ideological components were removed? I would argue that provided primary process remained intact, little of substance would be lost: the 'intertia principle' is neurologically false any way, the 'Death Instinct' is a speculative afterthought, and the inevitability of the patriarchal nuclear family was never a truly *psychological* postulate in the first place. A psychoanalytic account of child development which takes into account the infant's sociability already exists, in the British school of 'object-relations theory'. Obviously the question deserves a more careful answer than these few lines provide; but I do not think that the removal of ideological preconceptions from psychoanalysis would leave the theory either unrecognisable or unworkable. Unfortunately, until the necessity of this task is appreciated, progress on it is bound to be slow.

What of the remaining postulate, primary process? It could be argued that a species with such a talent for self-deception as Freud ascribes to the human race had but a miserable prospect of discovering a rational mode of social organisation, and could only make things worse if it tried to seek one.

However, primary process is not as incompatible with Marxism as this argument implies. Firstly, as we noted above, the theory that *all* thought is a delusion is self-refuting. Although Freud's theory of rationality is unsatisfactory, psychoanalysis needs such a theory in order not simply to be 'acceptably' optimistic, but to be coherent as a theory *at all*. Secondly, Marx himself (who incidentally shares this problem) places considerable emphasis on self-deception or 'false consciousness' in his account of the production and reproduction of social systems. Although self-deception for Freud operated primarily to maintain mental (rather than social) order, there is no reason why false-consciousness and emotional defences should not take the same form (the paradigm case being, perhaps, that of religion).

Hence, Freud is useful to a critical view of society not simply because he *describes* the inner conflicts of its members so faithfully—in contrast to the bland reassurances of 'humanistic' psychology; he also offers a detailed *explanation* of the compulsions and delusions which make people more at home in an oppressive society than they would be in a free one, and hence suggests what changes are necessary in order to make social progress psychologically possible. It is this psychological problem which Marxists after World War I, and feminists after the 1960s, turned to psychoanalysis to solve. Why was it that when the conditions for social change seemed ripe that people seemed emotionally incapable of accepting a new order? The Freudo-Marxists answered this question in terms of 'the 'normal' neuroses' and compulsions which serve from one point of view, as emotional defences, and, from another, as social ideologies.

What Reich, Fromm, Marcuse *et al*, were essentially arguing was that a society which runs on fairy-tales *requires* that, in certain fundamental respects, its members should not grow up—particularly the less privileged ones; the task for radical psychoanalysis is to show how crippling compulsions arise in the course of *normal* socialisation, and persist because they serve so well the maintenance of oppressive institutions. Freud himself inevitably started this line of criticism by blurring the distinction between sanity and madness, arguing that religion, mass movements and character traits manifested the same structure (in psychological terms) as neuroses.

The development of a truly 'emancipatory' form of psychoanalysis, however, requires its disembedding from the system of practices—the spy complex—within whose constraints it must remain an individualist, adaptationist and essentially conservative form of praxis.

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The Printed Word

Newsclippings on Mental Health

Neglected Mental Health

IT is highly distressing to note that mental health is not receiving the priority it deserves from the government. An estimated 14 million people in this country suffer from severe mental illnesses. Besides, nearly 40 million people who include an increasing number of drug addicts and alcoholics, require mental care... (according to Dr. G.N.Reddy) a disproportionate amount has always been granted to technology at the cost of human health. It pains one to note that health, education and social welfare have taken the backseat... (according to Mohsina Kidwai) only 10 per cent of mental patients were being cared for at present as there were only 1,000 qualified psychiatrists, either working in hospitals or practising on their own in the country... and for every 32,000 people there was only one psychiatric bed (*Deccan Herald,* Bangalore, 20 August 1985).

No Hope for the Insane

The Lumbini Park mental hospital (Calcutta), set up in 1940... (has) no treatment facilities at the hospital, no surgical equipments ... not even an X-ray machine. Though there are six visiting physicians only one psychoanalyst works part-time at the clinic, while three resident physicians, two of them superannuated, hold the fort in their absence. This is hardly sufficient for the 160 inmates, 125 male and 35 female. The patients are kept in sub-human conditions and provided whatever meagre meal is available at a government subsidy of Rs.4 a day... Even drugs, requisitioned from the Central Medicine Store, it is alleged, are insufficient, if available (*Statesman,* Calcutta, 21 April 1985).

Clinical Depression

Depression, a modern term for melancholia, is a common mood (affective) disorder with a long ancestry. The others in this group of disorders are mania and anxiety neurosis...Nearly 100 million people in the world suffer from depression each year... A study from Chandigarh indicates that nearly 20 per cent of patients seen in general medical practice suffer from depressive symptoms with or without any physical illness... In a mental health survey carried out recently near Madurai, depressive illness was found to affect 60 persons per 100 among those aged 60 and above... The drugs which are used to treat high blood pressure, and psychotropic agents which are used for mental illness like tranquillisers, barbiturates, and hormonal preparations such as ACTH cortisone and contraceptive pills tend to induce 'iatrogenic' depression. There has been an increasing use of these depressogenic drugs over the years. The fast disappearance of the protective influences of the family and social support, a sense of 'anomie', a dessication of values, a mode of living bereft of ethics, and a state of 'existential despair', have contributed to augment the numbers depressed... Depression, a recurring illness, affects personal health, bringing psychological misery, precipitates domestic unhappiness, entails a loss of man-hours, and is a significant cause of mortality through self destruction (suicide) (*Science Today,* November 1984).

Ranchi Asylum Deaths: PUCL Report Indicts Government

A non-government inquiry conducted by the Bihar unit of PUCL has indicted the State Government for inhuman conditions in the Ranchi Mansik Arogyashala. Several hundred patients had escaped from this asylum last month... The Committee found that requests by the hospital managing committee to the state government to increase its annual outlay from Rs. 87 lakhs to over Rs. 2 crores went unheeded. The government allowed doctors' posts to lie vacant for years, sanctioning only 14 posts for nearly 1300 patients. Moreover, just one post of lady doctor existed for over 400 female patients. The Committee found no trace of nursing staff, nearly 80 of whom are supposedly employed. There was no staff room in any of the wards... The report said the mortality rate at the asylum has risen alarmingly from seven per cent in 1979 to 20 per cent in the first eight months of this year. In other asylums in the country the mortality rate is one per cent. The report attributes the high death rate to government "indifference". The asylum's medical records indicated that a majority had died of prolonged malnutrition. Deaths were also caused by diarrhoea and dehydration. The Committee felt concerned that 58 patients had died over a span of 37 days... (*The Telegraph,* Calcutta, 21 October 1984).

Corruption in Mental Hospital

Relatives of the mentally ill accuse hospital staff (of Agra Mental Hospital) of corruption and callousness and of trying to fleece penurious patients. The staff they say refuse to admit those who do not have clout or cannot pay. The relatives, along with their mentally ill wards, have been forced to hire cots and live on the pavement. They struggle to cope with a situation which looks more hopeless with every passing day, aggravated by rapidly diminishing funds. Apart from paying for the cots, they have to buy food from the numerous shanty stalls that have sprung up to cater to the unexpected refugees. According to Dr. B. S. Yadav, senior medical superintendent of the hospital, patients coming from wealthy families are admitted to the paying ward which charges about Rs. 200 per month. For poor patients, provision of food, medicine and treatment is free at the general ward... Hospital sources allege that free medicines meant for poor patients are being sold... A visit inside the hospital has its own tale to tell—bare bodied patients in tattered khaki shorts cower in fright as guards force them to pull weed or cut grass in the fields (*Indian Express,* Bombay, 13 October 1984).

Mental Institute only in Name

The Institute of Mental Health, housed in the Alipore special jail, is still virtually a jail even though the state government declared it to be a mental institute for lunatic prisoners a year and a half ago. In fact, the government renovated the special jail and converted it into a mental institute for accommodating non-criminal lunatics (NCL) of the Dum Dum Central Jail with a promise to give them a fair deal... Investigations have revealed that only about 200 NCLs were taken to the institute from the Dum Dum Central Jail, out of a total of 800 NCLs languishing there (*Business Standard,* 1 October 1984).

Compiled by r.d. from the files of Centre for Education and Documentation, Bombay.

Making of a Psychiatrist

anand nadkarni

The author is a practising psychiatrist as well as a teacher of the subject. In this article he looks critically at the training of a psychiatrist. He highlights the deficiency of the clinical approach and hopes for the emergence of a more socially relevant psychiatry.

PSYCHIATRY as a science never had a privileged position in medical education until recently. The picture has started changing slowly though not substantially. A major reason for this is the undue emphasis on the *biomedical model* of medicine in clinical training. An integrated or *bio-psycho-social model* of medicine even today seems a distant subject. I must confess that my comment is mainly based on my own experience in Bombay and some medical institutions in Maharashtra. But people will agree about similarities in the situation all over the country, with a few notable exceptions.

When I was on undergraduate student, not long ago, our month long clinical term in psychiatry was usually designated as a "leisure term" because we used to get only an optional short question (of 5 marks) on psychiatry in the theory papers of general medicine. The insistence by undergraduate students to take 'clinics', which usually takes resident doctors on an egotrip, was a privilege shared only by our medical and surgical colleagues. Things have changed of late. Students attend the term in psychiatry, and more sincerely. However, much of the credit for this goes to the introduction of a 35 marks section on psychiatry in the medicine theory paper by the University of Bombay.

Now, it is for the teachers in psychiatry to use this opportunity to inculcate genuine psychological awareness in students who will be general practitioners and consultants of the future. Recently one of our patients suffering from schizophrenia was advised by a medical consultant to get married, as that was the only remedy. Such statements although given (presumably) with a lot of goodwill underline the lack of basic psychiatric training given hitherto to the undergraduate students.

The average student, because of these lacunae, never ever develops a sound psychosomatic approach in his future career. Hence a patient complaining of persistent functional vomiting entering a general-surgical OPD of a big hospital first undergoes a series of investigations, including 'scopy', before being referred for a psychiatric evaluation.

This attitude of looking towards a patient as a mere 'case' stems from the basic lack of psychosocial orientation. Undergraduate students are never taught essentials of doctor-patient relationship, therapeutic effects of doctor-patient interactions, communication skills which can have both good and bad prognostic implications for the patient. It will be a surprising fact for some, but these subjects are not taught even to most postgraduate students of psychiatry. Virtues of spontaneity and intution are seldom stressed. Failure to master communication skills, makes us mere 'tic-markers' on the symptom check-list. Suppose I want to examine a four year old child in the psychiatry OPD, I make him sit on a stool near me. He has to literally strain his neck to look upto me. But suppose I place him on the table before me, our eyes come on the same level; I can pat his shoulder; I can also observe the spectrum of emotions on his face and corroborate it with his words.

Unfortunately we tend to cover up our failures to communicate under the term 'clinical distance'. To keep clinical distance between a patient and a doctor is one of the vague terms in an otherwise accurate medical vocabulary. If I visit some of my recovering patients' homes as a part of the process of rehabilitation, I am branded as a 'social worker' as if a doctor cannot and should not be a 'social worker' when the patient's welfare demands it. If a consistent bond of friendship is built between a patient and a clinician, which helps the medical bond then either the clinician is labelled as having a 'counter transference problem' or is simply ridiculed. Again, everybody in theory acknowledges the need for better communication, and everybody tries to explain the 'nobleness' of our profession on that basis. But 'doublespeak' is the rule of the day.

Most undergraduate studnets never grasp objectivity of mental status examination, during their clinical term. It has been a troublesome experience for me, when our clinical (mental status) examinations are often branded subjective; whereas even if two or more cardiologists argue on presence or absence of a murmur, the objectivity of their examination is never in doubt Fluctuating signs and symptoms is as much a property of schizophrenia as multiple sclerosis. This fact is often forgotten. One of my undergraduate students was amazed to note that 'insight' and 'judgement' could be really tested. He had thought of mental status examination as a mere data of inferences.

It is important to note that the average postgraduate student in psychiatry comes for his clinical training with such a background. In addition, I have often seen fresh entrants coming with a lot of dreamy notions about psychiatry. They think of it as a merely 'interesting' subject, something that is thrilling. During their period of residency their views usually get crystalised in the domain of biological psychiatry in contrast. After all the undergraduate biomedical influence tells, and that spicious by their absence in the postgraduate arena. But even a broad based psychosocial perspective is lacking. Average postgraduate students do not come to terms with the prevalent psychosocial reality of people from various stratas of society. Many students brand psychological and social angles as too theoretical and too abstract. Nor surprisingly, *psychotherapy techniques* never come higher up on the priority list for such students. Any psychotherapeutic work that the student does is only out of that perosn's own initiative and is hardly supervised. Wherever 'honorary' system for teachers is prevalent, this is likely to be 'the truth'. One of the essential therapeutic tools for a psychiatrist in our circumstances is to be conversant with

techniques of group psychotherapy. Many postgraduate students pass their examinations without even facing a single group. No wonder, patient-education is conspicous by its absence in psychiatry. Psychiatry students (postgraduate) seldom venture into explaining the essence of psychopathology in simple terms to the patient.

Not that postgraduate training is totally deficient; analysis and elicitation of signs and symptoms is taught upto the mark. At many places, training in psychopharmacology is adequate. What is not taught, is how to face many controversies in psychiatry with a balanced head. We are encouraged to take sides too early in our training. Hence we come out either as 'pro-ECT' or 'anti-ECT', to take one example. What is not realised is that such crystallisation of views essentially does not evolve from our own studies and clinical experience but as continuation of what 'boss' (i.e. senior teacher) is following over the years. Clinical training in general is more by precept than debate.

Because of our emphasis on western textbooks we tend to see many problems through their viewpoints. Let us take a concrete example of a young patient suffering from drug addiction. It is a widely noted observation that psychopathic personality traits are more common (either primary or secondary in origin) among drug addicts. Many of our urban addicts, especially from the working class, start the habit not because of these traits but because of ignorance about the whole process. Examples are coming to light from rural Maharashtra, where some unscruplous chemists had started giving unpurified heroin (brown sugar) as medicine to unsuspecting rural patients who approached them with a prescription note from the doctors. Some children in Bombay who earn money by collecting garbage have been lured by their area-goons into becoming brown-sugar addicts; many of them are in the age group between 9 and 11 years. The moral of the story is that any disease neds a dynamic question of oetiology and it cannot be rigid and purifan. We should also contemplate new equations and then try to analyse them.

I think, during our postgraduate training we let ourselves be moulded too much by our mileu. By mileu I mean the outlook of the institution in which we are trained, inclinations of our teachers and the general clinical value-systems adopted. A colleague of mine does not give an injectionof an antipsychotic depot preparation in the buttock of male schizophrenia oatuebt but prefers to give it in the arm so as not to arouse the latent homosexuality conflict which is thought to be present in schizophrenia according to the freudian school. His teacher believed in this and so does he. I personally think this to be too farfetched, though I must admit of having seen a couple of schizophrenics who had accusatory hallucinations with emphasis on homosexuality.

Most of our biases which arise from our training are because we tend to try and fit things into established, rigid models rather than using them as a base and then basing our interpretation in accordance with the unique characteristics that every patient brings in with him or her.

The entire medical training is devoid of the study of philosophical issues in medicine and a candid exposure to the student of social realities. This is all the more reflected in a branch like psychiatry where the *art and science* of medicine should meet. Usually any medico turns defensive when he hears the word 'philosophy'. Philosophical issues in medicine are both simple and complex, depending on your abilities to face them. One of the major issues, for example, is about the scope and function of a 'clinician'. Is it to be restricted to only 'clinical' situations? Should a clinician be a willing analyst of the wider sociomedical issues? Should he take an active part in community-health education? Should he attempt to make creative use of the media . . . In short, should he metamorphose a clinician with a global perspective or get tied down to consulting rooms and operation theatres? In theory, many doctors agree to the expanded role of the doctor but in practice it is hard to behave that way. We fail to understand that the so called 'busy' schedule and social interactions limited to cocktail parties, indicate a philosophical shift under the guide of practicality.

Hence any correction in the present status of training in psychiatry should be one which will influence the overall training in medicine. Only then it will be useful and different from the patch-work remedies. Unfortunately most of the experts on medical education believe that if the present structure of examination is changed then the content and quality of medical training will also change. Hence the emphasis till now has been mainly on examination reforms and widening of curriculum, on paper. Concrete plans and methods of implementation are hardly discussed as they are likely to threaten the existing biomedical structure. Well, there is something called the 'expert's paradise'.

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Book Review

Different Voices

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"In a Different Voice: Psychological Theory and Women's Development": Carol Gilligan, Harvard University Press Cambridge, Massachusetts, and London, England, 1982, pp 184, 5.95 dollars.

A THEORY is only a representation of truth perceived from a particular point of view. When theorists formulate psychological theories based mostly on observations of men's lives and find that women's experiences do not fit, it is the women who are held at fault, not the theories. Since theory performs the powerful function of validating one's perceptions, when psychological theory negates the truth of women's perceptions, are not the seeds of madness being sown? For society, all perceptions, experiences and behaviour, that fit into a particular predetermined mould, are considered normal, those that do not fit are considered abnormal. Does this then mean that women are by definition abnormal?

A man named Heinz considers whether or not to steal a drug which he cannot afford to buy in order to save the life of his wife. Two eleven-year-olds are asked to resolve this dilemma, which is one in a series devised by Kohlberg to measure moral development in adolescents by presenting a conflict between moral norms and exploring the logic of its resolution. In the standard format of Kohlberg's interviewing procedure, the description of the dilemma itself ... Heinz's predicament, the wife's disease, the druggist's refusal to lower his price ... is followed by the question, "Should Heinz steal the drug?" The reasons for and against stealing are then explored through a series of questions that vary and extend the parameters of the dilemma in a way designed to reveal the underlying structure of moral thought.

Jake, at eleven, views the dilemma as a conflict between the values of property and life, discerns the logical priority of life and concludes that Heinz should steal the drug. While taking the law into account and recognising its function in maintaining law and order, (the judge, Jake says, should give Heinz the lightest possible sentence) he also sees the law as man-made and therefore subject to error and change. Both his judgements, regarding what Heinz should do and the law being subject to change, rest on the assumption of agreement, a societal consensus around moral values that allows one to know and expect others to recognise "what is the right thing to do". Since his solution is rationally derived, he assumes that anyone following reason would arrive at the same conclusion, including the judge.

Amy's response to the dilemma is in sharp contrast to Jake's response. She replies in a way that seems evasive and unsure, and thinks that Heinz should not steal but find some other solution such as raising money somehow. According to her, neither should Heinz steal, nor should the wife die. She considers neither property nor law but the effect of theft on the relationship between Heinz and his wife. Even if Heinz saved his wife's life by stealing the drug, he might be sent to jail for it and then wouldn't be able to help his wife if she became sicker. So they should talk it over and find some way to make the money.

Unlike Jake, who is fascinated by the power of logic and considers the moral dilemma to be "sort of a math problem with humans", Amy views the dilemma as a narrative of relationships that extend over time. Her moral judgement is grounded in the belief that "if somebody has something that would keep somebody alive, then it is not right not to give it to them." She considers the problem in the dilemma to arise not from the druggist's assertion of rights but from his failure of response. Just as Jake is confident the judge would agree that stealing is the right thing for Heinz to do, so Amy is confident that "if Heinz and the druggist had talked it out long enough, they could reach something besides stealing." As he considers the law to have made mistakes, so she considers this drama as a mistake, believing that "the world should just share things more and then people wouldn't have to steal." *Both children thus recognise the need for agreement but see it mediated in different ways ... he impersonally through systems of logic and law, she through communication in relationship.* Just as he relies on the conventions of logic to deduce the solution to this dilemma, assuming these conventions to be shared, so she relies on a process of communication, assuming connection and believing that her voice will be heard, (emphasis mine).

The differences in the responses of these two children shows that infact they see very different moral problems in the dilemma. Jake responds to the question "*Should* Heinz steal the drug" whereas Amy responds to the question "should Heinz *steal* the drug." As can be expected these two responses receive different scores on Kohlberg's scale.

Kohlberg's six stages of moral development trace a three level progression; from an egocentric understanding of fairness based on individual need (stages one and two), to a conception of fariness anchored in the shared conventions of societal agreement (stages three and four), and finally to a principled understanding of fairness that rests on the free-standing logic of equality and reciprocity (stages five and six).

While Jake's judgements at eleven are scored as conventional on Kohlberg's scale, a mixture of stages three and four, his ability to bring deductive logic to bear on the solution of moral dilemmas, to differentiate morality from law, and to see how laws can be considered to have mistakes, points toward the principled conception of justice that Kohlberg equates with moral maturity. When considered in the light of Kohlberg's definition of the stages and sequence of moral development, Amy's moral judgements appear to be a full stage lower in maturity than Jake's. Scored as a mixture of stages two and three, her responses seem to reveal a feeling of powerlessness in the world, an inability to think systematically about the concepts of morality or law, a reluctance to challenge authority or to examine the logic of received moral truths, a failure even to conceive of acting directly to save a life or to consider that such an action, if taken, could possibly have an effect.

Asking different questions that arise different conceptions of the moral domain, the two children arrive at answers that fundamentally diverge, and the arrangement of these answers as successive stages on a scale of increasing moral maturity, caliberated by the logic of the boy's responses, misses the different truth revealed in the judgement of the girl. To the question, "What does he see that she does not?" Kohlberg's theory provides a ready response, manifest in the scoring of Jake's judgements a full stage higher than Amy's in moral maturity; to the question, "What does she see that he does not?" Kohlberg's theory has nothing to say. Since most of her responses fall through the sieve of Kohlberg's scoring system, her responses appear from his perspective to lie outside the moral domain.

Yet, the world she knows is a different world from that refracted by Kohlberg's construction of Heinz's dilemma. Her world is a world of relationships and psychological truths where

an awareness of the connection between people gives rise to a recognition of responsibility for one another, a perception of the need for response. Seen in this light, her understanding of morality as arising from the recognition of relationship, her belief in communication as the mode of conflict resolution, and her conviction that the solution to the dilemma will follow from its compelling representation, seem far from naive or cognitively immature. Instead, Amy's judgements contain the insights central to an ethic of care, just as Jake's judgements reflect the logic of the justic approach.

The above extracts represent the basic arguments set forth in Gilligan's book *In a Different Voice*. Her main contribution lies not in revealing sex differences, which she states have been noted throughout psychological literature. The importance of her contribution lies in discerning that these difference represent two entirely different yet cohesive ways of thinking and looking at the world. Consequently *unlike the interpretation offered by most developmental theorists that women's development is deficient because it does not fit into the male pattern, Gilligan interprets the difference as representing two different but equally valid patterns of development.*

Gender identity, the "unchanging core of personality formation" is "with rare exception firmly and irreversibly established for both sexes by the time a child is around three." Despite the fact that for both sexes the "primary caretaker" in the first three years of life is usually female, the interpersonal dynamics of gender formation are different for boys and girls. Since girls experience themselves and are experienced by their mothers as being more "like, and continous with, themselves," for girls identity formation is fused with the experience of attachment. In contrast, boys experience themselves and are experienced by their mothers as being different and separate, hence male identity formation entails a "more emphatic individuation and a more defensive firming of experienced ego boundaries."

From here on each sex starts off viewing themselves and others as if through a different lens. Gilligan says, "From the different dynamics of separation and attachment in their gender identity formation through the divergence of identity and intimacy that marks their experience in the adolescent years, male and female voices typically speak of the importance of different truths, the former of the role of separation as it defines and empowers the self, the latter of the ongoing process of attachment that creates and sustains the human community."

In the transition from adolesence to adulthood, while the dilemma itself is the same for both sexes, a conflict between integrity and care, a recognition of the need for intimacy becomes the critical experience for men, while for women it is the experience of choice. Since this conflict is approached from different perspectives by both sexes, it generates the recognition of opposite truths. This gets reflected in two different moral ideologies, "since separation is justified by an ethic of rights while attachment is supported by an ethic of care."

Criticising the one-sideness of development theory, Gilligan says, "Attachment and separation anchor the cycle of human life, describing the biology of human reproduction and the psychology of human development. The concepts of attachment and separation that depict the nature and sequence of infant development appear in adolesence as identity and intimacy and then in adulthood as love and work.

"*This reiterative counterpoint in human experience,* however, when moulded into a developmental ordering, *tends to disappear in the course of its linear reduction into the equation of development with separation*" (emphasis mine).

The real significance of Gilligan's work becomes apparent when we consider how development theory shapes the viewpoint of not just psychologists and psychiatrists, but also the general understanding of female nature as portrayed in humour, literature, the media. This has serious implications for the way in which women view themselves in relation to society and in turn how society views women in relation to itself.

Since women do not fit into the pattern of male development, they are considered to have a weak sense of self, an inability for clear thought and action, a lack of objectivity . . . This image of womanhood gets reflected in day to day interactions, and for women, becomes a very debilitating image of themselves to live with. "Women's place in man's life cycle has been that of nurturer, caretaker, and helpmate, the weaver of those networks of relationships on which she in turn relies. But while women have thus taken care of men, men have, in their theories of psychological development, as in their economic arrangements, tended to assume or devalue that care. When the focus on individuation and individual achievement extends into adulthood, and maturity is equated with personal autonomy, concern with relationships appears as a weakness of women rather than as a human strength."

For all of us, our sense of self depends on a validation of our perceptions from others. When women continually feel that they are not being understood or are somehow not saying the right thing, they become more and more unsure of themselves. "As the interviewer conveys through repetition of questions that the answers Amy gave were not heard or not right, her confidence begins to diminish, and her replies become more constrained and unsure." It is this sense of vulnerability, repeatedly heard in women's vioces, that "impedes women from taking a stand, what George Eliot regards as the girl's 'susceptibility' to adverse judgements by others, which stems from her lack of power and consequent inability 'to do something in the world'."

"Further, in a society where women have an unequal status with men, the above mentioned perceptions of women give men the 'right' to view women as inferior, especially since their views are backed by 'scientific theories' which consider women to be deficient. This also gives men the right to exclude women from direct participation in society, and women are thus forced to see themselves "as subject to a consensus or judgement made and enforced by the men on whose protection and support they depend any by whose names they are known."

According to Gilligan, the notion that virtue for women lies in self-sacrifice has "complicated the course of women's development by pitting the moral issue of goodness against the adult questions of responsibility and choice". For women the ethic of self-sacrifice is directly in conflict with the concept of their rights as individuals. This conflict also surfaces time and again within the women's movement, which has emerged in an effort to raise the collective demands of women and to struggle for their right to choose. Strangely, men, whose moral development is so much focussed on the question of rights, in reacting to the women's movement often revert from the higher stages of maturity to stage one or two of Kohlberg's scale of moral development!

The paradox of women's lives lies in the fact that the "very traits that traditionally have defined the 'goodness' of women, their care for and sensitivity to the need of others, are those that mark them as deficient in moral development." Yet if women were to be equally concerned with separation, autonomy, individuation, and their natural rights, as men are, women would cease to fit into the social roles assigned to them by society. Seen from this viewpoint, women would again appear 'abnormal', and perhaps their own family would take them to psychiatrists who would then attempt to make them 'adjust' better to society.

In this context, Gilligan's assertion of the need to broaden development theory, so that it encompasses the various dimensions of human existence, is a necessary first step. A broadening of development theory would mean incorporating the positive aspects of both male and female development as it exists at present. This would also amount to recognising that both male

(Continued on p. 178)

nounced several military and police doctors had approached the members of ethics committee to report that they had been asked by the authorities to examine or treat prisoners who had been tortured. They also sought assistance from the Association in informing military authorities that they would not become involved in covering up torture.

In a backward bourgeois democracy like India, the flagrant violation of democratic rights of people is a routine affair. Our readers need no introduction on the daily torture of detenus carried out in a small police station to a well maintained torture chamber (like the 'retreat'in Calcutta) all over the country. The women prisoners need a special mention as they, in addition, face sexual abuse. In fact, the rape of a teen age woman triggered off a new wave of protest in the women's movement in recent times.

The democratic rights organisations have done significant work in making torture a political issue. No doubt, doctors have also participated in such organisations. The recent killings of a doctor, who was a prominent human right activist, by the police in Andhra Pradesh shows that individual doctors have played their role, even at the risk of their lives.

However, the medical community as such has much at stake in the system and therefore, its official organisations have consistently shunned responsibility to do anything in this matter. They did not have enough courage even to issue a statement when a doctor was killed for his human rights activities. Indeed, they will take a long time to learn from what their counterparts are doing in Chile. Thus, the responsibility is now with voluntary organisations of socially-conscious individuals working in the field of health to show courage, to build public opinion and agitate in the official associations to pressurise the medical community.

Secondly, at the same time, socially-conscious doctors will have to look into the medical aspects of the problem. As Stover and Nightingale suggest in their report, "physicians (particularly psychiatrists) need to become familiar with immediate and long-term physical and psychological effects of torture, for the purpose of diagnosis and treatment. Although research on the after effects of torture and the means of treating these effects is still in its infancy, recent medical research indicates that the major symptoms of torture victims, which sometimes occur years after the torture, include feeling of helplessness, heightened anxiety, impaired memory and inability to concentrate, nightmares and phobias. Publishing research on victims aids in the prevention of torture by informing the public of the pernicious effects of torture on victims, their families and society at large."

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Review Article

The Sorry Story of Psychosurgery

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"The Stealers—Psychosurgery and Mind Control" By Samuel Chavin, Houghton Mifflin Co. Boston, 1978 $ 8.95.

'What is matter? Never Mind,
What is mind? No matter.' Punch.

THE human condition, through history, has always been marked with dread, anxiety, awe, fear, humbug and much confusion about the entity of 'insanity'. Everyone seems to know what it is, yet there is no general agreement about the whole concept of psychiatric illness, much less regarding the constituents of possibly specific entities like schizophrenia of hyperactivity. For instance, the diagnosis of schizophrenia varies with geography; it is made more stringently in Great Britain than in the United States or the Soviet Union where the condition mushrooms into subtypes (Szasz, 1976). It may have biological markers such as neurotransmitters or chemical messengers that affect the way brain cells work. However 'no unequivocal abnormalities' have been found in the neurotransmitters after three decades of intensive research into their possible role (Snyder, 1982). Both a genetic pre-disposition and as yet undefined infectious agent have been suggested as causative factors (Crow, 1983). Arguments continue whether schizophrenia is one disease or a group of widely different entities presently erroneously being lumped together, nearly a century after the disorder was identified (Hays, 1984).

There are other ill defined entities, that once appearing on the medical scene grow with time. The 'hyperactive' child in the U S or the 'maladjusted' child in the U K grew from three per cent of the U S school children in 1971 to 15 per cent in 1974, with about two per cent of all school age children receiving medications to control hyperactivity in that year. Hyperactivity is defined as: unmanageable, defiant, disobedient, aggressive, lying, truant, unable to concentrate, violent, overactive etc. No wonder Thomas Szasz calls all mental illness a myth—a category error. The brain can be sick says Szasz, but the mind is not an organ; "it is an abstract noun that lacks a concrete referant". (Szasz, 1984)

So we have a field of study where the entities themselves are not clearly defined, the possible underlying mechanisms ill-understood, the role and effect of mainstays of therapy like shock-therapy (E C T) and drugs (the major tranquillisers) controversial. In all of this for the past five decades there was yet another aspect—the surgical removal or destruction of a part of the brain to help or cure individuals with severe mental illness.

It is this form of brain-surgery or psychosurgery that Samuel Chavkin's book discusses, not only in a narrow medical sense but in its wider social and political context. On reviewing Chavkin's book on other related material, I am amazed at the virtual absence of any medical or scientific basis for psychosurgery and of the overwhelming social, political and cultural influences that determined the indications for it. For any surgery, say removal of an abscess or an inflammed appendix, the rationale is two-fold: non-removal will result in greater harm or fatality, and removal result in some alleviation or even a permanent cure. In a non-life threatening condition such as chronic mental illness one is presumably aiming at substantial alleviation if not a cure. Surely removal or destruction of as important and crucial a part of the body as bits of brain requires clearly defined entities at the outset, which have disrupted or incapacitated the individual's life and which no other form of therapy can help. The method of surgery itself should be a standard one so that identical areas are removed or destroyed at the patient's outcome judged not by the operating surgeon but by an impartial observer. None of this was true for psychosurgery.

The Historical Perspective

"This was the most unkindest cut of all" Julius Ceasar.

The history of psychosurgery, even as recounted by the strictly 'medical' account of Kucharski (1984), reads like a macabre piece of science fiction. In fact, the initial proponent of psychosurgery was a world renowned professor of neurology, Egas Moniz of Lisbon, who had invented the technique of cerebral angiography, a method by which dye was injected and x-rays taken to see the blood vessels of the brain. In 1935, Moniz heard two American neuroscientists present a paper at an international conference. They described the effects of destroying the prefrontal area of the brain of two trained chimpanzees thus: "the animal without frontal areas no longer appears to worry over mistakes. Whereas the normal monkey or chimpanzee may become excited, cry or have a temper tantrum or on the other hand turn away and ignore the problem after several successive failures, the subject lacking frontal areas seems quite impervious to any frustrating effects or errors" (Jacobsen, 1936). After the presentation, Moniz stood up and asked "Why would it not be feasible to relieve anxiety states in man by surgical means?" A few months later, Moniz's colleague Almeida Limm used alcohol injections to destory areas of the frontal lobe of a middle-aged woman with 'agitated depression'. Following surgery the woman was said to be markedly less agitated than before. After four patients had been operated upon, Moniz admitted that the patients were more apathetic than he had hoped. The four were sluggish, disoriented and incontinent. The alcohol that had been injected tended to seep further down into the brain than intended, and damaged vital centres that regulate breathing and blood pressure in the brain stem. The referring psychiatrist refused to send further patients for surgery.

But the era of psychosurgery had begun and in the next two decades nearly 100,000 individuals were operated upon (BMJ, 1971) in many countries including India (Valenstein, 1980). The operations were performed for a variety of conditions: aggression, neurotic depression, psychotic depression obsessive-compulsive neurosis, schizophrenia and other psychosis etc., with surgical procedures directed at different parts of the brain: the frontal lobe, the cingulum, the amygdala, or multiple sites. Moniz refined the technique of injecting alcohol to a leucotome—a mental rod with a wire loop that could be extended from its end to cut a bit of the white matter of the brain. In the U S A with true American expertise the technique was further simplified so that the operation could be performed in the doctor's office. Initially an icepick was used as a leucotome by the American psychosurgeon Walter Freeman because other instruments "dog-gone things would break. They weren't as good as an ice-pick."

(Shutts, 1982). The ice-pick leucotome would be forced through the skull immediately above the eye, and the surgeon destroy parts of the frontal lobe by manipulating the instrument. Moniz was awarded the Nobel prize for medicine in 1949 "for his discovery of the therapeutic value of the prefrontal leucotomy in certain psychoses".

Opinions on psychosurgery divided the scientific community almost from the beginning of the operation with proponents consisitently claiming that the procedure made it possible for patients who were suffering from crippling mental illness to lead normal or near normal lives. Others strongly disagreed. They viewed psychosurgery as a multilation of the brain to eliminate troublesome behaviour which turned the patients into 'vegetables'. Informed consent, that is, the patient's active consent to the procedure was not a factor in the decision to operate. Children too were operated upon.

All the while the operation rested on the basis that mental characteristics as different as creativity, memory, initiative and anger were transmitted via a fixed pathway in brains of the mentally ill. A normal person could be angry, happy or sad at various times, but not any of these all the time. Cutting the fixed abnormal fibres in the mentally ill would discontinue their sending the same emotion through the brain. Contrast Moniz's certainty with the comments of Phillips et al, in 1984. They are answering questions put by an imaginary individual who meets neurobiologists every 50 or hundred years. To the question "but can you tell me how the areas of the brain interact to display the integration evident in thought and behaviour?" The answer today would be "no". (Phillips et al., 1984). Surgeons who had performed hundreds of leucotomies were themselves aware of the lack of any physiological basis. One of them, Dr Harry Solomon had been asked by the Veterans Administration in 1948 to "describe the rationale of the operation at somewhat greater length and in terms of pathologic physiology". Solomon replied that a discussion of the rationale "would of necessity be very theoretical, and probably completely unsound. We would be better advised not to attempt it" (Shutts, 1982).

Not only did the psychosurgeons lack a theoretical basis for their procedure, 'they had no way of knowing what they had cut when they made radical stabs with their instruments' (Kucharshi, 1984). They failed to consider damage to blood vessels, or to make allowance for differences in skull size when they made their cuts. The fibres that were supposedly intended to be cut changed as autopsy failed to provide evidence to corroborate the surgeon's theory. Though editorials in the medical literature had repeatedly asked for carefully controlled studies to assess lobotomy (Finesinger, 1949) none were done. A long term follow-up of 707 patients who had undergone lobotomy four to 30 years before showed that 70 per cent of those hospitalised for less than a year prior to surgery were either still living in hospital or were at home in a 'state of idle dependancy'. (Kucharski, 1984).

The Recent Past

"That's the reason they're called lessons" the Gryphon remarked, "because they lessen from day to day." Alice in Wonderland.

The advent of major tranquillisers in the early fifties and their widespread use led to a decrease in the number of psychosurgical operations. However in the late sixties, these operations were advocated as a means of controlling urban unrest. Summer after summer in the years 1964-1968 American cities exploded in anger. In 1967 alone, there were riots in 127 cities as black people in the urban areas vented their frustration, despair and rage. Some Harvard doctors chose to interpret these riots differently, as follows.

"It is important to realise that only a small number of the millions of slum dwellers have taken part in the riots, and that only a sub-fraction of these rioters have indulged in arson, sniping and assault. Yet, if slum conditions alone determined and initiated riots, why are the vast majority of slum dwellers able to resist the temptation of unrestrained violence? Is there something peculiar about the violent slum dweller that differentiates him from his peaceful neighbour?

"There is evidence from several sources, recently collated by the Neuro-Research Foundation, that brain dysfunction related to a focal lesion plays a significant role in the violent and assaultive behaviour of throughly studies patients... we need intensive research and clinical studies of individuals committing the violence. The goal of such studies would be to pinpoint, diagnose and treat those people with low violence thresholds before they contribute to further tragedies" (Mark, Sweet, and Ervin, 1967).

Not surprisingly their view was popular with the U S establishment, for here social injustice was medicalised, racism not mentioned, the victims were blamed, declared to be mentally ill, suitable as candidates for 'scientific research', and possible psychosurgery. The letter caused a furore in the U S but was not without its defendants. The two main authors subsequently published a book called *Violence and the Brain* and continue to hold prestigious university appointments to this day.

Psychosurgery is performed very infrequently nowadays, but it has not been rejected by the medical community. It has an aura of respect, and its opponents are labelled as politically motivated, fanatic in their hatred etc. (Morley, 1985). Psychosurgery is a tragically perfect example that "science is not an objective truth machine, but a quintessentially human activity, affected by passions, hopes, and cultural biases" (Gould, 1980). Many examples of such science and of the pursuit of sociobiological determinism, its popularity and its extensive patronage by the rich and powerful are found in Chavkin's book. It is a chilling story which continues... Every field in biology is claimed as fortifying the belief that while "we may not live in the best of all *conceivable* worlds we live in the best of all *possible* worlds" (Lewontin, 1984). Needless to say such a world is capitalist with the white males at the very top. Biology is recruited to convince us that intelligence is genetically determined, that we have 'selfish geners', and that men are "compelled by their gender to be rogues". (Beckwith, 1984). For a reader who wants to know more about the sorry story of psychosurgery and the larger dimension of sociobiology *The Mind Stealers* can be highly recommended as a good introducton.

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nounced several military and police doctors had approached the members of ethics committee to report that they had been asked by the authorities to examine or treat prisoners who had been tortured. They also sought assistance from the Association in informing military authorities that they would not become involved in covering up torture.

In a backward bourgeois democracy like India, the flagrant violation of democratic rights of people is a routine affair. Our readers need no introduction on the daily torture of detenus carried out in a small police station to a well maintained torture chamber (like the 'retreat'in Calcutta) all over the country. The women prisoners need a special mention as they, in addition, face sexual abuse. In fact, the rape of a teen age woman triggered off a new wave of protest in the women's movement in recent times.

The democratic rights organisations have done significant work in making torture a political issue. No doubt, doctors have also participated in such organisations. The recent killings of a doctor, who was a prominent human right activist, by the police in Andhra Pradesh shows that individual doctors have played their role, even at the risk of their lives.

However, the medical community as such has much at stake in the system and therefore, its official organisations have consistently shunned responsibility to do anything in this matter. They did not have enough courage even to issue a statement when a doctor was killed for his human rights activities. Indeed, they will take a long time to learn from what their counterparts are doing in Chile. Thus, the responsibility is now with voluntary organisations of socially-conscious individuals working in the field of health to show courage, to build public opinion and agitate in the official associations to pressurise the medical community.

Secondly, at the same time, socially-conscious doctors will have to look into the medical aspects of the problem. As Stover and Nightingale suggest in their report, "physicians (particularly psychiatrists) need to become familiar with immediate and long-term physical and psychological effects of torture, for the purpose of diagnosis and treatment. Although research on the after effects of torture and the means of treating these effects is still in its infancy, recent medical research indicates that the major symptoms of torture victims, which sometimes occur years after the torture, include feeling of helplessness, heightened anxiety, impaired memory and inability to concentrate, nightmares and phobias. Publishing research on victims aids in the prevention of torture by informing the public of the pernicious effects of torture on victims, their families and society at large."

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Doctors and Torture

A Report on Chile

AS the strength and awareness of organisations working in the field of health and medicine increase, they will have to identify newer areas and issues to intervene into the many social, economic and political processes in society. For only by generalising their intervention or activities they will be able to generate a health movement. One such issue is the alliance and complicity of the medical profession with the repressive apparatus of the state in both capitalist and post-revolutionary societies. There are many ways in which the individuals and the established organisations of medical profession help the state to better implement, cover-up and justify the repression and its repressive function. One of the most inhuman of them is the torture of dissident political activists and all other prisoners who refuses to submit to the wills of the law-enforcing personnel.

Democratic rights organisations in our country, as well as all over the world have taken up numerous cases of systematic violation of rights of dissidents, more consistently in the last 15 years. Interrogation, torture and other harassments with the complicity of medical personnel have been reported. They have also campaigned to build up public opinion and have pressurised governments on this issue. However, they have not been able to draw the serious attention of the organisations working in the field of health to the complicity of medical personnel in their inhuman acts. Such health organisations, due to their own weakness and the fact that they have started working independently only very recently, have not yet taken cognisance of the very political as well as medical nature of this issue.

A country which has witnessed the most brutal repression for over a decade has now shown the way. If the medical profession decides to fight, decides to genuinely observe and implement the code of ethics it always talks about, it can take positive steps in this regard. This is the country where a doctor social democrat, who also became its president tried to change the social order through parliamentary reforms and was overthrown by a military coup sponsored by the CIA. He and his supporters, and tens of thousands who protested were brutally massacred in 1973 by the military junta of Pinochet. Yes, this country is Chile, and the president was Dr Allende.

Action of Medical Profession Against Torture

A special report submitted by Eric Stover and Elena Nightangle of the Committee on Scientific Freedom and Responsibility, Washington DC, and published in the *New England Journal of Medicine* (October 24, 1985), under the title, "The Medical Profession and the Prevention of Torture" states that the Chilean Medical Association "has called on the military government to end secret detention, the situation in which torture is most likely to take place. Its leaders have met with members of the judiciary to press for the expedition of more than 200 complaints of torture that are stalled in court proceedings." This is indeed a highly politically conscious and bold act in a country where political dissent is dealt with bullets.

The leaders of the Association, of course, suffered for their boldness. Last August, Dr Pinto Castillo, a member of the Association's ethics committee and a Fellow of the American College of Surgeons, was detained by Chilean security forces. This act instead of demoralising these progressive forces in the medical community brought out a new mood of solidarity amongst them, and the medical and scientific associations in Chile, USA and other places came out in aid of Dr Castillo who was banished for 90 days to a small desolate island in Southern Chile without charging him with an offence. The international protest, however, had its effect and on August 22, 1985, 16 days after he was banished, the Chilean military dictators were forced to release him.

The Chilean Medical Association (Colegio Medico de Chile) was established in 1948 and has now a membership of more than 9000 doctors who constitute about 90 per cent of all medical practitioners in Chile. After the military coup of 1973, the Association, along with all other such professional bodies, lost its right to elect its own office bearers. However, this right was restored to it in 1981, and since then, it has played a key role in focussing attention in Chile as well as abroad, on the medical profession's complicity in torture. Dr. Castillo, other members of the Association have done painstaking work in documenting the use of torture by the state and in providing treatment to victims. Dr. Jaun Gonzales, president of the Association in November 1984, presented to the Chilean supreme court documentary evidence of cases of torture, and expressed his concern over the continuing practice of torture. The association has not restricted its activities only to Chile. In mid-1985, Dr. Gonzales along with Dr. Carlos Trejo, Chairman of its ethics committee, testified before the US Congress about the Association's efforts to stop professional complicity in torture.

Guidelines to Prevent Professional Complicity in Torture

Stover and Nightingale in their above mentioned report inform that the Association issued in March 1985, a set of guidelines instructing physicians not to attend to patients under certain conditions. This was as a follow-up to the Association's public statement in November 1984 warning that it would not allow itself to be "turned into a haven and bastion for people who transgress professional ethics". According to the guidelines, doctors should not attend to patients:

(1) If the physician has been ordered not to identify himself or to conceal his identify by physical means;
(2) If the physician encounters a patient who is blindfolded or hooded or otherwise prevented from seeing the examining physician;
(3) If the patient is held in a secret detention centre; or
(4) If contact between the patient and physican can be carried out only in the presence of a third party.

The association has also taken concrete steps to see that these guidelines do not remain on paper. It has held disciplinary hearings on the role of five doctors alleged to participated in the abuse of political detainees. They have also suspended one army physician, Dr. Carlos Herman Perez Castro, for certifying that a political prisoner who was tortured, was in a good physical condition upon her release from a secret detention centre. It should be added here that all such investigations and hearings are conducted by the Association in secrecy and public announcement is made only after its 20 member council reaches a verdict. According to Dr. Gonzales, the president of the Association, as many as 30 to 40 physicians have participated in covering up torture in the last one decade and they will continue their investigations till each is properly examined by the committee.

Although these guidelines were issued less than a year back, they have started to show positive effect. The Association's ethics committee chairman reported that after the guidelines were an-

nounced several military and police doctors had approached the members of ethics committee to report that they had been asked by the authorities to examine or treat prisoners who had been tortured. They also sought assistance from the Association in informing military authorities that they would not become involved in covering up torture.

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OUR BODIES, OURSELVES

Organising Women on Health Issues

gabriele dietrich

This article tries to draw on experiences which were made while organising rural women in Tamil Nadu, mainly landless agricultural labourers of Dalit background. Health had not been a primary aspect in this process of organisation, it had been used as one of several "entry points", but as things developed, it turned out that health education became a focal point since it raises the crucial question of women gaining control over their own bodies. This control over women's bodies, as it emerged, is one of the most important factors conditioning women's potential to organise and to participate in decision making. This discovery came as a surprise because "health" is not usually seen as a high priority by village women themselves. The participatory research process itself was a means to build consciousness about such social controls and to find ways and means to break them down.

THE participatory research process which was part of a project of PRIA (Participatory Research in Asia), took place in villages near Arkonam, North Arcot among members of a voluntary organisation called Society for Rural Education and Development (SRED) and among women belonging to an independent organisation called Rural Women's Liberation Movement.

It is characteristic that even the formation of SRED as an organisation trying to facilitate rural women's movement; was already the result of a longer process of organisational experience. The initial attempt had been to organise Dalits (they were using the term Harijans at the time).

SRED today works in 50 villages of Arkonam and Thiruttanni taluks, 35 villages are "consolidated" villages where cells of the Agricultural Labourers Union and the Rural Women's Liberation Movement Sanghams (founded in 1982) have been formed, 15 villages are "new" villages in which work has only started recently. Women's Sanghams and Agricultural Labourers Union function largely independent of SRED. North Arcot, like Chingleput, is on the whole a very dry area depending on the monsoon which often fails. Irrigation will be by wells and village tanks. As in many other parts of Tamil Nadu, the water table has been affected by the bore wells. There are two crops, mainly rice, but also dry crops like ragi, maize and kambu (a millet).

Women agricultural labourers have 120-180 days of employment, men up to 220 days. Agricultural wages are as low as Rs. 6 for men and Rs. 4 for women. Supplementary income comes from wood-cutting and selling, also from brickmaking. The land holding pattern is such that there are largely small holdings and only very few cases of land concentration. This of course confines the scope for wage struggles within narrow limits. It is obvious from this background that the people with whom SRED works live in abject poverty and struggle for their very survival.

Integrating Health Work with Women's Organisation

The SRED did not start off as a health organisation. However, poverty being so rampant, health is clearly an important problem. Thus, health work came in mainly as an entry point for women's organisation. It was integrated with other activities like self-employment schemes: mainly embroidery and tailoring to start with, then mat-weaving, weaving of towels and sarees and carpentry. Plans are in process to branch out into cycle and transistor repair. Dairy and poultry schemes have also been tried.

In Arkonam, a special women's shop sells sarees and readymades. The effort to offer weekly opportunity for gyneacological check-up had to be abandoned due to lack of response. Apart from such attempts of income generation, building up rural women's organisation was the main objective. The Rural Women's Organisation has again and again taken up rape cases, wife murder cases, wife-beating cases, also issues like water supply and road building, accessibility of the village tank to *all* (i.e. including harijans and menstruating women) as well as health issues, much of the time by putting organisational pressure to make defunct government services available to the people. Recently, a journal Women's Voice (Mahalir Kural) has been launched to report on women's problem and the activities of Rural Women's Organisation. Again, the journal will also have a section on health, especially drawing attention to nattu vaittyam (indigenous herbal medicine). A drawback is that there are too many men on the editorial board because women lack training in journalism.

The basic concept is to equip women activists to be barefoot doctors, to have a basic understanding of common illnesses and treatments and to make them conscious of improving nutritional standards even under pressure of abject poverty.

The need for sustained health work first became visible in 1979, when a widow approached the organisation in need of an abortion. Since she was ashamed of expressing her problem straight away, she shrouded it in flowery expressions commonly available in village Tamil for this kind of occasion. (I have "not taken bath" for 2 months, i.e. missed the menses). The two young health workers did not understand her and sent her away with some aspirin. A few days later the village drums announced a death. The widow, in fear of ostracism, had committed suicide. It was decided to intensify health work and to link it up with rehabilitation of widows who are generally considered to be inauspicious and a social liability. A full time health worker trained in primary health was appointed and she took responsibility for training mainly middle aged and elderly women in primary health, among these a number of widows and village dais.

From the original 35 villages covered by SRED work, the women were drawn to get training as barefoot doctors. Since they are nearly all illiterate, the training went on for three to four years.

There are hardly any institutionalised health services provided by SRED. The community centre at Ulliambakkam runs a primary health clinic providing allopathic as well as nattu vaittyam (non-allopathic) services for common illness. Once in a week a private allopathic doctor comes voluntarily for consultation in more serious cases. At Kaverirajapuram, a cobblers village, once in a week a health clinic goes on under a tree with a homeopathy doctor who comes as volunteer. In Konalam centre, clinic work was started but had to be abandoned because of transport problem (it is inaccessible by public transport). At Mulvai a clinic was started with a gynaecologist, but this too had to be abandoned because of transport problem.

There are now eleven girls at the Kallaru centre who are working in self-employment schemes. Six of these also do part time health work. Three women full timers of SRED are appointed for training work in primary health. SRED has altogether eleven full-timers now (seven men and four women). Even the men animators who mainly work with the union and do work with men and women there, get all the primary health education with special emphasis on women's problems.

Emerging Concepts of Health

When health work was taken up by SRED, it was only partly integrated with the perspective of women's organisation. It was intended that health work should help to rehabilitate widows and would make basic knowledge of primary health available to a large number of women. However, the content of health education was rather complex and, as it turned out, rather contradictory. It cannot be claimed that all the underlying assumptions have been fully clarified but at least certain trends have become identifiable.

On the one hand, there was an attempt to make government health services available which would imply a curative allopathic approach. This was complemented by seeking the help of voluntary agencies working with an approach of preventive medicine along allopathic lines. This also implied a certain technical enlightenment about family planning methods, much along the lines of government programmes but without the coercive implication of these. The underlying assumption here was that use of family planning methods would automatically benefit women. On the other hand, there was an effort to enable women to really master their own health situation as self-reliantly as possible. This effort was undertaken by methods of nattu vaittyam mainly on herbal base, as well as cheap food supplements. The participatory method which was pursued, finally led to the insight that, instead of using health exhibitions prepared by experts, a team would be formed to prepare an exhibition, especially on the reproductive cycle and birth control. This led to a conflict with the technical approach pursued before and to the discovery that perceptions of sexuality were crucially influencing women's ability to apply birth control methods as well as women's ability to gain mobility and organise. Since these discoveries were an integral part of the participatory research process, it is necessary to follow this process step by step.

In the initial phase, a two day meeting took place, one day with animators of SRED and one day with about 30 women from the Rural Women's Liberation Sanghams. Initial discussions circled around questions like: (1) What are the most common illnesses? (2) How frequent are death in childbirth and child mortality? (3) How frequent are abortions? and so on. It turned out that all of these questions can only be answered within the overall context of abject poverty of the people in this area. Most common illnesses like diarrhoea, dysentery, fevers, breathing problems have all to do with general malnutrition, lack of water and basic hygiene and the constant worries of survival. Apart from this, some ailments were identified as occupational or environmental. There was widespread tuberculosis, probably with underlying byssinosis, among the workers of a cotton mill and there was a village where people suffered from water-induced paralysis. While death in childbirth is not a very frequent occurrence nowadays (partly because of the thorough retraining of village dais), child mortality remains high, especially among girls. Abortions were obviously widespread and a follow-up on this question showed that they are more rampant than assumed. While government services are available in a number of places, they are often defunct and in many cases people also do not have the money for the bus to go to the next health centre.

This overall situation accounts for some of the basic priorities in the health work which were pointed out: To strengthen self-reliance by teaching cheap basic nutrition and herbal medicine; to help to make existing government services available; to propagate family planning.

It was then decided to proceed with the participatory research in the following manner: (1) To document experience where people had organised in order to make government health services available to them. (2) To document the use of herbs, home remedies, indigenous medicines (nattu vaittyam) and to record the positive and negative experiences with such methods; also to document positive and negative experiences with allopathy in comparison. (3) To go more specifically into the question of *women* and health—how do women understand their own bodies? What is their understanding of the reproductive cycle, of birth control etc? Are information and contraceptives available? What are the social taboos? (4) In which sense is the health work an entry point for other women's work? How does it relate to the other work and to the process of getting organised? Why does this work pick up in some places and not in others? (5) What are the most important aspects of the women's work to the women themselves? Why do they feel it is an advantage to get organised? What are their difficulties in getting organised?

It was felt that in order to come to grips with questions 2-5, it would be necessary to have extended discussions and one way to generate them would be to conduct health festivals in different villages with exhibitions, skits, songs and pattimantrams (debate). Apart from the festival itself, the collective process of preparing it would give a lot of opportunities for exchange and clarification.

Already at this stage it became visible that there are indeed very strong social barriers against women taking control over their own bodies. It turned out that many of the village dais who knew everything about delivery, have a very rudimentary understanding of the reproductive cycle. Many women said they did not know about birth control methods. Some had used abstinence in order to space births.

The women said that the health work helped them a lot to build women's sanghams and most sangham members have an acute awareness of health and nutrition, so much so that many sangham leaders become free lance barefoot doctors and health workers. They felt that they learned a lot in the process and derived self respect from this. At the same time their competence about nutrition and simple illnesses also had increased their awareness of health as a business, the profits of the drug industries. Ironically, it seemed often to be the abject poverty which turned out to be a learning aid here. Since expensive nutri-

tional supplements and sophisticated medical services were out of reach anyway, the "do it yourself" approach looked like the only viable option. Among the slightly more affluent families, the drive for self-reliance would be less and the influence of advertising and impact of a consumerist allopathic approach to health more. It was also felt that the health topic needed to be discussed more in the agricultural labourers union and that building a new health system needs to be part of overall transformation of society.

Deepening Levels of Participation

Originally, the health festivals which were organised also included family planning propaganda. Though this propaganda was not particularly oriented towards achieving targets, it shared the commonplace middle class assumption that small families are necessarily happy families, that women only have too many children out of sheer ignorance and that women will happily apply family planning methods once they get acquainted with them. These assumptions had obviously been inculcated in the process of training health workers to propagate family planning and were not supported by the actual experience of working with village women. It became clear in the process of the participatory research where they went wrong and how they needed to be corrected.

A series of health education meetings were held with different types of people, e.g. the girls who learn tailoring in the Kallaru Centre, social workers, nurses, village dais, women who belong to the women's organisation. Apart from general health topics like hygiene, use of native medicine, etc. special emphasis was laid in these meetings in building up knowledge about the functioning of the reproductive system and to build up a different attitude among women towards their own bodies. This is no doubt an extremely difficult task, since everything related to menstruation, sex, childbearing and childbirth is usually taboo and it definitely belongs to the upbringing of a "good girl" not to mention about "these things". The general pattern is that "men are supposed to know" while women are best kept in ignorance. The underlying social assumption is that a girl who has any sexual experience, has been "spoilt". A further assumption often is that even "knowing about those things" "spoils" a girl.

It is also difficult to evolve methods which allow women to open up. One method is sharing personal problems in small groups of two and three. Another method is to talk about all parts of the human body and their functions in order to build an awareness that sexual and reproductive functions are as natural as any other functions of the body. Besides, slide shows were used about the reproductive system. On delivery, role playing has also been used.

There are different kinds of barriers to be overcome in different categories of participants in this kind of a programme. Among young participants, most of whom will be unmarried, there is a general embarrassment which has to be dealt with, giggling, and a certain reluctance to face realities. Among village dais and more elderly women from the women's sangham, there is greater sobriety in facing reality and drawing on one's own experience but the actual level of information is very low.

In a meeting with young girls in which I participated, the embarrassment was such that participants closed all the windows while slide show was going on so that nobody would be able to overhear what was discussed and the showing of slides was accompanied by exclamations and giggles. While the girls expressed afterwards that they found it useful to know all these facts, the question arises how they can be dealt with in real life since the actual taboo of knowing is so great that admitting such knowledge easily leads to accusations.

In another meeting with elderly women (village dais and women's sangham leaders) it turned out that though the women had experience and understanding about childbearing and delivery, many of them did not know about methods of birth control. Some of them had used abstinence in order to space child births. Some confessed to having had abortions. Some had reservations because they found it risky to go in for permanent methods because of child mortality. The tendency in the discussions was to place before the woman the options of birth control (e.g. loop and copper T, operation, etc.) in such a way that they appeared as the scientific way to go about things while abstinence from intercourse was looked at as unscientific and unnecessary infringement of the marital rights of the husband which would create tension and misunderstanding.

In the course of the discussions it became visible that the approach of the SERD animators was somewhat inconsistent. They had the tendency to depict tubectomy as a very good method of family planning because it solved the problem once and for all. It also transpired that, if a woman gets operated, she may have even less control over the frequency of intercourse than before because "nothing can happen" anyway. The man can assert his "right" over her body more easily since no risk of creating further offspring is involved. Woman also felt that they would face more accusations of infidelity if they used contraceptives. The animators applied a "harmony model" oriented towards fertility control only, suggesting that it was quite unnecessary and unscientific to deny a man intercourse in order to space births. It became visible that abstinence in some cases was a simple way of ascertaining sovereignty over one's body—an effect which could not be achieved with all the nice scientific technical methods which may in fact contribute to weaken a woman's control over her sexuality. Women also come up with their views that having to be sexually available hampered their mobility. They found it difficult to come for night meetings because they would be late in coming home. Even elderly women complained of the need to be sexually available very frequently. Sexuality was very much perceived as part of the sexual division of labour, women providing services and man consuming the same. It also became apparent that even women's access to hygiene is very much related to sexual division of labour as well as threat of sexual violence.

While certain general rules like tethering cattle or covering food can be easily followed, it turned out that women do not easily have basic access to hygiene. On being questioned about when they take bath, the usual answer is "on Friday". Friday is the day then they take bath, put turmeric, flowers and clean clothes and go to the temple. The men on the other hand have a daily bath. The problem is not scarcity of water because women may be handling water all the time, washing clothes, scrubbing vessels, watering plants. The problem is one of the division of labour and length of the working day. Women simply do not find the time to take bath. A bath is a luxury reserved for man. (Indeed, detailed enquiries into the working day of women and men among landless agricultural labourers have shown that women work up to six hours more every day.)

Another problem is the lack of privacy. It is more difficult for women to take a bath because women have to be constantly careful not to expose themselves to other men's eyes. This problem also affects their toilet habits. Women go to the fields very

early in the morning or late in the evening. The contradiction is that it should be dark in order to be less exposed, on the other hand, it is more dangerous to go out in the dark because of the danger of assault. All this leads to constipation and strain on the bladder. The problem gets aggravated during menstruation and pregnancy.

These conditions are so much taken for granted that it is extremely difficult to discuss them at all. It is extremely hard to think of any alternatives. Common toilets in the villages ("WCR toilets", a government programme) never work for lack of maintenance. One also wonders whether it is right to have public toilets for women and men in one cubicle just separated by a wall and with different entrances. If the toilets for women were in one locality and those for men in another, it might work better. Private toilets are entirely absent because of the money investment, water problem and fear of bad smell close to the living place. An experiment with a Gandhian dry toilet by two health workers was also given up. So at the moment, it is very unclear in which direction to go. However, by being able to slowly talk about the problem it becomes clear that the situation is quite unbearable and thus the motivation to tackle it slowly grows.

There are also questions about how to deal with menstruation. Women use old rags for sanitary towels and it should be explored whether it could become an avenue of self-employment to produce cheap sanitary towels at the sewing centre in Kallaru. It was also observed that bathing places for women have vanished over the last ten years due to environmental factors. Generally, the water table in the area has gone down because of bore wells. Many temple tanks have gone dry and others have been reclaimed for agriculture. Even where they still exist, the men are washing lorries in them. So the old custom of women going to the village tank to bathe, wash clothes and chat with each other has been abandoned. This not only undermines cleanliness but also women's solidarity. The question comes up whether the women's organisation can try to create a new place for women where they can wash, bathe, chat and spend some time together.

The Social Roots of Abortion

It transpired in the course of time that abortion is a much more gigantic problem than was evident from the beginning. In a discussion with middle aged and elderly village women it turned out that nearly all of them had experience with abortion, either undergoing them or performing them or both. Abortion is virtually a 'cottage industry'. It is usually carried out with home remedies as eating green papaya, swallowing large quantities of camphor and turmeric. The most widespread and most dangerous method seems to be the use of irakkan chedi (a plant the white blossoms of which are offered at Ganesh chathurthi). A dried yellow leaf of the plant is taken and the stick in the middle of the leaf is taken out and shoved up the birth channel into the uterus. This procedure causes ferocious infection and bleeding and any lead to severe puss formation and even blood poisoning and death. All the same, the method is widespread since it is free of cost and very "reliable" in the sense that the foetus does not survive. Often women have to go in for medical treatment in order to survive.

As far as infanticide is concerned, it remains a pious wish to say that girl babies should be treated equal with male babies. A substantial part of the problem of child mortality is in fact the problem of the morbidity of the social system of patriarchy. At the present moment, it is not yet visible how the women can go beyond discussions towards concrete solutions. The sobriety with which some of them admit infanticide is breathtaking and heartrending at the same time.

The facts of abortion and infanticide again raised the question why family planning is used only by a few. It was recognised in the course of the discussions that "family planning" as such is often resented as a form of government interference in family affairs. It is therefore much more meaningful to discuss the problem as birth control in the overall context of allowing women control over their bodies and over their health. The unpopularity of sterilisations is based on two factors: a) People shun irreversible methods because of child mortality, b) socio-cultural barriers. Men think they lose their "virility" when they get sterilised. They think they will be "weak" and unable to work sufficiently to support the family. There is also a feeling that a woman who has lost her fertility for good is treated with less respect. The problem seems to be that such "loss of respect" does not get compensated by a feeling of having gained control over one's own body because control over sexuality remains entirely with the man and may in fact be more than before. So the humiliation and actual subjugation which may go with operation may make it less acceptable than the risk of having abortions. Though the abortions entail great suffering, they are a matter of woman's own choice at a crucial moment and they are executed entirely among women. Thus, to get away from the abortions can only be achieved by means which would in fact enhance a woman's control over her own body.

Conceptualising Sexuality, Fertility and Male-Female Relationships

A series of 45 posters was made (basically using VHAI slides and *Our Bodies, Ourselves* as models) entirely on the the reproductive cycle, the sexual and reproductive organs, ovulation, fertilisation, pregnancies, the birthing process, cancer detection, sterilisation etc.

This exhibition has advantages over slides in that it can be used without electricity and that women can look at it at their own place. While a slide show just reels off under their eyes, they can go back to earlier posters for clarification, can contemplate them at length if necessary and ask for explanations. It is very important to be able to dwell on the problem at length because the actual embarrassment of facing one's own insides in this way is beyond all measure. Women admitted again and again to have been shocked at what they saw but they also expressed surprises, joy and pride. Even the health-worker who explained the posters had to fight her embarrassment and had a tendency to rattle down the information in great haste in order to have done with it as soon as possible. It was later decided to avoid this and to first give the women a chance to react and to ask questions. One old woman objected violently: If women know all this in advance, how will they ever have the courage to get married at all. But young women counter-argued that this would support them to be less ignorant and helpless than before.

The exhibition was first shown in Ulliambakkam to about 50 women of different ages who had come from surrounding as well as far away villages. They were all sangham members. It was later shown to the girls in the Kallary centre who are in the self-employment training and partly in health training. When we discussed the exhibition in these different collectives, we discovered some lacuna in it which were later overcome as a result of these discussions. The 45 posters only dealt with the female body exclusively. It therefore did show tubectomy but not vasectomy.

This had done out of a feminist motivation to come to terms with "our bodies, ourselves". However, it was felt that this approach was not true to reality. The male contribution to pregnancy became visible only in the form of a few sperms, the

most expressive poster of this kind being that of a giant sperm wriggling its way towards the egg ("pampu pole"—"like a snake", as the women said). It was felt that there is surely more to getting pregnant than just that. Why did it seem to be difficult to face and depict this "more"? One underlying problem seems to be the sheer habit of exhibiting, exposing and even dissecting a women's body without great problems, quite in contrast to the actually imposed "modesty" and "shyness" of women. On the other hand, while men uninhibitedly and even shamelessly expose themselves, including their private parts in public while they relieve themselves, there is much more of a tamboo to actually depict a man's body, leave alone his genitals on a poster. This is one reason why we feel so free to dissect a woman's genitals and reproductive organs while we find it difficult to look at a man's penis and testicles with the same kind of detachment. It was therefore felt necessary to depict the man's reproductive system as well and to admit the involvement of the penis in intercourse. It slowly surfaced that there is a need to understand in greater depth the relationship between sexuality and fertility in order to come to terms with the overall problem of birth control and control over a woman's body.

The difficulty in doing this can be easily illustrated by the fact that one of the great revelations to women is the news that they actually have "three holes" i.e. urinary outlet, vagina and anus. Virtually none of the women were aware of this before marriage since there is total taboo on talking about one's body. One young girl said that she thought for a long time that talking to a man and laughing could make a girl pregnant since this was what her parents forbade her to do. Even when giving birth the first time, some women are still confused where the child actually comes out. In the posters, the female genital organs were entirely depicted from the point of view of fertility. The fact that women have a sexual organ of their own in the form of the clitoris which is not related to fertility was felt to be too much of a shock to be disclosed at this stage. The female body is seen entirely in terms of fertility, even as far as woman's own subjectivity is concerned. Women may be "male sex objects" but the question how they could possibly be subject of their sexuality and perhaps enjoy it, is kept out completely. Even women's protest against making women sex objects is often carried out by mobilising values of motherhood and nurturing. Women as sovereign sexual being seem to be unthinkable to women and men alike. However, this is not just a question of a women's general quality of life, it has quite devastating medical implications and at times becomes a question of life and death.

Men, on the other hand, are primarily seen in terms of sexuality, they are first of all sexual beings. The fact that their orgasm is achieved by ejaculation of sperm which make pregnant (while a woman's orgasm is entirely independent of fertility) is generally neglected. Since it is the woman who gets pregnant, fertility is "her" problem. But in fact "her" problem is that sexual satisfaction *in the man* is related to fertility. Precisely this is her actual health hazard. It was therefore felt that an exhibition on the reproductive cycle needs to depict these facts of life in a truthful manner.

Summing up, it can be said that the health work had focus entirely on problems of fertility which was seen as a "women's problem" which had virtually nothing to do with sexuality as far as the woman is concerned. Sexuality only came into the picture in the form of rendering sexual services to men who were seen as sexually starved and needy but had virtually nothing to do with fertility except that, unfortunately, the sexual act does make women pregnant. The task identified was therefore to acknowledge woman as a sexual being, to acknowledge the right to control her own sexuality to acknowledge man's responsibility for fertility which would also establish the necessity to see male sexual needs in relationship to female sexual and other physical needs and to the problems of fertility as a shared problem.

Perceptions of Marriage

These discoveries led to deeper discussions on sexuality and fertility and on the actually existing patriarchal system of the family. It came out that women, while they see themselves as childbearers and as beasts of burden, most of the time experience sex as one more household chore like fetching water and firewood, cooking and serving food, finally surrendering their own body. These discussions were very interesting because the women felt free to speak out in a large group while at the same time a few of the men animators were also present so that there was a certain amount of interaction between women and men as well. Since men are seen as primarily sexual beings, the assumption seems to be that sex is their birthright and their supreme need, their "full satisfaction" an ultimate goal to which all other considerations have to be subordinated (e.g. refusal to use condoms). In a big meeting with fifty women only two said their husbands used them. On the other hand the sexual satisfaction of the women does not come into the picture. Since the men enjoy sex, they presuppose that women also do so. On the question whether they know what their women feel they said: How can we know, we have no words to talk about "such things". Men were completely taken aback when married young women said that they enjoyed caresses and tenderness while they often hated actual penetration.

Since "full sastifaction" of the man is the supreme value, the women needs to be ever ready. Women are often not allowed to go to night meetings leave alone to seminars which last several days, because they will not be available at home. The women are also frightened that if they do not provide these constant services, the man may shift to another woman and ditch them. Even elderly women face the problem of daily intercourse.

This led to the characterisation of a man's attitude towards marriage as a "facility" (Tamil: vasathi). Men get married when their mothers get too old to cook for them and they expect from it all the services like cooking, washing, health care, childbearing and rearing and sex. The one service they render in return is "protection"(pathukappu) which in fact only becomes necessary because of the general violence against women in society which makes marital rape preferable to the constant danger of indiscriminate sexual use, gang rape and the like.

It seems to be clear that unless woman's right to control their own bodies becomes an accepted human right, the use of contraceptives remains a remote possibility and women may go on for a long time undergoing home made abortions and allow their babies to die of neglect.

Discussions on Menstruation, Pregnancy and Delivery

In the workshop which accompanied the exhibition and which brought out most of the crucial insights which are summed up above, a lot of other information also came to light which, at a closer look, seems to be very much related to the social mechanisms which withhold from a woman control over her own body. All the women believe in seclusion during menstruation. They should not touch foodstuffs (especially pickles), should not go out, should not bathe and put flowers etc. They experience

themselves as impure and weak. They should not use disposable sanitary napkins because if some animal eats these, this will cause the fertilised egg not to settle in the uterus or early miscarriage. If menstruation ceases in a woman due to anaemia (which does happen since anaemia is widespread), this is ascribed to a "spirit". It is also related to the goddess Katteri. When they are pregnant, women are more susceptible to be possessed by spirits. They are also not to cross rivers and should avoid going out. There are the most comprehensive food taboos on pregnant women (on the list of foodstuffs to be avoided are : coconut, mango, papaya, jaggery, raw rice, grapes, bananas, jack-fruit, sweet potato, potato, maize, kambu (a millet), tinai (another millet) and a number of vegetables, including kirai, and eggs). Women are even restricted in their water intake. One really wonders how they keep alive at all with a diet chiefly consisting of rice and virtually nothing else to go with it. The idea is that the placenta may grow too big or that the child will be too big and delivery difficult.

Women are also kept in the dark about delivery. Since they are brought up in the belief that a spirit or a god leaves the child at the doorstep or that the old lady who sells vegetables has brought it along, they find it difficult to envisage the process of delivery even during first pregnancy. Some think the child many come out through vomiting from the mouth, others believe the belly may open underneath the naval. Some believe that the child comes out from the rectum. Some believe that the child comes out piece by piece, hand from hand, eye from eye and then gets assembled. Only three young girls had learned about pregnancy and delivery at school and one girl had got a rather realistic picture by overhearing other women talk about it. While exposures like the poster exhibition go a long way to set such beliefs right, a lot remains to be done to enable women to be in command of their bodies during delivery, by breathing exercise and methods of natural childbirth. It is quite a step to recognise that the pain during labour is due to contractions and that the most efficient way of dealing with it is not to clench one's fists and grind one's teeth while waiting for it to go over, but that there is an active way of combatting the pain by systematic breathing and relaxation. It is envisaged as a future step to go into methods of natural childbirth more systematically. It also remains to be explored to what extent this process can be explained to men and whether men can be involved in deliveries in a supportive way.

It is also important to see these prevailing superstitions about women's bodies during menstruation and pregnancy in the overall perspective of violence against women and oppression through perpetuated ignorance. The tendency sometimes is to ridicule women for their ignorance and superstitions. However, many of these are just an expression of concretely experienced powerlessness and isolation. Nodbody would nowdays easily come forward to blame a Dalit for his belief in untouchability. His mindset will be seen as the product of an oppressive system. Women's minds deserve to be understood in this overall framework as well.

Lessons Drawn

It is certainly not easy to draw clear cut lessons from a learning process as complex as the above described. One definite result is that the participatory research project itself has created more intense involvement and mass participation in the health education. Apart from this, the following observations can be made:

1. Certain contradictions were discovered between different objectives within the health programme, e.g. the activity of making defunct government services available and then dispensing health services rather at random, was in contradiction with the overall approach of using nattu vaittyam, making people subjects in dealing with their bodies instead of making them objects and consumers of treatment.

This is no doubt a very far reaching and complicated problem which can probably not be resolved on the ground of experience within SRED alone. Experiences of a more participatory use of allopathy have to be taken into account and also experience in the use of different systems (like, ayurveda, homeopathy, yoga treatments) need to be absorbed.

2. Another contradiction which became visible was between organising and pursuing a very technical, propagandistic approach towards family planning, much along the lines of government programmes. In the course of the research this approach changed completely towards birth control in the context of establishing women's control over their own bodies and their own health, and becoming clearer about the link between sexuality, fertility and social controls.

3. During the change of approach, major changes in language became necessary, e.g. today it will no longer be said that a girl "has been spoilt" if she has been sexually used. Also, the traditional word karparhippy for rape (which means destruction of chastity) has been replaced by balat karama (sexual violence). While it may look surprising that all this should be part of a health programme, it touches deeply upon the underlying assumptions about and attitudes towards a woman's body.

4. It became increasingly clear thay many health problems cannot be tackled without tackling the underlying social root cause. E.g. the prevalence of illicit abortion and occurrence of female infanticide cannot be tackled without making the effort to break male sexual controls over women's bodies and transforming social relations and production relations within the family. Even access to basic hygiene is dependent on this.

5. It was felt that this is indeed quite a frightening perspective because it means overthrowing thousands of years of historical heritage. The question is how this can be done concretely. Some possibilities seem to emerge: (a) The discussion on the relationship between sexuality and fertility as reproduced above and the different impact it makes on the roles of men and women in the family and in society at large needs to be deepened in the women's sangham and among men as well. (b) Methods have to be evolved to help people, women and men alike, to face these new insights and to live with them. Since women in the village as a rule cannot walk out on their husbands, they have to find a way to survive in dignity as also to take a lead to transforming the relationship. Since women are traditional relationship-builders, they have the wealth of a historical heritages to own and to fall back on. Of course, their major objective should not be to redeem men but to learn to live their own lives. All the same, some redemption of man may occur in the process.

Apart from the need to collectively support women (e.g. against wife-beating in concrete cases or by holding seminars on rape, including marital rape), there will also be the need for individual counselling of persons and couples. If such counselling happens in the overall context of building women's movement, agricultural labourers union, health movement and people's science movement, the effects of it will be much more constructive and transforming than the normal opiatic marriage counselling or just technical advice on family planning.

The experience of SRED on the relationship between women's health and the structures of patriarchy in the family and society at large need to be shared with people working in the field but also in the women's movement, people's science movement and other mass movements.

—**gabriele dietrich**
c/o ECC
Whitefield
Bangalore

Politics of Information

rosalie bertell

Recently two US women whose husbands had died of cancer due to radiation exposure filed a suit for damages against the company concerned as well as the United States government. This article, condensed from "Index on Censorship" (14: 5 October, 1985) reports how the US judge assigned to the case subordinated public health and safety to the interests of the government nuclear programmes. Nuclear advocates including scientists and scientific journals have applauded the judgement and have widely circulated it. What is being sought to be overlooked is that the judgement is not only biased but uses false scientific arguments and is full of obvious errors and misstatements.

TWO widows of cancer victims and two survivors of cancer among former employees of the Aircraft Instrument and Development Company (AID Co) brought suit against that company, 23 other companies and the US federal government, which has the ultimate responsibility for regulating industries using radioactive material. This case, cited legally as Johnston vs United States, 597 F. Supp. 374 (D.Kan. 1984), involved a company which purchased instruments with radium-painted dials at salvage for reconditioning. In addition to its regulatory role, the US government was the first owner of the instruments purchased by AID Co. The 23 companies had manufactured and marketed these instruments without warning signs.

The companies involved, after reviewing the plaintiffs' case, the expert testimony and their own defence, decided to settle out of court, jointly awarding $ 400,000 to each of the four plaintiffs. The federal government however, refused to settle out of court and launched a vigorous case defended by a team of seven US Justice Department lawyers in the US District Court for the District of Kansas. The judge was Patrick F. Kelly and there was no jury. After 42 days of testimony (5,509 pages of transcript), Judge Kelly closed the case of Johnston versus US government with a 150-page opinion issued on 15 November 1984, ruling against the plaintiffs and for the government.

The extraordinary aspect of this ruling concerns the use of this case to vilify three expert witnesses called to testify for the workers: Dr Karl Z. Morgan, Dr Carl Johnson and Dr John Gofman. To quote from Judge Kelly's written opinion:

> The paramount and obvious everriding interest (of this case) has been to 'put to rest once and for all, the likes of Drs Gofman, Morgan and Johnson'. . .
>
> The plaintiffs' claims are simply secondary to the interest of the United States.

He expressed the hope that his views of Drs Gofman, Morgan and Johnson would influence other courts in which they are scheduled to appear. On the other hand, Judge Kelly finds the US government's expert witnesses, Drs Maletskos and Auxier's methods 'wholly objective,honest and reliable'. Judge Kelly declared that he believed nothing of plaintiff's expert testimony and *all* of the government's expert testimony. He praised the government's witnesses as 'superb', 'eminent', 'the court's favourite witness', 'a refreshing and wholly qualified witness', 'wholly effective, honest and reliable'. 'brilliant', 'realistic and sound', 'impressive' and 'most convincing'. The opposite remarks were made about Dr Karl Morgan, Dr John Gofman and Dr Carl Johnson.

Judge Kelly's conclusions do not merely pose a question of unrestrained character defamation. They also represent a break with previous US court cases dealing with exposure to ionising radiation. Judge Kelly failed to quote or append to his ruling any previous court rulings, even the recent Colorado, Utah and Pennsylvania court decisions in which radiation injury settlements were awarded. In these cases the expert witnesses produced by the government failed to convince the court that exposure to ionising radiation at low levels was harmless.

Nuclear advocates have widely distrubuted Judge Kelly's conclusions. Both Cliff Goff and Dr Michael Fox, workers at the Hanford nuclear facility (a US weapon factory complex), have used it as the basis for letters-to-the-editor attacks on reporters who have quoted Dr John Gofman. Dr Sidney Marks of Battelle Northwest Laboratories—a former Atomic Energy Commission official who has tried to suppress the findings of excess cancer among Hanford workers as reported by Drs Thomas Mancuso, Alice Stewart and George Kneale—has handed reporter Karen Dorn Steele an underlined copy of the Kelly opinion. The February 1985 issue of *Nuclear News* contained an uncritical summary of the judge's opinion with no reference to the underlying scientific debate or issues in question. The magazine has never carried stories on the praise given these same scientists in other court cases.

The April 1985 *Newsletter* of the Health Physics Society contained the first article of a four part series called: 'Highlights from the Decision of Judge Patrick F. Kelly in the case of Johnson vs United States', by John R. Horan, former Chief of Radiological Safety, International Automic Energy Commission (retired 1983). This lead article gives some background to the Kansas event mentioning the case previously lost by the US government, the more than 4,000 lawsuits pending against the United States alone, and the 1979 decision of the US Department of Justice to devote 'the necessary time and effort to developing a team of specialised lawyers with the requisite scientific background and expertise'. It was this specially developed team which the US government used to fight the two widows and two surviving cancer victims and 'discredit' their expert witnesses in the Kansas court-room.

This is an extraordinary way to conduct science. The first three pages of the Health Physics *Newsletter* contain nothing but exerpts from the Kelly opinion, without allusion to even one piece of scientific evidence or interpretation disputed before his court. Unless the readers had access to the 5,409 pages of trial transcripts they would have no way to test Judge Kelly's opinion on the health effects of radiation against their own opinions. Similar excerpted vignettes from the Kelly opinion have been duplicated by General Public Utilities, the company responsible for the Three Mile Island reactor accident, on 20 x 20 inch posters and sent all over the world.

What Is 'Safe'?

This extraordinary personal attack on three US scientists calls us to a serious study of its motivation. It requires, at the very least, a reflection on the basic scientific issues 'settled' by the court. The passing off of a judge's opinion which apparently endorses the nuclear industry and censures its critics, without issue discussion is unprofessional, to say the least. Never before have scientists appeared so needy of praise from a non-scientist as the nuclear community exhibits in this instance.

First let us look at Judge Kelly's logic. He repeatedly extols the Biological Effects of Ionising Radiation Committee (BEIR) of the US National Academy of Science as the 'world's irrefutable experts'. Although the BEIR committee states that

a 0.5 rem radiation dose to the general public yearly will result in 6 per cent cancer increase, 0.6 per cent increase in birth defects and a 15 per cent increase in ill health, Judge Kelly concludes to the contrary that there is no evidence leading one to expect radiation injury at exposures less than 50 rads (this is comparable to 50 rem). He states that even 72 rads may be safe. This conclusion of the court was not quoted in the Health Physics *Newsletter* or the other nuclear public relations material. The judge's notion of 'safe' is not clear, but certainly most persons in the Health Physics community would find even 0.5 rem per year to the general public 'not safe'. Judge Kelly's opinion (that allowing such high exposures carries no risk, is the 'international consensus among experts') is quite false.

Judge Kelly's preferred experts pronounced 40,000 picocuries of plutonium and americium a 'safe' body burden for atomic workers. In contrast, a US Department of Energy study showed a 33 per cent increase in chromosome damage among workers receiving 400 to 4,000 picocuries body burden. These studies of workers have also shown excess brain, lung, central nervous system and digestive system cancers, and leukemia (see *New Scientist*, 11 October 1984). Judge Kelly wrote: 'The four plaintiffs in this case have had numerous whole body counts (of radioactivity), each reported as negative, and which conclusively prove that they have no radium in their bodies.' This is in direct contradiction of the trial Exhibit No 12, 148, showing that the plaintiffs had whole body counts, performed by Helgerson Nuclear Services, which were between 132 and 330 times normal. The judge apparently confused the radium dial painters' exposure and the exposure of the plaintiffs to the hardened, flaked radium dust 10 to 20 years later. The GI tract uptake for the water soluble radium paint would have been much higher, and incorporation of radium in bone for dial painters was detectable with whole body scans. Three of the four plaintiffs were exposed primarily to inhaled radon gases and its decay products, not to radium. One plaintiff had cancer of the colon. For these types of exposure there is no expectation of finding radium, the precursor of radon gas, in bone. These facts were not conveyed to the Health Physics audiences.

The company at which the plaintiffs worked had dubious radiation safety practices. A letter from Mr Gaughan, Radiation Officer to Mr Fulks, Manager of Aircraft Instruments Development (AID Co) was also submitted to the court as evidence. The four workers with cancer had never been warned of the hazards of radium dials and pointers of the instruments they were re-conditioning or the dubious safety record of the plant. A US Occupational Safety and Health Administration inspection of the AID Co reported readings up to 100 mR/hr (a reading which would be normal for a year but not an hour) and over 2 million counts per minute (2 to 25 counts would be considered normal). It was only after the plant had operated for over 15 years that it first purchased an instrument capable

of measuring the beta and gamma radiation to which workers were exposed. It never possessed instruments for measuring the radon gas released continuously from the radium which was the principal hazard in the plant. The plant had received numerous complaints from the Kansas Department of Health and Environment because of its lack of radiation protection and the high levels of contamination throughout the plant. None of this worried Judge Kelly. None of this was reported to the Health Physics or nuclear establishment audiences.

The risk coefficients for cancer were another point of contention in the trial. Dr Karl Morgan was criticised for 'inflating' the predicted number of cancers. Dr Morgan had doubled the BEIR III estimates, a practice now accepted by Seymore Jablon, US National Research Council, and Dr Edward Radford currently correcting the atomic bomb survivor data on which the BEIR III estimates are based. On the other hand, Judge Kelly accepted the dose estimates for the plaintiffs calculated by Dr John Auxier, the person most responsible for the errors of dose calculation in the atomic bomb data (*Science* Vol 12, 22 May 1981). Since Dr Morgan made only a correction of 2 on the BEIR II cancer risk estimates, and did not use the added correction factor of 2 to 3 for conversion from absolute to relative risk, his cancer estimates would be generally considered conservative, ie too low, by most radiobiologists.

Justified Lying

The 'court's favourite witness', Dr Lauriston Taylor, perhaps gives us the best clue to understanding why the US specially prepared legal team was sent to Kansas to defend an obviously poorly run second-hand aviation instrument factory against the cancer death claims of two widows. He helps to situate the verbal attacks on the three scientists who tried to assist the court in coming to a verdict within the overall US predicament. Dr Taylor was quoted on Seattle television in February 1985, by Dr Richard Rappaport, president of the Seattle Physicians for Social Responsibility, as having said that lying to the public about nuclear matters is sometimes justified. As reported in the recently released minutes of the US National Advisory Committee on Radiation, 10 November 1958, Dr Taylor participated in the cover-up of a fall-out episode in Los Angeles caused by a nuclear test at the Nevada Test Site. The accident was described by Dr Edward B. Lewis of the California Institute of Technology as a 'really serious episode. We measured hot spots of about 2 mR/hr on the roof of our building and 2 mR/hr on our shoes... The real hazard is the inhalation of these in the lungs'. These exposures were much lower than those experienced by the deceased workers. In spite of the danger to the public, Dr Lauriston Taylor urged that the public be assured that all was well. In the 1958 minutes, Dr Taylor was quoted as having said that in order to actually protect the public from genetic damage 'you will have to talk about values set down by one hundredth or more'. He stressed that 'if you ever let these numbers get out to the public you have had it'. Birth defect rates have doubled in the US over the past 25 years according to a recent *New York Times* special report, but Judge Kelly wrote:

> This court finds that sincere and eminent scientists, like Dr Taylor, who have constituted the radiation protection community for over a half a century, have carefully studied all known literature on the carcinogenic potential of radiation and have set safety standards that were not expected to cause bodily injury during the lifetime of exposed individuals.

Just as Lauriston Taylor avoided public disclosure in the Los Angeles fall-out episode to safeguard the US nuclear weapon testing programme, so perhaps Judge Kelly found similar reasons to cause him to conclude that 'the plaintiffs' claims are simply secondary to the interests of the United States'. Those interests are the same in 1985 as they were in 1958, namely to convince people (however wrongly) that exposure to low level radiation causes no harm. Thus the American people will be willing to handle the uranium, run the nuclear reactors, separate out the plutonium, fabricate and test the bombs, and tolerate the radioactive debris from each part of the weapon cycle. The victims of this deception must be ignored because of the greater 'good' of national security in a nuclear age.

Although the Judge made many obvious errors and misstatements, these were not reported either in Donald Jose's letter, the Health Physics *Newsletter*, or the nuclear public relations material. The Judge referred to autoradiographs as audiographs; called the inverse square law the immense square law; thought MeV was a unit of power whereas it is a unit of energy; described alpha rays as bombarding tissues in millicuries per second; and said that electrons gave off daughter products. In a still more serious error, he claimed that there were no epidemiological studies or findings to support occurrence of cancer at radiation exposure levels below 50 rad.

The government lawyers used some rather crude tricks to convince the Judge that the radium handled by AID Co employees was harmless. They brought the dials into court and had Dr Robley Evans explain radiation threshold theory which was scientifically discredited in the late 1960s. This false theory led to an estimated 1100 excess lung cancer deaths among US uranium miners. They also brought into court a camping mantle whose beta emissions caused impressive clicks on a geiger counter. They failed to make available to the Judge the US Nuclear Regulatory Report No NU REG/GR-1910 , ORNL-5815, 1981, 'An Assessment of Radiation Doses from Incandescent Gas Mantles that Contain Thorium', which assessed the hazards of occasional use of such mantles. These two court-room demonstrations were used to minimise the years of work by the plaintiffs under unsafe radiological conditions at the AID Co plant. A special committee has been appointed to develop cancer risk assessment tables to estimate the probability that a particular cancer is attributable to radiation given the victim's age, sex, cancer type and radiation exposure dose.

The six-person committee is composed of three of the government's expert witnesses who testified against the plaintiffs who had lived downwind of the Nevada nuclear test site and who had contracted cancer. The government lost this lawsuit in Utah. None of the experts who testified on behalf of the persons exposed to fallout were asked to be on the Risk Assessment committee. None of the scientists who have published research papers on the cancer effects of low-level radiation were invited to sit on the committee. It is expected that the government will settle the 'scientific dispute' its own way—by legislative decree. This new tool will add to the effectiveness of the legal team with its scientific disinformation.

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AUTHOR INDEX

Why don't you write for us?

This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

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will measure
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our love of life,

and the worries
about our children
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for the humiliations
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from the inside
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the tubes inserted,
the bloodstained pads
the fact that
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the same again
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for the tortures
inflicted
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our lives
and we wonder
how they can live
doing this
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—Gabriele Dietrich
January 1986
Bangalore

The poem in the issue II:3 was by **Sachidanandan**. *We regret the omission.*