RT: A Journal of Radical Therapy is now called

STATE AND MIND

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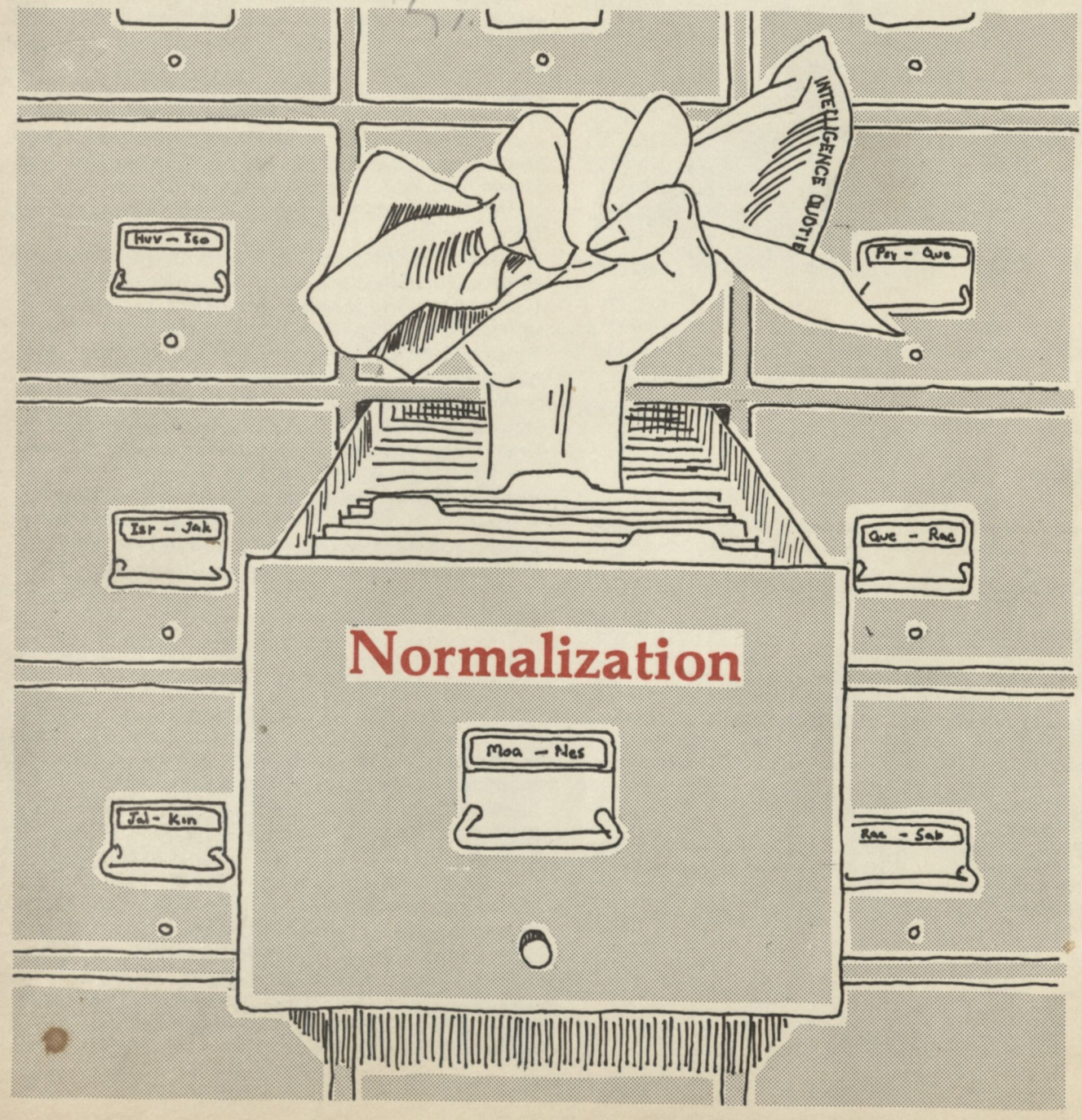

Normalization

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Collective Notes

The long days of summer have provided us at State and Mind with an opportunity to enjoy the warm weather as well as each other. Meetings have been incorporated into outdoor picnics, followed by softball and frisbee games.

Some of us have recently formed a weekly study group, discussing such topics as alternative communities, the forms of violence in our society, and recent attempts at a Marx-Freud synthesis. We hope that this group will generate articles and community projects, with input from our readers.

Since our last issue, several friends have come to visit and share information and ideas: Bob and Diane from ALMP in Philadelphia, Ann, an activist in the European movement, and Ted from NAPA-San Francisco.

These experiences, together with the likelihood of present collective members living outside the Boston/Cambridge area, has excited many of us about developing ways that people can work with State and Mind from other parts of this and other countries.

We also hope to have State and Mind representatives at both the L.A. Conference on Human Rights and Psychiatric Oppression (see p. 11) and the European Alternatives to Psychiatry Conference in Trieste, Italy (see p. 5). We are looking forward both to seeing some of you at these conferences and to sharing our experiences with our entire readership.

In the last issue, there were several errors: We failed to list Michael Galan as a member of the business committee. Our apologies to Ellen Shub for misspelling her name. We neglected to credit Anthony Colletti as the author of the Manifesto of the Mental Patients Liberation Project of New York City, which was originally titled *The Jailers of the People*. "Mental Patients Groups" should have been listed as "Psychiatric Inmate, Anti-Psychiatry, Legal Advocacy Groups, Organizations and Journals." The correct address for the Coalition to Stop Institutional Violence is P.O. Box 1, Cambridge, MA 02139.

Table of Contents

Manuscript Guidelines

- Please save your original copy and send us two or three xeroxed copies as we no longer return manuscripts.
- We welcome manuscripts of varying lengths up to a maximum of ten typewritten, double-spaced pages.
- We often correspond with authors concerning revisions and would appreciate an indication of your willingness to work on revisions.
- Please include a few sentences about yourself that could be used as a biographical note to accompany the article.
- If you have an idea for an article, but are unsure about how to approach it or whether we would be interested in the subject, send us an outline or prospectus and we will reply with some suggestions, possible avenues of research, and other journals that may be interested in the subject if we are not.

Copy deadline for the next issue is October 10.

Correspondence: We get lots. If you want information from us or a personal response, you must send us a *self-addressed, stamped envelope.*

We subscribe to *Liberation News Service* (LNS); *Community Press Features* (CPF); RT/State and Mind is indexed in the *Alternative Press Index.*

State and Mind is put together by RT, Inc., P.O. Box 89, West Somerville, MA 02144. Subscriptions are figured on the basis of six issues per volume; a volume takes a year and a half.

If you need to contact us by phone, call (617) 776-7285.

by Steve Kaiser and Sheila Koren

CIA's "Mind-Control" Scheme Exposed

CIA files released in early July, disclose that this agency performed "behavior control" experiments on unsuspecting American prisoners and employed American universities as research centers.

More than 1000 pages of documents released under the Freedom of Information Act detail use during the Cold War of mind-bending and memory-erasing drugs and other techniques that the agency admits were "distasteful and unethical."

The documents revealed that the name of the CIA research in "mind-control" was known as *MK-Ultra*. In 1952, for example, "mind-control" techniques were used against two people suspected of being double agents for the Soviet Union.

The documents do not say what happened to the pair. But they describe how one, under drugs and hypnosis, regressed 15 years to relive activities in his native Georgia in the Soviet Republic.

—Boston Globe, *7/4/77*

Mother of Psychosurgery Victim Appeals for Help

Louis Byers, a young black man, admitted to a California Veterans' Hospital in September 1976 in order to avoid being sent to prison on a parole violation, is now nearly a human vegetable after a psychosurgery operation. The hospital asked permission to do an exploratory operation over his left ear. Although this permission was not granted by anyone, the operation was performed and Louis' mother arrived at the hospital to find her son in a near death-like condition.

Before entering the hospital, Louis was in the army stationed in Germany. "Lou told me it was hell there," his mother said, "he had to fight the Ku Klux Klan in the army and against racist Germans in the area." He was discharged from the army for a drug habit developed *there* and which with the help of his family he kicked. But the hatred built up within him led to several altercations, all of them with whites. The psychosurgery operation robbed him of his anger, his feelings and the ability to use his own mind.

—Black Panther, *5/7/77*

Ange Bylczyk

The Supreme Court and Child Abuse

The Supreme Court decision of April 18 by a 5-4 vote decreed that: "The Eighth Amendment's prohibition against cruel and unusual punishments is inapplicable to school paddlings, and the Fourteenth Amendment's requirement of procedural due process is satisfied by . . . common law constraints and remedies."

The judges said, in effect, that children have no civil liberties and that it is up to us the people to provide this "societal advance," by the "normal processes of community debate and legislative action."

Stressing the broad public acceptance of the practice it was considering, the majority of judges agreed that, "Professional and public opinion is sharply divided and has been for more than a century. Yet we can discern no trend toward its elimination."

Previously the Court has agreed that they are moved by "the evolving standards of decency that mark the progress" of a civilization. In this case as in others, however, those stan-

dards of decency have apparently not evolved far enough to include the protection of children against the invasion of the integrity of their bodies (and minds). An erroneous conception of the child as having been conceived as it were "in sin and born into savagery, needing the rod to drive foolishness from him/her," still dominates too large a number of people to make the mandate for an evolutionary step forward conspicuous to the Court.

—The Last? Resort, *May/June 1977*

LNS

New Trends in Argentinian Psychiatry

Psychiatry is one of the instruments that the *Junta* of Argentina is using to control the people and to strengthen its reign over the country. Barbaric methods such as electro-shock, straitjackets and insulin therapy are being administered to people who deviate from the *Junta*'s code of ethics.

Torture is another area where the *Junta* is employing psychiatrists who agree with its policies. Dr. Atlantico Francia was executed several months ago by a left guerrilla band because of his connections with the police as well as certain fascist groups. Psychiatrists and psychologists are collaborating with the government in torture sessions and are aiding the police in interrogating political prisoners. In all of the South Cone, Brazil, Uruguay and Chile as well as Argentina, this connection has been confirmed.

Most all progressive mental health workers in Argentina have been imprisoned. Those in exile supplied this information.

Laissez-Faire Therapy — It Works!!

A recent study published in the *Journal of Studies of Alcohol* gives credit to British psychiatry for developing a low-key, money-saving way to "treat" alcoholics. Essentially, leave them alone!!!

The British doctors say it works as well as expensive treatments, including those involving admission to rehabilitation facilities.

In the "simple" program, alcoholics are told they have a huge problem, given advice and informed that the outcome is in their own hands. They are asked to report back on their progress in a year.

Drs. Griffin Edwards and Jim Orford from the Family Alcoholism Clinic, London Institute of Psychiatry, said their findings imply that present concepts of treatment for alcoholism may be in need of revision.

—San Francisco Chronicle, *6/15/77*

Rape: A Sexual Norm!

A Madison, Wisconsin group is working to recall Judge Archie Simonson who ruled recently that a 15-year-old boy's rape of a high school girl was a "normal" reaction to sexual permissiveness and women's clothing.

Dane County Citizens to recall Judge Simonson have begun circulating petitions in an effort to get the 22,049 signatures necessary for recall after the judge, citing advertisements, prostitution arrests, bars with nude dancing and young women who appear "even in court" wearing revealing clothing, gave the youth one year's probation.

"The community is well known to be sexually permissive," said Simonson. "Should we punish a 15- or 16-year-old boy who reacts normally?"

Protesting "the most serious crime in the history of Madison's public schools," a three-hour rally on May 31 drew hundreds of angry protesters. "We want to get across that rape is a crime of violence and power, not a normal response to certain kinds of dress," said Pam Pierson for the citizens' group.

—In These Times, *June 8-14*

When in Trouble, Call a Psychotic

Brain/Mind Bulletin reports that the so-called "mentally ill" may, in fact, be more socially responsible than their uninstitutionalized neighbors. In a study conducted at Fairfield University in Connecticut, "mental patients" proved more altruistic than "normal" subjects in responding to a contrived emergency.

The subjects in the series of experiments were seated in classrooms and asked to wait for an "instructor." Shortly thereafter an individual on crutches would enter, pretend to fall, and cry out in pain while observers noted the subjects' reactions.

Every "psychotic" patient tested offered at least verbal expressions of aid, while 28% of the controls said nothing. Even "severely disturbed" patients were found to be more likely than the "controls" to offer help. Aid was actually rendered by 72% of the mental patients, but only by 32% of the uninstitutionalized. Characteristics such

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as "altruism" and "helpfulness" are apparently still suspect by psychiatric ideology, diagnosed as evidence of "weak ego boundaries" and intentionally eradicated, leaving the "apathetic" and "uncaring" "lurking in the streets" as our models of sanity.

—New Age Journal, *7/77*

The Badgered Husband Crisis?

Dr. Pierre Mornell, an Assistant Professor of Clinical Psychiatry at the University of California's Medical School (and author of a book on sexual relations considered the best "how-to" book by *Cosmopolitan* magazine) has discovered a marital syndrome he calls "passive men and wild, wild women."

Mornell describes a symptomatic evening with such a pair as one in which the husband arrives home "exhausted from a day at the office. He has usually spent his day dealing with people and their problems [she hasn't] and he's had it up to his eyeballs. He wants to hide, withdraw, retreat from everyone — including (or especially) his family." Mornell goes on to say that the wife in turn "feels more pressured, becomes abusive. He retreats further. She becomes hysterical, bitchy," and then the "Wild, Wild Woman" which he uses as the title of the thesis.

Mornell diplomatically claims that he does not believe feminists have "created" this unfortunate male passivity syndrome, though they may, he suggests, "aggravate" it.

—New York Post, *5/12/77*

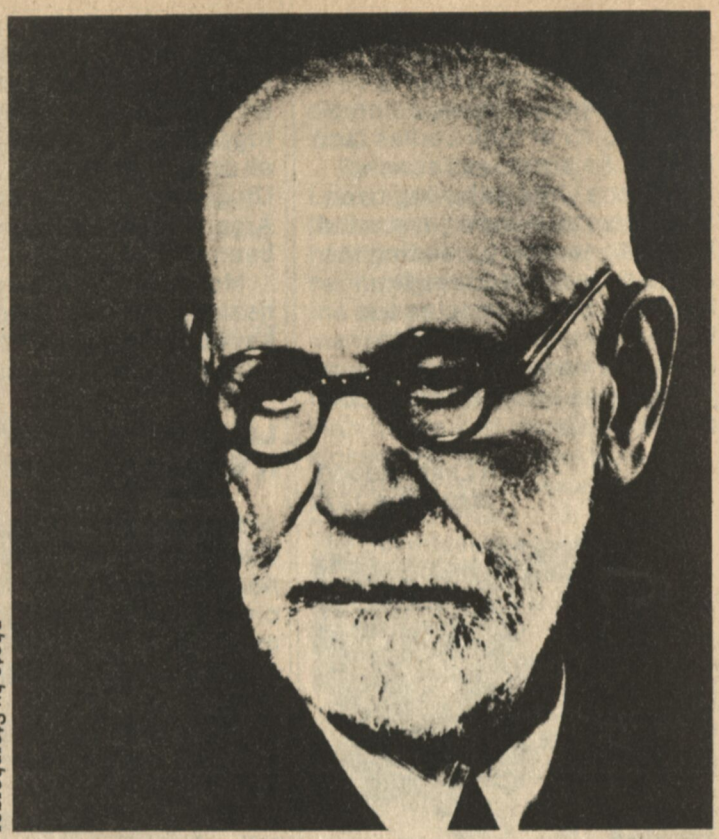


photo by Sternberger

God Maybe, But Not Freud

Anita Bryant and her Save Our Children fanaticists will have to stick to the bible for evidence in proving the "perversity of homosexuality." Four documents have recently been discovered that show Dr. Sigmund Freud, whose psychoanalytical investigations into the matter have long been used by anti-gay proponents, to have been himself consistently *opposed to the oppression of homosexuals.* Although none of the documents are lacking in some amount of objectionable content (and the question remains as to how Freud's "personal" opinions on the rights of gay people are related to his overall psychological theory), the most striking document discovered by James D. Steakley, author of *The Homosexual Emancipation Movement in Germany*, is a petition signed by Freud to the Bilateral Commission which, in 1930, was attempting to formulate a standardized penal code for the German Republic and Austria. This petition urged that a paragraph which criminalized homosexual behavior be repealed in the proposed new code. "In the name of justice," it said, "we demand that legislation give them the same civil rights by repealing the law in question." Freud's support was further reported in a Vienna labor daily on May 16, 1930.

—The Body Politic, *5/77*

Alternatives Conference

A conference on *Radical Alternatives to Psychiatric Control* was held at the Free Association in New York City on June 18th and 19th. It was sponsored by an

ad-hoc committee and attended by approximately 50 people; some currently involved in alternative projects, some who would like to be, and others working within conventional institutions who were seeking collective ways of struggling to change those institutions. The conference was called to discuss means and strategies for struggling *against* psychotherapy and the "mental health system" as instruments of socio-political control as well as struggling *for* alternatives *which do not themselves become vehicles of oppression.*

"The techniques of social control," said the conference's opening statement, "are not restricted to crude, brutal and inhuman (psychiatric) practices such as electroshock, lobotomy and drugging. They also take more insidious and subtle forms often proclaimed in the name of humanitarian treatment and reform, including: screening, testing, dossierization, behavior modification, regulation of diversion and work. . . . Their aim is to *normalize*, i.e., to induce obedience to the dominant norms of society and to prevent deviance and political defiance of all sorts. . . If our fight is not only and simply against the most visible forms of oppression but also to counter the more sophisticated and diversified modes of control, reversal of this *psychiatrization network* cannot be brought about through the reversal of any single institution; it must be fought through means appropriate to the variety and specificity of its aims."

After a general introductory meeting on Saturday morning, the conference broke up into three different workshops: "Building Radical Community Crisis Centers," "Struggling within Institutions," and "Experiences in Alternative Asylums."

On Sunday, people from these workshops gathered together to share and evaluate their experiences of the previous day. The whole group decided to keep in touch over the summer (via a circulated mailing list) and set a meeting for the fall at which time proposals for common actions would be discussed and initiations of them begun. Anyone interested in working on the above issues should contact Joyce Jed, 427 3rd St., Brooklyn, NY for more information.

European News

International "Alternatives to Psychiatry" Network
Third International Meeting — Trieste, Italy

Compiled by Mark Seem

The Third International Meeting of the "Alternatives to Psychiatry" Network will take place at the Psychiatric Hospital of Trieste from September 14-18, 1977.

This will not be a congress, but an occasion to exchange experiences currently underway in the different member countries.

The following activities and events are planned:

1) An Alternative Film Festival, and a festival of institutional criticism, in downtown Trieste, organized by the International Center for Study and Research — "Critica Delle Istituzioni."

2) The showing of films, video, underground documents, a retrospective on the theme of institutional violence.

3) An exposition of psychiatric techniques: from controversial methods to psychopharmacology.

Each country participating will have an area of the hospital at their disposal, where people can distribute information and where discussions on previously designated topics will take place.

The General Secretariat of the "Network" is located at 39, avenue Louis Bertrand, Brussels, Belgium. The International Research and Study Center — "Critica Delle Istituzioni" (Venice — Zattore 51, Italy, telephone 041-34899) will serve as the international secretariat of the colloquium.

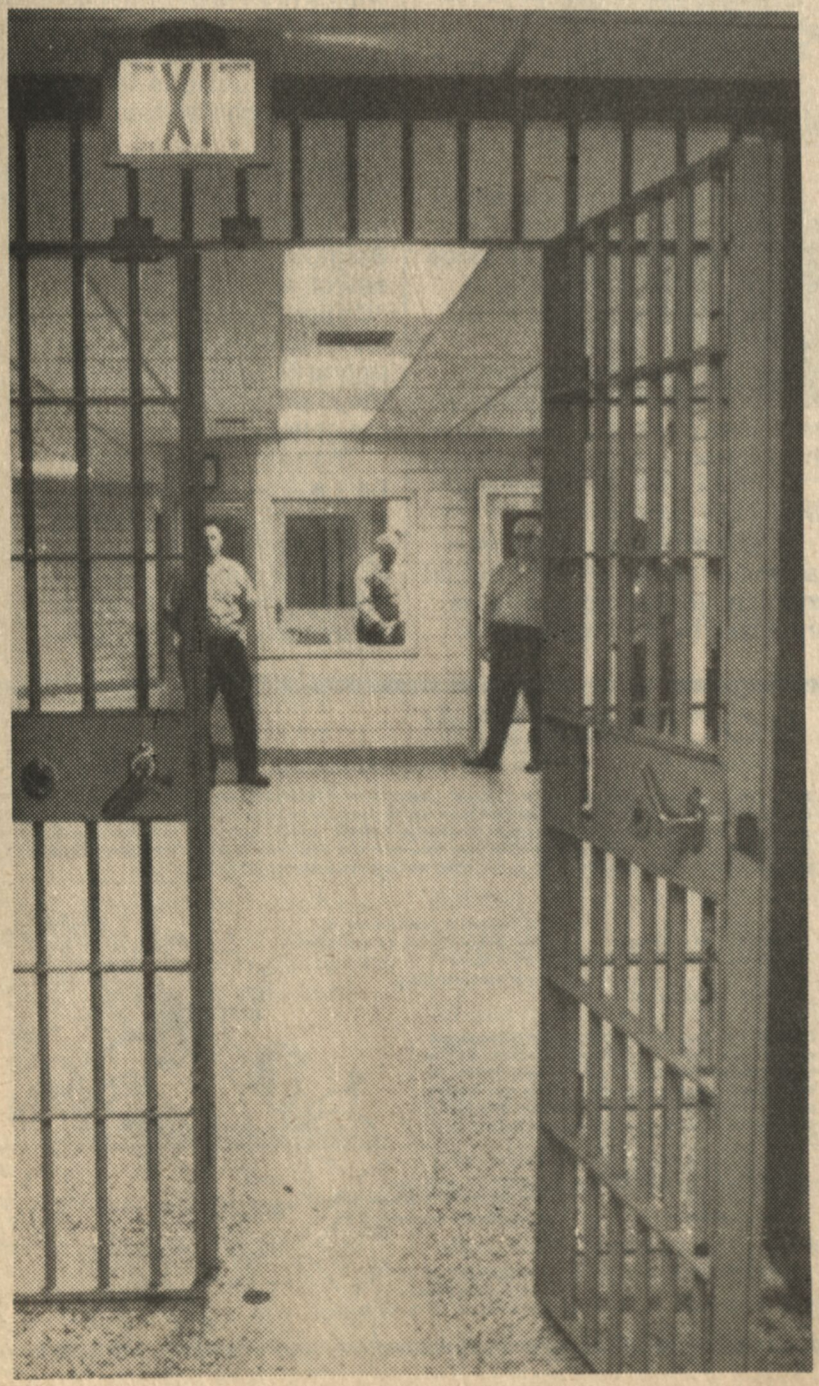
The national secretariat in Italy will be located in the Psychiatric Hospital of Trieste.

For more information, contact *State and Mind*, P.O. Box 89, West Somerville, MA 02144. Telephone: (617) 776-7285.

Brutality Unmasked

On December 5, 1974, "Smith" (department head), Farview State Hospital, executed a signed sworn statement, salient portion of which is set forth verbatim as follows:

Sometime in (month) 1974, patient "Jonsohn" informed me of an incident that he witnessed on repeated occasions. "Jonsohn" stated that guards would have a patient, "Reggie," strip and then they would taunt "Reggie" verbally until he would scream and carry on. The guards did this as a form of amusement.



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A letter from "Jones," Caseworker, Farview State Hospital, to Dr. "Bond," staff, FSH, is quoted verbatim as follows:

. . . The guards proceeded to unlock the door and the patient came out to receive his medication. As the patient was taking the medication he immediately bolted for the gate. The guards yelled to him to stop and quite surprisingly the patient stopped. Two guards ran up to him and one grabbed his arms. The other guard immediately began swinging his fists at the patient. . . . Finally the patient fell to the floor. . . . The two guards quite sadistically began kicking him. They continued to kick the patient as he crawled to his cell. When the patient arrived at his cell by way of being kicked and dragged, he was immediately pushed into his room. All five of the guards then followed into the room and I could hear very distinct blows given to the patient as well as yelling "Are you going to do that again?" They continued yelling this, striking the patient each time. Finally the guards came out of the room and the door was locked.

These quotes are taken directly from *The Farview Papers*, a once secret report of the Pennsylvania Attorney General's 1975 investigation into abuses at Farview State Hospital for the Criminally Insane. The papers have just been published in book form by the Alliance for the Liberation of Mental Patients (ALMP), a Philadelphia ex-inmate group, and David Ferleger, an attorney and advocate for people incarcerated in mental institutions.

The 86-page report was never released to the public by the Justice Department (although it was quoted by the *Philadelphia Inquirer* in its expose of Farview last year). In fact, on April 16, 1975, after the five-month investigation was completed, revealing page after page of incidents like the ones cited above, Pennsylvania Attorney General Robert Kane officially concluded that there was "no evidence supporting allegations of criminal violations at the Hospital," and no "excessive or un-

Philadelphia Inquirer/William E. Steinmetz

lawful" force used at Farview against inmates. At a June press conference and demonstration in Philadelphia, ALMP released this secret report of the Pennsylvania Attorney General's 1975 investigation and ask now that "the public be the judge."

Every interview with every witness, inmate, guard, doctor, and administrator is recorded and the familiar allegations of threats, beatings and illegal contraband are fully and graphically documented. Fictitious names and identifications have been substituted, say the Alliance, to protect the innocent and the guilty.

On publication of the previously covered-up report, A.G. Kane retreated to a more spurious defense of his failure to prosecute anyone shown to have participated in perpetrating or in condoning the abuses. According to ALMP's Bob Harris, the Attorney General insisted that he couldn't prosecute because the inmate/victims' testimony wouldn't hold up in court. (This despite the fact that, as noted above, evidence was also provided by non-inmate witnesses.) The State of Pennsylvania's message to its mental inmates, then, is clear: don't bother to try to report or to protest against being kicked, punched or choked; because no one will believe you, since we have determined you crazy.

Farview, in the words of Bob Harris, is nothing less than a "modern day concentration camp. Its internal functioning is dependent on the systematic brutalization and exploitation of its residents. It can be 'reformed' no more than could have Auschwitz as its very existence is based on the distorted logic of 'mentalism.' Nor should the racist character of Farview be ignored. Nearly 50% of the inmates at Farview are Black; at last count there were only two Blacks on the entire staff. The town of Waymart (where Farview is located) and its surrounding communities consist of exclusively white populations. Geographical considerations preclude any substantial alleviation of the racist staff structure, and the effects of this situation are duly reflected in *The Farview Papers.*"

David Ferleger explained his participation in revealing the report: "The people of Pennsylvania have been denied the facts. The full story of Farview has been kept under wraps. Not only has there been a cover-up but there has been a unwarranted blanket denial by state officials who — unlike the public — have been privy to the truth."

In its introduction to the report, ALMP provides a theoretical and practical perspective for their demand that Farview State Hospital be closed, that for an interim period, a team of civilian observers be hired by the Pennsylvania Dept. of Public Welfare to monitor each ward at Farview and report all incidents of in-

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mate abuse: "The connections between the struggles of prisoners and 'mental patients' are perhaps never more apparent than when we examine institutions such as Farview State Hospital. People adjudged 'criminal' become the target of moral contempt and the physical and psychological degradation of prison. Those diagnosed 'mentally ill' become the recipients (often unwillingly) of a condescending, paternalistic 'sympathy' and 'concern' on the part of the mental health profession, which incarcerates them in mental institutions and subjects them to [brutal] psychiatric treatments . . . Thus, when individuals are labelled as both 'criminal' and 'insane,' the combined oppressiveness of the prison and psychiatric systems produces an effect no less lethal than the combination of alcohol and barbituates in the bloodstream. Such is the case at Farview at this moment."

In light of the report's revelations these demands can be seen as nothing more than a moderate first step. The complete abolition of institutions in which routine degradation of human beings can flourish can only come about through a radical change in consciousness. "The contempt expressed on the part of politicians, judges, psychiatrists, and the public at large toward those held to be morally inferior and those declared to be mentally inferior stems from a common root. This is the need to avoid recognizing that the pain, fear, and frustration of those considered as outcasts is not substantially different from that felt by large segments of the general public . . . We hide from this frightful fact and from an understanding of our common humanity by drawing arbitrary lines between 'us' and 'them.' "

Copies of *The Farview Papers* are available at $3.00 each ($2.00 to ex- and current psychiatric inmates) from: ALMP, 112 South 16th Street, Suite 1305, Philadelphia, PA 19102.

Hard Rock Returns to Prison from the Hospital for the Criminal Insane

Hard Rock was "known not to take no shit
From nobody," and he had the scars to prove it:
Split purple lips, lumped ears, welts above
His yellow eyes, and one long scar that cut
Across his temple and plowed through a thick
Canopy of kinky hair.

The WORD was that Hard Rock wasn't a mean nigger
Anymore, that the doctors had bored a hole in his head,
Cut out part of his brain, and shot electricity
Through the rest. When they brought Hard Rock back,
Handcuffed and chained, he was turned loose,
Like a freshly gelded stallion, to try his new status.
And we all waited and watched, like indians at the corral,
To see if the WORD was true.

As we waited we wrapped ourselves in the cloak
Of his exploits: "Man, the last time, it took eight
Screws to put him in the Hole." "Yeah, remember when he
Smacked the Captain with his dinner tray?" "He set
The record for time in the Hole — 67 straight days!"
"Ol Hard Rock! man, that's one crazy nigger."
And then the jewel of a myth that Hard Rock had once bit
A screw on the thumb and poisoned him with syphilitic spit.

The testing came, to see if Hard Rock was really tame.
A hillbilly called him a black son of a bitch
And didn't lose his teeth, a screw who knew Hard Rock
From before shook him down and barked in his face.
And Hard Rock did nothing. Just grinned and looked silly,
His eyes empty like knot holes in a fence.

And even after we discovered that it took Hard Rock
Exactly 3 minutes to tell you his first name,
We told ourselves that he had just wised up,
Was being cool; but we could not fool ourselves for long,
And we turned away, our eyes on the ground. Crushed.
He had been our Destroyer, the doer of things
We dreamed of doing but could not bring ourselves to do,
The fears of years, like a biting whip,
Had cut grooves too deeply across our backs.

—Etheridge Knight

Why Do These People Need Money?

We like to monkey around and while our bananas may grow on trees, money doesn't. We want to continue improving the quality of *State and Mind* and feel this includes:

- ★ expanding staff and office resources
- ★ continuing our free subscription policy to prisoners and psychiatric inmates
- ★ increasing our communications and contacts with people and organizations outside the Boston area
- ★ maintaining and improving our function as an information and resource center.

Please Send Us A Donation Now!
(even a dollar will help)

For a contribution of $10.00 or more, we'll send you a set of *ten* very special back issues.

Make checks payable to RT, Inc., P.O. Box 89, W. Somerville, MA 02144.

PUBLICATIONS: *Legal Advocacy Programs for the Mentally Disabled: A Preliminary Survey and Directory.* This booklet was prepared for the National Committee on Patients' Rights by the American Bar Association Commission on the Mentally Disabled. It includes a listing of several hundred agencies and organizations around the country interested in legal advocacy services. It was issued in a limited printing and if you'd like a copy or want more information, contact the American Bar Association Commission on the Mentally Disabled, 1800 M Street, N.W., Washington, D.C. 20036.

The Toronto-based group, Wages Due Lesbians, has published a booklet entitled "Motherhood, Lesbianism and Child Custody." It contains important information about the law and how to build a custody case. It costs $1.20 and is available in the U.S. from Women in Distribution, P.O. Box 8858, Washington, D.C. 20003.

The Pennsylvania Department of Health has issued a useful pamphlet called "What to Ask Your Doctor." It's a sensible list of questions to insure the informed consent of patients and it's available free from the Pennsylvania Department of Health, Division of Community Education, P.O. Box 90, Harrisburg, PA 17120.

SURVEY: A gay sexuality survey is being conducted by Karla Jay and Allen Young. Selected responses to its detailed anonymous questionnaire and statistical compilations are expected to be published in 1978 by Summit Books. If you'd like to help by answering the questionnaire or distributing it, write to: SURVEY, Box 98, Orange, MA 01364. Indicate the number of questionnaires you want and don't forget to specify male or female.

MEETING: The Association for Humanistic Psychology will hold its 15th annual meeting in Berkeley from September 1st through the 5th. Daniel Berrigan, June Singer, and Philip Slater will be there with a host of other notables. If you would like to attend, become a member of the Association, or both, write to: The Association for Humanistic Psychology, 325 Ninth Street, San Francisco, CA 94103.

NEWSLETTER: The Benjamin Rush Society is an organization devoted to studying the behavioral sciences from a Marxist viewpoint. Topics under discussion at some of the Society's recent workshops and meetings have included Women in the Kibbutz, R.D. Laing, Vygotsky, and the Family under Capitalism. If you'd like to receive their newsletter, write to F. Bartlett, 119 W. 87th Street, New York, NY 10024. For information on the Society and becoming a member, write to Francis Touchet, 345 W. 88th Street, New York, NY 10024.

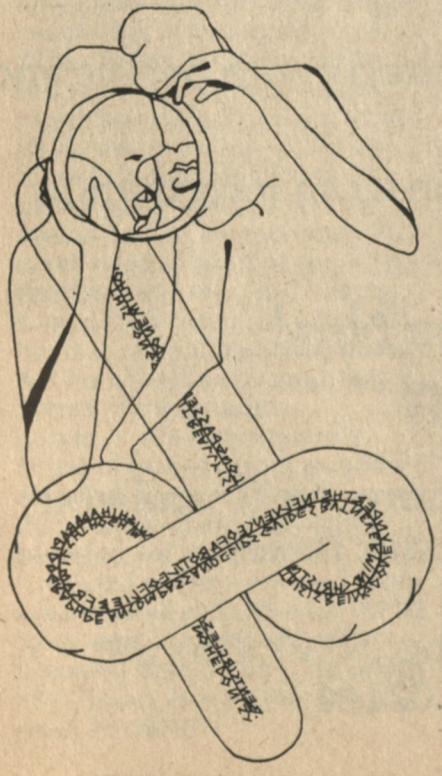
SYMPOSIA: The University of California will be holding two weekend symposia this fall, one on Patient Education and another on Stress Management and Approaches to Stress. The Patient Education symposium is scheduled for September 24-25th, and the one on stress will be held the following weekend. For further information call (415) 666-2894, or write: University of California, Continuing Education in Health Sciences, 1308 3rd Avenue, San Francisco, CA 94143.

Ear to the Ground

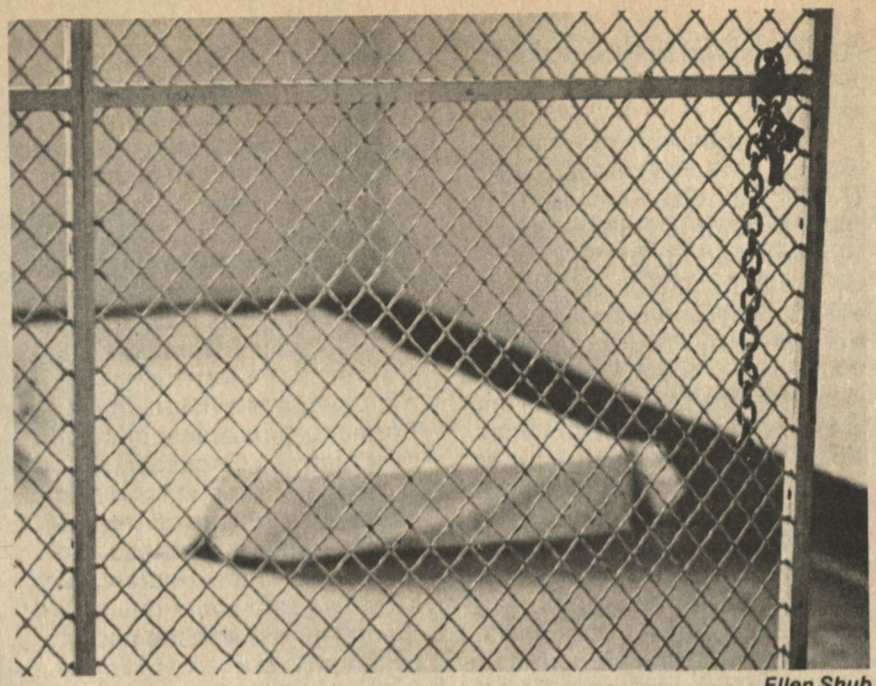
We received a particularly repellent brochure the other day touting Norman Tallent's *Psychological Report Writing.* "If psychological report writing is taking up too much of your time and energy, then see how you can write reports faster, easier — AND at the same time make them more effective!" If this grammatically indigestible call-to-arms is any indication of Dr. Tallent's writing talents, we advise the bleary-eyed psychologist to give his book a wide berth, or switch professions.

—Jennie H. Rathbun

Ange Byjczyk



Several members of San Francisco NAPA went to Los Angeles late in July to help with the organizing of the 1977 Conference on Human Rights and Psychiatric Oppression. The conference, originally scheduled for the July 4th weekend, was delayed because the original organizers dropped out. A definite site has now been found, a children's camp in Griffith Park, located in the Hollywood Hills, and the conference will take place from Thursday, September 15, through Monday, September 19. The first half of the conference, as was decided last year in Boston, will be open only to ex-inmates or people already active in the anti-psychiatry movement. The cost will be $38 for four nights and ten meals. Cheap



Ellen Shub

Mad with the Truth

transportation (charter bus or car pools) may be organized if there is enough interest. For more info, contact the conference c/o Richard Stanley, P.O. Box 1545, Studio City, CA 91604.

The drop-in center and home visiting service of Project Release, 97 Victoria St. N., Kitchener, Ontario (*note corrected address*), is run by and for former psychiatric inmates. The group tries to provide a "home away from home . . . an alternative to the psychiatrist-patient structure" for ex-inmates.

The Support Group for Psychiatric Patients in Denver voted recently to become a chapter of the Network Against Psychiatric Assault. The group is made up of ex-inmates and other people concerned about the "mental health" system, including legal workers from two local mental patients' rights offices.

Members of Colorado NAPA lobbied during the last session of the (very conservative) state legislature to keep some bills which would reduce inmates' rights from being passed. Several Colorado NAPA members are giving a class on psychiatry as social control at the Denver Free University, and the group has begun publishing a newsletter. They can be reached at 3520 E. 17th Ave., Denver, CO 80206.

Colorado NAPA voted at its July 5 meeting to work towards a coalition with other local groups to free Cecelia Gonzalez. Cecelia is a young Chicana who was arrested, then shipped off to Colorado State Hospital without a trial. After several years of the usual psychiatric tortures like forced drugging and seclusion, plus special harassment for being a lesbian, Cecelia escaped to California. Despite protests by WAPA and other San Francisco women's groups, Governor Brown extradited Cecelia back to Colorado, where she was arrested for the crime of escaping from the state hospital, then "released" on bail back to the same hospital she escaped from. Letters of support and contributions to her legal defense should be sent to Cecelia Gonzales Defense Committee, c/o Deborah Taylor, 1458 Gaylord Street, Denver, CO 80206. Cecelia would also like to receive letters. Her address is Colorado State Hospital, Ward 67, 1600 W. 24th Street, Pueblo, CO 81003.

After the suicide of a member of Advocates for Freedom in Mental Health while incarcerated at Topeka State Hospital, the group demanded a meeting with the "hospital" administration. This has developed into regular negotiating sessions over the general conditions at Topeka State, whose director is Walter Menninger, one of the family dynasty who run psychiatry in Kansas. For more info, contact Advocates at 928 North 62nd Street, Kansas City, KS 66102.

The Patients Rights Center, 121 East 6th St., Topeka, KS 66603, works out of the Legal Aid Society office there, and provides current and former psychiatric inmates with informaton and counseling on their legal rights. They are preparing a Patients Rights Handbook and

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have a referral service also. The Center is staffed by VISTA volunteers.

Ex-inmates from groups in Boston (MPLF), Philadelphia (ALMP), and San Francisco (NAPA), testified in May and June at hearings of the President's Commission on Mental Health. The Commission was appointed by President Carter in February to "identify the mental health needs of the nation" and make recommendations about how these "needs" can be met. The twenty members of the commission include a majority of professionals and one token ex-inmate. The chairperson is Rosalyn Carter. At a public hearing in San Francisco on June 22, many commission members noted that the ex-"consumers" who testified were unanimous in their condemnation of psychiatry; NAPA members who were there got the impression that the commission's preliminary report to President Carter (due Sept. 1) may include some recognition of the need to protect inmates' rights. The commission may hold further public hearings around the country before its final report, due June 1, 1978.

The anti-psychiatry movement has now reached as far as Hawaii. We've heard from a group there called the Psychiatric Inmates Solidarity Movement. They can be reached at P.O. Box 88228, Honolulu, Hawaii 96815.

Activists in the anti-psychiatry movement were seen over nationwide television on May 26. Former psychiatric inmates and psychiatrists discussed the pros and cons of various forms of psychiatric torture on the ABC News special, "Madness and Medicine." Unfortunately, very little was said about the myth of mental illness and the use of psychiatry as a form of social control, but there was documentary footage of inmates being given multiple electro-shocks and a lobotomy, as well as being put in seclusion. As a result of the program, the two ex-inmate groups featured on the show (San Francisco NAPA and the Mental Patients Liberation Front of Boston) have received lots of calls and letters expressing support.

The Network Against Psychiatric Assault in San Francisco recently held two demonstrations to protest the endorsement of psychosurgery by the National Commission for the Protection (sic) of Human Subjects of Biomedical and Behavioral Research. Seventy-five people marched on April 7 in front of the UC-Berkeley Law School, where Commission member David Louisell teaches, and over 200 participated in the demonstration April 15 at the Federal Building in San Francisco, where the full commission was meeting inside. After the April 15 rally, many of the crowd tried to attend the hearing, but were barred by security guards on the ground that the room was too small. People then refused to leave until a larger room was found, and the commission members were forced to deal firsthand with some of the people they are "protecting."

After moving in June to its new headquarters, which are shared with the National Lawyers Guild and other progressive groups, NAPA-SF is now gearing up for another demonstration. This one is against St. Francis Hospital, the first San Francisco institution to resume electroshock "therapy" since state legislation was passed in 1975 restricting forced shock. NAPA people will be in front of St. Francis August 18 to protest what they see as the "opening wedge" by the city's shock doctors to bring their profitable torture back to San Francisco.

Members of Women Against Psychiatric Assault edited the current (Summer '77) special women's issue of *Madness Network News.* And WAPA continues its leaderless support groups for women ex-inmates. The well-attended meetings happen every Sunday afternoon at the new NAPA/WAPA/MNN office, 558 Capp Street, San Francisco, CA 94110.

—Ted

"Mental Health," Normalization and Resistance

Mark Seem and John Parkin

Two Statements

Growing out of conferences in both Europe and North America, two recent statements on "the politics of mental health" show evidence of a broadening of focus for the "anti-psychiatry and alternatives to psychiatry" movement. The current concerns and criticisms these statements reflect are directed not only at the blatant abuses of psychiatry in institutions but at the whole of the psychiatric system and the technology of normalization that supports it.

The first of these statements, the founding document of the European *Network for an Alternative to Community Psychiatry*,[1] seeks to reach "all those who demand that real problems be dealt with in other than a technocratic mode." The *Network* has been coordinating exchanges of information on experiences with and struggles against psychiatric oppression and on the building of common actions and alternatives. Early in its statement, the *Network*'s position becomes clear: "We refuse to confine the problem of alienation and marginalization, fostered by the socio-political system, to psychiatric terminology." Instead they say they will work to introduce a political analysis of "mental illness" there where psychiatric and psychoanalytical discourses have been dominant. Such a political analysis of the psychiatric system maintains that just because a person is in pain or suffering it does not mean that one must defer automatically to the "psycho-medical machine." Such an observation applies even to practices on the "left," where people in crisis are often rejected from groups for being "irrational," "emotional" or "untogether" until they "get it together" again, i.e., return to the group's prescribed standards of *acceptable behavior*. A truly radical struggle against psychiatric power would have to confront such exclusionary, segregative attitudes, and analyze what sorts of ideals or fears concerning "breakdown" are present in any group so as to develop collective methods for providing non-psychiatrizing support for its own people.

The European Network sets itself the following immediate tasks: to stop new construction of psychiatric hospitals and special services; to reconvert existing structures in line with a politics of self-determination and self-management (this reconversion) would involve "the entire constella-

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*This paper will appear in two more complete forms in: *Handbook on the Politics of Mental Health*, Hannah Levin, ed., Marcel Dekker, New York, for publication in Spring, 1978; and in *Alternative a la Psychiatry*, by the "Network of Alternatives to Psychiatry," 10/18, Paris, September 1977.

tion of people who live madness, who live with madness, and who live off madness"); to struggle against the implementation of psychiatric ideology and techniques in schools and daycare facilities, where they function as subtle means to control and normalize children; to participate in the defense of psychiatric inmates and struggle for their rights — not as "mental patients," but as ordinary citizens; to fight for the psychiatrized population's rights to any and all information about the psychiatric system, and to prepare information pamphlets for this purpose; to struggle against the growing intervention of psychiatry in prisons, including the use of drugging to maintain order; to refuse the law enforcement role of community psychiatry; to combat psychiatric and psychoanalytic ideologies that co-opt the psychiatrized population's own discourses, analyses, and actions; and to fight against psychiatric classification and involuntary intervention.

The second statement, growing out of the Fourth Annual North American Conference on Human Rights and Psychiatric Oppression, held in Boston in May 1976, adopted the following positions along very similar lines: to struggle against involuntary psychiatric intervention, including all forms of forced psychiatric procedures (drugging, shock, psychosurgery, restraint, seclusion and aversive behavior modification); to develop a strategy that focuses on the psychiatric system as a whole, viewing it as "an extra-legal, parallel police force that suppresses cultural and political dissidence," and whose growing influence in education, in prisons, in the military, in government and industry, "threatens to turn society into a 'psychiatric' state"; to abandon the concept of "mental illness" and the *psychiatric terminology* that envelops it.

Psychiatry must be combatted not as an isolated unit of repression, but as a major system and technology for forging a society-wide pacification program "to help persuade and coerce people into adjusting to established social norms."

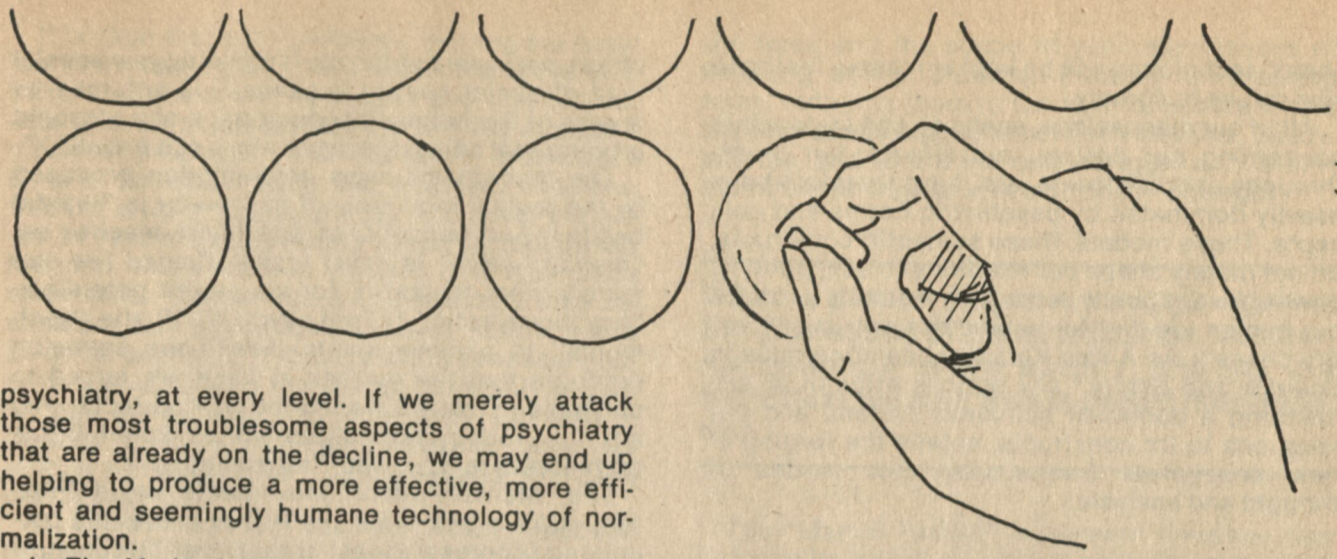
It is this last focus, on psychiatric terminology and concepts, that seems to represent a major advance in the struggle against the technology of normalization. Being a major focus of the European statement as well, it provides a strong common field for struggle and exploration. This struggle will be a matter of not only criticizing but of moving beyond dependence on ruling semantic and conceptual frameworks for defining and classifying people's behavior, their desires, fears and conflicts. The statement of the North American conference suggests that more objectively descriptive terms be used in place of psychiatric ones. For example, instead of "mental hospital," one would speak of a psychiatric institution; instead of the "mental health system," the psychiatric system; instead of "treatment," psychiatric procedures; and instead of "chemotherapy," drugging.

Psychiatry must be combatted not as an isolated unit of repression, but as a major system and technology for forging a society-wide pacification program "to help persuade and coerce people into adjusting to established social norms. Throughout society, more and more people are abandoning these norms. More and more people are demanding self-determination and community control."

It seems to us that the focus of all groups working against psychiatric oppression must include a serious analysis of the overall strategy and tactics of the psychiatric system as it develops finer and more precise techniques for mass normalization. Groups within the "Mental Patient" Movement, at least in North America, had for too long limited their focus to the overt, seemingly most repressive forms of psychiatric intervention — shock, psychosurgery, forced drugging, etc. — without placing these techniques within the framework of psychiatry as a whole. Yet it is becoming progressively more apparent that the main thrust of this technology of normalization, as it moves out of the institutions and into the community, is toward "kind and usual treatment,"[2] toward an exercise of "disciplinary power"[3] that aims to eventually function without the *overtly* abusive techniques. Within the context of community psychiatry, it is clear that money and thought are going into research to develop supposedly "humane" techniques of behavioral control.

Normalization and the "Mental Patient" Movement

It is therefore an illusion to think that the "hard" psychiatric techniques are more oppressive, more potentially totalitarian,[4] than the "soft," so-called "humane" forms of intervention: continual surveillance; examination; referral to other normalizing agencies; dossierization (where everyone becomes a case study); the fixing of sexual roles; the forging of set attitudes concerning the family, the nation, love, marriage, etc.; and the use of psychoanalytic mystifications (such as the notion of "oedipal conflicts")[5] that pervade all of the "helping" professions. Is it less repressive, less dangerous, to impose a totalized and totalitarian set of ideas, a rigid chain of associations to control people's concepts of who they are and what society expects of them, etc., than it is to drug them or segregate them against their will? We must oppose all totalitarian tendencies and potentials of



Geraldine Murphy

psychiatry, at every level. If we merely attack those most troublesome aspects of psychiatry that are already on the decline, we may end up helping to produce a more effective, more efficient and seemingly humane technology of normalization.

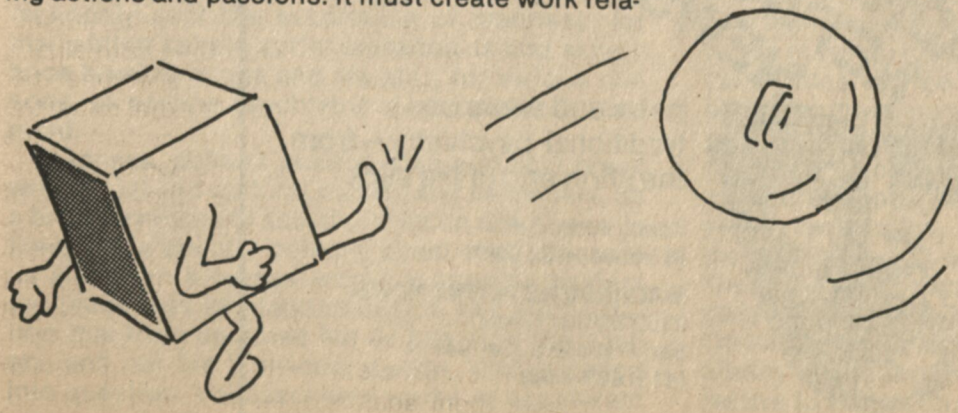
In *The Myth of the Hyperactive Child*, authors Peter Schrag and Diane Divoky eloquently and angrily describe the psychiatric normalization of children as

> a gradual, subtle, and seductive process [of which] the political and social consequences are enormous. When the impositions come in the name of diagnosis and treatment . . ., not in the name of punishment and control, otherwise arbitrary institutional procedures begin to look reasonable and the power to manipulate is immeasurably enhanced. This is science talking, it is the natural order of things; what we are doing to you has nothing to do with the arbitrary decisions of school administrators or cops of the social bias of the community. . . . What is certain is that the new ideology and the associated techniques — screens, drugs, behavior modification, special programs — all serve the purpose of legitimizing and enlarging the power of institutions over individuals.[6]

This brings us back to our first point. A struggle against psychiatric intervention must not be narrowly focused. The powers of psychiatry have invaded every level of our waking and sleeping lives. A commitment to struggle against normalization must do more than combat psychiatric atrocities (although it must do that also), it must forge alternative, joyous, de-normalizing and de-psychiatrizing actions and passions. It must create work relations that completely transform the function of work into intensive, struggling, and unalienating activity for social change.

People who have been psychiatrized and normalized in capitalist institutions (i.e., all people) are conditioned to distrust their desires and emotions, to regard their deviations from the accepted norms as "sickness," "and to rely on the institutions of the state and on technology to define and engineer . . . 'health.' " Children are being "accustomed" to such "treatment" at an early age say Schrag and Divoky — accustomed to being watched, graded, examined, diagnosed, dossierized, psychiatrized, analyzed — in short, *normalized* — and it might well become a matter of course for them *never* to feel that they have *the right to be left alone:* ". . . because they have never been left alone, and they will therefore never suspect that there might have been another way"[7] (p. 207).

Psychiatric techniques are fast becoming a generalized method for not only defining different norms for different populations of the society, but also for enforcing and imposing those norms. The "soft" techniques, the methods for conditioning behavior, will be used on the general masses; the →



"hard" techniques will be kept in reserve for those who refuse to comply.

All of our discussions, analyses and statements concerning our desires, our affects, our breakthroughs or breakdowns, etc., have therefore been heavily dominated by psychiatric norms and concepts. These models, these semantic constructs, do not merely shape our reactions to sex, politics, power, love, society, etc.: they actually *produce* our human identity for us and the ensuing "identity crises"! As Alfred Korzybski demonstrates in *Science and Sanity*,[8] any serious attempt at dismantling a dominant semantic system, and our reactions to its constructs, entails the forging of new conceptual frameworks, new modes of thought and analysis.

The Psychiatry Monopoly

Ivan Illich describes the dominance of social institutions as "radical monopolies," when they exercise exclusive control over people's attempts to satisfy some pressing need (i.e., for good health care or support in times of stress), thereby excluding the possibility for non-professional, non-technological, lay activities. School, for example, monopolizes the *natural* process of learning by labeling it "education" and setting up specialized, exclusive spaces and times where learning is permitted to take place. Medicine deprives people in a similar way of their natural capacities to care for themselves, making it virtually impossible to receive "care" other than that prescribed by legitimized doctors. In short, a radical monopoly, such as education, medicine or, indeed, psychiatry, exists "where a major tool rules out natural competence. A radical monopoly imposes compulsory consumption and thereby restricts personal autonomy. It constitutes a special kind of social control because it is enforced by means of the imposed consumption of a standard product that only large institutions can provide."[9]

The product for mass consumption produced by the radical monopoly of psychiatry is "mental health." And because, as psychiatry teaches us, "mental health" is never really attained (we can merely work toward it, for we are all potentially "psychoneurotic" or "pre-psychotic"!), the "treatments" to achieve mental health are semantic products that the masses at large are forced to consume in many different forms. And those who are not properly normalized will be forcefully re-normalized, re-educated, "rehabilitated"!

The "Mental Patient" Movements would therefore make a grave mistake if they presented psychiatric oppression as something that comes down exclusively on those labeled "mentally ill." While the psychiatric techniques are used most blatantly on this population, the more widespread technology of normalization extends across the entire social field and affects everyone. We are *all* avid consumers of "normality" and "mental health," we are *all* addicted to psychiatric definitions of who is normal and who is not, and these definitions have invaded not only the psychiatric field, but all of the human and social sciences, all of the "helping" professions, and indeed the field of liberal education as well. Illich makes a very important point in this respect. He says that radical monopolies rob people of their "native capacity for healing, consoling, moving, learning, building their houses, and burying their dead."[10] Alternatives to the radical monopoly of the "mental health industry" must work to develop people's capacities for self-care and mutual support, thereby ending the reign of dependency on psychiatric expertise for handling "problems in living."

It is clear that such problems in living are never just individual. Rather, they reflect the social relations that occur among people and institutions. And it is the *internal relations*[11] of the capitalist mode of production that define an individual's state of alienation such that problems of alienation are always socio-political, and never individual in nature as psychiatry tends to reductively interpret them. In this context, Thomas Szasz comments: "The language of psychiatry thus deethicizes and depoliticizes human relations and personal conduct."[12] It is therefore necessary not only to disestablish the radical monopoly of psychiatric terminology and technology, but also to develop what Illich terms "convivial tools" for mutual self-support of a collective and politically radical nature.

It is precisely here that the North American Movement against psychiatric oppression has been weakest. While there was some thinking in this direction around the work of Laing and Cooper in the early 70's, in most cases this led to a romanticization of the experience of breakdown and a sort of radical monopoly in reverse within the "mental patient" movement itself, where those defined and certified by the psychiatric system as "insane" started to proclaim their own expertise in psychiatric matters. In many cases, rather than evolving radical alternatives, they merely established parallel institutions that in no way endangered or countered the institutions of psychiatry. There has been a tendency in many groups to exclude psychiatric professionals, for example, only to internalize this professional expertise within their own ranks, thereby reproducing alienated patterns of interaction. But if such a self-willed segregation (no one but psychiatric inmates and ex-inmates allowed!) accepts *only* those people *defined by psychiatry* as "insane," how can they be conceived as running *counter to psychiatry*? In short, the "mental patient" movement has a definite tendency to accept psychiatric definitions on a very basic level and to remain isolated ("yes, we are different, crazier, sicker . . .") rather than view breakdown and breakthrough as social events that affect not only those confined or in "treatment," but everyone else as well. Psychiatric inmates, in other words, have no monopoly over the experience of madness, for many other people suffer breakdowns and experience breakthroughs and are able, for various reasons, to escape psychiatric diagnosis and treatment.

Madness, defined positively as a radical break with social and cultural norms, and negatively, as a breakdown due to social alienation and stress, is therefore a directly political event that concerns us all. When a person wages a struggle against the processes of standardization and normalization that have confined her or him, it is the society, and not the individual person, that is called into question. Yet psychiatry works to counteract the force and the scope of such experiences of breaking down, breaking through, or breaking away, reducing them to the familial sphere where the only scene staged is between mommy, daddy, and me, and where the only struggle one is ever permitted to engage in is with one's lone ego!

When a person wages a struggle against the processes of standardization and normalization, it is the society, and not the individual person, that is called into question.

The "Mental Patient" Movement therefore has to focus its attack on what is socially considered to be normal, and reject a ready-made and mass-fabricated "human identity." This entails revealing the socio-political forces that shape this identity for us and shove it, even more effectively than a pill, down our throats. It must be an *anti-normal* movement, aimed at discrediting the societal norms that stigmatize those who have dared to break with them, and force everyone else to stay in line. The "Mental Patient" Movement must never strive, like a good therapist, to make its members "normal" again. Instead it must vigorously work to dismantle all the belief-systems and semantic constructs that define someone as "mentally ill" in the first place. "Sanity" and "normality" would then join the list of sexism, ageism and racism, as major threats for transformation.

The Will to Change[13]

Our task then is to focus our work against the ever expanding technology of normalization. All techniques aimed at *representing* "client" groups by working and speaking *for them* (extending help, care, services, knowledge, skills, etc.)[14] must be criticized as practices of extension and representation and *replaced* by self-managed, self-defined collective practices for *transforming* people's lives by working *with them*. Freire stresses that new techniques and concepts cannot be extended to the masses, just as Guattari stresses that radical politics can no longer claim to represent or speak for the masses.[15] Extending "care" and representing "client" groups are part of the same totalizing, unidirectional, hierarchical politics separating those who possess the "correct" analyses, techniques, and aspirations, from the masses of people who must be "educated" and "helped." To work to adapt people to a rigid, externally imposed set of norms and values (even if "revolutionary") tends to develop social irresponsibility and fear of change, rendering people ineffective to transform their own lives.

In the statement of the European Network already cited, the crucial point is raised that work directed against the monopoly of psychiatric terminology must "combat psychiatric and psychoanalytic ideologies that co-opt the psychiatrized population's own discourses, analyses, and actions." Thomas Szasz states much the same thing, on a more general level, when he says that psychiatric terminology and concepts have so invaded our lives that they "have succeeded in depriving vast numbers of people — sometimes it seems nearly everyone — of a vocabulary of their own."[16]

A movement against such a psychiatric monopoly must recognize that, in order to be able to determine the nature and course of their own lives, people must be able to describe, explain and evaluate their experiences, feelings and actions in their own terms.

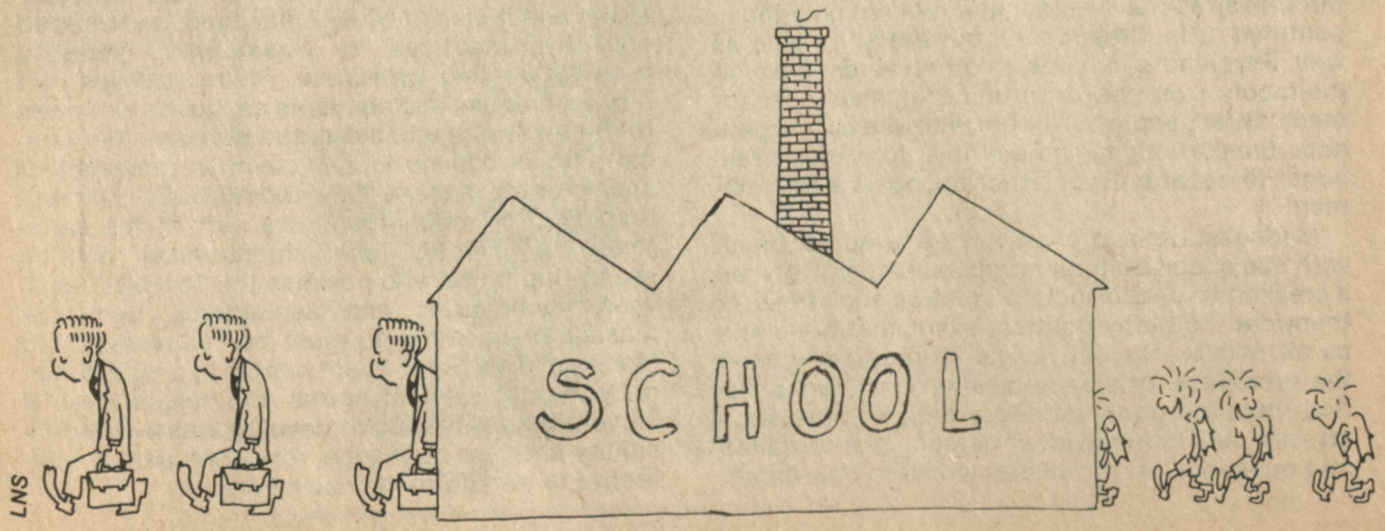
In a situation in which there is a growing trend toward psychiatrizing and normalizing the entire world ("Actually, no less than the entire world is a proper catchment area for present-day psychiatry, and psychiatry need not be appalled by the magnitude of this task"[17]), the goal of disestablishing the psychiatric system of normalization becomes essential, not only for the "mental patient" movements and the movements against psychiatric oppression, but for all those engaged in struggles to gain control of their own lives.✱

John Parkin has been involved in the "Mental Patient" Movement, including the Mental Patients' Liberation Project *(MPLP) of New York City since 1971; he has also been a participant in the North American Conference on Human Rights and Psychiatric Oppression, held annually since 1973. He is currently conducting a workshop at Freespace Alternate U (New York City) on the theory and practice of liberation from psychiatric oppression, and is a member of the Network Against Psychiatric Oppression (NAPO) of New York City.*

Mark Seem participated in the founding meeting of the European Network of Alternatives to Psychiatry *in Brussels in January 1975; he took part in a month-long training session in institutional analysis under the supervision of Felix Guattari at La Borde Clinic in France. He has worked with, and translated some of the works of, Guattari, Michel Foucault and Gilles Deleuze. He is currently a member of NAPO (New York City), and* State and Mind *correspondent for the European* Network.

Footnotes

1. See *State and Mind*, Vol. 5, Nos. 5 and 6, and this issue for a more complete description of the *Network* (European News by Mark Seem).
2. Cf. Jessica Mitford, *Kind and Usual Punishment*, Vintage Books, Random House, New York, 1971, for an analysis of this "humane" focus: her analysis of "the prison business" extends easily to "the psychiatry business."
3. Cf. Mark Seem, "A Review of Michel Foucault's *Surveiller et Punir*," *Telos*, No. 29, Fall '76, pages 245-254, for a discussion of Foucault's concept of the "technology of disciplinary power" and its relationship to psychiatry.
4. For an analysis of some of the modern forms of totalitarianism, cf. Felix Guattari, "Everybody wants to be a Fascist," in *Semiotexte*, Vol. II, No. 3, 1977, on *Anti-Oedipus*, pp. 87-98.
5. For a detailed analysis of the mystifying notions of "oedipal conflicts," cf. Gilles Deleuze and Felix Guattari, *Anti-Oedipus: Capitalism and Schizophrenia*, translated from the French by Robert Hurley, Mark Seem and Helen R. Lane, Richard Seaver Books, Viking Press, New York, *for September 1977 publication.*
6. Peter Schrag and Diane Divoky, *The Myth of the Hyperactive Child: and Other Means of Child Control*, Pantheon Books, New York, 1975, p. XVIII.
7. *Ibid.*, p. 201.



8. Alfred Korzybski, *Science and Sanity: An Introduction to Non-Aristotlean Systems and General Semantics*, 4th Edition, The International Non-Aristotlean Publishing Company, Lakeville, Connecticut, 1958.

9. Ivan Illich, *Tools for Conviviality*, Harper and Row, New York, 1973, pp. 51-2.

10. *Ibid.*, p. 54.

11. Bertell Ollman, *Alienation: Marx's Conception of Man in Capitalist Society*, Cambridge University Press, 2nd Edition, New York, 1976, for an in-depth discussion of "internal relations and alienation."

12. Thomas Szasz, *Ideology and Insanity*, Doubleday & Co., Garden City, New York, 1970, p. 2.

13. For an excellent discussion of "the will to change" as a will to *transformation power* as opposed to normalizing *power over*, cf. Adrienne Rich, *Of Woman Born*, W.W. Norton, New York, 1976, especially pp. 97-99.

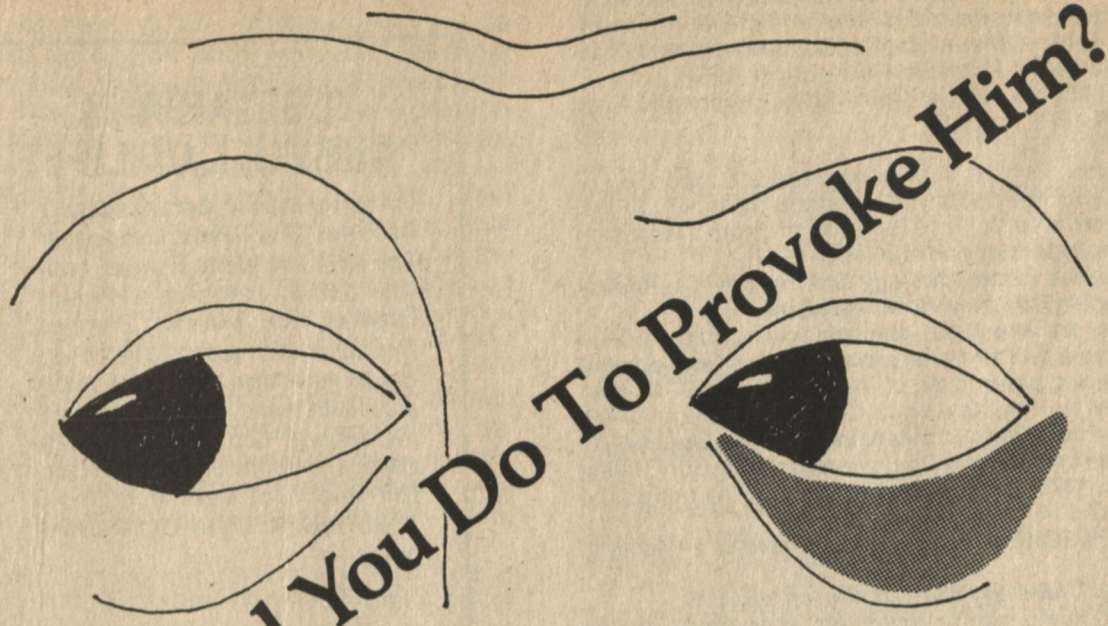
14. Cf. Paulo Freire, "Extension or Communication?" in *Education for Critical Consciousness*, Seabury Press, New York, 1973, for a detailed critique of the politics of extension.

15. Felix Guattari, "Everybody wants to be a Fascist," *op. cit.*

16. Szasz, *Ideology and Insanity*, *op. cit.*, p. 5.

17. H.P. Rome (senior consultant in psychiatry at the Mayo Clinic and former president of the American Psychiatric Association), "Psychiatry and Foreign Affairs: The Expanding Competence of Psychiatry," *American Journal of Psychiatry*, 125: pp. 725-30 (December 1968), quoted in Szasz, *Ideology and Insanity*, *op. cit.*, p. 4.

graphics by Geraldine Murphy



What Did You Do To Provoke Him?

Mary Metzger

Though a particularly obvious and repugnant feature of woman's general oppression, wifebeating[1] has nonetheless remained for too long a subject veiled in silence. The police, the courts, the medical and psychiatric professions and social service agencies have paid little attention to the battered wives. There is an undeniable ring of truth to Thomas Cannon's statement that in a system controlled by men, the abuse of women is not considered a problem.[2] Even among feminists the problem of wifebeating has lagged behind other admittedly important issues, such as sexism in education and discrimination in employment. For the first time at a NOW national convention held last October in Philadelphia, the subject of wifebeating appeared on the agenda. Yet the "battered wife syndrome" occurs in epidemic proportions. Del Martin, author of *Battered Wives*, states that the phenomenon affects at least three times as many women as rape.[3] FBI statistics indicate that in New York State in 1973, there were 4,746 reported cases of rape, while 14,000 wife abuse cases were taken to court.[4] In the period from July 1, 1973 to June 30, 1974, the Family Court of the State of New York reported 2,584 new assault petitions filed by women against their husbands.[5] In Boston, city police receive 45 wifebeating reports a day, while police in Atlanta claim that 60% of all nightly police calls are for "domestic disturbances," primarily cases of wifebeating.[6] The Citizens Dispute Settlement Center in Dade County, Florida received 721 complaints involving "assault or battery by a male upon a female" in seven months.[7] At Boston City Hospital approximately 70% of all assault victims are women who have been assaulted in the home.[8] Sgt. David Hubenette of the St. Paul, Minnesota police department said about 100 police reports dealing with wifebeating are written each week:[9] as usual, however, this figure does not include police responses to domestic incidents in which the woman decides not to press charges; nor does it include the uncounted cases in which beaten women do not even call the police. Wifebeating, like rape, remains an often unreported crime, quite often for the same reasons: the guilt, embarrassment and fear of the victim.

If the magnitude of the problem cannot adequately be depicted by statistics, perhaps it can be seen in terms of the results:

> Pat is in her mid-twenties, pretty, intelligent, articulate and six months pregnant. She is also blind in one eye. Her husband is kind and considerate five days a week. On Friday and Saturday night he goes drinking and beats her. Pat's blindness is the result of one of those beatings.
>
> Sharon was beaten badly enough by her husband to need hospital treatment on 27 occasions.

> She didn't bother about the straightforward black eyes and cut lips, but she remembers the time he split her head open with his boot, and the occasion he tried to strangle her with a telephone wire, but the details become a little vague because she passed out.[10]

Then there is the case of a 28-year-old woman from Lexington, Kentucky married to a sociology professor who has beaten her more times than she cares to remember during their four-year marriage. "Always careful to avoid the telltale black eye or broken nose that might arouse suspicion, he beats her at the base of the spine and punches her in the stomach."[11]

Although wifebeating is supposedly more common in families of lower socio-economic status, it in part transcends class and cultural lines in much the same way that many other aspects of women's oppression go beyond a particular class or culture. It is found in the Black communities, the Latin communities, and in white communities. Judges beat their wives, as do psychologists, lawyers, policemen, college professors and presidents of huge corporations.

One woman, the wife of a successful physician, recounts her story:

> When I told my parents I was marrying a doctor, they were really impressed. I was very excited too, but for much different reasons. People in the hospital respected Larry, both as a doctor and as a person. I found him very sensitive and supportive, always ready to listen and help me when I had difficulty on the job of with my roommates. [*Kamisher*, 1976: p. 21.]

After their marriage her husband's job became increasingly more demanding, and he increasingly more frustrated and pressured. She became the brunt of his frustrations; gradually his outlet after a hard day at the hospital was to batter her. After numerous and progressively more violent encounters, she decided in desperation to consult a psychiatrist. However, when she explained her situation to him he "intimated that perhaps I had a masochistic need to be abused or had provoked Larry into hitting me for some unconscious reason." After all, why else would she put up with being beaten?

Why, indeed, do women continue to tolerate beatings, imprisonment, maiming, torture and the accompanying destruction of the self which occurs for 10, 20, or 30 years, and sometimes the entire period of their adult lives?

. . . a woman who was verbally abusive to her husband was to have her name engraved on a brick which would then be used to bash her teeth out.

Why do women stay? This question is of central importance to the ultimate question of why women are oppressed. Wife battering, like rape, constitutes but one aspect of women's oppression, and cannot be examined out of the context of its relations with other aspects. In the same sense, the totality of women's oppression cannot be understood unless it, in turn, is perceived in its historical evolution.

The oppression of women has existed as a transhistorical, transcultural phenomenon encompassing all social classes. The ideological ramifications of this transhistorical powerlessness have been that all conceptions of woman and her "nature" have been the products of the dominant male frame of reference. The raising of women's consciousness, however, has meant the calling into question of many of these time-worn ideological assumptions. Thus, an understanding of why battered women tend to stay in abusive relationships, must include an understanding of the (ideological) mechanisms which have justified wifebeating in particular, and of course the larger framework of women's oppression in general.

There are several ideological assumptions that apply directly to the "battered-wife syndrome." The prevailing myths of women's inferiority vis-a-vis men serve to ensure such socially-defined inferiority. These myths assume numerous forms, but in general three ideological "motifs" recur over a period of 2500 years, and remain operative under our current mode of social organization. Caroline Whitbeck[12] identifies one as the concept of "woman as partial man," in which the woman is viewed as lacking some important ingredient which the male ostensibly possesses. In the case of Aristotle, for example, this was perceived as woman's "inability to concoct semen"; in the works of Freud and his vulgarizers, it is the lack of a penis. A second motif identifies in nature and human nature two opposing principles, placing on the one hand, the male or conscious self, and, on the other, the female or feminine principle, en-

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compassing those qualities accruing by default, as it were, to the inferior other. The Pythagorean Monad/Dyad concept, the Eastern concept of Yin and Yang, and contemporary concepts of masculinity and femininity which define and limit "maleness" and "femaleness" in and through certain qualities of personality and behavior (strength, aggression, passivity, dependency), are but salient examples of this motif.

The third motif is reflected most clearly in classical Judeo-Christian mythology, defining women in terms of man's needs (God created Eve as a companion for Adam) — just as today she is seen as the bearer of his children, keeper of his home, and servant to his needs, both physical and psychological.

From these basic assumptions logically flow modern psychological concepts of woman as man's property, of her "natural" inclination to the supportive, mothering role, of woman as "childlike" and therefore in need of the discipline and guidance of the male. All such notions serve to justify the multifaceted violence directed toward women. Women who do not live up to their socially/sexually determined roles as established by the state or the husband, could and have "legitimately" been punished by beatings, torture, rape and imprisonment, or in any other manner determined by the male authority figures involved.

Judges beat their wives, as do psychologists, lawyers, policemen, college professors and presidents of huge corporations.

Ruby Rohrlich-Leavitt, speaking at the recent Tribunal on Crimes Against Women in New York, dealt with the subject of woman's oppression in a cross-cultural perspective. Following the development of surplus labor and food, Leavitt believes, was the subsequent confinement of women within the isolation of the home, reflective of the newly-established patrilineal descent of property. Leavitt points out that the first known written laws, dating approximately to 2500 B.C., in addition to establishing rules governing private property relations, included a "reform" measure denying women the right to two husbands; her punishment for so doing was death by stoning. Furthermore, it decreed that a woman who was verbally abusive to her husband was to have her name engraved on a brick which would then be used to bash her teeth out.

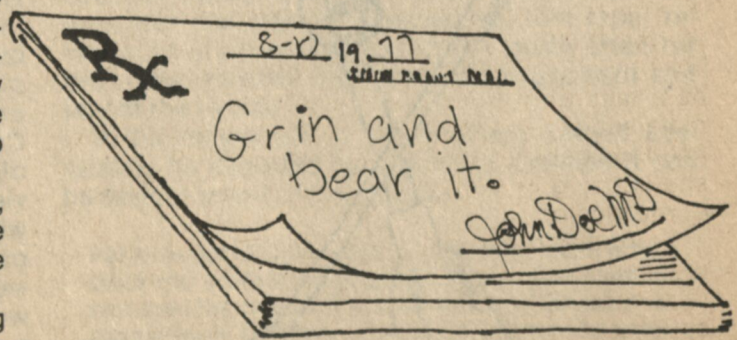
The Code of Hammurabi, dating to 1750 B.C., reinforced these attitudes and maintained the sacredness of the family and of the position of the woman within the family.

The Roman term "Patria Potestas," meaning "father's authority," reflected the male's position of absolute ruler over the household. Confarreation, the Roman marriage ceremony, passed ownership of the woman formally from father to husband, and directed wives to live so as to please their husbands only. While divorce, at least in early Rome, was illegal, the Romans did justify the husband's right to *kill* his wife for any of the following reasons: adultery, drinking wine or any other "disgusting behavior."

During the Middle Ages violence against women was openly encouraged by the Catholic church, as men were urged from the pulpit "to beat their wives and their wives to kiss the rod that beat them." Only within the past few decades have the French dropped the expression, "Women, like walnut trees, should be beaten every day," from the Napoleonic Codes.

With the development of the monopoly phase of capitalism, a new material situation confronted women, and thus new ideological justifications of woman's oppression were evolved. The functionalist school of psychology incorporated evolutionary theory into their psychological practice, and in this way "legitimized" their "study" of women. The *leitmotiv* of evolutionary theory as it was applied in the social sciences was the evolutionary supremacy of the Caucasian male. The functionalists viewed female thought as distinctly different from and complementary to that of the male. Freud posited that, "Women are like the masses in wanting to be mastered and ruled." Thus, male violence against women, while no longer justified by biblical scripture or legally sanctioned by statute, was still not perceived as a problem, but rather as the natural, masculine, aggressive response to "woman's innate masochism." It formed the "natural" relationship between the sexes.

Yet even in contemporary society where intellectuals and social scientists often reject theories of *innate* masochism, there are those who remark simply that, "Every once in a while a woman needs it." One lawyer recently recalled the case of a husband who was being brought up on charges for →



severely and chronically beating his wife throughout the years of their marriage. When confronted, the man responded incredulously: "Do you mean to tell me *I can't beat my wife*?" This example points to the fact that despite laws that have evolved which prohibit assault, and declare that the physical chastisement of a woman by her husband be at least legally unacceptable, in reality there exist implicit and unrecognized norms which operate within our society that either encourage or permit husbands to beat their wives. Woody Allen's Humphrey Bogart character in *Play It Again Sam* says he never met "a woman who didn't understand a slap in the mouth." For years the "Honeymooners' " Ralph Cramden admonished his wife with clenched teeth and fist, "One of these days, Alice, bam! I'm gonna send you right to the moon!" while America laughed.

In a recent study conducted by three psychologists from Michigan State University, a series of fights were staged to be witnessed by unsuspecting pedestrian subjects. The researchers found that while men rushed to the aid of men being assaulted by either men or women, and aided women being assaulted by other women, *not one* intervened when a male actor apparently assaulted a woman [Pogrebin, 1974, p. 55]. Thus, attitudes condoning wifebeating continue to be operant, both reflecting and supporting the denigration of women that is general in our society.

Marcuse posits that the "success of the system is to make unthinkable the possibility of its alternatives." This goes to the heart of the entire issue of why battered women stay. For many battered women the ideology, which has branded them inferior as women, maintained their position as their husbands' property, and mandated their subordination to their husbands' wills, has been internalized to the degree that they often accept being beaten as somehow a "just" due. Not only men, but women also accept that women should be, or deserve to be, or even need to be beaten, and that husbands have a right to do so. In a study done by Gelles, there were statements from women such as, "I asked for it," and "I deserved it." One woman said: "I kept thinking it must be my fault . . . what did I do to provoke him? Then one night I was in bed asleep and he came in and started hitting me, and I said, 'Boy, I didn't provoke this.' "[13] The battered wife often sees herself as a failure in those primary roles by which the male society defines her (wife, mate and mother), and thus believes that it is somehow her fault that she is being beaten. Herein lies the true efficacy of the ideology.

For many other women, however, the point is reached when they will no longer tolerate the beatings. Often when the violence extends to her children, or when fear for her own life overcomes fear of her husband, the breaking point occurs. What happens, then, when a battered woman decides that she has had enough? The remainder of the reasons why women stay can best be understood by examining the mechanisms which maintain her dependent status even when she has taken affirmative action to alleviate her situation.

The Medical Profession

Doctors have shown little concern for the battered woman beyond patching up her injuries. Even when they are aware of how a woman received her injuries they rarely offer sympathy or advice. Occasionally tranquilizers are provided for the husband and/or the wife and the case is rarely recorded or reported as "wifebeating." When a particular woman asked her doctor to write a report of her injuries for her upcoming divorce proceedings, the doctor refused on the ground of professional secrecy. Another woman in a hospital with a fractured skull said that a doctor tried to persuade her to report the beatings as a mishap on the stairs. "He's remorseful. Go back to him," the doctor told her. She did.[14]

The Therapist

As already pointed out in the case of the functionalist and Freudian schools of psychology, woman is often viewed as having an intrinsically masochistic "nature"; thus the male violence must be desired by her. Even before Freud, Kraft-Ebbing argued that masochism was only a perversion in the male, while natural to the female (in which sadism is a perversion). This attitude is maintained by far too many therapists even today, as in the case of the woman married to the young doctor, cited earlier. This explanation — women's supposed "provocation" — entails an interesting transferral of responsibility from dominator to dominated. As an explanation for the phenomenon in question, such "provocation" tells us more about the therapist than the "patient."

At a recent meeting of feminists trying to set up a refuge for battered women here in New York, a former city consultant in the Bureau of Social Services said to me: "It's a masochistic situation. You can't believe what these women do to provoke getting beaten." This is but a reassertion of the familiar masochism "theory." I must repeatedly reiterate my belief that this is a wholly false and tendentious assumption, and more, that it tends to blur the sexual qualities of sado-masochism with the decidedly non-erotic situation in which women are beaten. Gayford states that few of the assaults in his study had a (sexually) sadistic component, and *none* of the women involved received any sort of masochistic sexual gratification from their beatings. Yet, too often, the two phenomena become enmeshed in the mind of the therapist, especially the male therapist, who sees in the battered woman, desperately seeking but often unable to find a way out of her situation, that "innately masochistic creature." Indeed, even the assumption of a "neutral attitude" by psychologists and psychiatrists to the parties involved serves to support the interests of the "beater."

Freud posited that, "Women are like the masses in wanting to be mastered and ruled."

The Police

The response of the police when called in wife-beating cases usually ranges from none at all (and thus implicit approval) to explicit support of the abuser. As one woman recalls: "I kept calling the police and they would come over and just tell me to calm down. They didn't care until one time he slapped one of them and then they had him up for assault and battery."[15]

A case recently occured in Dade County, Florida in which a woman was viciously assaulted by her husband with a claw hammer. A neighbor called the police. When they arrived, they saw the woman half naked and bleeding, a bloody hammer on the floor, and the husband standing outside. They questioned the husband, never spoke to the victim involved, and made out the report based upon what the caller had said. No charges were filed, and the woman had to transport herself to the hospital the next day after her husband had gone to work.[16] (It is not uncommon, however, for husbands of battered women to deny them medical treatment.)

The responses of the police are often strikingly similar to those of psychiatrists, psychologists, and social scientists: "What did you do to provoke him?" Women are often reminded by the police that if their husband goes to jail, he won't be earning a paycheck; or, "Think how mad he'll be when he gets out." This, then, goes to the very heart of

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the relations of dependency in and through which women are constrained to endure their suffering.

When arrests are made, they are made in cases involving the use of a deadly weapon, or when the private matter of the couple involved becomes a "public" matter and the neighborhood peace and tranquility have been disturbed, or, lastly, in cases of repeated and severe beatings.

In a report entitled, "Law Enforcement Problems with Intra-Family Violence," written by Commander James Bannon of the Detroit Police Department, the problem of typical police responses to wifebeating is reviewed with amazing perceptivity. It is best to let the words of Captain Bannon speak for themselves, rather than presenting a summary of his comments:

> It is my view that police and later prosecutors and courts contribute to domestic violence by their *laissez faire* attitudes toward what they view as essentially a personal problem. Further, that this view is held because police are socialized to regard females in general as subordinate. The superordinancy of the male coupled with his socially mandated self-reliance on violence to resolve personal problems without outside assistance, assures us that wives will continue to be battered in record numbers. [Bannon, 1975, p. 4.]

Bannon points out the "not atypical" policy of "call screening" which evolved as a result of police inability to respond to all calls received. Call screening involved the decision not to respond to certain kinds of calls — not surprisingly, the first calls screened out were family disputes.

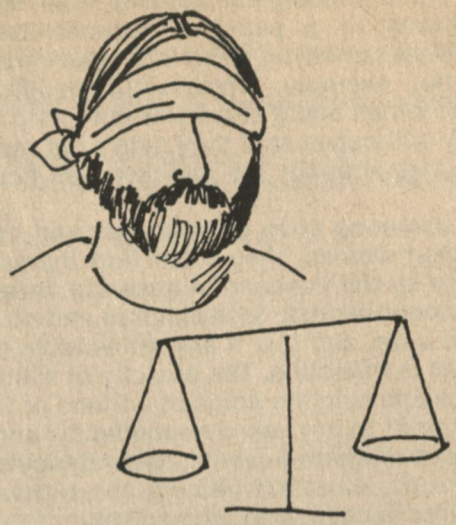
"The criminal justice system," said Bannon, "affirmatively responded to the brutalization of children who shared the female's property classification. It must now do more to assure the same safeguards for women."

The Judiciary

In those cases in which women have been persistent enough to press charges, few of these ultimately end in trial or with a guilty plea, by which time the crime charged has become a misdemeanor rather than a felony. Straus points out in his study that "the failure to invoke criminal penalties reflects historical continuities in the cultural norms which make the marriage license a hitting license." [Straus, 1975: 1.]

The concept of "spousal immunity," for example, contributes to the unjust treatment of battered women by denying them the right to sue their husbands for assault and battery. Somehow, the marital bond replaces traditional legal sanctions against physical assault.

In *Self v. Self* (1962) the wife alleged that "the defendant husband . . . unlawfully assaulted plaintiff and beat upon, scratched, and abused the person of the plaintiff," and that as a result she "sustained physical injury to her person and emotional distress, and among other injuries did receive a broken arm." The husband's motion for a summary judgment, however, in which "spousal immunity" would be upheld, was granted by the trial court.



In another case involving a woman whose husband had chronically beaten her and threatened her with a knife, the husband's lawyer intimated that the wife was seeing another man. Though the woman's lawyer protested, the judge said that he had heard enough. Handing down a two-month suspended sentence, he stated: "You know, you can't go around beating up your wife anymore. But if I was in your position I probably would have done the same thing."[17]

Family, Neighbors and Friends

The desire not to get involved in domestic disputes that end in physical violence is nourished by a strong belief that what is done in the privacy of the home is sacrosanct. Which is part and parcel of the inability of family, neighbors and friends to come to the aid of an abused woman.

On appeal, the California Supreme Court reversed the lower court's judgment, thus overruling several older California cases supporting interspousal immunity. Interestingly, the rationale of the courts retaining the common-law spousal immunity was that it was needed for the preservation of the family. The fear, apparently, was that allowing such action (the taking of legal action by the woman) "would destroy the peace and harmony of the home, and thus would be contrary to the policy of the law." [Straus, 1975: 5.]

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Once again ideological assumptions are the preconditions of a passive response to wife abuse. The case of Kitty Genovese is an excellent, if extreme, example. Thirty-eight people witnessed a woman being killed without going to her aid; many witnesses said they didn't get involved because they thought the attacker was her husband.

When someone does offer shelter and help to the battered woman, they often find themselves threatened by the husband in question. In reality, with little or no money, with children and no available child care, and few if any marketable skills, the woman is immobile. The scarcity of viable options once she is in the home of a friend or family member, point to her naked dependency, and it is this real and ultimate financial dependency of the female on the male that perhaps more than any other factors explains why women stay.

While divorce. . . was illegal, the Romans did justify the husband's right to kill his wife.

Even in cases in which, if she were to leave, the husband would or could pay alimony and/or child support, statistics indicate that these payments are seldom maintained for any great length of time. As the socially-defined agency responsible for the rearing of the children, the battered wife encounters the first obstacle before she even enters or attempts to enter the job market — she must find child care facilities.

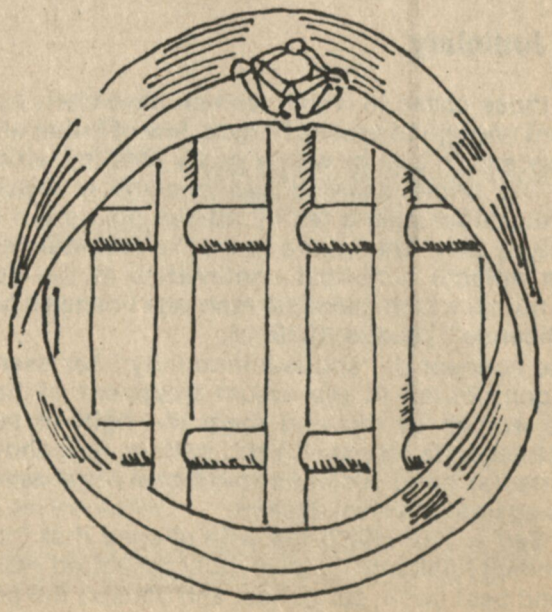
The possibility of a woman with one or more children leaving her husband and earning enough to sustain herself and her family becomes increasingly more, rather than less, difficult. Even the possibility of going on welfare poses difficulties, for to do so she must first establish a legal residence apart from her husband. She thus must have the means to secure an apartment and support herself before her first welfare check arrives.

Many women, far too many women, do find one way out: suicide. Gayford states in his study that "suicidal gestures were usually treated in hospitals without the true fact being revealed." Sometimes, however, those facts do emerge. I distinctly recall reading in the newspaper several years ago an article about a woman who had locked herself and her three children in the kitchen and turned on the gas. When asked why she had done this, she replied that she and her children had been beaten so often that she was "tired of this living hell."

This has been a difficult paper for me. It has been difficult to remain aloof and unemotional in a scholarly sense from the subject of wifebeating, and I must admit that I am not at all disturbed about such a difficulty. For though we have narrowed down our central point of focus to the battering of women, it is primarily as a vantage point from which to attack, or grasp, the broader problematic of the complex unity of women's oppression. In a most fundamental sense, it seems to me, women's status is commensurate with that of political prisoners; this imprisonment, however, is one enforced and ensured in and through the roles, functions and qualities that the dominant masculine political culture prescribes for, and indeed demands of, women. The physical abuse of women is the most extreme of the many forms that their hidden imprisonment assumes.

The elimination of wifebeating in particular and women's oppression in general ultimately entails not only a change in the sexual division of labor and roles, but in the economic system of which such a division of labor is a function. It must be the backdrop to all reform efforts; without it, "women's liberation" becomes a fraudulent exercise to co-opt potentially "disruptive" elements.

With this in mind, let us turn to feasible reforms within the established framework. Homes and refuges for battered women, only recently emerging on a small scale in this country, must be established in numbers sufficient to accommodate *all* women in need of such services. There are over 75 such centers in England; Sweden, Canada, Holland and other countries have appropriated funds for similar projects. The feminist movement must make the demand for homes for abused women a priority. Centers for battered women already exist in Boston, Cambridge, Seattle, Los Angeles and St. Paul. In New York, Maria Roy has established a hot line and advocate counseling for battered women. The Mayor's Task Force on Rape has established a committee, of which I am a member, to work toward opening a shelter for battered women in Brooklyn. Though band-aids on a gaping wound, with need far exceeding availability of



space, they represent an important beginning. For many abused women, symbols of the brutality of women's oppression, it often means the first possibility to escape their brutalization, and gain a new perspective on the social aspects of their plight.

It is unreasonable to expect from the capitalist state actions that are actually or potentially detrimental to the interests of capital. There is little reason to believe that the state will take affirmative action against the multiplicity of crimes against women, nor should we expect a thorough or permanent end to such crimes in the foreseeable future. Only through the eradication of all aspects of male privilege and domination can we transform a society in which human life is denigrated before the altar of capital.✸

Footnotes

1. In using the term "wife" I am referring not only to those women who are legally married but to women in any number of situations which would be socially defined as husband-wife-like relationships.
2. Huston, Margo, "Abused Women, Who's at Fault," no page listed.
3. Martin, Del, "Beating Her, Slamming Her, Making Her Cry," Op. Ed.
4. Associated Press, "Wife Beating," p. 20.
5. Fields, Marjory D., "Wife Beating, The Hidden Offense," p. 1.
6. Associated Press, *ibid.*, p. 20.
7. Francke, "Battered Women," no page listed.
8. McCabe, Bruce, "The Tragic Signs of Wifebeating," no page listed.
9. Livingston, Nancy, "Wife beating looms as major city crime," p. 1.
10. Warrior, Betsy in *Houseworkers Handbook*, pp. 46-47.
11. Associated Press, *op. cit.*, p. 20.
12. Whitbeck, Caroline, "Theories of Sex Difference," *in toto.*
13. Associated Press, *op. cit.*, p. 20.
14. *Ibid.*
15. *Ibid.*
16. Nauton, Ena, "Beating of Women is Major Crime Source," no page listed.
17. *Ibid.*

Mary Metzger has done research in New York on wife abuse for the Center for the Prevention of Violence in the Family, The Mayor's Task Force on Rape, and is a member of and researcher for The Jane Addams Center, a New York group working with battered women. She is currently working on her doctorate in politics at New York University. She is married and has three children.

Working on Wife Abuse, *a directory of refuges for women in the U.S. and abroad and groups studying the battered-wife syndrome, is available from Betsy Warrior, 46 Pleasant St., Cambridge, MA 02139. The cost is $3.00 plus 50¢ postage per copy.*

Men's Awareness

Jack C. Sternbach

For a year now I have been doing group and individual therapy and awareness work with other men. Some come to me as strangers. Others have known me previously. My home is my office, the fees are low and negotiable, and both my life situation and my self are open to the men I work with.

I am 48, divorced, with five children — four of whom (all girls) are college age. And I have a 15-year-old son. I live with a feminist woman who does therapy with other women — also from our home. Our combined personal-work-political lives are mutually supportive and joyful.

Nell Schill

In the late 1960s, as a direct result of the anti-Vietnam War Movement, major shifts in my life took place. At that time I began a quest for the kind of life situation which would permit me, in the words of a friend, "to make my life and work one."

Much has gone down since then — suffice it to say that, like so many others, I have been through numerous changes. The work I do is my current attempt to continue the quest. I advance the term therapy, with considerable reluctance, to describe the process. There is just so much mystification and self-serving exploitation which goes with the term. Nonetheless, the word therapy does come closest to giving a sense of what I am about.

In fact, I describe myself as a Radical Therapist, and I think my current work does open the possibility for some creative resolution of the contradictions inherent in therapeutic activity. Choosing to work only with other men and centering that work on men's issues makes it possible for both the men I work with and me to experience solidarity. The issues we deal with are mine as well as theirs. I share freely my personal feelings and life situation as a man in both group and individual therapy. Sometimes I share more, sometimes less, but I think all the men I work with have a pretty good idea that we are on the same trip together.

Charging a low fee, which is negotiable, and opening my personal life, relationships, and habits to the men I work with helps to remove distance and resentment. It is a very difficult things to go for help and open oneself to another human being. I think that, at least in my case, money and mystification are not added to the already heavy load.

Above all, the content and direction of the work I do is centered on my political understanding — that most of the pain and oppression suffered by all of us is a direct result of a ruling class drive for profit and power.

In the account which follows I have described what I think is a fair sample of how the men and I work together. There are eight men present, including myself, ranging in age from 22-48, all white, most with a human service background. I am the leader-therapist as well as first person narrator. This narrative has been read to the group and approved by them for submission to *State and Mind.*

In this approach to the development of men's consciousness there seem to be three major principles. The first is *getting in touch*, on a body and feeling level, with the rage, terror and pain which is our heritage as men in this society. This means letting go of intellectuality, of rigid controls, of our fear of being over-emotional. *Getting in touch* includes expression of the feelings within the group.

Second is that of the *leader-therapist's participation* in the process as one able to expose his own feelings and fears as a man. Although this is not a traditional role for the therapist, I find it comfortable and have thus far received mostly positive feedback from the men I work with in so sharing myself. This seems necessary to establish com-

Neil Schill

radely solidarity in the group.

And third, *a political understanding* of how our personal pain is a function of the very specific economic-social structures and cultural norms designed to keep us alienated from ourselves and from each other.

The effect of all these taken together can be to release the feeling and expression which are so often denied to men; and which if denied, effectively cripple both awareness and action. A man who is out of touch with his own internal processes and who does not understand the politics of the male sex role and of sexism cannot act upon the world in any other role than oppressor, victim or exploiter. And if not in touch with or not able to stand together with other men of like consciousness, he will be isolated, impotent, alienated.

Stephen said he wanted to work on stuff about his father. I described how Gestalt worked and asked if he wanted to try it. He said yes and we got started. What was of concern to him was his internalization of many of his father's negative attributes: biting his lip, becoming closed to people, sitting stiffly, forbidding himself pleasure. I had Stephen place that part of him which was like his father on a pillow in front of him and he started talking to it. Eventually he led himself to a confrontation with a double who stood on the other side of a heavy door and who would not help Stephen to open and go through the door to the void wherein his growth and creativity and love lay... and the father who wasn't accessible to him. It was really emotional, and at the end Stephen was in tears and sniffling and he exchanged hugs with Nathan and with me.

Nate, who has adult children like I do, shared how he felt reconciled with his own father, but his pain right now was with his 21-year-old son. Steve was crying, and told us how badly it felt to have his 8-year-old son raised by another man.

Bill started telling us of the deep feelings stirred up by Stephen's Gestalt work — of how he had cried and been held by his father and how his father had also cried in his arms. Steve and Marv drew close to Bill on either side and I knelt in front of him. As he kept talking he came very close to tears several times.

Looking around the group it felt as if we were all in a state of altered consciousness — all wired together — and centered on this process. I realized I was holding a big pillow between my legs and was hugging and kissing it. It was clear to me I was in touch with the time three years before when I had had an incredibly emotional reconciliation with my own father when he was very ill in the hospital. We had cried and kissed each other and told each other of our love and need for one another.

At first I thought I had better hold back out of concern for the needs of the group but then I realized on some level that I simply needed to go with the feelings and that it was alright. It would fit with the flow of the group rather than blocking it. All this was of course a streaming kind of decision-making and, as I say, not really all that well thought out. But I let myself go into it and heard myself sobbing, moaning and crying out. Then the tears began to flow. I would alternate between crying out and silent tears while I hugged and kissed the pillow, on which I could see my father's face.

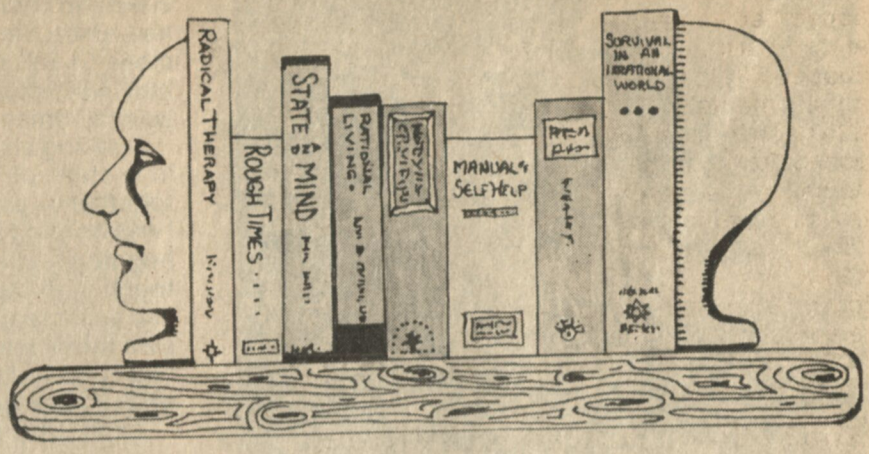
As I tripped into another level of consciousness I was able to commence a dialogue with the group members about where I was — how that moment of reconciliation with my father had wiped away 35 years of distance and resentment and that, although my father had fucked me over and failed me in many ways, it was all okay at this point in our lives together. All I knew was that I didn't want to let him go and that the prospect of being here, alive and in this world without him, was a terrifying thought.

As I went on, various group members, all of whom were leaning toward me with reddening eyes and incredible loving faces, were beginning to cry — especially Nate, Stephen and Timothy. Various people dialogued with me (Marvin, Stephen and Bill) about the way the inexorable wheel turns and there is nothing we can do to halt or slow it, but only let go of it when the time comes. Marv helped me to understand how my terror of letting go of my father was a foretaste of what would face me at my own death which was to come some day.

My thoughts switched a bit and I began to feel and express the rage within me at a social system, a culture which so drives apart fathers and sons — which makes the fathers ashamed of where they came from (in my case, immigrant Central European Jewish stock), and the sons ashamed of them in turn. It is a culture which defines emotionality and lovingness as attributes of a weak character and rewards only the go-getter, the tight-ass holder-owner, he who acquires and grasps. Bill,

(continued on page 31)

Mindreading



by the Librarian

The Committee for the Defense of Soviet Political Prisoners has published a 28-page pamphlet entitled "The Abuse of Psychiatry in the USSR; Soviet dissenters in psychiatric prisons." The report unfortunately falls into the trap of taking for granted that inmates who are not strictly political prisoners are in fact "crazy." But it does contain a number of powerful accounts of such familiar practices as the use of physical violence and psychiatric drugs on inmates, in addition to considering the labeling of political dissenters as mentally ill. Personal accounts, brief biographical sketches, advice for inmates, a selected bibliography, and a list of committees defending political prisoners in the USSR are all included in the pamphlet, which is available for 75¢ from the Committee at P.O. Box 142, Cooper Station, New York, NY 10003.

One of the groups most active recently in the publication of material helpful to those who suffer at the hands of the "mental health" industry is the Philadelphia-based Alliance for the Liberation of Mental Patients (ALMP). In addition to making public *The Farview Papers* (see the News Analysis piece in this issue), ALMP has begun issuing a newsletter containing sections of local and of more widespread interest, and has prepared a "Patients' Rights and Resources Handbook" available free to all current "mental patients." The Handbook provides valuable information on mental inmates' legal rights, on how to get welfare and social security benefits upon leaving the institution, and much more. Write to ALMP, 112 S. 16th St., #1305, Philadelphia, PA 19102.

Sexism and nonviolence, prisons, action and civil disobedience, pacifism, and the Third World are just some of the subjects on which books and pamphlets are available from the War Resisters League, 339 Lafayette St., New York, NY 10012. For details, send for a copy of their 1977 literature list.

"For Democracy Where We Work," by David DeLeon (85¢ plus 25¢ postage) is a review of the arguments and evidence for the viability of workers' self-management. It's Report #28 in a series put out by Research Group One (2743 Maryland Ave., Baltimore, MD 21218), a "radical social science research collective." Some of the other titles in the series are "Education in the People's Republic of China" (65¢), "Selected Differences in the Life Chances of Black and White in the U.S." (35¢), and "The Conditions of Feminist Research" (75¢). We're especially looking forward to seeing their soon-to-be-published report entitled "The American Ruling Class is Crazy."

Lambda Rising, a Washington, D.C. bookstore dealing exclusively in books and merchandise concerning gay and lesbian lifestyles, has recently issued a mail-order catalog. Their stock of books, which "attempts to balance the anti-gay viewpoints of works that have long been available in bookstores and libraries," includes many non-fiction, poetry, literature and guidebook titles. To request a copy of the catalog, write the store at 1724 20th St., N.W., Washington, D.C. 20009.

Joel Kovel's *A Complete Guide to Therapy, from Psychoanalysis to Behavior Modification* (now out in paperback) is a 284-page consumer guide in which the author admittedly applies "political criteria to the evaluation of therapies." Kovel devotes about one page to "radical therapy," which he describes as a movement which "flared up in the activist Sixties and has since somewhat subsided, but not without leaving its mark on theory and practice." His summative evaluation is that "the radical critique, at least as it has been made with respect to therapy, fritters itself away into mindless sloganeering." *It seems that there are those who make blanket* STATE*ments* AND *there are those who* MIND*lessly sloganeer. RT fritters, anyone?*

Decarceration: Community Treatment and the Deviant — A Radical View. By Andrew T.

Scull (A Spectrum Book, Prentice-Hall, Inc., 1977). For anyone concerned about the political and social implications of the supposedly "progressive" community mental health system, this book is essential. Scull exposes the gross inadequacies as well as the more subtle control mechanisms involved in "community treatment," and shows that in practice the "reforms" allegedly intended bear remarkably little resemblance to liberal rhetoric on the subject. The real reason behind the sudden shift in mental health and penal policies, he argues, is the state's urgent need to cut the costs of social control. Although his own solution leaves much to be desired (return to institutions), the basic critique is good and there is an excellent chapter called "the technological fix" about psychoactive drugs.

Ideology and Consciousness is a new British journal contributing to the advancement of political and theoretical struggle in the areas of psychology, education and the media. It is produced by a Marxist Collective which is attempting to develop alternative approaches and methods for understanding and changing the social relations in which we are engaged. For information write to: *Ideology and Consciousness*, 1 Woburn Mansions, Torrington Place, London W.C. 1, England.

Men's Awareness, continued

who is Irish-Catholic, and I had a dialogue about the heroism, the beauty of our fathers' lives and how this society took from them any sense of their own stature as human beings: how the classrooms we studied in should have been hung with the pictures of our families; not those dim, abstract, contradictory historical figures of no moment in our lives and who only alienated us from ourselves and our foreparents. It felt like all of us in the group were tuned together at this point: sharing the emotion, digging on the awareness — the awareness of how our fathers as well as we ourselves were victims of this society.

Near the end of my expressions Timothy began sobbing and Alan and Marv made a kind of sandwich of their bodies for him while he lay on the floor. Later he told us some of his pain as a boy of five who had been sent (abandoned) by his parents to a boarding school till he was 18. . . of the aloneness, the hatred. We ended the group with all of us stroking Tim and then picking him up and rocking him for a bit.✸

Jack Sternbach is "white, bisexual, age 49, a father; loving, learning, and working with a wonderful feminist woman. Practicing radical therapy, mostly with men, from a socialist-feminist-gestalt stance. I also paint water colors, mostly dragons."

We need graphic artists and photographers who would be interested in working regularly on *State and Mind*. Please contact the office by phone or mail.

Book Review

British Anti-Psychiatry: How It Was

Nancy Henley

Zone of the Interior *by Clancy Sigal (Thomas Y. Crowell, 1976, $8.95, 277 pp.).*

If you're ready for a sobering look at R.D. Laing and the British anti-psychiatry of the 60's, this novel will probably give you a better perspective on it than many writings of the "masters" themselves. They are all here: Laing, Cooper, Villa 21, Kingsley Hall complete with Mary Barnes and Joe Berke, and many other known and unknown lights. Clancy Sigal documents his protagonist Sid Bell's (and presumably his own) seduction into their world, as a self-exiled American leftist writer in London with problems. Burned out from the movement, suffering from aches, sweats, fevers, and anxiety, Bell bounces from shrink to shrink and lands on Willie Last. Willie Last is the alter ego of Ronnie Laing, with his heavy Scottish burr and his convoluted but often piercing profundities. Last's analysis of the purpose and terrorism of mental hospitals and diagnoses is right on the head, and his insights into the conspiracies of the family are liberating. His therapy for Sid consists of working class straight talk combined with ever-farther excursions on high dosages of LSD with his patient.

Sid's odyssey of the next few years consists of intermittent stays at a place called Conolly House, and spells of work on Last's Clare Council. Conolly House is a double for David Cooper's Villa 21, an experimental anti-psychiatry ward inside a repressively tolerant government hospital outside London. Clare Council is another Philadelphia Association, which sets up its own Kingsley Hall, called Meditation Manor — a private therapeutic community in which people can go through their madness undisturbed. There are no "patients" or "staff" at Meditation Manor, rather everyone is to be helper and helped as needed. There is, in fact, a competition — among the non-professionals — to go as crazy as possible. But, as Sid writes,

> It did not occur immediately to me that while I (and others) risked everything on Last's magical mystery tour, the way he freaked out rarely took him too far from his couch or desk. At his nuttiest he never stopped lecturing or writing.

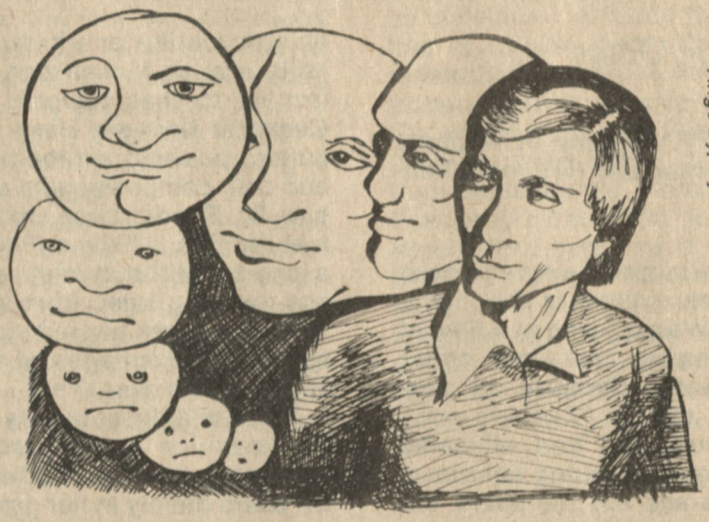
Over the years Willie Last, lionized by the media, by the attention of American curiosity seekers from psychiatry and show biz, and by his own personal gang of hangers-on, changes from the refreshing streetwise working-class (though "knot"-spouting) anti-doctor into the fashionable, kimono-dressed, pronouncement-spouting fakir-figurehead of Meditation Manor. Sigal seems to have little regard for what came out of Kingsley Hall; the experimental ward, though, is another matter.

Sid's experiences in Conolly House get to the heart of many questions of institutions. The residents here at first seem a typical British-movie collection of lovable zanies, and their real anguish seems somewhat removed as they take each other's pain for granted. But the built-in repressive forces of the hospital and the capitalist society which it reinforces bring home to us their consequences in the day-to-day lives of the seemingly most carefree of its patients. In one case, Con House members attempt to save one of their own from being transferred to the violent ward, and certain mental dismemberment, by tending him themselves round the clock. This plan fizzles out as the residents themselves face the question of how much attention one member of a group can legitimately command, and how much is their commitment outside themselves. It is the question faced by Meditation Manor in the extreme, when Anna Shepherd (who parallels the real-life Mary Barnes) regresses to fish stage and slings her feces everywhere. It has been a question faced at many meetings, including the Conference on Human Rights and Psychiatric Oppression, and in our own living and working groups over and over.

But the reactionary forces of the state are what really does in this attempt to transcend institutionalized relationships. Again and again the liberal facade is toppled to expose fascism beneath — as when the vultures of the hospital not only wait gleefully for Conolly House to crumble, but go beyond vultures and undermine it at every opportunity. Or as in Meditation Manor, where the private anti-patients, as far off the shelf as they are supposed to be, recognize medical hierarchy

and refuse help from the non-degreed Clare Council staff like writer Sid.

At Conolly House Dr. Dick Drummond (presumably Cooper) appears seldom and in the background as ghostly figure, either not speaking out of indecision, or speaking in incomprehensible jargon — for example, "Prima facie, Derek bears the unbearable burden of our reductively totalized psychopathy" — which brings appropriate groans and disparagements from the inmates. Nevertheless they are surprisingly tolerant of him — they recognize what he is trying to create, and see Con House as, for many, the only "sane" or live alternative.



Ange Byjczyk

Conolly House, with all its faults and all its promise, is finally forced out of existence, and its breakup is personally reminiscent. I have been in communes that are falling apart, and the house dies mentally, or relationally, before it dies physically. Con House's last days are like this. Old human cement crumbles as people start the transition to their future states; they are in each other's past tense, and living in a dying commune is among the most painful of experiences.

Other personal/political issues faced in left-political (and other) groups come up in Sigal's novel, particularly in Last's circle: personal differences masked in psychiatric jargon; the mental (sometimes physical) goon squad that forms around a current guru; shitting on one's friends; following irrational fashion; rationalizing apolitical activity; disguising hostility as submissiveness; using political jargon to legitimate inaction in the face of need; and snowing people with esoteric analysis. In one example of the latter, another Clare Council member remarks to Sid, listening at a "Liberation Psych-In" at the Manor, "I feel a bit thick. Why *is* Fidel Castro an ontological externalization of Lyndon Johnson's castration fantasy?"

Sexism is rampant in all parts of the community in most blatant and unapologetic form. Sid at times seems to recognize this but at the same time is exploitative and shamelessly misogynist himself. Women are the forgotten casualities of the anti-psychiatry movement, as he recognizes at the end: all the doctors involved in this novel shucked their wives and used their female comrades/commune members as unpaid housekeepers, unloved sexual partners, and repositories for their hatred and fear of women, their fantasies of grandeur and power.

Sigal writes well and his characters live. Readers may be familiar with his previous novels, *Weekend in Dinlock* and the much-acclaimed *Going Away.* This is a good book. Some of the characters, like some of the real-life anti-psychiatrists, tend to scapegoat the family and look for no other causes of distress, but this does not seem to be Sigal's (Sid's) own view.

For those who lived through some of those times and vicariously soared with Kingsley Hall residents, or wondered where it all would lead, *Zone of the Interior* is a good remembrance and re-evaluation. And from the inside, apparently; the novel is said to be autobiographical. For those who have not read the anti-psychiatry canon, it is a merciful way to absorb the ideas in practice without having to read the involuted words in which they have so often been couched. Sid Bell near the end of the book, in his height of madness, has a "revelation" that he considers the ultimate in ordinariness, truth so common his old union friend would have dropped it out the side of his mouth. It is, however, a revelation of common sense, and Clancy Sigal has escaped with his common sense to write straight for us.

Nancy Henley, a member of the State and Mind *collective, teaches psychology at the University of Lowell (Massachusetts). She is the author of* Body Politics *(Prentice-Hall, 1977, $3.95.)*

Between Never and Maybe: A Film Review of *I Never Promised You a Rose Garden*

Sheila Koren and Don Obers

A New World Picture, 1977. Directed by Anthony Page. Starring Bibi Andersson and Kathleen Quinlan.

It is not surprising that an increasingly popular genre in current American cinema is the "intrapsychic disaster movie." We are living in a time of tremendous social pressures, economic crises and political contradictions. Because of this, more people are "going crazy," "freaking out," becoming depressed, frustrated and alienated than ever before; and they are seeking solutions, not only in cult religions and hip therapies, but also from television, books and films from which they hope to find empathy, understanding and vicarious solutions for their own seemingly "personal" life situations. And Hollywood, always searching for a good market, creates films that plug into and exploit such needs with little or no concern about the social implications of what it portrays.

The basic pattern of these twentieth century combination disaster film/fairy tales seems to be the same: the presence of a fantastic yet ultimately natural force that threatens "the good life," followed by the emergence of a fantastic yet ultimately natural savior to preserve or restore it. *I Never Promised You a Rose Garden*, though undoubtedly a more touching, intelligent and provocative film than, for example, *The Exorcist*, is a film about such an extraordinary madness and its fortunate — but unusual — "cure," that it is actually no more giving of real solutions than *Cinderella* — leaving its viewers waiting for their individual saviors to magically arrive and save the day.

The film is based on Joanne Greenberg's 1964 semi-autobiographical novel about fifteen-year-old Deborah Blake's ascent out of *Yr* — an hallucinatory retreat of bizarre desert gods commanding her to repeated and barbaric suicide attempts. She is taken by her parents to an upper-class psychiatric institution where, amid the absurdity, brutality and de-humanizing hospital regimentation (similar to that depicted in *One Flew Over the Cuckoo's Nest* and *Hurry Tomorrow*), she is fortunate to be assigned the hospital's seemingly one and only compassionate and skillful psychotherapist, Dr. Fried (whose character is based upon the real-life Frieda Fromm-Reichman). They engage in a long and difficult relationship of mutual struggle and evolving trust, from which Deborah emerges victorious over her menacing gods, yet skeptical as to the advantages of the "real" world's evils and cruelties over *Yr*'s.

The film's finest quality is its sensitive and honest depiction of the precarious bridge between Deborah's mind territories of Never and Maybe; we share deeply in her gradual realization that her possibilities for sustaining happiness in her inner world are none — while in the "real" world her possibilities are, at best, limited. R.V. Cassill, in *The New York Times*' book review of the original novel called it a "faultless series of discriminations between the justifications for living in an evil and complex reality and the justifications for retreating into the security of madness."

The film gives a somewhat critical (but not unfair) treatment of psychotherapy, attempting to portray both its potential effectiveness as well as its considerable limitations. The title line ("I never promised you a rose garden") is Dr. Fried's reply when Deborah complains that the "real" world is also painful (she has just witnessed a hospital attendant beating up another patient). The film deserves praise for also managing to avoid cliched Freudian interpretations for Deborah's original *Fall*. Rather than dump the blame for a childhood trauma totally on her parents, who are not without their faults and weaknesses, the institution of medicine is given a deserved slap-in-the-face for operating on a five-year-old child to remove an ovarian tumor without her knowledge, understanding or consent — leaving her feeling horrifyingly invaded, raped, dehumanized and deserving of punishment for a long time.

Despite its merits, however, and its real life

basis, *I Never Promised You a Rose Garden* is ultimately a political injustice in that it does not reflect either the kind of therapy or the kind of madness experienced by most people today, whether inside or outside of psychiatric hospitals. Even by the film's own standards, Dr. Fried is a highly unusual therapist. Unlike her vacation replacement, who comes off as a cold, analytical decoder of Deborah's words, Dr. Fried demands Deborah's involvement in the therapeutic process, speaks out against the barbaric and tortuous hospital procedures, opens up her own life to her patient, and does not lie to or mystify Deborah's experience. Throughout the film, we experience the two women engaged in a relationship that finally enables Deborah to truly feel again in *this* world. Perhaps the film's most beautiful scene is the one in which, after several "entranced" and non-feeling suicide attempts ordered by her superiors in *Yr*, Deborah burns herself with a cigarette butt and glorifies (to most everyone's misunderstanding) in the wonder of her newly felt *pain.*

However, most people incarcerated in mental hospitals today are not upper class Deborah Blakes. They are, for the most part, society's outcasts — those too poor, too jobless, too uneducated and unable to feed, house and clothe themselves anywhere else. Rather than create mythological inner worlds, more people in hospitals actually experience themselves being surveilled by the CIA, the FBI, or the welfare office than by desert gods such as those in *Yr.* (And in some way, most of us *are* indeed being tracked by records and dossiers — of schools, unemployment offices, medicaid, etc. — a bizarre and frightening situation from which no amount of psychotherapy can "cure" us.)

We think it is reprehensible in this time of such massive social breakdown to present a film that suggests a solution to our collective pain that is so individual, so much the exception, and so limited at its very best. Though the film does not romanticize madness, we feel that it does romanticize psychotherapy in a way that also conveys the invalidating and painful message that only a creative, imaginative, upper class madness is *truly* deserving of literary, cinematic or psychotherapeutic treatment. It is in this context that *I Never Promised You a Rose Garden* is full of thorns. To anyone not very rich *and* very lucky, the solutions it offers are few, if any. And when there is a growing movement of people actively trying to create collective and revolutionary alternatives to psychiatric hospitalization and individual therapy, such an offering needs to be highly criticized.

The Psycho-Selling of America

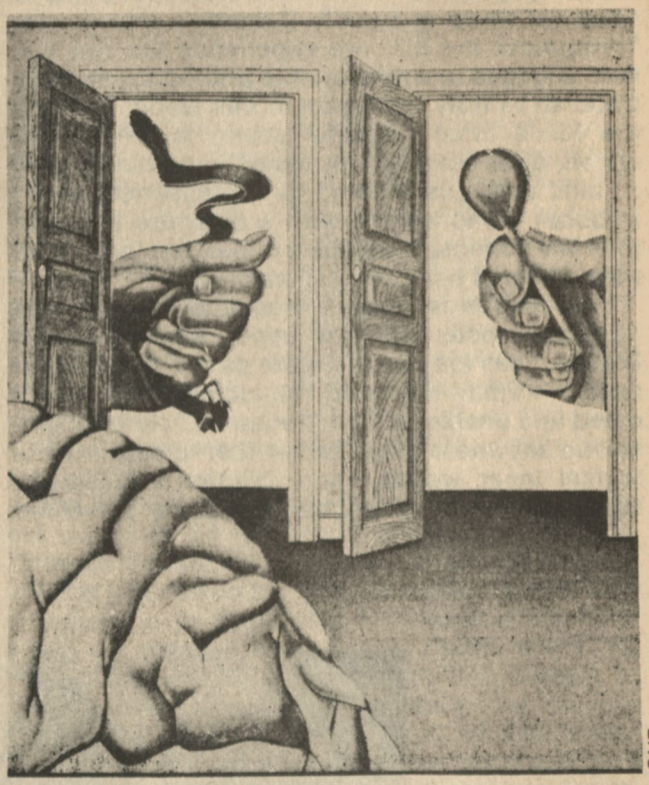
Sheila Koren

A Book Review of

Snap, Crackle and Popular Taste: The Illusion of Free Choice in America, by Jeffrey Schrank (Delta, 1977).

Captains of Consciousness: Advertising and the Social Roots of the Consumer Culture, by Stuart Ewen (McGraw-Hill, 1976).

Media Sexploitation, by Wilson Bryan Key (Signet, New American Library, 1976).



SN7

All three of these "now-in-paperback" books are about advertising and the mass media as instruments of social control. Each contributes from a different perspective to an understanding of how our needs and desires are not only being manipulated, but actually created by advertising and the mass media in the interests of those who own and control those industries.

Captains of Consciousness traces the history of the advertising industry and the consumer society back to its roots with the eruption of industry in America in the early part of this century. Ewen locates the triumph of American capitalism in its ability to penetrate and influence the character of daily life, even to borrow from the ideology of its oppression. For example, women of the 1920's, burdened by the excessive demands of industrial culture, were faced with the unhappy prospect of culturally identifying themselves in the isolation of the home and at the same time faced with the increasing economic reality of having to work outside the home. Such mothers became prime targets for ads which offered corporate aid in the problems of child-rearing.

Media Sexploitation is an extraordinary, though at times far-fetched, expose of all the ways in which newspapers, magazines, television, movies and popular music virtually *mind rape* the public. Key takes the position that the creators of the mass media know virtually everything about our fantasies, fears and intimate habits and consequently know how to manipulate our buying behavior (perhaps giving them too much analytic understanding as opposed to power to *tell us* what to fantasize, fear and desire). He shows how magazines like *Playgirl* and *Viva*, though supposedly "intended" for women, are really appealing to men, how cigarette ads make you stop fearing cancer (by making it a macho-like challenge to be conquered), and how four-letter words (and a particular three-letter one, sex) are often embedded in pictures of food and clothing to stir up sexual desires. He shows that the term "market management" is simply a euphemism for "people manipulation."

Snap, Crackle and Popular Taste is a witty and cheerfully political book that examines the seemingly insignificant choices we make constantly in everyday life and questions how much true freedom of choice is really involved. Some choices contribute, Schrank says, only to the illusion of freedom — those that he calls "pseudo-choices," i.e., decisions made without an awareness of the hidden forces at work shaping them. It examines some of the hidden factors that shape our everyday decisions and our experience of freedom. Ulti-

mately, *Snap, Crackle and Popular Taste* shows that "Freedom exists only in the presence of choices but it does not follow that the presence of choices creates freedom." Capitalism creates false needs that then have to be satisfied and the "pseudo-choices" made available to satisfy them in turn reinforce the control over our lives.

The following excerpt/parable from Schrank's book eloquently clarifies many of the above ideas:

> Once upon a time there was a town linked to the outside world by only one paved road. Every morning . . . a crew of men in a huge orange truck arrived and scattered nails on that road. . . . Unsuspecting motorists could invariably be seen along the side of the road repairing flat tires. The townspeople didn't like these drivers making tire tracks in the shoulders of the road and slowing traffic . . . and . . . finally asked the city council to do something about the problem.
>
> The city council responded quickly to the demands of the people by passing legislation that called for construction of a service station. The proposal was greeted with joy . . . and the station was quickly constructed and (just as quickly) began advertising its specialty.
>
> Drivers pulled into the station by the dozen each day, thankful that the service was so conveniently located. . . . The manager of the station became an honored citizen . . . (and) young people who wanted to "help people" would often put their idealism into practice by working in the station.
>
> The manager was a forward looking individual who introduced various reforms at the station, improving the method used to fix the flats . . . (and) when the number of needy motorists increased faster than the station could expand, . . . the people . . . willingly taxed themselves more to build another station.
>
> Dissidents in the town would occasionally demonstrate . . . they demanded that the service station do a better job. A few other townspeople saw that the problem would be solved if only those people would stop having flats, but such radicals were easily dismissed.
>
> Meanwile at 5:00 a.m. every morning, the huge orange truck lumbered over nearby dirt roads and made its way to the one paved road. There its crew scattered the nails . . . for another day. It had always been that way.

The Lethal Connection: Drug Abuse and the Medical Profession

Mike Smith

Testimony presented at National Hearings on the Heroin Epidemic, Washington, D.C., June 29, 1976.

Physicians play a crucial role in modern American society. No power of the physician has been more far reaching than the power to determine which drugs can be "safely" given to the American public. A relatively small number of doctors have almost absolute control over the safety and effectiveness standards used in marketing drugs. In the field of drug abuse treatment a handful of physicians control most of the important decisions in funding narcotic treatment programs, such as the multi-billion dollar "war on drugs" sponsored by the Nixon White House. Criticism of medical decisions is rarely given by non-physicians, because in some cases expertise is lacking but in many more cases because of the intimidating methods of the medical profession. To make matters worse, one of the basic lessons I was taught in medical school was that even a doctor shouldn't criticize another doctor in public. What happens in a country where powerful figures cannot be criticized and questioned about their actions?

Physicians Facilitate Illegal Drug Sales

If we search behind the scenes of the popularized histories of drug abuse, a frightening and dangerous story emerges. In 1898 Bayer Pharmaceutical Products, the aspirin people, invented heroin, a "non-addictive" treatment for coughs, minor aches and pains. Millions of bottles of heroin elixirs and tonics were sold. Heroin was also touted as a miraculous cure for morphine addiction. Heroin was substituted for morphine in thousands of clinics. Heroin maintenance would have been a appropriate name for the treatment. A massive advertising campaign led to AMA approval of heroin in 1906. By 1910 most scientists admitted that heroin is addictive and undesirable as a common home remedy. In 1914 Congress passed the Harrison Narcotics Act which outlawed most narcotics use but left loopholes just as today's laws often do. Up to this point we might conclude that it is tragic but perhaps excusable that the medical profession itself sold the country on one of the most devastating drugs in history. But the story continues.

In 1919, five years after the Harrison Act, Eli Lilly & Co. published a catalogue listing four kinds of heroin cough medicine — mixed with wild cherry syrup, white pine, etc. The catalogue did not mention how addicting and deadly their cough medicine was. The extra-strength brand was so powerful that eight ounces could kill an average person. Lilly's Glycerole Heroin Compound, for instance, was supplied in pint and gallon bottles.

It makes one very suspicious that Lilly's real intention was to supply the booming illegal mar-

ket in heroin at that time. We now know that Lilly has repeated these suspicious marketing techniques with many dangerous, addictive drugs — Seconal, Tuinal, and Methadone.

Immediately at the end of World War II in Europe, a Lilly research chemist named Dr. Ervin C. Kleiderer joined the Technical Industrial Intelligence Committee of the State Department which was investigating Nazi drug companies. Kleiderer's team brought methadone to this country. Two years later Lilly marketed Dolophine cough medicine, retaining the Nazi brand name for methadone which had been chosen to honor *Adolph* Hitler. Kleiderer soon became Executive Director of Development at Lilly. Lilly sold methadone cough syrup and tablets for 25 years, until the 1970's. It was supplied in pint and gallon bottles. Four ounces or four tablets would kill an average person. Does that sound familiar? Why would Dr. Ivan Bennett, the director of clinical research, and other medical professionals at Lilly take such a risk of malpractice? Methadone was never heavily advertised as a cough medicine. Federal researchers at Lexington, Kentucky had given it a bad reputation in 1947 by demonstrating how addictive and potentially fatal methadone is. However, methadone was slowly seeping out into the lucrative illegal drug market. It would only be a matter of time before some miracle-seeking doctor would "discover" that methadone could be used to treat heroin just as heroin had been used to treat morphine. In 1972 Lilly produced 90% of the methadone used by the tens of thousands of maintenance clients and the equal number of illicit users.

Lilly marketed Dolophine cough medicine, retaining the Nazi brand name for methadone which had been chosen to honor *Adolph* Hitler.

Propoxyphene, known as Darvon, is the latest addition to Lilly's narcotic family. Chemically very similar to methadone, Darvon was marketed since 1958 as a treatment for headaches and minor aches and pains. It has been phenomenally successful, accounting for $100 million in yearly sales for Lilly. Darvon was tested by narcotic researchers at Lexington in 1960 and found to be addictive and potentially fatal, yet paradoxically no more effective than a sugar pill for relieving pain. Darvon has always been used on the streets to get high and to maintain a narcotic habit. Medium-sized cities like Fort Worth or Oakland have consistently reported 30-40 Darvon-related deaths each year. Most cities do not keep such statistics. Darvon death reports have been printed in *The Wall Street Journal*, but because Darvon profits have been the keystone of Lilly's 20% yearly increase in profits; these reports have been kept out of mass circulation papers, keeping the public ignorant as to what is really going on.

As the 17-year patent on Darvon was running out in 1971, Lilly "invented" propoxyphene napsylate or Darvon-N, a nearly identical compound that could be exclusively patented for another 17 years. In 1973 Lilly's Dr. Bennett called a private conference on Darvon-N with top drug abuse officials in Washington. He proposed that Darvon-N maintenance might be able to replace methadone maintenance. Dr. Forest Tennant, who has run several drug clinics in poor communities in Los Angeles, stated that Black drug victims in Watts and young white victims in San Francisco have heard so many bad reports about methadone that they are refusing it for treatment. He explained that Darvon-N "helps us treat the thousands of addicts who don't find methadone acceptable." A free clinic doctor in San Francisco called Darvon-N "the hottest drug of the century." Regular side effects from Darvon maintenance include headache, rapid pulse, feeling spaced-out, hyperactivity, weight gain and persistent insomnia. Darvon maintenance has been used widely in California, but fortunately this latest narcotic bonanza has failed to spread.

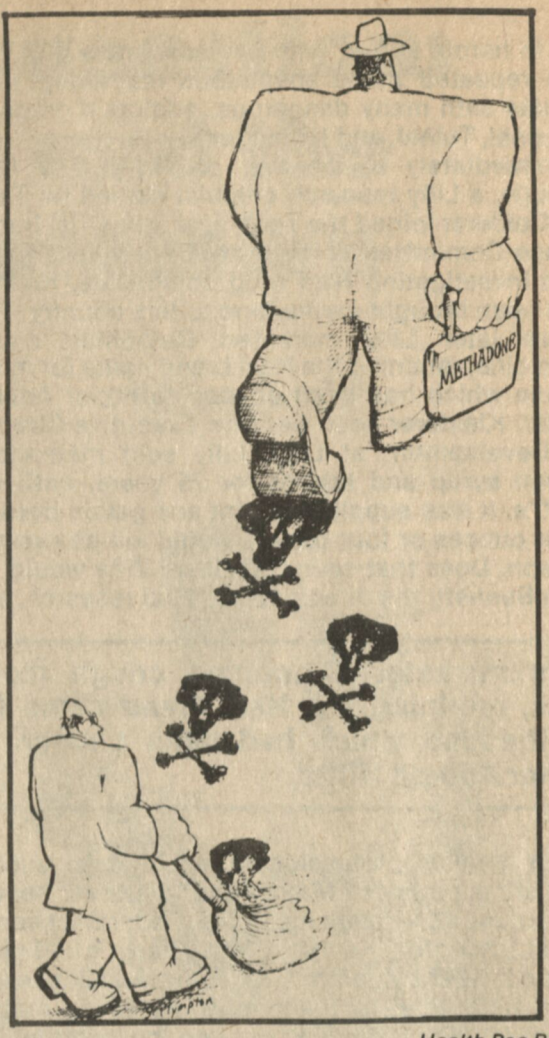
Each of the last 20 years Lilly has produced billions of its barbituates, Seconal and Tuinal, which have found their way into the illegal drug market. Lilly officials have been called before a number of House and Senate committee hearings to explain why they overproduce these "sleeping pills" which bring in $5 billion in street sales yearly. The answer is almost inescapable. Eli Lilly & Co. systematically markets addictive drugs. Under the direction of physicians such as Dr. Ivan Bennett, Lilly has developed a variety of legal and illegal tactics to sell the maximum number of addictive drugs and gain the maximum profits in the process.

Cover-Up of Methadone's Dangerous Effects

Methadone maintenance has been the most expensive and far-reaching medical treatment program ever financed by the federal government. The physicians entrusted to evaluate the safety and effectiveness of this program have been for the most part the very doctors who run the maintenance programs and who thus have a vested interest in keeping things quiet. For instance, Dr. Mary Jeanne Kreek of Rockefeller University, where methadone maintenance began, has reported in many articles that methadone maintenance is "medically safe, with minimal side effects and with no toxicitiy." She reports 14% impotence, but as one methadone program physician stated recently, "that's one of the side effects people have to learn to live with." Since insomnia cannot be measured by laboratory tests, Kreek minimizes →

this common effect of methadone maintenance. She never mentions the fact that pronounced edema and tissue swelling causing 20 pounds and more of weight gain occur in 5% of maintenance patients (by our estimates). Countless other complaints are passed off as "subjective" and unverifiable scientifically.

Methadone is five times as deadly as morphine in equivalent doses when tested on rats. Methadone-related overdose deaths outnumbered heroin-related overdose deaths in Washington, D.C. as early as 1971. Heroin overdose is treated by one to two injections of Narcan, the narcotic antagonist. Methadone overdose victims may require up to 20 injections of Narcan, given at two-hour intervals. One patient at Lincoln died because he did not receive his *17th* injection of Narcan. In 1974 I was a lecturer to emergency room staffs in New York City for the State Health Department, and I can assure you that almost none of the physicians and nurses were aware of how to treat methadone overdose victims. Evidently the government health agencies and Lilly Co. have made very little effort to teach medical personnel how to treat methadone overdoses. For example, in 1972 the New York City medical examiner Halperin suppressed any further announcements of methadone-related deaths "because the publicity is damaging to city-sponsored programs." The consistent record of issuing falsely positive information about methadone in both the public and the private sector leads one to assume that the information regarding treatment of methadone overdoses was probably deliberately withheld. Had medical personnel known how deadly methadone is, it would have been a blow to methadone sales.



Health Pac Bulletin

Heroin overdose is treated by one to two injections of Narcan, the narcotic antagonist. Methadone overdose victims may require up to 20 injections of Narcan . . .

The doctors who created the theory of methadone maintenance at Rockefeller University, Vincent Dole and Marie Nyswander, still claim that it is "relatively easy" to withdraw from methadone. During the first public discussions of methadone maintenance in 1967, *The New York Times* in its daily dispatches never once mentioned that this new "heroin cure" was itself highly addictive. Rockefeller University methadone supporters were able to blanket the media with favorable reports. Today almost all medical observers who are not biased by working in maintenance programs agree with the complaint that methadone patient-addicts have made for years: methadone is much harder to kick than heroin.

Withdrawal from methadone addiction is a long, drawn out, brutal experience. There is no two to five day crisis of vomiting and tremors as with heroin. During withdrawal from methadone the following problems occur: insomnia, depression, "bone pains," sweating, hot and cold flashes, intestinal disturbances, and the sensation of being unable to move your limbs. These symptoms occur for weeks and usually months on end. We have observed many well motivated people be unable to detoxify due to the prolonged anguish of gradual withdrawal from methadone.

The most bizarre and horrible effects of methadone withdrawal occur in infants born to mothers who are addicted to methadone. Dr. Rajegowda and Dr. Stephen Kendall reported the following study at the National Drug Abuse Conference in New Orleans in April 1975. Out of 187 methadone babies born at Jacobi and Lincoln Hospitals in the Bronx (in 1973-74), eight babies died of crib-death between two and six months of age. These methadone babies died of crib-death at 17 times the normal rate. Medical examinations prior to death showed no changes in symptoms or other signs that might have predicted which of the 187 babies

were going to die. No cause of death was found on autopsy. A previous study was done at the Yale University School of Medicine and was reported in the *Journal of the American Medical Association* on June 26, 1972. At Yale, three out of the 15 babies died of crib-death before three months of age. Heroin-addicted babies do not have as many withdrawal symptoms as methadone babies, and heroin is not associated with a higher rate of crib-deaths. With the exception of Thalidomide, none of the hundreds of drugs which have been outlawed by the Food and Drug Administration has caused such frightening human infant mortality as reported about methadone in these two studies.

The real owners of [methadone] clinics often include construction contractors, wholesale jewelers and real estate agents.

Both the Bronx and the Yale study were sponsored by agencies which run large methadone maintenance programs. Their statistical methods were able to be very straightforward and thus more inherently reliable than most medical surveys for adverse reactions. Methadone clients report to their program, and these babies were followed by the pediatrics departments of the same hospital as the methadone program. It would be very easy for any city health department to verify whether methadone babies have an unusually high death rate, since information on all methadone clients and all birth and death records are kept in those agencies. As fantastic as it might seem, this kind of statistical analysis has not been published. Most studies we have seen about methadone and infants evaluate withdrawal symptoms only while the child remains in the hospital. Comments are rarely made about the crib-death phenomenon in most of the studies.

We have spoken with a number of methadone maintenance clients whose babies died mysteriously in the first year of life. None of them were aware that their child's death might have been caused by methadone. They had not complained or sought further information when the doctors told them the children died "of unknown causes." Most of these mothers were afraid they had neglected their children in some unspecified way and hence they preferred to act as though the tragedy had never happened.

I have described a widespread medical cover-up of the risks of methadone treatment. In spite of methadone directors' complaints that federal agencies harass their programs, exactly the opposite is the case. The federal government has supported and protected methadone more than any other health treatment — of any kind — in U.S. history. More funds have gone to methadone than to any other medical treatment. In 1972, when the FDA gave its final approval for massive use of methadone maintenance, methadone overdose deaths already outnumbered heroin overdose deaths in the nation's capital. Of 560 drug abuse grants listed in the federal Research Grants Index for 1974, only 19 mention methadone in their title. Most of these studies concern what *will* happen to rats and guinea pigs. Very few of the research studies explore what *has* already happened to the hundreds of thousands of human methadone addicts. These research policies of the National Institute of Drug Abuse certainly suggest that official ignorance about the effects of methadone will continue.

Physicians' Greed

Private methadone clinics all have a doctor as a front man, as required by law. The real owners often include construction contractors, wholesale jewelers, and real estate agents — classes of people who often have strong underworld connections. This coincidence might explain the remarkable safety record that all methadone clinics that we know about have maintained. If any person tries to undersell the established heroin dealers in a neighborhood, his life could be forfeited. Yet this is exactly what public and private methadone clinics do: they offer a cheaper narcotic than heroin. What has been the reaction of large heroin

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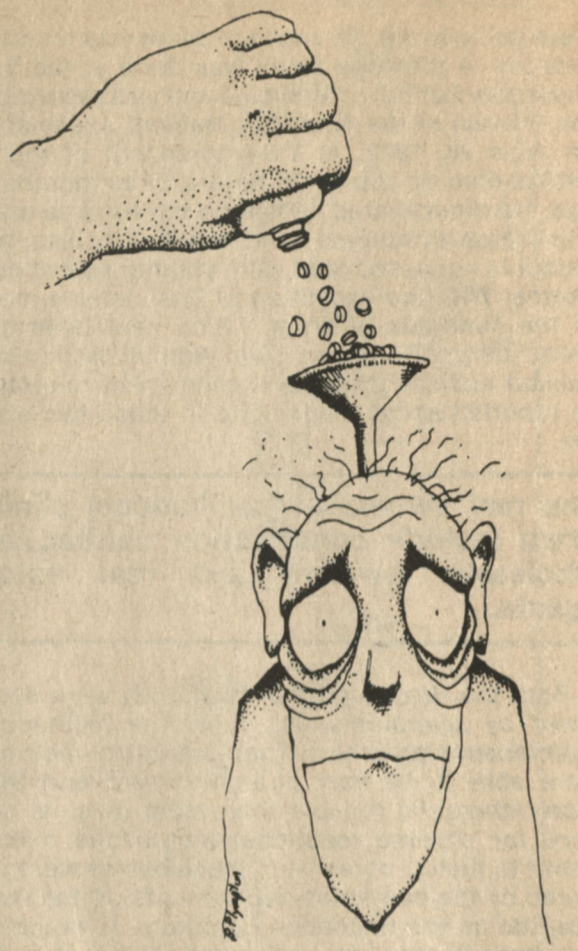
sellers to this apparently huge loss in business? Nothing. No methadone clinics have been firebombed or terrorized out of business. How could these organized crime czars be so calm about methadone and yet be so willing to murder people in penny-ante extortion rackets? Only one answer seems possible: payoffs, payoffs to the underworld bosses, to the cops on the pad, to buyers and sellers of all those stolen TV sets, to rich men all over the world.

The possible relationship between organized crime and the methadone business — both maintenance programs and the corporations that leak drugs on the street — suggests a new and more devastating level of corruption that physicians may be involved in. By using the medical profession and the pharmaceutical industry, organized crime could gain a further stranglehold on our lives.

Physicians Use Drugs to Control People Against Their Will

In my opinion the most dangerous aspect of physicians' involvement in the U.S. drug abuse policy is promoting the use of drugs to control people against their will. First of all, individual daily records on all methadone maintenance clients are registered in several computer systems. Methadone clients in New York City are registered in city computers and also in the computers of a private organization, the Community Treatment Foundation which is a subsidiary of Rockefeller University. One justification of the computerization is research. Yet high officials in the city Health Services Administration methadone section told us recently that they are aware of no research studies that have been published using Rockefeller's computer data. Another justification of the computerization is protection against clients signing up for more than one program. The necessary precautions in this regard could be accomplished by just using the city computer systems. It is hard to conceive of any valid justification which would require multiple computer systems or the use of private computer systems. One of the basic principles of medical ethics is total confidentiality between doctor and patient. Yet Dr. Vincent Dole, who was the co-founder of methadone maintenance at Rockefeller, has always been a foremost supporter of the computer systems.

Few of us have to be reminded how computer intelligence has been misused in recent times. The following report in the Atlanta Constitution (6/24/71) tells the story. "Carter met with Dr. Robert DuPont...who heads the District of Columbia's 16-month-old methadone program...DuPont showed Carter the District's computer center...A treatment aide pressed a few buttons



LNS

linked to a system in Boston and retrieved the name of a Washington addict named Jimmy Carter, who began the use of heroin at the age of 15." How can that Jimmy Carter of Washington be sure that credit bureaus, law enforcement agencies, potential employers and the like do not have access to that computer in Boston? The temptation to use this material, especially for law enforcement agencies, would be very great. Dr. Robert Newman of New York City was asked to search his files by the District Attorney. Newman refused and his decision was finally upheld by the Supreme Court. Nevertheless, it is difficult to imagine a system of record-keeping that is more prone to abuse than the methadone computer system. Richard Nixon's Special Action Office funded the system. Would he have tolerated any hesitation about leaking this information for the benefit of the White House?

Most methadone maintenance programs offer counseling and some kinds of therapy. In some instances we know that this counseling has been constructive and that a number of people on maintenance have stabilized and improved their lives despite the obstacles involved. However, in the majority of instances the main ingredient in this kind of "therapy" is the open or veiled threat: obey

the staff or get off the program. The threat of sudden methadone withdrawal or having to hustle drug money on the street again is very powerful. At first the victim is usually suspended for three days, just long enough for methadone withdrawal to begin to be felt. In addition, the clients' welfare and parole status often depend on continued good standing in the maintenance program. Furthermore the computer link-ups and agreements between the programs make it easy for expulsion from one program to mean expulsion from all programs if the program director wants it that way. As every street addict knows, you don't dare cross the pusherman.

I worked as a part-time psychiatrist in the Bronx County Jail for several years. A large number of inmates were offered the opportunity of parole to a methadone maintenance program as an alternative to a prison sentence. Sometimes it meant the chance to avoid up to five years in jail. In spite of my views on methadone, I never discouraged these men from taking what seemed to me at the time to be clearly the better of two evils, parole onto methadone. I was startled to learn that many of these prisoners chose to remain in jail for several years rather than take their chances on methadone maintenance. Need I say that these men hated being in prison and missed contact with their families very deeply. The prisoners I am referring to did not know most of the details about methadone that we are discussing today. They did not consider refusing methadone as a particular moral or political commitment. But they knew from street experience what methadone maintenance was all about and chose to do their time in a four-walled jail instead.

One doctor in Chicago is trying to perfect the manipulative aspect of methadone maintenance. He is Dr. Jordan Scher, the executive director of the National Council on Drug Abuse, director of the Methadone Maintenance Institute (MMI), and a visiting professor at the University of Miami. MMI has advertised that it could set up methadone maintenance clinics in any community that wanted one on a package basis. In a recent article Scher states the "conditioning nature of methadone...is insufficiently exploited. The patients are getting something they want in exchange for something we want." For example, MMI requires complete obedience to rules about dress and length and style of hair. In many parts of the country programs have harassed methadone clients who wear Black liberation buttons and demonstrate political beliefs in other (legal) ways. Women with a developing feminist consciousness and gay people have also been frequently harassed.

The most powerful encouragement for this type of coercive "therapy" has come from Dr. Peter Bourne. Bourne has repeatedly praised the addictiveness of methadone, saying that this quality of addictiveness "helps trust develop between the patient and the doctor." Examine the instructions he gives on page five of the Methadone Maintenance Treatment Manual prepared by the Department of Justice and the Law Enforcement Assistance Administration.

> "At the center," Dr. Bourne continues, "the patient is exposed to all of its rehabilitation services, including his relation with his counselor...which evolve into one of trust and intimacy with considerable therapeutic potential. The fact that methadone is addictive is essential to allow this to occur. Many addicts have difficulty establishing close relationships and were it not for the fact that they were addicted, they would find it extremely difficult, if not impossible, to return reliably on a daily basis and establish an ongoing relationship with the personnel of the clinic." The addicting nature of methadone, in short, "provides the critical element in allowing the establishment of a relationship with the addict with all of its therapeutic, rehabilitative potential." A non-addicting substitute for methadone would lack this essential characteristic.

As director of Drug Abuse Services in Georgia, Bourne established what he proudly admits was the most rigid computerized system of methadone maintenance in the country. He was chosen to be the only doctor in the state to have the power to prescribe methadone. Shortly after Bourne wrote a medical journal article praising the addictiveness of methadone, he was promoted to be second-in-charge of Nixon's Special Action Office on drugs. Dr. Bourne is now one of Carter's top five campaign managers. [Update: At this time, Bourne is special advisor on drug abuse to the president.]

In many parts of the country programs have harassed methadone clients who wear Black liberation buttons and demonstrate political beliefs in other (legal) ways.

The overall picture of methadone maintenance is frightening in its potential for social control. Using the methadone computer system, one can locate any of the hundred thousand methadone clients in a moment's notice. The dose of methadone that particular client is taking, the name of the program director, and important background information is provided. In the name of "therapy" that program director might be asked to encourage the client to cooperate with police authorities, provide information about certain community activities, or perform whatever task might be deemed in the "public interest." The potential exists for this coercion to happen. We have no proof that it has happened, but then I doubt that we would if it had occurred.

Schemes for social control are not described in the laws authorizing methadone maintenance which Congress passed. The critical aspects of

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the program — 1) massive computerization and 2) "therapeutic" use of the addictiveness of methadone — were developed by physicians who claim to be acting in the interests of their patients. Medical theories have been used to justify extremely inhumane actions, as occurred in Germany, for example. I do not know of any safeguards or watchdog agencies which would protect against the coercion of methadone maintenance clients for social control purposes.

How Physicians Can Begin to Combat Drugs

Let me conclude by mentioning the positive actions that a few physicians have taken and must continue to take in our fight against drug abuse in America. First of all, there must be a primary concern for the drug-abusing patients' welfare. Drug addicts are victims of the drug that they abuse, and in many ways they are victims of society as well. The people most likely to turn to drugs are the people at the bottom of the ladder — who live in the worst housing, go to the worst schools, and get the worst jobs, if they get any at all. They seek some pleasure, a kick, a high, anything that will make them oblivious in a world of too much pain. Victims of drugs who are trying to seek help are harassed in numerous ways by medical institutions and other sectors of society. At Lincoln Detox we have been advocates for drug victims in thousands of situations where we were seeking just the bare minimum of health care and found endless roadblocks in our path. How many drug abuse programs take an active concern in improving their clients' health care? We have found that community-run programs almost always have this priority, but in our experience generally programs run by physicians — by and large methadone programs — have a very poor record in this regard. It takes considerable patience and energy to cope with drug victims' health needs, but if we are helping people rehabilitate themselves, how else can we proceed?

Secondly, physicians must discard chemical and psychoanalytic approaches to drug abuse. It is simply absurd to compare methadone with insulin. It is equally absurd to say that individual "character disorders" caused drug abuse among 700,000 GIs, for instance. Drug abuse is primarily a social problem and can only be alleviated by socially-oriented solutions. In these areas the physician does not have any expertise. Therefore he

or she must function as a student or an assistant to other more knowledgeable people in order to have any positive effect on the drug abuse epidemic. When doctors in drug abuse programs have not taken criticism and advice from community people, including ex-addicts, the results have been consistently disastrous. The fact that this humble and rational response has rarely occurred among physicians is one of the main reasons for the failure of U.S. drug abuse policy.

At Lincoln Detox we have sought alternatives to the seemingly endless cycle of chemical "solutions" to drug abuse. We have used acupuncture for two years and are now beginning to investigate herbology as well. When I first saw people sitting around the room with acupuncture needles in their ears, I couldn't help thinking that it was all some kind of hoax. My training in the ways of western medicine blinded me to what was really happening. Acupuncture has proven to be a very valuable tool in eliminating the physical problems of drug withdrawal and rehabilitation.

In every poor neighborhood in America certain individuals or small groups of people have stood up to the drug bosses in their area. We would do well to honor these people on a memorial day. One of these honored dead is Dr. Richard Taft, who worked for the Lincoln Detox program. On October 29, 1974, Richard was found stuffed in a closet, shot up with heroin on the morning he was to meet with a powerful Washington official about

Many prisoners chose to remain in jail for several years rather than take their chances on methadone maintenance.

funding our acupuncture program. As an alternative to methadone and as part of a people's program against drug abuse, the Lincoln Detox acupuncture program has been very threatening to those who want to expand the drug pushing business. Richard's death has never been investigated by the police or by any of the drug abuse agencies we are involved with. Further harassment and incidents have occurred after his death.

The acupuncture demonstration van outside this building was Richard Taft's suggestion. Help us carry on the work that he and many others have begun.*

References will be supplied on request.

Mike Smith is the medical director of the Lincoln Detox Program, a community-based drug program in the South Bronx. Lincoln Detox is the largest ambulatory detoxification program in the country and has the largest acupuncture drug abuse treatment component in the country.

Health Pac Bulletin

Letters

Source Discovered

Ms. and Sir:

The charge that Nazi psychiatrists pre-dating Hitler's atrocities "murder[ed] hundreds of thousands of so-called mental patients" is too serious to make without documentation (Vol. 5, No. 6, p. 7). If there is really any truth to it, I would be grateful to know Ms. Greenspan's sources.

Sincerely,
Robert C. Murphy, M.D.
Dalton, Pennsylvania

P.S. R.T. is too important a publication to take any chances with accuracy. If its basic protest is to be effective I feel it must be scrupulously accurate about facts and, when they are as in this case open to question, sources, with, at the very least, editorial disclaimers as to the accuracy of statements made by others.

Dear Ms. and Sir:

Since writing you a few days ago for documentation of the German psychiatrists' genocide preceding the Nazi holocaust, I have found the — or at least a — source: *A Sign for Cain* by Frederick Wertham, M.D., Warner, 1966. It is a frightful history, and I don't know how much my not knowing about it is due to unawareness on my part, or to the fact that it has been conveniently "forgotten" and not spoken of.

Anyway, it is certainly true.

Sincerely,
Robert C. Murphy, M.D.

Feeding the System

To the Editors and Readers:

Fat is fostered upon certain susceptible individuals in our society by a Food Industry concerned with profits rather than nutrition. Fat is induced by the ingestion of white flour and white sugar, convenience foods, metabolism-altering additives, fast-food and restaurant diets — the disgustingly imbalanced and de-natured eating habits prescribed for us by Big Money. How is it then that we should support "Fat Liberation," when by so doing we are condoning the oppressive, irresponsible Industry which sells "fat"? It is true that reducing Diets are ineffective because they treat the symptoms of obesity; they are designed to eliminate the most weight in the shortest time, thus overloading the organs of elimination. But there are things that can be done: 1) Swear off processed "junk" food. 2) Use organically-grown raw fruits and vegetables. 3) Get off meat — it contains hormones which disrupt the normal functioning of the body. 4) Use organic vitamin-mineral supplements, rather than synthetic chemicals. Weight isn't gained overnight and won't be lost that way. It comes with a gradual readjust-

Unless otherwise indicated by writers, we will begin assuming permission to edit and publish any letters we receive. We get a lot of mail and unfortunately cannot answer all of it.

ment of the metabolism to undo the damage perpetrated upon you. Don't allow the Food Industry to kill you because you can't see behind the brainwashing. Confront the real Enemy.

Thank you,
David W. Lowe
Columbus, Ohio

Drugs

Dear Friends,

Received S&M yesterday and was very impressed. As the ad says, "You're not getting older, you're getting better." I liked Sue Landers' drug article and the excerpt from Nancy's book. I haven't yet got a copy of Nancy's book but the excerpt really whets my appetite. Sue's article is a good step in the right direction of doing more work on political economy.

One thought which came to mind reading Sue's article is that it doesn't really deal with the question of the use of drugs. She dismisses them at the beginning of the article, but I think that dismissal is somewhat simplistic. I'm strongly against the use of drugs as they are poorly researched and dispensed by the "mental health" industry, but I have to say from my experience that I've seen too many people ("patients" at the Center, friends, a relative) who have had serious mental crises, been climbing the walls, been totally incoherent, and been totally incapable of beginning to deal with the crisis without drugs. I think (as do the Cubans and Chinese) that they are useful in minimal doses and as a *brief, interim* measure. If the left is opposed to drugs, it has to come up with a successful alternative to deal with crises. Without it, we weaken our criticism. These remarks, as I've said, have nothing to do with drug use as practiced in the U.S. today, but they do point to the need for a more thorough analysis.

Best wishes,
Jerry Coles

Dialectics

Dear Collective,

Please receive my criticism of the new name on the in other aspects improved journai.

"State and Mind" is giving the false impression that state and mind should be of different origins. The philosopher Hegel has examined that at length.

"State of Mind" or "State is Mind" should be more correctly.

Not seeing mentality and civilization as an integrated whole, except for some peoples living in extremely isolated communities, is to underestimate the need for survival and "resurrection" of the identity in favor of mentality or community change. Something which of course is of need, but takes longer time than the life of the individual.

Yours Sincerely,
Kjell Myrberg
Stockholm, Sweden

No Comment

Editorial Note: The following letter was sent to a Wisconsin State Mental Hospital.

Dear Sir:

The United States Secret Service is responsible for the protection of the President of the United States and the members of his immediate family. The Secret Service is also authorized to protect others such as:

— the President-elect
— the Vice President
— the Vice President-elect
— a former President and his wife during his lifetime
— the person of the widow of a former President until her death or remarriage, and minor children of a former President until they reach sixteen years of age
— major Presidential and Vice Presidential candidates
— heads of foreign states and other foreign dignitaries the President may designate.

In order to more efficiently perform these duties, the Secret Service requests cooperation in obtaining information from every reliable source. One of the principal sources is hospitals housing the mentally ill.

The purpose of this letter is to ask for your assistance in informing us of the identity of persons in your institution who have done any of the following:

(1) Attempted to telephone, write or personally contact individuals within our protective jurisdiction

(2) Threatened or assaulted local, state, or Federal Government officials, excluding law enforcement officers

(3) Expressed an unusual interest in individuals within our protective jurisdiction

(4) Any individual, who, in the opinion of your staff or you may be of protective interest to this Service.

Since this request is in the National interest, it is imperative that such information be received by us immediately. Please be assured that any facts given to us relative to the above will be kept in strict confidence.

Will you please assist us in this important matter by reviewing this letter with your staff and advising us of anyone in your institution in whom we may be interested?

The telephone number for the Milwaukee office of the United States Secret Service is Area Code 414 224-3587.

Thank you for your cooperation in this matter.

Very truly yours,
Richard E. Artison
Special Agent in Charge

Classified Ads

Ad Rates

DISPLAY (CAMERA-READY)

$10 per column inch
$30 for 1/8 page
$60 for 1/4 page
$110 for 1/2 page
$200 for full page

Classified Rates: 10 cents a word for individuals, 20 cents a word commercial. (We will accept free classifieds from movement groups that are broke, in exchange for services or materials.)

Make checks payable to RT, Inc., P.O Box 89, W. Somerville, MA 02144.

State and Mind does not assume responsibility for the opinions or politics expressed in our paid advertising.

Groups

WINGS — Women in New Growth Situations. A feminist counseling collective offering skilled, supportive counseling for individuals, couples and groups. Negotiable fees; no charge for initial meeting. Located in Boston (Allston-Brighton-Brookline area), call (617) 277-1761.

Protection Against Psychiatric Abuses — People interested in forming such a group in the Montreal area, contact Daniel Reicher at 2086 Westmore, #3, Montreal, Quebec, Canada H4B 1Z6, (504) 482-7024.

Counseling

Radical Therapy Self-directed change, not adjustment to a sick society. Begin creating your own alternative now. Call Alex, Boston-area (617) 267-7860, 492-4169.

Boston Gay Hotline needs volunteers. Call 426-9371 (M-F) 6-9 p.m.

Publications

Moving Out is a seven-year-old feminist literary magazine. Fiction, poetry, articles on writing and literary criticism are some of the features of the publication dedicated to the "emergence of a true woman's aesthetic." One-year subs (two issues) are $3. Write to Moving Out, 4866 Third, Wayne State University, Detroit, MI 48202.

The Fat Review — radical Fat Liberation newsletter needs readers and contributors. Consciousness-raising, survival information, alternative health, politics and news affecting fat people. Sample $1.00; year-subscription (6 issues) $6.00, 50¢/$3.00 for welfare, unemployed; c/o Scott-Jones, 14 Jean Street, Hamden, CT 06517.

Teenage Women, before you volunteer for the military, be sure you know what happens to women who are tricked into enlisting. Read *Women: The Recruiter's Last Resort*, 75¢ and 25¢ postage, from RECON, 702 Stanley St., Ypsilanti, MI 48197.

Back in Print! Your Rights as a Mental Patient in Massachusetts is free to inmates and $2.00 to others. Send to: Mental Patients Liberation Front, Box 156, W. Somerville, MA 02144.

Education

Goddard-Cambridge Graduate Program in Social Change. An accredited one year M.A. program of Goddard College, accepting students for 1977-78. Project areas include Hussein A. Bulhan's "Imperialism vs. Radical Psychology"; and projects in Feminist Counseling with Donna Medley and Elizabeth Robson. For catalog, write or call: 186 Hampshire St., Cambridge, MA 02139, (617) 492-0700.

Information

Issues in Radical Therapy receives a number of requests each week from people who are seeking Radical Therapy Collectives in various parts of the U.S. In the past we have not had this information and are now endeavoring to bridge this gap. If you are an established Radical Therapy Collective currently practicing in the U.S. or abroad, please send us the specifics of what you are into, your collective address, fees, and the names of your members along with a telephone number if you have one. We intend to compile a list of collectives which will be printed in a later issue. IRT, Box 23544, Oakland, CA 94623.

Ad Deadlines: Camera-Ready Display — November 1
Classifieds — October 20

Book/Poster

Rough Times is a collection of some of our best from the second year. It contains articles on hospitals and change, professionalism, self-help and oppression as mental health. ($1.80)

Our poster features Judy Greenberg's beautiful "phoenix" graphic (the Phoenix-woman rising from the burning couch and hospital). Black and red on heavy grey poster stock. ($1.50)

(See opposite page for order form)

Back Issues

VOL. 5 BACK ISSUES — $.75 each

☐ Vol. 5, No. 6 Seventh Anniversary Issue; RT Sampler; Capitalism and Drugs; excerpt from Nancy Henley's *Body Politics*; Fat Liberation; review of Laing's *Facts of Life*.

☐ Vol. 5, No. 5 Critique of new psychosurgery studies by Gerald Coles; Atheism in the 1970s; "Violent" Women at Worcester State; Medicaid; lots more.

☐ Vol. 5, No. 4 Special Section on Spirituality includes an article by Karen Lindsey; Rev. Moon expose; Anna Kingsford history; review of Marge Piercy's *Woman on the Edge of Time*; much more.

☐ Vol. 5, No. 3 includes articles on the 4th Conference on Human Rights and Psychiatric Oppression; Cover-up of Detox Doctor Death; Chesler's *Women, Money, and Power*; Work and Alienation; Feminists and Therapy Conference; and more.

☐ Vol. 5, No. 2 articles on The Elizabeth Stone House; A Feminist Alternative; Boston State Suit; Sado-Masochism; Assertiveness Training; and more.

☐ Vol. 5, No. 1 Special Children's Issue — with articles on sexuality; child care; hyperactivity; etc.

VOL. 4 BACK ISSUES — $.75 each, 2-10 at $.60 each, 10 or more at $.50 each

☐ Vol. 4, No. 8 includes articles on lesbians in therapy; the psychology of fat; a critique of RT up til now; etc.

☐ Vol. 4, No. 7 includes a history of RT up til now; an article comparing prostitution and therapy; news about a feminist therapy conference; etc.

☐ Vol. 4, No. 6 contains articles on Elizabeth Stone House; behavior mod; Struggle to Grow; book reviews and news.

☐ Vol. 4, No. 5 Our latest women's issue — anger; rape; women as healers; heterosexual politics; women and psychology; resource list.

☐ Vol. 4, No. 3 articles on behavior mod; feminist therapy; job redesign; Nixon; menstruation; yoga.

☐ Vol. 4, No. 2 includes feminist counseling; gay view of primal therapy; review of *Repression of Revolution*; fat liberation manifesto.

☐ Vol. 4, No. 1 articles on "The Killing of Mental Patients"; psychoanalysis and the menarche; the politics of group process; behavior mod.

(Note: There is no Vol. 4, No. 4.)

VOL. 3 BACK ISSUES — Special Offer — $.50 each

All available Vol. 3 Back Issues for $3.00 (all but Vol. 3, No. 1)

☐ Vol. 3, No. 8 articles on psychosurgery; radical psychology vs. behaviorism; Detroit MP conference; the uses of madness.

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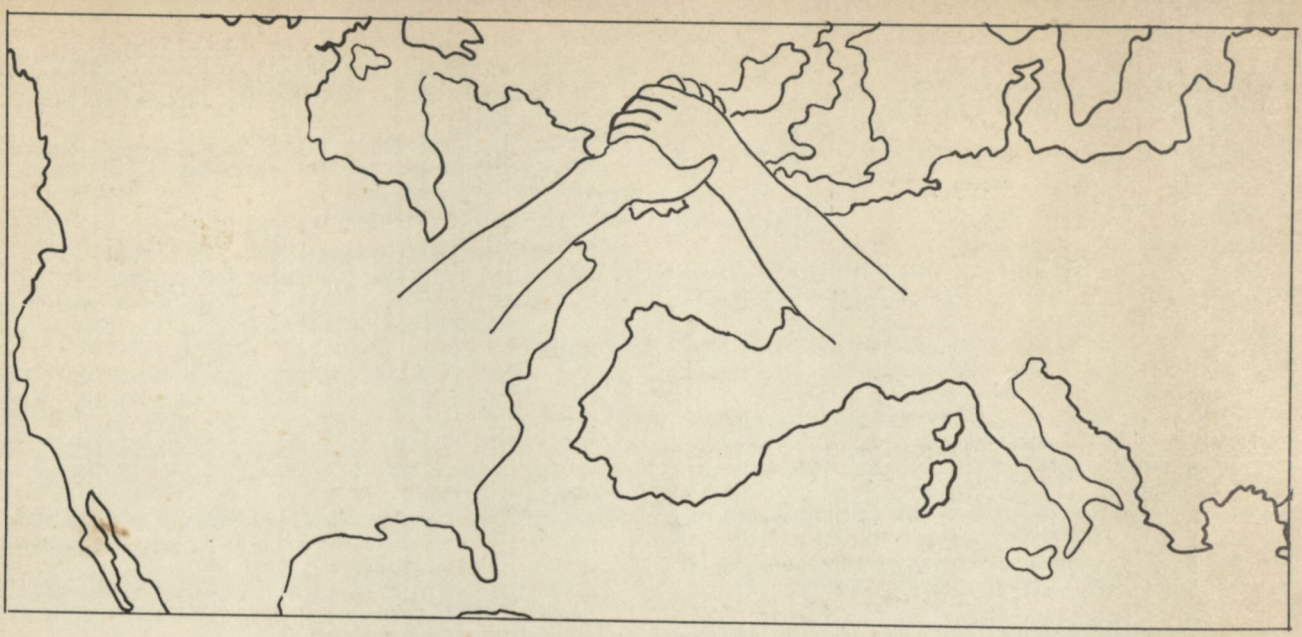

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