ABSTRACT OF THESIS

PASTORAL CARE IN PSYCHIATRIC HOSPITALS: AN APPROACH BASED ON SOME OF THE INSIGHTS AND METHODS OF LIBERATION THEOLOGY

In this work some of the insights and methods of a particular form of political theology, liberation theology, are used as a basis for constructing a critique of a specific type of pastoral care, that undertaken in English and Welsh psychiatric hospitals.

In the first part of the thesis the background, character and method of liberation theology are described. A 'methodological spiral' based on, and integrating, some of the insights and methods of liberation theology is outlined. This determines the rest of the work. It requires that the socio-political factors surrounding pastoral care should be thoroughly explored using the insights of the social sciences, and that particular attention should be paid throughout to matters of injustice, inequality and impotence before pastoral care and its political significance is assessed and suggestions are made for its re-orientation.

Analysis of the broad socio-political context of pastoral care in psychiatric hospitals is undertaken in the second part. The Marxist analytical perspective, which is the main perspective used, is described and discussed. There follows a consideration of the place and function of the State in late capitalist society, social policy and the Welfare State, the evolution and functioning of the National Health Service and a political economic critique of that institution.

The psychiatric hospital and socio-political factors affecting its contemporary functioning and the lives of those living or working within it is the focus of the next part. The evolution of the psychiatric hospital is considered and its contemporary goals and organisations are described. A staff/patient divide is identified and patient and staff groups and relevant socio-political factors affecting them and their mutual interaction are surveyed. An examination of some models of mental disorder and modes of treatment and their socio-political implications is undertaken. Finally, some of the problems of the contemporary psychiatric hospital are outlined and the future of this institution is discussed. It is concluded that socio-political factors play a large part in the functioning of the psychiatric hospital and that the inequalities and injustices revealed in the foregoing analysis can contribute to human suffering.

In the light of these findings, the final part is concerned with an examination of the practice and ideology of

pastoral care in the psychiatric hospital. The role of the chaplain in the hospital is described. Socio-political awareness among chaplains is assessed and found to be minimal. A Marxist analysis of the role of the chaplain reveals a mainly conservative function. Turning to the wider pastoral care tradition of the Church, it is argued that the socio-political dimension is not incompatible with the essential nature of pastoral care and that it should on occasion stand at the centre of this activity. In conclusion, some principles orientating pastoral care in psychiatric hospitals towards socio-political awareness and commitment are outlined.

PASTORAL CARE IN PSYCHIATRIC HOSPITALS : AN APPROACH BASED ON SOME OF THE INSIGHTS AND METHODS OF LIBERATION THEOLOGY

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PREFACE

As is usual in works of this kind, an enormous amount is owed to more people than can be individually mentioned here. My primary debt is to the patients and staff of a psychiatric hospital in the North of England where I worked as honorary assistant chaplain during the writing of this thesis. They taught me what life is like in this type of institution and kept me in touch with the reality about which I was writing.

Four individuals deserve particular mention here. Alastair Campbell and Una Maclean have supervised my work and my sincere thanks are due to them for the time, patience and effort which they have expended on my behalf. Duncan Forrester and Peter Selby have both gone out of their way to provide me with critical support in this venture and I count myself fortunate to number them among my friends.

A special word of thanks must go to Fred Leigh and his staff at the S.P.C K. bookshop in Newcastle on Tyne. They have never baulked at ordering the most obscure American tomes for me, even though this is completely outside the normal perameters of their trade. I thank them for their unfailing efficiency, courtesy and kindness.

Eileen Witts has worked long and very hard to transform my original manuscript into a legible document. Thanks are hardly adequate as a tribute to her industry and perseverance.

Only Jane knows the cost of this work. It is for her with my love and thanks. It is also for Peter Purves and Michael Coleman whose futures are inextricably bound up with the future of the psychiatric hospital.

The faults and inadequacies of this thesis are, sadly, all ascribable to me.

Stephen Pattison

St Mary's Monastery,
Kinnoull,
Nativity of St. John the Baptist, 1982.

I declare that this thesis is based on my own work and that I have composed it myself.

Stephen Pattison

CONTENTS

ABBREVIATIONS USED IN THE TEXT

A.H.A.	Area Health Authority
C.P.E.	Clinical Pastoral Education
D.G.H.	District General Hospital
D.H.A.	District Health Authority
D.H.S.S.	Department of Health and Social Security
D.M.T.	District Management Team
G.P.	General Practitioner
MIND	National Association for Mental Health
N.H.S.	National Health Service
N.T.	New Testament
O.T.	Old Testament
R.H.A.	Regional Health Authority

INTRODUCTION

This work has its genesis in two currents prevalent in contemporary church life and theology. The first, and perhaps more familiar and accepted of these, is the practice, theory and theology of pastoral care. The second is the emerging, and rapidly developing, field of political theology and the socio-political concerns and activities which are concomitant with it.

Both pastoral care and socio-political concern and theory have been present in the church from the earliest times. It is necessary therefore to distinguish the key elements of these areas as they are found in the contemporary church, for the modern manifestations of these are my concern, and not their historical antecedents.

Pastoral care has undergone something of a revolution in the present century. Having become almost entirely concerned with the practicalities of administering sacraments, and other types of ministerial activity (the so-called 'hints and tips' approach) (1), pastoral care has been transformed by encountering dynamic psychology. This kind of psychology originated with Freud and has led to the development of 'pastoral psychology' within the church. Techniques and understandings in pastoral care have been radically changed by this movement which originated

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(1) See further Robin Gill, 'The Future of Practical Theology', Contact, 56, 1977, 17-22.

principally among Protestant clergy in North America (2).

The pastoral psychology movement has grown greatly in size and influence since the last war and has now thoroughly permeated ministerial training and practice in most Western countries. Several journals, notably the Journal of Pastoral Care and Pastoral Psychology, document and propagate the growth of the movement. Indeed, the movement is large enough now to contain a variety of different 'schools' of theory and practice. Perhaps the most important of these is that of Clinical Pastoral Education (C.P.E.) which has exercised an enormous influence in the U.S.A. and latterly in this country (3). Techniques and understandings developed within pastoral psychology have tended, not surprisingly, to focus on improving care for individuals and small groups. There has recently been a move towards a broader 'systems' approach (4).

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(2) See Seward Hiltner, Preface to Pastoral Theology (New York : Abingdon, 1958) and Daniel Day Williams, The Minister and the Cure of Souls (New York : Harper and Row, 1977) for two of the earliest systematic attempts by pastoral care theorists to meet the challenge and insights of dynamic or humanistic psychology.

(3) C.P.E. has been developed principally in hospital settings and has therefore influenced hospital chaplaincy methods to a considerable degree. More concerning the history, principles and practice of C.P.E. is to be found in David Lyall, "Theological Education in a Clinical Situation", unpublished Ph.D diss., University of Edinburgh, 1979. See especially pp. 41 ff.

(4) For more on this see e.g. E. Mansell Pattison, 'Systems Pastoral Care', Journal of Pastoral Care, 26, 1972, 1-14 and, E. Mansell Pattison, Pastor and Parish - a Systems Approach (Philadelphia : Fortress, 1977).

It is important to note that in Britain the pastoral psychology movement has not held such broad sway as it has on the other side of the Atlantic. Even now, there is suspicion and ignorance of psychology and its attendant therapeutic techniques. There is also a tendency towards pastoral pragmatism based on traditional methods, e.g. administration of sacraments, particularly among older pastors. Nonetheless, even doctrinally very conservative clergy will often recognise the value of psychological insights in pastoral care, if only theoretically.

One of the most important effects of basing pastoral care on psychological and counselling insights and techniques has been the drawing together of pastors with other professionals using similar resources and conceptualisations. Thus, it is not uncommon to find pastors of various kinds working closely with psychologists, doctors, social workers, family therapists and members of other 'caring' professions to ameliorate the sufferings of individuals or small groups.

The same period which has witnessed the psychological revolution in pastoral care, namely the period following the last war, has also seen the growth of a very different area of ecclesiastical concern and activity, that of concern for the socio-political order and the effect which it can have, for good or ill, on human groups. It has become increasingly obvious to Christians, especially over the last two decades, that massive impersonal social and political forces play a crucial role in determining the nature and quality of human existence. This concern has come to the fore most forcibly in connection with the 'third world' and the challenge presented by those who stand in imminent danger of extinction due to lack of resources of one kind or another. The political and financial inequality in developed countries has

also brought this issue into prominence (5).

This has led Christians to seek to develop a relevant and authentic practice which is concerned with socio-political action for change and which incorporates an effective critique of the present unjust social order. It is against this background that various types of 'political' theology have developed throughout the world, e.g. black theology in South Africa and the U.S.A., revolutionary theology in the U.S.A., and the theology of liberation in Latin America (6). Most, if not all of these political theologies have demanded that new ways be found of looking at the Christian tradition which make it aware of its political implications and which liberate it from collusion with the forces of injustice and oppression. Predictably, this type of theology has devoted relatively little attention to the existential concerns or suffering of particular individuals. It has sought instead to extrapolate socio-political and corporate aspects of the Christian tradition and to free that tradition from exclusively individualistic a-political concerns and

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(5) See further J. Andrew Kirk, Theology Encounters Revolution (Leicester : Inter-Varsity Press, 1980), Ch. 3 .

(6) Alistair Kee, ed., A Reader In Political Theology (London : S.C.M., 1974) and Alistair Kee, ed., The Scope of Political Theology (London : S.C.M., 1978) give an overview of the various types of political theology which have emerged. See also Kirk, op. cit.

interpretations (7).

It is against this broad background of pastoral care and political theology that the present work seeks to address the general question "What have the methods and insights of contemporary political theology to contribute to the modern theory, theology and practice of pastoral care?". Behind this question lies a suspicion that contemporary pastoral care, developed under the aegis of the professional classes in the wealthiest nations on earth where the individual tends to be the most important entity, has social and political implications and determinants which it has, for the most part, failed to recognise and explore.

This suspicion can be expressed in rather different terms. Crudely stated, it is suggested that pastoral care in its concern for the suffering of the individual or small group has, unconsciously, ignored suffering whose aetiology

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(7) It should be noted that, as yet, no coherent political theology has yet emerged in Britain. Rex Ambler and David Haslam, eds., Agenda for Prophets (London : Bowerdean, 1980) represents an attempt to begin to develop a British political theology. Michael Paget-Wilkins, Poverty, Revolution and the Church (Exeter : Peternoster, 1981), also contributes to this development, as do many articles and journals in a mostly piecemeal fashion. Political theology has attained a degree of controversial public interest however due to Dr Edward Norman's 1978 Reith Lectures. See further Edward Norman, Christianity and the World Order (Oxford : OUP, 1979). Responses to Norman's views are to be found in Charles Elliott et al., Christian Faith and Political Hopes (London : Epworth, 1979). As economic recession and political polarisation in Britain grows, it seems likely that theology will have to consider the socio-political dimension at greater depth .

lies in the injustice, inequality and oppression of the social order. Rather than changing the social order which causes much suffering, pastoral care has chosen to deal with symptomatic treatment concerned with making adjustments in the individual or small group so that they can function more efficiently within a particular social order. In polarised terms this may be characterised as a schism between concern for the individual and therapy on the one hand and concern for the community and social action for a more just social order on the other. This polarisation has been neatly labelled as a tension between 'the personal and the political' (8). It may also be regarded as a tension between love and justice.

The Judaeo-Christian tradition has a considerable element of corporate, socio-political concern as well as being concerned with individuals. The Bible is full of language about corporate and political entities. Indeed, the Old Testament (OT) is mainly preoccupied with a nation, Israel. Even the individuals mentioned in the OT, e.g. kings, Moses, the Suffering Servant of Deutero-Isaiah, tend to serve a socio-political or corporate function rather than being seen important in their own right. The teaching of the OT about God and his will largely concerns the maintenance and ordering of social relations within the chosen people. Although less concerned with a geographical entity than the OT, the New Testament (NT) also displays much socio-political awareness and concern. Jesus himself used the term 'Kingdom of God' to convey the central meaning of his message. This term is meaningless if denuded of its corporate and socio-political content. It should also be

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(8) See further Paul Halmos, The Personal and the Political (London : Hutchinson, 1978).

remembered that Jesus was perceived to be a threat to the socio-political order of Palestine in his day and was executed as a political criminal by the civil authorities. The apostle Paul devoted his energies to building up a corporate entity, the church, which he characterised as the Body of Christ. Although he was not concerned with the secular social order to any great extent, Paul did devote some consideration to it, principally in Romans 13. The Revelation of St. John the Divine also deals with the contemporary socio-political order, but takes a rather different attitude to it from that of Paul (9). Other NT writers, while not overtly writing about matters of direct social or political nature record ethical precepts which have a bearing on this area (10).

Subsequent writers and thinkers in the Christian tradition have often devoted a good deal of time and energy to formulating theories of the social and political order and to working out the place and role of the church within it. Prominent among these are theologians and church leaders like Augustine, Aquinas, Calvin and Luther. More recently, in nineteenth century Britain the evangelical social reform movement and the Christian Socialists attempted to orientate the gospel towards the iniquities of social reality as they saw them. This concern continues in our own time with the writing of leaders like William Temple and movements like Christians for Socialism and the Jubilee Group.

The Christian concern for the social and corporate dimension of human experience has been nurtured and reinforced

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(9) See Rev. 13.

(10) See e.g. 1 Jn. 3^{16}ff., Jas. 1^{27} .

by a fundamental insight into the nature of the Godhead itself. From the time of the OT it has been believed that God is not only a God of love but also a God of justice. This perception is stated most clearly in the OT prophets:

> "He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God." (11)

The integral nature of the two principles of love and justice has been restated by Tillich (12).

In the light of this tradition then, it seem appropriate to examine the contemporary practice of loving and caring for suffering individuals from the perspective of the Christian awareness of the need for social justice, equality and change in society as a whole. Furthermore, it must be recognised that to fail to identify the social and political values and implications of pastoral care practice and theology is not to have a pastoral care which is free of these elements, but rather to have a pastoral care which is ignorant of its own socio-political context and impact. There is thus a danger that the loving activity of individually-focused pastoral care may be effectively denied by an incapacity to pursue justice and to be free of collusion with undesirable social and political forces.

To be considered effectively, the broad question of the social and political implications of pastoral care raised by the tradition mentioned above and by contemporary political theology must be narrowed down and examined more specifically.

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(11) Micah 6^{8}. New International Version.

(12) See Paul Tillich, Love, Power and Justice (Oxford : O.U.P., 1954).

To be most illuminating, it is necessary to consider one particular form of contemporary pastoral care from the perspective of one specific form of political theology. I have therefore elected to consider the theology of liberation which has emerged in Latin America and to apply some of its methods and insights to the practice and theology of pastoral care in English and Welsh psychiatric hospitals. The choice of these particular areas requires explanation.

The theology of liberation has been chosen from amongst the various types of contemporary political theology for a number of reasons. This theology represents perhaps the most important development in the field of contemporary political theology. Alone amongst such theology it provides a systematic attempt to re-interpret theology from a particular perspective. A reasonably comprehensive literature from the pens of several authors is now available in English translation. Perhaps most important of all, this theology has its own distinctive methodology which is clearly expressed. This distinctive methodology seems more likely to provide new and stimulating insights in the field of pastoral care than those which might be obtained if the method of a less original and incisive theology were to be used.

Pastoral care in English and Welsh psychiatric hospitals has been selected as a paradigm for analysis from the perspective of liberation theology firstly because the kind of analysis demanded by the method derived from liberation theology requires an extended and thorough analysis of the socio-political context of pastoral care. The psychiatric hospital provides a finite area for such

analysis while providing an extensive and coherent sociological literature which is illuminating in this respect. Such a literature would not be so readily available if, for example, the vast area of pastoral care in parishes was selected. The literature on mental disorder and psychiatric hospitals is also reasonably accessible to the non-sociologist. Secondly, mental distress and its treatment has figured prominently in the modern pastoral care tradition and has been regarded as essentially a matter for individuals or small groups, e.g. families. This then seems a good place to begin to expose social and political factors and implications within pastoral care. Thirdly, pastoral care in psychiatric hospitals is an area of which I have personal experience. Throughout the writing of this work I have acted as a chaplain in a relatively large English psychiatric hospital. This is significant in the present context as the theology of liberation emphasises the need to relate theory and practice in particular situations. Theological reflection must arise from and must feed back into practical action rather than be a solely theoretical exercise. Finally, a word need needs to be said about the exclusion of Scotland and Northern Ireland from my field of study. Unfortunately, separate laws and conditions apply in these countries from those in England and Wales. Since most psychiatric hospitals in the British Isles are in England and Wales, it seems simpler to concentrate on these countries to prevent the necessity for frequent modifying footnotes in the text.

Having written above that I have myself exercised pastoral care in a psychiatric hospital and regard this as important in the context of the present study, it might be expected that the pages which follow should contain a

great deal of exemplary material - case studies and the like - culled from my own experience and that of other chaplains. Unfortunately this has not been possible here. While such material could have been provided, it would have precluded thorough discussion of the large amount of literature which has to be considered below. This concentrates almost exclusively on theoretical material which is used to explore and substantiate a basic approach to pastoral care in psychiatric hospitals. It should be noted however that the theoretical material included herein has been evaluated against my experience of working in psychiatric hospitals and is congruent with that experience. My approach to theoretical material has also been influenced by informal interviews with, and observation of, five full-time psychiatric hospital chaplains in England. It is my hope that the preliminary discussion and examination of theoretical material here might lead to the formulation of more empirically-based research in the future. Such research, however, remains beyond the perameters of the present work.

A further absence which might be noted by the reader is the comparative lack of overtly theological material below. Indeed, Parts Two and Three of this thesis contain no theological material whatsoever and, although Part Four addresses pastoral care directly, there is not a great deal of doctrinal material there. This omission may be perceived as disappointing in the light of the earlier promise of the theology of liberation to produce new theological insights from a re-orientated practice of pastoral care.

These omissions need to be explained severally. Parts

Two and Three contain no theological material because they set out to explore the social and political aspects of the psychiatric hospital and its context. Theology would not be appropriate here, but it must be recalled that this non-theological socio-political analysis actually forms a very important part of a theological method derived from liberation theology. The theology of liberation, it will be seen, demands that the voice of the social sciences should be heard before the voice of theology and before the socio-political position of the church and its practice can be evaluated. This means that space must be given to a really thorough social and political analysis. Without such an analysis there can be no accurate understanding of the socio-political implications of pastoral care and its theology. This means no effective re-orientation of practice can take place and so no new theological standpoint or insights can be arrived at.

The comparative absence of overtly theological material in the fourth part below which considers pastoral care in psychiatric hospitals is compounded of two factors. Firstly, there is a dearth of formal theological foundation and reflection within the modern pastoral care tradition generally (13). Secondly, it must be acknowledged that genuinely new and valuable insights which add to the corpus of the cognitive academic discipline of theology gained inductively through the practice of pastoral care take a great deal of time and trouble to acquire and

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(13) See further Stephen Pattison, 'Images of Inadequacy : Some Theoretical Models of Hospital Chaplaincy', Contact, 69, 1980, 6-15. In this paper one of my constant observations of the writers considered was a lack of theological basis and understanding for pastoral care.

evaluate. It is this which perhaps explains the disappointment of Hiltner in a recent article where he noted with regret that the inductive insights into theological knowledge which he hoped would come from the practice of pastoral care have not, for the most part, emerged (14). It is not, therefore, surprising that the approach based on the method of liberation theology, a primarily inductive method, advocated here does not immediately give rise to theological data. It must be

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(14) See Seward Hiltner, 'A Descriptive Appraisal 1935-1980', Pastoral Psychology, 29, 1980, 86-98. Hiltner expressed his original hopes in his Preface to Pastoral Theology (1958). There are interesting parallels between the theology of liberation and the pastoral theology proposed by Hiltner. Both share a primarily inductive method, both are anthropocentric and arise out of the need to improve and alleviate the human condition, both focus on the transformation of present human reality, both claim to be able to provide new insights into theology working from present human experience and both share an incompleteness and a certain untidyness. However, there are great differences also. The theology of liberation leans on the social and political sciences for its insights into the working of God in contemporary human history, while Hiltner's pastoral theology gains insights into the workings of intra-psychic events and God's activity there by using psychology as a preliminary means of discernment. The theology of pastoral care is concerned chiefly with individuals and small groups while the theology of liberation concentrates on socio-political entities and groups. The theology of pastoral care aims to establish the reign of God by alleviating individual intra-psychic suffering while the theology of liberation arises out of a concern to make profound social and political changes to relieve the oppressed. If the loadstar of pastoral theology is Freud, that of the theology of liberation is Marx. No doubt many of the differences between these two different types of theology can be accounted for by the fact that one has arisen in middle class North America while the other has arisen from the poverty of peasants struggling for freedon from oppression in Latin America.

acknowledged, however, that the theology of liberation itself has produced many original and distinctive contributions to theological knowledge and understanding. There is every reason to hope that, in due course, a socio-politically aware and committed pastoral care could also make a contribution in this direction. It is only unfortunate that this contribution cannot be made here and that only the preconditions for its emergence can be outlined.

Before setting forth the shape of the rest of this work, it is necessary to spend some time in the discussion of some of the key terms and assumptions used in it. Firstly, then, the term 'socio-political'. This is used to designate that area of human existence which concerns corporate and social life rather than that of the individual. It is intended to be broad in its designation. The 'political' component of this term denotes a concern with the organisation of corporate human relations and especially with the place of power in those relations. Again, the 'political' aspect encompasses all levels of corporate organisation from the running of the State and the economy on the one hand to the micro-political level of the small group or the relationship between two or more individuals.

'Pastoral care' has been variously defined and further discussion of this term will take place below. For the present, it is adequate to define it as that activity undertaken by representative Christian persons which is directed towards the elimination of sin and sorrow and towards nurturing human beings so that they may be presented in the fullness of their potential in Christ to God.

Throughout the remainder of this work I shall use the terms 'mental hospital', 'psychiatric hospital' and 'mental illness hospital' interchangeably. This reflects common usage. In talking of these hospitals I have in mind large buildings, built in the latter part of the last century or the early years of the present one, often remote from centres of population which devote most of their bed space and facilities to the care and treatment of those who have come to be regarded as mentally ill (15).

The next terms which must be discussed are particularly problematic. Throughout the rest of this thesis an assumption is made that social justice and equality of power, status and resources are, if not Christian ideals in themselves, ideals which Christians should espouse and work towards realising in the contemporary world. As I noted above, the Judaeo-Christian tradition sees the aspect of justice as an integral part of the nature of God and his will for human beings. The concepts of justice and equality are closely related in political philosophy. They pose a problem here because the actual meaning content imputed to them can vary enormously. Even a cursory glance at the literature on these topics reveals a plurality of meaning and usage. One writer, for instance, identifies three basic, and to some extent conflicting, core principles within the concept of social justice. He maintains that there is a 'conservative' principle which advocates distribution to each according to his means; an 'ideal' principle which advocates distribution to each according to

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(15) For elements of this definition see Douglas Bennett, 'The Future of the Mental Hospitals - An Introduction to the Issues' in MIND, The Future of the Mental Hospitals (London : MIND, 1981) pp1-3, p1.

his deserts; and a 'prosthetic' principle which advocates distribution to each according to his needs. Things are further complicated by the fact that these core principles tend to be adopted by different groups at different times and their dominance is therefore affected by the social and historical context in which social justice is being enunciated (16).

Equality, similarly, can have different usages and meanings which are widely varied. It is possible in talking of equality to be referring to equality before the law, equality of basic human rights, economic equality, equality of opportunity, equality of consideration or absolute equality of treatment, amongst other usages (17). I do not propose to consider these complexities further here. However, it is important that I should make clear the way in which I intend to use these terms. I propose to use the terms justice and equality to refer to the necessity for distribution of power, status and resources according to need rather than to any other criteria. I believe that this usage corresponds most closely with that implicit

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(16) See David Miller, Social Justice (Oxford : O.U.P., 1976), Ch. 1. See also D.D. Raphael, Problems of Political Philosophy, Revised Edn., (London : Macmillan, 1976), Ch. 7. Raphael rightly notes that justice is 'a complex concept' (Op. cit., p.165).

(17) See further John Rees, Equality (London : Macmillan, 1972), especially Ch. 7, also R.H. Tawney, Equality (London : Unwin, 1964).

in the writings of the theologians of liberation (18).

The last concept which requires definition here is that of 'power'. Following Lukes, I shall define power by saying that A exercises power over B when A affects power in a manner contrary to B's interests. This definition is equally appropriate when talking of the power used by individuals or that of groups or nations. It must be noted that the notion of interests used in the definition proposed inevitably implies a prominent element of judgement of an irreducibly moral and political character (19).

The work which follows is divided into four Parts of varying lengths. The first of these anatomises the background, nature, problems and methods of the theology of liberation. It concludes with a methodology derived from that of the theology of liberation which determines the structure of the rest of the thesis. Arising from this methodology, Parts Two and Three consist of a thorough analysis of the socio-political context of pastoral care in psychiatric hospitals. The size of this analysis is justified by its methodological necessity and also by the fact that no similar

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(18) It must be recognised that the concept of need itself is a problematic one. Needs can be defined variously according to historical, geographical and social factors. It is sufficient here to adopt a 'common sense' approach to the definition of human need. I shall assume that all human beings in our society need to have their basic physical, social and spiritual needs met and that the level of these needs is determined by the standards of our society. For a more detailed discussion of the nature of need see especially Raymond Plant, Harry Lesser and Peter Gooby-Taylor, Political Philosophy and Social Welfare (London : R.K.P., 1980).

(19) See further Stephen Lukes, Power (London : Macmillan, 1974), p.34.

analysis from a socio-political perspective has been undertaken in this way before. Part Two situates the hospital within the wider socio-economic order of Britain, within the welfare state and within the National Health Service (N.H.S.). Part Three expounds and considers social and political issues arising out of a sociological analysis of the hospital itself. This socio-political critique is followed by consideration of the place and function of pastoral care in psychiatric hospitals in the light of the foregoing critique. The thesis concludes with some proposals which attempt to orientate pastoral care in a more socio-politically aware and committed direction which both integrates and develops further some of the methods and insights of the theology of liberation in the situation of the English and Welsh psychiatric hospitals.

The reader may notice that the voice in which the thesis is written changes from time to time from the third person to the first person. This is a deliberate feature which has stylistic reasons. In general, I have adhered to the third person in my account. However, this can become tedious and clumsy, both for writer and for reader and so I have elected to change voice particularly at moments where an explanation is being given as to the direction of the work as a whole. This permits a temporary respite from endless 'it is' constructions throughout and I hope that it will lighten the text to some extent.

PART ONE

THE THEOLOGY OF LIBERATION

CHAPTER 1

THE BACKGROUND, CHARACTER AND METHOD OF LIBERATION THEOLOGY

Before seeking to use some of the insights and methods of liberation theology to illuminate the theology and practice of pastoral care in psychiatric hospitals in this country, it is necessary to explore thoroughly the nature of this theology. This task is undertaken here. Because liberation theology claims to be a political theology contextually specific to Latin America, the starting point for this examination is a short account of the social and historical background in that continent. This is followed by a survey of the situation of the church in Latin America. The theological background to liberation theology is examined and then the nature of liberation theology is described and discussed. The method of this theology is considered and this is followed by a critical evaluation of that method which draws attention to some of the problems and weaknesses inherent in its usage. Finally, I shall relate the method of liberation theology to the methodology which is to be used in the present work. I will then outline my own methodology.

A few preliminary remarks are necessary before commencing this task. Firstly, it must be made clear that there is no homogeneous corpus of work which can be designated 'liberation theology'. Latin America is comprised of many different countries separated by distance and culture. Within those countries are theologians who produce theology with certain broad similarities. However, it would be quite inaccurate to minimise the differences between these theologians. In this respect 'liberation theology' must be seen as a very rough categorisation which is useful

and accurate up to a point, but which disguises a rich plurality of theologies. This factor must be borne in mind throughout this chapter. I do not think that the necessary over-simplification involved in using the term 'liberation theology' detracts significantly from the analysis which follows.

Secondly, it should be noted that only English translations of the works of the various theologians discussed below have been used. The difficulties associated with this are twofold. In the first place this has the effect that the meaning of the original Spanish may have become distorted. Secondly, and more significantly, it means that there is an inevitable time-lag between the original production of books and their appearance in English. This means that substantial changes may have taken place in the thinking of Latin American theologians, provoked perhaps by social and political developments, of which I am simply unaware. This is regrettable.

Related to the previous point is the fact that much of the output of liberation theologians has not been produced in published form. Because of the political situation often to be found in Latin American countries which precludes criticism of the State, because of the urgency of the church's task in that continent, and because of the contingent nature of this type of theology, much of the writing of liberation theologians has attained only cyclostyled form and its circulation has been limited.

Finally, biographical information about liberation theologians and their involvement in the liberation struggle in their respective countries is difficult to obtain. Given that one of the central assertions of liberation theology

generally is that theology can only arise out of practical involvement in the struggle for liberation, it seems unfortunate that these theologians have not included more in their work about their own socio-political involvement.

1. The Social and Historical Background in Latin America (1).

Essentially, the Latin American experience since the sixteenth century has been one of conquest and exploitation by European, or at any rate 'First World' powers. This process began with the Spanish conquistadors, was continued by the nineteenth century modernising industrialists and latterly the U.S.A. has been the chief exploitative and colonialising influence. The U.S.A. maintains many unjust and oppressive situations in the continent with financial support and activity. Comblin's book The Church and the National Security State explores the vast influence of U.S. military philosophy and support in contemporary Latin America (2).

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(1) Accounts of the social and historical background of the church in Latin America and of liberation theology specifically may be found in Jose Miguez Bonino, Revolutionary Theology Comes of Age (London : S.P.C.K., 1975), especially Chs. 1-3, J. Andrew Kirk, Liberation Theology (London : Marshall, Morgan and Scott, 1979) Ch. 1, Enrique Dussell, History and the Theology of; Liberation (Maryknoll : Orbis, 1976) and in Gustavo Gutierrez, A Theology of Liberation (London : S.C.M. 1974), especially Chs. 2, 6, 7 and 8. Valuable material concerning the political philosophy of Latin American states is contained in Jose Comblin, The Church and the National Security State (Maryknoll : Orbis, 1979). Paul Gallet, Freedom to Starve (Harmondsworth : Penguin, 1972), Alain Gheerbrant, The Rebel Church in Latin America (Harmondsworth : Penguin, 1974) and John Eagleson, ed., Christians and Socialism (Maryknoll : Orbis, 1975) provide useful information about Latin American society and the place of the church within it.

(2) See Comblin, op. cit.

During the 1950's and 1960's, Latin American peoples saw themselves as being in a situation of development which would eventually end in their enjoying prosperity such as that enjoyed by nations in the developed world. The dream did not materialise. As a consequence, the language of development and evolutionary change gave way to that of revolution, liberation and dependence. It was realised that if the wealthy nations remained wealthy there could be no end to the poverty of Latin America as the two facts have a direct correlation. This meant the rejection of the liberal-modernist viewpoint with its pseudo-promises: "Latin America has discovered the basic fact of its dependence. This is the real meaning of the liberal modernist project"(3).

The concept of liberation has been of the utmost importance in the new understanding which Latin Americans have gained of their own situation. It is important to spend some time exploring its meaning here as it has had a profound effect on the species of theology presently under consideration. It is difficult to find a comprehensive and exact definition of the term'liberation'but several key elements within it can be identified. First and foremost, it denotes freedom from all that limits and keeps people from self-fulfillment and from all impediments to human freedom (4). Thus understood, liberation implies both freedom from that which inhibits and oppresses and freedom to find new areas which can be developed once oppression has been conquered. In the case of Latin America the quest for freedom and liberation clearly demands the demise of inequality, injustice and poverty before positive development

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(3) Bonino, op. cit., p.15.

(4) See Gutierrez, op. cit., p.27.

can take place. This means that liberation must take the form of active, corporate, social and political struggle rather than being an individual or intra-psychic activity as it might be in the developed world. While liberty or freedom is an ideal which may or may not have concrete content, liberation has the connotation of being a present activity which has no meaning apart from action. In this sense, liberation must precede liberty when subjugation or oppression of some sort prevails (5).

2. The Situation of the Church in Latin America (6)

Along with the dawning awareness of the exploitation of Latin America and the growing understanding of its dependent relationship with affluent countries, has come an awareness of the church as a social institution. In the Latin American context most Christians are Roman Catholics (as indeed are most of the liberation theologians) and the Catholic church has played a most important part in the life of the continent. From the first conquests in the sixteenth century, there has been a continuous and influential Catholic presence, but with a few notable exceptions this influence has been directed towards pleasing the rich and powerful who could grant favours to the church, rather than towards protecting the poor and oppressed.

The church has traditionally seen itself as heavenly and divine and it made alliances with those who

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(5) The most comprehensive survey of the meaning of liberation which I have found is contained in M. Merle, 'Liberty and Liberation' in Rene Metz and Jean Schlick, eds., Liberation Theology and the Message of Salvation (Pittsburg : Pickwick Press, 1978) pp.3-22.

(6) For the place of the church in Latin America see the works cited in note 1, above, especially Gheerbrant, op.cit.

could best further its expansionist aims, or 'mission'. Initially, this was supported by the notion of Christendom (7) which had come into being after the Constantinian settlement in the fourth century. This maintained that the church and the state are essentially one. With the rise of secular states in the nineteenth century this idea had to be radically modified, but even in the nineteenth and twentieth centuries it was possible for a 'New Christendom' ideal to arise. This worked on the basis that lay Christians should be able to 'Christianise' wider society by implementing their Christian principles in public life. The Catholic church, then, has always had a strong interest in society and politics. Although it has seen this realm as subsidiary and inferior, it has also realised its importance in serving the interests of the divine society of the elect, outside whose ranks none are saved.

In the light of this kind of thinking, it came as a complete reversal when the church in Latin America had to come to terms with the fact that it was more human than divine, more earthly than heavenly, and far from being the realm of grace and salvation, was actually firmly entrenched in the exploitation and continuing injustice of Latin America. For the church, rather than using the state for its own ends was actually seen to be being used by the state for its ends. In making good relationships with the ruling elites of Latin America in order to retain its own peace, influence and privileges, the church was defending the exploiters against the exploited. It was

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(7) The notion of Christendom and the other typologies of the relation of the church to the state and secular society is explored further in Gutierrez, op.cit., Chs. 4 and 5, and in Alfredo Fierro, The Militant Gospel (London : S.C.M., 1977), Ch. 2.

legitimising and sacralising the existing social order, making it appear as part of the divine order rather than a situation created and maintained by the injustice of men.

Since this awareness has come, some Christians have tried to de-ideologise their own stance and that of the church. That is to say, they have tried to distance themselves from the Christian legitimation of the unjust social order in order to discover and proclaim the justice of the gospel. Amongst them are the liberation theologians. Not many of those protesting against injustice are theologians. A tiny minority of priests and religious have in fact involved themselves concretely in the people's struggle for liberation from social and economic oppression. Camillo Torres, a priest and sociologist took to the hills and joined in the guerilla struggle of the people of Columbia. Archbishop Helder Camera has witnessed in word and deed to the oppression of the people of Brazil (8)). But it is important to realise that such people are the exception rather than the rule in the Latin American church. Because of the fear of communism carefully nurtured by the church in the past, because of rejection of violence as a Christian option, because of privileges from the state, and because of the fear that they will be seen to be canonising a particular political ideology, many church people have held themselves aloof. The hierarchy particularly, despite the conference of Latin American Bishops at Medellin where the concept of 'liberation' first came into common usage, seems particularly anxious to avoid concrete commitment to

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(8) Accounts of, and excerpts from, the writings of these and other Christian activists are contained in Gheerbrant, op. cit. See especially Part 3.

the liberation struggle (9).

3. The Theological Background

While the methods and concerns of liberation theology are in many ways different from those of other contemporary theologies, there are continuities as well as discontinuities. Some account of recent and contemporary antecedents of liberation theology is therefore necessary.

Fierro characterises all modern political theologies as having three things in common. They are all practical, public and critical (10). The precise meaning of these terms is not relevant here; the point being made is that liberation theology is not unrelated to those European and North American theologies which concern themselves with social and political change. These theologies include the work of Moltmann, Metz, Lehmann, Cox, Cone and others and may all be described as in some sense political (11). Comblin actually asserts that liberation theology is really a part of the wider, inter-continental theological movement whose distinctive characteristic is that it is concerned with revolution. He does not see it as a

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(9) The Medellin conference of the Latin American Hierarchy of the Roman Catholic Church is named thus because of the Columbian city in which it took place in August - September 1968. An account of this crucial event and the pressures, dynamics and thought which surrounded it is contained in Gheerbrant, op.cit., Pt 2. Extracts from the final document of the Conference are on pp.254-7 of that work.

(10) See Fierro, op.cit., pp. 17-28.

(11) For an overview of contemporary political theologies world wide, see Kee, ed. A Reader in Political Theology, and Kee, ed., The Scope of Political Theology. Fierro, op.cit., gives critical consideration to all the main contemporary political theologies.

totally separate thought system (12). Other liberation theologians, though, would want to affirm its separateness and discontinuity (13). However, here the connections and influences from the wider theological spectrum will be traced before going on briefly to consider that which is distinctive in the content and method of liberation theology.

Liberation theology is an anthropocentric and humanistic theology (14). In these emphases on the importance of man and his development now as subject of his own history, liberation theology is not just reflecting the influence of Marx, but also that of Bultmann and Tillich earlier in this century. While modern political theologies have a concern for the social and political rather than for the psychological and existential, they do not reject the thought of their predecessors entirely.

Indeed, Bultmann's work has been particularly influential. It was he who coined the term 'hermeneutic circle' which has played an important part in the methodology of liberation theology (15). The work and methods of Bultmann and other biblical scholars has been accepted as valid and useful by many Latin American theologians. While realising the need for it to be de-ideoligised from its European concerns, at least one liberation theologian would claim that European-developed methods and insights in exegesis can lead to the liberation

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(12) Comblin, op.cit., p.30.

(13) See Comblin, Op. Cit., p.18.

(14) Fierro, op. cit., p.1.

(15) See Kirk, op. cit., pp. 37, 72, 89. Also Juan Luis Segundo, The Liberation of Theology (Dublin : Gill and Macmillan, 1977), p. 8f.

and recovery of the text of Scripture (16).

The liberation theologians owe much to the theologies of the Europeans Metz and Moltmann (17). The concept of the 'de-privatisation of religion' developed by Metz has been very important as have Moltmann's ideas about hope and the nature of the God revealed on the cross (18). While Latin American theologians do not respect the idealistic starting point or the lack of concrete social analysis and commitment in the work of Moltmann and Metz, they welcome some of their theological insights.

The theology of secularisation which flourished in the 1960's in the U.S.A. and Europe has also influenced liberation theology (19). The main emphasis of this theology was on coming to terms with the separation of the religious and social orders in the developed world. It is because of this influence, which gave the secular world its due importance, that the Latin American theologians make it very clear that they do not want to revive Christendom (20).

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(16) See Jose Miranda, Marx and the Bible (London : S.C.M., 1977), Jose Miranda, Being and the Messiah (Maryknoll : Orbis, 1977). Leonardo Boff, Jesus Christ Liberator (London : S.P.C.K., 1980) also makes use of modern Western methods of biblical scholarship and criticism.

(17) See Kirk, op. cit., p.26.

(18) See further e.g. Johannes B. Metz, 'The Privatization of Religion' in Alistair Kee, ed., The Scope of Political Theology (London : S.C.M., 1978), pp. 4-15, Jurgen Moltmann, Theology of Hope (London : S.C.M., 1967) Jurgen Moltmann, The Crucified God (London : S.C.M., 1974).

(19) See e.g. Harvey Cox, The Secular City (Harmondsworth : Penguin, 1968).

(20) See references in n. 7, above.

While in some ways liberation theology is an attempt at 'putting God back into the world', and showing that God is alive and active, this is not to be at the expense of diminishing the significance and importance of the secular. Liberation theology does not claim to be an attempt at Christian imperialism, or a part of a re-sacralisation process.

Last, but perhaps most important for tracing the theological influences on liberation theology, specifically Roman Catholic influences on it should be recognised. The most significant of these influences are the Second Vatican Council and the social encyclical Populorum Progressio (1967). Together, these have combined to bring about a much more concerned and open attitude to the world, and permitted much greater involvement and thought in extra-ecclesiastical matters (21).

4. The Nature of Liberation Theology

A Committed Theology

Above all, liberation theology is a theology of active and concrete commitment in the struggle of the oppressed peoples of Latin America to throw off their yoke. The definitions by liberation theologians of their own activity in theology reflect their paramount concern for this struggle and their involvement in it. In a situation in which the challenge to theology

> does not come primarily from the man who does not believe, but from the man who is not a man, who is not recognised as such by the existing social order ... the question is not how ...

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(21) The respective influences of European theologies, secular theologies and the theology emerging from the second Vatican Council on political theology are surveyed in Fierro, op.cit., pp.12-16.

> to speak of God in an adult world, but how to proclaim him as a Father in a world that is not human (22).

It is this inhuman situation which conditions definitions of theology such as those of Gutierrez: "Theology will be a critical reflection from and about the historical praxis of liberation in confrontation with the word of the Lord lived and accepted in faith" (23). Again he writes:

> Theology is an understanding of the faith and a re-reading of the word as it is lived in the Christian community. The ensuing reflection is orientated towards the communication of the faith and the proclamation of the good news of the Father's love for all men (24).

His most succinct definition of theology is that it is "a critical reflection on Christian praxis in the light of the Word " (25). Assmann adds to this and clarifies it in stating: "Theological reflection is impelled by a desire to speak the word of the Lord to all men from a position of solidarity" (26).

A Practical Theology

Flowing from its concern with the struggle of the poor and oppressed is a strong emphasis in liberation theology

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(22) Gustavo Gutierrez, 'Liberation, Theology and Proclamation'. Concilium, 6, 1974, 57-77, pp.68-9.

(23) Ibid., p.70.

(24) Ibid., p.57.

(25) Gutierrez, A Theology of Liberation, p.13.

(26) Hugo Assmann, Practical Theology of Liberation (London : Search Press, 1975).

on the importance of liberating action or praxis. Picking up the Marxist emphasis on truth and knowledge being discovered through the dialectic interaction of thought and concrete action to change the world, the liberation theologians emphasise the primacy of action (27). Truth, in this mode of thought, ceases to be an intellectual abstraction and becomes active involvement. Knowledge worthy of the name must verify itself in praxis (28). This must include any knowledge of God, who is actively working in the liberation process. It is only in action that the meaning of love or charity can be revealed. This coincides with God's mode of revealing himself in the Bible: "Biblical truth is characterised by the fact that it is projected into history ... (and) ... is related to the history ... by virtue of its content" (29).

The emphasis on historical praxis as the starting point for theological reflection and understanding means that the liberation theologians often have scant respect for apparently abstract and academic theologies such as are found in Europe and the U.S.A. These theologies, more 'classical' in their

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(27) See T.B. Bottomore and Maximilien Rubel, Karl Marx on Sociology and Social Philosophy (Harmondsworth : Penguin, 1963) pp.82-4, for Marx's 'Theses on Fueurbach'. See especially the eleventh thesis: "The philosophers have only interpreted the world in different ways; the point is to change it". (Italics original). Cf. Gutierrez, A Theology of Liberation, p.9.

(28) See Fierro, op.cit., pp.19-23 and Assmann, op.cit., p.74ff., especially p.76.

(29) Raul Vidales 'Methodological Issues in Liberation Theology' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980), pp. 34-57, p.38.

primary attention to the Bible and the Christian tradition rather than to praxis are regarded as irrelevant as they do not respond to the present needs of the oppressed among whom God is revealing himself in saving activity. Such theologies, in their concern for orthodoxy, i.e. right believing and thinking, are ignoring the more fundamental dimension of orthopraxis, i.e. correct action in accordance with the will and purposes of God. It is orthopraxis only which can verify the validity of theological reflection now (30).

An Ideologically Self-aware Theology

The liberation theologian's suspicion is that "anything and everything involving ideas, including theology, is intimately bound up with the existing social situation in at least an unconscious way."(31). Using Marxist critiques of ideology and the findings of other sociologists of knowledge, liberation theologians have become very aware of the ideological usage to which theology may be put. The concept of ideology is complex and can have many meanings (32).

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(30) For more on the concept of 'orthopraxis' see Gutierrez, A Theology of Liberation, p.10. For a critique of orthodoxy see Joseph Comblin, 'What Sort of Service Might Theology Render?' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980), pp58-78, p.58 ff.

(31) Segundo, op. cit., p.8. Cf. Karl Mannheim, Ideology and Utopia (London : R.K.P., 1936), p.76 : "We must realise once and for all that the meanings which make up our world are simply an historically determined and continually developing structure in which man develops, and are in no sense absolute." See also ibid., p.71: "... the vain hope of discovering truth in a form which is independent of an historically and socially determined set of meanings will have to be given up."

(32) For more about the concept of ideology and its uses see e.g. John Plamenatz, Ideology (London : Macmillan, 1971), also Mannheim, op. cit.

It can mean ideas in general or, as here, it can refer to the negative concept of ideas being able to obscure and disguise the true nature of reality. Accepting Marx's tenet that ideas are basically determined by the economic substructure, and therefore reflect the interests of the dominant class in a particular age, the liberation theologians have tried to expose ideological uses to which theology has been put (33). They also attempt to be quite explicit in trying to show from which vantage point ideologically their own theology is written.

This means that the theologians of liberation have accepted that theology is essentially human language about God which is largely conditioned and moulded by its specific social context. It therefore does not necessarily reflect the truth about God :

> Theology is now learning that it is only human discourse after all ... . Theology is not what mediates the faith, and it is not the theory of

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(33) See e.g. Karl Marx, Preface to a Contribution to the Critique of Political Economy in Karl Marx and Frederick Engels, Selected Works in One Volume (London : Lawrence and Wishart, 1968) pp.180-84: "The mode of production of material life conditions the social, political and intellectual life process in general. It is not the consciousness of men that determines their being but, on the contrary, their social being that determines their consciousness" (p.181). Also see Karl Marx and Frederick Engels 'Manifesto of the Communist Party' in Karl Marx and Frederick Engels, Selected Works on One Volume (London : Lawrence and Wishart, 1968), pp.31-63 : "What else does the history of ideas prove, than that intellectual production changes its character in proportion as material production is changed? The ruling ideas of each age have ever been the ideas of its ruling class" (p.51). While not adopting a Marxist position, some Western theologians have acknowledged the impact of social order on theological ideas. See, e.g. Robin Gill, Social Context of Theology (London : Mowbray, 1975).

> Christian practice. Manipulating or using the words of which God made use in the Bible for our own discourse does not confer the qualities of God's word on our human discourse... . As human utterance, theology belongs to this world. It is wholly conditioned by the portion of the world in which it itself is immersed. Far from trying to protect itself from all analysis by the human sciences, it should be completely open to such analysis" (34).

In ignoring the essentially human nature of theological discourse with its socio-political context, theology has made the mistake of thinking of itself as a divine science and politically neutral. By thinking in this way, its concerns and concepts have reflected directly the situation of theologians who have served those who are dominant in the established social order. Because of this unwitting bias, the voice and concerns of the oppressed could not be heard (35).

Segundo illustrates this phenomenon most vividly. He shows how sacramental theology has helped to devalue history, how an emphasis on universality and ecumenism has helped to conceal class conflict, and how the false passive God of Greek philosophy has supplanted the active, historically-involved God of the Bible (36).

A Biased Theology

Since all theology is human discourse, and all human

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(34) Comblin 'What Sort of Service Might Theology Render?' p.66.

(35) See especially Comblin The Church and the National Security State, Ch.1 for a critique of the way in which theology has failed to serve the interests of the poor and oppressed.

(36) See Segundo, op.cit., especially Ch.2.

discourse is conditioned by the socio-political nature of reality, all theology is biased. The difference in the case of liberation theology is that it is conscious of its bias and tries to make it as explicit as possible:

> Liberation theology consciously and explicitly accepts its relationship with politics. First of all, it incorporates into its own methodology the task of ideological analysis ... and insofar as direct politics is concerned, it is more concerned about avoiding the (false) impartiality of academic theology than it is about taking sides and consequently giving ammunition to those who accuse it of partisanship (37).

Liberation theology is biased in two ways. Practically, it is biased in terms of its support of the revolutionary struggle of the oppressed. It sees exclusively in the poor and oppressed the locus theologicus, the place where God is working and truth is revealed:

> ... the poor are the ones who change the course of history into a more humane and universal one ... the kingdom grows and finds expression in the struggles to humanize the world which the poor and lowly initiate with their lives (38).

The option for the poor and doing theology from their stand point is a fundamental feature of all liberation theologies.

The second element of bias in liberation theology is its decision to adopt Marxist sociological analysis to understand contemporary Latin America and its own position in society. Since all analyses have an ideological bias,

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(37) Segundo, op.cit., p.75.

(38) Alejandro Cussianovich, Religious Life and the Poor (Dublin : Gill and Macmillan, 1979), p.88. See also Enrique Dussell, Ethics and the Theology of Liberation (Maryknoll : Orbis, 1978), Ch. 2.

because of their basic presuppositions, liberation theology opts for

> those analyses, postulates and diagnoses which are more closely in line with the goal of discerning and achieving a social order in which human beings can live as true adults, as 'new persons' after the ideal of Jesus Christ (39).

Again,

> Change can only come from a view centred on social class ... . This class-oriented view enables us to grasp the exploited, marginalized and alienated character of the people. It also highlights the interests of the dominant class which are at work" (40).

A Historical Theology

"The theology of liberation is a theology of salvation in the light of the concrete history and political conditions of the present day" (41).

In talking of liberation theology as a historical theology, it is not meant that it concerns itself chiefly with past history, either of the church or of the world. Rather it concerns itself with God's action in the world of the present. It is maintained that God's most important

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(39) Vidales, op.cit., p.42. See also Segundo, op.cit., Ch. 2, Bonino, op.cit., p.34ff. Bonino, in common with all the theologians of liberation, rejects a 'rigid Marxist orthodoxy or dogmatism', but maintains that all the categories and tools of Marxist socio-political analysis are the most appropriate in trying to come to terms with the reality of Latin American society.

(40) Cussianovich, op.cit., p.96.

(41) Gustavo Gutierrez, 'Liberation Praxis and Christian Faith' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980), pp.1-33, p.23.

activity is taking place here and now in the liberation struggle and that it is in our present history that God is revealed: "History is the locale where God reveals his person" (42). Again, Gutierrez writes that "history is a process of the liberation of man" (43). In other words, the liberation theologians see history as the realm where man forges his own destiny as a subject in his own right under God. In adopting this standpoint, the liberation theologians are following Marx and proceeding with this emphasis means that "faith becomes no more or less than man's historical activity" (44). In history man continues the process of his own self-creation in response to the grace of God, liberating himself from all that dehumanizes.

The corollary of this view is that the liberation theologians are very anxious to understand present historical events and processes as fully as they can:

> Instead of using only revelation and tradition as starting points, as classical theology has generally done, it (liberation theology) must start with facts and questions derived from the world and from history (45).

This implies the need for the use of social and political sciences in order to understand what questions are in fact being posed and what facts there are available. The social sciences enable liberation theology to read "the signs of the times" (46). The Christian faith itself and theology have no suitable tools or programmes, and so must turn to the human sciences for possible political courses of action

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(42) Ibid., p.16.

(43) Gutierrez, A Theology of Liberation, p.32.

(44) Assmann, op.cit., p.35.

(45) Gutierrez, A Theology of Liberation, p.12.

(46) Ibid., p.8.

and for information about socio-historical reality: "Liberation theology presupposes the voice of the human sciences, of the social sciences in particular as its first or preliminary theological word" (47).

Having emphasised the over-riding importance of the present for liberation theologians it must be pointed out that they ignore neither the past nor the future. Indeed, these constitute a significant aspect of liberation theology.

Present history is seen as being dynamised by God's eschatological promises whose fulfillment lies in the future, but whose effect is felt even now. "The commitment to the creation of a just society and, ultimately, to a new man, presupposes confidence in the future", writes Gutierrez (48). It must be underlined that this future hope does not devalue man's struggle for liberation/salvation now. The liberation theologians have been very critical of the way in which the future promises have been privatised, individualised and deprived of any critical historical potential in the present. However, they are also aware of the dangers of identifying any present action or ideology with the totality of God's coming kingdom. While they maintain the absolute importance of committed Christian action in the present and see the liberation struggle as the concrete project of God's salvation now (49), they also maintain that there is a radical discontinuity between the present and God's ultimate future

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(47) Vidales, op.cit., p.44.

(48) Gutierrez, A Theology of Liberation, p.213.

(49) See e.g. Assmann, op.cit., p.68.

plans (50). Thus it may be said that the importance of history and historical commitment in particular situations is absolute, while no one ideology or action is absolutised (51).

The seriousness about history is extended to the past too. Liberation theologians have been very active in trying to de-ideologise the Christian tradition and the Bible in order to understand their historical contexts so that a dialogue may be entered into. In particular, they have seen it as important to try and re-discover the 'Jesus of history', and to get behind the shadowy 'Christ of faith', whose non-particularity has made him an easy prey to sectional interests (52). Those parts of the Bible which provide paradigms and models for political struggle have been particularly significant in this connection. Events such as the Exodus have been enormously important in re-discovering the historical God of the Bible who is apprehended by his liberating deeds (53). The attempt to

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(50) Gutierrez, A Theology of Liberation, p. 168. See also Juan Luis Segundo,'Capitalism Versus Socialism; Crux Theologica' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980) pp. 240-59. It is argued in this article that the absolute must be found in the relativity of the present rather than the present being relativised.

(51) See Jose Miguez Bonino, 'Historical Praxis and Christian Identity' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980) pp. 260-83. Bonino proposes a model of continuity and discontinuity between the present human historical liberation struggle and God's ultimate eschatological action and purposes.

(52) See Boff, op. cit., and more significantly Jon Sobrino, Christology at the Crossroads (London : S.C.M., 1978).

(53) See e.g. Gutierrez' treatment of the Exodus in A Theology of Liberation, pp. 155ff. Kirk, op. cit., Ch. 8, discusses the use of the Exodus by the theologians of liberation in general.

anchor the Christian tradition in the historical deeds of Jesus rescues him from being used to canonise any form of human activity. This Jesus of history can challenge and not be manipulated, unlike the amorphous and malleable 'Christ of faith'.

Liberation theology is a historical theology, principally concerned with identifying God's salvific acts in the "Bible of the present" (54), but it is also involved in a critical and dialectic relationship with the tradition of the past and promises of the future.

A Relative Theology

Liberation theology denies any claim to absolute knowledge of the truth. Since it sees any theology as a product of a particular social situation, it cannot make claims to eternal validity as classical and European theologies have done. European theology "has absolutized an aspect of the present world situation ... thus ... it covers up rather than uncovers reality"(55). Dussel describes European theology as "totalised". This means that it is a theology closed to the in-breaking of the theological awareness of non-Europeans and to the questions which emanate from the periphery rather than the centre of the theological world.

If the theology of liberation is to avoid becoming

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(54) See Vidales, op.cit , p. 40.

(55) Dussel, Ethics and the Theology of Liberation, p. 150. Cf. Mannheim, op. cit., p. 78: "... the absolute which was once a means of entering into communion with the divine, has now become an instrument used by those who profit from it, to distort, pervert, and conceal the meaning of the present ."

another totalised system which does not respond to the needs of the present and those who live in a non-European socio-political milieu, it must always be prepared to change its content, concerns and methodology. It is thus constantly changing, and at any one time sees itself as only partially reflecting God's word and truth.

Liberation theology has no desire to standardise, nor to reflect the concerns of those outside Latin America. In fact, Dussell refers to it positively as a theology of the periphery. He calls for theological pluralism within the Catholic church rather than for a universal discourse which cannot reflect particular historical situations (56).

Liberation theology predicts its own passing and welcomes the prospect.

A Complete Theology

> What is designated as 'liberation theology' does not purport to be merely one sector of theology, like the 'theology of work' or the 'theology of death'. Liberation is meant to designate and cover theology as a whole. What is more, it does not purport to cover theology from one of many possible standpoints. Instead it claims to view theology from the standpoint which the Christian fonts point up as the only authentic and privileged standpoint for arriving at a full and complete understanding of God's revelation

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(56) See Enrique Dussel, 'Historical and Philosophical Presuppositions for Latin American Theology' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980) pp. 184-212.

in Jesus Christ (57).

In asserting this, Segundo is emphasising one of the major differences between liberation theology and other social and political theologies. In the Christian tradition it has been more usual, both in the past and the present, to see society as belonging to a realm of theological discourse which is subsidiary to, and derived from, the realm of dogmatic theology. This sphere has been described as that of Christian social ethics. While it has occupied an important place in the church's teaching, it has never been seen as a source of potential information about the nature of the divine revelation. It has instead been the place where the general dogmatic truths of revelation have been translated into moral axioms by deduction from fundamental principles. Thus there have been many ethical theologies which have tried to apply dogmatic verities to particular social situations by a process of deduction from basic principles. These ethical theologies have been fragmented and partial. They have not sought to add to the corpus of theological dogma about God, Christ, the nature of revelation, man, salvation, and the other main themes of doctrinal theology.

Liberation theology does not accept the same position vis à vis Christian doctrine. It claims that its particular stance means that the whole of Christian dogma must begin

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(57) Segundo 'Capitalism Versus Socialism : Crux Theologica', p.241. This assertion is perhaps illuminated by Mannheim's observation that "it is certain that there is a wide range of subject-matter which is accessible only either to certain subjects, or in certain historical periods, and which becomes apparent through the social purposes of individuals". (Mannheim, op.cit., p.150).

from the option for the poor. This option puts the whole of the Christian tradition in a completely different light. Starting from the (ethical) commitment to fight injustice in the present and to try and see the world and everything else from the standpoint of the oppressed, the liberation theologians go on to argue that the whole method and content of theology must be re-assessed. Since all theology is human language and reflects specific socio-political conditions, a change in the socio-political conditions and perspective of theologians demands the growth of a whole new way of looking at, and understanding the Christian tradition. All the major doctrines of that tradition must be re-examined and re-assessed from the viewpoint of the oppressed. An inductive method must be used to see whether the tenets of Christian dogma reflect or deny the concerns and insights of the oppressed. Only in this way can the tradition have any real and de-ideologised value for Christians struggling for liberation in Latin America today.

This awareness is gradually leading to the emergence of a complete theology of liberation which re-claims traditions and doctrines for the poor and oppressed. Thus, there have been attempts to develop new and critical accounts of the major Christian doctrines including Christology, the nature of God, the nature of revelation, soteriology, ecclesiology

and others (58).

A Political Theology

Liberation theology is political in two ways. Firstly it focuses upon, and gives primacy to, the political dimensions of human existence. Secondly, it is a politically mediated theology (59). It is this second dimension which makes it fundamentally different from classical theology and Christian social ethics. It is not merely a theology concerned about politics, or with applying Christian dogmas to the political realm. Instead, it is a theology which must use the language and concepts of politics to mediate and make real the central truths of the gospel message today. These two features are now examined more closely.

The liberation theologies, in common with some other contemporary political theologies, see the political aspect of life as the most important and fundamental. Gutierrez writes

> The construction of the 'polis' ... is a dimension which encompasses and severally conditions all of man's activity... .

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(58) See e.g. Sobrino, op.cit., for an approach to Christology from the perspective of the theology of liberation. Antonio Perez-Escarlin, Atheism and Liberation (London : S.C.M., 1980) provides an approach to the doctrine of God. The five volumes of Segundo's A Theology for Artisans of a New Humanity provides the most comprehensive and systematic approach to the classic elements of Christian theology from this perspective. See Juan Luis Segundo, A Community Called Church (Maryknoll : Orbis, 1973), Grace and the Human Condition (Maryknoll : Orbis, 1973), Our Idea of God (Maryknoll : Orbis, 1974), The Sacraments Today (Maryknoll : 1974), Evolution and Guilt (Maryknoll : Orbis, 1974). Segundo's theology is discussed in detail in Alfred T. Hennelly, Theologies in Conflict (Maryknoll : Orbis, 1979).

(59) See further Fierro, op.cit., p.28ff.

> Everything has a political colour. It is always in the political fabric that a person emerges as a free and responsible being, as a person relating to other people, as someone who takes on a political task (60).

Politics here is defined as "the sphere for the exercise of a critical freedom which is won down through history" (61). It is within this broad realm that politics as an 'orientation to power' is to be seen.

This emphasis on man as a political creature goes hand in hand with the liberation theologians' rejection of 'privatisation' and individualism along with theologies which emphasise those aspects of existence. Vidales writes:

> The Christian message is not simply a word whispered to individuals in their isolated lives as lone persons. It is also a public proclamation to society in the fact of its concrete structures and the prevailing system (62).

All Christian theology must attempt to de-privatise itself in order to speak to socio-political reality. Concepts like sin must be seen in their corporate and social dimensions: "Sin has become a very private affair. But the great historic and communitarian sins of humankind pass unnoticed by all", writes Dussel, who also points out that "the modern experience of the church, European or even Latin American, has 'privatised' the individual" (63). This kind of criticism is echoed by Comblin in his criticisms of theology which he sees as "saturated to the point of nausea with existentialist and

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(60) Gutierrez, A Theology of Liberation, p.47.

(61) Ibid., p.47.

(62) Vidales, op.cit., p.53.

(63) Dussel, Ethics and the Theology of Liberation, pp.27,89.

personalist themes" (64).

This brings me to the discussion of the political mediation of theology. In every generation theology has to adopt and adapt the language and concepts which will enable it to speak meaningfully to its own times. In the past, theology has used many different thought and language systems to re-interpret and communicate its message. Aquinas, for example, used Aristotelian philosophy (65), Bultmann and Tillich utilised existentialism to re-express the truth of the gospel in the mid-twentieth century. It follows that in a generation where politics is the central dimension and means of understanding the human situation, political language and concepts must be used by theology. It is due to adaptation of this kind that the central concepts of liberation theology, for example the concept of 'liberation' itself, have a great many political connotations and may appear to some to have no theological content in the usual understanding of that term.

Much of the political language used to mediate theological concepts in liberation theology is drawn from Marxism. This is defended on the grounds that "after Marx our way of conceiving and posing the problems of society

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(64) Comblin, 'What Sort of Service Might Theology Render?', p.74. It should be noted that the theologians of liberation do not reject the importance of the individual. Assmann, for example, writes: "Politicizing private life doesn't mean threatening its precious inner core of personal intensity, but making it conscious of its true historical character." (Assmann, op.cit. p.32). For further discussion of the political nature of theology see Fierro, op.cit., p.41ff.

(65) See further Gutierrez, A Theology of Liberation, p.5.

will never be the same again" (66). In much the same way as we live in a post-Aristotelian or post-Freudian age, we now live in a post-Marxian age where his concepts and methods must form an important part of our ways of thinking and communicating.

If all theology is historically conditioned and mediated, liberation theology must necessarily be politically mediated in its particular socio-political situation: "From the standpoint of this cultural universe we re-shape the message of the gospel and the faith for our contemporaries and ourselves" (67).

A Universalistic Theology

Liberation theology tends to affirm the unity of Christian salvation and the liberation struggle. Having stated that "(t)he idea of the universality of the salvific will of God, clearly enunciated by Paul in his letter to Timothy, has been established", Gutierrez goes on to add that

> there is only one human destiny, irreversibly assumed by Christ, the Lord of history. His redemptive work embraces all the dimensions of existence and brings them to their fullness. The history of salvation is the very heart of human history" (68).

The implications of this affirmation of the unity between the saving action of God and human history are manifold.

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(66) Segundo, The Liberation of Theology, p.35, n.10. See also Fierro, op.cit., p.78f.

(67) Gutierrez, 'Liberation, Theology and Proclamation', p.68.

(68) Gutierrez, A Theology of Liberation, pp.150, 153. See also ibid., p.165.

Firstly, the church is no longer the place where salvation takes place, it takes place among the poor in the realm of human history in general (69). Secondly, liberative activity on the part of the poor and oppressed to become the subjects of their own history becomes salvific activity (70). Thirdly, faith within this view becomes no more nor less than man's historical activity (which is essentially political) (71).

This kind of unifying and universalising thinking is attractive but presents many problems. It can be seen as an attempt to re-sacralise the world and to reduce its autonomous secularity, a manifest nonsense in the latter part of the twentieth century (72). This danger is revealed when authors like Gutierrez state that "man is saved if he opens himself to God, and to others, even if he is not clearly aware that he is doing so"(73). This statement also reveals the other main danger, which is that of diluting and evacuating Christian language and faith of any distinctive content, to the point where it can perform no autonomous, useful or creative function. Without making all action, however unconscious, Christian and all faith meaningless, theology must find a way of asserting the real and present activity of God with those struggling for socio-political liberation now.

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(69) See further Bonino, Revolutionary Theology Comes of Age, Ch. 6., Gutierrez, A Theology of Liberation, Ch.12.

(70) See Gutierrez, A Theology of Liberation, p.159f.

(71) See Assmann, op. cit., p. 35.

(72) See Fierro, op. cit., p. 339ff., for a discussion of this danger.

(73) Gutierrez, A Theology of Liberation, p. 151.

The best model for doing this so far suggested is that of Bonino (74). He advances a continuity/discontinuity model based on Paul's theology of the body. Thus he firmly asserts the importance of human activity and commitment in secular history to help in bringing about God's kingdom on earth. But he also affirms the otherness of God's salvation history whose nature does not coincide exactly with any human activity or model. There is thus continuity and discontinuity between present human activity and God's eschatological salvific purposes. Christians must therefore take the present very seriously and act on the signs of the times to avoid uncreative and unrealistic idealism. But they must also realise the relativity of what they do, and see that not all of their actions will have ultimately helped to realise the kingdom on earth. This model leaves room for a distinctive Christian faith with its eschatological future, while not de-valuing earthly commitment to the relative.

A Pre-critical Theology

In many ways, liberation theology has not sorted out what sort of theology it is. For example, it has not decided in what sense it is language about God rather than about man. Is it symbolic or scientific language? Again, it has not considered seriously in what sense it may be described as an ethic rather than a theology. Is it a normative praxis for Christians, or is it strictly talk about God? (75). It is this kind of confusion and lack of critical awareness which

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(74) See Bonino, 'Historical Praxis and Christian Identity'. Other theologians have also made some effort to discus this problem. See e.g. Gutierrez, A Theology of Liberation, Ch. 11., especially p. 238.

(75) Cf. Fierro, op. cit., p. 305 ff.

has led Fierro to characterise liberation theology as pre-critical theological language which makes direct and symbolic assertions about God arising from praxis, rather than operating at one remove and being rigorously critical on the level of rational meta-language (76). It is this level which Fierro regards as the real theological level. He writes that liberation theology is "the direct and spontaneous expression of a politically involved and committed faith, not second-stage critical reflection on that direct expression" (77). This is not condemned by Fierro, but he points out that such confusion easily leads to internal contradictions in liberation theology and to an inability to engage in effective dialogue with other, more critical and reflective theologies with their theories, scientific method and rational discourse.

5. The Method of Liberation Theology

Having spent some time outlining the character of liberation theology above, it is now possible to proceed to a description of the method of this theology against that background. The treatment will be brief, as the actual methodology itself is relatively simple to outline. However, certain issues emerge from the description of method which will require further discussion.

The Task of Liberation Theology

Here it is sufficient to reiterate Gutierrez's definition of the task of liberation theology as essentially "a critical reflection on Christian praxis in the light of

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(76) Cf. ibid., p. 316.

(77) Ibid., p. 317

the Word" (78). Its purpose is to help Christians to understand their praxis and to modify and suggest practical action: "The theology of liberation tries to enlighten and guide the church toward pastoral practice, and geopolitics, and a strategy of liberation" (79).

Any theology which seeks to take on this task must, according to Assmann, be "inductive, pluralistic, experiential, partial, and related to their environment in order to be relevant"(80). Its basic method is outlined by del Valle: "Theology is an inductive science ascending from the ground up. It does not start from basic principles and then draw conclusions from them" (81).

The Place of Liberation Theology in the Liberation Struggle

It is important to recognise that theology is not seen as a primary and vitally necessary part of the liberation struggle. The liberation theologians admit that theirs is but a secondary activity which flows from the active involvement of Christians in the struggle.

Not only is liberation theology secondary to active commitment, it is also a secondary word following the first word of the human sciences which give an analysis of present

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(78) Gutierrez, A Theology of Liberation, p. 13

(79) Comblin, The Church and the National Security State, p. 216.

(80) Hugo Assmann, 'The Power of Christ in History ; Conflicting Christologies and Discernment' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980) pp. 133-50, p. 134.

(81) Luis G. del Valle, 'Towards a Theological Outlook Starting from Concrete Events' in Rosino Gibellini, ed., Frontiers of Theology in Latin America (London : S.C.M., 1980) pp. 79-99, p. 85.

socio-political reality in which God is acting in a way totally beyond the capacity of theology itself. Thus, theology is

> ... a second act in relation to the first act of Christian commitment, and the second word in relation to the first word of the human sciences, especially those whose analyses and diagnoses impinge directly on oppression-liberation (82).

The Locus Theologicus

Where is it possible to do authentic theology today in Latin America? Where is it possible to see God acting now so that statements can be made about his activity? The answer to these questions for liberation theology is that the locus theologicus is among the poor struggling for liberation (83). The sine qua non and starting point for liberation theology is the pre-theological response of faith which is the option for the poor (84). It is only from this option and perspective that the word of God, both past and present, can be understood correctly. Only among the poor does it loose its ideological shackles.

The place for theology exists both in space and time. That is to say, theology must be concerned to operate from the place where the poor are now. God's activity

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(82) Raul Vidales, 'Some Recent Publications in Latin America on the Theology of Liberation' Concilium, 6, 1974, pp.127-36, p.130. See also Assman, Practical Theology of Liberation, p.38.

(83) See Vidales, op.cit., p.129.

(84) See particularly Gutierrez' 'Introduction' to Assmann, Practical Theology of Liberation for the importance of the pre-theological option for the poor.

and self-revelation occurs primarily in the present. The importance of God's revelation in present human history has made one theologian refer to human history as 'the other "Bible"'(85). The Bible and Christian tradition are important, but they are conditioned by their historical and social context, i.e. ideologised. They have their roots in past historical events and are therefore only secondary sources of God's revelation for people in Latin America today (86). The present must be understood first and only then can the Christian tradition be re-discovered and properly understood.

The Tools of Liberation Theology

The Christian tradition, in and of itself, provides no cognitive tools or analyses for the understanding of present social reality. Liberation theology needs to understand and to de-ideologise the Christian faith and the practice of that faith in that situation. It must therefore use the tools of a new rational discourse, i.e. those of the social sciences. Liberation theology "must accept the mediation of a new type of scientific rationality to which it has not been accustomed. This new line of reasoning is a contribution of the human sciences, of the social sciences specifically" (87). Christians cannot possibly fashion a language which meaningfully reflects the experience of faith unless it includes social analyses and political

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(85) Vidales, 'Methodological Issues in Liberation Theology', p. 40. Cf. Assmann, Practical Theology of Liberation, p.60f.

(86) See Assmann, Practical Theology of Liberation, p. 60f. Also Assmann, 'The Power of Christ in History : Conflicting Christologies and Discernment', p. 135.

(87) Vidales, 'Methodological Issues in Liberation Theology', p. 38. Cf. Assmann, Practical Theology of Liberation, pp.38, 59ff.

strategies (88).

The most important usage of the social sciences is to understand the situation of liberation-dependence in Latin America. But they have also been useful in freeing the Christian traditions 'dangerous' and liberative memories from their ideological bondage to the dominant classes and the status quo. As noted before, theology, being human language, reflects and is distorted by its particular socio-political context. The theologian must therefore suspect that "anything and everything involving ideas, including theology, is intimately bound up with the existing social situation in at least an unconscious way"(89). Only by subjecting Christian ideas to sociological scrutiny can their unseen biases and interests be discovered.

While the social sciences are the main tool of the methodology of liberation theology, it should be noted that the modern tools of biblical scholarship have also played an important part. Miranda in particular seems to believe that correct and rigorous study and exegesis of Scripture will in itself produce dangerous memories which will confirm the liberation ethic (90). He therefore proceeds straight from the text to the present day without extensive sociological reflection and analysis of the present historical situation or of the ideological bias of the Christian tradition.

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(88) Assmann, 'The Power of Christ in History : Conflicting Christologies and Discernment', p. 134.

(89) Segundo, The Liberation of Theology, p. 8.

(90) See n. 16 above for references to Miranda's work on the Bible.

The Verification Principle

In liberation theology, as in Marxism, truth and knowledge must always be evaluated against the praxis of modifying the real world. Only if knowledge appears to reflect reality as it is discovered in trying to change the world can it be regarded as true. Biblical truths and the truths of the Christian revelation must be verified and evaluated against Christian praxis in the liberation struggle (91).

The Dialectical Method

The dialectical method is a central feature in the method of liberation theology. Having analysed present socio-political reality using the tools of the social sciences and de-ideologised the Christian tradition, Christians, actively involved in the liberation struggle, can begin to enter into a critical dialogue with that tradition. This dialogue should serve both to encourage and to modify Christian praxis, since the tradition contains its own liberative content and therefore presents its own challenges.

The dialectical process may be seen as a circle whereby ideology and action continually modify and stimulate one another as people continue to advance towards becoming the subjects of their own destiny under God. The use of

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(91) See Segundo, The Liberation of Theology, p. 39, and Assmann, Practical Theology of Liberation, pp 74ff., for the necessity for liberation theology to be 'praxiology'. Segundo writes "... a theology worthy of the attention of a whole human being is not the outcome of abstract scientific or academic interest. It stems from a pre-theological human commitment to change and improve the world."(op.cit., p. 39).

the method is best and most explicitly seen in Segundo's treatment of the 'hermeneutic circle' (92). This is defined as "the continuing change in our interpretation of the Bible which is dictated by the continuing changes in our present day reality, both individual and social"(93). The circle has four stages. Firstly comes "our way of experiencing reality, which leads to profound ideological suspicion". This arises from Christian praxis for liberation in a situation of oppression. Secondly, "there is the application of our ideological suspicion to the whole ideological superstructure in general and to theology in particular". Thirdly, "there comes a new way of experiencing theological reality that leads to exeretical suspicion, that is to the suspicion that the prevailing interpretation has not taken important pieces of data into account". Fourthly, "we have our new hermeneutic" (94). The process does not finish here though. For the circle is in fact a spiral which requires that the process is continually repeated and modified to take into account the changing situation of socio-political reality. It should be noted too that when the fourth stage is reached, the Christian tradition is able to speak with integrity and influence to the contemporary situation, modifying it and posing questions for praxis rather than being simply determined by praxis: "Every new reality obliges us to interpret the word of God afresh, to change reality accordingly, and then go back and

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(92) See particularly Segundo, The Liberation of Theology, pp.8-9, for a preliminary discussion and description of the hermeneutic circle. Segundo acknowledges his debt to Bultmann for this device. See op. cit., p. 8.

(93) Segundo, The Liberation of Theology, p. 8.

(94) Ibid., p.8.

reinterpret the word of God again, and so on" (95).

This method has many attractions. It is fluid and progressive, not static. It allows the interaction of belief and action, both present and past, without confusion of the autonomy of the two realms. It could be applied to other aspects of the Christian ideology to allow their liberative voice to be heard. Indeed, later I will suggest that a modified version of this circle will be the key to methodology in trying to incorporate some of the insights and methods of Latin American theology into the sphere of pastoral care and theology in Britain.

6. Critical Evaluation of the Methodology of Liberation Theology

The Hidden Ethical Basis of Liberation Theology

Liberation theology claims to take as its starting point Christian praxis to transform the world. Praxis is the starting point for all correct thinking. Before theology can take place there must be a pre-theological commitment to the oppressed and their liberation struggle, i.e. to liberating praxis.

But behind this commitment to praxis there can be, and in most cases is, a pre-practical and therefore ideological commitment to certain values which provides the motivation to make the option for the poor and oppressed in the first place. Behind the overt starting point of liberation theology in praxis, there lies a metaphysical, idealistic and ethical structure which is not made explicit by this theology. This omission is made in the interests of making it look as though this theology is scientific, descriptive

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(95) Ibid., p.8.

and empirical and is not caught in the trap of other-wordly idealism, open to exploitation and perversion by the dominant powers of the age. Liberation theology tries to escape from its roots in metaphysical and normative idealism by dressing itself up as a discipline which only describes the facts about reality and has no truck with the speculative realm of ethics. It often seems to deny any inspiration from an ethical vision. Only Dussel takes the ethical basis of liberation theology seriously. He states that "theology is essentially an ethic, and most important, a political ethic" (96). For an ethic to have any power to inspire a vision and action it must stand apart from and beyond the empirical realm in some way. As soon as this assertion is accepted the realm of the metaphysical and non-empirical, the normative rather than the positive, is entered.

There are many non-empirical, normative ethical assumptions which lie behind the commitment of liberation theology to the struggle of the poor. They include convictions such as the belief that history is progressive, that man is progressing in that history, that man needs to be free and the subject of his own destiny, that there is such a thing as injustice, that there is a God who is active in the affairs of men, that there should be harmony and justice on earth, that historical progress takes place through conflict, and that the poor are the harbingers and instruments of the new age. The concept of liberation itself has an ethical and normative content. To talk of liberation is to pre-suppose an ideal concept of the nature of human beings and the circumstances which encourage or

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(96) Enrique Dussel, 'Domination-Liberation : A New Approach', Concilium, 6, 1974, pp.34-56, note on p.52.

stunt their ability to be fully human (97).

The source of many of these norms and also of the confusion about their existence and value is Karl Marx, whose thinking and modes of analysis have had an enormous influence on liberation theology. The difficulty arises because Marx was essentially an idealist philosopher in the succession of Kant and Hegel. While he rejected and inverted Hegel's metaphysical speculation, he retained many of Hegel's basic assumptions, for example about the progress of history. He also retained the belief that reason would ultimately triumph and would usher in an era of human harmony and freedom. In this new era, there would be no need for formal normative morality which in the present is a sign of man's alienation from his own destiny. Thus, while Marx was a philosopher holding such metaphysical ethical beliefs, he condemned contemporary ethical norms as perverted and alienating, having no basis in rational reality. As a social 'scientist', using a mixture of positivist empirical methodology and idealist metaphysical assumptions, he gave no credence at all to idealist ethics such as those of the Christian ideology. He tried to argue that norms about good and evil have no substance if they are not derivable from empirical observation of reality. He wanted to make ethics a descriptive rather than a normative discipline (98).

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(97) Assmann, Practical Theology of Liberation, p.65ff., shows clearly some of the a priori values implicit in liberation theology. It should be recognised that these values are not all on the same level of ethical discourse but this need not be discussed further here.

(98) For this account of the ethical presuppositions underlying Marx's thought, I have drawn extensively on Eugene Kamenka, The Ethical Foundations of Marxism, Rev. Edn., (London : R.K.P., 1972), and Eugene Kamenka, Marxism and Ethics (London : Macmillan, 1969).

The consequence for liberation theology of this kind of thought is that even if it has an a priori belief in values such as the need for justice and the love of God, it cannot admit the importance and determining nature of them if it is to remain true to the method of Marx.

Having said this, it is obvious that many of the liberation theologians do start from the realm of metaphysical ethical ideals. This is particularly noticeable in some treatments of the life of Jesus. Some authors attach normative significance to the fact that Jesus identified himself with the poor. Again, when a writer like Bonino states that "the values of justice and human dignity inherent in the Christian tradition ... awaken a reaction of pain and anger" (99), it is apparent that the realm of the ideal and normative has a very real influence on the starting point of liberation theology. This theology thus starts with an idealistic and ethical option which it is then tempted to ignore and dismiss because it does not fall within the realm of the empirical and positive and so cannot be encountered and justified by descriptive scientific observation.

Such a dismissal of the realm of the ideal is unnecessary on the part of liberation theology. Apart from anything else, Christians must always be prepared to

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(99) Bonino, Revolutionary Theology Comes of Age, p. 32. See also, e.g. Gutierrez' assertion in his introduction to Assmann's Practical Theology of Liberation that Christians involved in solidarity with the poor are taking part in a "practice of love which is rooted in the gratuitous love of the Father" (p.11). In 'Liberation Praxis and Christian Faith', Gutierrez maintains that the poor, exploited and oppressed are"the supreme embodiment of our neighbour" (p.8).

give a place to the realm of the ideal, if only to admit that God exists, a fact which cannot be empirically observed. But beyond this, even the Marxist tradition allows some autonomous value to the ideological superstructure. Potentially art, literature and other parts of the ideological superstructure can be liberative in their content and effect (100). If this were not the case the task of constructing a liberation theology would be doomed from the start. If the superstructure can have a liberating effect, there is no reason why Christian values should not form a perfectly acceptable starting point for involvement in praxis. Again, there is no reason why the entry point of Christians should not be at the point of ideology which leads to praxis rather than at the point of praxis itself.

In its eagerness to avoid becoming pre-occupied with the metaphysical and idealistic, which so often prevents the gospel being relevant to present realities and can so easily be made the tool of the dominant classes in society, liberation theology has sometimes inadvertently refused to acknowledge its metaphysical and idealistic dimension. This is a grave and unnecessary omission in a theology which claims to be ideologically self-aware and explicit (101).

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(100) See Segundo, The Liberation of Theology, p.13 ff., for a discussion of Marx's concept of religion as a part of the ideological superstructure of society. Also ibid., pp. 57ff., for the relative autonomy and potentially liberating role of ideological factors.

(101) Segundo, in op. cit., pp. 98ff., acknowledges the importance of ideological commitment in contra-distinction to writers like Assmann.

The Use of Marxism

Marxism has influenced the method and content of liberation theology to a very large extent. In many ways it has been beneficial to the development of this theology, but unfortunately the relationship between Marxism and the various liberation theologies is seldom made explicit.

This is a serious matter. Marxism, like Christianity, has many different aspects and interpretations. It is both a way of analysing society and a critical philosophy and ethical theory of the nature and destiny of man. It is ambivalent in its tradition about such crucial aspects as the relationship between economic determinism and man's self determination. The ideological superstructure, of which the Christian faith must form a part is also ambivalent in its ability to react on the economic substructure in a liberative way in the Marxist tradition.

Factors such as these pose enormous problems for the relations between theology and Marxism. For example, it is very important to determine the relationship between the ideological and the economic levels of human existence as this will determine the weight and value of theology as a liberative influence with a positive contribution to make to the liberation struggle. Again, it is vital that theology should make explicit whether it is simply using Marxism as the most important sociological tool for understanding the Latin American situation and its own ideological position in society, or whether it is in fact adopting Marx's philosophical vision of the future of human society under

communism (102). Marxist views on atheism and ideological determinism of belief and ideas should also be critically considered by liberation theology and it should then make its position explicit. The effect of not for the most part considering this relationship has been to put in jeopardy the real point and value of the Christian ideology in the liberation struggle (103).

While for many reasons Marxism has been the appropriate means of mediating and criticising theology in Latin America, it has left many questions unanswered. Now that theologians have become aware of their ideological function and presuppositions, they have the task of showing what the positive and liberative content of the Christian tradition really is. Liberation theology must be positive and constructive as well as negative and critical activity, though in the first place the latter has necessarily taken priority. While recognising the secondary nature of

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(102) Tom Bottomore, Marxist Sociology (London : Macmillan, 1975) explores the relationship between Marxism as a complete philosophy and as a tool of social analysis. Bottomore writes: "Marx's conceptions were capable of giving rise, in one direction, to a broadly positivist sociology and in another direction to a style of thought which has generally been referred to as 'critical philosophy'."(p.11).

(103) The only detailed work on Marx by a liberation theologian is Jose P. Miranda, Marx against the Marxists (London : S.C.M., 1980). There has been an extensive Christian consideration of Marxism elsewhere in the world. See e.g. Jan Milic Lochman, Encountering Marx (Belfast : Christian Journals, 1977), Peter Hebblethwaite, The Christian-Marxist Dialogue (London : D.L.T., 1977), Roger Garaudy, The Alternative Future (Harmondsworth : Penguin, 1976), Charles Davis, Theology and Political Society (Cambridge : C.U.P., 1980), Mervyn Stockwood, The Cross and the Sickle (London : Sheldon, 1978).

theoretical factors, real problems must not be avoided on this level and critical self-awareness is vital. A vague affirmation of some kind of relationship which is undefined to Marxism is unrealistic and unhelpful.

Among the key concepts in liberation theology whose ancestry lies in Marxism as much, if not more, than in the Christian tradition, is that of the poor. Since the option for the poor is the starting point for reflection in liberation theology, it is important to understand where they fit into the Marxist and Christian traditions respectively. Happy coincidence between these traditions in giving the poor/proletariat a prominent place in the process of historical development hardly seems an adequate description of the relationship between them. It can only lead to dishonest and blind synthesis which denies the distinctiveness of each of the traditions. The Bible in its concern for the poor of Yahweh did not have the urban proletariat of Marx's nineteenth century Europe specifically in mind (104). Indeed, it is arguable that Marx himself was not much concerned with the poor in the same way as the Bible is at all. While the Bible has a humanistic concern for the well-being of all God's people, Marx seems to have been more interested in finding a group of people who would conform to his philosophical pre-conceptions of historical change to transform the world from that which is to that which rationally ought to be (105). In his scheme the

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(104) A good introduction to Biblical conceptions of the poor is to be found in the work of the European writer Boerma. See Conrad Boerma, Rich Man, Poor Man, and the Bible (London : S.C.M., 1979).

(105) For Marx's selection of the proletariat as the motive force for social change see Shlomo Avineri, The Social and Political Thought of Karl Marx (Cambridge : C.U.P., 1968), pp. 52-64.

proletariat was the most likely group to initiate this transformation as it had no positive investment in the present order. Far from being a holy and privileged group, they were just part of an inevitable rational process. Seeing a group as chosen of God and as just part of an inevitable social process determined by an atheistic, idealistic philosophy of social progress would seem to be very different starting points. Undoubtedly there are similarities, many of them helpful, between the two traditions. But there is a great danger of unhelpful 'eisegesis' from the Marxist tradition into the Bible which can only succeed at the expense of adopting a fundamentalistic selective and normative view of the latter. This has the effect of diminishing the real autonomy of the Christian tradition, and of denying its historical particularity. It may also diminish the proper autonomy of the Marxist tradition 'baptising' an alien concept against its stated will.

It could be argued that liberation theology, in emphasising the importance of the poor in history and in the Bible is performing a valuable exercise in de-ideologisation. The emphasis is certainly a useful corrective to the theology of the last two millenia which has all but totally ignored the traditions concerning the poor and their perspective. Nonetheless, making the strands of the Marxist -Biblical synthesis more explicit and specific would be a valuable exercise in self-criticism.

The Use of the Bible and the Content of the Christian Tradition

It is here above all that the problem of the positive, autonomous, concrete content of Christian tradition is confronted. It is in the area of the use and authority of the foundation texts of Christianity that there is found

much confusion and ambivalence within the various liberation theologies. They differ between each other and even within the work of particular authors as to the usage and positive content of the Christian tradition (106).

The problem focuses round the question of the relativity or absoluteness of the dominical sayings and acts in the New Testament. How far do Christ's words and acts form an absolute norm for Christian faith? How far are these words and actions binding on the practice and thought of Christians today? If they are seen as absolute and binding on contemporary practice there is no room for contemporary interpretation and modification. If, on the other hand, they give only a very general direction, they must be fleshed out in contemporary ideological terms and programmes. Here again, the problem of the relativity of ideology is raised. It must be asked how far the words and actions of Jesus reflected current ideologies in his particular historical involvement, and how far the N.T. authors distorted the teaching of Christ under the influence of their own socio-political sitz im leben.

Liberation theologians have responded in very different ways to these problems. Those like Sobrino and Miranda tend to the attitude that the historical Jesus and his teaching can be rescued from subsequent ideological distortion of the early church in its particular socio-political situation. Since they believe Jesus' message, once de-ideologised, to

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(106) Kirk points out that Gutierrez uses the Bible in different ways even within the same work. While his usage of the Exodus story in A Theology of Liberation is typological, he seeks to deduce normative principles from the life and teaching of Jesus. See further Kirk, Liberation Theology, pp. 61-5.

be essentially about socio-political involvement and liberation, they are prepared to endow it with absolute, normative and authoritative qualities.

This view may be criticised on several grounds. Firstly, it is doubtful whether it is possible to get behind the textual problems of Scripture to the historical Jesus, although the quality of the scholarship and exegesis of these liberation theologians who try to do so should not be minimised. Much of their work is very fine and provides a much-needed corrective to some of the assumptions of recent Biblical scholarship. Again, in terms of de-ideologising Jesus so that he is seen as a real historical person involved in a concrete historical situation who did not permit or encourage every kind of human endeavour, these theologians have performed a useful function.

The second, and more important, ground for criticising this kind of view of the life of Christ, is that it threatens the historical particularity of the incarnation. If Jesus' teaching and acts were not bound up with the relative situation of his time with all its ambiguities, this would seem to suggest that Jesus did not in fact take the history of his own time seriously. His message, on such a view was eternal and not mediated by the relative ideologies of his own day. At the same time, it binds contemporary Christians to a fundamentalistic and static view of revelation which prevents new programmes and ideological interpretations which would make the absolute elements in Jesus' message truly relevant in the world of today. To absolutise one particular historical period is to relativise all others. If Jesus' life, actions and states are seen as absolute and eternal, all other lives and historical involvements must be relative and less important.

The contemporary therefore becomes secondary.

At the other end of the spectrum from Sobrino and Miranda stands Segundo. He takes the necessity of relative ideology so seriously that he denies that there is any way in which the absolute content of faith may be known: "Faith is an absolute insofar as it is a truth revealed by God, an absolute truth ... . (But) ideologies constitute the absolute feature of a functional faith" (107). On this view the absolute can only be discovered through relative ideologies, there is no certainty beyond this. This does not mean that people should not make a firm commitment to a particular ideological tradition, for example, the Biblical one (108). It is only by such concrete commitment that they enter into the deutero-learning process whereby they "learn how to learn in and through the Bible" (109). They must keep on re-living the experiences of the Biblical peoples, thereby giving them an absolute value. The Bible will "point out the road to be travelled by faith, but (will) never provide us with the journey completed" (110).

This position seems a more flexible and logical one for a theology which wishes to take the problems of biblical

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(107) Segundo, The Liberation of Theology, p.154.

(108) In 'Capitalism Versus Socialism : Crux Theologica', Segundo suggests that theology must be prepared to take the importance of the present and the relative so seriously that it makes options for particular contemporary political ideologies.

(109) Segundo, The Liberation of Theology, p.180.

(110) Ibid., p.181. Emphasis original.

criticism and the importance of the present seriously. However, it still leaves the specific ideological contribution of the Christian tradition to the liberation struggle vague and nebulous, to say the least. Once again it suggests that liberation theology is much better at stating what Jesus and faith are not, rather than suggesting anything very positive or definite in these areas.

It is necessary now to consider briefly and more specifically some of the ways in which liberation theologians have used the Bible (111).

The common denominator of their usage is that all the liberation theologies are selective in their use of Biblical texts and events. Events like the Exodus occupy a prominent place as does the life of Jesus. Much of the rest of the Bible is ignored entirely. It is only those parts of it which provide models and paradigms appropriate to the situation of socio-political struggle which are selected.

Much of the usage of Biblical events is typological. That is to say, most authors see the Biblical events as revealing their full meaning in the context of the present rather than in the past, even though they were not recorded with the twentieth century in mind. Much in the same way as the N.T. authors saw Jesus' life as re-interpreting and fulfilling the events and prophecies of the O.T., liberation theologians often feel they can legitimately use the Bible as a source of types of liberating/saving events which find and give meaning in the present day as much as

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(111) The following owes much to the work of Kirk in Liberation Theology.

in the past. The biblical events find their sensus plenior by being re-interpreted in the light of the liberating events of today.

Some of the liberation theologians treat the Bible as a source of ethical norms and commands. This fundamentalistic view with its drawbacks and limitations has been considered and criticised in previous discussion above. Useful though it might be to have a clear-cut and authoritative code for contemporary Christian practice, this view can be seen to be wanting as soon as the problems of Biblical criticism and the passing of time are considered. Even if the exact teaching and ethics of Christ could be known, it is doubtful whether Christians should slavishly and literally imitate what he did in his own particular historical situation. In trying to follow exactly in his steps they would be denying their own place as subjects under God of their own human destiny. They would also be devaluing the value of their own time for seeking to understand and interpret the action of God. Space, time and purpose separate contemporary Christians from the slavish and exact imitation of the son of God.

If this rejection is followed through to its logical conclusion, all principles which purport to be derived from Biblical principles must be dismissed as illegitimate. Even such fundamental principles as opting for the poor cannot be deduced from the Bible. It cannot be used as a source for prescribed Christian involvement today. Instead people must see themselves as humans before they are Christians with the same moral resources and decisions as their contemporaries. Christians can only be secondarily concerned with the Christian traditions of the past with their anachronist concerns and ethics. They must not resort to deduction, however covert,

from the Bible of ethics if they are to remain true to the method and concerns of liberation theology.

If the Bible cannot be treated as normative, it can at least be treated as permissive. If it cannot tell contemporary Christians precisely what they ought to do, it can suggest and inspire ways of acting which are consistent with, and have played a part in the Christian tradition. Thus, while a concern for the poor may not be deduced for our time from the life and works of Jesus, it can at least be said that it is not incompatible with that life and with the wider Biblical tradition. Once again, the method of liberation theology must proceed by the via negativa rather than being able to give a very positive role to the sources and traditions of the Christian ideological tradition.

7. Liberation Theology and Pastoral Care

Having surveyed the background, character, methods and some of the problems of the theology of liberation, it must now be made clear in what way some of its insights and methods are to be used in coming to a new understanding and practice of pastoral care in this country. It is necessary to outline a method based on some of the insights and methods of liberation theology which will determine the shape of the rest of the present work.

I suggest that the starting point for such a method should be the methods and insights of the theology of liberation itself. This is in contrast with the contention of that theology which maintains that praxis rather than theory should be the first step in method. This apparent contradiction of such a fundamental principle is justified by the fact that, as I have argued above, theory and

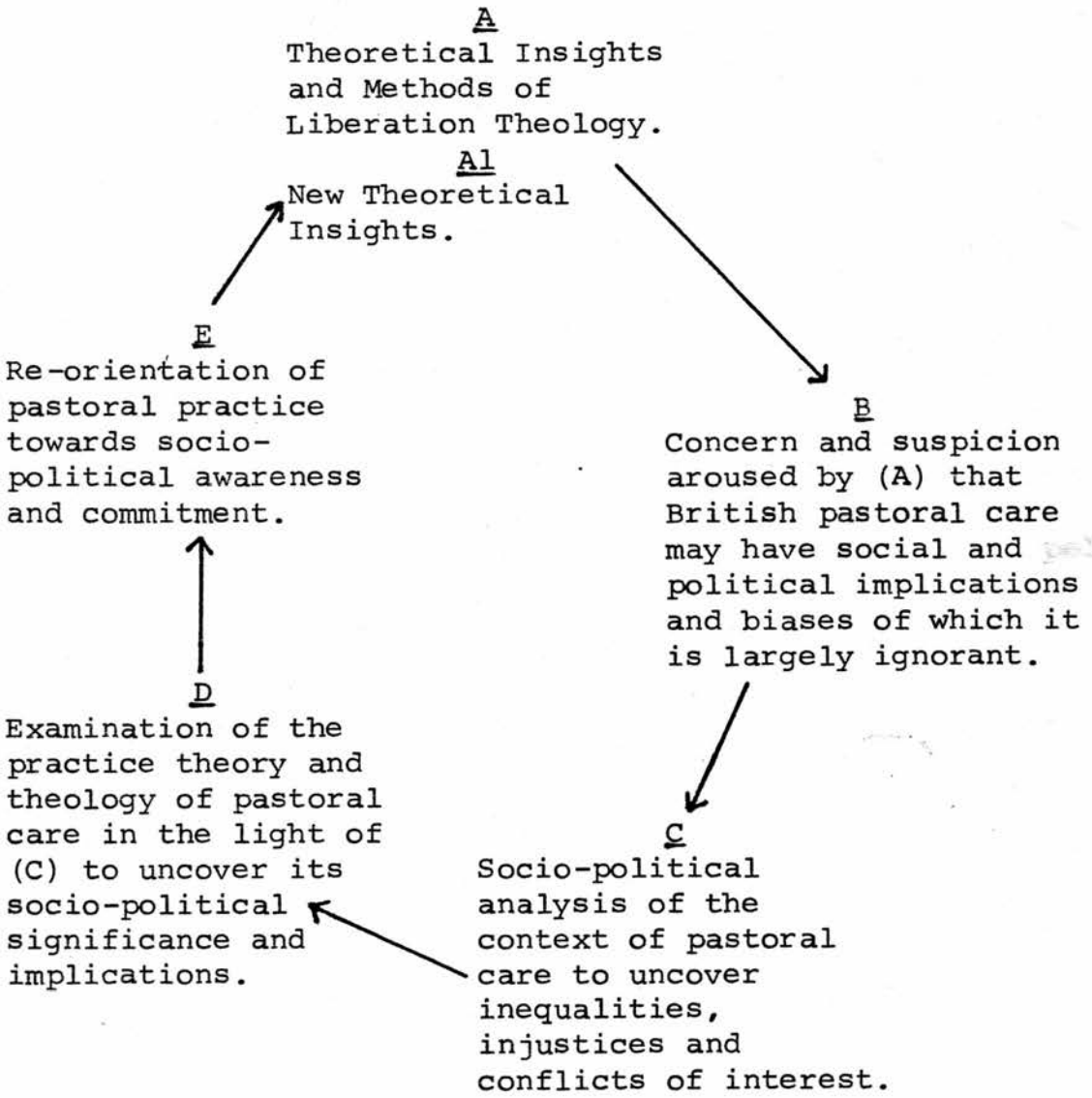
ideology are part of the dialectic method and so a theoretical starting point is as legitimate as one that is founded on praxis. If ideology can itself be liberating and contribute positively to the process of liberation, there seems to be no need to relegate it to a secondary position. Indeed, it has been argued that the commitment of liberation theologians themselves to the struggle for liberation may often flow from an a priori ideological or ethical commitment. If it is accepted that a theoretical position is a legitimate one to start from methodologically, then it is possible to begin to apply some of the methods and insights of the theology of liberation to pastoral care, its practice, theory and theology in this country. It should be noted that this is not intended in any way to minimise the very real differences between the situations and concerns which prevail in Britain and in Latin America. Neither is it intended that a flight into theory and ideology should follow. The underlying purpose of the following chapters is to come to a better understanding of pastoral practice and its context in order that such practice and its context may be actively affected. This practical intention is congruent with the concerns of the liberation theologians.

If a theoretical or ideological starting point is allowed for this exercise, it is then possible to outline a'methodological spiral', based loosely on, and inspired by, the hermeneutic circle enunciated by Segundo, (see above p.57). It has been necessary to adapt Segundo's categories and analytic stages for this purpose as the intention here is not primarily to examine the relationship of Christians to theological tradition in general, but rather to examine the specific area of pastoral care and the theology which

underlies it. I have chosen the idea of a spiral for a number of reasons. Firstly, it makes clear the nature of the dialectic nature of the method used, albeit in a stylised way as an 'ideal type'. This is faithful to the method of liberation theology. Secondly, the notion of a spiral rather than a circle allows for a continuous historical evolution whereby the methodological stages are traversed again and again but the conclusions reached change because of the introduction of new historical factors. It must be made clear that although this method has clearly delineated stages as set out below, the reality of its application in practice is much more confusing. The different stages are not neatly separated or progressive and to some degree all take place at the same time. Such confusion would not be helpful in a work of this sort and so the different stages are clearly separated here for heuristic clarity.

The methodology proposed here is illustrated diagramatically in Figure 1 on p.75. The starting point for this methodology is the insights and methods of liberation theology, (A), which have arisen from Christian reflection on praxis in the context of the struggle for liberation in Latin America. This suggests the second stage (B), which is the concern and suspicion aroused by the insights of liberation theology that much British pastoral practice and theology may itself have social and political implications of which it is unaware. It could be that, unwittingly, there is a bias against the powerless and oppressed in this area of which pastors are themselves unaware. In the third stage of the method, (C), a socio-political analysis of the context of pastoral care, in this case that of the psychiatric hospital specifically, is undertaken. This stage reflects the

Figure 1. A Diagramatic Representation of a 'Methodological Spiral' integrating some of the Insights and Methods of Liberation Theology and the Practice Theory and Theology of British Pastoral Care.



importance which liberation theology attaches to understanding present socio-political reality and events and to hear the voice of the social sciences before attempting an analysis of the place of the church or of theology. The purpose of this exercise is to uncover whether, and to what extent, there are inequalities, injustices and conflicts of interest in the socio-political context of pastoral care. Following the theologians of liberation, I propose to use a broadly Marxist perspective in sociological and political analysis. The use of this perspective in the context of Britain will be justified at a later point. It is, perhaps, important to emphasise here that the use of this tool for analytic purposes does not imply adherence to Marxist social and political solutions. Furthermore, it must be realised that other tools could be adopted for this purpose. The fourth stage in the methodology, (D), is the examination of the practice, theory and theology of pastoral care in the particular situation under consideration to discover how far there is any awareness of the factors uncovered in the previous stage and to expose the socio-political significance of pastoral care in that situation. This is followed, in the fifth stage of the methodology, (E), by a re-orientation of pastoral practice and theology so that it begins to become the instrument of oppressed groups, rather than being the unwitting servant of the powerful. It is from a practical re-orientation of this sort that new, ideological, theological and theoretical insights might be expected to emerge and so the methodological spiral is completed by arriving at point (A1).

Some of the possible advantages of this schema should be noted here. In the first place, it permits both continuity and discontinuity between the theology of liberation with

its methods and insights and pastoral care, its practice, theory and theology in a particular context in this country. A dynamic relationship is brought into being between these two traditions while unhelpful or dubious synthesis or simple imitation is avoided. This allows a socio-politically aware and committed pastoral practice and theology to arise in the British context which is certainly indebted to the insights and methods of liberation theology, but which is by no means enslaved to it and which can develop in its own distinctive direction. Preserving a degree of distinction between these two traditions is of the utmost importance if their respective integrity is to be honoured and if matters of particular context are to be taken seriously. Secondly, this methodology also allows a fruitful and dynamic interaction between the social sciences, theory and theology, and the practice of pastoral care. Thirdly, unlike the published work of the liberation theologians, the methodology will actually show, in concrete terms, the kind of process which needs to be undertaken if a new stance and new theological and theoretical insights are to be arrived at in a particular context.

The rest of the present work is devoted to the third, fourth, and to a certain extent the fifth stages of the methodological spiral. Having studied the work of the liberation theologians and realised that some of their findings and methods give reason to have suspicions about the socio-political context and effects of British pastoral theology and practice, the next stage is to move on to examine the social context and relations of the mentally ill in society at large and in the psychiatric hospitals in particular. This is undertaken in the next two parts of this work. After that it will be appropriate to consider

the theology and practice of pastoral care in psychiatric hospitals in this country. Following that, some suggestions can be made concerning a re-orientation of theory and practice in order that pastors may be identified with the unjustly treated and oppressed. Only when such a re-orientation has taken place in a practical way will it be possible to produce new theological and theoretical insights.

In conclusion it should be noted that throughout the following, I shall accept for heuristic purposes many of the fundamental assumptions of the liberation theologians on theological issues. These include the notions that salvation is universal, that human beings should be the subjects of their own history, that salvation history and human history are one, that the world as a whole is where that history is enacted and that the church is not, therefore, the exclusive realm of salvation, that the socio-political dimension is the most important dimension of human experience today, that the love of God demands loving one's neighbour and seeking justice for him, that discovering where God is working in social and political structures and trying to co-operate with him is the most important task facing Christians today, and that theology and theory must emerge from, be modified by, and be verified by praxis. Some of these assumptions may be regarded as contentious. I would argue that it is worth adopting them for present purposes in order that the consequences of an approach based on some of the methods and insights of liberation theology may be clearly seen.

PART TWO

THE BROAD OVERVIEW : MARXIST ANALYSIS, THE STATE, WELFARE AND THE NATIONAL HEALTH SERVICE

INTRODUCTION

In the previous part, the background, method and character of liberation theology was outlined and a method for the remainder of the work was formulated. This method requires a thorough analysis of the socio-political context of pastoral care in psychiatric hospitals. The chapters in this part form a preliminary investigation into the broad socio-political context of the psychiatric hospital in British society. This investigation is undertaken from a broadly Marxist, or materialist, perspective. The first chapter therefore considers this perspective and its usage in the present work. The role of the State in capitalist society is examined in the second chapter, for most provision for the mentally disordered in this country, including hospital provision, is made by the State. A third chapter surveys some of the main ideological perspectives on State welfare provision of which the National Health Service forms a part. This illuminates and shows up the distinctiveness of the Marxist perspective on this subject. This is followed by a summary of the history of health service provision from the beginning of the nineteenth century to the present day. That history is then subjected to Marxist analysis. A historical overview of this sort is important as it puts the functioning of the contemporary National Health Service in perspective and points up many of the key issues surrounding this institution. Finally, the functioning of the contemporary National Health Service is examined using the same analytical perspective.

By this means the way is prepared for the more specific account of the psychiatric hospital as a particular social institution which follows in Part Three.

CHAPTER II

THE MARXIST PERSPECTIVE IN SOCIO-POLITICAL ANALYSIS

In considering the sociological and political material relating to psychiatric hospitals and mental illness, I have elected to adopt a basically Marxist perspective. That is to say that, as far as it is possible to do so, Marxist understandings and frameworks will be employed to inform my discussion.

Before going on to discuss the difficulties and advantages associated with trying to adopt a Marxist perspective, it is necessary to outline the central features and presuppositions of this perspective. These are succinctly stated by Jenkins:

> 1. Members of all human societies (other than the most primitive) fall into two categories - the ruling class and the subject class or classes.
>
> 2. The dominance of the ruling class is explained by their control of the means of economic production. This dominance is consolidated politically by the ruling class's control over military force and over the production of ideas.
>
> 3. The ruling class and the subject classes are in conflict. The developments in this conflict are influenced primarily by technological changes affecting the methods and means of production.
>
> 4. Modern capitalist societies make the class conflict clearer because they promote a polarization of wealth and power over against poverty and dependance.
>
> 5. The class struggle will end with the

victory of the working class and out of this will emerge a classless society (1).

This basic perspective highlights three aspects of life in society which are often ignored; namely exploitation, conflict and the control of the production of ideas.

There are several very real advantages in using a Marxist perspective in sociological and political analysis. Firstly, this perspective preserves a continuity with the type of social analysis used by the liberation theologians. Thus the usage of this analysis in Britain can be compared with that of those theologians and can be evaluated as relevant or irrelevant.

Secondly, it seems important that a commitment should be made to a particular perspective, even if it cannot ultimately be justified as having an adequate or superior scientific basis to that of other analytical perspectives. If the Marxist perspective is seen only as a heuristic hypothesis, it has a value in that it provides a structure for understanding the whole of society and human relations and is conscious of its own methodological presuppositions and biases. This seems preferable to a vague, non-specific,

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(1) David E Jenkins, The Contradiction of Christianity (London : S.C.M., 1976) pp.32-3. For other views of Marxist thought and analysis see e.g. Avineri, op.cit., David McLellan, The Thoughts of Karl Marx (London : Macmillan, 1971), David McLellan, Karl Marx (London : Paladin, 1976), [illegible] Lichtheim, op.cit.

uncommitted overview of society with concealed presuppositions (2).

Thirdly, Marxist analysis is one of the most effective tools of sociological investigation so far developed. In terms of trying to expose the relations of society in such a way as to expose where inequality and injustice lie, it has no equal. Jenkins writes:

> Marxist diagnoses and intuitions about certain central features and forces of present social reality are the most appropriate, challenging and creative that are available to us... . The Marxist critique seems to be the most powerful pointer to our sharpest present human contradictions and sources of inhumanity (3).

Again, Bottomore defends Marxist analysis, stating that:

> other sociological theories have been exposed to even more damaging criticism; and ... no other general theory has shown anything like the same power to define and analyse significant problems in the development of societies, to formulate quasi-causal connections, and to provoke argument on fundamental theoretical issues (4).

Gooby-Taylor and Dale in a recent analysis of the Welfare State also commend the materialist or Marxist

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(2) Liberation theologians like Bonino reject other forms of socio-political analysis than the Marxist one on the grounds that no form of analysis is neutral (in that there are built-in pre-suppositions in all analytic perspectives and categories), so it is important to use a perspective which reflects most closely the experience of society in Latin America. "A neutral science of society does not exist." (Bonino, Revolutionary Theology Comes of Age, p.34).

(3) Jenkins, op. cit., p.32.

(4) Bottomore, op.cit., p.75.

approach over against other methods. They argue that "materialist methods offer the most useful theories of the welfare state advanced to date" (5). While individualist theories of the Welfare State fail to establish a convincing link between social problems and individual characteristics and virtually deny structural social processes, and reformist theories stress abstract ideals unrelated to social relations and rational action to attain those ideals, materialism can relate all these factors. "Individualism implies a complete divorce of political and economic realms; idealism brings them into close, but none the less contingent relationships; materialism suggests complete interpenetration" (6). The authors therefore conclude:

> Marxism appears to us to offer the most fruitful approach because it makes it possible to unite an account of social structure resting on the notion of mode of production with an account of human action resting on a theory of ideology (7).

These points are amplified and reinforced by Gough's assertion that materialist analysis permits an integrated approach to the social sciences which have become compartmentalised over the last century or so (8).

In the light of statements like these, it is not surprising that much of the radical critique of society, health, and the Welfare State starts from a fundamentally

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(5) Peter Gooby-Taylor and Jennifer Dale, Social Theory and Social Welfare (London : Arnold, 1981), pp.121-2.

(6) Op. cit., p.117.

(7) Ibid., p.127.

(8) See Ian Gough, The Political Economy of the Welfare State (London : Macmillan, 1979), p.6f.

Marxist perspective. This makes the Marxist perspective not only desirable, but also expedient here.

While adhering to the appropriateness of using a Marxist perspective as far as possible in what follows, it has to be recognised that there are real difficulties involved in this usage. For example, it is very important to distinguish between the diagnoses and intuitions of Marxist analysis and the ideological prescriptions and predictions about the future of mankind which have come to be associated with Marxist political solutions. It must be remembered that Marx himself was both a positivist sociologist and also an idealist philosopher. Bottomore warns that:

> Marx's conceptions were capable of giving rise in one direction to a broadly positivist sociology, and in another direction to a style of thought which has generally been referred to as 'critical philosophy';... (T)hese possibilities existed side by side in his thought from the outset, even though the emphasis in his early writings appears more Hegelian and his later writings more positivist (9).

It is the confusion of a particular mode of social analysis with the communist political vision in general which has often deterred people from considering the value of Marxist sociological insights. In Christian circles particularly, Marxist assertions about the necessity of atheism and the withering away of religion with the advent of the classless society have perhaps caused many to reject prematurely the useful analytic tools provided by the Marxist sociological perspective.

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(9) Bottomore, op.cit., p.11.

Within sociology itself there are criticisms and difficulties associated with the Marxist perspective which must not be glossed over. Some critics would maintain that, while the Marxist perspective is illuminating and useful in investigating the societies of underdeveloped countries, such as those of Latin America, it is outmoded and unhelpful in considering the advanced capitalist societies of the developed western world. Such critics would suggest that Marx's analytical insights were developed when capitalism was in its infancy and that they are no longer applicable in the contemporary West because of the many social and economic changes which have taken place subsequently. It is, for example, argued that the notion that society is divided into two opposing classes, a central concept in Marxist analysis, is now known to be false. It is suggested that in contemporary Britain inequalities of wealth and opportunity are diminishing, that there has been a massive growth of the middle class which means that there is no longer a simple dichotomy of classes in society, that the working class itself has become affluent, that the growth of 'managerialism' means that the owners of the means of production now no longer control production, that power is now equally and democratically distributed in society, that class solidarity is decreasing and that there is no sign of anything which resembles a revolution against the upper classes. Critics who cite this kind of evidence talk of 'the end of ideology' and reject Marxist perspectives as anachronistic, inaccurate and invalid.

Marxist writers have not been slow to respond to these criticisms and to confute them. It is not necessary to go into their counter arguments in detail here, but it can be asserted that Marxists have defended their analytical position satisfactorily. There is a good

deal of evidence to suggest that there is still a fundamental dichotomy of socio-economic classes and interests in British advanced capitalist society. Convincing arguments can be set forth showing that there has been no real distribution of wealth and power over the last century and that improvements in living standards throughout society generated by overall increased affluence conceal a rift between classes which is still as wide and fundamental as it ever has been. The rise of the middle class and the 'embourgeoisement' of the workers may similarly be seen as misleading secondary phenomena disguising the continuing class divide (10).

Further objections to the Marxist perspective in sociological analysis come from disciples of the sociologist Max Weber. Like the critics cited above, Weberian social analysts raise questions concerning the Marxist concept of class. Rather than seeing social stratification as simply a product of the relations between people and the means of production whereby status and power are essentially economically determined and linked, it is suggested that status and power in society are independent social variables with their own influence on people's overall social position. Again, it is not possible to evaluate this position properly here, but it must be

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(10) See Paget-Wilkins, op. cit., Ch. 1, Anthony Giddens, The Class Structure of the Advanced Societies, (London : Hutchinson, 1973), John Westergaard and Henrietta Resler, Class in a Capitalist Society (Harmondsworth : Penguin, 1976), Graham Room, The Sociology of Welfare (Oxford : Basil Blackwell and Martin Robertson, 1979), T.B. Bottomore, Classes in Modern Society (London : George Allen and Unwin, 1965), all deal with the contemporary debate about the nature of class in British society. Westergaard and Resler and Bottomore are explicitly committed to the Marxist perspective and defend it ably against the kinds of criticisms advanced above.

borne in mind as an important alternative theory of social stratification. In the present work it will be assumed that status and power are, to all intents and purposes dependent on economic position. A high economic position will generally be accompanied by high social status and power as well and so these two factors will be seen as dependent variables (11).

Apart from the theoretical objections to the Marxist perspective just mentioned, there are practical difficulties associated with trying to apply it to the field of the sociology of health, illness and medicine. Most writers in this sphere have not adopted this approach. This means that while much of the material in this sphere is based on positivist and empirical methods which are compatible in general with Marxist sociological methods, the questions which are posed and studied are not necessarily, or even often directly, related to those which a Marxist sociological perspective would consider most important. Frequently the work of non-Marxist medical sociologists can bear only tangentially on the main questions which are being considered here. This has varying effects and importance according to the topic which is being examined. In looking at the effects of class on the aetiology and incidence of mental disorder, for example, non-Marxist empirical sociologists supply valuable data which can relatively easily be integrated into a Marxist perspective. On the other hand, when considering the evidence of those who write about the doctor-patient relationship it becomes much more difficult to locate this within a thoroughgoing Marxist approach. It is important not to violate the integrity of a particular approach by

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(11) See Giddens, op. cit., p. 41 ff, for a detailed discussion and critique of Weber's ideas about class and social stratification.

forcing it willy nilly into a Marxist mould. However it seems legitimate, wherever possible, to draw out the implications of that approach for a Marxist perspective on the topic under consideration. To this end, close attention is paid in what follows to trying to extrapolate and underline factors which have a bearing on class, class conflict, power, inequality, exploitation and ideology.

To summarise: a generally Marxist perspective is going to be used throughout the remainder of this work in trying to examine social policy, medical sociology and, eventually, pastoral care in psychiatric hospitals. This seems the most appropriate perspective because it follows the approach of the liberation theologians, because it is a methodologically self-aware perspective and because it seems to provide the best analytic tools for excavating inequality and injustice in contemporary British society. While recognising that there are very real objections to adopting this perspective, and that it is bound to be biased and one-sided, a way of not seeing as well as a way of seeing, it is proposed that this approach should be adopted. Thus it will be assumed hereafter that society is divided into two main classes determined by the relation of people to the means of production; that status and power are distributed unequally according to people's position in the class structure; that there is a real conflict of interests between the two main classes in society; that all social relationships and institutions reflect the class conflict; that social relationships and institutions are biased heavily in favour of those who have social and economic power, i.e. the ruling and upper classes who own and control the means of production in late capitalist society.

Having thus consciously adopted this perspective, I will now turn to a discussion of the place of the State in capitalist society as a preliminary to discussing the place of welfare provision within it. This in turn must be seen as a preliminary for considering the role of psychiatric hospitals in contemporary society as these are State-run institutions.

CHAPTER III

THE STATE IN LATE CAPITALIST SOCIETY

As with so many other key concepts in Marxist thought, the State never received a comprehensive and systematic analysis by Marx himself. His views have, therefore, to be largely deduced from a variety of fragmented sources and contexts. This does not mean, however, that the State was not an important entity to Marx. Indeed at the centre of Marx's argument in one of his earliest works, The Critique of Hegel's Philosophy of Right, stands the political State. Hegel had seen the State in its nineteenth century political form as an embodiment of the ideal, universal, harmonious and rational. The State stood above and beyond the civil order of society and was completely autonomous. Marx countered this assertion by showing that far from being universal and therefore rational, the political State was in fact the tool of particular sectional interests who used the mechanisms of politics to further their own ends. Ultimately, those who controlled the State were not a universal class, but rather those who owned the means of production and those who represented them. Thus, Marx contended, the State was the instrument of the dominant class almost exclusively, but it also refused to recognise its own basis in the class system. So, while citizenship was held to be of great importance, it was in fact divorced from the real life of civil society. People were seen to have a public life as citizens which was completely separate from their private lives as entrepreneurs or workers. This allowed the market maximum freedom from effective interference, while grandiose concepts about the rights of man could dominate the constitutions and political writings of the day. The State, like religion, was seen by Marx as a sign of human alienation. For at the same time as it

proclaimed the dignity and rights of human beings, giving the illusion of universality, it actually served the interests of a particular group in society. It was because of this spurious universality that Marx predicted the withering away of the State when the classless society was initiated (1).

Marx's attack on the State as an idealised illusion which ignored the material basis of its own existence in the class divisions of capitalist society and which acted as "a committee for managing the common affairs of the whole bourgeoisie" (2) forms the basis of the contemporary Marxist critiques of the State. Unfortunately, very little has been written which explores in detail the ways in which the modern State may be seen as a class-bound organisation which serves the interests of those who own and control the means of production, the ruling and dominant class. In Britain the most complete attempt at a systematic critique of the capitalist State is that of Miliband (3). Miliband's work draws out the class basis of the State, while it remains sensitive to the fact that contemporary Marxism, like Christianity, is pluralistic in its thought about such issues as politics (4).

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(1) This account is largely culled from Avineri, op. cit., p. 43ff.

(2) K. Marx and F. Engels, Manifesto of the Communist Party in Karl Marx and Frederick Engels Selected Works (London : Laurence and Wishart, 1968), pp.31-83, p.37.

(3) Ralph Miliband, The State in Capitalist Society, (London : Quartet, 1973).

(4) Ralph Miliband, Marxism and Politics (Oxford : O.U.P., 1977). This work also contains material on the State in capitalist society.

Miliband asserts the persistence of a basic dichotomy in society between those who own assets and the means of production and those who do not, the working class. The latter are those who generally "get least of what there is to get", and who have to work hardest to get it (5). Although there are other classes in society than the owning and the working classes, they are not nearly so significant as these two. The conflict of interests between these classes is the primary (but not the only) determinant of political life. Miliband goes on to show that the economic elite is fundamentally identical with the dominant group in society as a whole. He rejects the notion that the growth of a managerial class has affected the nature of production relations in industry. The basic motive of making a profit remains and there is therefore still a community of interest between managers and owners. Both groups have similar origins in the propertied and professional classes. It is maintained that there has been little or no real social mobility or equalisation of wealth. Institutions such as education have served to perpetuate and serve the ruling elite. Wealth has united the elite in political and ideological terms. Such plurality of belief and practice which does exist amongst the elite, for example between Conservative and Labour politicians falls within a narrow and fundamentally conservative spectrum and effectively precludes fundamental changes in the status quo.

Miliband demonstrates that the institutions of State, i.e. government, administration, the military, the police, the sub-central government, parliamentary assemblies, and the judiciary, are run basically by members of the same

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(5) Miliband, The State in Capitalist Society, p.16.

classes, namely the upper and ruling classes. Members of the working class seldom attain entry to the ruling class, and when they do they too adopt bourgeois attitudes and values. This is the case even in pluralist democratic societies like Britain. Key positions in the life of the country are almost always held by members of the upper and middle classes who cannot be seen as representative of the population in general.

The social composition of the institutions of State is underlined by Miliband because it illuminates the reasons why particular ideologies, outlooks and biases are almost universally shared. He argues that the governments of the most advanced capitalist countries

> have mostly been composed of men who beyond all their differences and diversities have at least had in common a basic and usually explicit belief in the validity and virtues of the capitalist system ... and ... have ... shared a quite basic and unswerving hostility to any socialist alternative to that system (6).

While

> opponents of capitalism believe it to be a system whose very nature nowadays makes impossible the optimum utilisation of resources for human ends; whose inherent character is one of compulsion, domination and parasitic appropriation; whose spirit and purpose fatally corrode all human relations; and whose maintenance is today the major obstacle to human progress,

bourgeois governments and politicians

> view the system in precisely opposite terms - as most congruent with 'human nature', as uniquely capable of combining efficiency, welfare and freedom, as the best means of releasing human initiative and energy in socially beneficent directions,

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(6) Ibid., p.65.

and as providing the necessary and only possible basis for a satisfactory social order (7).

Because of this inherent approval of the capitalist order of society, governments and States tend not to act against the interests of that order and the class which benefits most from that order. Policy on all issues will tend to strengthen and defend the status quo and those who have power within it. They will certainly not pose any fundamental threat to it.

Public servants should not be seen as neutral within the capitalist state either. While it may be desirable for them to appear neutral and impartial, those in positions of public responsibility within the state, especially those at the top, also share a common, fundamentally conservative, attitude towards the existing order and will defend it in their activities.

Miliband suggests that there can be little effective opposition to the dominance of conservative, pro-capitalist forces within the State. Business interests have greater influence over government than working class movements and can bring greater forces to bear at all levels to legitimate the present social order. Greater financial resources backed up by ideological influence from institutions like churches, schools and the mass media, have traditionally helped to maintain the established order. Thus a climate which is fundamentally inimical to the interests of the working class has emerged and is sustained.

Summarising briefly, Miliband argues that economic inequality produces a political inequality which almost invariably favours the class in society which owns and controls the means of production over against the working

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(7) Ibid., p.68.

class. Social policy, as will be shown, is therefore congruent with, and supportive of, the status quo in the capitalist Welfare State. The notion of democratic pluralism and the fundamental equality of all citizens is essentially an illusion since those who occupy a lowly position in the economic order also lack political power and influence.

CHAPTER IV

SOCIAL POLICY AND THE WELFARE STATE

In this section I shall develop further the Marxist critique of the Welfare State, of which the psychiatric services form a part. In the last section the Marxist view of the state was expounded and the specific subject of the welfare State follows on from that. However, it is important to realise that the Marxist view of the Welfare State is not the only one available. In fact, it is a minority view. For this reason, I shall spend some time discussing other ideological perspectives on this subject before moving to the Marxist perspective proper.

Before commencing an account of the different perspectives of the Welfare State and social policy, it must be emphasised that these views are very much ideal views. None of them can actually be found operating in a pure form in contemporary British society. This is partly due to the complex historical evolution of the Welfare State which has emerged through many tensions and compromises (1).

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(1) Parker points out that social policies change "in response to the varying pressures of different interests, and the balance of power and thus the pattern of welfare provision shifts through time" (Julia Parker, Social Policy and Citizenship (London : Macmillan, 1975), p.32). Pinker suggests that the evolution of social policy must be seen as a compromise - between normative philosophical theories (such as those which are detailed below) and expedient pragmatism, (Robert Pinker, Social Theory and Social Policy (London : Heinemann : London, 1971), p.55ff.) Fraser similarly maintains that the development of the Welfare State must be seen not as the unfolding of a comprehensive and well thought-out plan, but rather as an erratic and pragmatic response to the practical individual and community problems of an industrialised society. (Derek Fraser, The Evolution of the Welfare State (London : Macmillan, 1973), p.1.)

In addition to noting the lack of practical and philosophical cohesion in the development of contemporary social policy, it is also important to recognise that the whole notion of welfare is problematical. This will become particularly apparent when the Marxist critique of the Welfare State is examined. However, other critics in the sphere of social policy have also shown an awareness of this feature. Titmuss, for example, warns that "When we use the term 'social policy' we must not ... automatically react by investing it with a halo of altruism" (2). He adds that social policies do not necessarily "actually operate in practice to further the ends of progressive redistribution, equality and social altruism. What is 'welfare' for some groups may be 'illfare' for others" (3). This kind of remark opens the door to all sorts of questions concerning welfare. For example, it raises the issue of how needs and resources should be recognised and correlated, and who should have the power to define need and social policy. These and other questions are of great importance in the National Health Service (N.H.S.) and they will be more fully considered in that context. However, such issues can be more effectively addressed if the ideological framework of welfare has been outlined.

Four main approaches to the Welfare State will now be considered. These are the conservative, social democratic, libertarian and Marxist perspectives, and they will be dealt with in that order.

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(2) Richard Titmuss, Social Policy, ed. Brian Abel-Smith and Kay Titmuss (London : George Allen and Unwin, 1974), p.27.

(3) Ibid., p.27.

The approach to social policy, called here the conservative approach, is also designated the liberal approach in some typologies of welfare theory (4). It is the oldest of the perspectives to be examined here and arose at the beginning of the nineteenth century as a response to the growth of industrialised society. In the society of that time, dominated by the growth and needs of the market, there evolved a philosophy based on the freedom of the individual, self-help and the equality of all in the market (5). This philosophy, which thrust the responsibility for his own welfare on to the individual and his own efforts while abhorring the organised interference of the state, has often been called the philosophy of 'laissez faire'.

The 'laissez-faire' approach is based on a rather simple form of individualism. It puts great value on economic growth and maximising wealth and emphasises individual free choice in making contracts and agreements of all kinds. The distribution of income and wealth, education, medical services and other forms of social care depends on the productive system and on individual bargaining power with a minimum of interference from the state either to protect the weak or to restrain the powerful. Poverty tends to be taken for granted as the lot of a large proportion of the population. It becomes a matter for the government at the point at which living standards fall below the minimum for subsistence or threaten the rest of the community (6). The consequences of this kind of

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(4) See e.g. Room, op. cit.

(5) See Fraser, op. cit., p. 5 .

(6) Parker, op. cit., p.4.

theory are seen more clearly, perhaps in Titmuss' caricature. He regards conservative philosophy as an extreme approach to social policy which maintains that

> it is morally indefensible to force or compel some individuals, irrespective of their circumstances, wishes or beliefs, to give help, either in cash or in kind ... to beneficiaries whose incomes and circumstances have not been enquired into. It is the case for minimum government, maximum liberation from State intervention, a residual role for (preferably) a voluntary social policy, and maximum permission (or freedom) for the individual to act according to his own conscience and to spend his own money as he wishes in the private market without let or hindrance from officials or bueaucrats 'who cannot know best' (7).

It is an ideology very close to this one which survives today at the heart of the contemporary Conservative party's thinking on social policy (8).

In such a perspective on social policy, the role of the State is minimal. It acts as umpire and rule-maker in the lives of its citizens but does little more than that. It will, however, intervene in the lives of those members of the community who are deemed to be incapable of looking after themselves (9).

The outcome of the 'laissez-faire' philosophy in terms of social policy is the emergence of the principles of

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(7) Titmuss, op.cit., p.33.

(8) See Bill Jordan, Freedom and the Welfare State (London : R.K.P., 1976), p.2f.

(9) See Vic George and Paul Wilding, Ideology and Social Welfare, (London : R.K.P., 1976), p.27f.

residual welfare and less eligibility. The residual welfare principle implies that the individual should normally meet his own needs and those of his dependents. Only in the last resort should the State have to make any provision for those needs, and dependence of individuals on state provision should be as brief as possible. To this end, the state should provide only a bare minimum so that individuals will be encouraged to try and find other ways of meeting their needs.

The principle of less eligibility is closely related to that of residual welfare. According to this principle only the genuinely needy and incapable should receive help from the State and so they must be carefully distinguished from the able poor, i.e. those who are indolent. Less eligibility was legally enshrined in the Poor Law Amendment Act of 1834. This piece of social policy legislation, which set the whole tone of nineteenth welfare provision, was enacted to discourage and penalise those who could not or would not work to the extent that any kind of employment would seem preferable in terms of remuneration and working conditions to being maintained under the Poor Law in a workhouse (10). It is ironic to recall that behind these draconian measures lay, in many ways, very altruistic intentions. It was hoped that the coercion of the Poor Law would encourage each citizen to play his full part in the market and so would discover his own autonomy, power and independence.

It was at about the time that the Poor Law Amendment Act came into being that lunatic asylums began to become the standard way of dealing with the insane in society. These

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(10) Fraser comments that the Act "was not intended to reduce poverty but to deter pauperism". (Fraser , op. cit., p.43.)

two phenomena are closely related and it will be necessary to bear this in mind when the history of the psychiatric hospital is considered. For the present, however, I will move on to discuss the social-democratic perspective on social policy.

While a strict 'laissez-faire' social policy based on minimal State interference in the lives of individuals, on deterring the indolent and attempting to force them onto the labour market, appeared satisfactory at the beginning of the nineteenth century, it became apparent that this kind of policy could not deal satisfactorily with all the problems which arose in society. As the century progressed, it became obvious that positive governmental intervention, going beyond the boundaries of the residual welfare model, was necessary. It was realised, for example, that a healthy work force was required and that only central government was in a position to implement the measures needed to attain this end. The first major piece of interventionist social policy legislation to be passed by the government was the Public Health Act of 1848. Gradually, government has become more and more involved in social policy legislation and has assembled the centralised administrative machinery necessary to implement it. At the same time, citizen participation in the running of the country had increased, at least formally, and the franchise had been extended to most adult members of the population.

It is the growth of state involvement with social policy and welfare legislation and the broadening of the principle of democracy which forms the background to the 'social-democratic' view of the Welfare State. This perspective has also been described as 'socialist'. It stresses

> ... the value of equality and common rights to take part in political, social and economic activities. Individual freedom is similarly emphasized but differently interpreted; it is a matter of 'freedom to', rather than 'freedom from'. The government becomes responsible for arranging the environment to permit everyone similar opportunities for making positive choices and to provide comparable standards of amenity, rather than limiting its activities to preventing acute destitution. Distribution is according to need so that in a perfectly working system, poverty would not exist (11).

Thinkers in this tradition (e.g. Tawney, Titmuss and Marshall) believe that the Welfare State can be the instrument for bringing about a greater equality in society based on the fundamental equality of all citizens. They maintain that recognition of social equality will eventually lead to a fully socialist society where inequalities of economic and political power will be subsidiary to the right of all citizens to have their needs met. In this evolution towards a more just society, universally provided social services such as health and education are to be regarded as great landmarks. The views of the social-democratic thinkers are firmly anchored in humanistic altruism expressed in socialistic values like freedom, fellowship and equality (12).

The role of the State for the social-democratic theorists is of vital importance in the evolution of socialism. It is the task of the government "to modify ... the injustices of the market system of distribution"(13). Although it is recognised that the Welfare State in itself cannot bring about the advent of a totally socialist society,

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(11) Parker, op. cit., p.5.

(12) For this last point see further George and Wilding, op. cit., p.62 f.

(13) Ibid., p.73.

the socialists' attitude towards the welfare state is one of enthusiastic approval and support. It will later be necessary to question the optimistic and enthusiastic estimate of the welfare state put forward above. The Marxist perspective, as will be shown, is a good deal less adulatory and positive about this aspect of life in late capitalist society. However, it should be realised that the social-democratic perspective on social policy and welfare has been very influential and central in British thinking. It cannot, therefore, be lightly dismissed although I do not propose to devote any more space to its consideration. I will turn instead to a consideration of the libertarian approach to social policy.

The libertarian view of the Welfare State and social policy is the most modern and also the least influential perspective to be examined here. It will receive only a brief account.

Libertarianism has its intellectual origins in two main streams of thought, Marxism and existentialism. It tends towards a mixture somewhere between anarchism and syndicalism. It rejects any centralised attempts at organising welfare as being the oppressive activity of the ruling class, whether in a capitalist or a Marxist societal order. A fundamental contradiction is perceived between the true interests of the individual and the demands of the social order and so the need for an organised State is disputed. Libertarian thinkers tend to be radically individualistic and the libertarian tradition seeks to promote a "programme for 'positive liberty' - self-determination, self-direction, and control of his own life by the individual - which it often refers to as 'liberation'." (14). The fundamentally

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(14) Jordan, op. cit., p.9.

individualistic outlook of the libertarian thinkers is disguised by their frequent allusions to the language of sociology and politics (15). However, the libertarians lack any really incisive and systematic critique of the major structural problems of society, e.g. poverty and injustice. Jordan points out that

> libertarian analyses are largely irrelevant to the problems of injustice and inequality in our society. Because they presuppose socialisation into awareness of self, and the ability to express creative feelings, they have no clue to offer on how to nurture the education of the underprivileged and encourage these perceptions and capacities... Libertarians bypass the great dilemmas of social policy in respect of treatment of problem behaviour; they thus give tacit consent to the continuation of such standard treatments for crime and mental illness as imprisonment and the traditional mental hospital (16).

In conclusion, it must be said that although libertarian thinkers like Marcuse, Laing and Cooper have become very well known over the past decade or so, particularly in connection with the movement which has come to be known as 'anti-psychiatry', their insights are of very little value in constructing a 'hard' socio-political critique of the Welfare State or of the psychiatric hospital. The individualistic, utopian vision of a society in which autonomous individuals simply choose to look after the destitute and impotent, presents no effective critique or programme for the Welfare State as it exists in contemporary society.

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(15) Laing, for example, writes of the 'politics of the family' and the 'politics of experience'.

(16) Ibid., p.107. For further analysis of the 'soft' politics of libertarianism, 'anti-psychiatry', etc., see also Geoffrey Pearson, The Deviant Imagination (London : Macmillan, 1975), especially chs. 3 and 4, and Peter Sedgwick Psycho Politics (London : Pluto, 1982), Part 1.

The Marxist, like the conservative, view of welfare and social policy, is in many ways a negative one. This is for very different reasons from those of the former perspective. Those who maintain a 'laissez-faire' philosophy object to state interference in the lives of individuals because they believe that it may discourage people from using their energy and initiative to earn a place of autonomy and equality in the market economy. Marxists, on the other hand, see the Welfare State as a means by which the unjust market economy can continue to operate against the interests of the majority, i.e. the working class, while serving the interests of the minority ruling class who own and control the means of production. The State is seen as reflecting the balance of power in the class struggle as a whole. The owners of the means of production and those who share their interests are the dominant group in the running of the state. Thus all the State's activities, including its welfare provisions and policies will reflect and maintain the status quo. State enacted social policy must be viewed as part of the mechanism whereby discontent, which might disrupt the economic system, is contained and the sorts of attitudes which favour the interests of the upper classes are nurtured and encouraged. George and Wilding conclude that the purpose of social legislation and provision is to "protect the system of class relations existing at any one time " (17). There appears to be a great deal of historical evidence which is compatible with this fundamental Marxist thesis. The employment of the less eligibility principle contained in the Poor Law Amendment Act of 1834, whereby people were compelled to support themselves by selling their labour in the market or suffer institutionalisation in the most appalling conditions may be seen as an example of social policy being

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(17) George and Wilding, op.cit., p.91.

used to ensure a plentiful supply of cheap labour for burgeoning nascent British industry. Again, the need to have a healthy and educated workforce in the latter part of the last century and in our own century may be regarded as the most powerful incentive for the State to provide 'enlightened and humane' social policy measures concerning health, education and housing. The social control aspect of welfare provision, containing revolt and discontent, should be noted also. Fraser notes that the growth of socialism came to be regarded as a serious threat to capitalist society towards the end of the last century and so attributes the growth of the Welfare State as much to the fear of social revolution as to humanitarian concern, the satisfying of psychological and social needs of noblesse oblige and the desire to improve the moral tone of the poor (18).

At the present time, too, much in State social policy may be seen as serving the need to preserve and propagate the late capitalist order of society. 'Radical' social workers, for example, much influenced by the Marxist way of looking at society, point out that much of their work seems to be orientated towards finding solutions to ameliorate the conditions of individuals when the origins of those individuals' problems lies in the wider social and economic order of society. The individual and limited approach sanctioned by contemporary social policy prevents wider factors such as the client's class position from being taken into account, and the individual is encouraged to see the origins of his problems as lying within himself. Thus social and political issues and problems are privatised and individualised, and the growth of any class solidarity which

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(18) Fraser, op. cit., p.117 f.

might lead to social unrest is prevented (19).

Many aspects of the contemporary welfare state may be regarded as upholding the established order of society. George and Wilding point out that, apart from being able to meet needs and direct the kind of solution which should be applied to them, those who hold power within the State are ultimately those who actually have the power to define what is, and what is not, a social problem:

> All social problems are products of a process of definition. Social policies are the product of legislation. An understanding of who does the defining, of what is defined as a social problem and how it is defined, as well as of who shapes legislation and in what ways is, clearly, crucial to the student of the welfare state. (20)

From a Marxist analysis of the nature and composition of the State and its apparatus, such as that of Miliband, it is obvious that it is those who have economic and therefore political power in society who define and legislate for social problems in capitalist society. The definition and legislation for social problems will fundamentally clash with the interests of the working class while serving the interests of those who have most power in society.

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(19) For the perspective of radical social work see Roy Bailey and Mike Brake, eds., Radical Social Work (London : Arnold, 1975), Mike Simpkin, Trapped within Welfare (London, Macmillan, 1979), especially ch.3, Paul Corrigan and Peter Leonard Social Work Practice Under Capitalism (London : Macmillan, 1978). This work is a more technical and detailed analysis of the position of social work from the Marxist perspective. See also Ray Lees, Politics and Social Work (London : R.K.P., 1972), Colin Pritchard and Richard Taylor, Social Work : Reform or Revolution? (London : R.K.P., 1978). Further reference will be made to radical social work later on as it has many similarities with the position of pastoral care within the Welfare State.

(20) George and Wilding, op. cit., p.2.

Although Marxist critics of the Welfare State see it as a part of the arena of class conflict and therefore as essentially determined in its nature by those who are economically and politically dominant, they are not so simplistic as to dismiss it as bringing no benefits of any kind to the working classes. While the welfare state does indeed reflect the requirements of capital and industry and is the price that the upper classes must pay for political security, it is also the product of the demands and struggle of the working class against domination and exploitation and so incorporates some features which are of real benefit to the working classes (21). It must be appreciated that the class struggle is a dialectical conflict and that although one side may be dominant, the other protagonist in the struggle can make some impact in terms of extracting concessions from the other. This means that, in that it improves present quality of the lives of working class people, the welfare state may be regarded as fulfilling a very valuable function. Similarly, present benefits raise people's expectations about life and so help to vitalise their struggle to obtain a greater share of goods and services (22). It is not totally unfair to describe the Welfare State in the Marxist perspective in terms of 'realised eschatology'. The benefits available today are the harbingers, or first fruits of the better order which will be initiated with the advent of the classless society. So although Marxists tend to regard the Welfare State as having delayed and possibly averted the collapse of the capitalist order, they also see the limited achievements and benefits of the welfare State as having a

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(21) See J. Saville,'The Welfare State - An Historical Approach,'in Mike Fitzgerald, Paul Halmos, John Muncie and David Zeldin, eds., Welfare in Action (London : R.K.P., 1977), pp.4-9.

(22) See George and Wilding, op. cit., p.99 f.

very positive significance. This is why most Marxists resist the notion of cuts in social services.

In conclusion, it can be asserted that Marxists reject the idea that the State as it presently exists in capitalist society represents any kind of democratic egalitarian pluralism. The State primarily serves the interests of the most powerful classes in society and so State welfare provision can only be of limited benefit in realising the true interests of those without the same amount of power, i.e. the working classes. Only when the classless society emerges in the future and the state withers away, along with class conflict will welfare provision serve the interests of the whole community properly. In the meanwhile, provision of welfare by the State acts as a panacea against radical social change. However, it may also be seen as the 'first fruits' of the era which is to come as it reflects the struggle of the working class to ameliorate their own contemporary conditions. Summarising this perspective, Gough asserts that

> the welfare state exhibits positive and negative features within a contradictory unity ... . It simultaneously embodies tendencies to enhance social welfare, to develop the powers of individuals, to exert social control over the blind play of market forces; and tendencies to repress and control people, to adapt them to the requirements of the capitalist economy. (23)

It is in the light of this perspective primarily that the present work proceeds. The points made here will be amplified by the analysis of the N.H.S. and of the situation of the psychiatric hospital within the health service which follows.

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(23) Gough, op.cit., pp.11-12.

CHAPTER V

THE EVOLUTION OF THE NATIONAL HEALTH SERVICE

The majority of mental health provision in Britain is made under the National Health Service. For this reason, before considering the psychiatric hospital in particular, it is necessary to locate that institution within the wider framework of the Health Service. In this section therefore an outline of the history of the N.H.S. is given. This is followed by a specifically Marxist analysis of that history. Finally, an account of the functioning of the N.H.S. today is outlined and analysed from the Marxist perspective.

In considering the historical evolution of health service provision in this country it is convenient to divide the period under consideration into three, viz. 1834 - 1911, 1911 - 1948, 1948 - the present day (1).

During the period 1834 - 1911, public provision of personal health services was minimal (2). Due to the 'laissez-faire' policy (outlined above) which lay behind the provisions of the 1984 Poor Law Amendment Act, only the most destitute members of society received aid from public funds. Such attention as was received by the indigent poor was in Workhouse Infirmaries where patients

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(1) This is D.G. Gill's arrangement. See D.G. Gill, 'The British National Health Service : Professional Determinants of Administrative Structure' in Caroline Cox and Adrianne Mead , eds., A Sociology of Medical Practice (London : Collier Macmillan, 1975), pp.155-69.

(2) The main outline of the following account is based on Fraser, op. cit., supplemented by other works cited below and especially by David Widgery, Health in Danger (London : Macmillan, 1979), Ch. 1.

had to suffer appalling conditions and were attended by physicians who were appointed by local Poor Law Guardians and who tendered for the contract at a particular infirmary. This meant that the cheapest, but not necessarily the best, physician was employed. The doctors were able to do little for their patients. They were regarded as relatively inferior by the Guardians and so had no influence to get better conditions within the infirmaries for their patients. Medical technology was limited and ineffective until the latter part of the nineteenth century.

Those who escaped the Workhouse Infirmary were dependent for hospital treatment on the voluntary hospitals in the large cities. These institutions were staffed by physicians and surgeons of a more socially superior type than those who staffed the Poor Law Infirmaries. Treatment was given free to the poor as the medical staff earned their living by charging their wealthy patients fees. However, in return for free medical care, patients had to endure being used for teaching purposes. Treatment of the lower social classes outside hospitals and infirmaries was undertaken by general practitioners (G.P's) and apothecaries in the patients' own homes. Again, fees were paid by the patient

for a practitioner's service (3).

Medical technology was grossly inadequate for most of the nineteenth century. For this reason, the most important feature of governmental action over health in that century was the public health legislation which was enacted. Chadwick's Report on the Sanitary Conditions of the Labouring Population of Great Britain (1842) led to the permissive Public Health Act of 1848 and eventually to the Public Health Act of 1875 which laid down statutory obligations for provision of various facilities by local authorities. These Acts may be seen as attempts to save

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(3) It should be mentioned, in passing, that there was a fundamental divide in the nineteenth century Medical profession whose effects have survived to the present day. This dichotomy was class related and separated the apothecaries and general practitioners from the physicians and surgeons who were based on the urban voluntary hospitals. The former came on the whole from lower class backgrounds than the latter, and their clientele similarly was largely composed of lower class people. The latter group came from the higher classes in society, belonged to the Royal Colleges (of Physicians and Surgeons respectively) and were principally responsible for the treatment of members of their own class. The latter group was more prestigious and influential, although far smaller numerically. Even the Medical Act of 1858 which introduced the Medical Register and the General Medical Council, thus standardising entry to the profession and eliminating 'quacks' and charlatans, failed to abnegate the basic schism between the two branches of the profession.

For more on the history of the medical profession and on the division within the medical profession and its significance, see Frank Honigsbaum, The Division in British Medicine (London : Kogan Page, 1979), Gordon Forsyth, Doctors and State Medicine (London : Pitman, 2nd edn., 1973), Vicente Navarro, Class Struggle, The State and Medicine (London : Martin Robertson, 1978), Noel Parry and Jose Parry, The Rise of the Medical Profession (London : Croom Helm, 1976).

money in poor relief for the dependents of those who died of contagious diseases as well as part of the attempt to ensure a more healthy workforce. It should also be noted that they, amongst other pieces of legislation, paved the way for the exercise of strong centralised action by the government. They thus form part of the process of evolution from little or no State interference, to universal health provision by the State.

In the latter part of the nineteenth century, several developments significant for the pattern of health provision emerged. Scientific developments such as the discovery of germs and aseptic techniques made the possibility of cure rather than simply care possible. Hospitals came to occupy a new position of prominence as they ceased to be places in which to die only, and the position of doctors and the 'medical'model of illness was also enhanced. At the same time organisational developments were taking place in the provision of health care. Friendly societies and insurance schemes whereby poorer people could have care from a doctor in time of need were coming into existence. G.P's were beginning to be employed by groups to look after a panel of patients.

The year 1911 marks the end of the first period of health service development because it was then that Lloyd-George's National Insurance Act passed through Parliament (4). This act obliged working men earning less than a certain amount to contribute to privately run insurance schemes so

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(4) See Fraser, op. cit., p.154 ff. for details of this measure, also Navarro, op. cit., p.9 ff.

that in time of illness and unemployment their needs might be met. It was selective in its provisions in that it was confined only to working men and not their families or working women. Similarly, it provided only for primary health care and not for hospital treatment. G.P's participating in the scheme charged a per capita fee for each man registered with them.

In the second period of State health service provision, from 1911 to 1948, the limited and selective measures of the 1911 Act continued to operate. There were few other important developments before the beginning of the Second World War.

In 1942, the Beveridge Report, outlining the programme of post-war reconstruction, was published. It provided a vision of universal State services including a comprehensive health service (5). This was expanded in the White Paper, A National Health Service, in 1944 and subsequently by the National Health Service Act of 1946. These policy developments were paralleled by practical developments. During the war an Emergency Medical Service had taken over the co-ordination of services at most municipal and voluntary hospitals. This had produced many benefits to patients and staff which extended beyond military personnel to the civilian population. As a result, both the specialist hospital consultants and the ordinary people of the country were keen to see that the advantages of this system were

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(5) See Fraser, op. cit., p. 194 and Forsyth, op. cit., p.20 ff., for further details of the Report .

not lost when hostilities ceased (6). For the consultants, a state co-ordinated health service offered the attraction of financial stability in the form of guaranteed salaries which did not depend on the referrals of G.P's. Private practice could be retained on a part-time basis. G.P's, on the other hand, did not favour the development of a national health service. These doctors were concerned about the sale of private practices, the equity of dismissal procedures, the possible introduction of a salaried medical service, and the possibility of the direction of medical labour by the government (7). Despite their objections, Bevan, the minister responsible for the new health service, was able to proceed with its implementation. He had the support of the populace at large who had voted for a Labour Government and also of the consultants who had been promised very generous salaries in the new service. Accordingly, the National Health Service came into existence in the year 1948.

At its inception the Health Service was divided into three autonomous areas; the hospital service, the primary care service, i.e. G.P's, and local authority services. All the voluntary and municipal hospitals, including nearly

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(6) For more about the Emergency Medical Service see Fraser, op. cit., p. 215.

(7) See further Fraser, op. cit., p.218 f.

(8) The above is a very abbreviated account of the development of the health services in Britain to 1948. More detail can be found in the sources cited in the test. I have followed Fraser principally, supplementing this with material from Navarro, and latterly particularly from Forsyth who provides detailed material on the development of specifically medical services and on doctors.

50% mental illness and mental handicap beds, were organised under fourteen Regional Hospital Boards (R.H.B's) (9). Teaching hospitals were, however, independent of the R.H.B's and had their own boards of governors responsible directly to the Ministry of Health. G.P's were organised under the aegis of 138 Local Executive Committees. Local authorities continued to provide public health and other community-based facilities.

The development of health service provision under the National Health Service, which constitutes the third period of the history of this account, started slowly during the 1950's. This was due to the lack of financial provision. Only nine new health centres for G.P's and very few hospitals were built. This situation changed in the middle of the next decade when a massive hospital building programme was commenced. The expenditure of the N.H.S. has grown from 3¾% of the G.N.P. in 1948 to about 5.3% of the G.N.P. in 1974 (10). At the same time, the number of people employed by the N.H.S. has risen from 425,000 to more than 750,000, making the Health Service the biggest single employer in the country (11). The average number of patients treated in hospital each year has grown from 4.1 million in 1960 to 5.5 million in 1974 (12). These figures give some indication of the way in which the service has expanded in the course of the last three decades.

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(9) There were 1,143 voluntary and 1,545 municipal hospitals in the country at that time. See Brian Abel-Smith, National Health Service - The First Thirty Years (London : H.M.S.O., 1978), pp.8-9. The basic outline of that which follows is taken from this work.

(10) Abel-Smith, op.cit., pp.30 and 57.

(11) Ibid., p.30.

(12) Ibid., p.29.

There have been several significant developments in policy since 1948. Perhaps the most important of these is the re-organisation of the N.H.S., in the 1970's in order to rationalise it. Almost since the beginning of the service in 1948, the tripartite split in service provision seemed cumbersome and an impediment in trying to offer properly co-ordinated comprehensive health care. In the psychiatric services, for example, there was an unsatisfactory gap in co-ordination between services provided by the hospitals and those offered by the local authorities. Various groups drew attention to this deficiency, for example the Guillebaud Committee in 1955 and the unofficial medical report produced by Porritt in 1962 (13). Eventually, this was dealt with in a government Green Paper on re-organisation in 1968 (14). Another Green Paper followed in 1970, and in 1972 a White Paper outlining the proposals which were eventually implemented was published.

Under the re-organisation proposals, fourteen Regional Health Authorities (R.H.A's), directly responsible to the Secretary of State, were set up. Beneath them there were Area Health Authorities (A.H.A's) which were to be accountable to the R.H.A's. Each A.H.A. was to cover an area which corresponded with that of the new county councils. Large A.H.A's were to sub-divide into districts which again had their own areas of autonomy and jurisdiction (15). Community Health Councils were also proposed as part of re-organisation so that the consumer's voice might be heard

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(13) Ibid., pp.34-5.

(14) Ibid., p.37.

(15) It is worth noting that efforts by local authorities to achieve the decisive voice in the N.H.S. were defeated by this scheme which retained the autonomy of the health sector and its direct responsibility to central government.

by this very centralised system of organisation (16).

The 1974 re-organisation has not seen the end of structural changes in the N.H.S. The government published a consultative document, Patients First (17), as a response to the Royal Commission on the National Health Service which submitted its findings in 1979 (18). That body's criticisms are summarised in Patients First thus:

- too many tiers
- too many administrators in all disciplines
- failure to take quick decisions
- money wasted (19)

Accordingly, the government proposed that A.H.A's should be dissolved to leave R.H.A's and District Health Authorities (D.H.A's) which cover a smaller area than that covered by the A.H.A's. In addition, management at local level was to be strengthened. Professional advisory machinery was to be simplified so that the views of professional workers in the service can be heard more clearly. The planning system was also to be modified to allow greater sensitivity to District needs (20).

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(16) A full account of the re-organised N.H.S. can be found in Ruth Levitt, The Re-organised National Health Service (London : Croom Helm, rev. edn., 1979).

(17) D.H.S.S., Patients First (London : H.M.S.O., 1979).

(18) See Royal Commission on the National Health Service, Report (London : H.M.S.O., 1979).

(19) Patients First, para. 3.

(20) For a brief summary of these proposals see Patients First, para.7. Since the publication of this document the D.H.S.S. has issued a circular which gives more details of the proposed restructuring of the N.H.S. See D.H.S.S., Circular HC(80)8, Health Service Development Structure and Management (London : D.H.S.S., 1980). The main substance of the recommendations of Patients First were implemented in 1982.

The second major policy development in the N.H.S. in the last decade has been the growing emphasis on community care and on the individual's responsibility for his own health (21). Bodies like the Health Education Council have assumed a new importance as it comes to be realised that "while the N.H.S. (can provide health services, it (can) not provide better health" (22).

The account of the history of health service provision above is one which lacks a proper socio-economic perspective which would link events in wider society to those in the development of the health sector. Here that perspective is filled in using principally the Marxist analysis developed by Navarro (23).

Navarro asserts that, fundamentally, the development of the health sector should be seen within the context of class relations and conflict in wider society, and thus within the development of capitalism. Although forces within the health sector such as the conflict between interest groups (e.g. different groups of doctors and administrators) are important and influence the shape of the sector profoundly, the primary determinants of the health sector lie outside (24).

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(21) See e.g. D.H.S.S., Prevention and Health : Everybody's Business (London : H.M.S.O., 1976).

(22) Abel-Smith, op.cit., p.45.

(23) See Navarro, op.cit.

(24) See Navarro, op.cit., pp.xiv-xv.

Navarro writes

> I consider social policy in social sectors to be the dialectical result of forces that exist both outside and inside these sectors. In a gradient of influence, however, the former ranks higher than the latter (25).

He emphasises that social legislation comes about

> not in the arena of values ... but in the reality of a struggle among classes, and primarily between the capitalist and working classes, whose interests are intrinsically in conflict (26).

The configuration of health service provision must be seen therefore as "dialectically determined by the social demands of Labour on the one hand and the social needs of Capital on the other"(27). In other words, it is argued that health policy comes about as a result of the working class making demands for more and better services, while the capitalist class strives to maintain a stable social order, to legitimate their right to rule, and to produce a healthy workforce for industry. Navarro proceeds from these premises to show how the conflictual pattern of class relations has influenced the development of the health sector in Britain as capitalism has evolved. (This basic perspective is shared by other critics of the health sector. Waitzkin and Waterman, for example, write that "the organisation of health services within a given society depends to a great extent on its broad socio-political context".(28).

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(25) Ibid., p.xiv.

(26) Ibid., p.xiv.

(27) Ibid., p.xvi.

(28) Howard B. Waitzkin and Barbara Waterman, The Exploitation of Illness in Capitalist Society (Indianapolis : Bobbs Merrill, 1974), p.15.

However, Waitzkin and Waterman are chiefly concerned with health services in the U.S.A. and in addition do not follow a strictly Marxist paradigm in that they do not focus primarily on the class struggle in capitalist society. For these reasons, Navarro is the main source here.)

Navarro starts his analysis of the British health sector by filling in the social and political context of the 1911 National Insurance Act. The rapid growth of the working class in the nineteenth century, along with the rise of that of the bourgeoisie is demonstrated and it is pointed out that this class distinction was reflected in the medical profession. Steady growth in the allied power of the working and middle classes led to successful demands for unification in the medical profession and the monopolisation of practice and organisation. It was this which led to the 1858 Medical Act which increased the status of the middle class G.P's considerably, although it left the balance of power within the profession very uneven still.

Towards the end of the last century, the working class became very much more militant and politically organised into unions. Vociferous demands for improved working conditions, wages and security were made. Such pressure from below added to the needs of capitalists to prevent social unrest and to have a healthy workforce, produced ameliorative legislation which culminated in the 1911 Act (29). Navarro notes that this ameliorative action was strictly limited by the dominant class and in many ways served the interests of groups within the ruling classes rather than the working classes. The doctors, for example gained by receiving a higher and more regular income. Insurance companies

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(29) Navarro, op. cit., p.10.

similarly benefitted as they gained many compulsory contributors (30). Since only men were insured under the 1911 Act, it was perfectly clear that the ruling classes were more concerned about the best interests of industry and the military machine than in the true welfare of working class families. It would be a mistake to see the advent of national insurance as a thoroughgoing humanitarian social reform based principally upon compassion and 'noblesse oblige'.

Navarro sees the Dawson Report of 1920 in the same light as the National Insurance Act. This Report should be regarded as the Conservative response to the Socialist threat. The socialist State Medical Services Association, backed by working class militancy which had been fuelled by the successful Russian revolution of 1917 and the suffering of British working classes in World War I, had proposed nationalisation and regionalisation of health service facilities (31). The Dawson Report diluted these proposals which were ultimately not implemented because the labour movement capitulated to Lloyd George in 1921.

After the Dawson Report, the idea of a state health service was virtually forgotten until 1926, the year of the General Strike. In that year, the Royal Commission on National Insurance proposed an extension of coverage so

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(30) See further Fraser, op. cit., p.156. Fraser points out that in actual fact a great deal of money was taken away from working people by the national insurance measures while nothing was done to ameliorate the causes of poverty and ill health which would have been more beneficial in ultimate terms.

(31) See Navarro, op.cit., p.17f.

that the dependants of workers would be insured. The Commission also recommended an expansion of facilities covered under National Insurance so that specialised services would become available in addition to primary care. Reforms like these are regarded by Navarro as a 'carrot' to encourage the working class to re-commence co-operation with the ruling classes.

According to Navarro (32), the depression of the economy in the 1930's fuelled working class discontent with the established order. Increasingly, more far-reaching demands were made by the Labour Party and these included renewed demands for a nationalised, centrally-planned and universal health service. In 1938 the B.M.A. produced a report which recommended voluntary co-ordination between hospitals. This may be seen as a response to the socialist 'threat' as, in general, the B.M.A. worked principally in the interests of its own members and the welfare of the general public was a secondary consideration. Limited change, such as that suggested in the 1938 report, would allow the conditions which favoured the interests of the doctors to remain substantially the same.

The Beveridge Report of 1942 was partly a response to the need to unite all the social classes in Britain to fight and win the Second World War after the class conflict of the 1930's. This was accompanied by the need and demand for massive state intervention in all spheres of economic and social life, and by a concern on the part of the upper classes that working class support in the economy should be ensured in the period of post-war recovery. The British people as

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(32) Ibid., p.26 ff.

a whole looked beyond the end of the war and was determined to ensure a better future (33).

The Labour Party was elected to power with a massive majority in 1945. It had a mandate from the electorate to make massive changes in the life of the nation, including initiating a state health service. Despite this, the Labour Party singularly failed in its response to government, made few radical changes, and adopted a positively conciliatory policy towards the ruling and upper classes. Navarro concludes that "It was never Labour's intention, either inside or outside the health sector, to shift the existent pattern of class control in British society." (34). Thus, although the N.H.S. was brought into being, this was done only at the cost of placating and favouring the interests of the most influential and upper class group within the health sector, i.e. the hospital consultants. This group was given priority in the system of rewards, (very good salaries augmented by undisclosed merit awards), practical control over the apparatus of production of human health resources, the possibility of private practice within the N.H.S., heavy influence 'tantamount to control' over the main decisionmaking bodies of the N.H.S., (local authorities were not to control the hospitals, and teaching hospitals were to be totally autonomous, being responsible only to the Minister of Health) and a pattern of class dominance and professional influence over the main administrative bodies of the

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(33) See ibid., Ch. 4.

(34) Ibid., p.46.

N.H.S. (35).

Turning to the 1974 re-organisation of the N.H.S. (36), Navarro argues that this must not be seen as emanating from within the health sector and its demands for better co-ordination and integration of services (37). Rather, the re-organisation must be regarded as emanating from the economic crises of the 1960's and from the Labour Party's desire to save the capitalist economy. By centralising the organisation and administration of the health services, a more economic and efficient organisation could be produced. The setting up of the R.H.A's and A.H.A's was fundamentally a managerial revolution along the lines of management developed in industry to maximise the exploitation of resources, both material and human (38). Navarro writes:

> Strengthening the central power of the N.H.S. has determined a further deepening of, primarily, the class dominance and, secondarily, the professional dominance of the system (39).

The new Health Authorities, like their predecessors, are dominated by members of the upper classes appointed ultimately by the Secretary of State. The voice of the

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(35) No other health workers were represented on the R.H.A's. Navarro goes on to show that this pattern of upper class and professional dominance has continued in the N.H.S. to the present day. See ibid., pp.44ff.

(36) See op.cit., ch.6.

(37) This is the interpretation of 'orthodox' commentators like Abel-Smith. See Abel-Smith, op.cit., p.50.

(38) In this connection, it is not surprising to discover that the American McKinsey Corporation of industrial management consultants had an enormous influence on the shape of the 1974 re-organisation proposals.

(39) Navarro, op.cit., p.58.

medical profession is very well represented. However, although the actual organisation has changed, few improvements have taken place in its actual functioning. There is little more integration of services, G.P's remain independent, local authority health services continue to exist, weakened by lack of funds and responsibility, and hospitals continue to dominate the R.H.A's and to take the vast majority of the N.H.S. budget.

Patients First continues in the same vein as the 1974 re-organisation. Although there is some de-centralisation of power to the local level and some elimination of bureaucratic tiers of management, the model of essentially centralised management remains (40). Efficiency and economy are the keynotes of the paper. No attempt has been made to increase democracy in the organisation. Rather, there has been a concerted attempt to eliminate non-professionals and laymen from the new D.H.A's. Representation from local authorities is to be reduced and the paper emphasises that nominees to the D.H.A's should not be chosen for their representative qualities but for "their personal qualities and their ability to bring a professional viewpoint to bear across the broad range of authority business". (41). Doctors will continue to be formally respresented, as will nurses, but no mention is made of other health service staff.

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(40) For criticism of this model see Stuart Heywood and Andy Alaszewski, Crisis in the National Health Service (London : Croom Helm, 1980).

(41) Patients First, para.23 (d). Emphasis added.

It appears, then, that as Britain faces a deepening economic crisis, that the basic tendencies described by Navarro of increasing centralisation, managerialism and professional dominance are developing and continuing in the health sector, although restructuring will allow more local responsiveness in the day to day running of the Health Service. These points will be touched on in more depth when the present functioning of the N.H.S. is considered. Before that, however, some space must be devoted to criticising Navarro's analysis of the history of the N.H.S.

Navarro's analysis of the history of the health sector is attractive and useful partly because it is almost the only systematic and comprehehsive account available but also because it is accessible, readable and uncluttered. However, it must be said that it is over-simplified and uneven in its shape and content. This means that there is a danger in it of justice being done neither to the complexity of the evolution of the health sector and the factors involved in that, nor to the Marxist perspective which has its own complexities (42). Examples could be multiplied of Navarro's over-simplification. Perhaps the best example is that of his treatment of the medical profession. It seems difficult to accept that doctors in the middle part of the present century can be thought to come from different social classes. In this century, even before the N.H.S. came into existence, it seems likely that while G.P's did not perhaps enjoy the prestige of their consultant brethren, they came from almost identical upper class backgrounds. So while there may have been a real division in the medical profession along class lines in the

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(42) See e.g. Karl Marx, Capital for an example of just how complex a comprehensive socio-political analysis can be .

last century, and while some of the effects of that divide may have survived until the 1940's, it seems naive to suggest that there is any real class divide between these two groups of doctors, even though their interests may be different. Again, Navarro's treatment of the Labour Party leaves much to be desired. Until 1946, the Labour Party is seen as the party of the working class. After its failure to make radical reforms in the running of industry and the country generally, Navarro treats it as a reactionary force. No explanation is given for this radical volte face which is surely of crucial importance. Similarly, Navarro's treatment of the external determinants of the health sector is remarkably uneven. Thus a detailed account of the class structure of nineteenth century Britain is given, but there is no similar account of the class structure of twentieth century British society and the way in which working class movements today are making an impact on the health sector.

The most detailed challenge to Navarro's analysis has come from Walters. In her book Class Inequality and Health Care (43), Navarro's whole analysis of the evolution of the N.H.S. is challen ged. Walters argues that there was no groundswell of working class demand for a national health service till the very last stage before the inception of the N.H.S. The demand came rather from the upper and middle classes who fell outside the provisions of the National Insurance Act and were hard pressed to pay medical fees. These classes also wanted to put health provision on a sound financial footing (44). Walters goes on to show that the N.H.S. has done nothing to close the gap in morbidity and

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(43) Vivienne Walters, Class Inequality and Health Care (London : Croom Helm, 1980).

(44) See Walters, op. cit., p.47f.

access to services that has always existed between the upper and lower classes, so that if the advent of the N.H.S. is supposed to be regarded as at least a partial victory for the working class, it is a hollow one. Ultimately, she suggests, the N.H.S. must be regarded as a triumph for the upper and middle classes who were chiefly responsible for its inception and have reaped most benefit from its existence. While Walters' evidence shows Navarro to be wrong in some fundamental aspects of his analysis, this does not invalidate the use of a Marxist paradigm for understanding the evolution of the nationalised health services. Rather, it requires that the emphasis in the analysis must be shifted from concentrating on the demands of labour to concentrating on the interests of the ruling class and its dependant classes as the driving force in the conflict of classes which determined the need for this new institution. As will be shown below, it is arguable that the advent of a centralised State health service can serve the interests of the capitalist classes much better than a fragmented service offering only private care (45).

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(45) Not only can a nationalised service offer cheap care to the upper and middle classes, it can also make available equipment which could not be afforded in the private sector. This has the desirable effect too of providing new markets for private industry which would not be available without state control and purchasing - several hospitals were close to financial ruin when the N.H.S. was introduced.

CHAPTER VI

A POLITICAL-ECONOMIC CRITIQUE OF THE FUNCTIONING OF THE CONTEMPORARY NATIONAL HEALTH SERVICE

Ehrenreich makes a useful distinction in looking at the two main strands of the radical critique of contemporary health service provision. One strand, the 'political-economic' critique, focuses on inequalities in health service distribution and on other factors which are chiefly concerned with the economic and social structure of society. The Marxist perspective has been very influential in this area, and its influence and concerns will be clearly seen in what follows below. However, it is important to mention and take account of the other main critical tradition currently used in evaluating the health services, the 'cultural critique'. This perspective, representatives of which include writers like Illich, McKeown and Cochrane, questions whether medicine as it presently exists is even desirable, as well as casting doubt on its efficiency and potential to enhance the quality of human life (1). Obviously writers within this broad tradition vary enormously in their approaches and emphases. It is still possible though to distinguish between essentially political critics and less politically concerned 'cultural' critics who have no stated political analytic position. That is not to say that there are no political and economic implications emergent from the 'cultural' critics.

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(1) See Ivan Illich, Limits to Medicine (London : Marion Boyars, 1976), Thomas McKeown, The Role of Medicine (Oxford : Basil Blackwell, 1979), A.L. Cochrane, Effectiveness and Efficiency (n.p. : Nuffield Provincial Hospitals Trust, 1971).

While the two strands of criticism mentioned above are not completely separable, (each can, and does, inform the other as will be argued below), the emphasis in this section will fall on the 'political-economic' strand. In discussing power and influence, the class structure of the workforce, various kinds of inequality, the influence of external profit-making interests and other questions concerning the contemporary N.H.S., questions about the value of contemporary medicine and its models and political implications will not be dealt with and these will be discussed later on. This omission is deliberate. It is remarked on here because its effect on the political-economic critique is to make it seem as if the basic concepts about medicine and health care are perfectly acceptable and uncontroversial and so all that is necessary is a change in the distribution and organisation of health services so that more people can influence its functioning and have greater access to its facilities. This is far from being the case (2).

In the account which follows two areas will be focused on and discussed. These are the areas of dominance and distribution, or influence and inequality, in the N.H.S. It will be argued that both power and resources are differentially distributed within the N.H.S. and that this uneven distribution reflects the pattern of inequality in society in general. That is to say that middle and upper class consumers and staff in the health service have considerably more influence and resources at their disposal than patients and staff from lower class backgrounds. An

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(2) For Ehrenreich's distinction see John Ehrenreich, ed., The Cultural Crisis of Modern Medicine (Monthly Review Press : New York, 1978), Introduction, p.1 ff.

attempt is then made to show why the N.H.S. functions in this unequal way by locating it within the wider context of capitalist society. Where appropriate the place of the psychiatric services will be specifically mentioned.

1. Dominance and Influence in the N.H.S.

Before describing the patterns of dominance and influence in the N.H.S. it is necessary to describe the composition of the workforce of that organisation. From the Marxist perspective, it is particularly important to try and give some account of the socio-economic background of the different elements within the workforce, and to a lesser extent of the class background of the consumers of health services provided by the N.H.S.

The N.H.S. employs over 750,000 people (3). Of these employees, 39% are para-medical workers, technicians, nurses, physiotherapists and the like. 54% are unskilled or semi-skilled ancillary workers. This means that only 7% of the workers in the N.H.S. are doctors (4). Navarro and Doyal point out that both in Britain and America, the division of labour within the health sector reflects the class division of society as a whole. Navarro writes:

> within the health team, we find a well-defined hierarchical order with the physician, most often a man of upper-middle class extraction at the top; below him, the supportive nurses, most often women with lower-middle class backgrounds; and at the bottom, under both of them, we find the

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(3) Abel Smith, op.cit., p.30

(4) Statistics from Lesley Doyal, The Political Economy of Health (London : Pluto Press, 1979).

attendants and auxilliaries, the service workers, who most frequently are of working class backgrounds (5).

In the light of the figures given above, it is interesting to note that decision-making in the N.H.S. is dominated almost entirely by two comparatively small groups, doctors and administrators. Both these groups, particularly the doctors, draw their membership principally from the higher social classes. (6)

Heller claims that the shape of the N.H.S. has been determined by the conflict between the two major decision-making groups within it, the medical profession and the management/administration.(7) Robson notes that the medical profession has been present since the very beginnings of the N.H.S., when doctors played a vital role in shaping the new service over against the interests of

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(5) Navarro, op.cit., p.87 Cf. Vicente Navarro, Medicine Under Capitalism (New York : Prodist, 1976) p.206: "Within the health sector, the state replicates the class hierarchy that characterizes capitalist societies...." About 75% of the N.H.S. workforce is composed of women but only 20% of doctors are female (Doyal, op.cit., p.202). Most women in the health sector are therefore working in the lower-status, lower-paid jobs - again this reflects the trend in society at large.

(6) For accounts of the upper class origins of doctors see e.g. John Robson, 'The N.H.S. Co.Inc?', International Journal of Health Services, 3, 3, 1973, 413-25, and Kennedy Cruickshank and Chris McManus 'Getting Into Medicine', New Society, 15th Jan 1976, 112-3.

(7) Tom Heller, Restructuring the Health Service (London : Croom Helm, 1978), p.11.

other groups. He points out that

> the Guillebaud Committee recommended in 1956 that medical representation on the Regional Hospital Boards ... and ... on the Hospital Management Committees ... should be reduced to no more than 25 per cent ... (8).

Again, he cites a 1964 study in which it was shown that 46% of members of R.H.B's had a medical background. Of these, 69% were professors, deans, or top consultants, and only a tiny percentage G.P's. This domination of policy-making bodies by doctors from the teaching hospital and acute sectors has had a very considerable effect on policy and spending in the evolution of the N.H.S. and is still operant today. This will be further considered when inequalities in the N.H.S. are examined (9).

The corollary of the medical domination of health service policy is that there is little representation of the interests of other groups. The general public is supposed to have a considerable influence on the policy of the N.H.S. However, the lay members of A.H.A's and R.H.A's are not elected to their positions and are nominated either by the Secretary of State or by other groups which are not necessarily representative of the population as a whole. There appears to be a considerable class bias in the membership of health authorities. So while the upper classes (social classes 1 and 2) form only a minority of the population of the country, they are over-represented on A.H.A's and R.H.A's. Tudor Hart reports that of the 281 members of these authorities nominated by the Secretary of State in 1973

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(8) Robson, op.cit.

(9) For the continuing dominance of doctors from the acute sector in determining the distribution of resources, see Haywood and Alaszewski, op.cit., especially Ch.6.

> 78 are bankers, company directors, business executives, property developers and brokers; 39 are doctors; and there are 19 solicitors, 6 accountants, 5 retired army officers, 3 ex-colonial governors and 24 other professionals. Representing the sons of toil, we have 6 farmers (1 lord and 1 knight), 11 shopkeepers, 10 supervisory staff, 18 full-time trade union officials, 3 railwaymen, 1 coalminer and 1 engineer. There are 4 of unstated occupation, and as most of the 53 women are listed as housewives, they are difficult to classify... . (10).

If the Health Authorities are composed of an unrepresentative, unelected group of people whose backgrounds are mainly among the upper classes and who therefore on the whole favour policies compatible with their own class in interests, it might be hoped that the Community Health Councils (C.H.C's) would provide a more democratic input into the N.H.S. However, they too have an unelected membership, appointed by the very Health Authorities whose work they are supposed to monitor and criticise. Membership is again unrepresentative, and in any case the power of the C.H.C's is severely limited. Without any executive power or real sanctions, their effect on policy-making in the Health

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(10) Julian Tudor-Hart, 'Industry and the Health Service' Letter to the Lancet, Lancet, 2, 1973, Sept. 15th. For class composition of British society see Ivan Reid, Social Class Differences in Britain (London : Open Books, 1977), p.63f.

Service has not been as great as had been hoped (11).

A very sizeable group within the workforce of the health service which represents many employees and has a democratic basis is the trade union movement. Potentially, this group can exert a great deal of 'grass roots' pressure from the lower classes on N.H.S. policy at all levels. Token recognition of the strength and importance of the unions is made in allotting a place for a trade union representative on the new D.H.A's proposed in Patients First (12). However, it is emphasised in that document that the trade unionist selected for membership of the D.H.A. should be nominated by the R.H.A. and not in any

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(11) In Patients First, the dissolution of the C.H.C's was proposed (Patients First para.45). In view of the relative impotence of these bodies in the Health Service, this may not have been a very bad idea. For a pessimistic account of the C.H.C's and their impotence, see Heller, op.cit., Ch.5. For an optimistic and more detailed appraisal see Ruth Levitt, The People's Voice in the N.H.S. (London : King's Fund, 1980). For a typology of representation in the N.H.S. see Chris J. Ham, 'Power, Patients and Pluralism' in Keith Barnard and Kenneth Lee, eds., Conflicts in the National Health Service (London and New York : Croom Helm and Prodist, 1977), pp.99-120. In this article, Ham comments concerning the C.H.C's that while some C.H.C's have been prepared to be critical and conflictual in relation to their A.H.A's

> the majority ... have tended towards the consensual end of the role spectrum. They exhibit many of the attitudes formerly associated with the H.M.C's (Hospital Management Committees), are deferential to officers, believe they have to earn the respect of those in authority, and espouse a philosophy which emphasizes responsibility.

(Ham, op.cit., pp.103-4.)

(12) See Patients First, para.23c.

sense elected by the staff of the N.H.S. (13).

Over the past decade there has been growing militancy and self-awareness amongst health sector trade unions. Most union concern and action has been directed towards better pay and conditions for members. Some effort has been given to wider issues of policy such as resisting cuts in the N.H.S. and trying to eliminate private beds within the service It may be that as cuts in services continue, trade unions will become even more involved in issues of policy. At the moment, however, Heller concludes that the impact of the unions is not as great as it might be. Since they have no plans for themselves for developments in the health services, they can only react to plans set out by management and they remain relatively ineffective (14).

In conclusion, it can be seen that policy decisions in the N.H.S. are, for the most part, in the hands of a very unrepresentative cross section of the population. There is a distinct bias in decision-making bodies towards the upper social classes who form only a minority of the consumers and providers of health services. Doctors in particular have a vastly disproportionate influence on policy, and they come mainly from upper class backgrounds. Bodies which might be expected to correct this bias and put the point of view of the lower class majority, e.g. C.H.C's and trade unions are relatively impotent and ineffective.

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(13) Patients First, see para 23d.

(14) For accounts of the place and development of union activity in the N.H.S. see Heller, op.cit., Ch.5, Widgery op.cit., Ch.8, Stuart J. Dimmock, 'Participation or Control? The Workers' Involvement in Management' in Keith Barnard and Kenneth Lee, eds., Conflicts in the National Health Service, (London and New York : Croom Helm and Prodist, 1977), pp.121-44.

There is no direct representation of the majority of patients or staff by members of their own class.

2. Inequalities of Provision in the N.H.S

The present policies implemented in the N.H.S. give rise to several kinds of inequality of health service provision. These inequalities are now discussed under three headings: geographical inequality, class inequality and inequality between different areas -of the health sector. Coverage of these areas will be variable as they are not all equally important for present purposes.

Geographical Inequality

Some impression of the kinds of geographical equality within Britain within the N.H.S. may be gained from Robson (15). Robson clearly shows that over a wide range of measurements there is a substantial bias of resources towards London and the south east, and away from the other regions. Even within regions, however, there are geographical inequalities of provision (16). It is this form of inequality which has caused Tudor Hart, a socialist critic of the Health Service, to coin the term 'the inverse care law'. This 'law' states that "the availability of good medical care tends to vary inversely with the needs of the

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(15) See Robson, op.cit.

(16) See Heller, op.cit., p.50f, for a detailed analysis of geographical inequality of provision in one particular region.

population served" (17). Since morbidity and mortality are more prevalent among the lower classes and they therefore have greater needs of health service provision, the regions which have the greatest lower class population also have least provision. This means that areas like South Wales, the North of England and inner city areas generally have less resources than areas with a greater upper class population (18).

With specific reference to psychiatric facilities in different parts of the country, no figures are readily obtainable concerning differential regional expenditure. It seems reasonable, however, to extrapolate from the findings above to say that shortage of provision in general is bound to have an effect on facilities for the mentally ill. Less provision of primary care must obviously affect the mentally ill and their treatment as much, if not more, than any other group of potential consumers of health services. Similarly, reduced capital and expenditure within and between regions must affect the amount of money available

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(17) Julian Tudor Hart 'The Inverse Care Law' in Caroline Cox and Adrianne Mead, eds., A Sociology of Medical Practice (London : Collier Macmillan, 1975), pp.189-206, p.205. Tudor Hart adds that

> the force that creates and maintains the inverse care law is the operation of the market and its cultural and ideological superstructure which has permeated the thought and directed the ambitions of our (medical) profession during all of its history.

(18) See Doyal, op.cit., p.197, on the differential geographical distribution of resources, also D.H.S.S., Inequalities in Health (London : D.H.S.S., 1980), 4.35ff. For differential distribution of classes in different areas of the country see Reid, op.cit., p.65ff. For higher morbidity and mortality among the working and lower classes see D.H.S.S., op.cit., Chs. 2 and 3, and Walters, op.cit., pp.117ff.

for psychiatric services, including hospitals. It seems reasonable to suggest, therefore, that in general psychiatric services in poorer regions are less well financed than those in wealthier regions. In the light of the fact that working class people seem to suffer greater psychiatric morbidity than those in higher classes, it is possible to suggest that demand for psychiatric services and treatment is likely to be higher in the very areas where services are most in short supply. Brown et al. concluded that "the same social factors that increase the risk of psychiatric disorder greatly reduce the chances of reaching psychiatric services." (19).

Class Inequality

Class inequality in health care provision is very difficult to measure, although it is very important in assessing the effectiveness and fairness of the N.H.S. The difficulty arises because "so few studies have questioned whether working class patients are disadvantaged in their access to medical care." (20). The dearth in such investigation is ascribed by Walters to the assumption that the N.H.S. has eliminated any differentials that there may have been between consumers of different social classes over the last 30 years. Walters disputes this assumption and using such material as is available, shows that not only are morbidity and mortality rates higher among the lower classes, but also the greater needs of the lower classes do not correspond with greater access to services. She states that

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(19) G.W. Brown, Maire Ni Bhrolchain and Tirril Harris, 'Social Class and psychiatric Disturbance Among Women in an Urban Population' Sociology 9, 1975, 225-54.

(20) Walters, op.cit., p.140. This point is also made in D.H.S.S., op.cit., Ch.7.

> a variety of studies indicate class inequalities in access to care under the N.H.S. Working class patients consult with G.P's less frequently than we would expect on the basis of certain measurements of morbidity and there is evidence that the care they receive is of lesser quality than that received by middle class patients (21).

Walters also points out that

> while it is not altogether clear whether working class patients are disadvantaged in their access to N.H.S. hospitals, the availability of private health care represents the institutionalisation of class inequalities in access to hospital care (22).

That is to say that while the utilisation of private care is always a possibility for the more affluent classes in society, and therefore access to hospital care can be obtained as and when necessary, this is not at any time a real option for members of the lower classes (23).

From the evidence available it seems more than likely that there is differential access to health care services according to social class position. It is difficult to evaluate how far this class related differential access affects the mentally ill. Once again, the shortage of primary health care services must have an effect on potential or actual psychiatric casualties. For example, difficulty of access to a G.P. may be a contributory factor in mental disorder not being treated at an early stage and so leading to the necessity for more radical treatment, e.g. hospitalisation

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(21) Walters, op.cit., p.140

(22) Walters, op.cit., p.153

(23) See also Heller, op.cit., p.40f, where the point is made that effectively the upper classes use the N.H.S. to subsidise their treatment rather than depending on it entirely for health care. They thus obtain better care.

at a later stage. Again, doctors may be more willing to take time and trouble with higher class patients than with lower class patients. Some of these points will be explored in greater depth at a later point. It is questionable whether in the case of the psychiatric hospitals there is negative discrimination access towards the working class. Although this may come into play in the case of D.G.H. psychiatric units, the stigmatising nature of the old psychiatric hospital may in fact mean that there is positive discrimination in favour of the lower classes in these institutions. It seems likely that higher class people are treated in other settings to a greater extent wherever possible.

Inequality Between Different Sectors of the N.H.S.

Apart from the inequalities of provision between different geographical areas and different social classes, there are considerable inequalities of resources between different sectors and specialities in the N.H.S. These are of particular interest and relevance when it comes to a consideration of the psychiatric sector.

Several types of inequality of resources can be identified. For example, very little is given to preventive medicine, while a large amount is devoted to acute and institutional health services (24). This fact is not surprising given that doctors have a disproportionate influence over N.H.S. policy-making and that they work on a model of acute internal intervention rather than one of prevention (25).

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(24) See Heller, op.cit., p.50

(25) McKeown describes the basic medical model thus: "It is assumed that the body can be regarded as a machine whose protection from disease and its effects depends primarily on internal intervention".(Op.cit., p.xvi.)

Coupled with the fact that "the medical profession ... in pursuing its own aims, is not necessarily acting in the best interests of the health service, or the majority of the community" (26), much of the bias towards acute services is explained. Later on, this bias and the hegemony of the acute model will be discussed in greater detail but now I will turn to the discrepancy of resources given to the psychiatric sector as compared to that expended on the acute medical sector.

Although in many ways the psychiatric services adopt the institutional and acute models of treatment in their approach to the mentally ill, they do not obtain the level of resources which they both need and deserve. In 1971, about 30% of all N.H.S. hospital beds were occupied by the mentally ill (27). This is certainly not reflected in the weighting of resources available in the psychiatric sector. Only 11% of all hospital consultants are psychiatrists. Only 20% of all nurses work in psychiatric hospitals or units. A consultant psychiatrist has an average of 154 in-patients to care for, while his non-psychiatric colleague has only about 30. In psychiatric hospitals there are an average of around 36 nurses to every 100 patients, while non-psychiatric hospitals have an average of 121 nurses for every 100 patients (28). Examination of cost per in-patient bed per week reveals that at the same time that it cost £131.50 to maintain a patient in a teaching hospital and £104.78 in a non-teaching acute hospital, only £36.60 being expended on each patient

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(26) Heller, op.cit., p.34.

(27) Anthony Clare, Psychiatry in Dissent, First Edn., (London : Tavistock, 1976), p.381.

(28) 1976 D.H.S.S. figures quoted in Doyal, op.cit., p.196.

in psychiatric hospitals. It is doubtful that this discrepancy can be accounted for entirely by the greater medical needs of patients being treated in the acute sector. It seems fairer to conclude that the needs of patients in the psychiatric sector are simply not being properly met. The majority of patients in psychiatric hospitals live in inadequate, over-crowded, depressing conditions. The buildings are ancient and out-moded (29). There are insufficient medical and nursing staff to permit anything more than drug therapy, custodial care and basic physical nursing in many parts of many hospitals. Physical conditions are often bad, resources for up-grading are scarce and the staff may be ill-trained, over-worked and demoralised. Many of these ills must be accounted for to a large extent by lack of resources.

Further analysis of the situation of the contemporary mental hospital's situation follows later. It is now necessary to turn once again to the Marxist perspective in order to try and account for the inequalities which have been described and also for the nature of power and influence in N.H.S. policy-making.

3. Discussion

The question of why N.H.S. policies are determined principally by unrepresentative members of the upper classes need not be discussed in detail here. It is sufficient to

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(29) 65% of psychiatric hospitals were built before 1891 and 40% are over 100 years old. See Clare, op.cit., p.381.

refer back to the previous discussion of the composition of state institutions above. It was seen there that all State institutions tend to be dominated by members of the upper classes. This means that they make policies which are fundamentally compatible with their own interests and so with the capitalist order of society.

Many of the inequalities mentioned above owe their origins to policies which are compatible with the interests of the capitalist classes in society. The correction of these inequalities would demand actions or policies which would be essentially inimical to the interests of the ruling class. For example, greater provision of health care facilities in areas which are currently deprived of such facilities might demand a cut in services in areas which have a substantial upper class population. Alternatively, it might demand greater public expenditure and/or taxation. It could also require the direction of the labour force, particularly the medical sector of it. Any or all of these features would appear very unattractive to upper class policy-makers, of whom doctors form a vociferous and influential part (30).

The bias towards acute medicine in the N.H.S. in general, and the hegemony of doctors and their medical model requires more explanation. McKeown and other writers have demonstrated convincingly that the techniques of acute medical intervention have had remarkably little impact on disease and ill health

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(30) This is not a speculative assertion. In 1980 similar measures to these were proposed in the D.H.S.S. report 'Inequalities in Health'. They were rejected by the Conservative Secretary of State for Health and Social Security in his preface to the report.

in British society, as compared to that of environmental and nutritional changes. Many diseases common in our society could be reduced or eliminated by preventive social or environmental measures. However, the State fails to implement such measures, and concentrates instead on providing expensive curative facilities of dubious value. Prevention and care take a very secondary role in health care policy.

This paradoxical situation can be understood by asking which wider interests in the socio-economic order are being served by this arrangement. On the broadest level, the answer to this question is that the needs and interests of the capitalist order of society are being met by the dominance of the acute model of medical intervention. The provision of acute medical facilities to deal with individual pathology prevents questions being asked about wider social and economic changes which would adversely affect the capitalist order. At the same time, acute facilities serve the function of making citizens feel that the capitalist State cares for them thus legitimating the status quo of the social order (31). Powerful private interest groups in the upper classes gain a great deal from the hegemony of the acute model. Industry, for example, can make enormous profits from the sale of drugs and sophisticated

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(31) Walters comments:

> The State has served an ideological function, in that it has helped to create a belief in the decline of class inequalities and permitted an interpretation of continuing inequalities in terms which emphasise the individual's responsibility for his or her own health.
>
> (Walters, op.cit., p.160).

equipment to the N.H.S. (32). Hospital consultants too can command high salaries on the basis that they alone have the necessary expertise to apply technology to the cure of patients. At the same time they can supplement their incomes with private practice in N.H.S-subsidised facilities (33). Neither preventive medicine, demanding changes in the socio-economic order, nor care of the chronically ill, would be nearly as lucrative or favourable for the capitalist classes. (Arguably, neither of these emphases would require the services or dominance of doctors trained specifically in acute medical skills).

The upshot of the dominance of the acute model of medical intervention in the lives of individuals is that more caring or preventively-oriented parts of the N.H.S. like the psychiatric services are neglected. Since these sectors do not have a powerful or influential clientele this situation is unlikely to change unless the socio-economic order of society changes to allow different priorities to come to the fore.

Waitzkin and Waterman have pointed out that "the sick do not suffer in isolation from the broad socio-political structures of the society in which they live." (34). They further assert that "the organisation of health services

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(32) See Heller, op.cit., p.35f, Widgery, op.cit., Ch.6., Brian Abel Smith, Value for Money in Health Services (London : Heinemann, 1976), Ch. 6., especially p.87ff.

(33) See Doyal, op.cit., pp.181-2, 188f, Widgery, op.cit., Ch. 7., Heller, op.cit., p.40f.

(34) Waitzkin and Waterman, op. cit., p.8.

within a given society depends to a great extent on its broad socio-political context." (35). That this is the case in the British N.H.S. has now been argued from a Marxist perspective.

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(35) Ibid., p.15.

SUMMARY

The purpose of this first Part has been to set the stage for the more specific examination of the socio-political context of the psychiatric hospital which follows. I have attempted to justify and expound the use of the Marxist perspective, given some account of the Marxist perspective on the State and compared this with other perspectives in relation to the provision of welfare. Subsequently, I have turned to the history and functioning of the National Health Service as a particular institution within the Welfare State. In this context I have endeavoured to point up issues of inequality and power and to show how these may be linked to the wider functioning of the socio-economic order of the country as a whole.

This very broad survey provides a necessary backdrop for the consideration of the psychiatric hospital as a particular social institution existing at a certain time and for a specific function within a definite socio-political order. It is now possible to go on to examine that institution more closely before turning in Part Four to the place of pastoral care within it.

PART THREE

THE PSYCHIATRIC HOSPITAL

INTRODUCTION

Having described the broad socio-political context in which the psychiatric hospital is situated, it is now appropriate to undertake a closer and more specific analysis of this institution. Throughout the chapters which follow once again broader social and political factors and their influence are emphasised. As far as possible, the whole is fitted into a Marxist perspective.

The analysis which follows begins with an account of the evolution of the psychiatric hospital from the beginning of the nineteenth century to the present day. This shows how this institution has its genesis and evolution shaped by the needs of a particular socio-economic order. The contemporary hospital is then considered with particular reference to its goals and organisation. An investigation of the social groups within the hospital is then undertaken and attention is given to the major social divide between patients and staff. Subsequently the different patient and staff groups are considered in more detail. After this, models of mental disorder and their socio-political implications are discussed. This leads to an examination of modes of treatment available in the hospital and the social and political concomitants inherent in them. The analysis of the socio-political context of a particular form of pastoral care is thus completed and the way is then clear for Part Four which examines the practice, theory and theology of pastoral care in psychiatric hospitals more specifically (1).

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(1) It will be seen that I rely in this Part to a large, though not exclusive, extent on North American literature on the nature and function of psychiatric hospitals. Similarly, many of the works cited are now somewhat

dated, most having been published before 1970. It must, therefore, be recognised that there is a real danger of anachronism and inaccuracy in describing the contemporary mental hospital using these sources. Unfortunately, however, these are the main sources available and, in any case, it seems unlikely that psychiatric hospitals have changed altogether beyond recognition in the meanwhile given the lack of resources made available to them. It seems reasonable to attribute the lack of very much research into these institutions in the last decade or so to the current emphasis on community, rather than institutional, care for the mentally disordered in both Britain and the U.S.A.

CHAPTER VII

THE EVOLUTION OF THE PSYCHIATRIC HOSPITAL

Having spent some time in considering the N.H.S. as a whole in the context of the Marxist socio-political perspective, I will now go on to look at the psychiatric hospital as a particular institution more specifically. To this end, a history of the evolution of this institution will be given. This will be based on Jones' standard history of the British mental health services (1). This 'orthodox' account will then be examined from a Marxist perspective, outlined principally by Scull (2).

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(1) Kathleen Jones, A History of the Mental Health Services (London : R.K.P., 1972). Further material relating to the history and background of the psychiatric hospital in Britain and abroad is to be found in Patricia Allderidge, 'Hospitals, Madhouses and Asylums : Cycles in the Care of the Insane.', British Journal of Psychiatry 134, 1979, 321-4, Vieda Skultans, English Madness (London : R.K.P., 1979), Michel Foucault, Madness and Civilization (London : Tavistock, 1971), Andrew Scull, ed., Madhouses, Mad-doctors and Madmen (London : Athlone, 1981), and in Klaus Doerner, Madmen and the Bourgeoisie (Oxford : Blackwell, 1981). An interesting account of the development and conditions in one particular asylum is to be found in John Walton, 'The Treatment of Pauper Lunatics in Victorian England : The Case of Lancaster Asylum 1816 - 1870' in Andrew Scull, ed., Madhouses, Mad-doctors and Madmen (London : Athlone, 1981), pp.166-97.

(2) Throughout this section material on the changing ideas of the nature of mental illness, the place of the medical profession and legislative developments will be given only minimal coverage. It is inevitable, however, that they be included to some extent, as they have a vital bearing on the nature and function of the psychiatric hospitals. More coverage of these topics will be given later on in the present work.

Despite their physical prominence in Britain today, the large mental hospital has not always been a feature of the landscape. Before the eighteenth century, there was only one hospital in this country exclusively for the insane (or mentally ill, as they are now called). This was Bethlem, founded in London in 1377. Even during the eighteenth century there were, for the most part, no public facilities for dealing specifically with the insane. Some of the mentally ill were accomodated in small privately run madhouses. Most were looked after in their own homes by their families (aided towards the end of the century by outdoor relief provided by the parish under the Poor Law), in ordinary poor houses and workhouses, or in prisons or Bridewells. It is thought that more than 4,000 insane persons were in work- and poor houses before 1789 out of a total national population of around five and a half million (3). In penal and Poor Law institutions the insane were undifferentiated from other inmates and no special provision was made for them (4).

The first formal differentiation between the insane and other dependant groups in society came with the revision of the Vagrancy Laws in 1744. The new legislation enacted in that year provided for the insane to be sent to special accommodation as and where it was provided. The task of identifying and disposing of the insane fell to law legal officials in the form of gaolers and magistrates.

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(3) Jones, op.cit., p.18.

(4) A situation with striking parallels to the present situation in hostels and shelters for the down and out. See further below.

Thirty years after this, in 1774, an Act for Regulating Private Madhouses was passed. This was a response to the illegal imprisonment of those who were not insane in private madhouses. Its provisions, which did not affect public institutions containing insane people, made it necessary for madhouse proprietors to obtain a licence. Proprietors also had to allow inspection of their premises by the Metropolitan Lunacy Commissioners (in London) or by two magistrates and a physician elsewhere in the country. These officials had no sanctions by which they could bring pressure for reform on proprietors if conditions were found to be bad. Madhouse owners were also required to notify the relevant authorities of the reception of any new inmates (5).

The latter part of the eighteenth century saw the rise of a new kind of institution, the subscription hospital for the insane. In 1751, St Luke's hospital was founded in London. This was followed by the Manchester Lunatic Hospital in 1763. In 1792 the York Retreat was founded by the Religious Society of Friends. These institutions aimed to provide more humane and adequate treatment, care and cure. However, treatment, with the exception of that at The Retreat, remained custodial and mechanical. At The Retreat, 'moral treatment' was used. This was based on kindness, common-sense and 'Christian' principles. The behaviour of patients was firmly but gently modified until they could be restored to reason and to their place in society (6).

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(5) Jones, op.cit., p.28f.

(6) For a description of moral treatment and its ends, see Skultans, op.cit., pp.52-68.

The asylums mentioned above were built for a small number of patients. It was not until 1808 that the growth of asylums (as they were to be called) received its main impetus and the reform movement began to get properly under way. As a result of a Select Committee of Parliament into the state of criminal and pauper lunatics in England and the laws relating to them, the insane were, for the first time, formally differentiated from criminals and other paupers. This distinction was made to facilitate the reform of the Poor Law and the criminal laws. The findings of the Select Committee led to the enactment of the 1808 County Asylum Act, which enshrined the principles of public care for the insane, non-deterrent treatment, and concentration on the causes rather than the symptoms of insanity. The Act was permissive rather than obligatory, so only nine counties erected special asylums for the insane before 1828. However, it was this piece of legislation and the institutions which were built as a result of it which laid the foundations of the major development of the asylum which was to take place later in the nineteenth century (7).

Public concern about the state of the insane and their conditions grew throughout the second decade of the nineteenth century. Both private and public facilities were found to

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(7) See Jones, op.cit., Ch.3, for the beginnings of the asylum movement.

be inadequate, indeed scandalous (8). A Select Committee was therefore appointed to look into the situation of the institutionalised insane. Attempts at reforming legislation failed in Parliament however and the reform movement faltered between 1819 and 1827. In the latter year, another Select Committee was convened to look into the state of pauper lunatics in the metropolis. The investigations of this committee led to the 1828 County Asylums Act, a consolidating and centralising measure, and the Madhouse Act whose chief innovation was to place the power of inspection of private madhouses with a statutory body of Commissioners appointed by the Secretary of State for the Home Department rather than with the medical profession (9).

Throughout the period 1800-1844, treatment of the insane remained very poor. Despite lip-service paid to the ideas of moral treatment, most asylums depended chiefly on restraint and custodial methods. They were often over-crowded and short-staffed. Staff were in any case mostly poorly qualified. These features were to continue throughout the

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(8) The exposure of the scandal of the conditions in institutions designed for their care and rehabilitation runs like a leitmotif through the whole history of the asylums and psychiatric hospitals. Belknap has pointed out the recurrent pattern of public scandal, temporary improvement, public apathy and the consequent deterioration of conditions, followed once again by outcry and scandal. This pattern persists to the present day. See for example the reports of the committees of enquiry into psychiatric hospitals published in the last decade or so. Belknap's description of this pattern is to be found in Ivan Belknap, Human Problems of a State Mental Hospital, (New York ; McGraw-Hill, 1956), pp.vii-viii.

(9) See Jones, op.cit., Ch.4, for the above.

nineteenth century and into the next century (10). Visiting magistrates were dilatory and quiescent in the pursuit of their inspection duties. Superintendents were often absent. Many patients were illegally detained. Only in exceptional places like The Retreat and Hanwell was humane, non-restrictive treatment really implemented. Despite the Poor Law Amendment Act of 1834, about 4,000 pauper lunatics continued to be accommodated in workhouses where no separate provision was made for them. This was due to the lack of space in the asylums (11).

In the 1840's the reform movement entered a new phase in its development under the leadership of Lord Ashley, later Earl of Shaftesbury. An Act was passed in 1842 empowering the Metropolitan Lunacy Commissioners to inspect all asylums and madhouses in the country. The Commissioners reported to Parliament in 1844 and as a result a Lunatics Bill was introduced and passed in the next year. It tightened up the form of certification of patients to prevent illegal detention. Further, all institutions for the insane were required to possess an admissions book. Three Amending

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(10) See Jones, op.cit., p.96. One of the most interesting features of the development of asylum facilities in the nineteenth century is that supply of facilities was always exceeded by demand. Thus while the average size of the nine asylums built before 1827 was 116 beds, by 1870 the average asylum accomodated 542 beds and asylums built for small numbers had to cope with many more patients than their facilities were intended to cater for. This, among other reasons, is why moral treatment was not a feasible proposition in many institutions. Rothman notes a similar development in North America. See David J. Rothman, The Discovery of the Asylum (Boston : Little Brown, 1971). Cf. Jones, op.cit., pp.226-7.

(11) See Jones, op.cit., Ch.5, for the above.

Acts were enacted in 1853 which consolidated the Lunatics Act. The second of these made the setting up of county and borough asylums for insane mandatory (12).

It was this legislation which solidified the pattern of asylum provision which was to dominate mental health care services for over a century. The latter half of the nineteenth century saw the consolidation of the asylum at the centre of provision for the insane. Perhaps the most significant development in policy during this period was the growth of legal safeguards to prevent wrongful detention. Rather than developing along social, humanitarian lines, or along medical lines, asylum reform became dominated by legal procedure. These legal reforms culminated in the Lunatic Acts Amendment Bill of 1888 which was passed by Parliament in 1890. This made a magistrate's order necessary before anyone could be committed to an asylum, and also made numerous other detailed provisions about the admission, treatment, restraint and discharge of patients who were to be the legal responsibility now of the Lord Chancellor. Such legal domination, while it carefully protected the rights of the citizen, made medical treatment of the insane very difficult. Early diagnosis and treatment were hindered by the need for a lay magistrate to be able to recognise that a person was insane, since asylums could only admit those who had been certified by a Justice of the Peace. Many of the cases which could have been treated in the asylum were missed out on because of this. At the same time, good doctors and staff were unwilling to work in asylums where the population was composed of chronically ill patients for whom little could be done. Because of these legal restrictions therefore, the new methods of care and treatment of the mentally disordered

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(12) See Jones, op.cit., Ch.6, for the above.

had to develop elsewhere (13).

At the beginning of this century, little had changed for the better in the asylums. The poor conditions were exacerbated by the First World War which deprived these institutions of large numbers of staff, some of them experienced and able. Dr Montague Lomax's book The Experiences of an Asylum Doctor caused an outcry on its appearance after the end of the war and led to the 1922 Enquiry into conditions at Prestwich Hospital. This enquiry found that facilities and staffing were far from adequate, findings which would have been true of many asylums at the time.

As the twentieth century has progressed, the legal dominance over the treatment of the insane has given way to medical dominance. For various reasons, discussed at greater length below, insanity came to be regarded as analogous to physical illness and doctors rather than lawyers became the group chiefly responsible for defining and treating disorders of the mind.

In 1918, the Board of Control recommended reforms such as the possibility of voluntary admission for short periods, wider provision for voluntary treatment, treatment in general hospitals, grants for after-care services and higher medical qualifications for psychiatrists. Because no money was made available, these reforms were mostly discarded.

The year 1919 saw the formation of the Ministry of Health which took over responsibility for the asylums, thus ending their long association with the Poor Law administration. Soon after this, in 1923, the Maudsley Hospital was given

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(13) See Jones, Ch.7 for the above.

special Parliamentary permission to accept voluntary patients. The general move away from compulsory care and containment in asylums and towards an illness model of mental disorder to be treated as any other illness might be as far as possible was continued by the Royal Commission on Lunacy and Mental Disorder which reported in 1926. This report decisively changed the emphasis in dealing with the insane from one of detention to one of prevention and treatment. It further recommended that treatment for mental disorder should be as analogous as possible to the treatment of physical illness. Many of the report's recommendations were incorporated into the 1930 Mental Treatment Act (14). Under its provisions, the Board of Control was re-organised, voluntary treatment and admission was permitted, outpatient clinics and short-term observation wards were encouraged, and terms like 'lunatic' and 'asylum' were replaced by medical terms like 'person of unsound mind' and 'hospital'. Many people would see this Act as both the continuation of the humane traditions of the early nineteenth century and also the beginning of modern medically-orientated psychiatric methods.

Jones regards the 1930's as a time of great improvement in the mental hospitals and also in other services for the mentally ill. The Board of Control was able to campaign for better conditions for patients in terms of better clothing, occupational and diversionary therapy, limited integration between men and women and some opening of locked wards. More, and better calibre, staff were attracted into the psychiatric services and there were the beginnings of more specialised training for these workers. Social workers and occupational therapists began to appear at about this time. Some attempt was made to produce integrated hospital and community services.

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(14) For further details of this see Jones, op.cit., p.249f.

However, such attempts were few and far between due to lack of local authority interest and finance. The Feversham Report on voluntary agencies in 1939 emphasised the growing importance of community care, but further developments in this direction were postponed by the war (15).

For the mental hospitals, the most important event to take place immediately after the war was their integration into the National Health Service. Since the inception of the N.H.S. mental hospitals have been regarded as essentially the same as all other hospitals. During the late 1940's and early 1950's, the innovations initiated by the 1930 Act continued, especially those concerned with the development of local authority services.

Within the hospitals themselves in this period, new therapies and forms of organisation were experimented with. Maxwell Jones, for example, began his experiments with therapeutic communities and the levelling of hierarchies in the hospital. David Clark and others experimented with 'administrative therapy', i.e. organising the hospital in such a way as to maximise the patient's chances of recovery and rehabilitation (16). Open doors, day hospitals, outpatient clinics, hostels, industrial and occupational therapies, and general hospital psychiatric units, amongst other things, all became more common and combined to make the mood of the mental hospitals much more optimistic.

The administrative, social and therapeutic community experiments in the mental hospitals may be seen as linear

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(15) For the above, see Jones, op.cit., Chs. 9 and 10.

(16) See further David Clark, Administrative Therapy (London : Tavistock, 1964).

descendants of the moral treatment concepts developed early in the nineteenth century. The drug treatments which developed in the 1950's were an entirely new factor in the treatment of the mentally ill. The discovery of the chlorpromazines which could extensively modify the symptoms of those suffering from previously intractable psychoses opened the way to patients going back into the community and also allowed many more possibilities within the hospitals themselves. Custody and restraint could thus give way to therapeutic optimism (17).

Administrative and pharmacological reforms were accompanied by a complete revision of the legislation relating to the mentally ill. A Parliamentary debate in 1954 recognised once again that there were considerable deficiencies in provision of facilities for the mentally ill, and that there was a lack of staff, money, buildings, beds and research for this part of the health sector. A Royal Commission was therefore inaugurated to perform a comprehensive investigation of the situation of the mentally ill and mentally defective. This body reported in 1957 and the result of its work was the Mental Health Act of 1959. From the point of view of the mental hospital, the most important features of the Act were firstly, that it confirmed the use of the medical model of mental illness and so affirmed the centrality of the role of doctors within the hospital; secondly, that it continued to emphasise voluntary rather than compulsory admission and treatment wherever possible; and thirdly, that it gave much scope (but no money) for local authorities to provide community services for the mentally ill. In many ways, the Mental Health Act and the developments

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(17) For these developments see Jones, op.cit., p.283ff.

of the decade preceding it must be regarded as the beginning of the modern era in the mental health services in general and in the psychiatric hospitals in particular (18).

During the 1960's there was an increased impetus to move both sufferers from mental disorder and services for them into the community. Enoch Powell as Minister of Health talked of mental hospitals as 'doomed institutions' in 1961 (19). He outlined a policy in which there would be a gradual reduction of mental hospital beds while community services increased. In this way, be believed, 75,000 beds could be emptied by 1975. Community care and hospitalisation in small District General Hospital Units would replace long term institutional care in the mental hospitals. The 1962 Hospital Plan for England and Wales expands on Powell's assertions (20). It states that

> it is now generally accepted that short-stay patients should be treated in units nearer to their homes than is generally possible in large isolated mental hospitals and that it will usually be desirable to have these units attached to general hospitals. The plan therefore provides for a considerable increase in the number of short-stay units of this kind. To ensure adequate treatment they will need to be of a certain size, which will range from 30 beds up to 60 or more depending on the population to be served... In this new pattern there will be no place for many of the existing mental hospitals (21).

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(18) For more about the Act see Jones, op.cit., Ch.12.

(19) Quoted in Jones, op.cit., p.322.

(20) See Ministry of Health, A Hospital Plan for England and Wales (London : H.M.S.O., 1962).

(21) Ibid., para.27. Emphasis added. See also para.17 for reasons behind this policy towards the mentally ill and para. 41 for details of the expansion of community services.

The move towards community care backed up by small District General Hospital psychiatric units was fuelled further by a strong public reaction against the old mental hospitals. During the 1950's and 1960's several apparently damning sociological studies were produced, mainly in the U.S.A. The most famous of these was Goffman's Asylums. However, Barton's book on British hospitals, Institutional Neurosis, which showed the negative effects of the large mental hospitals on their patients, probably had more real influence on the actual running of these hospitals (22).

The policy proposed by Powell is essentially the one which is currently in operation in the provision of services for the mentally ill. Its basic tenets have been re-affirmed in documents like Hospital Services for the Mentally Ill and Better Services for the Mentally Ill (23). It has, however, become increasingly obvious that the large psychiatric hospitals are not going to be closed down entirely. This is acknowledged in Better Services for the Mentally Ill (24), and more explicitly by the Royal Commission on the N.H.S.(25). Until now only one hospital has been closed (26). This

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(22) See Erving Goffman, Asylums (Harmondsworth : Penguin, 1968), Russell Barton, Institutional Neurosis, Third Edn., ((Bristol : Wright, 1977). These works along with more of the American studies are considered and used at a later point in the present work.

(23) D.H.S.S., Hospital Services for the Mentally Ill (London : D.H.S.S., 1971) and D.H.S.S., Better Services for the Mentally Ill (London : H.M.S.O., 1975).

(24) Op.cit., 11.5.

(25) See Royal Commission on the National Health Service, Report, 10.60.

(26) Ibid., 10.55.

apparent reprieve for the mental hospitals is a recognition of the fact that community services are not, and cannot be, adequately financed in the foreseeable future (27) and that a new long-stay psychiatric population is beginning to emerge (28). It is important to recognise that the hospital population has been reduced by the current policy (29). However, there seems little chance that it will be reduced to nothing when few other facilities in the community are available. Abel-Smith notes that

> only about one-third of districts provide a comprehensive psychiatric service in their general hospitals, only a fifth of the 30,000 places needed in day centres are provided and only a third of the 12,000 places needed in residential homes. Adequate accomodation for mentally infirm old people is sadly lacking (30).

Both the hospital and the community services are bound to be badly hit by the economic recession, so there is little hope of a change for the better (31).

The account given above of the history of the mental hospital has several weaknesses. It fails to consider several vital and relevant factors which are of great importance if the full significance of the emergence of these institutions is to be understood. Jones, in common

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(27) See Better Services for the Mentally Ill, Foreword, para.10.

(28) See ibid., 4.52f.

(29) See Table 4 in Jones, op.cit., p.358.

(30) Abel-Smith, National Health Service - The First Thirty Years, p.54.

(31) Heller notes that, despite the intentions of government to devote more money to mental health services, expenditure has not increased since 1970-71 and in one year 1975-76 it actually fell. See Heller, op.cit., p.97.

with most writers on the mental hospital, omits to look at the hospital in its wider social and historical context. Its role as an institution of social control is not examined. The socio-economic factors which affected the emergence and development of the mental hospital are not considered to any considerable extent. Although occasional allusions are made to historical and social factors, no coherent attempt is made at relating such factors to the particular institution under discussion. Rather than questioning why asylums should emerge at the particular time that they did, what service they performed, and in whose interests they came , and continued in being, writers like Jones have seen the history of the mental hospital as an essentially progressive and reforming movement. This movement is believed to have its origins in the realisation of the ideals of humanitarian compassion rather than in a particular socio-economic order. This idealistic view is well illustrated by the following passage from Baldwin:

> The history of the development, consolidation, and ultimate devolution of the mental hospital movement shows how powerful social, political and economic forces were involved in the name of the great but conflicting moral virtues of humanity and the freedom of the individual. The basic motivations in the growth of the mental hospital were to make a refuge from the degradation and anti-therapy of the poorhouse, a place of safety from the cruelty and inhumanity of both the public gaze and the private madhouse, and a hospital where hope and the possibility of treatment were not altogether lacking. These worthy aims were thwarted by the very size of the problem they sought to master, leading to the self strangulation of the mental institution as a hospital and its replacement by the crowded, stagnant, medically impotent asylum. With the end of the growth phase of the 'total institution' there has appeared over the past fifty years a degree of therapeutic optimism born of specifically medical advances both within the mental hospital and in the developing extramural services (32).

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(32) J.A. Baldwin, The Mental Hospital in the Psychiatric Service (London: O.U.P., 1971), p.5.

I propose to challenge the idealistic understanding of the history of the mental hospital and to suggest that the ideals of the reformists and models of treatment must be seen as, to a large extent, dependent upon underlying social and economic forces. These forces must be regarded as the primary determinants of any ideology. (This is not to deny, however, the influence and importance of ideas reacting back onto the socio-economic substructure). To provide a Marxist or materialist perspective on the history of the mental hospital, the insights developed principally by Scull will be used. These will be supplemented by those of Baruch and Treacher where appropriate (33).

The starting point for a materialist critique of the emergence and persistence of the mental hospital must be an examination of the socio-economic conditions which produced this institution almost ex nihilo at the beginning of the nineteenth century. It has been seen that there were almost no special public institutions for the insane before the beginning of the last century. This suggests that vast socio-economic changes must have taken place at about this time for such large and expensive institutions to come into being. If late eighteenth century Britain is considered,

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(33) Andrew T. Scull, Decarceration (Englewood Cliffs, N.J. : Prentice Hall, 1977), Andrew T. Scull, Museums of Madness (London : Allen Lane, 1979), Andrew T. Scull, 'The Social History of Psychiatry in the Victorian Era' in Andrew T. Scull, ed., Madhouses, Mad-doctors and Madmen, (London : Athlone, 1981), pp.5-32, Andrew T. Scull, 'Moral Treatment Reconsidered : Some Sociological Comments on an Episode in the History of British Psychiatry' in Andrew T. Scull, ed., Madhouses, Mad-doctors and Madmen (London : Athlone, 1981) pp.105-18, Geoff Baruch and Andrew Treacher, Psychiatry Observed (London : R.K.P., 1978). Rothman, op.cit., also provides interesting background material to this account from the history of the asylum in North America.

major social and economic changes are obvious. The growth of the capitalist market economy was changing the whole order and organisation of society. The old feudal links between rich and poor were disintegrating to allow a large, cheap workforce to come into existence. In this situation, poor people were very vulnerable and could no longer afford to maintain idle or impotent dependents, including the insane. At the beginning of the nineteenth century the ruling classes rejected the idea of outdoor relief (which had been given in the latter part of the previous century) as this would encourage indolence among the poorer classes. This meant that the indolent poor had to be accommodated in extra-familial institutions like workhouses. In those institutions, it was hoped that the poor would learn industrious habits which would ultimately fit them for putting their labour on the open market and at the disposal of the needs of industry. However, this function of the workhouses would have been enormously hampered by the inclusion of the insane who would prevent their fellows from being trained in this way. Thus it became necessary to provide differential treatment for different groups among the poorer and working classes. Those who might be assimilated into the workforce were retained in the workhouses, while the economically useless, criminals and the insane for example, were sent to special institutions which would be more effective in dealing with them, less expensive than outdoor relief, better controlled, more of a deterrent for potential 'scroungers' and more able to socialise their inmates to become good workers. It is important to note that such a solution for the segregation of the insane would not have been possible fiscally before the beginning of the nineteenth century. It was only then that the central government and bureaucracy became strong enough and wealthy enough to respond to problems of deviance on a national

rather than a local scale (34).

If the segregation of the insane into special institutions is seen as principally a product of the needs of the developing capitalist economy, how should the 'humane' reformers of the early nineteenth century be seen? This group was principally composed of Evangelicals and Benthamites. Most of them came from the upper classes. Scull regards their attitudes as self-righteous and their perspective as "classically that adopted by a dominant class towards those less favourably situated in the social structure" (35). Evangelicalism Scull sees as a

> conservative movement, concerned to shore up a disintegrating social structure and paternalistic morality against the threats posed by an undisciplined lower class rabble and by a purely materialistic entrepreneurial class (36).

This brand of conservative evangelicalism became allied with a kind of utilitarian Benthamism which sought to find institutional and centralised bureaucratic administrative means to improve society. Thus a powerful lobby was formed in the ruling class which campaigned for more and better public asylums. "Only the asylum offered the advantage of allowing scope for the exercise of humanitarian impulses, without requiring any fundamental changes in society " (37). This is not an assertion that the reformers were conscious and cynical tools of the capitalist system with no genuine compassion for the insane. The sincerity of their quest

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(34) For all the above see Scull, Museums of Madness, Ch.1.

(35) Scull, op.cit., p.56.

(36) Ibid., p.57.

(37) Ibid., p.101.

cannot be doubted. The point is that the reformers could not act fundamentally against their own class interests and so would only suggest solutions which were compatible and serviceable within the aims of the capitalist economy as a whole.

Much contemporary evidence in the nineteenth century suggested that asylums were in fact potentially very harmful institutions. The Parliamentary investigations in 1815-16 and 1827 provided evidence of terrible conditions and few demonstrable benefits to the insane in these institutions. The lack of positive benefits to patients, coupled with the enormous expense of building and maintaining public asylums, suggests that control factors were ultimately more important than therapeutic factors in the establishment of these institutions. Esentially, they suited the needs of the ruling classes, within a particular socio-economic order, and so came into existence, whatever their potential for good or ill so far as the individual patient was concerned.

It has been argued that the advent of the asylum and its subsequent existence, lurching from public scandal to public scandal with little evidence of any kind of beneficial effect on inmates, can be seen as primarily a function of the needs of the prevailing socio-economic order rather than of humanistic ideals based on scientific knowledge. The eclipse of the asylum in modern times must be regarded in a similar light. It has been seen above that writers like Jones regard the growth of community care and deinstitution-alisation as the product of the combination of the pharmacological revolution, administrative and social therapies and anti-institutional sentiment on the part of an ever-more tolerant public which was appalled by the affront to humane ideals represented by the conditions of the mental

hospitals. Once again, the materialist critique of this phenomenon suggests that these factors are dependent on the particular state of the socio-economic order rather than on 'progress' in psychiatry or in the organisation of institutions. Evidence can be presented to substantiate this view. Scull argues that the new patterns of releasing or 'decarcerating' more patients into the community began before the chlorpromazine drugs came to be widely used. He argues that the effect of these drugs has been exaggerated. He points out that the move to deinstitutionalise the mentally ill came at exactly the same time that other groups of inmates, e.g. prisoners, were being released into the community and that drugs would have had no bearing on the treatment of these other groups at all (38).

As to the argument that the public sudden ly found the asylums intolerable and this was a large factor in their demise, Scull demonstrates that there had been evidence available almost since the beginnings of these institutions that they were prone to becoming untherapeutic and that their inmates lived in appalling and unacceptable conditions (39). He argues that there was no evidence that the public was more tolerant of the mentally ill in their midst than they

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(38) For the above see Scull, Decarceration, especially Ch.5.

(39) It is interesting to note that the option of some form of community care based on the largely successful system operated in the Dutch town of Geel was proposed seriously yet rejected in the late nineteenth century in Britain. The chief opponents of this treatment were the asylum superintendents who were chiefly worried about potential abuse of patients if this kind of care came into existence. See further William Ll. Parry-Jones, 'The Model of the Geel Lunatic Colony and its Influence on the Nineteenth Century Asylum System in Britain' in Andrew Scull, ed., Madhouses, Mad-doctors and Madmen (London : Athlone, 1981), pp.201-17.

had ever been, and that little empirical research had been conducted into the effectiveness of community care when government policy suddenly changed to favour this option (40). All this suggests that the new policies and ideas about treatment of the insane were in fact motivated by other than theoretical or idealistic considerations. Pragmatically, it became expedient for the ruling classes to change their policy and this was glossed with the factors and ideals mentioned. It is necessary to consider now what benefits to the ruling classes in the socio-economic order of late capitalism accrued through this radical change in direction (41).

The most obvious advantage to government of a policy based on community care is that it is far cheaper than one based on permanent or semi-permanent institutionalisation (42). Hospitals are expensive to run. This is especially true when many of the mental hospitals have out-lived their working lives. During the 1950's it became increasingly obvious that, if institutionalisation were to continue on the same scale as it had in the past, there would have to be a

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(40) See Baruch and Treacher, who, discussing the rise of the D.G.H. psychiatric unit, remark: "One can readily agree that some alternative to the Victorian mental hospital must be developed, but why should 'progressive' opinion assume that (the) psychiatric unit in the general hospital is the only alternative?" (Baruch and Treacher, op.cit., p.73.)

(41) For the above see Scull, Decarceration, Ch.6.

(42) A recent D.H.S.S. discussion paper on the topic of community care asserts that "although the cost to the community health and social services of providing care for people transferred from hospital is difficult to assess, there are good reasons for believing that in many cases it would be both lower and better value." (D.H.S.S., Care in the Community (London : D.H.S.S., 1981), 3.7.)

considerable outlay on new buildings. Faced with the prospect of building large expensive new hospitals and furnishing them with an adequate staff over against community care which required little outlay in this direction, it is obvious which way governments committed to minimising public expenditure (and so minimising taxation) would turn. A second important factor in making this policy change was that outdoor relief, so inimical to nineteenth Tory ideology, was no longer proscribed and had come into existence in the form of social security payments (43). Welfare capitalism permits, even encourages outdoor relief as, once again, this saves on public expenditure.

The materialist critique of the new policies of community care and deinstitutionalisation might seem cynical and untrue if it could be demonstrated that patients had unequivocally benefitted from this change. It is, however, arguable that the new 'humane' policy has been of little real advantage to the mentally ill. For some it has meant being uprooted from a familiar and fairly intimate environment to be 'rehabilitated' in an alien environment, often in the most undesirable parts of inner cities, amongst ghetto-like communities of other deviants. Others end up on the streets. It is questionable whether constant re-admission to hospital for short periods, the corollary of the community care policy, may be regarded as a real improvement on permanent institutionalisation for many patients. Community provision of facilities remains grossly inadequate (44). Large mental hospitals remain, but they have less facilities and morale

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(43) For the above, see Scull, Decarceration, Ch.8.

(44) For a critique of community facilities see Baruch and Treacher, op.cit., p.55f.

can easily become very low. It is true that patients in these hospitals benefit from having less crowded wards and a better staff-patient ratio allowing more individual attention and therapy. This must be set against the possible disadvantages set out above.

Some groups in society do benefit from the new policy. Those classes which subsidise public expenditure by taxation gain from it, if only indirectly. Within the workforce of the N.H.S. there is one powerful upper class interest group which benefits considerably, namely the doctors. It is interesting to note how little opposition there was to the implementation of community care and deinstitutionalisation on the part of the medical profession. It might be expected that this group would have offered considerable resistance to such a change whereas on the whole it welcomed it. Two factors present themselves as possible attractions to doctors in the new ordering of services for the mentally ill. Firstly, the new arrangements allowed for the desegregation of the psychiatric profession, removing it from the isolation and stigmatisation of the mental hospital clogged with chronically ill patients in need of care rather than cure based on the medical model of illness and treatment. Drug and other physical treatments administered alongside the other doctors in the general hospital avoids the stigma and marginality of the mental hospital and provides more job satisfaction (45). Apart from increasing the status and prestige of psychiatrists, the new community care policies may well have increased their incomes. More frequent admissions, demanded by maintaining

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(45) Baruch and Treacher write: "the latent function of the shift in policy was to provide for the desegregation of the psychiatric profession", (op.cit., p.vii). See also Clare, op.cit., first edn., p.397, for this point.

patients primarily in the community, provide opportunities for domiciliary visits which command a fee over and above the doctor's basic salary. Several thousand pounds a year may be earned in this way by consultant psychiatrists employed by the N.H.S.

In conclusion, it has been argued that policy towards the insane in society must not be accepted uncritically as de facto 'progressive' and 'humane' (although it may indeed be so). Instead, policies and ideas must be seen as in some way dependent on the material socio-economic order for their dominance and ascendancy at a particular point in history. In order to be implemented, an ideal or policy must be congruent and compatible with the interests and values of the dominant class in a particular social order. This has been illustrated vividly in the history of the mental hospital which replaced outdoor relief as a means of dealing with the insane at the beginning of the last century when the capitalist socio-economic order was in its infancy, and is now being supplanted by a new form of policy based on outdoor relief in the era of advanced 'welfare' capitalism.

CHAPTER VIII

THE CONTEMPORARY PSYCHIATRIC HOSPITAL : GOALS AND ORGANISATION

There are, in England and Wales today, some 177 hospitals which cater principally for the mentally ill (1). Most of them were built before the First World War and were originally designated as 'asylums' rather than as 'hospitals'. Over 40% of these large hospitals are 100 years old (2). Although new units have often been added to the old buildings, the latter still form the substance of these institutions.

Geographically, the large mental hospitals are concentrated on the fringes of the Greater London conurbation and in a belt covering the Liverpool, Manchester and Leeds conurbations. More often than not the hospitals are isolated, standing in a rural setting and often far away from the communities they serve (3).

Until comparatively recently in their history, the large psychiatric hospitals were very overcrowded with patients, most of whom were chronically ill or institutionalised. In recent years however, patient numbers have fallen. In 1966 there were 91 hospitals with over 1,000 beds. By 1977 there were only 27, and numbers of beds for patients continue to

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(1) Figure calculated from Institute of Health Service Administrators, Hospitals and Health Services Year Book 1978 (London : Institute of Health Service Administrators, 1978).

(2) See Clare, op.cit., First Edn., p.381.

(3) See Kathleen Jones and Roy Sidebotham, Mental Hospitals at Work (London : R.K.P., 1962), p.7f.

fall at the rate of about 3% per annum (4). In 1970, there were 107, 977 patients resident in mental illness hospitals and units in the whole of England. This number had diminished to 83,939 in 1976. During this period, there was a particularly marked drop in the number of patients resident for three years or more in hospital, i.e. in the chronic long stay population which has traditionally provided the main clientele for the psychiatric hospital (5). Despite diminishing numbers of patients, only one psychiatric hospital has been closed since their closure was planned in 1961.

In this chapter and those which follow, I propose to examine the state of the contemporary psychiatric hospital in some detail. The goals and organisation of the institution are considered along with the different types of people working in the hospitals and living in them and their relations with each other. A considerable amount of space is devoted to the place of the patients in the hospital. Some of the problems of the contemporary hospital are anatomised, as are treatment methods. Finally, attention is given to the question of the future of this institution and the merits and demerits of its continued existence. At all times, the Marxist perspective is employed as much as is feasible, and questions about power and injustice are pointed up as and when they arise.

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(4) D.H.S.S., Report of a Working Group on Organisational and Management Problems of Mental Illness Hospitals (London : D.H.S.S., 1980), 4.4.

(5) See 'Resident Patients in Mental Illness Hospitals and Units' in MIND, Mental Health Statistics (London : MIND, 1980), p.4.

1. The Goals of the Psychiatric Hospital

It seems appropriate, in outlining the functioning of the psychiatric hospital today, to start by examining the goals and aims of this institution. It is not difficult to set out the formal, socially recognised and legitimate aims of the mental hospital. In broad terms, the goal of the psychiatric hospital has been characterised by Parsons as "To cope with the consequences for the individual patient and for patients as a social group, of a condition of mental illness" (6).

Parsons would have been more accurate in his definition if he had recognised that the mental hospital performs a function for society as a whole in dealing with the consequences of mental illness and not merely for individual patients or patients as a social group. This definition is far too general to be of real use. It is therefore necessary to evolve a more precise typology of formal goals. The typology used here is thoroughly eclectic, but most writers vary only slightly in their own typologies of these aims, so none of them have been compromised by being included in this way.

The most obvious specific goal for an institution designated 'hospital' is the treatment and therapy of those suffering from mental illness. This main goal can be broken down into two subsidiary aims. Firstly, that of <u>care</u> and maintenance of the mentally ill while they are judged to be unresponsible for themselves and unable to manage themselves as independent citizens. Secondly, that of active intervention

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(6) Talcott Parsons, 'The Mental Hospital as a Type of Organization', in Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, eds., <u>The Patient and the Mental Hospital</u> (Glencoe : Free Press, 1957), pp.108-29. Emphasis omitted.

in the lives of patients to restore them to active participation in the world outside the hospital. This may be characterised as the therapeutic-rehabilitative aim or goal (7).

As has been shown, behind the modern psychiatric hospital lies the old asylum. This points to the second main goal of this institution, namely that of confining and controlling the mentally ill. The original asylums were built to remove the mentally ill from society and the custodial goal of the mental hospital remains a very important one (8). Once again, this main custodial goal may be divided into two subsidiary goals. One of these is that of protecting (in the widest sense) the community from the mentally ill and may be denoted the incarcerative goal. The other is that of protecting the patient from his or her own life destroying impulses. This is the life-maintaining aspect of the custodial goal (9).

(7) For this particular typology see Daniel J. Levinson and Eugene B. Gallagher, Patienthood in the Mental Hospital (Boston : Houghton Mifflin, 1964), p.14f.

(8) See Elizabeth Bott, 'Hospital and Society' British Journal of Medical Psychology, 49, 1976, 97-140:

> in spite of many changes in psychiatric treatments and in the organisation of mental health services, mental hospitals are still constrained to perform the task which they have always carried out for society, which is temporarily or permanently to remove from their place in society people who are socially defined as mentally ill ... The custodial function of the hospital has continued, but a new short-stay function has been added.

(Op.cit., p.97.)

(9) See Levinson and Gallagher, op.cit., p.14, for this typology.

Rather less obvious or explicit than the therapeutic and custodial goals of the hospital is the goal of maintaining the hospital as a working organisation. The psychiatric hospital is a publicly funded large institution dealing with considerable numbers of patients, staff and materials. It must therefore make one of its principal goals the fulfillment of its own organisational and institutional needs (10).

In addition to the three main goals of therapy, custody and maintenance, there are two rather less important goals. These are the goals of training personnel to work with the mentally ill and of researching into aspects of mental illness and its treatment. These should be borne in mind, but little more will be said about them here.

To return to the three main goals outlined, it might be supposed that these goals have been listed in order of importance and of priority, so that the therapeutic needs are considered and attended to first, while custodial and maintenance or bureaucratic needs are secondary. While it might be desirable that a hospital should order its goals in this way, it is often not the case in practice. Indeed, the order above may be effectively reversed so that the therapeutic needs of the patient are ignored until institutional and custodial goals have been accomplished. I will now go on to try and demonstrate why the theoretical, legitimate, socially sanctioned goals I have outlined may be frustrated or modified in practice.

In the first place, it should be realised that the

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(10) See A.H. Stanton and M.S. Schwartz, The Mental Hospital (New York : Basic Books, 1954), p.27 for more about this goal.

the broad goals of custody, therapy and maintenance are not necessarily compatible and are, in many ways, in tension with each other. The therapeutic needs of a patient may be incompatible with the maintenance needs of the hospital for example. It is not uncommon to find staff unable to spend time with patients because they must attend to administrative matters (11). In the same way, the need to prevent patients from escaping or damaging themselves and others may conflict with the therapeutic needs of patients as the staff may be completely involved in observation duties and unable to organise or take part in therapeutic activities.

The underlying conflict between the main goals of the psychiatric hospital may be disguised by these aims remaining unstated (12). Thus goals which should be pursued more vigorously and should be given priority are ignored, while those which should, perhaps, occupy a subsidiary position are given undue prominence and effort. Talbott writes of

> the paucity of clearly stated and communicated goals or, if there are goals, an overattention to tangible, quantitative, efficiency-orientated goals and an underemphasis on comprehensive, qualitative, effectiveness-related goals.

The consequences of this are that "objects, buildings and figures receive more attention than people, programs and

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(11) See John A. Talbott, The Death of the Asylum (New York : Grune and Stratton, 1978), p.55f, for the precedence of bureaucracy over therapy in psychiatric hospitals. Belknap observed that doctors in the hospital he studied spent 60% of their time in administration. See Belknap, op.cit., p.67. See also Stanton and Schwartz, op.cit., p.143, where the precedence of the needs of the hospital over the needs of the patients is discussed.

(12) See Talbott, op.cit., p.55.

personal interactions."(13).

Another tension surrounding the main formal goals of the hospital is the existence of informal goals (14). These goals too may be in conflict with the main goals of the hospital. For example, many writers have commented on the importance of socialising patients into their role in the hospital so that they do not disrupt the values and routines of the hospital. However, this informal aim may well conflict with one of the formal aims of the hospital, the cure and rehabilitation of the patient back into the community. Indeed, patients can become so well socialised into the ways of the hospital that they are incapable of returning to their former roles and way of life. Commenting on this feature, Goffman notes that "this contradiction, between what the institution does and what officials say it does, forms the basic context of the staff's daily life."(15).

The goals and aims of a hospital should not be regarded as unchanging or static. The hospital is a living and changing institution set in the midst of a changing society. It reflects significant changes therefore. This adds considerably to the confusion about the purposes and priorities of the hospital (16).

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(13) Talbott, op.cit., p.55.

(14) This point is made by Robinson. See David Robinson, Patients, Practitioners and Medical Care, second edition, (London : Heinemann, 1978), Ch.6.

(15) Goffman, op.cit., p.73.

(16) See further Robinson, op.cit., Ch.6 for this.

Even when the goals and aims of a hospital at a particular time are clearly formulated and communicated, which they often are not, they may not be properly understood or accepted by all the groups living and working in the institution. Strauss et al. show that nursing aides in American hospitals had little understanding of the therapeutic process on which the doctors were engaged (17).

Different groups and individuals within the hospital, with different needs, interests, amounts of status and power etc., may have very different outlooks and goals which they will strive to see implemented. Doctors, for example, are often chiefly concerned to further active therapeutic and rehabilitative goals. Nurses, on the other hand may focus chiefly on the goals of care and custody within the hospital. Administrators see the smooth running and organisation of the hospital as of vital importance. Here again, then, there is enormous potential for conflict, implicit or explicit, which affects the selection and relative priority of the hospital's aims. In this situation, it is the most powerful groups within the hospital who are most likely to be able to have their particular goals implemented. However, it is not true to say that any one group on its own has the exclusive power to determine the goals of the hospital as a whole (although certain groups may have a disproportionately large amount of influence). Alliances are made between different groups, coalitions of interest are made and compromises are found between the

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(17) Anselm Strauss, Leonard Schatzman, Rue Bucher, Danuta Ehrlich and Lemvin Sabshin, Psychiatric Ideologies and Institions (London : Transaction, 1981), p.244.

different groups and their goals (18).

Physical factors, such as the way a hospital was built, may affect the types of goals which can be selected and implemented. Part of this influence may be directly to do with lack of appropriate space and facilities which prevents certain kinds of activity taking place. For example, a ward built primarily for custodial care may convert very badly to use as, say, a therapeutic community. Another way in which the physical surroundings of the hospital may affect the adoption and implementation of certain goals is in the engendering of different kinds of mentality among inmates and staff. Jones and Sidebotham note:

> The purpose for which the hospital was built, and the buildings which express that purpose, have an enduring influence. They create stereo types, perhaps not consciously formulated, in the minds of both patients and staff. The nurse whose impression is "This place is like a hotel" will behave very differently from the nurse whose impression is "This place is like a prison" (19).

They add that

> the best staff cannot create the right relations in the wrong setting. Mental hospitals ... cannot altogether make a fresh start at any point in time (20).

So it can be seen that the physical and historical aspects of the hospital have a considerable influence on its goals

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(18) See Robinson, op.cit., ch.6, also David Tuckett, 'The Organisation of Hospitals' in David Tuckett, ed., An Introduction to Medical Sociology (London : Tavistock, 1976), pp.225-53, p.235f.

(19) Jones and Sidebotham, op.cit., p.118.

(20) Op. cit., p.118.

Resources, human and physical, or the lack of them are also a factor in the selection and pursuit of goals. If a hospital has a good staff-patient ratio and plenty of material resources, then some goals can be aimed at which are not possible where resources are lacking. Unfortunately mental hospitals are often short of such resources. This means that custodial goals supplemented by pharmacotherapy, which demand few personnel and little cost, will tend to predominate over therapeutic goals which demand staff, intensive activity, and special facilities. As it happens, the custodial/pharmacotherapy model of care and treatment fits in well with the bureaucratic maintenance goals of the hospital and so there is often little effective protest against its prevalence.

So far, only internal factors affecting goals in the hospital have been considered. There are, however, external factors which exercise considerable influence. Ultimately, the hospital depends on wider society for its continued existence. It must therefore perform the tasks, and so select goals, which are felt to be desirable in that wider society. There can be little doubt that, in many ways, society at large sees the value of the mental hospital as removing socially deviant and undesirable citizens from its midst. Hospitalisation disposes of the problem of madness and the mentally ill (21). Perhaps the most important goal for the hospital for society is that it should contain and control the mentally ill, and protect it from their disruptive and possibly dangerous behaviour. Beyond this, there is little interest in what happens within the psychiatric hospital. This

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(21) See Bott, op.cit., p.120.

means that the public may be prepared to provide money and resources sufficient to allow custodial and maintenance goals to be met, but not enough to provide for effective therapy and rehabilitation goals. Hospitals may therefore be forced to adopt and give priority to the former while actually aspiring towards the latter goals.

Within this general framework of external influence, Talbott lists several specific external sources of influence on the goals of the hospital. These include judicial decisions, legal advocacy activities, governmental agencies, accrediting agencies, state agencies, patients' and relations groups, human rights groups, the press and the fragmentation of services generally for the mentally ill (22).

A picture has been drawn showing that although the main formal goals of the mental hospital are easy to outline, the area of goals is in fact fraught with contradictions, conflicts and tensions. The main, legitimate, socially sanctioned goals of the hospital conflict with each other in many ways. Goals may be unstated and so ignored. Informal goals may supplant formal, and implicit goals may be more important practically than those which are explicit. Goals may change. They may not be properly understood by those working in the hospital. Different groups and individuals amongst staff and patients may have very different aims so that political power may be the crucial factor in ensuring the implementation of particular goals. Physical and historical factors have an important effect on the selection and implementation of goals, as does the availability of resources and the various external factors which bear upon the hospital.

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(22) See Talbott, op.cit., Ch.5.

In the light of this kind of conflict and tension, it is not surprising that mental hospitals can easily find themselves in a position of confusion and stagnation. This contributes in a large measure to many of the problems of the mental hospital today.

2. The Organisation of the Psychiatric Hospital

Having spent some time in examining the aims and goals of the psychiatric hospital, it is appropriate to turn now to the organisation of this institution. The actual structure and organisation again plays a vital part in determining the kind of milieu which is ultimately produced in a hospital.

The psychiatric hospital, in common with all other hospitals of whatever type, is a complex organisation. That is to say that large numbers of people are involved in it and that the organisation must therefore be highly co-ordinated so that the needs of the patients can be met by the personnel and services which are provided by the hospital. To perform this function efficiently and to meet its stated goals, the hospital is organised as a rational-legal bureaucracy. This means that, in general terms, the hospital is structured as a centralised hierarchy of different officials, each having authority and responsibility for those lower in the hierarchy, each subordinate to those higher in the hierarchy, and all implementing and obeying certain agreed and predictable rules.

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(23) See M.W. Susser and W. Watson, Sociology in Medicine, (Oxford : O.U.P., second edn., 1971), p.241f., for more on rational-legal bureaucracies and the organisation of hospitals.

While the rational-legal bureaucratic arrangement described above may sound simple and efficient, it is complicated in the case of the hospital by the existence of not one, but several bureaucratic hierarchies. Each of these hierarchies has a good deal of autonomy, a different area of responsibility and concern, and sometimes a very different goal from that of the others. The three main hierarchies within the hospital are those of medicine, nursing and administration. The medical hierarchy has as its main focus the diagnosis and treatment of patients for whom doctors have ultimate legal responsibility in the hospital. Nurses tend to focus on the day to day care of patients and the effective and efficient running of the wards. The administrative hierarchy is chiefly responsible for organising the institutional and support services of the hospital, for providing administrative services and for generally co-ordinating the activities of the hospital (24).

The arrangement of having parallel bureaucratic hierarchies within the hospital can easily lead to conflict and confusion of organisation and organisational goals. There is a real tension between the different hierarchies in many hospitals. Any of them can either fail to take responsibility for its own area of concern for example. On the other hand, one hierarchy may attempt to influence or take responsibility for the area of concern of another. A primarily nursing concern, for instance, may be regarded by the medical hierarchy

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(24) See further, Levitt, The Reorganised National Health Service, p.159f, for more on this. Susser and Watson note with reference to administrators that they tend to focus too much on the means of health care provision and not enough on the ends which are pursued by the therapeutic staff. See Susser and Watson, op.cit., p.247.

as within its terms of reference, or by the administrators as falling within their domain.

The confusion of hierarchies in the hospital leads to the consideration of authority within the institution. Weber, Tuckett points out, distinguished three main types of authority in society (25). These are traditional authority, based on heredity, bureaucratic authority, that is to say rational authority which is based on having a hierarchical system where there are clear goals and rules and where occupants of a particular position of responsibility and authority are qualified for that position and can be replaced by an equally qualified bureaucrat, and charismatic authority, based on an individual's own personal qualities which legitimate that individual's right to obedience from others. In hospitals, two of these types of authority are predominant; bureaucratic and charismatic. Of the two, the former is more common. However, charismatic authority is also important, particularly when the position of doctors within the organisation is considered. Effectively, doctors base a great deal of their power on charismatic authority accruing to them because of their ostensible power to heal. Doctors as individuals are responsible only to themselves, and not to any official above them in the bureaucratic hierarchy. Technically all doctors are equal in rank and so the medical hierarchy depends on "tacit agreement rather than on a system of ranks and job specifications" (26). Consultants, in particular, are not answerable to anyone else within the hospital for their actions. Insofar as doctors are responsible to any group, it is to their own professional peers.

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(25) See Tuckett, op.cit., p.231f.

(26) Una Maclean, Nursing in Contemporary Society (London : R.K.P., 1974), p.108.

The charismatic authority of the doctor and his primacy in the psychiatric hospital was formally acknowledged in the position of Medical Superintendent. This doctor took responsibility for all the services in the hospital before the reorganisation of the N.H.S. in 1974. Even since that date, despite efforts to share responsibility equally and to increase mutual co-operation and equality, doctors have retained a considerable degree of autonomous authority. They tend to be far more influential in the hospital than their numbers would suggest (27). In fact it has been possible to draw most elements in the life of the hospital into the medical ambit when this has seemed desirable to the medical staff of the institution.

In order to try and ensure that the different hierarchies in the hospital work together towards the same ends, most psychiatric hospitals have developed inter-disciplinary structures for consultation and co-operation. These may be present at all levels of the institution's structure, or they may be restricted to particular levels. They may have actual executive functions and power so that binding decisions can be made for a certain area of policy, or they may simply be consultative and advisory bodies. Individual hospitals vary enormously in the consultative structures which they employ. However, it is common to find the following or their equivalents in contemporary psychiatric hospitals:

i) Multidisciplinary meetings at ward level which consider and implement policies and treatment programmes on particular wards.

ii) A multidisciplinary committee composed of heads of all the departments in the hospital which meets

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(27) See Susser and Watson, op.cit., p.256.

occasionally to act in an advisory or executive capacity over decisions which concern the running of the whole hospital.

iii) A tripartite management team consisting of the senior administrator, the senior nurse, and a senior consultant in the hospital. This group will meet very frequently and will take responsibility for the implementation of policy on a day to day basis. This team is always an executive as well as a policy-making body, but it has not got absolute power as it is itself responsible to the District management team which formulates and executes policy on a broader level.

Apart from the formal organisational aspects of the hospital, it is important to recognise that there are informal organisational features. For example, although trade unions are not formally represented in any of the structures accounted for above, they are consulted about matters constantly and often have considerable influence. This is particularly true in the psychiatric hospitals where trade unions have traditionally been strong and militant because of their predominantly male membership. The management methods of the last decade or so, based on those of industry, have made unions much more aware of their own importance and power (28).

At a more informal level than that of the unions, there is the kind of informal organisation which takes place behind and beneath the official bureaucratic rules and structures. Unofficial organisation, strategy and policy exists at all

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(28) See Ham, op.cit.

levels of the hospital but is most apparent and effective on the wards. Belknap has shown how, in a hospital where there were few qualified staff, the unqualified attendants were able to order the wards on which they worked so that it suited them. This did not accord with the official view of how the hospital was run (29). Goffman has demonstrated that patients too evolve modes of living 'between the rules' in such a way that they can preserve some freedom and individual identity within the structure of the hospital without evoking negative sanctions upon themselves (30).

Mention of Goffman brings me to his characterisation of the mental hospital as a 'total institution', a vital concept in considering the organisation of psychiatric hospitals. The characteristics of the total institution according to Goffman are as follows: firstly, all aspects of life are conducted in the same place and under a single authority. Secondly, each phase of the members' daily activity is carried out in the immediate company of other people all of whom are treated alike and required to do the same thing together. Thirdly, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution (31). These features emanate

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(29) See Belknap, op.cit., especially ch. 9.

(30) See Goffman, op.cit., p.187ff.

(31) See ibid., p.17.

directly from one key fact, namely "the handling of many human needs by the bureaucratic organisation of whole blocks of people" (32).

Psychiatric hospitals today seldom, if ever, conform entirely to Goffman's definition of a total institution. The definition has been criticised for being "overdrawn and spuriously monolithic" and also for not distinguishing the differences between the psychiatric hospital and other types of social institution in terms of goals, professional ideologies, and societal context (33). Despite these criticisms and the passage of time which has brought enormous changes in the mental hospital, the concept of the total institution still has much validity and usefulness. It must still be seen as a combination of bureaucracy and community, the central elements in Goffman's definition of the 'ideal type' of the total institution.

This survey of the mental hospital as an organisation has been far from exhaustive. It has tried only to give a very general picture of the arrangement of the hospital so that this aspect may be more clearly understood. It is in discussing specific groups and problems in the hospital that the above material will be amplified and its relevance will be seen (34).

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(32) Ibid., p.18.

(33) See Levinson and Gallagher, op.cit., p.17ff.

(34) For this section the principal sources have been Robinson, op.cit., ch.6, Tuckett, op.cit., Susser and Watson, op.cit., ch.7, Maclean, op.cit., ch.5.

CHAPTER IX

THE STAFF-PATIENT DIVIDE

Having examined the goals and organisation of the psychiatric hospital, I turn now to the various groups who make up the population of the hospital. In examining these groups and trying to elicit their relative position to each other, their distinctive features, their particular attitudes, their class positions, their relative power and their special functions, it will be convenient to deal with patients as a group first, and then to examine the various different staff groups. This arrangement reflects a fundamental divide in the hospital, the staff-patient divide. It is necessary to dwell on this schism for a while before looking in detail at the different groups.

The basic split between the inmates of a total institution and those who have responsibility for managing and supervising them is seen by Goffman as an essential aspect of a custodial bureaucratic organisation (1). Many features differentiate inmates from staff. While staff have free and frequent access to the outside world, inmates have only very restricted and rare contact with it, for example. Goffman states

> Each grouping tends to conceive of the other in terms of narrow hostile stereotypes ... . Staff tend to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy and guilty (2).

Social mobility between staff and patient groupings is very restricted, as is communication and the passing of information.

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(1) See Goffman, op.cit., p.18f.

(2) Ibid., p.18.

Effectively,

> Two different social and cultural worlds develop, jogging alongside each other with points of official contact but little mutual penetration (3).

This might seem a commonplace and unimportant observation in this account, but for the crucial fact that the balance of power between these two groupings is heavily weighted in favour of the staff and against the inmates or patients. While both groupings are mutually dependent on each other for continued existence and adopt a pattern of behaviour which is complementary, it is undoubtedly the staff who have greater power over the patients.

The relative power of the patients and staff can be assessed by examining the sanctions, both positive and negative, which each group can exert against the other. Staff have at their disposal considerable resources of reward and punishment which can be used to ensure the compliance of patients. Rewards may include such everyday comforts as cigarettes, money, and being able to go out of the hospital, while punishments can consist of undesirable or unpleasant forms of treatment, confinement, deprivation or threats (4). Whether they are rewarding 'good' behaviour, or punishing 'bad' behaviour, staff clearly demonstrate that they have power.

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(3) Ibid., p.20.

(4) See further Arlene Kaplan Daniels, 'Advisory and Coercive Functions in the Hospital' in Gary L. Albrecht and Paul C. Higgins, eds., Health, Illness and Medicine (Chicago : Rand McNally, 1979) pp.297-311, particularly p.301.

By contrast, patients can bring very few sanctions to bear on the staff, whether formal or informal. Ultimate sanctions, like withdrawing from the hospital or committing suicide can be made ineffectual or impossible by staff intervention (legal detention, observation). The most patients can do is to disrupt the running of the hospital, to make life difficult for the staff, or to reward with esteem and co-operation those staff members who are thought to be worthy of such positive sanctions. Formal procedures do exist for patients who wish to complain about the way they are being treated by staff in the hospital. However, an officially upheld complaint may be of little comfort to a patient who has to continue to accept the ministrations of those about whom the complaint was made. The victims of complaints and their colleagues may feel that patients who complain should be punished in some way for their audacity.

It is not only through sanctions that the power of the staff over the patient is asserted. Often, staff know more about the patient's destiny and future treatment than the patient does himself. It is fairly unusual for patients to be privy to decisions on these matters. Similarly, patients are seldom included in helping to make decisions about the policy and running of the hospital. Goffman writes:

> Significantly, the institutional plant and name come to be identified by both staff and inmates as somehow belonging to the staff, so that when either grouping refers to the views or interests of 'the institution' by implication they are referring to the view and concerns of the staff (5).

The doctor-patient relationship perhaps exemplifies the absolute nature of the staff-patient divide and the power

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(5) Goffman, op.cit., p.20.

differential which that implies best. Notionally, the doctor is employed to serve the needs and interests of his patients. However, patients may have little real choice as to which doctor they have (6), and in any case they are unlikely to see very much of their psychiatrists (7). Doctors, who have ultimate power over the lives of their patients, especially if they are committed, make many of their decisions on the basis of reports from, and consultation with, other staff members and not on the basis of consultation with the patients (8).

Attempts have been made to break down the staff-patient divide and to equalise power in some psychiatric hospitals. This is particularly true of hospitals which have experimented with social therapies and therapeutic communities (9). However, even in these experiments, attempts have only been of limited success and the divide has continued. Jones and Sidebotham report on one hospital where a patients' committee was closed by the staff because it was an irritant and challenged staff views (10). Writing about an American

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(6) See Strauss et al., op.cit., p.266.

(7) See Jones and Sidebotham, op.cit., p.67, Cf. Clare, op.cit., First Edn., p.370: "Even a recently admitted patient is seen by a doctor on an average of only 20 minutes each week."

(8) Cf. Belknap, op.cit., Ch.5, which explores the vast influence ward staff can have as gatekeepers for the doctor who depends on their reports to make his decisions.

(9) See David H. Clark, Social Therapy in Psychiatry (Edinburgh : Churchill Livingstone, Second Edn., 1981), especially Ch. 3, for a general account of such experiments.

(10) Jones and Sidebotham, op.cit., p.76 .

private hospital, Rubenstein and Lasswell observed that an experiment in therapeutic community was not as successful as it might have been because the staff insisted on retaining power over patients. They record:

> The pre-innovation hospital was authoritarian. Decisions about fundamental and pressing issues in the lives of patients were decided by others than the individuals most concerned. Despite the modifications introduced, the basically authoritarian character of the hospital was substantially unchanged. The staff, particularly the director, retained the deciding voice (11).

It would be very convenient from the Marxist perspective of the present work if the staff-patient divide reflected the boundaries between upper and lower social classes exactly. In fact, it does not. Although there is a bias towards the lower classes amongst the patient population (12) a fairly large group amongst the staff, namely the nursing assistants, also comes largely from the lower social classes (13). As will be shown later, this closeness of social and cultural background does little to modify the schism between staff and patients and may be seen as deepening it in some ways. Lower class nursing assistants are likely to be keen to take an authoritarian line, and to distance themselves from the patients (14).

Although the staff-patient divide does not follow the

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(11) Robert Rubenstein and Howard D. Laswell, The Sharing of Power in a Psychiatric Hospital (New Haven : Yale University Press, 1966), p.257.

(12) See Appendix.

(13) See below p.242.

(14) See below p.242.

division between higher and lower classes exactly, it is true to say that in general terms, the people who have most power over patients do come from higher class backgrounds. In the case of nursing assistants, they have adopted a mode of behaviour which in no way reduced the gap between patients and staff and which is therefore compatible with the interests of the staff as a group rather than those of the patients.

Having dwelt at some length on the almost absolute nature of the staff-patient divide and the differential distribution of power connected with it, it is necessary to modify this by counterposing it with the notion of hierarchy. This implies a much more gradual and less severe division amongst the groups in the hospital. Belknap suggests that the groups in the hospital can be seen as a descending hierarchy, with doctors at the top going down through various levels of socio-economic status and background to lower class patients at the bottom (15). Even within the group designated patients, it is suggested that there is an informal hierarchy, ranging from patients who are regarded as hopeful and curable, through patients who are seen as potentially hopeful, to patients who are regarded as having little hope of recovery. Patients in the first group may to some extent bridge the gap between staff and patients at the level of being admitted to some degree to attendant society. However this closeness to the staff is always a privilege and never an automatic right.

I have argued that in bureaucratic organisations such as psychiatric hospitals, there is a divide between staff and patients which is almost absolute in terms of communication, information, status and power. I have further indicated that

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(15) Belknap, op.cit., p.68.

effectively, though not precisely, this divide follows the division between higher and lower classes in the hospital. Lastly, I have suggested that while the staff-patient split is fundamental and real, it must be modified by taking into account the notion of hierarchy among the groups in the hospital. This moderates the monolithic nature of the schism between patients and staff.

Before going on to examine the different groups in the hospital more specifically, it must be said here that the staff-patient split seems inevitable in the psychiatric hospital as long as that institution is bound to exercise social control and thus gives to some members of its population, willy nilly, more power and authority. Equality and integration could only take place if society as a whole no longer required the control of deviants by doctors and paramedical staff. Even then, the superior social status of therapeutic personnel might prevent true equality of power and an end to the staff-patient divide.

CHAPTER X

PATIENTS

Having established the concept of the staff-patient divide, discussion of the groups in the hospital will commence by looking at the patient group. At the outset of this consideration, it must be pointed out that several different types of patient are to be found in contemporary psychiatric hospitals. Most large hospitals will contain some acute, short-stay patients suffering from mental illness. These people will be young by contrast with the majority of the patient population and they may be accomodated in a building detached from the main hospital. Often they remain in hospital only a matter of weeks before being discharged.

A second type of patient is the long-stay chronically ill patient who remains in the hospital for over two years, and often considerably longer than that. Some remain in hospital for most of their lives. Long-stay patients used to predominate in psychiatric hospital populations. However, since the deinstitutionalising activities of the 1950's their numbers have declined and the elderly have replaced them as the most numerous group. This latter group is composed of people suffering principally from organic deterioration of the brain, senile dementia, rather than from mental disorder of more uncertain aetiology. Most patients admitted with senile dementia have had no previous history of mental illness. Many hospitals now have more than half their beds taken up by the elderly mentally ill.

The division of the patient group into three sub-groups of the acute, the chronically ill and the elderly mentally ill has important implications for aims, treatment and care in

psychiatric hospitals. Acute patients, for example, may appropriately receive intensive and active treatment in order that they may be rehabilitated and possibly cured, at least temporarily. For the chronically mentally ill and for the elderly, there is often little hope of rehabilitation and cure so care becomes a very important goal. The elderly may require a great deal of simply physical care, while care for the chronically ill may need to be more imaginative and active so that the powers and interests of the patient can be maintained. Different emphases like these will necessitate very different attitudes, goals, policies and resources within psychiatric hospitals.

Given the Marxist perspective which has been adopted with reference to the socio-political context and structure of the mental hospital, it is important to consider the social class background of patients. Although there are few figures available showing this information (1), most people would assert that there are a disproportionate number of lower class patients in the large old psychiatric hospitals (2).

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(1) D.H.S.S., Inequalities in Health, 7.31, notes the absence of centrally-held statistics on occupational class in the Mental Health Enquiry. A fuller consideration of the relationship of social class and mental illness and its effects is to be found in the Appendix which should be referred to at this point.

(2) See e.g. Jones and Sidebotham, op.cit., p.113, Talbott, op.cit., p.50, Belknap, op.cit., p.68, Levinson and Gallagher, op.cit., p.171, E.M. Goldberg and S.L. Morrison, 'Schizophrenia and Social Class', British Journal of Psychiatry, 109, 1963, 785-802, J.N. Morris, 'Health and Social Class', Lancet, 1, 7.11.59, 303-5, Lilli Stein, 'Social Class Gradient in Schizophrenia', British Journal of Preventive Social Medicine, 11, 1957, 181-95. See Appendix for more on social class and mental disorder.

It seems fair to conclude from the research which has been done on social class and mental illness that it is to be expected that there will be more lower class people in psychiatric hospitals than might be expected from their prevalence in the population at large. In addition, the ethos of the mental hospital has always been the provision of care for the insane members of the lower classes.

The implications of this class bias among the patients in psychiatric hospitals are considerable. Firstly, it means that many of the patients come from the social classes with the lowest position in the socio-economic order. They come from the opposite end of the socio-economic spectrum from those who are responsible for their care ultimately in the hospital, i.e. the doctors. This means they have little common background or experience with them. This, combined with difficulties in communication due to the differential usage of linguistic codes, limits communication between the groups remarkably. It means that certain forms of therapy may be proscribed because they depend on linguistic skills, and so organic and behaviouristic therapies may be left as the only option (3).

Levinson and Gallagher sum up the position of the lower-class patient as follows.

> Lower-class patients are likely to delay entering a hospital until their outside social relationships have been severely damaged; they are likely to enter a public hospital which is ill-equipped and understaffed.

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(3) For differential use of linguistic codes between social classes see Peter Trudgill, Sociolinguistics (Harmondsworth : Penguin, 1974) Ch.2, and David Tuckett, 'Work, Life Chances, and Life-Styles' in David Tuckett, ed., An Introduction to Medical Sociology (London : Tavistock, 1976), pp.110-155, p.145ff.

> Once in the hospital, they are more likely to receive organic treatment (such as electric shock) or minimum custodial care than psychotherapy. Further, their hospital stay may be prolonged, partly because of severe pathology at admission, partly because of inadequate treatment, partly because their families have limited physical and emotional resources for dealing with a member now defined as mentally ill (4).

1. Patients' Understanding of Mental Illness and Its Treatment.

It has been argued that many, in fact a disproportionate number of the patients in the large old psychiatric hospitals come from the lower social classes. In turning to look at patients' attitudes towards mental illness and its treatment, it therefore seems legitimate to use material relating to the views of members of the lower classes about this subject. Accordingly, studies like that of Hollingshead and Redlich will be used as sources in addition to other material (5).

Hollingshead and Redlich found in their study that lower class people have little understanding of mental illness, its causes, or its treatment. Insofar as they do have any understanding, it tends to be that psychiatric disorder is a somatic disorder, much like any other disease: "Class IV and V family members regard mental illnesses as somatic

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(4) Levinson and Gallagher, op.cit., p.169.

(5) August B. Hollingshead and Fredrick C. Redlich, Social Class and Mental Illness (New York : John Wiley, 1958). See especially Ch. 11.

diseases" (6).

The corollary of a somatic view of mental illness is that lower class people expect physical or somatic treatment for it (7). They are rigid in their attitudes towards cures and the psychiatrists who administer them. They tend to dislike and distrust 'talking cures' like psychotherapy, whose purpose they fail to understand. Nonetheless, lower class patients are prepared to submit unquestioningly and passively to treatment procedures instituted by a psychiatrist. Psychiatrists are regarded as having every right to behave in an authoritative, even authoritarian manner. "Class V patients accept professional procedures which have no meaning to them and often arouse their anxiety" (8).

The findings of Hollingshead and Redlich and others, are echoed in studies of patients in hospital specifically. Levinson and Gallagher remark that "Although widespread on all levels, negative and poorly informed attitudes about mental

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(6) Op.cit., p.341. See also Robert A. Moore, Elissa P. Benedek and John G. Wallace, 'Social Class, Schizophrenia and the Psychiatrist', American Journal of Psychiatry, 120, 1963-4, 149-154, which shows that lower class women see mental disorder in physical terms unlike upper class women and their doctors who see mental disorder in more psychological terms. See also Dewitt L. Crandell and Bruce P. Dohrenwend, 'Some Relations Among Psychiatric Symptoms, Organic Illness and Social Class', American Journal of Psychiatry, 123, 1967, 1527-38. Dohrenwend and Crandell write: "There is a distinct tendency on the part of lower-class groups to express psychological distress in physiological terms," (Op.cit., p.1536.)

(7) Hollingshead and Redlich, op.cit., p.340.

(8) Hollingshead and Redlich, op.cit., p.340. See also p.343f for the authoritarian light in which the psychiatrist is viewed.

illness are more prevalent in the lower class than in the middle and upper classes" (9). Gallagher, Levinson and Ehrlich observe that lower class and older patient groups tend to be more authoritarian in personality and have a more custodial attitude to treatment than higher class and younger patients. They write,

> the more authoritarian, custodial-minded patient tends to see himself as a passive object in the hands of the physician; he expects to 'receive treatment' rather than to participate actively in a therapeutic relationship... .Conceiving of mental illness as a complete negation of reason and morality, he tends to regard himself not as 'mentally ill' but as a temporary victim of overwork or evil circumstance" (10).

It seems likely that the reason why lower class people prefer a somatic model of mental disorder which is cured by the active intervention of a physician in a custodial context while the patient remains fairly passive is to do with the broad characteristics and roles of this class in society as a whole. Inarticulacy, passivity, obedience to those from higher social strata and the need for order are characteristic of this class (11). The somatic model dovetails well with this.

Several implications arising from the lower class understanding of illness and treatment as somatic/custodial

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(10) Eugene B. Gallagher, Daniel J. Levinson, and Iza Ehrlich, 'Some Socio-psychological Characteristics of Patients and their Relevance for Psychiatric Treatment' in Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, eds., The Patient and the Mental Hospital (Glencoe : Free Press, 1957), pp.357-379.

(11) See further Kenneth Roberts, The Working Class (London : Longman, 1978), especially pp.85 ff, Melvin L. Kohn, 'Social Class and Schizophrenia - A Critical Review and Reformulation' in P.M. Roman and H.M. Trice, eds., Explorations in Social Psychiatry, (Philadelphia : F.A. Davies, 1974), pp.113-37, and Appendix.

should be mentioned before passing on. Firstly, this model is often the only model which psychiatric hospitals can afford to use anyway because of limited staff and resources. Secondly, and in the light of the first observation, this view of mental disorder may help to explain why patients in mental hospitals seem to have so few objections to their treatment and care. Thirdly, this suggests that Karmel's observation that 99% of patients saw the staff's job as being to keep the patients in line may mean that the patients saw the staff as doing a good and appropriate job for the benefit of patients, rather than being in any sense oppressors (12). Lastly, there are wider political implications of the custodial/somatic model of mental illness and its treatment, both within and outside the hospital. These will be further explored at the appropriate place below.

2. Patients' Views of the Hospital and its Staff.

It was noted above that there is a fundamental divide between patients and staff in the psychiatric hospital. Each of these groups may therefore be expected to have a distinctive view of the hospital and its occupants. Here evidence of the patients' views of the hospital and its staff are considered and assessed.

Evidence concerning patients' views of the hospital and its staff is relatively scarce. Much of it is not systematic and is open to the criticism of being laden with the ethical values of the collector rather than with objective

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(12) Madeline Karmel 'The Internalization of Social Roles in Institutionalized Chronic Mental Patients', Journal of Health and Human Behaviour, 11, 1970, 231-5.

information about patients. Similarly, much material is not substantiated with empirical evidence (13). Despite criticisms like these, I intend to include the evidence of researchers like Goffman here because I believe they still have a real value and validity, and, if nothing else, pose important questions which can then be examined in the light of the empirical, survey-type evidence included later on.

Goffman reports in Asylums that patients are often hostile to the hospital and its staff. The latter are seen as captors (14). Psychiatrists in particular, are seen not as the servants of the patients but rather as people with power who can impose their own will on patients (15). These essentially negative views are echoed in the findings of other researchers. Levinson and Gallagher record that lower class patients in the hospital they studied tend to see the hospital as exploitative and demanding, as opposed to higher class patients who see it in a more positive light (16). They also note that lower class patients have

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(13) Goffman's work in particular has been criticised on these counts. See L.S.Linn, 'The Mental Hospital from the Patient Perspective' Psychiatry, 3, 1968, 213-23, p.214. See also Strauss et al, op.cit., p.94f. This points out the way in which some observers of the psychiatric hospital have used sociology in the interests of particular psychiatric ideologies and have allowed their own middle class assumptions about privacy, human dignity and independence to colour their research.

(14) Goffman, op.cit., p.321.

(15) Ibid., p.320.

(16) Levinson and Gallagher, op.cit., p.176.

a low view of psychiatrists and the treatment they offer (17). They suggest, on the basis of research by writers like Hollingshead and Redlich, that lower class patients tend to see psychiatrists as a mixture of law enforcer and moral authority, as well as being 'regular' doctors (18). Rubenstein and Lasswell show that in the private hospital which they studied, nurses were regarded as part of the 'opposition' by patients. They write

> The nurses were clearly regarded as part of the opposition... against whom the patient struggled to maintain his dignity, privacy and integrity. Nurses were always about at regular intervals during the night, awakening patients, nagging about getting dressed and to breakfast, collecting laundry, serving meals, writing endless notes, handing out medications, enforcing rules and calling the doctor (19).

Despite the negative image presented in this quotation, it continues, "Although members of the opposition, nurses ... were comforting to have around". Rubenstein and Lasswell found that patients saw doctors as omnipotent, omniscient and inaccessible (20).

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(17) Ibid., p.167.

(18) For this authoritarian view of doctors see Hollingshead and Redlich, op.cit., p.345.

(19) Rubenstein and Lasswell, op.cit., p.55. It must be noted that not only lower class patients find staff authoritarian. A university student recently wrote the following concerning the nursing staff of a hospital where he was a patient, "I found the nurses flippant and impatient, and often authoritarian. They were used to dealing with awkward customers and you had to do what you were told." (See David Brandon et al., 'The Mental Hospital - A View from Inside' in MIND, The Future of the Mental Hospitals (London : MIND, 1981), pp.66-72, p.71.)

(20) See ibid., p.55.

The paradoxical attitude towards the nurses displayed by the patients in Rubenstein and Lasswell's study is echoed in Bott's finding that patients and staff collude in a reciprocal relationship which locates all power and goodness among the staff and all badness and impotence among the patients (21). It is perhaps not surprising that patients who consider themselves to be somatically ill and in need of medical treatment should show regressive traits and project both admiration and hatred upon the nursing staff.

It is necessary now to turn from the unempirical, unsystematic studies cited above to the more scientific studies and surveys of patients views of the psychiatric hospital. By contrast with the essentially negative perspective derived from the studies considered above, the empirical studies seem to present a much more positive view of the hospital and its staff.

There are two major studies of the patients' view of the mental hospital, one British and one American. The latter of these, that of Linn (22) reports the results of a survey conducted by interviewing 238 newly admitted patients in a state mental hospital in the U.S.A. This investigation disclosed that, amongst other things, 55% of patients wanted to come into the hospital as opposed to 39% who did not. 54% of patients said that they did not feel they had been forced to come into hospital while 44% felt that they had been. Although 60% of patients found that leaving home and coming into hospital was an unpleasant experience, 22% found it a relief. 46% of patients expected things to be better in hospital than they had been at home as against 31% who thought they would be worse.

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(21) See Bott, op.cit., p.133.

(22) See Linn, op.cit.

45% expected life in the hospital to be unpleasant, but 30% thought that it would be pleasant. 48% expected their freedom to be restricted but 16% expected to have more freedom than they had at home. Treatment in hospital was thought to be preferable by 44% as opposed to 43% who would have preferred home treatment. 36% had fears about being in hospital but 63% had no fears about this. Similarly, 36% of patients thought that being in hospital would deprive them of some of their rights, while 58% thought that it would not. No less than 75% of patients felt that they had not been betrayed by family or friends in being admitted to hospital (23).

The British study, that of Raphael (24), reports the results of a questionnaire survey of 2148 patients of all ages and lengths of stay (except geriatric patients) in six large psychiatric hospitals in the early 1970's. Answers to questions showed that 54% of patients liked being in the hospital, apart from being away from home (25). On the whole, patients were well satisfied with conditions and care. There was general satisfaction with nursing care (only 12% of patients were dissatisfied) and also with the amount of freedom given (26). Patients were very positive about staff, social activities, the grounds of the hospital, their treatment and the security they felt the hospital gave them (27). Space

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(23) For a full tabulation of these figures see ibid., p.217.

(24) Winifred Raphael, Psychiatric Hospitals Viewed by Their Patients (London : King Edward's Hospital Fund for London, second edition, 1977).

(25) Short stay patients (51%) did not like it as much as long stay patients (56%). See op.cit., p.11 for details.

(26) See ibid., p.19.

(27) Ibid., p.27.

in the wards was not regarded as a problem by patients except on very crowded wards. However, noise, adequate locker space and the lack of privacy were criticised by a substantial minority (28). The most unacceptable features of hospital life revealed by patients in the survey were that they felt they did not see enough of their doctors, they felt that doctors did not tell them enough about their condition (39%) and 36% complained of boredom and lack of activities (29). One further feature of the survey which should be mentioned is that it was found that long stay patients were less critical of the hospital than their short stay counterparts (30).

On the fact of it, as I said before, the empirical studies seem to present a more optimistic view of patients' attitudes towards their hospitals than that given in the accounts of the earlier critics. Generally, the picture presented by Linn and Raphael's studies conforms much more closely to the views that might be expected of inmates of a benevolent therapeutic institution rather than those of prisoners incarcerated against their will. How are these two contrary views to be reconciled?

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(28) Ibid., pp.14-15.

(29) See ibid., pp.18, 19, 23.

(30) It is unfortunate that so little research has been done on patients' views of the mental hospital. Even the two studies considered here are not as valuable as they might be because they are not directly comparable. Presumably the dearth of material on this subject reflects the belief that the psychiatric hospitals will not survive for very much longer. As I argue elsewhere, this is an unwarranted assumption in 1982. It is unfortunate too that there is little anecdotal evidence about the lives of patients in the contemporary psychiatric hospital. See, however, Brandon et al., op cit.

In considering this question, the starting point must be one of chronology. Goffman and the other 'non-empirical' participant researchers conducted their studies at a far earlier date than those of Linn and Raphael. During the intervening period, many things changed in the hospitals. The different pictures in the different studies may owe much to beneficial changes in these institutions.

A second consideration has already been touched on above. This is that the early critics of the mental hospital allowed their own values to colour their apprehension and presentation of the situation. It is important to remember that many patients come from lower class backgrounds and may not find the conditions and regime of the hospital so appalling as middle class observers. It has been argued that lower class people tend to be more authoritarian in their attitudes, so an authoritarian custodial regime may not seem at all as unpleasant to them as it would to the middle or upper class person. Conditions in the hospital where there is limited privacy and quite a lot of noise and interference is not as removed from ordinary lower class life as it is from the life style of the upper classes. On the same lines, Linn points out that, while critics like Goffman see the hospital depriving the patient of liberty and worthwhile life, for some patients it can actually enhance or restore rights and privileges lost in the world outside:

> Whereas Goffman assumed that all patients are mortified and stripped of all their liberties and rights by being subjected to the situation which the hospital presents to them, he failed to recognize that for some patients hospitalization provides a means of reclaiming rights and privileges lost in the outside world. Thus, to some, the hospital appears to be an avenue for social redemption, for reinstatement into the society from which they have been alienated and in which they could not function mentally,

physically or socially (31).

If the two previous considerations have appeared to minimise or dismiss the observations of the early critics of the mental hospital, the next point questions the value of the empirical studies. It must be asked how far the views of patients recorded in interviews and questionnaires are to be regarded as a true reflection of objective reality. It seems possible that there may be a gap between patients' actual attitudes and the answers which they might give in responding to an official survey. Possibly patients may respond more positively to questions than they actually feel because they may feel that negative responses may harm them in the eyes of those who have power over their lives in the hospital, i.e. the staff.

But even supposing that patients are completely frank in their answers in surveys, this does not necessarily mean that their answers reflect the objective situation in which they find themselves. In this connection the notion of 'false consciousness' is a useful one. This is a concept used in Marxist analysis to denote the way in which oppressed classes fail to perceive their situation of oppression correctly, and basically internalise and reproduce the perception of the dominant groups by which they are oppressed (32).

In discussing false consciousness at length, Plant et al.

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(31) Linn, op.cit., pp.222-23.

(32) See 'false consciousness' in G. Duncan Mitchell, ed., A New Dictionary of Sociology (London : R.K.P., 1979) for more about the Marxist usage of this concept. An example of its usage, though it is not explicitly stated, is to be found in Paulo Freire, Pedagogy of the Oppressed (Harmondsworth:Penguin, 1972), especially ch.1.

note that "Very often needs may not be expressed just because people's perceptions of what is possible may be diminished or inhibited" (33). It is suggested that, in some circumstances,

> not only will the existing structure of power prevent felt needs from being articulated within the political arena, but also, the power structure that is both legitimated by and reflected in all kinds of meaning systems - moral norms in institutions, social rituals, etc. - may so mould individuals that they are in some sense unaware of their real needs or the depths of their poverty and deprivation (34).

Although this remark is intended to refer to macro socio-political structures, it may equally be applied to smaller ones such as psychiatric hospitals. Unfortunately, there is a certain ambivalence in the use of the notion of false consciousness. Inevitably it is ascribed from within, and refers to particular moral, social, political and ideological standpoints and so there is an element of transience and subjectivity attached to it. Plant et al. note that "what constitutes false consciousness ... is going to involve assumptions - its ascription cannot be a straightforward, empirical, answerable question " (35). Despite its ambiguity, false consciousness can be illuminating in that it may give cause to question accounts of reality which reflect the interests and views of those who have power in society or in a particular society or institution.

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(33) Raymond Plant, Harry Lesser and Peter Taylor-Gooby, Political Philosophy and Social Welfare (London : R.K.P., 1980), p.105.

(34) Op.cit., p.107.

(35) Op.cit., p.120.

Using this concept here, I am suggesting that patients in psychiatric hospitals may internalise a view of the hospital and the way it treats them which in fact reflects the 'official' view of the hospital but does not fully or accurately reflect the reality of the situation. It is perhaps because of this that patients may have strongly antipathetic feelings towards the hospital and its staff, but when asked they can only say how good the institution is to them (36). Some evidence for a false consciousness theory is provided in Raphael's study. The fact that short stay patients were more critical than long stay suggests that longer term patients gradually internalised the official view of the institution and came to accept the actual more as the ideal.

Even if the criticisms of the empirical studies that patients may not express their true opinions or that those opinions may not reflect the reality of their situation are rejected, it is still arguable that the findings of these surveys are not totally contradictory of the evidence of the non-empirical critics of the hospital. For example, although 54% of patients in Raphael's study did like being in hospital, that still meant that 46%, nearly half the

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(36) It is perfectly possible in reality to talk to patients who have been badly treated in hospital and are aware of this, but who will still say that the staff are wonderful if asked their opinion about them. The image of doctors and nurses as demi-gods who invariably act in the best interests of the patient is such a dominant one in hospitals and in society as a whole that it is very difficult to obtain any other verbal opinion, even in psychiatric hospitals where the control aspect of life is very strong and medical and nursing skills are of more limited use.

patients, did not like being in the hospital (37). Often the other figures given by Linn and Raphael hardly provide evidence of overwhelming satisfaction with the hospitals. Many of them hover around the 50% mark and can be seen in a negative as well as a positive light. An example of this is to be found in Linn's figure that 46% of patients thought that things would be better in the hospital than they were at home, as opposed to 31% who thought they would be worse. This sort of statistic is thrown into stark contrast by figures from a previous investigation of Raphael's into general hospitals where it was found that no less than 94% of patients liked being there. Even in the psychiatric units of general hospitals 81% of patients liked being there as opposed to the 54% figure quoted above for patients in psychiatric hospitals. One may conclude from this kind of contrast that things in mental hospitals, even assessed by survey methods rather than subjective observation may not be so very much better than the non-empirical observers noted in their investigations. It seems fair to say that with 46% of patients not happy to be in psychiatric hospitals, their attitude to these institutions may still be characterised as basically negative. Ultimately, then, I do not see that there is a major discrepancy between the different sources of evidence cited above, despite differences of chronology, method, and reporting. Many of the features described by Goffman and others in the 1950's are still relevant and operational today.

Having made some attempt to try and explain and reconcile the differences in sources of evidence concerning patients'

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(37) The fact that so many patients did like being in the hospital may be seen as a sign of institutional dependence rather than as evidence of the merits of the hospitals.

views of psychiatric hospitals and their staff. It is perhaps worth mentioning that there is one area on which the empirical and non-empirical critics are in agreement. This concerns patients' views of their doctors. Raphael's finding that 31% of patients felt that they did not see enough of their doctors while 39% felt their doctors did not tell them enough is perfectly congruent with the observation of the earlier critics that doctors hardly ever saw their patients and were regarded by them as omnipotent, omniscient and inaccessible.

It may be concluded that patients' experience and view the hospital and its staff in largely negative ways. It would certainly not be true to say that they see the hospital and staff as caring and benevolent in the same way as they would view a general hospital. Although it may be that many of the worst features described by the early writers on the mental hospital have changed since their research in the 1950's, the more recent evidence summarised gives no grounds for believing that patients' predominantly negative feelings have substantially lessened. Indeed, there is evidence that patients regard hospitals as actively oppressive institutions still (38).

3. The Legal Position of Patients

Only a minority of patients are legally detained in psychiatric hospitals. However, the minority is a substantial one, and the laws under which they are detained are far-reaching in their effects. They considerably affect patients' powers and abilities to influence their own destiny and that

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(38) Karmel, in a study published in 1970, found that 99% of patients in a state hospital in the U.S.A. agreed with the statement "It is the main job of the attendants and nurses to see that the patients stay in line", Karmel, op.cit., p.234.

of the hospital and its staff. It is therefore necessary to devote further consideration to this matter (39).

Powers of legal restraint under the Mental Health Act of 1959 may be divided into two categories, short-term and long-term measures. There are five short-term measures. Under section 29 of the Act a person may be admitted to hospital for a period of 72 hours for observation. This admission takes place on the basis of an application by any relative or Mental Welfare Officer (now a social worker) and it requires the recommendation of a doctor. A patient may be admitted and detained for observation for up to 28 days under section 25 of the Act. This is done on the recommendation of two doctors (40). Section 135 of the Mental Health Act gives power for entry into premises without consent and the compulsory removal of a person to a place of safety (usually a hospital) for a period of assessment not exceeding 72 hours. Section 136 empowers police officers to remove a person suffering from mental disorder needing immediate care and control in his own interests or those of others, to a place of safety for assessment. The person can be detained under this section for 72 hours. The last of the short-term measures available is that of detention for up to

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(39) It should be remembered that voluntary patients can be compulsorily detained after admission to hospital if this is thought necessary.

(40) The 1978 Review of the Mental Health Act suggests that treatment, i.e. active intervention in the patient's life, could be administered without the patient's consent under this section as long as it was required by way of observation or was immediately necessary in the interests of the patients' own health and safety or for the protection of others. See D.H.S.S., Review of the Mental Health Act 1959, Cmnd. 7320, (London : H.M.S.O., 1978), 2.10.

72 hours of a patient already in the hospital. This provision under section 30 of the Act allows time for an application to be made under section 25 or 26 for treatment or observation.

There are two long term measures in the Mental Health Act which allow admission detention and compulsory treatment in hospital. Section 26 permits a person to be admitted and treated in hospital without his consent for up to a year, if he is found to be suffering from mental disorder (41). Application for admission under this section is made by a patients' nearest relative or by a Mental Welfare Officer (42) and must be recommended by two doctors, at least one of whom must have had specialised experience in the diagnosis and treatment of mental disorder in accordance with section 28 of the Act (43). The other doctor involved should normally have known the patient before, e.g. be the patient's G.P.

Section 60 of the Mental Health Act permits law courts to make orders for detention and treatment in hospital in respect of offenders suffering from mental illness, severe subnormality, or psychopathic disorder, irrespective of their ages. In addition, courts may make restriction orders under section 65 which prevent the patient from being discharged for a fixed period of time or without limit of time. Only the Home Secretary can authorize the discharge of a patient when a restriction order has been made (44).

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(41) See Mental Health Act 1959, Section 26 (b) for exact details of categories of patients covered.

(42) See ibid., section 27.

(43) Normally this doctor will be a psychiatrist.

(44) A patient detained under section 60 only can be discharged at any time by the responsible medical officer, the hospital managers, or a Mental Health Review Tribunal.

If a patient is committed to a hospital under sections 26 or 60, the order for this must be renewed if continued detention is required after a year, followed by renewal after one more year, followed by renewal every two years. In 1976, 800 people were admitted to hospital under section 26 and about 900 under section 60 (45).

Patients detained in hospital under the short-term orders for observation and assessment have no right of appeal against these orders. They may, however, be discharged during the period of time before their sections expire (46). Patients detained under sections 26 and 60 may also be discharged during the course of the order's validity. If they cannot obtain release from detention by application of their relatives, the responsible medical officer or the hospital managers, they can appeal to a Mental Health Review Tribunal (M.H.R.T.) within six months of their being committed under the Act. They can also apply for a M.H.R.T. once within each renewed period of detention under section 26 or 60 (47). Patients under section 65 restriction orders cannot appeal directly to M.H.R.T's but can ask the Home Secretary to refer their cases to them. The Home Secretary is not bound by the Tribunal's recommendation (48).

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(45) These figures from Review of the Mental Health Act, 2.36, Cf.5.2.; 1,440 orders were made under section 60 in 1966.

(46) See section 47 of the Act.

(47) Relatives can order the discharge of a patient under section 26 or can apply for a patient's discharge on that patient's behalf. See Larry Gostin, A Human Condition, Vol.1, (London : MIND, n.d.) p.57.

(48) For details of appeal procedure, see Gostin, op.cit., Ch.4 and Review of the Mental Health Act, Ch.6, especially 6.2.

The measures of the Mental Health Act are very far-reaching for those who fall within its scope. Patients have liberty of movement limited or denied. They may be subject to treatment which is dangerous or unpleasant against their will. Gostin writes, "This is an invasion of bodily privacy and integrity, which others are protected against by the criminal law as well as by the common law of torts" (49). A compulsorily detained patient may be moved at any time to any place at the discretion of the responsible minister.

Whether or not patients are legally committed under the Act, their lives are affected by it. All patients may have their mail censored. They may not, if they have no outside address, be able to vote in elections. They may be denied a driving licence. Patients regarded as being of unsound mind may be unable to make a will to convey real property, or to act as a guardian or trustee (50). Formally detained patients have no legal redress against those who commit and treat them under the Mental Health Act. Section 141 explicitly states,

> No person shall be liable ... to any civil or criminal procedings ... in respect of any act purporting to be done in pursuance of this Act ... unless the act was done in bad faith or without reasonable care.

There is no official external check on the implementation of the Mental Health Act. This means that abuses are possible and patients who could perhaps have entered the hospital voluntarily may be sectioned under the Act, suffering much

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(49) Gostin, op.cit., p.102.

(50) See further Gostin, op.cit., pp.101-103.

trauma and anguish (51). Again, patients who have entered the hospital voluntarily may be summarily sectioned or may be threatened with this if they fail to co-operate with staff. The fact that responsible medical officers can administer any kind of treatment they choose under the Act again exposes patients to potential abuses. Even the safeguards built into the Act are not as effective and fair as they might be. For example, patients on short-term orders, the majority of those detained under the Act, cannot appeal and so may suffer up to 28 days of involuntary detention (52). Those patients who can appeal usually do not (53). Gostin suggests that this happens because the onus of appealing is placed firmly on the patient who may be severely handicapped by 'institutional inertia' (54). Contributing factors to this inertia may be lethargy induced by sedation, an illness which may cause withdrawal isolation, apathy and an unwillingness to be assertive, awareness of the implied authority of the medical regime which discourages questioning and challenge, residence in an institution which prevents easy contact with lawyers and witnesses, so making the preparation of a tribunal case very arduous, and simple ignorance of legal rights and how to go about asserting them. In short, institutional inertia "has affected the patient's desire and initiative to exercise his rights under the law" (55).

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(51) See Gostin, ibid., pp.28-9.

(52) See ibid., p.66.

(53) Gostin points out that around 88% of patients compulsorily admitted to hospital presumably against their will fail to appeal.

(54) Ibid., p.67ff.

(55) Ibid., p.69.

Gostin goes on to show further inadequacies in the tribunal system. Patients are often not informed of their rights by hospital staff (56). This leads to discrepancies in the numbers of patients who appeal between the health Regions in the country (57). Patients are not necessarily allowed to read the medical report which the hospital sends back to the tribunal. In order to obtain a hearing in front of a tribunal, patients, or their relatives, must make a specific request - there is no automatic tribunal procedure for patients on sections. The burden of obtaining a public rather than a private tribunal hearing also rests with the patient. After the hearing has taken place, the decisions made by the tribunal are not made known to the patient unless he specifically requests them, and even then they are not necessarily disclosed (58). Gostin concludes,

> In sum, at every stage of the M.H.R.T. procedure - application, formal and public hearing, and reasoned decision - the burden to exercise his rights is on the patient. Predictably, he does not come forward and request his rights and, as a result, he does not receive them (59).

Even when a patient does appeal to a tribunal, he may experience a considerably delay in having his case heard. Meanwhile, he remains under involuntary detention. Since tribunal members are professional people, by and large, there may be an inherent class bias against the interests of

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(56) Ibid., p.70.

(57) Ibid., p.71.

(58) Ibid., p.74.

(59) Ibid., p.74.

the patient, and a lack of common background, experience, and communication. At least one of the tribunal members is a psychiatrist who may well know the psychiatrist who is looking after the patient, and who may well empathise more with his colleague than with the patient (60).

Gostin's work clearly shows that M.H.R.T's are an inadequate way of trying to preserve the rights of patients. He also points out that even when tribunals are held, they are very constrained in their powers. They cannot recommend modifications of treatment, conditional discharge or transfer to a different kind of institution. They can only either recommend the absolute release of the patient, or his retention (61). In the case of people who cannot appeal directly to tribunals, i.e. those on restriction orders under section 65, they may find themselves detained in hospital for a period of time which bears no relation to the seriousness of their original offence (62).

The far-reaching and oppressive effects of the Mental Health Act might be more acceptable if some of the fundamental concepts of this legislation were not also open to question. The Act embodies several dubious concepts. For example, it fails to define exactly what is meant by the term 'mental illness'. It will be argued later that this term is fraught

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(60) See ibid., p.84. Gostin relates there that

> the physician-superintendent of Broadmoor Hospital has told MIND staff that the R.M.O. and the tribunal doctors in Broadmoor cases used to call each other by their first names, until the patients objected, suspecting that such familiarity meant bias.

(61) Ibid., pp. 62-3.

(62) See Gostin, op.cit., Vol.2, p.73f.

with ambiguity and social and political implications and nuances (63). On a practical level, there is no standardised diagnosis for any mental illness (64), so the term comes to mean what a particular practitioner conceives it to mean. There is therefore the possibility of a considerable variation between psychiatrists who may thus be felt to be acting in an arbitrary way.

Evidently, the legislators who passed the 1959 Act saw doctors as the indisputed mediators of what the concept of mental illness means. For this reason, they placed massive powers in medical hands. They presumably saw doctors as benevolent scientists who would administer their power rightly and duly for the benefit of individual patients and for society as a whole. Again, it will be argued that doctors and the models of mental illness which they espouse, far from being 'scientific' and neutral have a social and political role in society and in the hospitals which may be seen as oppressive. It is they who must decide what the interests of health and safety of a patient are, and it would be wrong to suppose that they can do this in a way which is free of their own particular moral values which are compatible with the values of society as a whole.

At the time of writing, early in 1982, new legislation is being brought before Parliament to amend the Mental Health Act 1959 (65). Some of the criticisms of current mental health legislation mentioned above are met by the proposed new

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(63) See Appendix.

(64) See Gostin, op.cit., Vol. 1, p.37.

(65) See House of Lords, Mental Health (Amendment) Bill (London : H.M.S.O., 1981). See also the accompanying paper, D.H.S.S., Reform of Mental Health Legislation (London : H.M.S.O., 1981) which explains the Bill.

legislation. The period before detention has to be renewed or ended is halved, a treatability test is introduced for some groups before detention can take place, access to Mental Health Tribunals is increased considerably (66), automatic Review Tribunals will take place in some cases and the issue of patients' consent to treatment is clarified. However, while it may enhance patients' rights in some ways, in others it leaves things as they are or even diminishes them. The most obvious example of a case of the former is that the concept of mental illness or disorder is still left undefined, leaving a degree of possible arbitrariness available on the part of doctors. The possible diminishing of patients' rights and autonomy is to be found in the proposal that section 25 should permit treatment as part of positive assessment rather than simply allowing observation to take place. Similarly, clause 38 of the new Bill which deals with consent to treatment on the part of detained patients does not allow any element of non-medical assessment as to whether a person is or is not fit to consent to treatment (67).

The Government has stated that "the 1959 Act has worked well" (68). It is therefore not to be expected that major changes should be proposed in the Mental Health (Amendment) Bill. This means that a substantial minority of patients in hospitals will still have diminished rights and autonomy, for

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(66) Patients detained for 28 days under section 25 of the 1959 Act would be eligible to appeal to a Tribunal under the new legislation for example.

(67) See Larry O. Gostin, 'The Great Debate' (London : MIND, 1982) for this and other criticisms of the Amendment Bill.

(68) D.H.S.S., op.cit., 3.

better or worse and that others will still live under the threat of being compulsorily detained and/or treated (69). The existence of such legislation, necessary though it may be in some form or another, will therefore continue to be an important factor in assessing relative amounts of power and autonomy in the psychiatric hospital.

4. Patients as a Group

It has been suggested that the members of the hospital should be seen as belonging to one of two groups; patients or staff. Here the nature of the former group is explored in order to discover its distinctive qualities, its values, its divisions and its unities. This question is of vital importance if the political power and effectiveness of patients both inside and outside is to be assessed.

In fact, patient society, by its very nature, defies such enquiry. While patients evidently form a recognisable group within the hospital, they cannot be described as in any sense a distinctive community, society or culture. Sommer and Osmond have characterized the relations between patients as a group as the 'schizophrenic no-society' (70). Although many features of patient life would give patients opportunities to relate closely to each other, it seems that, for the most part, patients fail to relate to each other and to build up any coherent system of social relationships. Sommer and Osmond argue that the term 'society' cannot be

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(69) In this connection it is worth quoting Szasz's observation that "there is no such thing as voluntary mental hospitalization, nor can there be, so long as there is involuntary mental hospitalization". (Thomas S. Szasz, The Age of Madness (London : R.K.P., 1975), p.xviii.)

(70) R. Sommer and H. Osmond, 'The Schizophrenic No-Society', Psychiatry, 25, 1962, 244-55.

used appropriately of the patient grouping because societies demand mutual co-operation, and common expectations and understandings among individuals. This is largely lacking among schizophrenics. Sommer and Osmond similarly reject the notion that patients form a sort of community. If a community is defined as a place where there is communal work and a division of labour in order to derive sustenance from the environment, this is not an appropriate description of the patient group since all the patient's needs are met in the hospital without any effort on their part, and so there is little incentive to combine to gain sustenance. The idea that patients may form a distinctive culture or sub-culture is also inaccurate, as a culture depends on shared symbols and communication within a group giving rise, among other things, to features like distinctive traditions, values and mythology. Thus it appears that "mental patients live as an aggregate of discrete individuals" (71).

These observations are confirmed by those of Karmel (72). She found that while patients were stripped of their previous social roles and identity on admission to hospital, they did not acquire new ones in the hospital. This is attributed to the fact that there was no distinctive society or culture among the patients which would enable such roles and identity to develop. None of the features of a successful deviant sub-culture were present, so there was no successful re-socialisation.

Goffman emphasises the stripping of previous identity,

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(71) Sommer and Osmond, op.cit., p.252. This situation can be contrasted with that of, say, prisoners who do form a distinctive society and culture alongside that of the staff.

(72) See Karmel, op.cit.

family and friends. However, even he is not particularly able to describe the distinctive features of patient society and culture. Patients who have been stripped remain effectively without a social identity or culture.

Gallagher adds to the picture of isolation and fragmentation among patients as a group by pointing out that patients in hospital form few friendships with each other (73).

Further evidence of lack of a distinctive patient society is provided by the fact that there are few organisations composed of mental patients, or ex-patients, which campaign on behalf of the mentally ill (74).

It must be asked why patients as a group do not cohere more and develop a common society and culture. Sommer and Osmond attribute this situation of 'no-society' to the nature of mental illness itself: "Schizophrenia has accomplished what no tyranny, no inhumanity, of man to man, has ever been able to do - it has kept people from communicating with one another" (75). They also blame the organisation of the hospital and its design to some extent. There is, however, another important factor, stigma. All psychiatric patients occupy a negatively sanctioned social role. Similarly, all psychiatric patients are aware that other patients occupy a stigmatised position in society. It

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(73)Bernard J. Gallagher, The Sociology of Mental Disorder (Englewood Cliffs : Prentice Hall, 1980), pp.303-4.

(74) For information on those groups which do see Sedgwick Psycho Politics, Part 2 and L. Durkin and B. Donieb, 'The Mental Patients' Union' in B. Jones and M. Mayo, eds., Community Work Two (London : R.K.P., 1975).

(75) Op.cit., p.252-53.

is not therefore surprising that they wish to distance themselves from others whom they rightly perceive as occupying an undesirable social position. It is the notion of stigma which accounts for the fact that people in psychiatric hospitals will often seek to avoid contacts with their fellow patients - after all, they are mad (76).

It may well be that since Sommer and Osmond wrote about patient society in 1962, changes have occurred which have solidified that society. For example, experiments in social psychiatry may have done much to draw patients together. However, amongst various groups of patients, including the psychogeriatric, the psychotic and those whose treatment has not been on the lines of social therapy, the 'no-society' remains a very real feature. This has very important implications for the power and political organisation of patients in the hospital. If no cohesive group can emerge, there is little chance of effective organisation to effect desired change within and outside the institution. This will be picked up at a later point.

5. Patients, Power and Politics

It would be hard to think of a group of people in society at large or in the psychiatric hospital in particular who have less power than the mentally ill, especially those who spend a long time in psychiatric institutions. Writing of the situation of American patients in this regard, Talbott states,

> Mental patients do not write letters to their state representatives or to newspapers; they do not picket

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(76) For the effects of stigma among patients see Robert M. Swanson and Stephen P. Spitzer, 'Stigma and the Psychiatric Patient Career', Journal of Health and Social Behaviour, 11, 1970, 44-51.

> or demonstrate in front of state capitols; and they have no lobbying or public affairs representatives. As opposed to labor, business and the professions ... they are almost completely powerless to affect the political process. Even compared to other have-not groups - alcoholics, prisoners, or welfare mothers, - they have no clout... . The mentally ill do not have ... a body of mentally intact relatives, due to the complex socio-environmental and genetic etiology of serious mental illness.... As a result they constitute one of the truly powerless constituencies in our society (77).

To all intents and purposes, this judgement is as valid for British patients as it is for those in America. Until very recently some patients in British hospitals without any outside address were deprived of suffrage, the very minimum recognition of a citizen's political rights in a democratic society.

The roots of patient powerlessness lie in the nature of mental illness itself, but also to a very great extent in wider social factors. It may be that a genetic predisposition to serious mental disorder is distributed evenly through all the classes of society. It seems, however, that people born into the working classes have a greater chance of growing up to exhibit the symptoms of serious clinical disorder (78). Having been born into a class which does not control society and its political direction in the first place, lower class sufferers from mental disorder are then likely to find themselves isolated even from their own class by the nature of their disease and by the attitudes of those around them to it. It is likely that they may be treated in large isolated

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(77) Talbott, op.cit., p.68. Emphasis added.

(78) See further Appendix .

and antiquated psychiatric hospitals where, once again, they find themselves at the bottom of a class-related hierarchy where the staff, not the patients, have almost absolute power over their destiny and the organisation of the hospital. Patients mostly do not, or cannot, organise themselves into a cohesive group within or outside the hospital in order to gain more power. Their relatives tend to desert them and even if they do not, they too suffer from lack of organisation, articulacy and initiative and may be inhibited about challenging the status quo supported by the higher and professional classes inside and outside the hospital. Relatives may themselves be victims of mental disorder which further reduces their power to work for desired change.

The general public has never taken more than an occasional and often voyeuristic interest in the mentally ill and their situation. Belknap comments,

> The public in general, having achieved a comfortable disposition of its local responsibility by sending its mentally ill citizens to a large, centralized, and somewhat isolated institution, found it easy to forget them and settled into an indifference which has persisted well into the twentieth century (79).

Neither the ruling classes, nor the organised working class, have shown much interest in mental patients as a group. The former have perceived the mentally ill to be economically useless and a drain on public resources, and have tried as much as possible to dispose of the mentally ill with the least possible trouble and expense. The latter have never seen the mentally ill as potential allies in attempting to gain control of the power and economic structures of society (80).

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(79) Belknap, op.cit., p.18.

(80) For more on the lack of working class interest in the mentally ill, see Sedgwick, Psycho Politics, Pt.2.

In Marxist terms, this group must be regarded as part of the 'lumpen proletariat', i.e. those in society who, although their origins lie in the working classes and their interests are more closely related to those in that class than to those of the ruling class, are essentially non-participants in the class struggle because they do not and will not take part in production. The mentally ill can bring little pressure to bear on either side of the class divide, and have no material resources or sanctions with which to do this.

> Rubenstein and Lasswell comment that psychiatric patients:
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> have been defeated in long, protracted, at times subtle, at times violent, power struggles within their families, and by friends and colleagues in school, work and the other communities in which they have unsuccessfully sought to participate (81).

They further remark that "conventional psychiatric institutions reinforce the self-image of the hospitalized as losers, sufferers, victims" (82), by depriving patients of power over their own lives. Here I want to broaden this comment which has much truth in it to say that those who suffer from mental illness and become patients in psychiatric hospitals are to a large extent powerless at all levels of their history and existence, as much because of their lower class origins as because of any impotence induced by psychiatric disorder per se. In many ways, it is because the hospitalized mentally ill come disproportionately from the lower classes in society and so occupy an insignificant place in that society, that their rights, interests and needs can be ignored almost entirely by those with power. Until socio-economically significant political action is taken by, or on behalf of the mentally ill, it is likely that those who are born at the

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(81) Rubenstein and Lasswell, op.cit., p.4.

(82) Ibid., p.5

bottom of the social system and treated at the bottom of the N.H.S. system will continue to enjoy a minimal standard of life and a maximal degree of impotence.

There are some mechanisms whereby the interests of the mentally ill are represented, both within the hospital and outside it. Patients in hospitals run on social therapy lines may be allowed and encouraged to have a considerable degree of influence on what takes place in their ward or in the hospital as a whole. Some hospitals have patient-staff consultative committees where, again, patients may wield real influence. Outside the hospitals, there have been some attempts by ex-patients to organise Mental Patient's Unions to campaign for better conditions for this group. These, however, have only had a limited success and endurance, and are less common now than they were ten years ago.

Apart from these attempts at direct patient influence, mental patients depend chiefly on being represented by organisations which are, for the most part, composed of people of mainly middle class origin who have had little direct experience of mental illness or hospitalisation themselves. The National Association for Mental Health (MIND) is the most prominent organisation in this respect. The National Schizophrenia Fellowship acts as a pressure group on policy making, but its interests lie principally in responding to the needs of the relatives of the mentally ill, and not sufferers themselves directly. An all-party group of M.P's at Westminster also takes a close interest in the needs and conditions of patients, however, they, in common with the other groups mentioned, cannot exert as much pressure as is needed because they represent a constituency which can yield few returns in terms of votes or economic usefulness. Without

major changes in the economic order and in the values of society, this situation seems destined to continue for many years to come.

CHAPTER XI

THE STAFF

1. Introduction

Having spent some time looking at the situation of those on one side of the staff-patient divide, namely the patients, it is now time to turn to the staff. In the section which follows, the three most important staff groupings in the hospital - aides or nursing assistants, qualified nurses and doctors - will be examined in detail. The staff of a hospital do not form a homogenous group, and so it is necessary to treat these groups separately and to try and extrapolate their social class background, their history, their attitudes to patients and to each other, their relative power and their distinctive place within the institution. When this examination has been concluded, something will be said about other groups of staff within the hospital and then common attitudes of staff members will be discussed.

2. Nursing Assistants

One distinctive feature of the staffing of psychiatric hospitals is the size and importance of the group comprising the unqualified nursing staff (1). Members of this group are termed attendants, aides, or nursing asistants, the last term being the one most commonly used in contemporary British hospitals.

Whatever the designation, this group of personnel has a common ancestry in the asylum attendants who were the

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(1) See D.H.S.S., Report of a Working Group on Organisational and Management Problems of Mental Illness Hospitals, 2.10 and 8.26 which shows that 44% of nursing staff in psychiatric hospitals are unqualified.

dominant and most numerous group in the care of patients in the old custodial asylums. It was not until relatively recently that attendants could become qualified nurses along the same pattern as general nurses (2).

The literature on which this account of nursing assistants is based mainly reflects the situation of American hospitals in the 1950's. This literature gives a picture of hospitals being run mainly by attendants with just a few qualified nurses to supervise them. Although qualified nurses are much more common in contemporary British hospitals, unqualified staff still occupy a very prominent place in the life of our hospitals. This is especially the case in hospitals where there is a shortage of qualified staff (3), and in the less favoured parts of hospitals where nursing duties seem heavy and unrewarding, e.g. in chronic wards, in psycho geriatric wards and in wards which are, for one reason or another, run down (4). It is very important, therefore, to take account of nursing assistants as a group, even if the findings of researchers in the 1950's have to be modified to take account of the changes which have taken place between now and then.

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(2) See Jones, op.cit., p.334.

(3) Many hospitals do have a considerable shortage of qualified staff which can be as much or more than 30% -presumably there is a greater shortage in rural hospitals where there are fewer potential recruits than in towns.

(4) David Towell, Understanding Psychiatric Nursing (London :Royal College of Nursing, 1975), p.34. Table 1 clearly shows the bias towards nursing assistants against other staff grades in geriatric units.

Nursing assistants are the staff group which has most to do with patients directly. Since they are unqualified, nursing assistants are not regarded as competent to undertake administrative or medical functions and so spend most of their time in contact with the patients. This means that they generally know the patients better than the nurses and other qualified and professional staff and are more aware of their current conditions and needs (5). On a ward where there are few qualified nurses, nursing assistants form a vital mediating link between the patients and professional or qualified members of staff (6). The initial evaluation by a nursing assistant of a patient's condition may be crucial in ensuring that that person's needs are met.

Belknap and other observers of the U.S. psychiatric hospital in the 1950's found that attendants were able to run the lives of wards and patients to suit their own convenience. Because of the lack of qualified staff, attendants were left to run wards almost entirely on their own and were permitted to take informal responsibility far beyond their formally recognised competence. Attendants were able to classify patients in a completely different way from psychiatrists, according to their own perception of the organisational needs of the ward rather than according to medical diagnosis and treatment (7). Belknap reports,

> The main function of the informal organisation on the wards for the attendant is to set up a system which permits him to adjust personally the requirements of psychiatric treatment, as represented

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(5) Levinson and Gallagher write that "of the several staff roles, the attendant or aide is likely to know the patient best and to play a significant potentially therapeutic part in the patient's life." (Op.cit., pp.172-3.)

(6) See Belknap, op.cit., p.66.

(7) See Belknap, op.cit., Ch.8.

by the hospital's formal classification on the one hand, with the requirements of daily patient management on the other.

Attendants were able to mediate between patients and other, higher groups of staff in the hospital hierarchy, e.g. doctors. They used their power "not in terms of the individual patient's psychiatric needs but rather in terms of the requirements of their own social system" (8). Attendants instituted a system of rewards and punishments for patients to make the wards run as they wanted. Obstructive patients were punished by having their undesirable behaviour 'medicalised' so that some undesirable status change or treatment could be administered (9). In effect, where attendants were the dominant group on a ward, there existed a complete lay system of care (10).

With the rise in the numbers of qualified nursing staff in psychiatric hospitals, and the fall in patient numbers, such totally attendant-dominated care systems are rare now. Nonetheless, on wards where the ratio of unqualified to qualified staff is bad, elements of these systems survive. It is certainly true to say that, in terms of the everyday life of the patient in the hospital, nursing assistants can still be the most important and influential group with power and influence far beyond what is formally recognised in the hospital.

Nursing assistants are close to the patients, not only in terms of the amount of time they spend with them, but also in terms of common social and cultural background. Many

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(8) Belknap, op.cit., p.67.

(9) See Belknap, op.cit., pp.164, 170.

(10) See further Strauss et al., op.cit., p.95ff.

observers have noted that unqualified nursing staff come principally from working class backgrounds (11). Many of them are women also (12). This means that, all in all, they come from the most underprivileged and impotent within the contemporary socio-economic order. Nursing assistants are paid considerably less than qualified staff, even if they have worked in the hospital for many years and have acquired considerable experience.

The fact that nursing assistants share a common background with many of the patients in the hospital may be regarded as either good or bad. While it may mean that they can understand, empathise with and communicate with patients more easily than staff from higher class backgrounds, it can mean that 'splitting' occurs. That is to say that nursing assistants may reject in others the things that they face themselves and may try to distance themselves from them (13). There is some evidence that nursing assistants do try to distinguish themselves from patients and to distance themselves. Belknap records that new attendants were taught by their older colleagues to relate to patients as superiors to inferiors (14). The lack of official status and authority given to them by the institution may also cause them to want to emphasise the degree of authority and status which they do have over patients of their own and higher classes.

Coming from the lower classes also means that nursing assistants have a very different background from that of more

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(11) See Talbott, op.cit., p.48, Belknap, op.cit., pp.44,68, Strauss et al, op.cit., p.118f.

(12) See Navarro, Class Struggle, The State and Medicine, p.75.

(13) See Talbott, op.cit., p.48.

(14) See Belknap, op.cit., p.182.

highly qualified and professional staff who come for the most part from higher classes. This has serious consequences for concepts of mental illness and its treatment, and also for communication among staff members. Belknap writes:

> Our interviews and observations in the hospital indicate that levels I, II and III are separated from each other by wide differences in social background, with a particularly wide gulf between level III (attendants) and the two upper levels (professional and qualified staff). These social differences are sufficient to prevent any intimate communication between the professionals and the attendants, except in very rare cases. The attendant and the professional literally do not talk the same language. As a result there is much avoidance between groups, and a large amount of hostility, particularly on the part of the attendants (15).

This class-related non-communication is still present in the hospital today. It is rare for a nursing assistant to speak to or in front of a doctor or other professional worker on anything but the briefest and most superficial level.

Nursing assistants appear to share the concepts of mental illness and its treatment which are common throughout the working classes. Mental illness is conceived in essentially organic terms. Psychological and psychotherapeutic approaches are not understood or are rejected for the most part and nursing assistants are unable to distinguish between psychotherapy and their own talking to patients (16). Similarly, they find it difficult to distinguish between familiarity with patients and more abstract knowledge of them (17). As a result of this, and because they have little incentive in terms of rewards or career prospects, nursing assistants tend not to change so as to act therapeutically

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(15) Belknap, op.cit., p.45. Emphasis added.

(16) See Strauss et al., op. cit., pp.244-5.

(17) Ibid., p.244.

towards patients in their interactions. Rather, they prefer to adhere to a custodial-medical model of mental illness and its treatment and to concentrate on the physical and custodial tasks to do with patients (18). Unqualified staff tend to be authoritarian in their attitudes towards patients and their illnesses, believing that the patients are in some sense suffering from some kind of physical complaint but that they also need a strong hand. The custodial authoritarian approach which they display is accurately summed up in the following passage:

> The custodial aide handles the functions of authority and control that must be met in his role vis a vis the patient by showing that he is 'the boss' and by threatening the patient. He reacts personally to the patients who are assaultive or unco-operative and is likely to get back at these patients. His primary function is to keep the ward quiet .... In general he avoids all contacts with and leaves all 'therapy' to the doctors. He is relatively insensitive to the individual problems of patients.....He often talks in an angry or condescending way to patients. With supervisors he resents being given orders and when criticized, he justifies himself by blaming the patients. (19)

Although this description of the attitudes of attendants was written a long time ago and in the U.S.A., it will strike a chord with anyone familiar with the contemporary British psychiatric hospital. These attitudes are still common and may do much to explain why there are occasional incidents of violence in psychiatric hospitals and why Karmel found that many patients saw the job of the nurses as to keep

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(18) See Talbott, op.cit., p.48f.

(19) Doris C. Gilbert and Daniel J. Levinson, 'Role Performance, Ideology and Personality in Mental Hospital Aides' in Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, eds., The Patient and the Mental Hospital (Glencoe: Free Press, 1957), pp.197-208.

the patients in line (20). Needless to say, these attitudes are not exclusively confined to nursing assistants.

I have touched on the fact that nursing assistants do not occupy positions of formally recognised power and influence in the hospital despite their intimate knowledge of patients and the life of the wards on which they work. They have very few opportunities to contribute at an official level to the policies of the ward and the hospital except through their union representatives. However, it has been argued that unofficially and especially at ward level, unqualified staff may have a great deal of power and influence, particularly over those who have less power than themselves and come lower down in the hospital hierarchy, i.e. the patients. This power lies beyond the control of the professional and qualified members of the staff. Although unqualified staff are probably not as dominant now as they were in the 1950's in American hospitals, many of the features associated with that dominance continue. This is especially likely to be the case in hospitals or wards which have few qualified staff, or which work on a mainly custodial/medical model of mental illness and its treatment. It is likely to be the least prestigious and most isolated hospitals which find themselves in this position most acutely. As the present economic recession deepens, it may well be that the number of nursing assistants will grow as they are cheaper to employ than qualified nurses. If this occurs, there is no reason to suppose that basic attitudes and characteristics of dominance and organisation will be significantly different from those prevalent in the past.

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(20) See Karmel, op.cit.

3. Nurses

Nurses are the single most numerous group in the modern British psychiatric hospital. They are variously graded in a rigid hierarchy (21). This hierarchy ranges from pupil nurses studying to become 'practical' Enrolled Nurses, through student nurses training to become Registered Mental Nurses, to qualified staff nurses, sisters and charge nurses, then nursing officers at various grades up to the rank of principal nursing officer (22). In order to begin to ascend the nursing hierarchy, qualification as a Registered Mental Nurse is required. This qualification is awarded by the General Nursing Council. As a nurse ascends the hierarchy, his power and status increase. At the same time, he generally has less and less to do with patients and ward staff. In fact 'managerial' traits, as embodied in the Salmon Report of 1966 and implemented rapidly afterwards mean that a real split has emerged between nurse managers and patient contact staff, i.e. those working on the wards at or below sister or charge nurse level. This split is comparable to the division between managers and workers in capitalist industry (23). Despite this division, nursing may be treated for present purposes as a single profession.

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(21) See Susser and Watson, op. cit., p.257f.

(22) There are higher grades of nursing officer but these are not usually found at hospital level.

(23) See Mick Carpenter, 'Managerialism and the Division of Labour in Nursing' in Robert Dingwall and Jean McIntosh, eds., Readings in the Sociology of Nursing (Edinburgh : Churchill Livingstone, 1978) pp.87-103.

The roots of contemporary psychiatric nursing lie in two different areas. On the one hand, as their present designation implies, general nursing has been an obvious and important influence. On the other, psychiatric nursing owes much to the asylum attendants who dominated patient care in asylums throughout the nineteenth and well into the present century (24). Some of the features derived from each of these traditions will now be described.

General nursing as it now exists came into being in the middle of the last century with the innovations of Florence Nightingale. The untrained Sarah Gamp-like pauper nurses working in poor houses and peoples' homes were replaced by the trained women of good birth working in voluntary hospitals. These institutions came into their own in the middle and late part of the nineteenth century as, for the first time, cures and effective treatments became possible. Doctors too, were gaining increasing prominence and nurses became important aides to them, allowing the doctors' limited time to be spent more economically in expert diagnosis and prescription of treatment (25). In many ways, Nightingale's new nurses performed the role of passive wife, mother figure and help-mate in an unequal partnership with the male doctors. The latter took a much more active and decisive role in ordering the care and treatment of patients. This unequal partnership has

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(24) It should be noted that, until very recently, almost no serious interest has been taken in the genesis of psychiatric nursing. See Mick Carpenter, 'Asylum Nursing Before 1914 : A Chapter in the History of Labour', in Celia Davies, ed., Re-writing Nursing History (London : Croom Helm, 1980), pp.123-46, p.123.

(25) For the above see Maclean, op.cit., Ch.3., especially p.59f.

perpetuated itself to the present day in the doctor nurse relationship. Nurses are taught that doctors know more than they do and are not encouraged to exercise individual initiative. They are technically supposed to co-operate with and ultimately obey even the most junior and inexperienced doctor (26). Doctors, by the same token, are encouraged to see themselves as omniscient and omnipotent, so the unequal relationship described above is a perfectly congruent one in terms of role expectations etc. (27). The dimension of nurse subordination and passivity is one that is present in psychiatric hospitals today, especially where mental illness and its treatment are regarded as essentially medical problems. Attempts have been made to break this down, especially in those hospitals which are run on the lines of social therapy (28).

There are several other elements, apart from nurse passivity and subordination to doctors, which owe their origins to the ideology and practice of general nursing. The designation 'nurse' rather than 'attendant' is the most outwardly apparent of these. Training for a qualification in nursing from the General Nursing Council is another obvious feature. The adoption of uniforms similar to those worn in general hospitals, despite the fact that many nurses do not have to perform physically intimate or soiling tasks, is another feature. Similarly, the whole mode of occupational organisation and hierarchy is based on Nightingale's military model of hierarchical obedience in the 'battle' against

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(26) See Susser and Watson, op.cit., p.257.

(27) See Leonard Stein, 'The Doctor Nurse Game' in Robert Dingwall and Jean McIntosh, eds., Readings in the Sociology of Nursing (Edinburgh : Churchill Livingstone, 1978), pp.107-17.

(28) See Stein, op.cit., p.116.

disease and death (29).

Asylum attendants had little to do with the battle against disease and the medical model of treatment. Nineteenth century asylums had few doctors until the latter part of the century and were unable to effect cures. The attendants job was very much one of custody and control, rather than cure, or even care. Carpenter observes that asylum nursing was seen very much as an occupation of last resort:

> Given the low wages, long hours and poor conditions, widespread fears that sustained contact with the insane was contaminating, and the increasing general prosperity, it is not surprising that asylum work was often regarded as an occupation of last resort. (30)

He also notes, "Given the emphasis on order, it is also hardly surprising that in practice strength was prized above benevolence (31). This meant that sturdy men of working class backgrounds predominated in the asylums as opposed to young women of the higher classes, and that training was non-existent as it was seen as irrelevant. Medical Superintendants kept in the background and let the attendants organise the day to day running of the overcrowded wards as it best suited them (32).

Features which psychiatric nursing has inherited from the old attendant system include a much greater number of males than in general nursing, a greater sense of the power of the workforce due to the influence of militant union

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(29) See Maclean, op.cit., p.61. Much of nurse training and socialisation still has a very military feel to it.

(30) Carpenter, op.cit., p.134.

(31) Ibid., p.135.

(32) See Scull, Museums of Madness, Ch.5. Doctors, unable to effect cures, kept away from the patients as much as possible and made themselves busy with administrative tasks.

activities concomitant with a greater male presence, and a greater sense of equality and influence with other staff members than that experienced by general nurses due once again to male influence and also to the fact that for years the wards were dominated by the attendants while doctors had a much more limited role in the asylum. It must, however, be noted that apart from these positive features inherited from the asylum workers or attendants, an attitude of static custodial care and a sense of stigma is part of this legacy (34).

There is little information specifically about the social class background of qualified psychiatric nurses. Navarro, looking at occupations in the N.H.S. in general, classifies registered nurses and those training for registration as middle class in origin. Enrolled nurses and those training for enrolment are classified as lower middle class in social origin (35). Broadly speaking, this classification is probably accurate. It is, however, also true that qualified psychiatric nurses come from less high class backgrounds on aggregate than their counterparts in general nursing. Psychiatric nursing is less popular than general nursing because of the stigmatised nature of its clientele. Thus it is less difficult to get into, demanding on the whole less educational attainment. Since educational attainment is inversely linked with class position, this would point

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(34) "Despite wishful thinking in high places that asylum nursing could mirror general nursing in achieving public honour and dignity, work in asylums was considered largely to be a degrading occupation... .This general view has not disappeared." (Carpenter, op.cit., p.143).

(35) See Navarro, Class Struggle, The State and Medicine, Table 7.2, 'Persons Employed in the Delivery of Health Care Services in England, By Sex and Salary, in 1972', p.74.

towards a more working and lower middle class intake into psychiatric nursing (36). The working class background of the asylum attendants suggests that psychiatric nursing has traditionally been a lower status occupation than general nursing. These assertions are only enlightened conjecture and, in general, it must be recognised that registered psychiatric nurses do come from higher class backgrounds than enrolled nurses, assistants or patients. This means that they may have different values from these other groups and may have difficulty in understanding or communicating with them. At the same time, qualified nurses have more formal power and recognition in the hospital than these other groups and can exert more pressure on the destiny of the institution and on their own lives and those of others. It was noted above that, on the whole, nurses have less contact with patients than unqualified staff or staff in training. Instead, much of the time of qualified nurses is spent in administrative tasks and the formulation of policy at all levels.

On the subject of qualified nurses' distinctive attitudes to patients, treatment and mental illness there is little modern material. Once again American surveys conducted over twenty years ago provide much of the small amount of evidence which is available. Strauss et al. noted that nurses in a private psychotherapeutically-orientated psychiatric hospital had far less understanding of psychotherapy than psychiatrists and experienced greater difficulty in seeing their work as a valuable part of the psychotherapeutic treatment of patients (37). However, among professional groups

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(36) For educational attainment and social class, see Reid, op.cit., pp.164ff.

(37) Strauss et al., op.cit., p.222.

in different kinds of hospitals, including publicly funded state hospitals, it was found that nurses and psychologists were the groups who favoured psychotherapy as a means of treatment rather than any kind of social or somatic therapy (38). In the private psychotherapeutically oriented clinic, nurses experienced a constant conflict between their administrative, managerial, and custodial duties and roles (39). These insights are of limited value in looking at contemporary British psychiatric nurses as psychotherapy has usually been subsidiary to other, mostly somatic, forms of treatment here.

A more illuminating, and more exactly parallel, picture is presented in the research of Rubenstein and Lasswell. They give a description of the 'traditional' nurse in the psychiatric hospital. Despite the differences between private clinics in America in the 1960's and Britain's state hospitals today, much of this picture seems apposite. The nurses observed by Rubenstein and Lasswell were mainly trained in general nursing. They were essentially conservative, having only a limited interest in concepts like psychological insight, and concentrating on a practical, common-sense, non-intellectual approach. This attitude was basically congruent with general nursing attitudes which see mental illness as a medical problem. These nurses were not interested in changing the nature or routine of their tasks which they regarded as both practical and clear-cut. They saw themselves as part of a rigid hierarchy over which they had little control. Although they conceived of themselves as inferior to doctors with little power (a false perception), nurses had little desire to exert more influence in hospital affairs. They were

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(38) Ibid., p.69.

(39) Ibid., p.223.

happy simply to implement hospital rules and policy. They were also content with the rigid nature of the hierarchy, and respected hierarchical relationships. Nurses were clearly differentiated from patients by uniforms and only had highly structured and relatively infrequent contact with them.

The general impression emerging from the account above is that of a general nursing approach applied to psychiatry and psychiatric patients. In Britain, where most hospitals have retained a medical model approach to mental disorder and its treatment, much of this description would remain valid. Doctors are seen as the key figures in the diagnosis and treatment of the patient's 'illness' and nurses see themselves as subordinate as they would in a general hospital nursing the physically sick. While the rigid and hierarchical attitudes of the general hospital may be modified to some extent in the psychiatric hospitals and in the training of psychiatric nurses especially those in hospitals which have experimented with social therapies and various types of psychotherapy, much of the general approach remains with treatment focused on the organic (40).

Nurses have considerable formal and actual power in the hospital and have many opportunities to affect their own lives, those of the patients and other staff members and the life of the hospital as a whole. As the most numerous single group in the mental hospital, they have considerable powers of sanction over against other groups. Ultimately, without

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(40) See Rubenstein and Lasswell, op.cit., Ch. 4. The authoritarian and custodial attitudes of attendants to patients also permeate the ranks of qualified staff. This is especially true of those who adopt an organic approach to mental disorder. A good but fictional example of such an authoritarian approach is Nurse Ratched in Ken Kesey, One Flew Over the Cuckoo's Nest (London : Pan, 1973).

their labour hospitals could not function (41). The militancy and power of nursing unions within the psychiatric hospitals witnesses to the strength of the nurses as a group. Nonetheless, nurses tend to conceive of themselves as a subordinate group to doctors, without their authority and power (42). Essentially, in many hospitals, even now, nurses conceive of mental disorder as a medical problem and so are willing to give primacy to the medical profession in the diganosis and treatment of that disorder.

Before concluding this section about qualified nurses in the psychiatric hospital, some space must be devoted to a consideration of the distinctive position of student nurses. Training for registration as a nurse takes three years and consists of practical work on the wards supplemented by lectures, tutorials examinations etc. in a school of nursing attached to a hospital. While qualified nurses, especially charge nurses and sisters who are at the top of the ward hierarchy, may exert considerable control and influence over their own lives and those of the patients and staff in their charge, student nurses have little power or influence. This is partly due to their not remaining on one ward for any length of time. It is also due to the fact that those in charge of wards have an effective means of sanction over the students, while they have no reciprocal means of sanction. Ultimately a student's qualifying depends on favourable reports from senior ward staff, while those staff members do not depend on the students for anything except labour. Except where senior ward staff concede power and influence voluntarily to the student, they can remain relatively impotent within the structures of the hospital.

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(41) It is arguable that even doctors are dispensable, but nurses are not.

(42) See Susser and Watson, op.cit., p.257.

4. Doctors

Doctors form a relatively small group within the workforce of the N.H.S. as compared with other groups. There were approximately 62,000 doctors working in the N.H.S. in 1975, as compared with 400,000 nurses, 200,000 ancillary staff and approximately 100,000 administrative and clerical staff (43). Doctors are not equally spread through all specialisms in the N.H.S. Despite the fact that 43% of all hospital beds in 1976 were given over to psychiatry, only 11% of all consultants are psychiatrists (44). There are approximately 1,200 psychiatric consultants in Britain and some 1,000 doctors of more junior status training in the speciality. Over the years, there has been an increase in the number of doctors going into psychiatry. Between the years 1971 and 1977 there was a 22.3% increase in the number of consultants and the number of junior medical staff also expanded. Despite this, there is a shortage of medical manpower which necessitates each consultant psychiatrist having an inpatient caseload of 154 on average as opposed to the 30 inpatients which is the average for consultants in non-psychiatric hospitals (45).

All psychiatrists in Britain are medically qualified. This means that they have all undertaken a five or six year academic and clinical course leading to basic degrees in

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(43) See Ruth Levitt, The Reorganised National Health Service, Figure 17, 'N.H.S. Manpower 1975 (Great Britain)', p.144.

(44) Anthony Clare, Psychiatry in Dissent, second edn., (London :Tavistock, 1980), p. 400.

(45) See Clare, op.cit., p.400 for further statistics. The number of home-trained doctors in the speciality may be declining; Clare points out that between 1965 and 1972 there was a 12% drop in the number of doctors trained in the British Isles entering training for psychiatry.

medicine and surgery. During this initial training, some time, perhaps four to six weeks, is spent in a psychiatric context. However, the basically qualified doctor, if he wishes to specialise in psychiatry at consultant level, must go on to take a higher qualification, usually the membership of the Royal College of Psychiatrists. There is also a career structure resembling that of general hospitals whereby doctors ascend through the grades of Senior House Officer, Junior Registrar and then Senior Registrar until they have sufficient experience to take a post as a consultant. There are doctors working in the sphere of psychiatry who are neither in training nor have any higher qualifications. These doctors are not eligible to become consultants but may have a great deal of experience and responsibility.

Each patient in a psychiatric hospital is under the care of a particular consultant psychiatrist. This does not mean that the consultant will see the patient at regular or frequent intervals. It was noted above that each consultant has a large number of patients to look after and so many patients may hardly ever see their consultants. Usually the junior doctors are most in evidence on the wards and have most to do with patients. Even so, doctors are often too busy to give the time and attention which they should to individual patients. Patients suffering from acute episodes of mental disorder are likely to receive more of doctors' time than the old or chronically ill. However, even acute patients may only receive 30 minutes or so of consultant time in a week (46). In general, doctors have much less contact with patients than the other ward staff. Consultants, who have ultimate responsibility for the care and treatment of patients, have almost no contact with them at all.

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(46) See Clare, op.cit., first edn., pp.399-400.

Turning to the social background of doctors, it can be asserted that they typically come from the higher classes in society. In 1964, 75.7% of final year medical students came from social classes 1 and 2, while only 24.2% came from classes 3,4 and 5 together. Since social classes 1 and 2 make up only 18.3% of the total population in general, Doctors are largely unrepresentative in their social and educational origins of those to whom their skills are to be mainly directed, i.e. the lower classes. They occupy a higher social class position than most of the other employees of the N.H.S. too (47).

Mechanic characterises doctors in the U.S.A. as being by and large urban in origin, white, male and upper middle class (48). This profile applies to many British doctors also. However, within the speciality of psychiatry, lacking as it is in kudos, there is a substantial presence of overseas doctors. The proportion of such doctors in psychiatry rose from just over one third in 1965 to just over 50% in 1972 while the number of British graduates entering training in the speciality fell by 12% in the same period. Most of these immigrant doctors, who come to a large extent from under-developed countries, are to be found in non-teaching hospitals, while 90% of training posts are occupied by British graduates. Although foreign origin and class cannot be directly equated, there can be little doubt that, rightly or wrongly, overseas doctors are regarded as being less competent and desirable than their British counterparts. They therefore tend to

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(47) See Navarro, Class Struggle, The State and Medicine, p. 73f. For the statistics in the paragraph above see Robson, op.cit., pp.414-5. Cf. also Cruickshank and McManus, op.cit.

(48) David Mechanic, Medical Sociology, second edition, (London: Free Press, 1978), p.379.

occupy less prestigious posts in the less prestigious and more stigmatised medical specialities and receive a rather inferior training in psychiatry. Often overseas doctors come to Britain to study for a qualification in another medical discipline and end up in psychiatry as a last resort. They may be rather unmotivated about the discipline and experience considerable language and communication difficulties in relations with other staff members and with patients. The large, old and isolated mental hospitals in this country depend heavily for their functioning on such immigrant labour (49).

a) Medical Dominance in Psychiatry - A Historical Perspective

I now propose to spend some time in exploring the way in which doctors came to dominate psychiatry and psychiatric hospitals. The present dominance of the medical profession in this area must be seen as an exercise in 'moral entrepreneuralism' by the medical profession in the nineteenth century (50).

In the eighteenth century many groups were involved with the care and control of the insane. Although doctors had

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(49) For all the above see Clare, op.cit., second edn., p. 400ff. The issue of immigrant doctors in the psychiatric services raises the question of how far Britain is exploiting third world countries who need the services of their own graduates. This and other questions are explored by Clare in more detail.

(50) For a general history of the medical profession in that century see Parry and Parry, op.cit. This account shows the growth of strength, organisation and autonomy of doctors as a group. The account which follows of the rise of medical dominance in the psychiatric hospital is based on Scull, Museums of Madness, chs. 4 and 5, Baruch and Treacher, op.cit., Ch.1, and on Andy Treacher and Geoff Baruch, 'Towards a Critical History of the Psychiatric Profession' in David Ingleby, ed., Critical Psychiatry (Harmondsworth: Penguin, 1981), pp.120-49.

always had some involvement in the area, they had no monopoly of the care of the insane. Reformers like Tuke, who pioneered the moral treatment revolution in England, were not doctors. Gradually physicians began to assert themselves in this direction and their power grew. However, there were several obstacles in the way of their monopolising this area of care and cure of the insane. Their claims were challenged by claims from other, equally plausible groups who laid claim to the right to have influence here. Again, moral treatment emphasised self control on the part of the patient rather than the value of external interference such as that used by doctors, and moral treatment certainly seemed the most effective practice at the beginning of the era of the asylum. Lastly, there was no evidence at all for the effectiveness and efficiency of medical techniques, e.g. blood letting, which were applied to the insane in much the same way as they would be applied to any sufferer from physical disorder. In the face of such obstacles, it was difficult for doctors to assert that they should have a monopoly of control in this area because of their expertise and training.

Moral treatment posed a particular threat to medical ambitions at the beginning of the nineteenth century as it seemed to be more effective than medical treatments and it did not demand any medical training or knowledge on the part of the person who administered it. The doctors' way round this particular difficulty was to incorporate moral treatment into the medical armamentarium. A paradoxical position therefore came into being, whereby doctors became heavily dependent on a form of treatment which was not medical and used the fact that it was an effective method when used by doctors to justify medical hegemony and monopoly.

Throughout the nineteenth century, doctors fought hard

at all levels for the right to professional dominance and autonomy in treating the insane. They resisted attempts in 1817-79 to allow lay boards of enquiry to investigate the treatment and control of the insane because they felt this would interfere with medical autonomy. Learned articles were produced to vindicate the appropriateness of the medical viewpoint in dealing with the mentally disturbed and to assert the importance of medical autonomy. Efforts were made to extend the need for medical certification of insanity. Attempts were made to get doctors on asylum visiting committees and on to the Lunacy Commission. At the local level, physicians endeavoured to procure influential posts in asylums.

By 1845, mental disorder was widely acknowledged to be a disease. Acts of Parliament in 1828 and 1845 gave the medical profession almost exclusive rights to treat the insane. In 1851, a professional association was established for those doctors particularly involved in the care and treatment of the mentally disordered and specialist journals made their appearance at about the same time. All these things took place when there was still no evidence for a physical cause of mental disorder, while physical treatments administered by doctors were manifestly unsuccessful, and while there was still no scientific knowledge on which doctors could base their claims to be the appropriate group to have the monopoly of care and treatment in dealing with mental disorder.

Throughout the latter half of the nineteenth century, physicians were recognised as the official managers of the insane by society at large. The doctors were not deposed from this position of dominance because the managers of the asylums where they worked were not very concerned that very few patients responded to medical treatment by recovery.

Similarly, the general public was not much concerned with recovery rates in the asylums and so was also quite happy to allow medical management of these institutions to continue. In many ways, the involvement of doctors in the treatment of the insane and the running of the asylums legitimated social control of deviance in a very positive manner, making it seem essentially scientific and humanitarian. Doctors were able to look after the physical ailments of asylum inmates satisfactorily, and were, all in all, as efficient at managing the asylums as any other group in society would have been.

It should be noted that, while doctors were successful in their attempts to obtain monopoly control over the asylums and the management of the insane, once they had gained their position of dominance they tried to keep as far away from the patients as possible. Only by resorting to a bureaucratic and managerial role could the medical superintendant of an asylum avoid being faced with his lack of ability to effect much beneficial or therapeutic change amongst his patients.

Doctors continued to increase their influence and dominance in the treatment and care of the mentally disturbed during the present century. It has been shown above that in the nineteenth century lay people in the form of J.P's had a crucial and central role in the certification of the insane. Madness was regarded as a matter for the law and legal professionals as well as for medicine and the doctors. As the twentieth century has progressed, the hegemony of the latter has increased considerably at the expense of the former. The Royal Commission on Lunacy and Mental Disorder of 1924-26, heavily influenced by its medical members, stated: "It has become increasingly evident that there is no clear line of

demarcation between physical and mental illness" (51). The work of this commission led to the Mental Treatment Act of 1930 which, in addition to making voluntary admission and treatment possible in hospitals and other measures, transformed the custodial terminology of the nineteenth century into the language of medicine. 'Lunatics' became 'patients' and 'asylums' became 'hospitals' (52). The Act envisaged treatment being conducted exclusively by doctors along the same lines as any other medical treatment of a physical disorder. It was hailed as progressive and humanitarian by society in general and did much to consolidate the position of the psychiatrist as a medical practitioner like his colleagues in the medical profession.

The Mental Health Act of 1959 completed the victory of the medical profession as it finally replaced detention on the basis of legal authority and certification with detention on the basis of medical opinion (53). Under the 1959 Act, doctors alone are regarded as competent to diagnose, certify and treat mental disorder. Although the law courts do still have some jurisdiction here, in that they can order detention and treatment under the Mental Health Act, the medical profession has by far the most prominent part to play in dealing with the mentally disordered today. Within hospitals it is doctors alone who can admit and discharge patients and treatment of patients by other members of staff in hospital, e.g. by psychologists, is carried out on the authority of and by the sufferance of the doctors. There is little sign of

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(51) See Jones, op.cit., p.240.

(52) Jones, op.cit., p.249f. See also Baruch and Treacher, op.cit., Ch. 1 for this development of the dominance of the medical model and of doctors.

(53) See Baruch and Treacher, op.cit., pp.8-9.

any change in this professional dominance pattern.

b) The Profession of Medicine

Constant reference has been made in the foregoing account to the 'medical profession'. It is necessary to examine this term and the consequences it implies more closely.

There has been much debate about the meaning and content of terms such as 'profession' and 'professionalism' in recent sociological study (54). Here I will rely chiefly on Freidson (55). Freidson defines a profession as a particular occupation distinctively characterised by its legitimate organised autonomy, i.e. its right to control its own work (56). This organised autonomy comprises of freedom from competition or regulation by other workers, and freedom to regulate the other occupations within a specific division of labour, so that an occupation becomes a dominant profession. Insofar as it regulates its own work and members and is not subject to the regulation and evaluation of others, it educates itself so that entrants to the profession are trained separately from entrants to other occupations. If the profession is also a consulting profession, as medicine is,

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(54) See e.g. the discussion in Terence J. Johnson, Profession and Power (London : Macmillan, 1972) Ch.2, also 'Profession' in G. Duncan Mitchell, ed., A New Dictionary of Sociology, and Parry and Parry, op.cit.

(55) Eliot Freidson, Profession of Medicine (New York : Dodd Mead, 1975).

(56) See Freidson, op.cit., p.71. Other writers have isolated traits which tend to characterise all professions, e.g. skill based on theoretical knowledge, skill requiring training and education, the demonstration of competence by passing a test, a code of conduct, an ethic of service for the public good, and occupational organisation (see Mitchell, ed., op.cit., above for these) but characteristics are seen by Freidson as secondary to occupational autonony.

it will also regard itself as having the right to regulate its clientele (57).

Freidson goes on to point out that the more or less absolute autonomy enjoyed by a profession such as medicine can be its fatal flaw

> By allowing and encouraging the development of self-sufficient institutions, it develops and maintains in the profession a self-deceiving view of the objectivity and reliability of its knowledge and of the virtues of its members. Furthermore, it encourages the profession to see itself as the sole possessor of knowledge and virtue, to be somewhat suspicious of the technical and moral capacity of other occupations and to be at best patronizing and, at worst, contemptuous of its clientele (58).

Freidson adds,

> Consulting professions are not baldly self-interested unions struggling for their resources at the expense of others and of public interest, rather they are well-meaning groups which are protected from the public by their organised autonomy and at the same time protected from their own honest self-scrutiny by their sanctimonious myths of the inherently superior qualities of themselves as professionals... . Their autonomy has created their narrow perspective and their self-deceiving views of themselves and their work, their conviction that they know best what humanity needs (59).

Freidson concludes that, while autonomy may have helped medicine to develop its own foundations of knowledge in the past, it now impedes social modes of applying that knowledge (60).

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(57) See Freidson, op.cit., p.369, for the above.

(58) Ibid., pp.369-70.

(59) Ibid., p.370.

(60) See ibid., p.371.

After this brief survey of the distinctive features of the medical profession and some of the general consequences of this mode of occupational organisation, it is necessary to look at the specific effects of organisational autonomy in the psychiatric hospital. The first aspect to be considered here is the question of the responsibility of doctors. Nurses and other groups are ultimately responsible to the N.H.S. which employs them. Doctors, however, control their own work and are responsible ultimately only to the other members of their profession who form the General Medical Council (G.M.C.). Each practitioner has, at least technically, complete clinical freedom and an absolute 'charismatic' freedom (61).

It was shown above that under the 1959 Mental Health Act, doctors were given absolute and sole responsibility for diagnosing and treating mental disorder. All other workers in the hospital are subordinate to the clinical direction of the psychiatrists. Doctors therefore can be seen as having the right and power to regulate the work of other occupational groups, while those groups have no reciprocal rights over the doctors, even if they have more appropriate skills and specialised knowledge. The locus classicus for this domination/subordination relationship is to be found in the relationship between psychiatrists and psychologists in the hospital. While psychologists can put forward good arguments for having a primary responsibility based on expertise and knowledge in the diagnosis and treatment of the mentally disordered, they continue to be subordinated by the control of the medical profession. Smail argues that the modern psychologist "has far more on which to base his practice than an authoritarian and primarily medical tradition" (62).

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(61) See above on organisation in the hospital.

(62) D.J. Smail, 'Clinical Psychology and the Medical Model', Bulletin of the British Psychological Society, 26, 1973, 211-14, p.212.

Smail goes on to suggest that psychological diagnoses and techniques are far more grounded in a consistent and effective theory and practice than are the empirical and pragmatic techniques offered by psychiatrists. Goldie surveys the use of the medical mandate whereby psychiatry assumes dominance over all other disciplines in the 'therapeutic team' in the hospital (63). He shows that, while many psychiatrists see mental disorder as more than an illness and employ skills and techniques in their practice which are "more likely to be those of the social workers, nurses and clinical psychologists, rather than those taught in their medical schools" (64), they continue to regard 'lay' staff as supplementary rather than integral to the therapeutic process. He concludes that most psychiatrists are ideological in their assumptions about themselves and others in the 'therapeutic' team and that they legitimise their position

> either by referring to such 'rational' factors as the need for them to administer physical treatments, or by suggesting that there is a certain naturalness and inevitability about the present arrangements (65).

Routine activities such as diagnosis are mystified, and special skills are claimed by psychiatrists so that they can continue to dominate and direct the work of the 'lay' members of the staff. It is in this way that the profession of medicine regulates the work of other occupations while avoiding such regulation itself.

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(63) Nigel Goldie, 'Psychiatry and the Medical Mandate', in Michael Wadsworth and David Robinson, eds., Studies in Everyday Medical Life, (London : Martin Robertson, 1976) pp.177-93.

(64) Ibid., p.177.

(65) Ibid., p.193.

Apart from regulating the work of others in the psychiatric hospital, members of the medical profession attempt to regulate their clientele. Although the profession would argue strongly that its professional autonomy exists so that the needs of clients and patients may be better served, there can be little doubt that many doctors act in a way which indicates that they see themselves as having power over their patients rather than as their servants. As soon as a person is believed to have a medical problem, he is deemed to fall within the sphere of expertise of the doctor who thereafter assumes an almost unchallengable dominance over large areas of that patient's life. Tuckett gives an account of Szasz and Hollender's typology of doctor-patient interaction. There are basically three modes of interaction in this typology; doctor activity accompanied by patient passivity, guidance by the doctor accompanied by co-operation from the patient and mutual participation (66). He notes that there is no situation in this typology in which the doctor is not at least jointly in charge. More will be said about doctor-patient relationships at a later point, but here the important thing to note is that patients appear to have very little control over the treatments and attitudes of their doctors while the latter have a great deal of control over them.

Doctors regard themselves as undisputed experts in the sphere of illness and its treatment, and will brook little lay interference, even that of other patients. While patients have more control over their doctors if they

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(66) See David Tuckett, 'Doctors and Patients', in David Tuckett, ed., An Introduction to Medical Sociology (London : Tavistock, 1976), pp.190-224, p.200f.

personally employ them (67), this is not the case when there is no direct patronage between physician and patient. It might be supposed that where doctors are employed by the State, as in the case of Britain, that some form of control could be exercised over medical autonomy by consumers (mediative control). However, although the state defines the needs which are to be met, the medical profession still determines the manner in which they are met, calling this aspect 'clinical freedom'. Essentially, collegiate control, that is control over the profession by its members so that the needs of consumers and the manner in which those needs are met are determined by the profession itself, remains the dominant mode of control in the case of doctors working for the N.H.S. today. This means that patients continue to have little control over those who define and meet their needs. In the case of compulsorily detained psychiatric patients, the choice of whether or not to subject themselves to the dominance of the doctors and the amount of control they have over those professionals is even more curtailed (68).

Szasz has written of the medical profession serving the interests of the State rather than those of its patients (69). A similar point can be made concerning the danger of doctors serving the interests of their own profession with its need for dominance and the exclusion of lay interference taking precedence over the needs of the clientele. If anything,

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(67) Control by patronage. See Johnson, op.cit., Ch.3.

(68) For this typology of professional control see Johnson, op.cit., p.41ff.

(69) See T.S. Szasz, Law, Liberty and Psychiatry (London : R.K.P., 1974).

patients being treated under the N.H.S. are more likely to encounter the negative effects of this phenomenon than those who live under a system where treatment is privately paid for. As has been argued, under a State-run system patients have only very indirect control over their doctors. Psychiatric patients in particular may be especially disadvantaged in this respect as they may be wholly unable to remove themselves from the domain of the doctors.

So far, nothing has been said about the sociological reasons for the acceptability and continuance of the autonomy and dominance of the medical profession, which has, as has been seen, enormous practical implications in terms of the relations of doctors with other members of staff and also with patients. It is important to recognise that the claim of any profession to autonomy and dominance can only continue to be effective if it is sustained by a wider social movement or group. Freidson argues that professional dominance does not come into existence or remain in existence by accident or quirk of fate. Rather, "Autonomy is the critical outcome of the interaction between political and economic power and occupational representation..." (70). Freidson adds, "In one way or another, through a process of political negotiation and persuasion, society is led to believe that it is desirable to grant an occupation the professional status of self-regulative autonomy" (71). Earlier, in Profession of Medicine, he comments

> A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it

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(70) Freidson, op.cit., p.82.

(71) Ibid., p.83

> - an influence which drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation, and that requires still others to be subordinated to the profession (72).

Freidson further suggests that "the work of the chosen occupation is unlikely to have been singled out if it did not represent or express some of the important beliefs or values of the elite" (73). He argues that, since the work of a profession is selected by an elite for special priveleges and protection, it will be compatible with the beliefs and values of that elite, but may not reflect the values of the population at large. Furthermore, for a profession to continue to enjoy its privileged position, it must demonstrate to the dominant elite that its work has positive value for them, or at least that it will do them no harm (74).

Freidson's critique of the medical profession is not a Marxist one, so he does not extrapolate the wider socio-political implications of the reasons for the continued professional autonomy of medicine. He fails to point out that the elite which sponsors the autonomy of the profession is in fact the ruling class, the class in society which owns and controls the means of production in the late capitalist economic order. Following Freidson, it may be deduced that the reason this class has chosen to give so much power to the medical profession is that that profession embodies beliefs and values which are important to the ruling class and provides a means of dealing with some of the problems of

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(72) Ibid., p.72.

(73) Ibid., p.72-3.

(74) Ibid., p.73.

capitalist society which is compatible with, and supportive of, the interests of the ruling class. An individualistic model of disease and disorder and treatment administered under the direction of doctors whose beliefs and values are those of the ruling class because of their own social background would seem to be an excellent reason for the ruling classes to have given a great deal of power to this occupational group (75).

c) The Doctor-Patient Relationship

At this point, it is appropriate to consider the relationship of the doctor to his patient. Particular attention will be paid, in the account which follows, to social factors, and especially social class, which affect this relationship. The consideration of the doctor-patient relationship in general will be related to the psychiatric setting in particular where possible.

> Illness is not an autonomous entity, but a result of the confrontation of two individuals, the first contributing the mystery of his illness and the second proposing an explanation ... . (B)ehind the patient is the whole weight of collective representation which he and his friends and relations have of mental illness, and behind the doctor are the systems he has learned in books and during his training. The therapeutic dialogue is an exchange between two elements of society rather than individuals (76).

It might be supposed that two of the most important presuppositions of the doctor-patient relationship are that

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(75) Chapter XII deals in greater detail with models of illness and disease and their relationship to the wider social and political order.

(76) Roger Bastide, The Sociology of Mental Disorder (London : R.K.P., 1972), p.189. Quoted in Robinson, op.cit., p.61.

it is an encounter between individuals and that it is essentially a reciprocal and harmonious relationship oriented towards the treating, and, if possible, the curing of mental disorder which afflicts a particular patient. This section will be devoted to demonstrating that the encounter between doctors and patients is, in fact, profoundly social in its nature and that it is, in many ways, characterised by conflict between the principal subjects (77). Factors contributing to the relative power of the subjects in this conflictual relationship will be examined, with particular reference to the influence of social class position in this matter.

The socially pre-conditioned nature of the doctor patient relationship lies at the bottom of the conflict which takes place therein. Both patient and doctor encounter each other having been socialised into very different views of illness and its treatment:

> The professional's views, moulded by clinical experience and training, may differ in emphasis, detail or ordering of priorities from the patient's views, influenced by the need to cope with a particular problem and by his cultural and social understanding of the nature of the problem and the range of possible responses to it (78).

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(77) The notion that doctor and patient are involved in a fundamentally reciprocal,complementary harmonious relationship is to be found in the functionalist sociologist Parsons' ideal type of the sick role. A summary of Parsons' work is to be found in Freda Fitton and H.W.K. Acheson, The Doctor/Patient Relationship (London :H.M.S.O., 1979), pp.9-10. Fitton and Acheson comment later in the same work looking at the power structure of the doctor-patient relationship that "although in terms of social system maintenance the roles may be reciprocal, the dyad is inherently one of inequality and conflict." (op.cit., p.12)

(78) Robinson, op.cit., pp.62-3.

Patients do not consult their physicians having no preconceptions of what is wrong with them, or what they wish to see about it. Rather, they come to consult with a doctor with many preconceptions, expectations and aims which, although they may not be clearly articulated, are important and operationally effective. These may conflict strongly with the doctor's apprehension of the patient's disorder, determined by professional socialisation and clinical experience. Freidson writes, "It is my thesis that the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other" (79).

In the real conflict which takes place in the doctor-patient relationship, some kind of satisfactory resolution must be reached. Since the conflict is itself usually covert, resolution is often not perceived as being the aim of the encounter. A process of negotiation must be embarked upon whereby a mutually tolerable solution can evolve from widely disparate and conflicting starting points. Stimpson and Webb have shown that even where there is 'hard' evidence of a particular diagnosis, there still takes place the process of negotiation, mutual interaction and response to achieve a satisfactory definition of shared reality (80). Where accommodation between the doctor and patient does not take place, termination of the relationship which is now

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(79) Eliot Freidson 'Dilemmas in the Doctor-Patient Relationship', in Caroline Cox and Adrienne Mead, eds., Sociology in Medical Practice (London :Collier Macmillan, 1975), pp.285-96, p.286.

(80) See G. Stimpson and B. Webb, Going to see the Doctor (London : R.K.P., 1975), Ch.3.

unsatisfactory may ensue (81).

Before exploring the factors which affect the ability of the individuals concerned in the conflict to influence others and to attain their own ends, it is necessary to explore and emphasise some of the other external factors which influence the encounter and those taking part in it. The doctor will experience tension arising from the need to take into account the needs of other patients as well as those of the patient he is encountering at the moment. He must evaluate how he is to distribute his resources in terms of time and treatment. Again, the physician must balance the immediate and the long-term interests of the patient. Similarly, he must balance the needs of the patient against the needs of the patient's family, friends and community. The doctor must also balance the obligation he has to serve the patient against his duties as an agent of the State. His own career needs must also be taken into account over against the needs of the patient (82).

The patient too may experience constraints in the encounter with his physician. For example, the expectations of his relatives, his need to get time off work, his need to stay at work, etc. Both doctor and patient will be influenced by factors such as the length of time available for the

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(81) On conflict in the doctor-patient relationship, see Michael J. Bloor and Gordon W. Horobin, 'Conflict and Conflict Resolution in the Doctor-Patient Relationship' in Caroline Cox and Adrienne Mead, eds., Sociology in Medical Practice (London : Collier Macmillan, 1975) pp.271-84. For an interesting parallel example of conflict between laymen and professionals with different apprehensions of situations see John E. Mayer and Noel Timms, The Client Speaks (London : R.K.P., 1973).

(82) For these tensions see Tuckett, 'Doctors and Patients'.

encounter, the place where the encounter takes place, the competence gap between doctor and patient, class and culture gaps, and gaps in the ability to be able to communicate effectively (83). The mode of health service organisation within which the encounter takes place will also exercise an influence. In a fee-for-service situation where the patient directly employs the doctor, the latter is likely to be more compliant than in a situation such as that which exists in the N.H.S. where the doctor does not depend directly on the patient for his livelihood.

If the doctor-patient relationship may be legitimately be regarded, as has been suggested, as an essentially conflictual one, involving strategy, tactics and negotiation to obtain desired ends, the next task is to analyse the relative power of the protagonists, doctor and patient.

On first sight, the physician would seem to have much more power than the patient in the doctor-patient encounter. It is the physician who is sought out by the patient for expert advice and not vice versa. He has enormous authority of a charismatic nature.

This is supplemented by authority ostensibly based on the mastery of theoretical knowledge and technical skills. In addition physicians derive power and authority from what Freidson describes as 'latent social status'. Although this authority is difficult to define exactly, its effects can be described:

> If ... (the doctor) ... is, say, upper-middle-class, and his patient lower-class, he has leverage

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(83) For these, see Stimpson and Webb, op.cit., p.56f.

> over his patient which does not depend on authority of expert-ness....

Thus Freidson concludes that the physician in the consulting room may "be said to have the manifest status of the expert consultant and the latent status of his prestige in the community"(84).

Above and beyond the doctor's charismatic, expert and latent social authority, the doctor has the power to provide or deny resources. This means that he has at his dispsal a monopolistic control of important and sought-after treatments and can use this to sanction the behaviour of his patients. This degree of control may easily appear to overwhelm the power of the patient to oppose his physician's wishes.

It would, however, be a mistake to see patients as totally impotent in the doctor-patient encounter. It must be remembered that in most circumstances it is the patient who can choose whether or not to consult a physician; he need not do so if he does not want to, and by staying away patients can affect the incomes of their physicians in that their capitation rates go down and there is less demand for other services which carry separate fees. A doctor who refuses to co-operate all the time may find himself with very few patients. During a consultation, patients can manage the impression they give to the doctor to achieve their own ends. Once the consultation is ended, patients have considerable discretion as to whether or not they will follow their doctor's advice. They can seek advice from other, non-medical sources, and they can break down the competence gap in consultations by

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(84) Freidson, Profession of Medicine, p.294.

learning more about medicine themselves. They can organise themselves, with other patients, into groups to challenge the modes of diagnosis and treatment used by physicians. If necessary, they can change their doctor to find one who is more co-operative. Some patients do enjoy equal or superior social status to their physicians and this allows them more power over them, as does the ability to pay for the services of a doctor (85).

While the modes of action mentioned above are theoretically available to all potential patients in society, it should be remembered that, in practice, not all will have equal access to them. In particular, lower class people may not have a real choice of medical practitioner , for geographical and for other reasons. Similarly, such people may have difficulty in acquiring medical knowledge. Almost certainly, they will not exceed their doctors in terms of social status and will be unable to afford to pay for private treatment. It may be therefore that in order to obtain needed medical services and resources, the lower class members of society have to compromise more profoundly with their physicians in encounters with them than their higher class counterparts. It is probably true to say that they have less real power in medical encounters than their doctors.

Turning to the effect of social class on the doctor-patient relationship, it can clearly be seen that it is a very important factor, both in direct and indirect ways. In general terms, the doctor-patient relationship may be seen as reflecting the class structure and class divide in society as a whole. Waitzkin and Waterman observe that knowledge, authority and power in Western capitalist society are

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(85) Most of these points are taken from Stimpson and Webb, op.cit.

differentially distributed and reflect the stratification of society as a whole and that this is to be seen in the doctor-patient encounter where high-status, highly educated and powerful individuals in society encounter those who lack most of those qualities themselves for the most part. They further suggest that patients may be conceived of as a 'class' sharing common interests and occupying a similar position structurally under the authority of medicine (86). Although they use the notion of class analagously, there can be little doubt that the class of impotent patients which encounters the upper class medical profession is composed to a large extent of members of the lower social classes in the capitalist socio-economic order.

In more specific terms, social class position seems to have an enormous practical effect on the nature and content of doctor patient consultations. It seems likely that communication difficulties owe much to the lack of a common use of language which is directly related to socio-economic class position (87). It seems also to bear on the length of time that doctors spend in consultation with their patients. One study of G.P. consultations revealed that doctors spent an average of 6.2 minutes with middle class patients, but only 4.7 minutes with lower class patients (88). Cartwright and O'Brien also record that middle class people were more knowledgeable about their illnesses than lower class people and that they appeared to enjoy a better relationship with their

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(86) See Waitzkin and Waterman, op.cit., p.69.

(87) See further, Trudgill, op.cit., ch.2, Tuckett, 'Work, Life Chances and Life Styles', pp.145-7.

(88) Ann Cartwright and Maureen O'Brien, 'Social Class Variations in Health Care and in the Nature of G.P. Consultations', in Margaret Stacey, ed., The Sociology of the National Health Service (Keele : Keele University, 1976), pp.77-98, p.89.

G.P's, spending longer in conversation with them, asking more questions and giving more information. Lower class patients, by contrast, were more diffident towards their doctors and hesitated to request more information from them or to offer any criticism of them.

It has now been argued that the doctor-patient relationship is profoundly influenced by social factors and is in many ways conflictual in its nature. Doctors are more powerful than patients in general within the confines of the consultation, but patients too have power which can be deployed to attain their desired ends. However, this power is diminished among patients in the lower social classes and it has been suggested that this relative impotence may be exacerbated by doctors spending less time with their lower class patients and by a failure of effective communication.

If the doctor-patient relationship in the psychiatric hospital specifically is now examined, it can be seen that the balance of power in the conflict between the physician and patient is tipped even further in the direction of the former. It has already been argued that patients coming into psychiatric hospitals come disproportionately from lower class backgrounds and so lack social status and authority. These patients experience all the class-related difficulties referred to in the account above in encounters with doctors. In addition, they lack many of the potential means of resisting the power of the doctor mentioned above. They may not be able to choose whether or not to consult their doctor or which doctor they will consult. Indirect sanctions such as withdrawing from a particular doctor's list will be ineffective as they carry no financial consequence for the doctor in the hospital. Treatment advice may not be able to be avoided with a constant surveillance by nursing staff

to see that the doctor's instructions are implemented. It has been seen that, because of the nature of psychiatric disorder, patients do not on the whole want to form groups to challenge the practices of their doctors. Patients who choose to learn more about their condition so they can challenge the opinions of their doctors may have their own opinions discounted on the basis that their illnesses make them unable to evaluate their own conditions.

In these circumstances of conflict and inequality between patient and doctor almost the only remaining effective means of exercising some degree of choice or autonomy left to the patient may be that of impression management. This involves the modification of behaviour or 'symptoms' in order to achieve desired ends, e.g. hospitalisation, transfer to another ward or discharge. It is clear that most psychiatric patients can alter their behaviour considerably in this way and that this is both a frequent and significant phenomenon in the doctor-patient relationship (89).

In conclusion, it has been argued that doctor-patient relationships are characterised by an unequal conflict in which the balance of power is with the doctor. In the case of psychiatric hospitals, the disparity of power in the doctor-patient relationship is such that conflict is almost annihilated by the total dominance of the doctor over his patient. The situation becomes even more one-sided when

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(89) See further Benjamin M Braginsky, Martin Grosse and Kenneth Ring, 'Controlling Outcomes Through Impression Management', Journal of Consulting and Clinical Psychology, 30, 1966, 295-300, Alan F. Fontana, Edward B. Klein, Everett Lewis and Lawrence Levine, 'Presentation of Self in Mental Illness', Journal of Clinical and Consulting Psychology, 32, 1968, 110-19, I. Pilowsky, 'Abnormal Illness Behaviour', British Journal of Medical Psychology, 42, 1969, 347-51.

patients are involuntarily detained in hospital and are forced to have the treatment prescribed by their doctors.

d) Medical Attitudes to Mental Disorder

It is now necessary to examine the attitudes of psychiatrists to mental disorder and its treatment. It has been mentioned above that psychiatrists begin their training with a course in general medicine and surgery. They are trained predominantly in general hospitals specialising in physical disorders and there are encouraged to regard disease on a mechanistic or medical model. This basic training encourages student doctors to see themselves as applied scientists whose job is to apply the rules and discoveries of science to cases of physical and mental disorder (90). Because of their general medical background and training, few psychiatrists escape from seeing mental disorder at least partly analagous to physical disorder and so requiring essentially the same diagnostic skills and medically-based treatments. Several eminent recent writers have defended the mechanistic disease model of mental disorders as useful in psychiatry, on pragmatic grounds (91). However, many psychiatrists regard the disease, or mechanistic medical model, as of only limited use in approaching mental disorder. Although these latter doctors continue to use the nomenclature of disease and to prescribe organic treatments to some extent, they are also prepared to consider other causes, concepts and treatments of mental disorder than organic ones, and are essentially eclectic in their approach.

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(90) For more about the mechanistic model of disease see Chapter XII.

(91) See e.g. Clare, op.cit.

A tiny minority of psychiatrists object to any use of disease concepts and medical treatments in psychiatry, seeing mental disorder as anything but an organic disease except in the case of those patients who are obviously suffering from some form of physical disorder, e.g. senile dementia.

Estimates vary as to the numbers of psychiatrists who fit into the three categories described above, i.e. into the categories of organic, disease-oriented psychiatrists, eclectic psychiatrists using all the available models of treatment and disorder which are available to some extent, and 'anti-disease' psychiatrists. Pallis and Stoffelmayer (92) investigating one particular region in Britain, found that most psychiatrists in their sample were eclectic in their methods of treatment (50%), while only a tiny minority used exclusively organic treatment (4%) and so, by implication, saw mental disorder as being like any other disease. Goldie (93) found in a sample of 38 psychiatrists from three British psychiatric hospitals that 19 regarded themselves as eclectic in their approach to mental disorder and its treatment. However, 17 psychiatrists saw themselves as strictly medical practitioners using the knowledge base, concepts and procedures provided by medicine. Only two psychiatrists in the survey took an anti-medical view of mental disorder.

Although the results of the studies considered above

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(92) D.J. Pallis and B.E. Stoffelmayer, 'Social Attitudes and Treatment Orientation Among Psychiatrists', British Journal of Medical Psychology, 46, 1973, 75-81.

(93) See Goldie, op.cit.

are not directly comparable, they seem to provide evidence for the strength and dominance of the eclectic position among British psychiatrists. It is noteworthy in this connection that the psychoanalytic view of mental disorder and its treatment which had an enormous influence on American psychiatrists has never had more than a minority following among psychiatrists in this country, although eclectic practitioners have sometimes chosen to use its insights and methods to a greater or lesser extent.

Apart from demonstrating that the majority of British psychiatrists are eclectic in their approach to mental disorder and its treatment, Pallis and Stoffelmayer showed that a preference for physical treatments among psychiatrists correlated positively with a more conservative social and political attitude. It was found that those psychiatrists who did not use psychotherapy at all were more conservative than other psychiatrists. This finding has fascinating implications for the present analysis, for it suggests that organically oriented psychiatrists are likely to have a conservative view of society and so are likely to favour and co-operate the forces of reaction and social control within the socio-political order. Thus it may well be that they do not object to being used as agents of social control by the ruling classes and that they are not as unwilling as might be supposed to put their skills at the service of maintaining the present order of society. If, as has been suggested, contemporary psychiatry is becoming more organically oriented (94) and is emphasising its links with

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(94) See Clare, op.cit., second edn., p.411f, Clark, Social Therapy, Preface.

mainstream physical medicine more and more, it may be that contemporary recruits to this speciality are more organically-orientated and thus more socially conservative. Psychiatry may therefore be in the process of becoming more conceptually and socially conservative than it has been hitherto. Certainly, there is no school of thought in contemporary psychiatry which is presenting any serious challenge to this in Britain in the way that critics like Laing and Cooper did in the 1960's. British psychiatry presently offers little threat to the established order of late capitalist society (95)and(96).

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(95) See works by Laing and Cooper for the 'anti-psychiatric' thought of the late 1960's which, based on psychoanalytic ideas and existentialism, put many questions against the nature of psychiatry and the nature of its function in society, but also against the ordering of society itself. A recent volume, David Ingleby, ed., Critical Psychiatry (Harmondsworth : Penguin, 1981), takes up where the anti-psychiatrists left off using Marxist and psychoanalytic insights. This work, however, has no contributions from British psychiatrists.

(96) There are other staff groups within the hospital apart from doctors, nurses and unqualified nursing staff. These include administrators, social workers, occupational and other therapists, psychologists and ancillary and maintenance staff. All of them play an important part in the life and running of the hospital and some at least have distinctive attitudes towards patients' therapy and mental illness. It is because of this significance that the omission of further discussion of these groups must be discussed and explained.

The first reason for such omission is that there is a lack of research and information about these groups. When studies were being undertaken in psychiatric hospitals in the 1950's, paramedical groups, other than nurses and attendants were largely ignored. Even had they not been ignored, it is doubtful how useful the evidence gleaned about them would be in looking at the contemporary British psychiatric hospital. For example it was noted that psychologists in Chicago in the early 1960's favoured psychotherapy as a treatment for patients. In contemporary British hospitals, most psychologists would not see this as a treatment of primary importance.

The lack of evidence concerning the attitudes of many groups in the hospital is indicative of the second

reason for not spending much time on discussing them. Most of these groups are relatively powerless in affecting the main structures of the hospital. So although workers like psychologists and occupational therapists come from fairly high class backgrounds and are fairly highly placed in terms of status in the hospital because they are professionals, they are numerically few and are not essential to the continued function of the institution (See Belknap's table of status in the hospital in Belknap, op.cit., p.39f). Because of this they have no real powers of sanction and can do relatively little to impose their will on other groups. Other workers who are essential for the continued functioning of the hospital, e.g. ancillary and maintenance staff, do have real powers of sanction but have not been primarily concerned with policy for the most part, nor with treatment and care of patients directly. For this reason, they have abdicated their influence to the two main power groups in the hospital, doctors and nurses.

Perhaps the one group which should receive more attention here is the administrative group. Since the inception of the N.H.S. and particularly over the last decade with the demise of the medical superintendant who performed the function of administrator, administrators have been becoming increasingly important. If the N.H.S. continues to run on the lines of a centralised bureaucracy, it seems likely that the power of administrators will continue to grow. However, at present, there is little material on the role and function of administrators, particularly with reference to their place in psychiatric hospitals.

In conclusion, groups other than doctors, nurses and unqualified nursing staff are not discussed in more detail here because there is a lack of useful information about them and because, for one reason or another, the other groups are less central, powerful and important in the life of the hospital and its patients than these three main ones.

e) Staff Attitudes in General

I have tried, as far as possible to outline the distinctive attitudes of particular staff groups above. There are, however, attitudes common to all the groups considered above, and especially to nursing staff, both qualified and unqualified. These attitudes are now to be considered.

The first of these shared attitudes is a common attitude towards the task which nurses are required to perform. Many nurses and nursing assistants may have a very negative attitude towards their tasks, seeing nursing as nothing more than a common job which is to be performed in a detached and mechanical way (96). This may be accompanied by ideas that the most important things about the job are the aspects of policing the patients, maintaining buildings and equipment, undertaking bureaucratic rather than therapeutic tasks, and above all, surviving within the system by doing nothing to upset its smooth running (97). Essentially, this may be characterised as a custodial-bureaucratic view of nursing in a psychiatric hospital as opposed to a caring-therapeutic attitude.

Staff groups also share common attitudes towards patients. Goffman notes that staff in general tend to see patients in terms of a stereotype, regarding them not as individuals but as types (98). Related to this is a tendency to depersonalise patients so that, instead of seeing a specific person struggling with a particular handicap, patients are seen as

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(96) See Talbott, op.cit., p.73.

(97) See ibid., p.74ff. for the above.

(98) Goffman, op.cit., p.18, cf. Towell, op.cit., Ch.4.

members of a certain class designated and treated as mental patients (99). This process is aided by the stripping of the patient's original identity (100). It may be that one of the reasons for this kind of depersonalisation taking place is that staff react in a fearful and emotional way to those suffering from mental disorder and try to locate all the 'bad' parts of themselves in the patients. They therefore try to build as large a barrier as they can between the patients and themselves (101). It seems likely also that staff with strongly-held humanitarian beliefs react to a situation where there are inadequate resources and staff numbers by coming to believe that patients really are different from themselves in order to overcome the dissonance between their ideals and beliefs and the real situation to which they and the patients are exposed. The only alternatives in such a situation are to change the situation, a task well-nigh impossible for the individual, or to leave the hospital altogether (102). An important aspect of stereotyping and distancing patients is that of 'medicalising' their behaviour. All a patient's actions, especially those which are regarded as deviant or non-conforming, are treated as functions of the patient's illness. Goffman records that even patients' past lives are medicalised so that their present condition can be seen as consistent with historical events which revealed symptoms of the patient's

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(99) Stanton and Schwartz, op.cit., p.214.

(100) See Goffman, Asylums especially p.73ff. Cf. Brandon et al., op.cit., p.67, for a contemporary personal account of the stripping process.

(101) See Bott, op.cit., p.133f.

(102) See G.W. Brown, 'The Mental Hospital as an Institution', Social Science and Medicine, 7, 1973, 407-424, p.413f.

present disorder (103).

Perhaps the most celebrated account of the medicalisation of behaviour in psychiatric hospitals is that of Rosenham (104). In this study, eight 'pseudo-patients' feigned psychiatric symptoms in order to gain admission to hospital, whereafter they behaved perfectly normally. Despite their public show of sanity, the 'pseudo-patients' were never detected to be such in hospital.

A more recent and bizarre example of the medicalisation of behaviour came to light in the report of the National Health Service Commissioner in 1980. A young schizophrenic patient in Whitecroft Hospital on the Isle of Wight did not receive treatment or examination until 19 days after he had broken his leg. According to the Commissioner this was because the medical and nursing staff did not believe him when he complained of pain and difficulty in walking. They concluded that the symptoms he displayed stemmed from his mental illness.

> It was left to the patient's mother to complain about the treatment her son was receiving. She reported that he was crawling about, supporting himself with the walls and used to have to slide down the stairs on his bottom (105).

While this is an exceptional case, scaled-down versions of it are an inevitable corollary of the medicalisation

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(103) See Goffman, op.cit., p.143f.

(104) David L. Rosenham, 'On Being Sane in Insane Places', in Alfred Dean, Alan M. Kraft and Bert Pepper, eds., The Social Setting of Mental Health (New York : Basic Books, 1976), pp.225-43.

(105) David Leigh, 'Hospital Named After X-Ray Row' in The Guardian, 2.12.80, p.2.

of behaviour (106).

Sutherland, a highly articulate and able intellectual, a professor of experimental psychology, gives a valuable account of medicalisation from his point of view as a patient hospitalised after a manic-depressive illness. He writes that "many of us felt oppressed because we could not deal on equal terms with doctors or nurses; we were mad, they did not need to take us seriously " (107). He also records,

> There was a further feature of life in hospital to which many inmates found it difficult to adjust. The younger doctors and nurses tended to treat patients as though they were insane, and this could be infuriating and upsetting ... The point is that none of the patients was totally out of touch with reality, and their illness only affected part of their lives.

Sutherland goes on to comment,

> Because doctors and nurses could always shelter behind the belief that the patients were mad, they were in an impregnable position, and it was easy for patients to feel completely in the power of the hospital authorities (108).

If these are the impressions of an articulate member of the upper middle classes with a similar or higher social background to that of the staff, it may be imagined how lower class patients in old, demoralised and badly staffed hospitals are treated.

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(106) In this particular instance it must be underlined that the only reason this case came to light is because the patient's mother had the courage and the ability to challenge the hospital. Many patients have no relatives or other advocates, let alone those who would be able to take on the N.H.S. and its professional employees.

(107) Stuart Sutherland, Breakdown (London : Granada, 1977) p.41.

(108) Ibid., p.30.

A consequence of the general medicalisation of patients' behaviour is that deviant and non-conforming acts can be regarded as symptoms and therapeutic procedures may likewise become sanctions or punishments. There may be a dangerous tendency to equate health with good behaviour in hospital and thus to blur the lines between sanctions and therapy. On this theme, Jordan writes,

> Treatment is clearly an attempt to influence behaviour and thus a form of control; but equally clearly it is not necessarily a punishment. However ... psychiatrists do overtly or covertly use the threat of compulsory detention to ensure voluntary admission, and of locked wards to procure co-operation in treatment methods (109).

It is important to point out, in concluding this discussion of the staff's attitude to the patients in hospital, that the reason they can objectify and distance patients and medicalise their behaviour, treating them as if they are insane and less than human is because patients have little power over the staff of the hospital, for reasons already discussed. Staff can impose their own ways and definitions on patients with little fear of a significant negative reaction from patients or from anyone else in society.

6. Hierarchy, Power, Status and Class in the Psychiatric Hospital

In the foregoing analysis of various groups within the hospital, I have tried, wherever possible, to comment on the relative amount of power and influence of each group. I have further commented on the class background from which the

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(109) Jordan, op.cit., p.153. Cf. Brandon et al., op.cit., One patient records therein that if he was disobedient, "they would threaten me with a locked ward." (op.cit., p.77).

members of the group largely come. This analysis has revealed that doctors have enormous, official and socially sanctioned power in the psychiatric hospital, especially considering the small number present in the institution. Qualified nurses too have a large amount of officially sanctioned power and influence, though not quite as much as doctors. Nursing assistants and other unqualified staff and ancillary powers have little formal power to affect policy, structures or other groups within the hospital but can have a great deal of very real informal power over the patients in their charge. At the bottom of the hierarchy of power and influence lie the patients, who have little power over their own lives and destinies, let alone those of other groups in the hospital, or over the structure and policy of the hospital.

This hierarchy of power and influence within the hospital reflects the class backgrounds of the members of the different groups. Patients in old N.H.S. hospitals come disproportionately from working and lower class backgrounds. Unqualified staff also come largely from lower class backgrounds and have the additional feature of being mainly female, i.e. they come from the less powerful sex in the present socio-economic order. Qualified nursing staff come from a higher class background than patients or unqualified staff. Other professional or qualified workers in the hospital, e.g. social workers, O.T's, psychologists, also tend to come from higher class backgrounds. In the case of doctors, it has been shown that they come from the highest social classes in society.

There would, then, seem to be a strong correlation between socio-economic class position in society at large and the status, power and position of the different groups in the psychiatric hospital. Waitzkin and Waterman make this

explicit in their analysis of the health sector. They claim that "Stratification in medicine is grounded in the class structure of a society" (110). This relationship has been observed by non-Marxist observers of the psychiatric hospital. Goffman, for example, notes that

> if staff leaders are uniformly recruited from a stratum in wider society which has a firmly legitimated higher ranking than the stratum from which the inmates are uniformly recruited, then the cleavage of the wider society will presumably lend support and stability to the rule of the staff(111).

Belknap comments,

> In practice, as it deals with its patients, the hospital operates in four somewhat separate groups arranged as a hierarchy with physicians at the top, social workers, psychologists, registered nurses and office workers in the second level, ward attendants and supervisors in the third, and patients in the fourth. These lev els not only reflect the formal authority of the internal hospital system but also <u>conform rather closely to the relative status of the groups in the outside world</u>. A further characteristic of this total system is that the level with the most authority, training, and prestige are the furthest removed from the patient population in terms of daily individual contact, and administrative work is most heavily concentrated on those positions in the system which also carry the greatest medical and psychiatric responsibility for treating the patient (112).

Although Belknap in the foregoing quotation refers to status rather than class, for present purposes it is reasonable to assume that status and class tend to be distributed in broadly the same way in society. A low class position is generally accompanied by low status in society and vice versa. Susser

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(110) Waitzkin and Waterman, op.cit., p.86.

(111) Goffman, <u>Asylums</u>, p.112.

(112) Belknap, op.cit., p.68. Emphasis added.

and Watson make a point which adds to Belknap's observations,

> The smallest rewards and the lowest status go to the persons who come into closest and most frequent contact with the patients. The highest status and the largest rewards go to those persons furthest removed from the patient (113).

It is worth mentioning that the status hierarchy outlined above is consciously recognised by workers in hospital themselves. In the U.S.A., Dinitz, Lefton and Pasamanick, in a study of status perceptions of six staff groups, ward administrators, resident doctors, psychologists, social workers, nurses and occupational therapists, discovered that all groups recognised doctors as having the highest status. After doctors in descending order came psychologists, social workers, nurses and occupational therapists (114). This study also noted that status was positively linked to decision-making power.

It can be deduced from this discussion that class, status and power in the psychiatric hospital are broadly distributed as they are in capitalist society as a whole. Those who are lacking in power and status in society at large, the lower classes, also lack status and power in hospital. The hospital, like other social institutions, is structured in such a way as to favour the members of the upper classes who work in it while the members of the lower classes and especially the patients have little influence. Such is the pattern of most other areas of social existence. Once again, it is impossible to see the hospital in isolation from the power distribution and structures of capitalist society as a whole.

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(113) Susser and Watson, op cit., p.258.

(114) Simon Dinitz, Mark Lefton, Benjamin Pasamanick, 'Status Perceptions in a Mental Hospital' Social Forces, 38, 1959-60, 124-28.

CHAPTER XII

SOME MODELS OF MENTAL DISORDER AND THEIR SOCIO-POLITICAL IMPLICATIONS

In this examination of various aspects of the psychiatric hospital so far little has been said about the nature of mental disorder itself. It has been assumed that the notion of 'mental illness' is unproblematic and no attempt has been made to look at this phenomenon from a sociological perspective. This analysis would be incomplete and inadequate if the sociology of mental disorder and its wider social and political determinants and implications was to be omitted.

For this reason in this chapter I propose to examine some of the available models of mental disorder, focusing on the medical model in the first instance and then looking at sociological insights and offering a critique of the medical model from that perspective. The medical model predominates in British psychiatric practice, and so must be examined in some depth. While sociological models and insights into mental disorder are not widely used, they raise substantive socio-political questions about the medical model which are of great relevance to the present investigation.

The ensuing discussion should illuminate various aspects of the psychiatric hospital already touched on, e.g. the dominance of the medical profession in the psychiatric hospital. At the same time, it prepares the way for more specific discussion of matters such as treatment modes in the hospital and their social and political connotations and implications.

Siegler and Osmond list eight models of mental disorder (1). In this typology, the authors indicate the nature of the definition or diagnosis, the etiology, the subject's behaviour, the treatment, the prognosis and the functions of institutions according to which model is utilised (2). The models contained in the typology are the following; the medical model, the moral model (based on a behavioural view of disorder), the impaired model (which becomes operant when a person is regarded as chronically mentally disordered and is so permanently handicapped), the psychoanalytic model (in which the disorder is seen to stem from the frustration of emotions earlier in the subject's life), the social model (in which disorder is regarded as resulting from the pathological organisation of society), the psychedelic model (in which disorder is regarded as a mind-expanding 'trip'), the conspiratorial model (in which disorder is seen as the produce of the labelling of the individual as 'mad' by other members of society) and, finally, the family interaction model (wherein the whole family of the individual sufferer is regarded as sick and as responsible for that individual's disorder). These models demonstrate the wide variety of ways in which mental disorder may be conceived, and they carry with them consequences in terms of treatment, apportionment of responsibility, blame etc. It must be added that they are, of course, 'ideal types' of ways of looking at mental disorder and so they simplify and separate theoretically that which is very complex and interwoven in reality.

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(1) Miriam Siegler and Humphrey Osmond, Models of Madness, Models of Medicine (New York : Macmillan, 1974).

(2) This typology is summarised in ibid., pp 16-18, in tabulated form.

Psychiatry tends to be eclectic in its approach to mental disorder, and so often models are used together in clinical practice.

I do not propose to examine all Siegler and Osmond's categories of models here because many are not particularly prevalent in British psychiatric practice (3). I intend rather to devote the ensuing discussion to a detailed consideration and critique of the medical model followed by a discussion of social models of mental disorder. In the case of the latter I shall supplement Siegler and Osmond's 'social' and 'conspiratorial' models with further sociological material to make up a more complete and satisfactory model.

1. The Medical Model of Mental Disorder

The dominant model used in understanding and treating mental disorder in British psychiatry is and has been for a very long time, the so-called 'medical model'. While there is almost universal agreement that this is the case, it is unclear as to quite what the medical model actually consists of. Clare writes, "The notion of the medical model is by no means unequivocal but is subject to much uncertainty and confusion" (4). He lists four main definitions of the medical model. First, it may be seen as treating psychological ailments analagous to physical ones, insofar as both sorts of ailments have ascertainable causes and the disease state is manifested in symptoms. His second definition is similar to

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(3) For example, the psychoanalytic model is only used to a very limited extent.

(4) Anthony Clare, 'The Disease Concept in Psychiatry', in Peter Hill, Robin Murray and Anthony Thorley, eds., Essentials of Postgraduate Psychiatry (London : Academic Press, 1979), pp.55-76.

the first, but it adds that the medical modal characteristically focuses on the causes of abnormal or maladaptive behaviours rather than on the behaviours themselves and construes the 'real' disorder in terms of an underlying disease state of the organism. The third definition holds that all mental disorders are discrete disease entities each with its own cause, prognosis and potential treatment. Lastly, Clare cites Szasz's definition of the medical model as being one in which mental disorder is presumed to come from some form of underlying neurological or physiochemical causes. Clare points out that this definition is the only one which attributes a physiological basis as being an essential part of the medical model (5).

> Ingleby defines the medical model thus
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> In the narrowest version (sometimes also called the 'disease model'), it is assumed that the origins of the problem in question lie in some process inside the individual - an 'illness' or 'disease' - which, although it may be initiated by external or genetic causes, can be regarded as autonomous once it is in existence. In the broadest sense, the 'medical model' may be taken to include any approach that defines the locus of the problem as within the individual....(6)

Despite the confusion surrounding the exact definition of the medical model, it is possible to isolate some of the

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(5) See Clare, op.cit., p.62, for all the above.

(6) David Ingleby, 'Sanity, Madness and the Welfare State', in Michael Wadsworth and David Robinson, eds , Studies in Everyday Medical Life (London : Martin Robinson, 1976), pp.194-211, p.194. For further definitions and discussion of the medical or disease model of disorder, see McKeown, op.cit., Ch.1 and Doyal, op.cit., pp.27-36.

common factors usually regarded as contributing to it. The language of disease and illness is used, for example, as opposed say to the notion of Szasz that mental disorders should be described as 'problems of living'(7). The classification and diagnosis of mental disorder is another feature which is common to the medical model and is directly analagous to the categories used in classifying and diagnosing physical disorder. Again, some psychiatrists using the medical model do undoubtedly believe that there often is some kind of physiological disorder underlying mental disturbance. This kind of thinking is supported by disorders such as senile dementia which undoubtedly do have physiological aetiology. Some may see psychiatric disorder as being caused ultimately by some kind of discrete disease entity which can eventually be isolated and effectively treated. Whatever their attitude to the origins of mental illness, most psychiatrists regard organic treatments as effective and necessary in trying to combat the symptoms of mental illness. Similarly, most would see their function as being to deal with the disorder as though its origins lay within the pathology of the individual patient.

It must be noted that although the medical model, in some form, is dominant in British psychiatry today, it is in fact of fairly recent origin. It was in the latter part of the last century and the early part of the present one

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(7) See further Thomas S. Szasz, 'The Myth of Mental Illness' in Thomas J. Scheff, ed., Mental Illness and Social Processes (New York : Harper Row, 1967), pp.242-54, also Thomas S. Szasz, The Myth of Mental Illness (St Albans : Granada, 1972) for a longer and more detailed exposition of Szasz's ideas of mental disorder. A consideration and detailed critique of Szasz's ideas is to be found in Sedgwick, Psycho Politics, Ch. 6.

that this model became universally credible or viable in relation to mental disorder. Only in the 1890's did Kahlbaum and Kraepelin begin to classify psychiatric disorders after the manner of other somatic diseases. Both of these men took it for granted that the variegated and shifting forms of mental illness with which they were confronted consisted of a finite number of disease entities, each with its own distinct cause, psychological form, outcome and cerebral pathology (8). The rise of the medical model was facilitated by successful developments in medicine in isolating the causes of many diseases at the end of the nineteenth century, and also by the discovery early in the present century that syphilis, which produced general paresis (a type of madness caused by neurological breakdown), was caused by a particular spirochaete. This lent credibility to the notion that a distinct disease entity was involved in insanity as in other physical disorders (9).

Since the beginning of the twentieth century, remarkably little has been discovered about the causal agents in mental disorder, despite a large amount of somatic research and the effectiveness of some somatic treatments. This puts a

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(8) See R.E. Kendell, The Role of Diagnosis in Psychiatry (Oxford : Basil Blackwell, 1975), p.62. It is interesting to note that earlier in his life Kraepelin had espoused an essentially social view of mental illness. See George Rosen, Madness in Society (Chicago : University of Chicago Press, 1980), Ch.10. Rosen explores nineteenth century views of insanity in some detail in this chapter and shows the dominance of the social view of disorder during the early and middle parts of the century.

(9) See Peter Conrad and Joseph W. Schneider, Deviance and Medicalization (St Louis : Mosby, 1980), Ch.3, for a more detailed account of the rise of the medical model.

question mark against some of the most fundamental tenets of the medical model of mental disorder. Most modern psychiatric theorists themselves admit that the medical model is inadequate and of limited use, but continue to employ its concepts on the grounds of pragmatic utility and because no other more useful concepts or systems of classification are presently available. Kendell, for example, defends the use of medical diagnosis and the disease concept in psychiatry on the basis that these are very useful for clinical and research purposes (10). Although he concedes that psychiatric diagnoses may not be as firmly grounded, as reliable or as valid as diagnoses in other medical specialities, they can be justified clinically on the grounds that they do have some value as to the course, prognosis and treatment of mental disorders (11). While the disease concept is essentially an abstraction it is of great practical utility (12).

Clare also justifies the use of the medical model on empirical grounds. He argues that there is no good reason why psychiatric diseases which can be defined only in terms of clusters of symptoms and signs rather than having a known underlying pathology should not be regarded as valid. He points out that, in the evolution of knowledge about many physical diseases, awareness of a particular set of signs and symptoms forming a syndrome and indicating a particular disorder has often preceded the discovery of its physiological basis. Writing about the use of the organic model of mental

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(10) See Kendell, op.cit., especially p.22 .

(11) See ibid., Ch. 3.

(12) Ibid., pp.22-3.

(13) Clare, Psychiatry in Dissent, first edn , pp.11-12.

disorder, Clare comments that

> the biologically inclined psychiatrist takes some satisfaction in the fact that the list of conditions in which psychological disturbances appear to be symptomatic of underlying physical pathology continues to expand (14).

He goes on to argue that, in any case, pragmatic adherence to an essentially medical model does not preclude a thoroughly desirable eclectic approach to other models and insights. He further states that

> the medical model ... takes into account not merely the symptom, syndrome, or disease, but the person who suffers, his personal and social situation, his biological, psychological and social status (15).

The medical model regarded in this way encompasses the best of all other available models of mental disorder.

Wing argues almost the opposite case to that which Clare presents in his defence of the use of the medical model. He suggests that the medical model should confine itself strictly to identifying and treating definite disease syndromes: "Disease theories of mental disorders, like other scientific theories should be specific, restricted and not amenable to generalization outside technically specificable referents" (16). Wing argues that far from the medical model comprehending and containing all other available models in an eclectic fashion, a tightening up of diagnostic labelling and usage would increase the clinical and research value of diagnosis while restricting medical imperialism over areas of life and problems beyond the competence and expertise of

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(14) Ibid , p.44.

(15) Ibid , p.69.

(16) J.K Wing, Reasoning About Madness (Oxford : Oxford University Press, 1978), p.166.

doctors. Given such a restricted usage of the disease model of mental disorder, Wing believes that it can be of great practical and theoretical utility.

Siegler and Osmond provide further arguments for the use and dominance of the medical model in psychiatry. They argue that, compared with other models of mental disorder, the medical model is more discriminating. It allows for differential diagnosis which in turn allows for a greater number of possible explanations of a disorder and so it is more scientific in its method. The medical model, they maintain, is better as a tool for aetiological investigation and offers more hope for discovering and implementing effective treatments. In addition, the sick role bestowed on those who are diagnosed and treated as ill provides clear rights and duties for the patient, the doctor and the patients' families. Instead of spending time apportioning blame (e.g. on society, on the family etc.), as the 'continuous' models of insanity do (17) the medical model, which is partial and 'discontinuous',is pragmatic and concentrates on normalising patients' behaviour. Its energy is "not wasted on vendettas but can be spent on returning the mad person to normal" (18).

I will turn now to a consideration of the social model of mental disorder having spent some time on the content, history and defence of the medical model. At a later point, it will be appropriate to examine from a sociological point of view why the medical model has become so popular and dominant in British psychiatry today. This will be more

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(17) I.e. those models which provide a complete and congruent explanation and solution for insanity.

(18) Siegler and Osmond, op.cit., p.176.

effective if the alternative sociological view of mental disorder has already been discussed.

2) Sociological Perspectives on Mental Disorder

For the sake of convenience, this discussion, of sociological perspectives on mental disorder, will be divided in several parts. In this part sociological theories of mental disorder proper are considered. Having recognised that the essence of the sociology of mental disorder is that of deviance, I will move on to consider the relations between deviance and the distribution of power in society. I shall then examine the relationship between the idea of mental illness and social control in our society. This will then lead on to the promised sociological critique of the medical model and the medicalisation of mental disorder and its significance in late capitalist society.

The starting point for a discussion of the various sociological perspectives on, and insights into, mental illness is a basic distinction in the terms disease and illness. As these terms are to be used here, 'disease' is to denote particular organic pathology underlying a clinical syndrome, while 'illness' is used to denote physical and behavioural deviations which pose problems for the individual and/or the society in which he lives. This distinction is of vital importance as it makes it possible to differentiate between pathology which is an objective, unchanging and potentially examinable entity, and human behaviour and its social recognition and consequences, which is prone to change and fluctuation. These things are by no means identical as biological pathology, i.e. disease, does not always lead to socially recognised 'illness' nor vice versa. This can for example be seen in the case of some sufferers from severe organic disorder, e.g. some cancer sufferers, who may

manifest no outward signs of disease while suffering from very serious biological disorder. Such people may not be recognised by themselves or others to be 'ill'. Equally, some individuals manifest 'illness behaviour' without having any perceptible underlying pathology (19). In the present work, discussion will focus on the concept I have defined as illness rather than that of disease. Sociological theorists do not regard it as desirable or indeed possible to pronounce on biological malfunction. Concerning the exact underlying causes of illness behaviour in physiological terms they prefer to remain agnostic for the purposes of their work which is to study and comment on the process whereby a person comes to be recognised as ill in a particular society, to be treated by particular groups in that society, and to be dealt with in society at large.

Fundamental to the sociological perspective on any kind of illness is the notion that illness behaviour is deviance. That is to say that illness behaviour is behaviour which is regarded as basically undesirable by the particular society in which it takes place. It is behaviour which is negatively defined or even condemned (20). It must be emphasised that this definition of illness as deviance and the sanctioning against it are features which apply to all illness and not just to that which is perceived to be mental illness. Sedgwick makes this clear: "All sickness is essentially deviance. That is to say, no attribution of sickness

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(19) For further discussion of the sociology of illness behaviour and disease and the distinction between them, see Mechanic, Medical Sociology, Chs. 1,2 and 3, also David Field,'The Social Definition of Illness', in David Tuckett, ed., An Introduction to Medical Sociology (London : Tavistock, 1976), pp.334-366, and Freidson, Profession of Medicine, Ch.10.

(20) See Conrad and Schneider, op.cit., p.3.

to any being can be made without the expectation of some alternative state of affairs which is considered more desirable" (21).

The corollary of the social definition of illness as deviance is that every kind of deviance reflects the norms and conventions of a specific society at a particular point in time. No act or condition perceived and defined as deviant in a particular society is deviant in itself. Deviance is socially constructed and attributed and so reflects particular social values and norms. Thus, that which is defined negatively in some societies as deviance, in other societies may seem perfectly normal or even desirable. Mechanic writes, "What may be viewed as deviant in one social group may be tolerated in another, and rewarded in still other groups" (22). The relativity of the attribution of deviance in the case of mental disorder can be seen most clearly by examining studies of other cultures, geographically and/or historically distinct from our own (23). These studies show that different societies

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(21) Peter Sedgwick, 'Mental Illness Is Illness , Salamagundi, 20, 1972, pp.196-224, p.213. Emphasis original.

(22) David Mechanic, 'Some Factors in Identifying and Defining Mental Illness', in Thomas J. Scheff, ed., Mental Illness and Social Processes (New York : Harper and Row, 1967), pp.23-32. A more recent and comprehensive account of Mechanic's views on the social nature of mental illness is to be found in David Mechanic, Mental Health and Social Policy, Second Edn., (Englewood Cliffs, N.J. : Prentice Hall, 1980). An interesting and amusing fictional account which demonstrated the relativity of deviance in general and illness in particular is to be found in Samuel Butler, Erewhon (Harmondsworth : Penguin, 1970).

(23) See e.g. Ari Kiev, Transcultural Psychiatry (Harmondsworth : Penguin, 1972), Rosen op.cit., Michael Macdonald, Mystical Bedlam (Cambridge : Cambridge University Press, 1981).

disorder from those prominent in our own, although it seems probable that all societies have members who would be regarded as mentally ill in the terminology of our own culture. They clearly show that concepts of mental disorder change radically as they continue to embody the values and norms of the society in which they come into being.

Deviance is a broad term which includes all kinds of negatively defined behaviour in our society, ranging from crime to sickness. However, not all deviance is regarded or sanctioned in the same way. Thus in our own culture, a distinction is made between those who fail to conform to social expectations because they are ill and those who are seen as criminals, and their treatment is similarly different. Boundaries between different types of deviance have considerable fluidity. Here, however, the point to note is that illness is a particular type of deviance. Parsons used the term 'the sick role' to describe the position of deviants who are perceived to be sick rather than actively sinful in modern Western society. In this role, the deviant individual has a conditional legitimacy in that he is not regarded as responsible for his failure to conform to the demands that society places upon him, he obtains exemptions from his normal role and duties in society and is not held responsible or blamed for his condition. He must, however, recognise that he occupies an essentially undesirable role and must want to recover and seek the help that will enable him to resume his proper place as soon as possible (24).

Mental illness must be regarded as a specific kind of deviance contained within the broad deviance category of illness. Scheff sees mental illness as a residual category

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(24) See Conrad and Schneider, op.cit., p.32, for a summary of Parsons' description of the sick role.

within the spectrum of deviance. By this he means that mental illness is used in our society as a general category for diverse kinds of rule and norm breaking for which society provides no more explicit designation (25). Those who come to be perceived as mentally ill are seen accordingly to occupy the sick role, but in a much less specific way than those whose deviance is attributable to physical causes.

Before proceeding to discuss the process by which individuals come to be regarded as mentally ill, a word should be said about the concept of stigma. Those who occupy negatively sanctioned and deviant roles in society are generally perceived to be inferior and undesirable by the majority of society's members. The breaking of social norms and conventions leads to negative sanctions being invoked against offenders and so stigma is conferred on those who are known to be deviant. This is part of the mechanism of encouraging social conformity and serves the purpose of discouraging and punishing deviant behaviour. Stigma exists wherever societal norms and values are negatively sanctioned. It is therefore conferred on the mentally ill as well as upon more directly culpable groups of deviants such as prisoners (26).

Not all those who are deviants are perceived to be so by those around them. This applies as much to the mentally ill as to any other kinds of deviants in society. Illness of any kind must come to be recognised as such before

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(25) See further, Thomas S. Scheff, Being Mentally Ill, (Chicago : Aldine, 1966), Ch.2, especially p.31f.

(26) For more about stigma, its effects and the response of the stigmatised see Erving Goffman, Stigma (Harmondsworth : Penguin, 1968).

it can be thus designated and appropriately dealt with. Much sociological writing has focused on the attribution of deviance and the approach which has become most associated with this area of study is that of labelling theory. Labelling theorists have concentrated not on the acts of the deviant himself, but rather on societal reaction to those acts and the way in which society, so to speak, 'creates' deviants and recognises who they are (27).

The labelling theory of mental disorder has been expounded most fully by Scheff in Being Mentally Ill. In this work he advances a number of propositions. He suggests that residual rule-breaking arises from very diverse sources, ranging from the organic to the volitional (28). He goes on to advance the notion that, as compared to the rate of treated mental illness, the rate of untreated, and so unrecorded, rule breaking of a residual nature is extremely high (29). Scheff further asserts that most residual rule-

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(27) For an outline of this general approach see Kai T. Erikson, 'Notes on the Sociology of Deviance' in Thomas J. Scheff, ed., Mental Illness and Social Processes (New York : Harper and Row, 1967), pp.294-304.

(28) Scheff, op.cit , p.40.

(29) Ibid., p.47. This is as true of physical illness behaviour as it is of the residual category of mental illness behaviour; many of those who show signs of illness are never recognised to be ill in any formal or socially recognised sense. See further David Tuckett, 'Becoming a Patient' in David Tuckett, ed., An Introduction to Medical Sociology (London : Tavistock, 1976), pp.159-89.

breaking is denied and is of only transitory significance (30). Scheff goes on to consider the social institution of insanity and suggests that members of society learn a stereotyped image of mental disorder (31). Stereotypes are continually affirmed in social interactions, thus maintaining and reinforcing a particular moral and cognitive view of the world and society (32). Residual rule breakers are either labelled by society or their rule breaking is denied or normalised. If they are labelled as deviants, their behaviour may be appropriately rewarded for performing and accepting a recognised stereotyped deviant role (33). It is suggested that such deviants are punished rather than rewarded when they attempt to escape from their deviant stereotype and return to conventional roles in society, i.e. they are stigmatised (34).

Scheff's model has not been without its critics (35).

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(30) See further Marian Radke-Yarrow, Charlotte Green Schwartz, Harriet S. Murphy and Leila Calhoun Deasy, 'The Psychological Meaning of Mental Illness in the Family', in David Tuckett and Joseph M. Kaufert, eds., Basic Readings in Medical Sociology (London : Tavistock, 1978) pp.55-63. This research shows how unwilling wives of working class men were to recognise their husbands' deviant behaviour and how persistently they tried to deny or normalise it.

(31) Scheff, op.cit., p.64.

(32) Ibid., p.67.

(33) Ibid., p.84.

(34) Ibid., p.87.

(35) See e.g. Walter R. Gove, 'Social Reaction as an Explanation of Mental Illness', American Sociological Review, 35, 1970, 873-84.

There is no need to go into this criticism here, but it is important to add that Scheff sees labelling leading to secondary deviance, i.e. a permanent deviant career, as taking place in its final form in the law courts when a public judgement is made on the behaviour of the deviant on behalf of the society in which he lives. While this cannot be seen as the crucial moment for most cases in British psychiatric hospitals, the moment of admission to hospital may be seen as a significant moment of labelling in our society.

Scheff sees the severity of societal reaction to residual rule-breaking as depending on several social variables. These include the degree, amount and visibility of the rule-breaking, the power of the rule-breaker, the social distance between him and the social control agents, the tolerance of the community, and the availability in the culture of alternative non-deviant roles (36).

Mechanic too has attempted to identify some of the intervening variables which affect the visibility of deviance in the community and the consequences of this for those deviants who come to be regarded as mentally ill. He suggests that the stigma attached to mental illness as a designation may make the primary group in which the life of the deviant takes place reluctant to label him as such. The size and form of the social structure in a particular group or community also has an effect on the labelling process, as do the circumstances of that community; in times of stress, for example, tolerance of the deviant may be reduced. Mechanic writes, "Whether a definition of deviancy is made and acted

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(36) Ibid., p.96-7.

upon will depend largely on how serious the consequences of this deviation are for the group (37). He emphasises that the basic decision as to whether or not a person should be labelled as deviant is not made by psychiatric specialists, but rather by the lay community which surrounds the deviant. Mental illness and other forms of deviance only become overt when persons in the deviant's significant social groups recognise that that particular individual is unable to conform to expectations concerning the proper response to his network of relationships (38).

Elsewhere, Mechanic has expanded on the determinants which play a part in deciding whether help is sought and obtained for those deviants who are identified as being ill, whether physically or mentally. These are listed here, as they help to illustrate the social process whereby the mentally ill come to be recognised as such by society in general and the medical profession in particular. There are ten determinants: (1) Visibility, recognizability, or perceptual salience of deviant signs and symptoms; (2) The extent to which symptoms are perceived as serious; (3) The extent to which symptoms disrupt family, work and other social activities; (4) The frequency of the appearance of the deviant signs or symptoms, their persistence, or their frequency of recurrence; (5) The tolerance threshold of those who are exposed to and evaluate the deviant signs and symptoms; (6) The availability of information, knowledge and cultural assumptions and understanding of the evaluator(s), (not necessarily the patient himself); (7) Basic needs which lead to denial of the signs and symptoms; (8) Needs which

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(37) Mechanic, 'Some Factors in Identifying and Defining Mental Illness', p.28.

(38) Ibid., p.25.

compete with the illness responses; (9) Competing possible interpretations which can be assigned to the symptoms once they are recognised; (10) The availability of treatment resources, physical proximity to them and the psychological and monetary costs of taking action (39).

It has been argued that, whatever the ultimate origins and causes of mental illness behaviour, (whether they be organic malfunction, family disruption, emotional disorder, etc.) the recognition of that behaviour is ineluctably a matter of social judgement and definition according to the norms of particular groups and societies. It is therefore true to describe mental illness as a form of social deviance, whose recognition and treatment as a residual deviance category, depends to a large extent on a variety of social factors. The foregoing account has, however, given no consideration to the politics of the labelling of deviants as mentally ill. Nothing has been said about the wider issues of power in society which determine who shall have the power to impose their values and expectations upon whom in a particular social order. I shall therefore go on to consider the relationship between deviance and power in society, the relationship between mental illness and social control and then the medicalisation of mental disorder, a particular response to deviance control in our own society. This last section will form a sociological critique of the medical model in psychiatry which was considered above.

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(39) See Mechanic, Medical Sociology, pp.268-9. Mechanic points out elsewhere that these variables are as applicable to physical as to mental illness behaviour and its recognition. See Mechanic, Mental Health and Social Policy, p.94.

3. Deviance and Power in Society

It has been suggested that mental illness must be seen as a particular residual category of deviance. It has further been argued that the attribution of a label denoting a deviant role to groups or individuals is a fundamentally social process. Mental illness has to be designated as such by a society or social group. It is now necessary to consider the relationship between the recognition and labelling of different kinds of deviance in society and power in that society.

Social norms and values are not created ex nihilo. They do not simply 'happen'. They are created by certain people and groups making claims based on their own particular interests, values, and views of the world. Reality, including the norms, values and moralities by which people live is socially constructed (40). A consequence of this social construction of reality is that social norms and values reflect the relative power of different groups and individuals in society to impose their view of reality on others. Those who have most power will be most able to impose norms and values reflecting their own views and interests on the rest of society. These points are encapsulated by Conrad and Schneider:

> Morality does not just happen; ... Morality becomes the product of certain people making claims based on their own particular interests, values and views of the world. Those who have comparatively more power in society are typically more able to impose their rules and sanctions on the less powerful. In consequence, deviance becomes actions or conditions that are defined as inappropriate to or in violation of certain powerful groups' conventions. Such

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(40) See further Peter L. Berger and Thomas Luckmann, The Social Construction of Reality (Harmondsworth : Penguin, 1971).

> deviance is believed to be caused not by mysterious forces beyond the individual's control but rather the consequence of particular definitions and rules being applied by members of certain groups to other people and/or situations (41).

Conrad and Schneider adopt a conflictual model of deviance designation. They see deviance designations as the result of social and political conflict:

> The conflict perspective sensitizes us to the fact that not all people are equal in their power to construct reality - that deviance designations may serve political interests and that they are created through some type of social conflict (42).

They refer to this conflict as 'the politics of definition' and add,

> What is considered deviant in a particular society is a product of a political process of decision-making. The behaviours or activities that are deviant in a given society are not self-evident; they are defined by groups with the ability to legitimate and enforce their definitions (43).

Rock, considering the designation of deviance in general, suggests that the power to make an effective designation closely follows general social stratification patterns: "In complex societies the distribution of deviant phenomena is closely linked to the distribution of power and life-chances" (44). He argues that the lower classes in society are more likely to experience designation as deviants

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(41) Conrad and Schneider, op.cit., p.2.

(42) Ibid., p.22.

(43) Ibid., p.22.

(44) Paul Rock, Deviant Behaviour (London : Hutchinson : London, 1973), p.47.

and to be labelled and treated as such (45). There is no reason to suppose that this observation is not applicable to the attribution of the mental illness designation in society.

A corollary of the unequal distribution of power, and so of the ability to designate deviance in society, is that those who are least powerful will have little chance of resisting or counter-designating the deviance designation of the powerful (46). Attempts to avoid designation as a deviant or to label others as deviants are liable to fail unless backed up by real social power, whether formal or informal.

Within the Marxist paradigm being used in this thesis, I would argue more specifically that the norms and values whereby deviance is evaluated reflect, or are at least compatible with, the interests of the ruling higher classes in capitalist society. It has been mentioned before that the ideological superstructure of society is determined by those who control the means of production. It is this class which determines the dominant ideology. The ruling classes designate deviance in such a way as it serves their interests best, and they also have the power to enforce their definitions on the lower classes. This is not to say that particular upper class individuals or groups consciously conspire to directly oppress and label individuals and groups with less power and influence. Rather, those who have most power in society

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(45) See ibid., pp.47f, 140f. Cf. Agnes Miles, The Mentally Ill in Contemporary Society, (Oxford : Martin Robertson, 1980), p.188f.

(46) See further Conrad and Schneider, op.cit., p.6, and Szasz, Law, Liberty and Psychiatry, p.42f, where it is pointed out that to successfully label another person it is necessary to outrank them in society and to have more power or they will be able to resist designation/ commital as mentally ill.

choose modes of deviance definition which conform generally with their own class interests, i.e. the material interests of capitalism. This assertion will become a good deal clearer when the political implications of medical models of mental disorder are discussed below. For the present, it is sufficient to note that the designation of mental disorder has substantial political implications. Firstly, because mental illness is evaluated against the relative values of a particular social and political context, secondly, because there is a differential distribution of the power to assign and resist the attribution of deviance which is related to social stratification in society, and thirdly because both these features mean that the lower classes have much less power to determine the nature of deviance designation and to resist its attribution to their members.

4. Mental Disorder and Social Control

Discussion of mental disorder as a type of social deviance leads on naturally to a consideration of the closely related subject of social control. Social control may be defined as "the means by which society secures adherence to social norms; specifically, how it minimizes, eliminates or normalizes deviant behaviour" (47). Social control is an inevitable aspect of any social situation which any kinds or norms or rules develop, and so is universal to all societies, although the content of the norms and rules varies considerably. While social control cannot be avoided, a critical awareness must be retained concerning the content of the rules and norms which provide the ends towards which

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(47) Conrad and Schneider, op.cit., p.7. For a consideration of social control in general see C. Ken Watkins, Social Control (London : Longman, 1975).

social control is directed (48).

Social control of deviance assumes many forms, both formal and informal. It can range from the internalised social norms within the individual ('conscience'), which prevent him from behaving in some ways and encourage him to behave in other ways, through the norm enforcement of small groups, to the full panoply of the state laws with their formal sanctions. Usually within society, there are formally or informally designated social control agents. They have a particular responsibility to deal with socially-defined problems falling within their sphere of competence. They may act as 'gate-keepers' to deviant roles and may be responsible for deviance designation of certain types of behaviour. In our own society, officials as diverse as doctors and prison officers perform the role of social control agents insofar as they are used to preserve the fabric of society by dealing with and treating certain varieties of deviance.

There may sometimes be confusion as to the exact nature and designation of a particular kind of deviant behaviour. It may be difficult on some occasions to decide what kind of deviance is taking place and how the deviant should be controlled, who should take responsibility for controlling him, etc. Thus, some apparently criminal behaviour may be attributed to mental illness and be treated by doctors rather than being seen as an offence against the criminal law and being treated by the legal system and its officers. As all

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(48) See Barbara and John Ehrenreich, 'Medicine and Social Control' in John Ehrenreich, d., The Cultural Crisis of Modern Medicine (New York : Monthly Review Press, 1978), pp.39-79, p.42, for this point.

deviance is socially defined and obtains its designation from social norms, it must be recognised that no species of deviant behaviour is self-evidently of one type or another. Mentally disordered behaviour may be seen as posing a theological, legal or medical problem for the social control agencies and may be treated differently accordingly.

This discussion sets the scene for an exploration of the reasons and ways mental disorder has come to be recognised as an essentially medical problem in our society. It will be seen from the subsequent discussion that there are major socio-political implications to this particular model of social control.

5. The 'Medicalization' of Mental Disorder

> Every society recognises certain extreme forms of aberrant behaviour as mental derangement or insanity. In other words, along the range of human behaviour, from that which a society considers normal to that which it regards as abnormal, there is some point or section at which a social judgement is made and an individual comes to be regarded as mad (49).

In the preceding discussion the truth of this assertion has been demonstrated and an attempt has been made to try and show the social processes whereby deviant behaviour comes to be recognised as 'madness' or insanity. However, as I noted in my discussion of social control, the identification of the residual deviant category of insanity or madness does not in itself indicate or imply a particular form of social control or treatment. The fact that mental disorder is currently treated almost exclusively as an illness must not obscure the fact that this is only one response to insanity which may be seen as arbitrary in absolute terms. In reality, treating mentally disordered behaviour as an illness and

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(49) Rosen, op.cit., p.101.

employing the medical profession to treat and control it is a fairly recent historical development. Conrad and Schneider write, "It is by no means obvious that madness is mental illness or even a medical problem"(50). It is important to realise that the deviant behaviour regarded as mental illness in contemporary Western society has only been seen as a primarily medical problem for the last hundred years or so.

A summary of the ways in which mental disorder has been regarded historically and in different cultures has been provided by Conrad and Schneider (51). Briefly, their discussion shows that mental disorder has been regarded as a supernatural or theological problem, a somatic problem, a legal problem and an environmental problem at different times and places. Although physicians have long been involved to some degree in the treatment of this form of deviance, from the time of the ancient Greeks onwards, the disease or illness model has played only a subordinate part for most of the last two millenia. The work of Scull and others shows that until the beginning of the nineteenth century the mentally disordered were, on the whole, not differentiated or treated differently from any other deviants in society. Even during the last century, mental disorder was regarded as an environmental rather than a medical problem and physicians played a relatively minor part in its treatment. Social change and disintegration were preferred as the causes of the disorder to notions of individual pathology. It was only towards the end of the last century that the environmental theory was

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(50) Conrad and Schneider, op.cit., p.38. Emphasis original.

(51) See ibid., Ch. 3, also Vieda Skultans, Madness and Morals (London : R.K.P., 1975), Rosen,op.cit., and Foucault, op.cit.

displaced by the disease model which contributed to the prevalent medical model of today (52).

It is important to recognise that changes in definitions of deviance and its treatment do not take place in a social vacuum. The fact that a disease model of mental disorder replaced the social model, does not mean that it was self-evidently better or more effective. It implies rather that it was a model which suited the interests of the kind of society in which it came to have dominance better than that which it supplanted at a particular point in history. It implies that this model was more compatible with the interests of the most influential members of society at the time when it emerged and that in some way it still best suits those interests. Furthermore, it suggests that it is a model which receives substantial support from those who are powerful in our society, albeit unconscious, and that the group which advanced this model, i.e. doctors, itself has substantial influence in society over against the influence of those supporting the environmental model. Thus Conrad and Schneider state, "The medical dominance of madness was a social and political rather than a scientific achievement" (53).

This judgement is borne out by Scull who shows how doctors in the nineteenth century became 'moral entrepreneurs' and made a strong bid to take over all responsibility for the identification and treatment of mental disorder while possessing no effective treatment methods other than

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(52) See Rosen, op.cit., ch. 10.

(53) Conrad and Schneider, op.cit., p.52.

non-medical environmental and social ones (54). Although later in the nineteenth century and at the beginning of the present century the disease and medical models of mental disorder achieved more substance and credibility due to developments in medicine generally, it must be recalled from the consideration of these models above that they owe their contemporary validity more to pragmatic utility than to adequate theoretical foundation. It will be appropriate to discuss the reasons for the contemporary dominance of the medical model in more depth when the socio-political implications of the model are considered below.

The process whereby mental disorder has come to be designated and treated as an illness in which medical personnel are the appropriate agents of social control has been called 'medicalization'. Over the last decade or so there has been increasing concern that more and more problems concerned with deviance and social control are coming to be regarded as lying within the province of medicine. Zola notes,

> Medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health (55).

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(54) See Scull, Museums of Madness, Ch.4.

(55) Irving Kenneth Zola, 'Medicine as an Institution of Social Control' in John Ehrenreich, ed., The Cultural Crisis of Modern Medicine (New York : Monthly Review Press, 1978), pp.80-100.

In no area has medicalization attained greater influence and progress than in that of mental disorder (56).

Conrad and Schneider echo Zola's findings and go on to assert that the medicalization of deviance results from political decisions to allow a particular group in society to define and treat a specific group of deviants in the same society. What proper deviance control is and who the appropriate control agents should be are essentially political questions which may even reach the degree of formality of being legislated upon by government (57). "Medical designations are social judgements, and the adoption of the medical model of behaviour (is) a political decision (58). Medicine, with its technology, collaboration with other social control agencies and its ideology which conceptualises deviance in medical terms may be seen as "the most powerful extralegal institution of social control" in our society (59).

Having established that the medicalization of mental

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(56) Zola goes on to point out that while psychiatry has been singled out as the locus classicus for the medicalisation process, as the main speciality seeking to gain hegemony over new areas of human behaviour, it has by no means distorted the medical mandate, "but indeed, though perhaps at a pace faster than other medical specialities, is following instead some of the basic claims and directives of that profession." (Ibid., p.80.) See also Sedgwick, 'Mental Illness <u>is</u> Illness', p.219.

(57) See e.g. the Mental Health Act, 1959.

(58) Conrad and Schneider, op.cit., p.35.

(59) Ibid., p.241.

illness is substantially a product of socio-political processes, it is now necessary to enquire into the reasons for the dominance of the medical model today. It must be asked why this particular model rather than any other has seemed most attractive to the interests of the ruling classes with the power to define and determine the treatment of the deviance labelled mental illness. How does this model fit in with the dominant ideology of late capitalist society?

Many of the criticisms of the medical model cited below have been applied in the first instance to the use of this model in the case of physical rather than mental disorder. It is therefore worth spending some time in describing the application of this model to physical illness. Firstly, it is assumed that the determinants of health and illness are predominantly biological so that patterns of morbidity and mortality are seen as having little to do with the social and economic environment in which they occur. Secondly, medicine is assumed to have its roots in natural science and therefore to have access to a body of information which is unaffected by wider social and economic factors. Thirdly, it is assumed that the means of scientifically-based medicine are the only effective available means for mediating between disease and the people which it afflicts (60). Despite protestations that psychiatry takes a broader view of illness than this, in practical terms many psychiatrists apply this same fundamental model to the treatment of mental disorder. This is not at all surprising in the light of their long initial training as physicians.

Turning now to the social and political implications of

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(60) See further Doyal, op.cit., pp.12-13, for these points.

the application of the medical model to mental disorder, it will be easiest if the advantages and disadvantages of the model are examined first and then its political implications are considered.

Among the possible advantages of designating and treating the deviance recognised as mental disorder as illness within the medical model are the following. Firstly, medicinal sanctions are non-punitive and may be regarded as more humane than, say, criminal sanctions administered under a criminal code. Although illness is socially negatively defined, people who are assigned the sickness role are not supposed to be actively punished for their deviance. Blame is removed from the deviant so that he is regarded as neither evil-doer nor sinner. Secondly, the medical model portrays a more optimistic outcome for the deviant than treatment on other models. Change, cure and the alleviation of symptoms are associated with this model (whether realistically or not) and this may mobilise hope both within the deviant himself and in surrounding society. Thirdly, the medicalization of mental disorder lends the prestige of the medical profession to deviance designation and treatment. Since doctors are one of the most prestigious and powerful professional groups in Western society, it may be perceived to be an advantage that deviance is placed in their supposedly benevolent hands and that the problems of a deviant become also the problems of a doctor. Finally, medical social control has the advantage of being more flexible and efficient in many ways than judicial and legal controls. Medical controls can be adjusted to fit the individual case, they circumvent many legal and judicial procedures, and they can be implemented quickly and

informally (61).

There are a number of possible disadvantages to the medical model also. Firstly, there is a dislocation of social responsibility when the medical model is used. It was shown above that the individual is not blamed for his deviance if he is regarded as ill. However, this means that the issue of responsibility for actions and their social effects becomes blurred and there is a tendency for a group of second class citizens to emerge. These people are beyond the sanction of the law, but they are, of course, also beyond the protection of the law (62).

The second possible objection to the use of the medical model in psychiatry is that medicine, and those who are involved in it, is assumed to be a morally neutral and benevolent enterprise because of its supposedly scientific basis. In fact, as I have argued, the perception and treatment of illness must be seen as a moral enterprise deeply involved in the business of making social, rather than scientific, judgements. Morals and norms of sickness

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(61) For all these points see Conrad and Schneider, op.cit. pp.246-248.

(62) This has been demonstrated in the consideration of the Mental Health Act, 1959, outlined above. This particular tendency has been vociferously attacked by Szasz. He argues that individuals committing deviant acts should be held entirely responsible for their behaviour before the law. If they are guilty of criminal offences, they should be punished like all other citizens who commit offences; if not, they should be allowed to behave as they want to. Basing his arguments on the moral principles of individualism, liberty and the rule of law, Szasz warns against the use of psychiatry as an instrument of benevolent totalitarianism which diminishes the rights and responsibilities of the individual citizen. See Szasz, Law, Liberty and Psychiatry, p. ix, for the philosophical basis for his criticism.

and health are socially constructed. Negatively defined behaviour depends for its definition on social value judgements. While medicine therefore acts in a moral and judgemental way, it assumes a face of scientific accuracy and moral neutrality which is misleading. Nowhere is this more true than in the case of psychiatry which, in the absence of empirical evidence of physiological disorder, is particularly likely to act on tacit social and moral norms in its practice. The moral nature of the psychiatric enterprise is particularly obvious in historical perspective. Dramatic examples of the making of blatant value judgements may be seen in the treatment by psychiatrists of masturbation, homosexuality, and of pregnancy outside wedlock. These phenomena were construed as mental disorders and treated by doctors (63). Although such glaring examples of the moral nature of psychiatric practice are not perhaps very apparent today, it may well be that, in time, much of contemporary psychiatric practice will be viewed as having been imbued with value judgements apparently every bit as arbitrary as those of psychiatrists in the past. Szasz has warned against the confusion between psychiatry and moral and political values, and he deplores the way in which the latter are transmuted into 'health values' which can be used to coerce individuals for their own good and that of society at large (64). Conrad and Schneider sum up the inherent dangers here in remarking that "defining deviance as disease allows behaviour to retain its negative judgement, but medical language veils

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(63) See further Skultans, Madness and Morals, Ch. 6.

(64) Szasz, op.cit., Introduction.

the political and moral nature of this decision in the guise of scientific fact"(65).

A further disadvantage of the medical model is that it places the care of a particular group of deviants almost exclusively in the hands of a small group of experts. Discussion of deviant behaviour, once it has been defined as a medical problem, is therefore removed from the arena of public debate and treatment and control become the province of a very particular group of people from a very particular section of society. This means that doctors have considerable hegemony over various areas of social behaviour which should be open to much wider debate and scrutiny. Considering this monopoly of dubious areas of social life, Szasz comments, "In morals, politics and psychiatry, experts are useful only as sources of information. They can advise or inform a society, but they cannot govern it (66).

A corollary of medical hegemony over deviance is that once a particular form of deviance becomes a problem which is seen to be a matter for medical social control, certain actions can be undertaken which could not otherwise be considered. For example, in psychiatry, physical treatment can be administered to patients against their will if it is felt that this will be of benefit. Such treatments may be far-reaching in their effects and would not normally be applied to deviants who were not regarded as ill, e.g. criminals.

The use of the medical model tends to individualise problems which are fundamentally social in nature. In

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(65) Op. cit., p.249.

(66) Szasz, op.cit., p.255.

concentrating on the individual patient and his symptomatology, it tends to encourage a narrow view of that person's problems, failing to relate them to the wider social economic and environmental context:

> Rather than seeing certain deviant behaviours as symptomatic of social conditions, the medical perspective focuses on the individual, diagnosing and treating the illness itself and generally ignoring the social situation (67).

Enough has already been said for it to be apparent that the designation of mental disorder as an illness owes much to the social setting in which it occurs. Later on, when social class and mental illness are discussed, the effect of the wider environment on mental disorder will be made clearer. It seems appropriate to note here, though, that a model which concentrates mainly on presumed individual pathology and symptomatology seems inadequate when dealing with a phenomenon so bound up with social processes and the wider environment as mental disorder is.

Medicalization and individualisation lead in turn to the depoliticisation of deviant behaviour. Protest and dissent against conditions in society and against that society's norms can come to be seen as symptoms of mental illness and their meaning can therefore be ignored. The locus classicus of this taking place is in Russia where dissidents against the present regime may receive psychiatric treatment rather than punishment for their deviance (68). On a less dramatic or obvious scale, it would be surprising if there were not examples of deviants' criticisms and comments

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(67) Conrad and Schneider, op.cit., p.250.

(68) See Malcolm Lader, Psychiatry on Trial (Harmondsworth: Penguin, 1977), for a full discussion of this.

on society being ignored and discredited because they are regarded as symptoms of disease. If only at the hospital level, it has been argued that the actions and utterances of the mentally ill are often seen as nothing more than functions of patients' illnesses and are all alike dismissed (69).

Having discussed some of the social consequences of the medicalization of mental disorder, it is now necessary to ask why this particular model of social control should be regarded as acceptable, even desirable in Western capitalist society today. It has been pointed out that the adoption of one model of deviance does not occur automatically or because it is actually inherently 'better' than any other model. (In this regard, the medical model may be seen as less effective than the social model which it replaced). Rather, models of deviance become dominant because they are compatible with the ruling values and norms of a particular society in which they have their being, and so, in Marxist terms, are loosely compatible with the interests and values of the dominant classes in that society. It must therefore now be asked how the medical model of mental disorder fits in with the interests of the dominant classes in British society, i.e. how it fits in with the values and norms of those who own and benefit most from the present organisation of the means of production.

Perhaps the chief attraction of the medical model in the present socio-economic order is that it focuses on the individual and his symptoms and not on society as a whole. Although it is known that many disorders, both physical and mental, are distributed inversely according to social class

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(69) For more on all the above disadvantages of the medical model, see Conrad and Schneider, op.cit., pp.248-251.

in British society and it is therefore obvious that social factors have an enormous impact on health, the medical model with its emphasis on the individual's symptoms and its assumption that disease can best be dealt with on the individual level, whether preventively or curatively, prevents the mass of the population from realising that the causes of their disorders may emanate from wider social factors. This means that they are less likely to demand fundamental changes in the established social order, so that disorders are eliminated, or at least more equally shared by all classes in the population. An individualised response to disorder in terms of diganosis and treatment does not call into question the fundamental organisation of society. In addition, it emphasises the uniqueness of the person suffering from a disorder thus making him more aware of himself as an individual. This reinforces the ideology of individualism which is necessary to the ideology of capitalism in general, for if people see themselves as 'atomised' individuals there are more opportunities for commodities to be sold in the market economy. Furthermore, those who see their problems and lives in individual terms rather than as members of a particular class are less likely to join in solidarity with others occupying a similar class position to organise for radical social change.

The use of medical language about disorder, with its emphasis on disease and related concepts, conjures up notions of external but essentially organic and biological causes for disorder. This may emphasise the role of the patient as impotent victim of external forces whilst shifting attention away from environmental factors which play a crucial role in the aetiology and progress of disorders. Reification of disease entities makes them appear natural, inevitable and unalterable and, again, prevents fundamental questions being raised about the nature of society.

Related to the foregoing observations is the fact that the medical model allows principally for curing the effects of disorders and only gives a very subordinate place to trying to tackle their causes, particularly when this might involve fundamental changes in the ordering of society. Cure rather than prevention or care has been the keynote of modern medical practice, and it is into the curative services that society has poured most of its resources. It seems probable that one of the reasons that the medical model supplanted the socio-environmental model of disorder in all sectors of health care in the early years of this century is that this model minimises possible interference in the running of society so that it best suits the interests of the owners of capital. While this is most obvious in the case of physical disorder, e.g. smoking, there is no reason to believe that a social view of mental disorder would not in the same way ultimately demand radical changes in society, industry, etc.

Another attraction of the medical model of mental and physical disorder in the present socio-economic environment is that it allows for a partial legitimation of deviance in the form of the sick role. This allows individuals to opt out of their roles and responsibilities on a temporary basis while de-fusing this deviance of any political significance or meaning. Potential conflict and social disruption in society are minimised by this form of social control. The deviant can be integrated back into a full part in capitalist society while he perceives himself to have been helped by that society with <u>his</u> problems (70).

Two more possible advantages of the medical model for the status quo should be mentioned. In the first place, the

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(70) See Waitzkin and Waterman, op.cit., Ch. 2 for this point.

medical model reposes power and control over the 'sick' person in the hands of the medical profession. Since the medical profession is overwhelmingly dominated by members of the upper classes and identifies closely with the interests of those classes, doctors can be relied upon as social control agents who will find solutions to deviance which raise no real threat to the values and structure of the established order. Furthermore, in their practice they will reinforce these values in their patients. Secondly, the treatments used to treat the 'sick' deviant may themselves provide a valuable sphere of exploitation for capitalist enterprise. In psychiatric disorder, for example, much of the treatment given to patients in this country takes the form of psychoactive drugs and these can provide considerable profits for drug manufacturers which would not be available to them if a programme of radical social reform was implemented to curb psychiatric disorder instead.

It should now be clear that one of the reasons for the hegemony and popularity of the medical model of mental disorder in contemporary capitalist society is that it provides effective social control which appears benevolent and morally neutral to its recipients while basically remaining compatible with the values and structures of the capitalist social order. With its emphasis on the individual rather than the class, cure rather than prevention, and disease rather than social structure, the medical model aids and abets the cohesion of society as it is, ignoring for the most part its injustices, class conflicts and pathogenic effects. In the light of this analysis, Clare's lip-service to wider factors in his statement that

> the medical model ... takes into account not merely the symptom, syndrome, or disease, but the person who suffers, his personal and social situation, his biological, psychological and social status

appears as little more than liberal window dressing for concentrating on the individual and upholding the status quo (71). Indeed, Clare's statement may be seen as an attempt to forestall critics who would try to widen the debate about psychiatry in society and to take much of their monopoly away from psychiatrists. By co-opting other views of mental illness into the medical model, 'liberal' psychiatrists like Clare can find further legitimation for medical domination while refusing to make any fundamental criticisms of society.

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(71) Clare, Psychiatry in Dissent, first edn., p.69.

CHAPTER XIII

MODES OF TREATMENT IN THE PSYCHIATRIC HOSPITAL AND THEIR POLITICAL IMPLICATIONS

In this chapter it is my purpose to examine the main modes of treatment available in British psychiatric hospitals today and their political implications. Details of exact methods of treatment are avoided because the main task here is to try and elicit the nature and balance of power between patients and therapists in each treatment mode. In this sense, it will be realised that 'political' implications here are mainly those of the micro-politics of human relations, rather than the politics of the state or of society as a whole, though the wider dimension still remains very important. It should be noted that the treatments considered here are often used in combinations with one another. In particular, organic, behavioural and custodial treatments are often to be found being used together, while psychotherapy and milieu therapies are also to be discovered being used alongside each other. It will be argued that the former group of therapies tends to strip patients of their own power, autonomy, responsibility and control over their destiny, and to give more power to the staff or therapist. Psychotherapy and milieu therapies tend to allow greater equality and power-sharing between patients and staff, but are still capable of being used to assert the power and values of the staff over against the patients. It is apparent therefore that in a situation where parties of unequal power meet in an institution of social control, all treatment procedures will involve fundamental inequalities of power and influence, with a bias towards the social control agents with their superior sanctions backed up by society and its values. Treatments will always be essentially compatible with the socially sanctioned role of the institution, i.e. to control and contain deviants, and/

or to change them into conforming members of a particular society. They will be compatible with the values of that society, and especially with the values of those who rule that society and thus promote the continued existence of the institution and the employment of its therapeutic staff.

1. Administrative or Milieu Therapies

Since the last war, some British hospitals have experimented a great deal with administrative or milieu therapies. These therapies are closely allied to the notions of moral treatment prevalent among asylum reformers and builders in the early part of the last century (1). Essentially, both moral treatment and modern milieu, or administrative, therapies are based on the idea that social organisation and environment can help or hinder a person in coming to terms with their problems.

During the 1950's, it became increasingly obvious to some psychiatrists that the organisation and environment of the psychiatric hospital was in itself an impediment to the recovery of patients. Indeed, it was observed that the hospital environment seemed to do some patients real harm during their stay. At the same time, it was noted that staff working closely together in teams while insulin therapy was being administered seemed able to exercise a beneficial effect on patients, even though the insulin therapy itself was found to be of little or no value (2). At this time

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(1) See Skultans, English Madness Ch. 4 for more about nineteenth century moral treatment. See Clark, Social Therapy in Psychiatry, Ch.2, and Scull, 'Moral Treatment Reconsidered : Some Sociological Comments on an Episode in British Psychiatry', for more on the history of moral treatment and milieu therapies.

(2) See Clark, Administrative Therapy, Ch.1, for the origins of modern milieu therapy.

also Dr Maxwell Jones was beginning his successful therapeutic community experiments at Belmont Hospital and its results were becoming more widely known (3). These innovations were followed by developments like the unlocking of the doors of wards and starting industrial therapy departments for patients to work in (4). The movement to provide a positive and therapeutic environment in the hospitals developed rapidly in the 1960's, although the 1970's saw a decline in its influence except in hospitals where it had gained a very strong hold.

Clark has outlined the general principles to be employed in trying to implement social, administrative, or milieu therapies (5). Drawing on the knowledge gained in this sphere throughout the last century and a half, he suggests that the following principles should be employed. These therapies should do no harm to the patients. Patients should receive sufficient support for life, e.g. food, clothing, etc. They should be protected from violence and abuse and should be given adequate medical care and protection from disease. The patient's personality, individuality, identity and relationships with the outside world should be preserved and patients should be trusted until they have proved themselves to be untrustworthy. They should be given purposeful and meaningful activities and work to perform. Staff should share good attitudes and relationships. Sanctions should preferably be administered by the peer group of the patient and should include positive sanctions for good behaviour as well as negative ones for bad

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(3) See Clark, Administrative Therapy, p.22f. for Jones' work and its antecedents.

(4) See further Clark, op.cit., Ch.2.

(5) See Clark, op.cit., Ch. 3.

behaviour. Therapeutic communities, as one particular type of milieu therapy, require additional principles. There should be free communication between all the members of the community, all events should be analysed, learning experiences should be provided, the pyramid of hierarchical authority should be flattened as far as possible, roles should be examined, and a regular community meeting, consisting of all the members of the community, should take place frequently.

The implications of these principles seem, on first sight to be enlightened and humane. Especially in the therapeutic community, flattening of the hierarchy and the sharing of power would seem to offer the possibility of groups other than doctors and nurses in the hospital to achieve some degree of control over their own lives and those of others. This contrasts favourably with some of the other treatments to be examined here which emphasise the power of doctors over against the impotence of other groups and especially the patients.

It must, however, be noted that words like 'humane' and 'enlightened' are value judgements and that they may conceal that which, on closer inspection, turns out to be of ambigious benefit to patients. For it has to be recognised that milieu therapies and therapeutic communities are aimed at producing desired change in individuals whose behaviour in society is unacceptable. Foucault points out that part of the purpose of the early moral managers was to produce responsible individual citizens who would be able to take a full part in the society of their day, sharing its virtues and

ideals (6). Scull writes concerning the moral manager, Tuke,

> ... just as hard work and self-discipline were the keys to the success of the urban bourgeoisie, from whose ranks Tuke came, so his moral treatment propounded these same qualities as the means of reclaiming the insane (7).

The organisation of the early asylums was not morally neutral and undirected, and it is not now in those hospitals where milieu therapies are practiced. Clark admits as much in stating, "We need ... have no qualms of guilt about saying that our therapeutic community is going to teach its members certain kinds of behaviour and discourage undesirable behaviour" (8). This is not very far from Goffman's perception that asylums are essentially "forcing houses for changing persons" (9). The methods are less obviously custodial and oppressive, but the aim of forcing particular groups or individuals to conform to behaviour compatible with the interests of the powerful in wider society is the same. Jordan sees the therapeutic communities as being more total institutions than those studied by Goffman in Asylums. This is because they ultimately hold personal liberty as being of no account and "they set no store by self-determination, or the right to privacy" (10). He sees the origins of and theoretical antecedents of the therapeutic community as lying more in

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(6) See Foucault, op.cit. The whole of chapter 9 of this work carries a complete critique of the early asylums and the means they employed to ensure patient conformity which essentially still gave little power to the patients although they did not suffer physical restraint.

(7) Scull, op.cit., p.115.

(8) Clark, Administrative Therapy, p.69.

(9) Goffman, op.cit., p.22.

(10) Jordan, op.cit., p.34.

behaviourism and learning theory than in existentialist philosophy or libertarianism (11).

The degree to which therapeutic communities may be regarded as part of the processes of social control and social engineering can be elicited by examining the role of doctors within them. Many therapeutic communities owe their origins to doctors taking the initiative, and it has subsequently often proved difficult for doctors not to take the lead in running the race, despite theoretical aims of flattening the hierarchy and sharing authority and responsibility. In the last analysis, doctors always remain legally responsible for the patients in the hospital and they can never share the responsibility and power which this brings on a truly equal basis with any other group. No one outside the medical profession has a formal right to this responsibility and authority. This means that even if a doctor informally tries to share power in a therapeutic community, in that very act he asserts the continuation of his power as no-one actually has the right to the power which he gives away. He is in the position of powerful benefactor where all his actions ultimately re-affirm his superior power. Many therapeutic communities in hospitals have come up against the problem of doctors having more power than other community members, patients or staff. Haddon states,

> It seems to me that medical leadership, while initially commanding a 'breathing-space' for the development of democratic psychiatry, eventually determines the limits of that democracy... Professional status, while losing its more formal and divisive trappings, is not ultimately relinquished: after all it provides a good salary and often 'instant leadership'. But, perhaps more correctly, doctors are functionally important for social control in our society, and hence serve political ends dimly perceived in the detail of

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(11) Ibid., p.34

therapeutic work (12).

This remark is congruent with the observations of Rubinstein and Lasswell who, observing change to therapeutic community organisation in an American hospital, noted that not only had doctors initiated the change but also that they found it very difficult to surrender real power to patients and staff (13).

Even when doctors do succeed in sharing much of their formal power, this does not necessarily mean that patients will have more. It must be remembered that patients coming from lower class backgrounds with different patterns of linguistic usage are at a considerable disadvantage in confronting professional or trained staff from higher class backgrounds. The latter will stand a much better chance of imposing their definitions on situations by virtue of superior status both in society and in the hospital.

In the light of the foregoing examination, it can be seen that milieu therapies are by no means the key to real equality of power sharing within the hospital. They may indeed be seen as an obstacle to such sharing insofar as they artificially disguise the fundamental inequalities and differences in the hospital and act as camouflage for the social control function which the hospital is still bound to exercise. Milieu therapies are just as concerned to produce a particular kind of socially acceptable result as any other therapeutic mode used in the hospital. It has been shown that some groups, notably doctors, are likely to have a

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(12) Brian Haddon, 'Political Implications of Therapeutic Communities' in R.D. Hinshelwood and Nick Manning, eds., Therapeutic Communities (London R.K.P., 1979) pp. 38-45, p.42.

(13) Rubenstein and Lasswell, op.cit., Ch.11.

disproportionate amount of power and influence still, because of their socially sanctioned formal power and because of their exalted status in society as a whole and in the psychiatric hospital in particular.

If milieu therapies are not the universal panacea and political leveller which they appear to be on first sight, they do however have some real and positive advantages. Amongst other things, they do increase the participation and activity of patients. They allow better communication between members of the hospital community. They tend to build up staff morale and allow a greater degree of participation on all levels than many other treatment modes. They tend to engender a greater sense of unity and purpose within the hospital and to minimise bureaucratic and custodial concerns, giving priority to human relations. That these possible benefits are part of an exercise in social control and engineering is inevitable in a State psychiatric hospital, a major part of whose task is to control and rehabilitate patients in capitalist society.

2) Psychotherapy

Psychotherapy is a generic term for those forms of therapy which use words and personal professional relationships to effect alleviation of patient's difficulties (14). Based on the psychodynamic views which were originated by Freud at the beginning of this century which have been developed and modified by others, contemporary psychotherapy tends to be

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(14) For this definition, see Anthony Storr, The Art of Psychotherapy (London : Secker and Warburg and Heinemann, 1979), p.vii.

an eclectic art (15). Classically, psychoanalysis, the technique developed by Freud, took the form of an individual spending several hours a week over a long period of time with a paid and qualified analyst. This kind of treatment is still available for individuals who care to pay for it privately. Psychotherapy, however, especially if it is obtained through the N.H.S., tends to be much less lengthy. It may take the form of a limited number of sessions where an individual sees a therapist who may be a doctor, nurse psychologist or chaplain. These therapists may have received a great deal of training or almost none. Psychotherapy may also take place in groups or communities run on psychodynamic principles (16).

Psychotherapeutic practices have not played as large a part in British psychiatric hospitals as they have in the U.S.A. American hospitals, particularly the private hospitals in the 1950's and 1960's, used psychotherapy as the main type of treatment for most mental disorders (17). However,

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(15) See Storr, op.cit., pp.vii-viii. For an account of the mainstreams of thought and practice in contemporary psychotherapy see Warren Kinston and Rachel Rosser, 'Individual Psychotherapy', in Peter Hill, Robin Murray and Antony Thorley, eds., Essentials of Postgraduate Psychiatry (London: Academic Press, 1979) pp.703-24, and Sutherland, op.cit., Ch.13. Also see Dennis Brown and Jonathan Pedder, Introduction to Psychotherapy (London : Tavistock, 1979) for a good account of psychodynamic principles and various types of practice.

(16) See further John Cobb, 'Group Interaction', in Peter Hill, Robin Murray and Antony Thorley, eds., op.cit., pp.749-74.

(17) See Rubinstein and Lasswell, op.cit., for an account of an American hospital trying to organise itself on psychotherapeutic principles.

even in America psychotherapeutic principles and treatments are now a good deal less dominant (18). In Britain psychodynamic treatments have always had less influence. They have been used most extensively in the treatment of neurotic disorders. There are two main reasons for the limited popularity of psychotherapy. Firstly the British psychiatrists have always remained more convinced of the merits of organic treatments than their American counterparts. Secondly, individual psychotherapy, and even small group psychotherapy is expensive in terms of professional time and its benefits and effectiveness are seen as dubious by many. In large, understaffed State psychiatric hospitals filled with the chronically mentally ill, it has therefore been regarded for the most part as an expensive luxury. Although individual units or psychiatrists may use its principles, methods and insights to a greater or lesser degree, it has attained dominance in very few hospitals in toto. As money supplies in the N.H.S. diminish, and the population of old patients with organic dementia who are not susceptible to this mode of treatment increases, it seems unlikely that it will become more popular. Indeed, a decline in its use in the N.H.S. may be predicted.

It was indicated above that psychotherapy "uses the healing effects of a personal relationship" (19). The ways in which the personal relationship of the patient and the therapist heals need not concern this account. My purpose here is to try and evaluate the political aspects of this mode of treatment. It is possible to assert that psychotherapy

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(18) See Sutherland,op.cit., p.139.

(19) Kinston and Rosser, op.cit., p.170.

allows a great deal of power and self-determination to the patient. The whole purpose of this treatment is to help the patient to come to terms with himself and his own problems. Heavy-handed dominance by the therapist which reduces the patient to silence and passive obedience is directly counter-productive to this end. There must therefore be a greater equality and mutuality in the psychotherapeutic relationship than in the traditional doctor-patient relationship. The fact that the therapist is not necessarily a doctor may mean that professional and client are not so widely separated by differences in status and class.

It must, however, be recognised that there is no such thing as the non-directive psychotherapeutic relationship. The therapist brings his own values into the psychotherapeutic encounter and will respond more positively to patient behaviour which conforms to those values, albeit unwittingly (20). He may also be perceived by his patient to possess more power than the latter, being a 'helper' who is sought out and has something to give which cannot be obtained by the patient elsewhere. Moreover, the therapist in the N.H.S. may well come from a higher class background than the majority of his patients and they may have difficulty in thinking of themselves as equal with him. Similarly, there may be class based communication difficulties between therapist and client. A failure to communicate with his therapist may increase a patient's sense of impotence and inadequacy. It is perhaps because of difficulties such as these that the use of the psychotherapeutic techniques works best, and is used most widely with patients from the middle and upper classes who are articulate and share a common class background with

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(20) See Paul Halmos, The Faith of the Counsellors (London: Constable, 1965), pp 90ff.

the psychotherapist (21).

In conclusion, it may be stated that psychotherapy permits and encourages patients, particularly upper and middle class patients who are articulate and suffering from neurotic disorders, to exercise considerable power and autonomy over their own lives. It is no accident that the most egalitarian form of treatment available is used principally with those who already have a great deal of power and status in their social lives in general. However, it has been argued that even psychotherapy is used as a tool for communicating desired values to patients who may well see themselves as much less powerful than their therapist. It may be that in the case of lower class patients, psychotherapy can have the effect of making them feel more inadequate and impotent than they were before. In any case, this treatment is only used to a limited extent in the N.H.S. because of its cost and dubious effectiveness. This means that further consideration need not be devoted to it here.

3. Behaviour Therapy

Over recent years, this mode of treatment has become increasingly popular. Sutherland, an experimental psychologist, states that it is "currently the most promising psychological approach to mental illness..." (22). Bebbington defines behaviour therapy as "treatment aimed at improving a patient's functioning and well-being by a directed change in

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(21) See Appendix for class-related distribution of psychotherapy.

(22) Sutherland, op.cit., p 181. See the whole of Ch. 18 in this work for a more complete account of the methods used in behaviour therapy. See also Paul Bebbington, 'Behaviour Therapy' in Peter Hill, Robin Murray and Anthony Thorley, eds., Essentials of Postgraduate Psychiatry (London : Academic Press, 1979), pp.683-702.

his behaviour" (23). The principles of behaviour modification are based broadly on experimental psychology and learning theory. Crudely stated, the main tenet underlying these principles is that human behaviour of all kinds is learned. It can be changed or re-learned by employing positive and negative sanctions which alter the previously learned behaviour patterns. Bebbington suggests that about 10% of patients consulting psychiatrists can benefit from behaviour al methods of treatment (24). Most of these patients will be suffering from some form of neurotic disorder such as a phobia or an obsessive compulsion. In undertaking behaviour therapy, they will negotiate an informal contract with a therapist to attain a particular agreed and desired end. Success rates are good among such patients, who generally undertake treatment voluntarily.

Behavioural methods may also be used for groups of patients in hospital. This kind of treatment may not be voluntarily undertaken. In an endeavour to counteract anti-social behaviour, induced perhaps by the effects of institutionalisation, some wards in British psychiatric hospitals operate behavioural regimes based on sanctions to attain desired change in their patients. The token economy is an example of one such commonly used method (25). This kind of regime presents difficulties:

> In order to set up a system of rewards, it is often necessary to deprive patients of other methods of gaining whatever is used as a reward. Hence, although staff may see patients as working for a system of rewards, the patients themselves may feel they are to escape from a punishment they have done nothing to deserve... . Furthermore, the system can never be

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(23) Bebbington, op.cit., p.683.

(24) Ibid., p.684.

(25) See Sutherland, op.cit., p.176-7, for a full account of this.

any better than those administering it, and the power to give rewards can always be misused to persuade patients to do things which are patently for the good of staff members but not so obviously for the patient's good (26).

Although Sutherland goes on to defend the use of this method as a means of enhancing patient's dignity and self-respect, the quotation cited is enough to indicate that a behavioural regime may be perilously close to being a custodial regime on a ward. Behaviour modification may b become a euphemism for the use of sanctions to control deviant behaviiur as perceived by the staff. This is a particularly important observation when it is recalled that many patients in psychiatric hospitals come from lower class backgrounds and are inarticulate and inclined to fit in with the desires of the staff. A behavioural approach may be particularly attractive where patients are unresponsive to psychotherapy and there are not very many staff to engage in other forms of therapy. Staff from higher class backgrounds in these situations may feel that they know what is best for the patient and may implement a regime to get patients to conform to their own values without there being any form of external scrutiny of those values and without the patient being able to make any effective protest - he is unable to thrust a token economy on the staff for example.

Reviewing the political implications of this form of

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(26) Sutherland, op.cit., p.177. The existence of this danger brings to mind Stanton and Schwartz's assertion that "a mental hospital is a place where ordinary civil liberties are called privileges", (Stanton and Schwartz, op.cit., p.244.).

treatment, it can be seen that in the case of the non-hospitalised voluntary individual seeking this treatment, there is a good deal of equality between therapist and patient. Although therapists may impose their own values on patients and may be controlling and directive, this is no worse than the influence of any other therapist and is more overt than psychotherapy (27). Sutherland points out the importance of the client co-operating and wanting to change in the individual patient therapist relationship (28). This means that it would be difficult for a therapist to impose his own values totally on the patient, for the latter cannot be forced to take part in therapy. In the wards of psychiatric hospitals, however, there is no effective means of stopping staff from imposing behavioural programmes on unwilling patients, according to their own lights and values. Patients have little or no means of redress in such a situation and considerable oppression may be dignified with the name of behaviour therapy. Obviously, this may do much to destroy the patient's sense of his own autonomy and power.

4. Organic Therapies

Organic therapies of mental disorders include the use of psychotropic drugs, psychosurgery and electroconvulsive therapy (E.C.T.) (29). Organic therapies vary considerably

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(27) See Bebbington, op.cit., p.685.

(28) Sutherland, op.cit , p.175.

(29) Accounts of these treatments are to be found in Peter Tyrer, 'The Basis of Drug Treatment' in Peter Hill, Robin Murray and Antony Thorley, eds., Essentials of Postgraduate Psychiatry (London: Academic Press, 1979), Anthony Clare, 'Psychosurgery and Electroconvulsive Treatment' in Peter Hill, Robin Murray and Antony Thorley, eds., Essentials of Postgraduate Psychiatry (London : Academic Press, First Edn., 1979), pp.55-76. See also Anthony Clare, Psychiatry in Dissent, Chs. 6 and 7, Sutherland, op.cit., Chs. 19 and 20 and Baruch and Treacher, op.cit., Ch.3.

in their methods, but all depend on the common principle of intervention in physyiological processes and organs to effect the cure or relief of the symptoms of mental disorder.

"Drugs are the most effective symptomatic treatment available ... "(30). They are widely used and probably most patients in psychiatric hospitals will take some form of drug as part of their therapy programme on a regular basis. Drug treatment is the most common treatment in British psychiatric hospitals, even though the mechanisms of the preparations used are often ill-understood. It must be emphasised that most psychotropic drugs effect symptom relief rather than cure. Frequently drugs have unpleasant but unavoidable side effects. Baruch and Treacher suggest that the efficacy of drugs is secondary to their cheapness in comparison to other forms of treatment. This allows a large number of both in- and out-patients to be treated at minimum expense (31).

Psychosurgery is no longer a popular method of treatment and indeed has never been widely used, although some psychiatric hospitals had their own facilities where operations could be performed. Essentially, psychosurgery involves the removal or destruction of brain tissue by various means to alter behaviour. Its lack of popularity reflects its dubious effects.

E.C.T., unlike psychosurgery, is still a very common

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(30) Tyrer, op.cit., p.628.

(31) See Baruch and Treacher, op.cit., p.55.

treatment mode in British psychiatric hospitals. It is now used mainly for the treatment of depressed patients, although others are treated by this means also in some instances. The treatment involves passing a current of electricity through the brain of a patient while he is under anaesthetic. It is not known quite why this should have ameliorative results, nor what aspects of the treatment produce the desired change in the patient's condition. Scientific evidence for the value of E.C.T. is controversial (32).

Of all the therapies available in psychiatric hospitals, organic therapies do most to affirm the power and significance of doctors, since only they are allowed to prescribe them.

Material on the medical model and the doctor-patient relationship is to be found elsewhere in the present work, along with the political implications involved in these topics. Here it is sufficient to reiterate that the medical model of illness and its treatment has the corollary of doctors actively fighting the patient's disorder using physical quasi-medical means, while the patient takes an essentially passive part, waiting for the treatments administered by the physicians to take effect. Patients are not able to take an active part in their own treatment and cure on this model as they have neither the knowledge nor the resources to do so. It has been argued before that patient passivity and acceptance of treatment under professional experts is reinforced by the class and status differences between patients and their doctors. Doctors are regarded by their patients as having more power, wisdom and authority than those who seek their help.

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(32) See Colin Brewer, 'E.C.T. -Forty Years On', New Behaviour, 9th October, 1975, pp.50-2.

The medical model and the organic treatments which it implies produces a relationship in which doctors take power and responsibility for the life and health of the patient while the patient loses his autonomy and power of self-direction (33). An unequal relationship of autocracy/dependence is created, albeit that the doctor is a benevolent autocrat. At the same time, while patients treated outside the psychiatric hospital may be able to reject or discount the treatment prescribed by doctors, this privilege does not extend to the hospitalised, and especially the involuntarily hospitalised, in the same way. It was noted that those who are compulsorily admitted under some sections of the Mental Health Act may be subjected to any treatment thought appropriate by their responsible medical officer in their own interests or those of others. Thus it may be suggested that organic treatment, which is commonly administered in British hospitals because of its effectiveness and its relative cheapness, tends to denude patients of power and autonomy and to repose power and responsibility in the hands of the staff, particularly medical staff.

5. Custodialism

It is doubtful if 'custodialism' can be regarded as a single, coherent, positive, theoretically-based system of treatment and care. It is perhaps most appropriate to regard it as an aggregate of miscellaneous views and practices which come into prominence in the absence of funds, staff, moral resources, and other treatment orientations. The 'ideal type' of custodialism has been characterised thus:

> The model of the custodial orientation is the traditional prison and the 'chronic' mental hospital which provide a highly controlled setting

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(33) For a typology of doctor-patient activity/passivity see Szasz and Hollender described in Tuckett, 'Doctors and Patients'.

> concerned mainly with the detention and safekeeping of its inmates. Patients are conceived in stereotyped terms as categorically different from 'normal' people, as totally irrational, insensitive to others, unpredictable and dangerous. Mental illness is attributed primarily to poor heredity, organic lesion and the like. In consequence, the staff cannot expect to understand the patients, to engage in meaningful relations with them, nor in most cases to do them any good. Custodialism is saturated with pessimism, impersonalness, and watchful distrust. The custodial conception of the hospital is autocratic, involving as it does a rigid status hierarchy, a unilateral downward flow of power, and a minimizing of communication within and across status lines (34).

This custodial model is one which was typical of most public mental hospitals before the developments of the 1950's. Talbott, writing in the America of the late 1970's was able to see it as still the dominant model in the treatment of the poor and chronically mentally ill (35). This observation is as true for this country as it is for America, despite the N.H.S. Even though the worst excesses of the custodial model are now gone, there is still evidence of survival of some custodial elements in many hospitals, especially where demoralisation and shortage of resources are prominent. The custodial model can easily be combined with an essentially medical model of mental illness and its treatment to provide a complete and rigid regime for the patient. It is less compatible with psychotherapy and milieu therapies.

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(34) Doris C. Gilbert and Daniel J Levinson, ''Custodialism' and 'Humanism' in Mental Hospital Structure and in Staff Ideology' in Milton Greenblatt, Daniel J Levinson and Richard H. Williams, eds., The Patient and the Mental Hospital (Glencoe : Free Press, 1957), pp.20-35, p.22.

(35) See Talbott, op.cit., ch. 7.

In terms of power, the custodial model encourages a wide discrepancy between the amounts of power given to staff and to the patients. The latter group are not encouraged to see themselves as in any sense equal to the staff, nor to retain or develop individual autonomy or independence. Passivity, dependency, obedience and respect for the staff are seen as virtues and are actively fostered under a custodial regime. Deviance from these virtues is rigorously stamped out. The custodial model of treatment and care is certainly the most overtly repressive model in psychiatric hospitals, in that it robs patients and junior staff of nearly all their power and autonomy in order to give it to those higher in the staff hierarchy. Unfortunately, this also happens to be one of the cheapest forms of therapeutic organisation in hospitals and the one which fits in best with bureaucratic organisation. This means that it is a constant threat for those hospitals which are deprived of resources in times of high demand and shortage of public money. It may therefore become very prevalent once again in the present era of economic recession when money is scarce and more beds are needed in the hospitals.

Custodialism has been a common mode of treatment in state mental hospitals in the past. It is autocratic and repressive and flourishes in conditions of deprivation and low morale. It may become more common in psychiatric hospitals once again than it has been in the last two decades.

CHAPTER XIV

SOME PROBLEMS OF THE CONTEMPORARY PSYCHIATRIC HOSPITAL

The Secretary of State for Health and Social Security, in setting up the working group to examine the organisational and management problems of psychiatric hospitals in 1977, identified several areas of concern in the functioning of these institutions. Lack of resources, low staff morale, lack of clear understanding by staff of their responsibilities, lack of effective leadership, and lack of contact and co-operation between different disciplines and departments of the hospitals were seen as some of the features of the hospitals which deserved further investigation (1).

Here I propose to expand on these problems at greater length. I will illustrate my discussion with examples and references taken mainly from two of the most recent reports on psychiatric hospitals where allegations of ill-treatment or neglect have been investigated by a committee of enquiry (2). These reports came into being because conditions of these particular hospitals had become a matter of intense public concern. However, many of the general conditions described in them are typical of large old psychiatric hospitals throughout the country, though perhaps not in such an extreme form. I suspect that many, if not most,

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(1) D.H.S.S., Report of a Working Group on Organisational and Management Problems of Mental Illness Hospitals, 1.1.

(2) S.E. Thames R.H.A., Report of a Committee of Enquiry, St Augustine's Hospital, Chartham Canterbury (n.p. : S.E. Thames R.H.A., 1976), and Surrey A.H.A., Report of a Committee of Enquiry into Standards of Patient Care at Brookwood Hospital (n.p.: Surrey A.H.A., 1980).

psychiatric hospitals would yield similar data if they were scrutinised closely (3). Evidence from these enquiries is not cited here for two reasons. Firstly, because the descriptions of those enquiries are now a decade old. Secondly, because the enquiries deal in the main with subnormal patients and their treatment. The reports of St Augustine's and Brookwood are among the more recent and comprehensive and deal specifically with the mentally ill (4).

Lack of resources, both human and financial, runs like a leitmotif through all the recent reports and literature on psychiatric hospitals. It has already been seen how much less well-staffed these hospitals are as compared to other hospitals in the N.H.S. However, these statistics do not in themselves give a full picture of the real consequences of the lack of resources.

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(3) Over the last decade or so a number of other psychiatric hospitals have been subjected to enquiries. These include N.H.S., Report of the Committee of Enquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at Ely Hospital, Cardiff, Cmnd. 3975, (London : H.M.S.O., 1969), N.H.S., Report of the Committee of Enquiry into Whittingham Hospital, Cmnd. 4861, (London : H.M.S.O., 1972), House of Commons, Report of the Committee of Enquiry into South Ockenden Hospital (London : House of Commons, 1974). Summaries of these and others can be found in Virginia Beardshaw, Conscientious Objectors at Work (London : Social Audit, 1981), pp.84-88.

(4) The other reports of committees of enquiry are worth consulting with reference to getting a feel of the kinds of problems with which all large bureaucratic institutions are faced and throw light onto the main subject of discussion below.

Writing of the shortage of staff at Brookwood Hospital, the committee of enquiry stated : "The most frequently mentioned of all the problems of Brookwood was the shortage of staff"(5). This shortage extended to all departments and disciplines, but particularly affected the nursing staff. The problem had not been solved by the diminishing numbers of patients in the hospital, nor by the number of nurses being increased (6). Shortages of occupational therapists (O.T's), psychologists and doctors are also detailed in the Brookwood report. The St.Augustine's report noted the shortage of staff in that hospital, especially on long-stay wards. Although there was supposed to be one nurse to every 1.6 beds, in 1975 there was a ration of one nurse to every 2.32 beds, only just above the minimum standards recommended by the D.H.S.S. In one ward this meant that sometimes there were only two nursing staff on duty to look after 39 psychogeriatric patients (7). It was further noted that doctors tended to concentrate their very limited time (8) on the short-stay rather than the long-stay wards (9).

The net practical consequences of the shortages of staff in both hospitals was that patients' activities were considerably curtailed. Only basic physical and custodial care could be given to patients. The St. Augustine's report noted that ,

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(5) Brookwood Report, 2.1.

(6) See ibid., 6.2.1 and 2.1.

(7) St Augustine's Report 2.187.

(8) Ibid., 6.41f.

(9) Ibid., 1.10.

> where there are overcrowded and understaffed wards, particularly those containing disturbed patients, there may often be a greater reliance on medication than if the same patients were cared for in smaller groups with a higher staff ratio (10).

Similar comments were also made in connection with the recent disquiet about the treatment of patients at Middlewood. Management stated that the main reason for over-medication of patients in that hospital was the lack of staff numbers (11). A charge nurse who gave evidence to the Brookwood enquiry stated,

> There was a chronic shortage of staff in the psycho-geriatric wards. If there had been more staff, more could have been done with the patients. A shortage of staff meant they did more for the patients (because it was quicker to do so) rather than letting the patients do things for themselves (which was slower but better for the patients). The shortage meant that patients became too dependent on the nurses (12).

The lack of physical resources was also a prominent feature at both Brookwood and St Augustine's. At Brookwood the Divisional Nursing Officer " mentioned lack of funds as being one of the main special difficulties in providing homely accommodation" for patients(13). The sector administrator said that the laundry facilities were inadequate and outmoded (14). It was also pointed out that there was a backlog of maintenance work dating from 1974. St. Augustine's furnishes an even more vivid example of what the lack of resources can mean. In that hospital such resources as were available were

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(10) St Augustine's Report, 3.23 (iii).

(11) See 'Problem Patients Drugged to Solve Staff Shortage', Daily Telegraph, 23.xii.80.

(12) Brookwood Report 2.36.

(13) Ibid., 2.8.

(14) Ibid., 2.39 (i).

directed towards the acute and short-stay areas of the hospital. Long-stay wards and psycho-geriatric wards were deprived of many of the supplies essential for the care of patients. There was, for example, a general shortage of linen (15). This led to nurses using one flannel for washing all parts of the bodies of different incontinent patients (16).

Supplies of clothes for patients were also inadequate (17). Requests for new essential equipment, e.g. new commodes for psycho-geriatric wards, were deferred so that old rusty commodes had to be used (18).

The lack of resources discussed above takes place against a background of the old, architecturally inadequate and neglected hospital buildings. In 1972 Ash Ward in St Augustine's

> really looked like a Victorian poor law institution. There were filthy floor boards, the furniture was dreadful, there were far too many patients, the ward had not seen even a lick of paint in donkey's years. The dormitory was shocking (19).

Some wards which did manage to improve their conditions had to seek financial help from outside the N.H.S. (20). Although the example of Ash Ward was extreme and is somewhat dated now, it does illustrate graphically an ever present factor in psychiatric hospitals even today. There is a constant need

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(15) St Augustine's Report, 3.88.

(16) Ibid., 2.16.

(17) Ibid., 5.19.

(18) Ibid., 2.48.

(19) Ibid., 2.57.

to upgrade, re-decorate and re-furnish wards which is seldom fully met in practice. The result is that patients, and especially those in the long-stay and psycho-geriatric wards of hospitals tend to live in conditions which most outside observers would regard as sub-standard and even on occasion, scandalous.

A second major problem in the psychiatric hospitals apart from resources has been that of lack of leadership which is effective. This problem has become particularly acute since the demise of the medical superintendent, matron and hospital secretary and the rise of a complicated and centralised bureacracy. There is now considerable confusion as to the particular responsibilities of individual staff members, especially at the level of middle management in the nursing hierarchy. Responsibility has often not been properly understood. Even when individuals have grasped the nature of their responsibilities, they have frequently been deprived of the authority and resources to execute those responsibilities effectively. The net result of this has been that concerted new policies have not come into being and, where they have existed on paper, they have not been implemented in practice. The D.H.S.S. report on organisational and management problems in mental illness hospitals recognised that "management has sometimes failed because it has too readily adopted a reactive role, has neglected leadership and in the event has been greatly shocked to learn of the inadequacies and poor standards brought to light (21).

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(21) D.H.S.S., Report of a Working Group on Organisational amd Management Problems of Mental Illness Hospitals, 3.1.

Turning to the specific situations of Brookwood and St Augustine's, it can readily be seen that these general criticisms are relevant to those hospitals. In both hospitals there was an expectation that doctors would provide leadership (22). Consultant psychiatrists at St. Augustine's tacitly accepted that they should lead and innovate, but failed to actually exercise leadership which would take the long-stay wards away from the regime of custodial care (23).

> They attributed this failure, with considerable justification to shortage of time, but they never informed the Management Committee that they were in default or invited the nursing staff into a join partnership of care to help fill the gap they left unfilled. It was left to individual nurses or groups of nurses to try to fill the gap if they so desired. It was management by default (24).

A further factor militating against the proper sharing of leadership and responsibility throughout the hospital hierarchy was the fact that power was concentrated in the hands of a triumvirate of sector administrator, a senior doctor and the principal nursing officer. This group was insultated from the needs of middle administration and junior nursing staff (25), and the concentration of power within it tended to destroy initiative from below. Unfortunately, the principal nursing officer saw himself as playing a subservient role to those of the doctor and the administrator, and so did not exert the kind of leadership which was necessary (26).

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(22) Brookwood Report, 2.23, St Augustine's Report, 2.83, 5.4 .

(23) St Augustine's Report, 2.107.

(24) Ibid., 2.107.

(25) Ibid., 5.46.

(26) Ibid., 1.12.

Emerging from the concentration of leadership and power in the hands of doctors and the triumvirate was the impotence and lack of initiative of the ordinary nursing officers (27). In turn this meant that staff below nursing officer level felt unsure as to their responsibilities and as to how far they were entitled to introduce innovations. One charge nurse was in fact reproved by a Senior Nursing Officer for taking the initiative of inviting the W.R.V.S. to provide the carpeting and dividing units which had not been obtainable from the hospital (28). This general situation can be summed up in the words of the report,

> With one exception there seems to have been no understanding of the duty that lies with the nursing staff to formulate and implement ward policies... . We believe that all, including the reformers, believed that the duty to initiate such changes lay with the Consultants (29).

Failure to understand the nature and importance of nursing leadership

> resulted in a failure to grasp occasions that should have been grasped, a failure to see that decisions that required taking were taken, and in a failure to lead forward those below for fear of impinging on their responsibility and so stifling their initiative (30).

Once again, it is necessary to point out that the examples given above are perhaps even more extreme than might be found in all hospitals. However, there is no doubt that many of the traits present at St Augustine's and Brookwood

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(27) See ibid., 2.83f, 5.4f and especially 5.9.

(28) Ibid., (2.50).

(29) Ibid., (2.83).

(30) Ibid., (2.84).

are to be found in a less acute form in other psychiatric hospitals. There is still an assumption in many hospitals that doctors should be the innovators and initiators. This is particularly true of hospitals which work on a medical model of mental disorder and its treatment, and in hospitals where nurses regard themselves as having secondary and custodial, rather than primary and therapeutic, functions. The lack of psychiatrists in many hospitals and the concentration of their efforts on the short-stay and acute patients in their care means that leadership vacuums are almost bound to develop.

There is an obvious political dimension to the leadership crisis described. Doctors, it was argued above, have achieved and maintained a position of power, dominance, leadership and pre-eminence in the hospital. The devolution of leadership and initiative depends on the sharing of real power with other groups in the hospital, especially nurses. Doctors are often reluctant to give up their power, and nurses, moulded by classical ideas of the nurses' role in relation to the medical profession as assistants and help-mates are often unwilling to demand or receive power. Equality and mutuality of leadership would demand major changes in the political relations between these two groups.

Related to the problem of the lack of leadership and proper responsibility in the hospital is the problem of communication (31). Theoretically, communications should take place smoothly up and down and between the various

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(31) See D.H.S.S., Report of Working Group on Organisational and Management Problems of Mental Illness Hospitals, 3.21f, on the need for communication.

hierarchies of the hospitals bureaucratic organisation. Such communication allows the making of appropriate decisions and policies to take place at the appropriate levels. In psychiatric hospitals this system often does not function very well. While some decisions may be communicated down the hierarchy, people at the bottom often feel that they have little opportunity or encouragement to communicate information or ideas up the hierarchy. Similarly, they may feel that the reasons for particular policies coming into being are not adequately explained to them.

Brookwood and St. Augustine's reveal failure of effective communication and understanding at many levels. At Brookwood the District Management Team (D.M.T.) felt that there was not enough communication between different groups of staff (32). This was echoed by the Patients' Activities Co-ordinator (33). The sector administrator felt that there was a lack of understanding between departments and that some departments actually were competing against other departments (34). The psychology department in particular was poor at communicating and co-operating with other staff groups in the hospital (35). The O.T. department felt that its work was not properly understood (36). It also felt that it was difficult to get its particular point of view through to higher levels of management (37).

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(32) Brookwood Report 2.21.

(33) Ibid., 2.31.

(34) Ibid., 2.39 (iii).

(35) Ibid., 3.7.

(36) Ibid., 2.32 (ii).

(37) Ibid., 2.32 (i).

There was some evidence at Brookwood that nursing management acted without full consultation (38).

At St. Augustine's communication was much worse at all levels. On many wards there were no case conferences or interdisciplinary meetings of any kind so there was no opportunity to discuss policy for the ward or for individual patients and to co-ordinate the efforts of the therapeutic team (39). There was a lack of understanding and there were clashes of interest between doctors and nurses. These were never properly discussed or resolved (40). Nurses felt their point of view was not properly attended to on the medically-dominated D.M.T.(41). When a Hospital Advisory Service (H.A.S.) report which was designed to try and help the staff make the hospital a more efficient and therapeutic institution was submitted, it was not discussed on a multi-disciplinary basis in the hospital (42). A recommendation in that same report that multi-disciplinary management by a committee including all heads of departments in the hospital should come into existence was rejected in favour of keeping tripartite management (43). In the light of all the above factors, it is not surprising that junior staff did not understand the policies which the hospital was supposed to be trying to implement.(44).

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(38) Ibid., 2.34 (ii).

(39) St Augustine's Report, 2.51, 2.208.

(40) Ibid., 2.154-15.

(41) Ibid., 2.156.

(42) Ibid., 4.21.

(43) Ibid., 4.27.

(44) Ibid., 4.73.

The most dramatic failures in effective communication in both of these hospitals came when concerned junior staff tried to bring abuses and inadequacies in the hospital to the attention of those higher up the hospital hierarchy. Without exception, these staff were discouraged in every possible way by colleagues and superiors from following their complaints through. In Brookwood, a pupil nurse who complained to his charge nurse about the latter's behaviour towards a patient was sanctioned by being given a poor ward report (45). Nurses would not give evidence to the Brookwood enquiry because they believed they would be regarded as 'informers' by their colleagues (46). Nurses who did complain were 'blacked' by their colleagues and a concerted campaign was organised against them (47). Ultimately, these nurses found their position in the hospital untenable and had to leave.

At St. Augustine's similar events took place. Two nurses submitted a critique of the hospital suggesting, in fairly general terms, that standards in long-stay wards were not all they might be and that there was a general lack of treatment policy for long-stay patients (48). Much of this critique was vindicated in the course of the enquiry (49). In the meanwhile, however, the critique had been shelved by the District Nursing Officer and the D.M.T. (50), ridiculed by nursing officers in the hospital (51), substantially

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(45) Brookwood Report 4.7.

(46) Ibid., 4.8.

(47) Ibid., 5.47, 5.51.

(48) St. Augustine's Report, 1.20.

(49) Ibid., 1.21.

(50) Ibid., 4.68, 4.82.

(51) Ibid., 4.69-70.

rejected by the medical staff and had been described by members of the A.H.A. as 'immature' (52). Other nurses in the hospital who complained about unsatisfactory aspects of its functioning and patients' care were persuaded that their complaints were misguided and unnecessary (53). When complaints were made, they were frequently rejected, mishandled, or not properly inviestigated (54). There is still no standard effective procedure to protect and encourage staff to come forward when they are concerned about unacceptable aspects of hospital life (55).

As long ago as 1959, Barton pointed out that management must always assume that there will be some incidence of cruelty and brutality in psychiatric hospitals, however good their overall standards may be. He wrote that "the presumption that such things do not or cannot happen has shown again and again to be naive and fatuous" (56). Barton further remarks that it is easy for management to feel "hurt and let down by witnesses who draw attention to such matters" (57) and to be critical and resentful of the complainant who may then be ostracised and victimised. He states that complaining should, on the whole, "be regarded as a very courageous gesture by a poorly paid attendant or nurse who stands to gain nothing and who risks her livelihood by coming

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(52) Ibid., 4.103.

(53) Ibid., 2.30.

(54) See e.g. ibid., 2.177, 2.183, 4.19.

(55) See further Beardshaw, op.cit., on this whole topic.

(56) Barton, op.cit., p.11. See also Clark, Administrative Therapy, p.35.

(57) Op.cit., p.11.

forward"(58).

It appears that little or nothing has been learnt about the importance of listening to and taking seriously the staff or patients over the years, despite the writings of Barton and Clark and the large number of committees of enquiry which have taken place. The effect of reacting negatively to criticism as a matter of course is twofold. Firstly, it means that many instances of unsatisfactory conditions and patient care do not come to the attention of the relevant authorities (59). Secondly, in the words of a witness at the Brookwood enquiry, "You have got to be a very strong person, or you have got to be prepared to leave the hospital" (60). In practice, even strong staff members usually find their position in the hospital becomes untenable and are lost to psychiatric nursing altogether.

Ultimately, lack of effective communication results in patients not being treated as well as they might be. They fall prey to communication gaps, incoherent policies of care and treatment or cruelty. Those nearest the patients on the staff, i.e. junior and unqualified nurses, also suffer as they remain confused and unsupported in their tasks and have little opportunity to suggest innovations or to point out inadequacies. The structure of the hospital can often ensure that those who have least power and influence in the hospital suffer most from the lack of communication.

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(58) Ibid., p.11.

(59) This point is made in Brookwood Report, 4.13.

(60) Ibid., 4.8.

I will now turn to the problem of staff mentalities and morale in psychiatric hospitals. In institutions where staff and resources are in short supply, where there is a lack of leadership and where communication is poor, high morale and positive attitudes among the staff occur very much against the odds. It must be acknowledged that some wards in some hospitals do achieve a high level of morale, despite unpromising circumstances. Generally, such wards have common features, e.g. effective leadership, stated goals, innovative practices, coherent patient treatment and ward policies and good communication. On many other wards, negative attitudes and poor morale prevail.

Talbott has anatomised some of the negative attitudes which are to be found among staff in psychiatric hospitals (61). He distinguishes the factory mentality where hospital workers see themselves much like any factory workers, simply doing a job, rather than seeing themselves as dedicated professionals. The bureaucratic mentality is that in which organisational detail, policy, procedure and structure are attended to at the expense of individuals, flexibility, and the utilisation of the unique assets of human energies. The police mentality is described by Talbott as that frame of mind in which "policing replaces caring, monitoring replaces evaluating, and personal surveillance replaces treatment supervision"(62). Talbott further comments,

> There is a great and natural temptation when things do not seem to be working right in large systems to stop attending to individuals and programmes that attempt to achieve certain goals and to begin to monitor, check, police, and scrutinize as much as

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(61) Talbott, op.cit., Ch.7.

(62) Ibid., p.75.

possible (63).

A fourth mentality is the survival mentality. This is when the desire to be able to continue in function within the system means that people act conservatively and cautiously to avoid drawing adverse attention to themselves. At the same time creativity, growth and risk are stifled. There is a property mentality among some staff members in psychiatric hospitals whereby buildings and structures are attended to more readily than programmes, people and services. This is closely related to the quantification mentality in which quantity, numbers and appearance are given more importance than more intangible features of quality, substance and inner workings. Talbott finally distinguishes the nihilistic mentality in which it is held that to do nothing is better than to do something because almost any action might produce negative results. This mentality leads, of course, rapidly to stagnation and the death of any innovative ideas.

Although Talbott draws his categories from his observation of American state hospitals, most of these mentalities can be found to greater and lesser degrees and in different combination in British hospitals today. All of them, individually and collectively, have a depressing effect on the hospitals. The report on St Augustine's provides clear examples of demoralisation and the flourishing of negative mentalities. Apathy and custodialism flourished in this hospital (64). The nihilistic mentality was allowed free rein (65). Staff on one ward were so demoralised that when their ward changed usage on the changeover day, "the chamber

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(63) St Augustine's Report, 2.2.

(64) Ibid., 2.58.

pots were unemptied. Two mattresses in side rooms were soaked in urine and covered in green mould on their underside, and the whole ward had to be disinfected" (66). One witness said of the staff on a psycho-geriatric ward in 1973, "I feel that the morale of the staff and the conditions of work were so bad that the only way they could tolerate the work was by getting it over in time for their (one hour) teabreak" (67). The same witness testified that the ward routine was unvaried and that only minimal care was given to patients (68). A charge nurse who had tried to introduce beneficial changes in the past had received insufficient support and so had given up (69). It has already been seen that initiative in St. Augustine's was sometimes reproved (70). The apathy and frustration of staff at all levels was even apparent to outside observers. One member of the Regional Advisory Team noted that "the initial enthusiasm with which the staff approach their role is replaced by a laissez-faire attitude when no-one in particular appears interested in their efforts" (71).

It must be concluded that low morale and negative attitudes are ever present and endemic in many psychiatric hospitals. Unfortunately, there is no reason to believe that the situation described at St. Augustine's is unique. Many

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(66) Ibid., 2.58.

(67) Ibid., 2.164.

(68) Ibid., 2.165-66.

(69) Ibid., 2.165.

(70) Ibid., 2.50.

(71) Ibid., 4.23.

contemporary hospitals exhibit similar features at least in certain areas, often in the long-stay and psycho-geriatric wards in particular.

There are a number of other problems which face the contemporary psychiatric hospital. These are of lesser importance than those mentioned above and so will receive only a brief mention. One such problem is the lack of trained and well-educated staff. No doubt one of the features which deters staff of that kind entering the psychiatric hospital is the kind of problem which has been discussed above.

Before turning to the victims of the problems of the mental hospital, it is perhaps worth reiterating in passing that a major factor in all the problems mentioned is the fact that psychiatric hospitals have a low social status clientele which is often chronically ill and on the face of it can offer little in the way of job satisfaction or status to those who work with them. Certainly they are of little concern to the majority of the population or to policy makers.

The ultimate victims of the problems of the mental hospital are always the patients, as has been noted before. It is they who suffer when resources, staff, leadership and communication are lacking so that hospitals lapse into minimal care of a custodial nature. The depths of the adverse conditions which patients may be required to bear can be illustrated by giving some account of the worst abuses to which patients have been subjected and by describing and discussing the condition which has come to be known as institutional neurosis.

The reports of committees of enquiry into various psychiatric hospitals have often emanated from publicly

reported incidents of abuse or cruelty. Public attention has tended to focus on the acts of aggression or neglect of staff members, but in the final analysis, while acts of cruelty or neglect do obviously concern individuals above all, they must be seen against the background of the larger problems described above which face the psychiatric hospitals. While there are probably acts of overt violence and neglect in most psychiatric hospitals, however good their reputation may be, they are more likely to be a feature in hospitals where the general state of the hospital is bedevilled by the problems which have been described. Physical cruelty and neglect, I suggest, must be seen as extreme expressions of a more fundamental malaise in the hospital and indeed in the N.H.S. as a whole. This malaise 'explodes', as it were, into particular acts. Incidents of cruelty and neglect by individuals should be seen as extreme symptoms of an underlying condition which must be dealt with at its roots by solving the larger problems of the psychiatric hospital. They must be seen on a continuum ranging from high morale and good practice and treatment at one extreme through to apathy and custodialism at the other. The grossly unacceptable actions of a tiny minority probably form the 'tip of an iceberg' of less unacceptable acts by many other staff members. Hitting a patient is undesirable, but so is threatening or shouting at a patient. Cruelty and bad practice may not always, or even frequently, be of the kind which becomes a matter of public attention or which can be detected and dealt with by an enquiry run on legal lines. I suggest therefore that the kinds of abuse described below should be seen as a kind of extreme 'thermometer' of the problems, attitudes and atmosphere prevalent in many psychiatric hospitals.

At Brookwood, one witness claimed that she had seen

patients handled roughly, slapped, kicked and abused (72). This evidence was not corroborrated because other staff members would not give evidence for fear of their colleagues or employers (73). Another witness at Brookwood alleged that a charge nurse had hit patients (74). He had also over-medicated a patient (75). These allegations were found proven by the enquiry.

At St. Augustine's the proven allegations included patients being threatened by a nurse, being sworn at and being hit around the head (76). Another patient was slapped for not urinating (77). E.C.T. was given to an unwilling voluntary patient who was bodily compelled to have the treatment (78). A patient was kept locked in a bare, smelly side room for a month (79). Psycho-geriatric patients on some wards received only very infrequent baths (80). Patients' property and presents were not distributed to them (81). Patients were deprived of their spectacles and had no opportunities for different kinds of stimulating activities (82) They did not receive the pocket money allowance to which

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(72) Brookwood Report 4.1, 4.3, 4.7.

(73) Ibid., 4.3.

(74) Ibid., 5.23, 5.25.

(75) Ibid., 5.24.

(76) St. Augustine's Report, 2.110.

(77) Ibid., 3.57, 3.62, 3.64.

(78) Ibid., 2.11.

(79) Ibid., 2.59.

(80) Ibid., 2.167.

(81) Ibid., 2.176, cf.2.32.

(82) Ibid., 2.175.

they were entitled. On one ward patients who were incontinent were deprived of adequate liquid (83). Sometimes patients were made to 'perform' in front of groups of student nurses by the ward charge nurse (84). Clothing supplies for patients were inadequate (85). One charge nurse deprived a patient of food for several weeks (86). Some patients were verbally abused and called 'dumbos' by nurses (87). One patient was kept in his pyjamas and dressing gown for nine months (88). Some patients almost never saw their doctors (89). One patient was given E.C.T. when she was not fit to have it without the proper medical examination (90).

The findings of the reports of the committees of enquiry into St. Augustine's and Brookwood present a gloomy and worrying picture of neglect and abuse in British psychiatric hospitals. However, it is important to emphasise that these features are extreme manifestations of how bad things can be in psychiatric hospitals. Mostly, the patients in hospitals have to endure poor conditions and boredom rather than active abuse and cruelty. For this reason, it is important to discuss the concept of institutional neurosis, in many ways a more illuminating area in terms of the everyday life in hospitals than that of cruelty and neglect, although

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(83) Ibid., 2.179.

(84) Ibid., 2.36.

(85) Ibid., 2.169.

(86) Ibid., 2.208.

(87) Ibid., 2.209.

(88) Ibid., 2.234.

(89) Ibid., 2.10, cf. 2.24, 3.26.

(90) Ibid., 3.64.

these two areas cannot actually be separated as they contribute to each other in many instances.

The term 'institutional neurosis' was coined by the medical superintendant of a British psychiatric hospital in the late 1950's. Russell Barton, in describing this 'syndrome' attempted to bring to the attention of staff in psychiatric hospitals the debilitating effects which an impoverished and negative environment could have on patients over and above the effects of their original disorder. At the time Institutional Neurosis was first written, there were many more young and middle aged long-stay psychotic patients in hospital. The book was written with that group particularly in mind. Wing and Brown's research on institutionalism which is considered later, also focusses on that group. However, many of the factors described by these writers with particular reference to these patients are also relevant to other categories. The insights of the work on institutional neurosis remain relevant today: a third edition of Barton's book was published as recently as 1976.

> Barton describes institutional neurosis as
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> a disease characterised by apathy, lack of initiative, loss of interest, especially in things of a personal nature, submissiveness, apparent inability to make plans for the future, lack of individuality, and sometimes a characteristic posture and gait (91).

He suggests that it can occur in any institution and not just in psychiatric hospitals. While the exact causes of institutional neurosis are not known, the factors which seem likely to contribute to it are loss of contact with the outside world, enforced idleness and loss of responsibility,

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(91) Barton, op.cit., p.76.

brutality, browbeating and teasing, bossiness of the professional staff, loss of personal friends, possessions, and personal events, drugs, ward atmosphere and loss of prospects outside the institution (92). The treatment of this syndrome includes re-establishing or maintaining contact with the outside world, encouraging patient activity, altering staff attitudes, eradicating brutality, browbeating and teasing, affirming the patient's personal individuality, cutting down on drugs where possible, producing a better ward atmosphere, and making patients aware of prospects outside the institution (93). Clearly, the kinds of causes of institutional neurosis mentioned by Barton were present in an acute form in the long-stay wards of St. Augustine's hospital as recently as the early 1970's. They continue in parts of many large, understaffed, demoralised psychiatric hospitals even today.

Wing and Brown (94) made a more detailed and scientific study of the effects of a hospital environment on schizophrenic patients. Looking at three British hospitals in the 1960's, they discovered that the environment of the hospital had a considerable influence for good or ill on patients. It was found that negative symptoms of schizophrenia, e.g. flatness of affect, poverty of speech, social withdrawal, were more likely to occur in an impoverished social environment, i.e. an environment in which there is little outside contact, where nursing attitudes are unfavourable, where patients have few personal possessions, little to occupy their time and live in restricted conditions

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(92) See ibid., p.77f.

(93) See ibid., p.77.

(94) J. K. Wing and G.W. Brown, Institutionalism and Schizophrenia (Cambridge : C.U.P., 1970).

(95). Although the hospital environment did not seem to affect patients suffering from florid, positive schizophrenic symptoms very much, it was discovered that negative secondary impairments affected patients with only moderate symptoms on admission the longer they remained in the hospital. It was concluded that " a substantial proportion, though by no means all, of the morbidity shown by long-stay schizophrenic patients is a product of their environment" (96). It was further found that measures taken to improve the environment in the three hospitals studied did reduce negative symptomatology (97). It was, however, noted that such environmental improvement ceased to produce such good results in alleviating symptoms after a period of time. This slowing down in the rate of desired change may have been caused by the increasing age of the patients, by staff becoming disheartened or less enthusiastic, or by staff priorities changing to community care concerns (98). Whatever the cause, Wing and Brown remark that it is "a salutary reminder that efforts must be kept up and that reform itself has a natural history" (99). In any case, without resources, leadership and good quality staff of high morale, no beneficial reform is possible in the first place, and long-stay patients are increasingly crippled by a negative and impoverished hospital environment.

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(95) See op.cit., p.33f. for this.

(96) Ibid., p.177.

(97) Ibid., p.177f.

(98) See ibid., p.189f.

(99) Ibid., p.193.

I shall conclude this section which has attempted to explore the problems of the psychiatric hospital and the effects of these on patients by quoting the words of the 1980 D.H.S.S. working group:

> It is in the care of long-stay patients that some of the most grievous derelictions of recent years have occurred. It is they who are most open to forms of abuse; it is they whose rights are most easily forgotten. The term 'back wards' may itself be significant - certainly they tend to acquire a second-class status - with poorer facilities, low staff ratios, a dull and unvarying regime, and a general atmosphere of lowered respect for patients in which carelessness, neglect and even ill-treatment can flourish. It is indeed only too easy for long-stay patients to be grouped in back wards, looked after by uninterested staff and allowed to sink into a disgraceful state of neglect. Their relations are often poor, elderly and not very likely to complain. To maintain a good level of service requires vigorous, vigilant hospital management (100).

In fact, even where good vigorous and vigilant hospital management exists, it is very difficult to eliminate the problems described. The reason for this is that the root of these problems lies outside the hospital itself, in the very structure of society at large. It is now necessary to consider, in the light of this section and its predecessors what the merits and demerits of the contemporary hospital are and to try and assess what its future should be and what its future is likely to be within the present socio-economic order.

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(100) D.H.S.S., Report of a Working Group on Organisational and Management Problems of Mental Illness Hospitals, 11.6.

CHAPTER XV

THE FUTURE OF THE PSYCHIATRIC HOSPITAL

> Society's creation and maintance (sic) of custodial mental hospitals is dependent on powerful forces, forces that do not individually or collectively lend themselves to easy alteration. This factor is one reason why, while internal and external changes may affect them it is probably not until there are systems or societal changes that the total functioning of the state hospitals can be improved (1).

The account given above of the history of the mental hospital and of its situation and problems today has given a fairly negative picture of this institution. It has been argued that, far from being positive, harmonious and therapeutic, psychiatric hospitals can easily be places of strife, apathy, pessimism, neglect and oppression, especially for their clientele, but also for members of staff. Critics of the psychiatric hospital have pointed out that these institutions have always been less than satisfactory in their performance, perpetually bound to a cycle of poor standards, abuse, public outrage, moderate and temporary reform which soon gives way once again to the poor standards which prevailed before. It may be argued with considerable justification that psychiatric hospitals are, and always have been, an inherently bad way of organising services for the mentally disordered in society. Belknap writes,

> Against continual deficits of staff and materiel (sic), and against occasional instances of indifference and neglect, or outright abuse, progress has been made from time to time; but the uneasy feeling exists that reform and regression in mental hospital affairs are inseparable processes. The cycle has repeated itself too often to be fortuitous. The sequence of expose, reform, progress,

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(1) Talbott, op.cit., p.88.

> indifference, apathy, and decline has been repeated with variations in a dozen states of the Union in the past twenty years (2).

He adds later,

> The indictment that can reasonably be levelled at the state hospital is not so much that it lacks treatment effectiveness, but rather, first that it has persistently developed conditions which are cruel and inhuman both for patients and employees, and, second, that it tends regularly to degenerate into the kind of social organisation that does not permit the application of the little that is actually known about the treatment of mental disease (3).

He goes on to state that the development of the mental hospital "looks ... like a process of incoherent patchwork, interspersed with alternating periods of improvement and decay"(4). From the outset, efforts to improve conditions in state hospitals for the mentally ill have been repeatedly hindered by public indifference, political manipulation, insufficient capital, and inadequate personnel (5). Although these words were written in 1956 of American hospitals, they can be seen as almost entirely relevant to British hospitals today as has been shown. These criticisms are echoed in the more recent work of Talbott. He writes,

> It should be obvious by now that state hospitals, as they are currently constituted, do not work, seem designed not to work, and have never worked... . Critics ... continue to point out the problems, decade after decade, without any perceivable effect (6).

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(2) Belknap, op.cit., pp.vii-viii.

(3) Ibid., p.13.

(4) Ibid., p.14.

(5) Ibid., p.14.

(6) Talbott, op.cit., p.125.

As to the future of the psychiatric hospital, Talbott concludes that "there is little evidence to suggest that state facilities have performed their tasks sufficiently well in the past 100 years to merit their continuing existence"(7).

Despite these damning criticisms, it is possible to make out a case for the continued existence of the mental hospital, or at any rate to find some positive features in the institution which may be of continuing or growing value. Essentially, these arguments for the continued existence of the hospital fall into two categories. Firstly, negative arguments which concentrate on the deficiencies of the forms of care which are supposed to replace the psychiatric hospital, i.e. care in the community and in D.G.H. psychiatric units. Secondly, there are positive arguments which emphasise the good features of the psychiatric hospitals themselves. These arguments will be considered in the order given above.

Community care for the mentally ill has been the aim of government policy since the demise of the psychiatric hospitals was first envisaged in the early 1960's. However, while this has been the ideal for many over the past two decades, much has remained very unsatisfactory in reality.

Community services have been very under-financed. This has been partly due to lack of political will on the part of the government. It has also been caused by money which should have been used for provisions for the mentally ill being diverted at the local level to other areas of need in the N.H.S. (8). In addition, local authorities have been unwilling

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(7) Ibid., p.146.

(8) See Haywood and Alaszewski, op.cit., p.43ff, for a discussion of how doctors divert resources to high prestige areas and away from the old, mentally ill, etc.

to divert resources away from established social service needs to the mentally ill, who until the 1970's were catered for exclusively under the N.H.S.(9). Another, perhaps the most crucial factor, is that much of the public money spent on the mentally ill is still tied up in keeping the psychiatric hospitals running. The basic cost of running these institutions, even with reduced patient numbers, is enormous. As a result, money has failed to follow the patients out of the hospitals into new facilities in the community. Talbott comments, "The most crucial problem that de-institutionalisation has pointed up is that we are unable to devise a mechanism thus far to allow money to follow patients wherever they are" (10). This is reflected in figures quoted for mental health expenditure in 1973-74, which show that while £300 million was spent on the hospitals, only £15 million was spent on personal social services (11).

Community services for the mentally ill have also suffered from lack of co-ordinated planning between the N.H.S. and Local Authority Social Service Departments. Although close co-operation between these agencies has been continually emphasised as the sine qua non of provision of effective community care (12), actual practice has been disappointing to

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(9) D.H.S.S., Report of a Working Group on Organisational and Management Problems of Mental Illness Hospitals, 9.9 .

(10) Talbott, op.cit., p.40.

(11) J.K. Wing and Rolf Olsen, 'Principles of the New Community Care' in J.K. Wing and Rolf Olsen, eds., Community Care of the Mentally Disabled (Oxford : O.U.P, 1979), pp.171-85, p.171.

(12) See D.H.S.S., Hospital Services for the Mentally Ill, 8, 10, also D.H.S.S., Report of a Working Group on Organisational and Management Problems in Mental Illness Hospitals, Ch.4.

say the least. Issues of finance and responsibility have not helped members of the respective sectors to work harmoniously together. Local Authorities have been reluctant to take on additional financial responsibilities when little money or increased influence have been forthcoming from the N.H.S. or from central government. Efficient co-ordination has also been hampered by frequent organisational changes over the last decade. The first part of this period saw the demise of the social worker trained and specialising in mental health, employed by the N.H.S. and based almost exclusively in the hospital. In 1974, further major organisational changes took place in that both the local authorities and the N.H.S. experienced major re-organisations. The N.H.S. has experienced another re-organisation in 1982. Such changes inevitably lead to upset, loss of contacts and the formation of new co-ordinating groups which have to learn how to function anew within the changed structure. The development of good community services for the mentally ill is considerably disrupted by these upheavals (13).

The net result of the lack of finance and co-ordination in the services for the mentally ill in the community is that residential and day care provision for patients is grossly inadequate. Abel-Smith recorded that in 1978 there was a shortfall in day care provision of some four fifths of the required number of 30,000 (14). Furthermore, there was only one third of the 12,000 places needed in residential homes and adequate accommodation for the elderly mentally ill which he described

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(13) See further D.H.S.S., Report of a Working Group on Organisational and Management Problems in Mental Illness Hospitals, Ch.9, for a more detailed discussion of the adverse effects of frequent change on community services.

(14) Abel-Smith, National Health Service, p.54.

as 'sadly lacking' (15). Ryan notes that only 43% of the short- and long-stay accommodation required was available in 1975, and this included accommodation provided by voluntary and private organisations (16). Despite governmental protestations that more community provision will be made in the future, the prospects are bleak in reality. Writing of the backlash in the 1970's in the U.S.A. against the policy of de-institutionalising mental patients into the community without providing adequate resources for them there, Talbott states that "there is not, and never has been, an adequate range of facilities for the mentally ill in the community, each with a wide range of programmes designed for individuals with different problems, levels of functioning, etc." (17). This observation would seem to be equally apt for the present situation in the U.K.

The consequences of the lack of adequate provision in the community have been touched on above. Patients are often left to rot in inadequate housing ghettoes, isolated and neglected (18). Some patients may find their way into second rate or institutionalised (in the negative sense of the term) residential care in public or private ownership where they face the same kind of negative atmosphere that pervades the large old mental hospitals, while remaining equally isolated from the community at large in effect (19). Others simply end

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(15) Abel-Smith, op.cit., p.54.

(16) Peter Ryan, 'Residential Care for the Mentally Disabled' in J.K Wing and Rolf Olsen, eds., Community Care for the Mentally Disabled (Oxford : O.U.P , 1979) pp.60-89, p.60.

(17) Talbott, op.cit., p.40.

(18) See Scull, Decarceration, p.153.

(19) See Ryan, op.cit.

up on the 'long stay wards' of the streets of the large cities. In a study reported in 1970, it was found that in an Edinburgh common lodging house 14% of the residents had previously been in psychiatric hospitals, while 26% were diagnosable as schizophrenic. In a similar study of the Camberwell Reception Centre in 1965, about one quarter of the residents had previously been in psychiatric hospitals (20).

The current lack of community services is indicative of, and compounded by, the sad truth that the community at large is not, and never has been tolerant of, or interested in, the mentally ill. The stigma attached to being an ex-patient of a psychiatric hospital or to being mentally ill has been greatly underestimated by those who have advocated community care. Scull has rightly pointed out that the new policy was initiated for reasons of expediency and economy and was not adequately researched before it was implemented (21). The shortcomings of the policy are becoming clear as misery of the mentally ill exposed to community neglect becomes more apparent.

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(20) For these figures and a more detailed discussion of destitution among the mentally ill see John Leach, 'Providing for the Destitute' in J.K Wing and Rolf Olsen, eds., Community Care for the Mentally Disabled (Oxford : O.U.P, 1979), pp.90-105, especially pp.92-3. Clare writes, "The running down of the large mental hospitals has not been accompanied by a significant development of community based resources. Instead, there has been overcrowding in the hospitals, a rise in the number of homeless and poorly-housed people, and a shift of people from the mental health and into the prison services." (Clare, op.cit., first edn., pp.411-12)

(21) See Scull Decarceration, Ch. 6.

Mechanic writes of the results of the community care policy,

> we have learned what we should have known but missed in our enthusiasm for change. Community life is no panacea unless the patient's suffering is alleviated and social functioning improved. We have learned that community life, without adequte services and supports, could be as dehumanising and debilitating as the poor mental hospital. We have learned that if the patient is sufficiently disturbed and disoriented, as many schizophrenic patients are, residence in the home or community can cause innumerable difficulties for family and others and may result in a general outcome inferior to good institutional care. We must understand more thoroughly what happens to the mental patient outside the hospital - the extent to which difficulties occur and the way they are handled. Intelligent planning of community services depends on a firm understanding of the true consequences of various policies (22).

In concluding this critique of the community care services, I turn once again to Talbott. He sums up the arguments thus, "No longer can anyone maintain that state hospitals must be emptied simply because they are so 'awful' - because the settings we have allowed to replace them are just as bad as their predecessors (23).

From the inadequacies of the community services I will now turn to a consideration of those of D.G.H. psychiatric units. The main criticism of this form of care is that it is simply not suitable for chronic sufferers from mental illness. General hospitals are places where the dominant ethos is one of cure rather than care. Since many patients suffering from mental disorder have little potential for rapid recovery during a short admission, the cure ethos can be of

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(22) David Mechanic, Mental Health and Social Policy, second edn , (Englewood Cliffs: Prentice Hall, 1980), p.120.

(23) Talbott, op.cit., p.38.

only limited value to them, especially if they suffer from chronic and recurrent disorder. Jones and Sidebotham point up the difference in ethos between general and psychiatric hospitals by contrasting the roles of nurses in these institutions. The aim of the good general nurse is to care for the physically incapacitated patient until that individual is recovered. Usually the physically ill patient is necessarily dependent in his relationship with the nurse. In a psychiatric hospital, the aim of the nurse is to foster the independence of the patient as far as possible. Talking to patients, taking an interest in their emotional reactions and hopes for the future and so on is more important than the rituals of the general hospital, e.g. pulse and temperature taking. Jones and Sidebotham write that "The stringent discipline and order which may be necessary in the acute general hospital are quite out of place in dealing with psychiatric patients, who need a slower pace and a more personal relationship with the nursing staff" (24).

Using a strict medical model and the attitudes which go with it in dealing with mental disorder may be a limited and dubious enterprise. This is discussed at greater length in Chapter XII.

Here, however, I will go on to describe some of the practical difficulties associated with trying to deal with mental disorder in D.G.H. psychiatric units. Most of these difficulties stem from lack of space and lack of finance. Because D.G.H's are usually situated in or near the centre of towns, they are often on geographically constricted sites and there is little room for expansion. This has serious implications for psychiatric units situated in them. Lack of space means that only a strictly limited number of patients

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(24) Jones and Sidebotham, op.cit., p.15.

can ever be accommodated in these units and these for a relatively short period of time. Following from this, the grounds for admission are necessarily clinical rather than social. The psychiatric unit because of its limited space cannot act as a hostel for those whose main needs are asylum from family or society, except to a very limited extent (25).

The size of the staff and the variety of disciplines available for patients is also limited in the psychiatric unit so that both scope and quantity are limited. Many units are dominated by a medical model approach to mental disorder which means that psychopharmacology may assume an over-influential position as opposed to the wide variety of treatments which can potentially be offered in the large psychiatric hospital (26).

The space factor also affects the quality of life of patients in D.G.H. psychiatric units. While traditional psychiatric hospitals often have spacious and attractive grounds and a great deal of space into which they might expand, this facility is denied to the psychiatric unit for the most part.

In considering the negative features of the D.G.H. psychiatric unit, the study of Baruch and Treacher, the first of its kind, which examined the functioning of one such unit must be considered. The authors discovered that the unit they studied was cut off from the community, that it was medically dominated and hierarchical in organisation. Staff were found

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(25) See Jones and Sidebotham, op.cit., p.16ff.

(26) For more on the limited nature of treatment available in psychiatric units see Baruch and Treacher, op.cit.

to be institutionalised, and senior medical staff who had least to do with the patients had most influence in decision-making. Staff coming from different social and professional backgrounds had contradictory attitudes to the patients. There was a failure on the part of staff to establish the true basis for patients' hospitalisation and everyday treatment was at odds with diagnostic and therapeutic formulations. Again, a 'treatment barrier' was formed whereby doctors were seen as active agents of treatment while patients and their relatives saw themselves as passive recipients of medical care (27). While many of these findings would also be true of hospitals devoted exclusively to psychiatry, at least they show that the D.G.H. psychiatric unit offers few improvements in terms of treatment and care over the psychiatric hospitals they are intended to replace. Furthermore, it is arguable that, with their greater resources and variety of therapeutic approaches, the traditional psychiatric hospital has at least the potential to offer more than simply physical treatments based on medical assumptions and direction which is all that is possible in the psychiatric unit.

One final negative feature of the psychiatric units must be mentioned. There is a tendency for good staff and resources to be drawn towards these units with their concentration on cure and treatment of acute cases and their use of the less-stigmatising medical model in the setting of the prestigious general hospital. This may lead to less good staff being left to care for the chronically mentally ill in the inadequate conditions of the old hospitals. There is therefore the possibility of the emergence of two tiers in the mental health

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(27) See Baruch and Treacher, op.cit., Conclusion, p.223ff.

services for patients in which the chronically ill will lose out badly. The 1978 Royal Commission on the National Health Service, while generally in favour of the development of the psychiatric units noted that it "has had the effect of leaving to the large specialist mental hospitals the incurable, the behaviourally disturbed, the old and demented" (28). Furthermore, it noted that "the policy of running down these institutions has undermined the morale of their staff" (29). Brown cites the example of the Manchester area as a place where a two tier system offering different standards has been allowed to emerge (30).

Having spent some time considering the negative aspects of the alternatives to the psychiatric hospital, the positive advantages of the psychiatric hospital itself are considered now. Many of the positive aspects of the traditional psychiatric hospital are simply the obverse of the negative remarks made concerning other forms of treatment and care. For example, the psychiatric hospital provides, or potentially can provide space, tolerance, some kind of community and friendship for patients, a variety of treatments which can be selected to meet specific individual needs, an emphasis on care and independence rather than cure and dependence, etc. Because of this, here I propose only to consider new positive factors.

In the first place, it may be argued that the centralisation of resources saves money and permits savings and other economies (31). The dispersal of scarce resources

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(28) Royal Commission on National Health Service, Report, 6.44.

(29) Ibid., 6.44.

(30) Brown, 'The Mental Hospital as an Institution', see esp. p.421.

(31) See Jones and Sidebotham, op.cit., p.20.

is less efficient than concentration. This would seem a particularly good and valid point to be making at a time of economic recession when money for the mental health services is in very short supply and little is likely to be available for the further development of community services. So it may be that for pragmatic and economic reasons the preservation and possible development of the psychiatric hospital over other forms of treatment is a wise thing to advocate.

Not unrelated to this point is the fact that at times of recession when unemployment increases, the rate of mental disorder also rises. This means that there is a greater demand for psychiatric resources and at the same time there is no money to provide these in the community (32).

Thirdly, it should be noted that while inpatient numbers have dropped in the psychiatric hospitals since the end of the 1950's, there are now many more short term admissions to the psychiatric hospitals. This means that, although patient numbers in hospitals are smaller, the activity of these institutions has not substantially diminished. The implication of this is that the psychiatric hospitals are still a living and very important part of the mental health services in this country. Many hospitals are now approaching a size and a staff-patient ratio which would allow them to attain some of the goals of the early asylum founders of providing high quality individualised care for those who need support and attention away from their families and the outside world in general. Ironically, at the very moment that

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(32) See Jones and Sidebotham, op.cit., p.17, also M. Harvey Brenner, Mental Illness and the Economy (Cambridge : Harvard Unnversity Press, 1973). The latter considers the relation between economic recession and mental illness incidence in the U.S.A. but there is no reason to suppose that his findings are not broadly applicable in this country.

this is happening, few efforts are being made to nurture it (33).

A further possible argument in favour of the mental hospital's continued existence is that many of the arguments used against these institutions in the early 1960's sprang from irrational and unacknowledged sources (34). Fear of mental hospitals, fuelled by, and rationalised with, sociological studies played a large part in producing a demand for their closure. Arguments based on emotion played a large part. It was, for example, argued that non-hospital treatment would be inherently 'better' and 'more humane' although no research had been undertaken to find out whether it would or would not be better for patients. The unsubstantiated value judgements which brought present policies into existence have yet to be vindicated in practice. As was argued above, unsubstantiated humane concern may have served as little more than an ideology for saving public expenditure.

The final, and perhaps most important argument to be advanced for the continued existence of the mental hospital is, quite simply, the continued existence of the chronically mentally ill. It appears that there are still those in our society who fall into this category, and there is little possibility of their numbers decreasing. Bott has noted the continued existence and growth of a core of chronically mentally ill persons needing asylum from the world at large (35). In fact, this category of patient never ceased to exist, although it was lost from sight in the euphoria of deinstitutionalisation in the 1960's. It is time that the

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(33) See Jones and Sidebotham, op.cit., pp.17f, 116f.

(34) See Jones and Sidebotham, op.cit., p.19.

(35) Bott, 'Hospital and Society'. See also D.H.S.S., Better Services for the Mentally Ill , 4.52f.

needs of those who can best survive in the protected environment of the hospital were once again considered seriously. A mental hospital can provide for the social physical and emotional needs of those who have no other means of having their needs met. It can in fact restore rights and dignity to people who have lost these things outside the hospital. These would seem to be as valuable and humane factors as the perpetual swinging of the 'revolving door' bequeathed to the mentally ill by the current policy of community care.

It seems in any case that the psychiatric hospital is here to stay. After all the reforming excitement of the 1950's, the sentences of death pronounced in the 1960's, and the scandals and demoralisation of these institutions in the last decade, the antiquated asylums have been granted a stay of execution which will probably extend the lives of most of them well into the next century (36). The rhetoric

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(36) See D.H.S.S., Better Services for the Mentally Ill, 11.5, and D.H.S.S., Priorities for Health and Social Services, (London : H.M.S.O., 1976), 8.3. For a less unambiguous statement concerning the future of the mental hospitals see Royal Commission on the National Health Service Report, 10.60: "We are certain that there is a continuing need for most of the mental illness hospitals, and we recommend that the health departments should now state categorically that they no longer expect health authorities to close them unless they are very isolated, in very bad repair or are obviously redundant due to major shifts of population. It should be made clear that they will be required throughout the remainder of this century and for as long ahead as it is possible to plan". More authoritatively, the then Secretary of State for Health and Social Services suggested in 1980 that while 30 hospitals might be closed, the rest should remain and should be integrated into the new pattern of mental health care provision based on the community. (See Patrick Jenkin, 'Mental Health and Mental Illness Services in the '80's', in MIND, The Future of the Mental Hospitals (London : MIND, 1981), pp.4-11, p.8. See also D.H.S.S., Care in the Community, (London : D.H.S.S., 1981)6.15.

of the 1960's has evaporated and the mental hospitals remain. In fact, only one mental illness hospital has been closed during the last 20 years and this has become a hospital for the mentally handicapped (37).

In many ways, news of the reprieve of the mental hospital comes at a bad time. Having suffered from two decades of 'planning blight', the hospitals are now even more decrepit and demoralised than they were when their total demise was proposed. Staff are demoralised in the face of a lack of either closure or improvement (38). There is a lack of experimentation with new and varied therapies in these institutions such as that which characterised the 1950's and 1960's. Many hospitals have ceased to innovate in patient care (39). Therapeutic communities and other innovations in social therapy have been routinised or have totally disappeared, having run the course of their natural lives. Industrial therapy of a genuinely varied and therapeutic nature has been badly hit by the current shortage of employment or work of any kind in this time of economic recession. Psychopharmacology seems to be in the ascendant once again as the dominant mode of treating the mentally ill in hospital (40), and this is accompanied by the dominance of the medical profession, the subordination of other forms of therapy and their practitioners and a tendency to an essentially custodial role for the staff of the hospitals. Sedgwick comments,

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(37) See Royal Commission on the National Health Service Report, 10.55.

(38) See D.H.S.S., Report of a Working Group on Organisational and Management Problems in Mental Illness Hospitals, 2.4.

(39) See, however, David Towell and Clive Harries, eds., Innovation in Patient Care (London : Croom Helm, 1979).

(40) See Clark, Social Therapy in Psychiatry, Preface.

> "The asylum structure, which processes the acute patient and warehouses the chronic, has long ago lost any contact with the ideals of open communication and therapeutic democracy which, in a small number of vanguard sectors, stimulated innovation from the forties through the sixties. For the political climate that fostered such idealistic ventures has been replaced by a rightward-moving, depoliticised submissiveness and cynicism (41).

Staff shortages in the hospitals are acute, and recruit ment of trainee staff is still low, despite the general shortage of jobs. There are few charismatic figures who seem able to offer a new vision of the role of the hospital and who can innovate anew to relieve the general malaise and despondency. There is, of course, no money for re-building out-moded hospital buildings which continue to become more decrepit and remain unsuitable for the tasks which they have to perform. In short, it seems that the mental hospitals may well be on the verge of a plunge into incapacity and despair such as has ever been a recurrent feature of their history.

I have prefaced my discussion with this resume of where I perceive the mental hospitals to be at present because it puts into perspective any question as to whether the mental hospital should or should not continue to exist. The fact is that the mental hospital at present looks as if it will continue to exist, whether or not this is thought to be a good thing or not. Circumstantial pragmatism has, as throughout the history of the mental hospital, overtaken enlightened ideological consideration, aided and abetted by the present era of financial stringency. The fact of the matter is that, unless there are changes in the wider economic order, the psychiatric hospital will continue to survive, whether it is thought that it should or not. The only point

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(41) Sedgwick, Psycho Politics, p.211.

then, in recounting the arguments for and against this institution above is to show that there are at least some potentially positive aspects in this situation. This may provide some hope and comfort for those who are concerned about the psychiatris hospitals and for those who have to work in them. Many of the arguments which I used to show the positive advantages of the mental hospital were first advanced in 1962 by Jones and Sidebotham (42). It was at that time perhaps that a real choice could have been made about the future of the mental hospitals. It would have been possible then, and possibly in the decade which followed, to develop real and effective alternatives to the old asylums for the chronically mentally ill, the demented and the behaviourally disordered. This could only have taken place however if capital had been released from the hospitals by their rapid closure so that it could follow the patients into the community. The plan to have a gradual transition from hospital- to community-based services has been only partially successful, and has led to second rate care in both sectors. The failure to either eradicate the hospitals or to improve alternative services has meant that the hospitals have survived in an emaciated and demoralised form to the present day and in that state are being thrust once again to a central position in services for the mentally ill.

The apparently inevitable continuation of the existence of the psychiatric hospitals and the impossibility of implementing the radical solution of closing them down altogether leaves those concerned with them a variety of options. The hospitals may be left to go on essentially as

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(42) Jones has recently assessed the mental hospital again in Kathleen Jones, 'Re-inventing the Wheel' in MIND, The Future of the Mental Hospitals (London : MIND, 1981), pp. 17-23. She concludes that many of the doubts expressed in Mental Hospitals at Work have been confirmed by the passage of time.

they are. This, basically conservative, solution which maintains the status quo will ensure that hospitals will continue to experience inadequate conditions and will furnish renewed scandals. The hospitals will remain as running sores on the face of society (43). The alternative to the conservative solution is that of reform within the hospitals. Talbott indicates that among the areas which will need to be changed to effect worthwhile reforms are those of personnel policy, budgeting, staffing, staff mentalities, education, training, physical structures, administrative structures, treatment programmes, legislature and law, government agencies and policies, and public attitudes (44). Such a programme of reforms would demand great energy and dedication on the part of those who initiated it and carried it out. They would run the real risk of being crushed by the forces of conservatism and reaction in the hospital. In addition, they would be in danger of only managing to implement superficial changes which would leave the hospital essentially the same as it was before (45). After all, despite all the attempts at reform in the past, the mental hospitals have still managed to fail "to address successfully the most pressing problems facing them and for which they were created - the care, treatment and rehabilitation of the severely and chronically mentally ill" (46). It should also be pointed out that the reformist solution to be effective would in fact be very expensive. It would certainly be much more expensive than

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(43) See Talbott, op.cit., p.128.

(44) See Talbott, op.cit., Ch.13.

(45) See ibid., p.138.

(46) Ibid., p.163.

simply closing the hospitals down altogether or leaving them as they are. This is emphasised by both Talbott and Jones and Sidebotham. As far back as 1962 when the latter wrote their book, it was seen that if the psychiatric hospitals were to improve their performance, greater expenditure on them would be essential (47). At present, when no public funds are available to give money, it seems unlikely that such expenditure will take place. The only thing which could bring this about would be a change in the political will of the government of the country. Assuming that this political will is not, and will not, be present in the foreseeable future, it must be recognised that the most that can be expected in trying to solve the problems of the psychiatric hospitals will be piecemeal reforms and that often the conservative solution will hold sway, as it has so often in the past.

Before concluding this section it is important to spend some time looking at the Marxist critique of the situation described above whereby it has been shown that whether or not the mental hospital should continue to exist, it will continue to exist. If it appears that the foregoing account has wandered far away from the Marxist perspective, this is because a Marxist analysis in itself has little to offer in terms of guidelines as to whether a particular social institution should or should not exist. By its very nature, such an analysis can only suggest how and why things are as they are in society under a particular socio-economic order. It cannot prescribe how social arrangements should be, nor evaluate those arrangements in ethical terms. This is because prescription and evaluation are ideal and ethical activities.

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(47) See Jones and Sidebotham, op.cit., p.21.

While a Marxist analysis may furnish useful insights into the origins, development and continuation of the particular institution under consideration in a particular socio-economic order, it cannot indicate, except perhaps inadvertently, whether that institution is good or bad, humane or inhumane. These judgements depend on ethical values. Thus this form of analysis cannot indicate whether the mental hospital should continue to function or not. It can however, provide valuable insights into the wider social and meterial factors which maintain the hospital in existence and which shape it in contemporary British society.

Essentially, the Marxist critique of the mental hospital and its existence has suggested that this institution will be maintained in existence for as long as the present order of society demands that this should be the case. As long as mental hospitals are a relatively cheap way of caring for t he mentally ill, an economically dependent and politically impotent and deviant group in the present social order, they will continue to exist, though inadequately financed. They will, perhaps, come to have a renewed importance in the control of deviants in late capitalist society as the economic crisis bites deeper and there is a greater demand for mental health services with the rising tide of mental disorder. A materialist analysis suggests that the present government's policy of retaining the mental hospitals is basically an economy measure at a time when the State wishes to make little further outlay on new community services. Whatever the positive side-effects of this may be in terms of restoring the morale of the psychiatric hospitals (and these possible side-effects are questionable given the need for expenditure on the hospitals themselves if they are to improve or even retain their present standards) the purpose of retaining the hospitals is essentially to provide the cheapest acceptable

service for those who have nothing to offer to the capitalist economy and whose powers to disrupt that economy are minimal.

It is, however, useful at this juncture to introduce another insight of materialist analysis, the concept of contradiction. It was noted in outlining the Marxist perspective that society reflects the dialectic conflict between classes in all its institutions. This means that while the ruling classes have the dominant influence in the ordering of society, social institutions do, to some extent, serve and reflect the interests of the lower classes. It was seen that because of this, it is not possible for a Marxist critique simply to dismiss the Welfare State, for instance, as the instrument of ruling class repression alone, though that is part of its function. The psychiatric hospital must be seen in the same light. Although many aspects of this institution are inimical to the interests of the mentally disordered, in at least some respects it serves their needs. It has been seen, for example, that the psychiatric hospital may in fact restore rights to some patients. For other patients needs of shelter, sustenance and society may be met. The psychiatric hospital is, therefore, an institution of contradictions. It has potential for both good and evil so far as its patients and staff are concerned. Although there is an inevitability about this institution in the present socio-economic order and there are many disquieting aspects to this, it must be recognised that there are features of this institution which are positive and which could be nurtured, over against the negative aspects of other types of care for the mentally disordered. Thus there are grounds for hope and positive action for this institution where presently it is easy to perceive only cynicism, apathy and despair. The psychiatric hospital is here to stay but much can be done within the present social

order to develop its positive rather than its negative potential.

SUMMARY

The analysis of the psychiatric hospital, its history, functioning, groups, and ideologies, undertaken above has revealed that this institution is permeated with, and affected by, many social and political factors. A Marxist perspective on the history of the hospital showed that this institution came into existence, and has been shaped and sustained by the evolving needs of the capitalist socio-economic order in Britain. Consideration of the goals of the hospital revealed many conflicts and tensions and underlined the importance of this institution for the function of the social control of a particular group of deviants rather than any therapeutic function. Further, it was discovered that the social organisation of the hospital plays an important part in the kind of milieu which evolved therein.

A fundamental social divide between the patient and staff social groups was identified and described. Close examination of the patient group showed the impotence of this constituency and underlined various aspects of social and political inequality, both within the hospital and outside it. Patient perspectives on mental disorder and on the hospital were discussed and a consideration of the legal position of patients in hospital also pointed up issues of inequality and impotence. It was found that patients do not cohere to form a politically powerful force in society or in the hospital. It was therefore concluded that the mentally disordered form one of the most powerless groups in our society.

Turning to the staff, it was possible to identify three main groups, nursing assistants, qualified nurses and doctors. The roles, history, social background, power and

attitudes to mental disorder of each of these groups was surveyed. In the case of doctors a historical perspective on medical dominance in psychiatry was outlined from a sociological perspective. The professional nature of medicine and its political significance was also considered. It was suggested that medical hegemony in psychiatry in capitalist society is dependent on the nature of the capitalist socio-economic order and on the interests of the ruling class within that order. Sociological accounts of the doctor-patient relationship revealed the importance of non-medical social and political factors therein. Examination of common staff attitudes towards patients showed up the danger of making social judgements and of de-personalisation and 'medicalisation' of patients' behaviour. Finally, a discussion of hierarchy, status and power in the hospital revealed that these elements reflected the ordering of society as a whole. Thus, patients and junior staff who come from predominantly lower to middle class backgrounds have far less power proportionately than doctors who come predominantly from the highest social classes.

A consideration of some models of mental disorder and their socio-political determinants and implications pointed up the importance of sociological factors in the recognition of mental disorder and its designation as 'illness'. In the light of this, the 'medical' model of mental disorder was criticised for its almost exclusive emphasis on the individual which distracts attention from more fundamental social changes which could be made, but which would be incompatible with the interests of the ruling classes in our society. Turning to modes of treatment available in the hospital, it was suggested that these have social and political implications also. Ultimately, it was argued, all these modes are compatible with the social control function of the hospital in capitalist society. It was, however, noted that some forms

of therapy, usually the more intensive and expensive, provide more autonomy and potential for self-direction than others.

Some of the problems of the contemporary psychiatric hospital were then examined The importance of fundamentally social and political factors, such as shortage of staff and resources, in nurturing positive or negative aspects of the institution's functioning was made evident. Finally, consideration of the future of the psychiatric hospital showed the necessity of its continued existence in the present socio-economic order. While recognising the enormity of the problems facing the psychiatric hospital, it was also seen that this institution has some positive and desirable features as against the other forms of care and treatment available for the mentally disordered in British society.

By no means all of this analysis has thrown light directly on issues of injustice, inequality, power and impotence, the central concerns of the present work. However, these issues have emerged clearly at many points. For example, the poor treatment, inequality and impotence of the mentally ill, both inside and outside the hospital has emerged many times and in many different ways. Conversely the disproportionate amount of power, influence and status of doctors has been noted many times. The individual-centred models of care and treatment which forestall questions of wider social inequality and injustice have also been recognised. Another prominent issue, that of lack of resources, staff, funds and political will for the mental health sector has also been noted. It is apparent that if these matters are to be altered some form of socio-political action will be necessary.

This concludes the analysis of the socio-political

context of the psychiatric hospital. It was, it will be recalled, undertaken in accordance with the methodological principle derived from the theology of liberation which demands that such analysis should take place before the place of the church, its teaching and practice may properly be evaluated. The way is now clear for an examination of the practice, theory and theology of pastoral care in psychiatric hospitals. Some attempt can be made in the next part to assess how far those involved in pastoral care in the psychiatric hospital have recognised and responded to the sorts of issues and insights put forward in the analysis above.

PART FOUR

PASTORAL CARE IN THE PSYCHIATRIC HOSPITAL

INTRODUCTION

In the previous two parts the socio-political context of the psychiatric hospital was thoroughly explored. It was recognised that there are substantial issues of injustice and inequality of power and resources facing this institution and those who live and work in it. Consequently, it is concluded that socio-political action and awareness are necessary for those who seek to alleviate suffering and the evils facing the hospital. In accordance with the methodology outlined in Part One, it is now appropriate to try and discern how far psychiatric hospital chaplains have, in their practice, theory and theology of pastoral care, displayed socio-political awareness and concern. The first chapter below describes the roles of psychiatric hospital chaplains. The chapter which follows specifically enquires into the socio-political awareness demonstrated by chaplains. Following this it is possible to assess the role of psychiatric hospital chaplains from a Marxist perspective and to ask what political function these pastors perform. Lastly, the wider Christian tradition of pastoral care is examined to discern how far a socio-politically aware and committed pastoral care is compatible with that tradition. This prepares the way for the concluding chapter of the present work which outlines some proposals for a socio-politically aware and committed pastoral care in psychiatric hospitals.

CHAPTER XVI

THE ROLE OF THE CHAPLAIN IN THE PSYCHIATRIC HOSPITAL

Sources of information about the function of chaplains in British psychiatric hospitals are not numerous, reflecting the comparatively small number of clergy involved in this activity full time, but also the general lack of literature on the practice of pastoral care. Many of the available sources refer to chaplains in general, psychiatric and mental handicap hospitals, and so do not provide distinctive information about psychiatric hospital chaplains alone. For the purposes of this section, I have drawn on very diverse sources. These range from official D.H.S.S. memoranda, through survey material collected by, or about, chaplains (1), to various reports and handbooks on hospital chaplaincy (2). In addition I have utilised written material which has arisen out of the practice of chaplaincy, both general and psychiatric, and material which may have influenced the shape

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(1) See Roger Grainger, Watching for Wings (London : D.L.T., 1979), Michael Wilson, The Hospital - A Place for Truth (Birmingham : University of Birmingham Institute for the Study of Worship and Religious Architecture, 1971). (This work contains a vast amount of survey material about chaplains, but most of it is concerned with all hospital chaplains and not only with those specialising in psychiatric hospitals).

(2) See e.g. Hospital Chaplaincies Council, A Handbook of Hospital Chaplaincy (London : Church Information Office, 1978), King Edward's Hospital Fund for London, The Hospital Chaplain (London : King Edward's Hospital Fund for London, 1966), Church Information Office, The Hospital Chaplain - Report of the Working Party Appointed by the Joint Committee (London : Church Information Office, 1973).

of chaplaincy in this country (3). The interdisciplinary periodical Contact has produced two issues devoted specifically to hospital chaplaincy (4), and other issues have contained individual articles relevant to chaplaincy (5). Other journals occasionally publish relevant material (6). The quarterly magazine of the Church of England Hospital Chaplains' Fellowship, Hospital Chaplain, is an additional and more informal source of material.

Apart from written material, an important source of data has been a series of five informal conversations with individual full-time psychiatric hospital chaplains. On the recommendation of Canon Eric Reid, of the Hospital Chaplaincies Council in London, I was able to visit and talk with a selection of chaplains in different parts of England in the autumn of 1980, spending a day observing their work and recording a two-hour conversation with each one. While the scientific value of these interviews is negligible, they have been invaluable in trying to grasp the nature of contemporary psychiatric hospital chaplaincy. Similarly, my own experience over the last few years, as a Clinical Pastoral Education student in one psychiatric hospital and latterly

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(3) Here again the work of Wilson and particularly that of Grainger may be cited. Norman Autton, Pastoral Care in Hospitals (London : S.P.C.K., 1968) and Norman Autton Pastoral Care of the Mentally Ill, second edn., (London : S.P.C.K., 1969) are also relevant, as is the work of the Dutch pastoral psychologist Heije Faber, Pastoral Care in the Modern Hospital (London : S.C.M., 1971).

(4) Contact, 16, 1966, and Contact, 69, 1980.

(5) These articles will be cited where appropriate below.

(6) See Michael Law, Douglas Hill and Clive Harries, 'Exploring the Work of the Hospital Chaplain in a Psychiatric Hospital', Nursing Times, 74, 36, 1978, 1478-82.

as honorary assistant chaplain of another has been helpful and has given scope for 'participant observation' of an informal nature.

1. History, Numbers and Types of Chaplains Working in The National Health Service

Before going on to look more specifically at the roles of chaplains in psychiatric hospitals today, it is necessary to spend some time in giving an account of the history, numbers and types of chaplains working in the N.H.S.

Before 1948, when the N.H.S. was inaugurated, only mental hospitals had to have a chaplain employed and appointed, either whole-time or part-time, by the hospital managers. This provision was made under the Lunacy Act of 1890 and the chaplain appointed was to be a minister of the Church of England. In 1948 the Ministry of Health circular R.H.B. (48) 76 specified that all hospital managers and boards should "give special attention to provide for the spiritual needs of both patients and staff" (7), and each hospital was required to appoint chaplains of different denominations (Church of England, Roman Catholic and Free Church) to meet these spiritual needs. Most of these chaplains were to be part-time, but in hospitals where there were more than 750 beds of a particular denomination or where there had already been a full-time chaplain before 1948, full-time appointments were made or retained.

> The number of official chaplains increased because every hospital was required to appoint them rather than the spiritual ministry to patients being left

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(7) Quoted in Church Information Office, op.cit., p.4.

- as it was in some cases before 1948 - to the perhaps changing good will of the local church and hospital (8).

This report notes that

> the most important change effected in 1948 was that the chaplain was paid for his work, and was paid by money provided by Parliament. His position in the hospital was recognised and the importance of that position emphasised (9).

Today there are some 6,000 part-time chaplains and approximately 150 full-time chaplains working in N.H.S. hospitals in England and Wales and paid by public funds (10). Most of these chaplains, particularly the full-time chaplains, are Anglicans. Whether full-time or part-time, Anglican or other, chaplains are appointed and paid by District Health Authorities to whom they are responsible (11). There are some 50 full-time psychiatric hospital chaplains, again mostly Anglican, though there are one or two full-time Free Church chaplains (12).

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(8) Church Information Office, op.cit., p.5.

(9) Ibid., p.5.

(10) Figures for 1977 from Hospital Chaplaincies Council, A Handbook on Hospital Chaplaincy (London : C.I.O., 1978) p.7.

(11) It should be noted that as ministers of various denominations chaplains are also responsible to their own denominational authorities.

(12) See Hospital Chaplaincies Council, Directory of Whole time Hospital Chaplains, Hospital Church Sisters and Chaplain's Assistants (London : Hospital Chaplaincies Council, 1980). It is difficult to be exact about these figures as some hospital chaplains cover more than one hospital and it is impossible to estimate whether they spend more time in work with the mentally ill than with, say, the mentally handicapped. In addition I have not included posts which were empty at the time the Directory was published.

It has to be recognised that there may be very real differences in outlook and practice between full-time and part-time chaplains. These are important in this context as, inevitably, most of the information which I am using here comes from the context of full-time chaplaincy. In general, part-time chaplains spend far less time in hospital than their full-time counterparts and therefore have a more proscribed role. Much of their time may be spent in performing 'essential' duties (13). It would, however, be a mistake to imagine that part-time chaplains can have no distinctive role in the psychiatric hospital and that they have produced no material about this role. Messenger, writing from the part-time perspective, shows how much can be done by part-time chaplains in leading worship, co-operating with therapy and in the 'therapeutic team' and in rehabilitation and community liaison work (14).

2. The Roles of Chaplains in the Psychiatric Hospital

I propose to deal with the various roles of chaplains in three different parts. Firstly, I shall examine the minimum role description for chaplains as set out by the Department of Health and Social Security (D.H.S.S.) and in A Handbook on Hospital Chaplaincy issued by the Hospital Chaplaincies Council. This will give some idea of the essential role of the hospital chaplain as it is seen by those who have oversight

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(13) See the description of these provided in Hospital Chaplaincies Council, A Handbook of Hospital Chaplaincy pp.9-10. See also Autton, Pastoral Care in Hospital, p.3f. and Wilson, op.cit., pp.57-73 for further discussion of the differences between full- and part-time roles.

(14) Ronald Messenger, 'The Church in the Hospital' in Elizabeth Schoenberg, ed , A Hospital Looks at Itself (London : Cassirer, 1972), pp.227-32.

of hospital chaplaincy in the N.H.S. and in the church. Secondly, I shall examine the descriptions of 'ideal types' of the chaplain's role put forward by writers about the subject to try and elicit how chaplains and others conceive their roles on a theoretical level. Finally, I shall attempt to give some account of the practical ways in which chaplains spend their time. The section will continue with a discussion about the way in which chaplains spend their time. It will conclude with a discussion about the way in which chaplains relate to the other groups within the hospital, especially with the 'therapeutic team'.

Surprisingly little material is available showing the expectations of the chaplains' role from the perspective of central government or church authorities. Ministry of Health circular R.H.B. (48) 76 seems to form the basis for D.H.S.S. thinking about the role of chaplaincy and it has already been mentioned that this seems to centre on providing for the spiritual needs of patients and staff. This role of meeting the spiritual needs of patients and staff is filled out to a greater extent in A Handbook on Hospital Chaplaincy published by the Hospital Chaplaincies Council with the sanction of the D.H.S.S. This lists the minimum duties and responsibilities of chaplains as follows:

1) To make provision for the spiritual needs of patients, staff and where applicable students within the hospital ... .

2) To conduct services of worship regularly... .

3) To visit patients and staff in wards and departments regularly... .

4) To meet and welcome new members of staff as soon as possible ... .

5) To co-operate with medical, nursing and administrative staff wherever possible in departmental meetings as and when his attendance is considered necessary. Many

hospitals now have multi- or inter-disciplinary meetings, professional executive and/or heads of department meetings. Chaplains should readily accept invitations to attend when invited to do so.

6) To be available wherever possible to relatives of patients ... .

7) To be available to parish priests and ministers ... .

8) To make public ... information about times of ... services and other such facilities ... .

9) To keep records of all services and ... to write reports for the Area Health Authority.

10) To ensure that chapels, places of worship and mortuary waiting and viewing rooms are suitably furnished ... (15).

Since these duties are enjoined upon all chaplains, whether they be full- or part-time and whatever kind of hospital they are serving in, it is perhaps necessary that they should be very general. However, they fail to provide a rationale for chaplaincy and lay down only a minimum role. For the full-time chaplain, especially in the psychiatric hospital with a relatively slow turn-over of patients and a lack of 'crisis' ministry in general, the role described would take up only a very small amount of time and energy. It is for this reason that I turn to the role models which chaplains have devised and used to provide a rationale in their work and to an account of the ways in which they spend their time.

Perhaps the most obvious, though not necessarily the most popular, ideal role of the chaplain is that of the priest. This role model has been most fully expounded by Autton who explores the nature of professional priesthood in the hospital and with the mentally ill in his books Pastoral Care in Hospitals and Pastoral Care of the Mentally Ill. The priest

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(15) Hospital Chaplaincies Council, A Handbook on Hospital Chaplaincy, pp.9-10.

is seen as one who has his own spiritual expertise and techniques which he uses to mediate between God and man and to make God's presence overt in the hospital. An important aspect of his role is his leading of worship and the administration of sacraments such as confession, holy unction and laying on of hands. As well as seeing himself as the representative of God in the hospital, he sees himself as the representative of the church, the Body of Christ. Some quotations from Autton will elicit more clearly the distinctively priestly role of the chaplain:

> He comes ... with no stethoscope or scalpel, but with instruments equally sensitive; with no drugs or doses but with remedies equally effective. He is chaplain rather than clinician and he works not to compete but to complement, not to supplant but to support. He it is who will be continually pointing away from the ordinary everyday activities to the extraordinary source from whom they originate, linking human needs to divine resources, placing the natural in the context of the supernatural, and explaining the temporal in terms of the eternal (16).

> The Church as the Body of Christ is at work in and through the chaplain, for he is in the hospital not as an individual but as a representative of that Christian community, and is always acting on behalf of the congregation (17).

With reference to psychiatry in particular the following quotations are apposite:

> The religious and sacramental approach ... must never be looked upon as just another branch of therapy. The priest is not just another therapist for it is not his sphere to treat those who are sick. His ministry often does have therapeutic effects, but these are quite secondary, although none the less important and necessary, to his prime ministry as a priest ... First and foremost

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(16) Autton, Pastoral Care in Hospitals, p.2.

(17) Ibid., p.15.

he is leading (his people) to God, and only secondarily to mental health. His sphere is spiritual care, or the 'cura animarum' ... . As well as his own 'instruments', the priest also has his traditional language, and this should not be put apart for psychiatric jargon or medical terminology (18).

There is no antidote to anxiety, depression, and fear which can compare with the reception of the body and blood of Christ in the Sacrament of the Altar. At the moment of the breaking of the Host, the mentally sick ... can offer up his broken mind in unison with Christ's broken body, and pray for the peace which passes all understanding (19).

He (the chaplain) will respect the members of the medical staff with whom he works, and give full co-operation to all of the efforts made by the various departments towards the rehabilitation of the patient, while at the same time cherishing his own sacramental ministry as a priest of God. The more he tries to imitate these other disciplines the less of a priest he will become (20).

Naturally the priest will be interested in the recovery of the patient and do all he possibly can to further such progress, but he must not lose his priestcraft in the midst of a psychiatric atmosphere. This perhaps applies even more so to priests who serve as full-time mental hospital chaplains. His whole approach should be easy and natural, leading the individual back to the sacraments, where he may have lapsed and to prayer which he may have neglected (21).

These quotations show clearly the centrality of a priestly role for Autton. He is not alone in this emphasis.

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(18) Autton, Pastoral Care of the Mentally Ill, p.142-3.

(19) Ibid., p.145. Emphasis original. This particular passage is significant for the priestly role of the chaplain as he alone is able to celebrate the eucharist.

(20) Ibid., p.155.

(21) Ibid., pp.81-2.

The report on the hospital chaplain published by King Edward's Fund, for example, talks of the chaplain as the one who dispenses word and sacrament and is a guide to forgiveness and reconciliation: "He it is who points away from the material to the spiritual, from the temporal to the eternal" (22). It is also true to say that many chaplains would want to describe at least part of their role in priestly, spiritual and mediatory terms, even though their expression of this may be less forthright or coherent than Autton's. One chaplain I interviewed for example talked of offering up the work of the hospital to God, while another saw praying for the hospital as important. Worship too was seen as an important part of the roles of most chaplains. Grainger, for example, sees the role of facilitating worship as being of enormous importance for some groups in the psychiatric hospital (23).

The role of pastor is an important 'ideal type' in chaplaincy. In general, it is expected that chaplains will exercise a considerable pastoral ministry of care and counselling with individuals in the course of their ministry in hospital. The Hospital Chaplaincies Council working party report states that the chaplain "should exercise the pastoral care which a Christian minister has for members of his church, and in a wider sense ... the counselling and ministry given, if sought, to all who ask" (24). The chaplain is required to "provide care and support to those patients who are of his

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(22) King Edward's Hospital Fund, The Hospital Chaplain, para.3.

(23) See especially Ch. 5 of Grainger, op.cit..

(24) Church Information Office, The Hospital Chaplain, p.17.

faith, to sustain and to strengthen them in their crises on the foundation of a shared Christian conviction"(25). A similar perspective is given by Autton who writes that the chaplain "will come to the patient as pastor to tend his spiritual growth" (26). Elsewhere, Autton devotes a whole chapter to the priest as pastoral counsellor (27). Faber too focuses on the pastoral nature of hospital ministry and discusses the pastoral problems of faith and illness, suffering and death (28). The minister in the hospital, according to Faber, uses the tool of the pastoral conversation to relate to patients. This kind of conversation is informed by the insights of psychology and theology. Faber, more vividly than any other writer, presents an image of the chaplain as a shepherd "who in the burden and heat of the day walks with them (the patients) for a while, above all one who as shepherd walks 'with' them and discloses the presence of that great Shepherd, the Christ..." (29).

Although overt references to the ideal pastoral role of the chaplain in hospital are not as common as might be expected, there can be little doubt that many chaplains see their activities as falling to a large extent within this role type. This is a point to which I shall return when I discuss the nature of pastoral care later on in this work.

Priesthood and pastorate are roles which have long been

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(25) Op.cit.,p.17.

(26) Autton, Pastoral Care in Hospital, p.31.

(27) Autton, Pastoral Care of the Mentally Ill, Ch. 2.

(28) See Faber, op.cit.,

(29) Faber, op.cit., p.78.

associated with Christian ministry. Prophecy is a further element which has long been regarded as a part of ministry and the ideal role type of the prophet is to be found amongst the others which refer to the ministry of hospital chaplains. Classically, a prophet is one who forthtells the action of God to a community in the present events of history. It is the prophet who uncovers God's action and purpose in order to evoke a response of faith and obedience from his audience. It should also be added that the notion of prophecy has within it the elements of judgement and going against the established socio-economic order if that order is found to be at variance with the will of God (30).

Autton speaks of the prophetic role of the chaplain thus,

> The chaplain comes to his people with the grace and authority of God, and so exercises the ministry of a prophet ... (H)e testifies to the fact of God's ever-ruling power and love in a community which is concerned with various forms of suffering and pain. He will see himself as someone who has been called to fulfill a very special task in the whole work of healing, not only for individuals but for the spiritual life of the community which is the hospital (31).

Wilson also proposes a prophetic role of a kind for the chaplain in advocating a Socratic or questioning function for him within the hospital. He suggests that "the Socratic role is one which a hospital chaplain could undertake; although at present chaplains are not trained for such a role, and

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(30) In a recent work Gill states, "There is now widespread agreement that Christian prophecy is primarily concerned with the specific moral, social and political implications of the Gospel, just as Old Testament prophecy was specific proclamation and action, addressed to specific societies."(Robin Gill, Prophecy and Praxis (London : Marshall, Morgan and Scott, 1981), p.13.)

(31) Autton, Pastoral Care in Hospitals, p.32.

tend to accept hospital ways of thought uncritically"(32). Similarly, there are elements of the prophetic role in the notion of the minister as clown or jester, developed by Grainger and Faber in their work. Since I shall be dealing at greater length with that type separately later, no more will be said about it here.

In most of my interviews with chaplains there was an important element of the prophet as a role type. Some simply said that they felt it was important to question the assumptions of the hospital and its ways of treating patients, "creative rocking of the boat", while others were happy to actually label this activity 'prophecy' or a prophetic role.

Turning from the traditional role types associated with ministry and their interpretation within the context of hospital chaplaincy, I shall now consider some of the newer ideal types advanced by Faber, Grainger and Wilson The work of Grainger is of particular importance in this context as the author is chaplain of a large old psychiatric hospital in West Yorkshire and is therefore writing in the context of the mainstream of British psychiatric hospital chaplaincy.

Faber has developed the ideal role type of the chaplain as clown within the hospital. This analogy seems appropriate to Faber because, like the clown, the minister in the hospital has to live with several tensions. These are the tension between being a member of a team and being isolated, the tension created by appearing to be and feeling like an amateur amongst professionals, and the tension between needing to study and be trained while at the same time needing to be creative and original (33).

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(32) Wilson, op.cit , p.96.

(33) Faber, op.cit., p.81ff.

Grainger approaches the role of the chaplain from the point of view of functionalist sociology rather than from Faber's essentially psychological viewpoint. In asking what the function of the chaplain is in the social institutions used for caring for the mentally ill, he produces an ideal type of the chaplain as a licensed anarchist, or jester:

> The chaplain is well-equipped for the role simply because he is in the hospital, but not of it. As a clergyman he is accustomed to represent alternatives to social norms. This is, and always has been his prophetic role in society. And when the normative force of society approaches totalitarian pitch, his critical presence is most necessary. So the chaplain is at hand to play the part in the hospital that the clergy should be prepared to play in wider society (34).

> The chaplain's lack of medical expertise gives him a con ensus philosophy of living and dying ....(I)n the highly organised, highly competent world of the hospital, the chaplain is a kind of comforting joke ....The absurdity of his professional presence here - his absurdity - isolates him, in the view of the patient arriving in hospital, from the rest of the establishment, and presents him as someone who can be used as a way of coming to terms with this terrifying 'official' reality, an invaluable go-between in his dealings with authority (35).

The chaplain provides a "focus for a measure of individual non-conformity" and works

> towards the establishment of personal identity, and proclaims the moral significance of awkwardness.

> Thus chaplain-as-jester manages, indirectly, to appear as chaplain-as-prophet. He creeps under the institutional guard, giving support to the individual staff member, challenging the individual patient, standing by at times of personal reappraisal and

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(34) Grainger, op.cit., p.7.

(35) Ibid., pp.6-7. Emphasis original.

> moments of self-discovery, encouraging that enterprise by which the psychoformative process, the process of individualisation, takes place, introducing the notion of distance into the monochrome landscape of institutional expectations and attitudes (36).

The chaplain is a clown with authority given to him by his membership of the staff of the hospital. As such he is an ally of the dominant social ethos but not a subscriber to it (37). He functions to ensure social stability while changing the face and form of the institution by creating space for himself, other people and the Spirit (38).

Grainger describes two more important roles or role elements of chaplains which should be mentioned here. The first is that of reconciler, "his ministry is above all a work of reconciliation" (39). The second is that of advocate and interpreter of the institution to the patient, apologist for the hospital: "From the point of view of the hospital, the chaplain justifies his place within the institution as its advocate and interpreter, explaining the ways of authority to the patient" (40).

Unlike the authors mentioned above, Wilson provides an ontological definition of the role of the hospital chaplain, i.e. he attempts to define what the chaplain <u>is</u> before defining what he does. Wilson argues that "the chaplain's role must first be described in ontological terms, then

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(36) All quotations from ibid., pp.8-9.

(37) Cf. ibid., p.121.

(38) Cf. ibid., pp.123-4.

(39) Ibid., p.41.

(40) Ibid., p.57.

functional terms" (41). The ontological nature of the chaplain is that he is trying to be fully human, "Above all he is a man" (42). This ontological definition and its consequences in terms of function may be expanded with further quotations:

> A chaplain, like all other men, has a vocation by birth to be human, and to be human means a consistent attempt to be yourself and no other person. A chaplain shares in the complexity of human life, being perhaps, both priest and man, husband, father or brother, vicar and taxpayer, citizen, artist or scholar, preacher and listener, individual and member of many groups, in and out of hospital. But always himself (43).

"The man who makes a consistent attempt to be himself in these different roles, to be truthful in his role relationships, will make truth possible for others" (44) The chaplain's skill lies not in his functional performance, but "in his knowledge and communication of what it means to be fully human that is to love God and his neighbour as himself in thought, word and deed" (45). It is important to add that Wilson does not eschew the activities of the chaplain, though he does see them as secondary expressions of being: "Of course a man cannot just <u>be</u>. He thinks, speaks and acts - this is how he expresses his being (46).

Having surveyed some of the main "ideal types" of roles for the hospital chaplain, I shall now move on to give an account of the way in which chaplains spend their

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(41) Wilson, op.cit., p.102.

(42) Ibid., p.105.

(43) Ibid., p.54-5.

(44) Ibid., p.55.

(45) Ibid., p.102.

(46) Ibid., p.102.

time in practical terms. This should supplement and ground the ideal in the practical (47).

Precise information as to the activities of psychiatric hospital chaplains is difficult to come by. Most chaplains themselves find it difficult to give an accurate account of their activities. There is only one detailed and properly constructed published survey of the work of a chaplain, that of Michael Law, chaplain of Fulbourn and Ida Darwin Hospitals in Cambridge (48). In that work, examples of two weekly schedules in the work of a chaplain are given. These are reproduced here:

The Chaplain's Weekly Schedule Before The Study Began

Day	Activities
Sunday	Sunday services in admission wards and the hospital chapel.
Monday	Attends an admission ward's community and staff meeting; holds a Christian discussion group for staff; attends an art therapy session in an admission ward and the monthly entertainments committee meeting.
Tuesday	He does three music sessions and attends a staff sensitivity group.
Wednesday	He celebrates Holy Communion in the chapel; attends a music session, a staff sensitivity group and makes a contribution to the Cambridge Theological Course.
Thursday	Today he is at the mental handicap hospital. He works with the occupational therapists narrating Bible stories and does a music session. He

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(47) For more on the roles of chaplains as described in the work of Autton, Faber and Wilson see my survey in Stephen Pattison, op.cit.

(48) Michael Law, Douglas Hill and Clive Harries, op.cit.

	attends a monthly relatives' group in an admission ward at Fulbourn.
Friday	He attends a small group in the social therapy area, attends an outside discussion group for clergy and holds a fortnightly communion in the geriatric area.
Saturday	Day Off. (49).

The Chaplain's Revised Schedule After the Study

Day	Activities
Sunday	Sunday services in the hospital chapel.
Monday	Attends an admission ward community and staff meetings; holds a Christian discussion group (fortnightly); chairs a meeting of the entertain-entertainments committee (monthly) and a session at outpatients for marital therapy (fortnightly).
Tuesday	Attends an admission ward community and staff meeting; undertakes a music session in an admission ward; attends the day centre (monthly), and attends a medical ethics discussion group (fortnightly).
Wednesday	He holds two Holy Communion Services in the chapel and an admission ward; undertakes a music session in an admission ward; attends the day centre (monthly), and attends a medical ethics discussion group.
Thursday	He spends at the mental handicap hospital working with O.T's; in the school and the behavioural training unit narrating Bible stories and music; attends a professional committee of Fulbourn Hospital (monthly) and a weekly session on group therapy held in the centre.
Friday	Attends small groups for patients in a rehabilitation ward; holds communion for psycho-geriatric patients (fortnightly) and attends a monthly study group for clergy in a neighbouring parish, and weekly family therapy workshop.
Saturday	This is his day off. (50).

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(49) Op.cit., Figure 2, p.1479.

(50) Op.cit., Figure 3, p.1482.

Law et al. give a comprehensive account of the work of one chaplain in a particular situation which shows the variety of activities in which chaplains can become involved in the lives of their hospitals. It must be recognised, however, that individual situations and styles vary enormously according to such factors as the nature and organisation of the hospital and the gifts and beliefs of the chaplain concerned. Beyond a core of liturgical duties which tends to take up a fair amount of the time of all chaplains, practice is very diverse. I will now list some of the activities in which chaplains said they were involved when I interviewed them in autumn 1980.

Many chaplains involve themselves in therapeutic activities in the hospital. Such involvement ranges from direct counselling or psychotherapy for patients or staff, to family therapy, staff group supervision, involvement in therapeutic community work or simply attending ward meetings. In this connection, it is common to find chaplains undertaking courses of one sort or another to improve their therapeutic skills (51).

Many chaplains are also engaged in some kind of teaching or training, both within the hospital (e.g. taking part in teaching nurses) and outside it (e.g. running courses for clergy and theological students which will help them to improve their understanding and practical skills).

Community liaison work in connection with rehabilitating the patients from the hospital also seems an important part

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(51) One chaplain I interviewed was undertaking training in both family therapy and psychotherapy while two others were also being trained in family therapy.

of the activity of most chaplains (52).

It is common for chaplains to be members of the hospital Heads of Department Meeting or its equivalent. Such a body may meet once a month. Apart from membership of this group, most chaplains seem to be involved in remarkably few hospital committees or policy-making groups.

Very few full-time chaplains would appear to have a policy of leaving their time unstructured or simply wandering round the hospital waiting to see what will happen or just talking generally to patients and staff. Contact comes mainly through purposeful activity, e.g. attendance at a unit community meeting, or through various types of referral.

Administration and planning takes up a certain amount of time for all chaplains. It can be very heavy for those who are involved in a great deal of organisation and planning e.g. of courses or conferences, local or national.

Over and above the foregoing generalisations, it is impossible to make broad statements. Individual chaplains I have encountered have been severally involved in editing hospital newspapers, relaxation sessions for patients, drama groups, discussion groups, the hospital League of Friends, District Joint Staff Committees, befriending patients, hospital radio and numerous other activities.

There is, however, one further common denominator in the activities of most chaplains. Almost all express the

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(52) For more on the liaison work between hospital and wider community by chaplains see Murray Leishman and Bruce Ritson, 'Working Together in Mental Health', Contact, 50, 1975, 18-24. See also Grainger, Watching for Wings, p.126ff.

importance of being available and not having to do anything if they do not wish to. Most see this as the most important asset they possess in the heavily demarcated life of the hospital (53). Availability allows the chaplain to respond to the needs as and when they arise, whether among individuals or groups. This represents one of the very significant differences between the chaplain and other members of the hospital staff who have, by and large, very clear directions as to their specific role and function. This point leads me to a short discussion of the relationship between chaplains and the other members of the staff, the 'therapeutic team'.

Some of the works on hospital chaplaincy in general cited above envisage a very high degree of co-operation between chaplains and the therapeutic staff of the hospital. Faber, for example, writes:

> The minister is ... not an isolated person, who can be left to go his own way, but a man who in the midst of all the many ways in which the sick are cared for has his own way of caring, one which fits in with all the others, a man who is in a real sense a colleague, a fellow-worker, primarily with doctor and nurse, but also with others such as the medical social worker (54).

Again he writes,

> The minister has his own task, with which the medical staff have little to do, but he is exercising this task in the domain of the doctor and stands within the hierarchy of which the latter is the head (55).

Later he states that he believes that the minister

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(53) It should be noted that this feature of freedom and availability is apparently in conflict with the desire of chaplains to engage in organised purposeful activity mentioned above. This paradox remains permanently unresolved in the lives of many chaplains.

(54) Faber, op.cit., pp.69-70.

(55) Ibid., p.71.

> will always find his place in the team, so long as he lets this place be determined by the needs of the patient, by his controbution to the patient's well-being and always seeks to establish ... where his care for the sick fits in best with the care of others (56).

The kind of thinking expressed in these quotations has been echoed by psychiatric hospital chaplains in interviews to some extent. One chaplain went as far as saying that if he did not co-operate closely with the staff teams of the various units in which he was involved he would be unable to function, there would be no job for him to perform. Here again, it must be recognised that individuals and hospitals differ so this is not necessarily a universal experience. It is, however, probably true to say that most chaplains do work closely with at least some therapeutic teams in their hospitals. It is also true to say that chaplains spend a considerable amount of their time meeting with staff, and providing support and counselling for them. One chaplain told me that his work was moving more and more in that direction and that he spent at least as much time with staff as he did with patients. This was echoed in the experience of others.

Having recognised the importance for chaplains of working with other staff members in the psychiatric hospital, it must also be seen that they see it as enormously important not to be identified with any one group of staff in the hospital. All the chaplains I interviewed emphasised how vital it was to them not to become a part of any one group over against others and regarded their independence as essential in the

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(56) Close co-operation between chaplains and the 'therapeutic team' has reached an even greater integration in the U.S.A. See e.g. Leonard R. Stein and John R Thomas, 'The Chaplain as a Member of the Psychiatric Team', Hospital and Community Psychiatry, 18, 1967, 197-200.

proper performance of their role. Not fitting into any part of the hierarchy was regarded as an asset and being available to all equally was seen as a cardinal virtue. Wilson has captured this attitude thus,

> The chaplain has access to every corner of the hospital: he is able to meet people at all levels and in all departments, whether student nurse or matron, professional or ward cleaner ....The chaplain is universal: he belongs to all men. In this regard he is like a naval chaplain, without rank (57).

Chaplains I interviewed saw their ability to minister to staff and also to question the institution as closely related to this kind of universality and independence. Chaplains are fond of speaking of themselves as "in the hospital, but not of it"(58).

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(57) Wilson, op.cit., p.53.

(58) Grainger, op.cit., p.7.

CHAPTER XVII

SOCIO-POLITICAL AWARENESS AMONGST PSYCHIATRIC HOSPITAL CHAPLAINS

In the section devoted to the socio-political analysis of the psychiatric hospital above it was argued that the situation of the mentally disordered and of mental hospitals must be seen in the context of the whole socio-political order. Furthermore, it was suggested that mental illness can be seen as a sociological phenomenon, that social class has a considerable effect on the incidence of mental disorder and its treatment, that mental hospitals form part of the mechanism of social control in capitalist society, that within the hospital there are conflicts and inequalities of power between groups which broadly reflect conflicts and class differences in society as a whole so that those with least power tend to come from the lowest social classes, and that those who are economically least powerful in society as a whole, i.e. the elderly, have least power and facilities in the hospital also.

It is now necessary to ask how far psychiatric hospital chaplains have shown any awareness of these factors and how far they have endeavoured to use such insights to inform their practice. In the first instance I shall turn to the theoretical understandings which chaplains have reached, or which may have influenced them, to elicit to what extent they portray any kind of socio-political awareness.

In general terms, there is little evidence that chaplains and those writing about chaplaincy are aware of the social and political context of the hospital or of the mentally ill. While chaplains can usually explain their

relationship to the N.H.S. and some of the works about chaplaincy contain diagrams and material about the organisational structure of the N.H.S. (1), none contain any critique of the N.H.S. such as that outlined above. Writings on chaplaincy are similarly tacit about the conflictual nature of the social structure of the hospital, the sociological aspects of mental disorder and the influence of wider social structures and organisation on hospitals for the most part, but there are a few exceptions to this generalisation. For example, in the 1960's articles were published in Contact about the myth of mental illness and social factors in mental illness. These may have been read by, and have influenced, chaplains to some extent (2).

Ainsworth-Smith and Perryman also give some emphasis to the importance and value of the social and political dimension for hospital chaplaincy in their article on the subject in A Dictionary of Medical Ethics. They write,

> The Judaeo-Christian tradition has been much concerned with the tension between the needs of the individual and of the society of which he is part. As a representative of this tradition the chaplain's professional skill and theological expertise may provide him with a different dimension to offer his colleagues w hen clinical or planning decisions are made (3).

It must be said, however, that Ainsworth-Smith and Perryman do not develop this theme at any length.

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(1) See e.g. Appendix, 'The National Health Service and the Chaplain' in Autton, Pastoral Care in Hospitals, p.130.

(2) See Anthony Bashford, 'The Myth of Mental Illness' Contact, 7, 1963, 22-5, And Denis Martin, 'Social Factors in Mental Illness', Contact, 13, 1965, 17-24.

(3) Ian Ainsworth-Smith and John Perryman, 'Hospital Chaplains' in A.S. Duncan, G.R. Dunstan and R.B. Welbourn, eds., A Dictionary of Medical Ethics, Rev. Edn., (London : D.L.T., 1981).

The work of Wilson displays a considerable awareness of the socio-political content and context of hospitals in particular and of health in general. Like his colleague Lambourne, Wilson spent a period of his life as a doctor working abroad and this has made him suspicious of individualistic models of health care and treatment. His later work, Health is for People (4) is an extended exploration of some of the dubious assumptions implicit in modern Western curative medicine. In it he points out that the hospital acts as "a mirror of social beliefs about man in society"(5). The power of staff over patients is questioned (6), the treatment of individuals in isolation from their families and society is criticised (7), and the way in which doctors practice medicine in isolation from socio-political concern is attacked (8). It is asserted that health is an interpersonal matter, not an individual one (9), and that it is a thing which can only exist when it is shared by both rich and poor alike. In this connection, justice and charity are one (10).

Health is for People was written for a wider audience than hospital chaplains. Nonetheless, many chaplains have read this book and have been influenced by it. Wilson's earlier book, The Hospital - A Place of Truth, which is a more specific study of hospital chaplaincy also emphasises

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(4) Michael Wilson, Health is for People (London : D.L.T., 1975).

(5) Wilson, op.cit., p.8ff.

(6) Ibid., p.12ff.

(7) Ibid., p.14ff.

(8) Ibid., p.24.

(9) Ibid., p.44.

(10) Ibid., p.62.

the corporate, social dimension of existence. It is suggested, for example, that "the primary task of the hospital is to enable patients, their families and staff, to learn from the experience of illness and death how to build a healthy society" (11). Wilson is critical of technologically-based modern medicine which leads to the neglect of those members of society who are not susceptible to its methods:

> Psychiatric, geriatric and mental subnormality hospitals exist to confound the assumption of the magic of technology. The isolation of stubborn illness into special institutions, less generously financed and dependent upon overseas nurses and doctors, tells us where the concerns of society really lie (12).

The corporate nature of health in society is affirmed:

> While the present tendency is to concentrate upon individual formation or growth towards maturity, it is necessary to emphasise that the Christian gospel is about life in community: this is not to deny the importance of the individual. It is to deny the possibility of becoming mature as a separate individual: and it is to affirm that true humanity and health are corporate states of being, not static qualities which a man can possess on his own (13).

Wilson devotes a whole chapter to chaplaincy to the hospital as an institution (14). He asserts the necessity of the chaplain seeing the hospital as an institution and ministering to that institution and not just to the individuals comprising it:

> The pattern of hospital chaplaincy work is directed at present for the most part to the service of the

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(11) Wilson, The Hospital - A Place of Truth, p.6. Emphasis added.

(12) Wilson, op.cit., p.21.

(13) Ibid., p.42. Emphasis original.

(14) See ibid., Ch. 4.

> individual patient in need ... .The individualism of hospital medicine and the clinical approach to illness create a milieu into which such a ministry fits comfortably ... .This means that hospital work may proceed faithfully and effectively (by present criteria) without influencing the institution. The essential power structures are untouched by the chaplain. Indeed he may feel impotent in the hospital ... and not see how the structure itself denies what he wants to say (15).

Turning to the biblical tradition to point up this concern, Wilson writes, "When we remember that the New Testament idea of love contains the Old Testament idea of righteousness, our concern for the hospital as an institution becomes a more natural part of our love for patients and staff" (16). He points out furthermore that while the chaplain in the hospital may not be able to have very much impact on the institution in which he ministers, as a member of staff he should realise that "he is involved in the institution and his role is creative or destructive for the life of the institution as a whole" (17).

It may be concluded from the copious citation of quotations embodying socio-political concern and awareness in the work of Wilson that the general contention that the literature emanating from, and influencing, chaplaincy in hospitals reveals little socio-political awareness is confuted. This is not the case. In the first place, the extraction of evidence of a particular thread running through Wilson's work distorts the balance of that writer's thought. It is true that Wilson is concerned about the corporate socio-political dimension of life, health and ministry. It is only

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(15) Ibid., p.107.

(16) Ibid., p.108.

(17) Ibid., p.110.

one element in his thought however. By contrast with his concern with social context, Wilson's ontological, individualistic model of chaplaincy described above may be cited as an example. Health is for People reveals a concern for many issues, e.g. birth and death, which are only tangentially related to socio-political context in Wilson's thinking.

Secondly, and more importantly, while Wilson raises the importance of the socio-political context of health and the hospital, he does little to analyse it in any systematic way. An example of Wilson's failure to become involved in thorough-going sociological or political analysis is to be found in his treatment of individualistic curative models of health care found in Western society today. In this instance it needs to be clearly understood why a society like ours chooses this model as its paradigm. A Marxist analysis here would reveal that individualistic health care mirrors and is compatible with the whole of the socio-economic order. This would suggest wider social changes than simply taking a different attitude to health by itself. For some reason Wilson refuses to take this step, although the logic of his position that health and hospitals reflect wider social values should compel him to do so. Thus Wilson's critique of socio-political structures and implications is left at a level of generality which makes it rather less useful than it might be. In the case of his attitude to hospital chaplaincy there is therefore a failure to undertake a thorough analysis of the health service, the welfare state and the philosophy and material factors affecting it, illness, professions, the relations within groups, the distribution of power and the influence of social class. The consequence is that there are no guidelines or prescriptions for a pastoral care which would be socio-politically informed and which would be committed to

the needs of the most oppressed. Ultimately, Wilson accepts a consensual view of the hospital and of society rather than a conflictual one. In this connection it is consistent that he should advocate a model of the chaplain as "universal man" rather than as one who takes sides (18).

Concluding this survey of Wilson's socio-political awareness, it is possible to say that he does display some awareness of this dimension. He fails to undertake specific sociological and political analysis however which makes his work more vague and superficial than it might be. Writing of Lambourne, Wilson suggests that he was a man who enjoyed the richness of diversity and was committed to the notion of conceptual repentance and balance (19). It would be possible to characterise Wilson himself in the same way. His work embodies both the strengths and the weaknesses of seeking equilibrium. The strengths of this position include broad-mindedness, diversity and opposition to extremism in thought or action. The obverse of these strengths includes superficiality, an inability to pursue any one idea or method so that it yields its full harvest, and failure to be committed, either in theory or practice.

Grainger's work is also pertinent here (20). His book, Watching for Wings, is the most recent and the most comprehensive

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(18) See Wilson, The Hospital - A Place of Truth, p.53.

(19) See Michael Wilson, 'Repent : Change Your Point of View' in Contact, 67, 1980, 2-10.

(20) I shall refer chiefly to Grainger, Watching for Wings here, but see also Roger Grainger, 'Sick = Bad', Contact, 46, 1974, 22-8, Roger Grainger, 'The Chaplain : Adept or Exorcist?', Contact, 69, 1980, 2-5.

statement of the situation of the chaplain in the psychiatric hospital and is written out of the author's own experience of being chaplain to a large old English psychiatric hospital. In addition, Grainger claims to be interested in studying the hospital from a sociological perspective in order to gain a perspective on contemporary British society as a whole:

> The hospital is to be seen both as an enclave of its own, and as a part of wider society; as a 'special' place with its own rules of personal meaning which are the reflection of a particular kind of social organisation, and as one in the network of institutions of every type which constitutes the outward form of society in twentieth-century Britain and which refers to (and also shapes) the attitude of mind of society as a whole (21).

Grainger is concerned that the book should be of interest to sociologists (22) in that the hospital can provide a microcosm of the world outside. In describing the theme of the work he writes, "We shall be concerned what it is that life in a mental hospital has to contribute to our understanding of life in the world" (23). Again he states,

> I am writing here as much about the wider society, the world existing outside the hospital gates, as about the narrow institutional society; my concern is with human relationships in particular and the organisation of societies in general as much as it is with pathology, whether social or individual (24).

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(21) Grainger, op.cit., p.xi.

(22) Cf. ibid., p.ix.

(23) Ibid., p.x. It should be observed that in these statements concerning his purpose and method Grainger sets out a programme which proceeds in the opposite direction methodologically from my own. While he hopes to gain an understanding of society from examining the microcosm of the hospital, I try to understand the hospital by looking first at wider society and its social and political structures.

(24) Ibid., p.x.

It is true to say that there is a substantial sociological content to Grainger's work. At one point he draws heavily on Goffman to discuss the position of the patient in the hospital (25), and throughout Grainger demonstrates an awareness of the hospital as an institution with various ambiguous attributes. He talks, for example, of the repressive potential of the hospital:

> The institutional structure of the hospital has preserved its own traditions. The machinery of repression still exists. And it is used. After all, it is much easier to use force than persuasion, if force is always readily available (26).

But having said this, it must be recognised that Grainger seems to espouse a species of functionalist sociological analysis which concentrates on the relations between various elements in the social structure of the hospital, while failing to ask vital questions about inequality, the differential distribution of power, issues of social control and the way in which the h ospital mirrors and serves the capitalist socio-economic order in which it exists. The consequence of such analysis can be seen in the role which Grainger ascribes to the chaplain. Essentially the chaplain is an individual deviant who serves the function of strengthening the established order by his basically harmless deviant acts (27). Grainger himself admits that the sort of licensed anarchy in which the chaplain is involved in ultimately affirms the social fabric of the hospital (28),

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(25) See ibid., pp.61ff.

(26) Ibid., p.63.

(27) This should be compared with the view espoused by Erikson that deviants serve a very useful function for affirming the status quo in that their deviant behaviour makes the norms of a society or group clearer. See Erikson, 'Notes on Deviance Today'.

(28) Cf. ibid., p.123.

although he also believes that it provides space in which the Spirit moves to transform the hospital and it is therefore, in some sense, subversive. This belief is revealed in the following passage about the place of the eucharist in the hospital:

> Here the structure of the hospital itself, its defined rules of corporate belonging, as these are internalised by the long-stay patient for whom they provide the grammar according to which the language of life is parsed, is brought face to face with the imagery of a wider society, a universal citizenship implying values and expectations which are qualitatively different .. . Within this alternative universe the institutionalised find a measure of freedom from the constraints which bind them elsewhere. In its official presentation as the Hospital Eucharist, the rite turns out to be anarchic and not conformist (29).

While the activities which the chaplain promotes may be regarded by him as anarchic and subversive, he emphasises that they do not constitute a social protest: "This corporate celebration is not, basically, an organised statement, a social protest ... . Fundamentally it remains the sum total of any number of individual communications, all of which are different" (30). "Liberation" in Grainger's usage refers principally to deliverance by the Spirit from psycho-spiritual alienation (31).

Ultimately, Grainger has been influenced far more by an individualistic psychological view of the hospital and of mental disorder than by sociological or political

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(29) Ibid., p.90.

(30) Ibid., p.104.

(31) Ibid., pp.70-1.

perspectives (32). This has been accompanied by the emphasis on existential theology which lays its emphasis on the individual consciousness and small-scale interpersonal relationships. The individual, atomised and set apart from his society, lies at the centre of Grainger's view of both patients and chaplains. It is no accident that the chaplain is described as a clown, one who acts essentially on his own.

Grainger is absolutely correct in seeing the chaplain as a licensed deviant who maintains the social fabric of the hospital and will say more about this later. That this is the role he ought to play is questionable and it is hard to believe that the chaplain of a large, old underfinanced psychiatric hospital with a large population of old people in a part of the country where there is a large working class population can make so little allusion to these factors. Notions of justice, social class and political equality make almost no appearance in Grainger's work, while they would seem to be at the centre of the issues facing the mental hospital today according to the analysis which was undertaken above. Whether the Holy Spirit will be given space to act by the anarchic activities of the chaplain is a matter of personal speculation. It would seem that these activities in themselves will not bring more money into the mental health services, nor will they prevent abuse, demoralisation and cruelty on the back wards of State psychiatric hospitals. Once again, although Grainger like Wilson provides material which can help towards a socio-political understanding of the role of the chaplain, his analysis is unsatisfactory.

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(32) The truth of this assertion may be verified by Grainger's citation of authors in the text.

For the sake of completeness, I conclude this analysis of the theoretical work on chaplaincy by a brief examination of the work of Faber and Cox. Faber shows some awareness of the social context of the hospital. In Chapter 1 of Pastoral Care in the Modern Hospital, he discusses the attitudes of society towards the sick and the social function of the hospital. However, beyond this he is fairly uncritical. He states, for instance, that admission to hospital has become a "purely medical concern" and welcomes this "progress" (33). Similarly, he takes up an uncritical attitude to the "therapeutic team" and recommends some kind of integration and co-operation with it. His emphasis falls on the pastor's relationship with the individual patient, and he approaches this relationship from a psychodynamic perspective (34). While for present purposes it would be wrong to attach too much significance to Faber's views, since he is writing about hospital chaplaincy in general and doing so from the shores of another country, it may be pointed out that here again chaplains seem to be embroiled in relations with individuals and small groups primarily, rather than posing any questions about the socio-political context, function and organisation of the hospital.

Cox writes from the specific context of a chaplaincy C.P.E. placement in a therapeutic community which forms part of a large psychiatric hospital in Birmingham. Despite the fact that his role was obviously a limited one for a limited period of time his work 'Anxiety and Authority in a Therapeutic Community' displays a degree of socio-political awareness. He notes that the mental health services are the

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(33) See Faber, op.cit., p.7.

(34) See especially Chapter 4 for examples of this.

'Cinderella' of the N.H.S.(35), that staff make judgements on patients which can have strong judgemental overtones and that a staff-patient divide can occur even in a therapeutic community whereby there is a danger of staff solidarity over against the patients (36). He comments on the traditional passivity of the patient role (37), and also explores the nature of the hierarchical organisation of the hospital and the difficulties which this presents in terms of communication (38). Cox draws on writers about the hospital like Stanton and Schwartz. However, it must be said again that Cox provides no thoroughgoing analysis of the socio-political factors involved in the occurrence and treatment of mental disorder such as the one outlined above.

Lack of socio-political awareness and analysis was also a feature of the interviews which I conducted with chaplains in the autumn of 1980. Although most chaplains had read or studied at least a little sociology (39), none had studied it in depth and only two of the five claimed to use its insights in their work. In the case of one of these two, it was very much a micro-sociological approach which was referred to, e.g. the sociology of the family. The other chaplain who claimed to use sociological insights was aware of the work of writers like Goffman, but had made no systematic analysis of the socio-political situation of the

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(35) J.S.Cox, 'Anxiety and Authority in a Therapeutic Community' in M.A.H. Melinsky, ed., Religion and Medicine (London : S.C.M., 1970), pp.32-79.

(36) Ibid., pp.36-7.

(37) Ibid., p.39.

(38) See ibid., p.40ff.

(39) None of the chaplains I interviewed had studied any economics or political science.

hospital and was apparently unaware of economic and class factors affecting mental disorder and its treatment. One chaplain rejected the notion that social class might be a significant variable in mental disorder completely. He asserted that he tried to see his patients as individuals and not as members of any kind of collective groups. While this was an extreme expression of an individualistic and psychological viewpoint in chaplaincy, there can be little doubt that, in practice, more chaplains are in sympathy with this approach than with a socio-political one. This is reflected in the types of training which they have undertaken, which tend to focus on individuals and small groups rather than on structures and politics (40). Chaplains seemed hazy as to the future and place of the psychiatric hospital in the mental health services, unaware of any class differences among different groups of hospital staff and, in general, accepting of the psychiatric hospital as it is presently constituted.

In this connection it is appropriate to examine once again the nature and content of the chaplain's role as prophet in the psychiatric hospital. It will be recalled that the prophetic aspect of ministry was seen as vital by both writers about chaplaincy and by chaplains themselves. In the light of the discussion above, however, it is difficult to see how the usage by chaplains of the terms 'prophet' or 'prophetic'

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(40) For example, two chaplains had undertaken Clinical Theology courses with their emphasis on the psychological dimension of life, two were undertaking family therapy courses with an emphasis on the family as a small system and one was undertaking a psychotherapy course. A chaplain who had undertaken a Richmond Fellowship course and another who had done the University of Birmingham D.P.S. course received both sociological and psychological input, but in both cases subsequent work had included work with individuals and small groups rather than wider involvement in society.

relate to the central aspects of the prophetic role to be found in the Judaeo-Christian tradition. In particular, there seems to be an almost total lack of emphasis on the socio-political dimension of existence and on features of injustice and inequality, central aspects of the classical prophetic tradition. The urgent pleas for social justice characteristic of the ancient prophets seem to become attenuated into a gentle and occasional questioning of the status quo in order that some of its superficially less acceptable features might be gradually altered. Idealistic debate about the nature of health, divorced from thorough socio-political analysis, seems to supplant necessary social action.

It is perhaps necessary that this emaciated understanding of prophecy should prevail among contemporary hospital chaplains. For if the hospital chaplain is to remain non-partisan, acceptable to all, identified with none and universal within the institution, he cannot afford to indulge in apparently one-sided criticism and action. If, however, this is the case it seems unhelpful to designate occasional critical aspects of the chaplain's role as prophetic. It would be more accurate to describe these as part of an essentially 'rabbinic' function working mainly within the perameters of the status quo. This point has been developed by Browning. He suggests that,

> On the whole the chaplain should resist seeing his or her moral concern in analogy with the prophet. Because of the high degree of autonomy which most secondary institutions have from the direct power of the church, the model of the ancient scribe and rabbi will serve the chaplain better. The moral concern and counselling of the chaplain should take the form of a midrash (a 'search' or 'enquiry') which can elicit the collaborative efforts of the other professionals (41).

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(41) Don Browning, 'Pastoral Care and Models of Training in Counselling', Contact, 57, 1977, 12-19, pp.17-18.

In the context of the present work it may be asserted that chaplains can, and should, exercise a prophetic role in the hospital. Using their positions as outsiders, 'laymen' and agents free of hierarchical control to a large extent, chaplains have enormous scope to become involved in genuinely prophetic activities. That is to say that they can have a primary concern for social justice, confront the evils of socio-political reality, and side with the oppressed over against the powerful. Browning has done a great service in providing another way of describing the actual critical role of the chaplain in the hospital as it is practised at the moment. By suggesting that it is in fact a rabbinic role, and therefore perhaps more conservative and accepting of the status quo than the prophetic role when the latter is understood fully, Browning has undertaken a clarificatory function which leaves the way clear for considering the nature of a truly prophetic ministry, and pastoral care in the psychiatric hospital.

The failure of chaplains to develop a socio-political prophetic critique of the psychiatric hospital has contributed to a failure in praxis, both within and outside the hospital. Chaplains have not, on the whole, become involved in political activities outside the hospital which would help to bring pressure on public agencies to give more money to, and pay more attention to, services for the mentally ill. They have not mobilised the political pressure of the church, nationally or locally, in this direction either. Only one of the chaplains I interviewed was a member of a political party, that being the Ecology party which has no particular policy towards the welfare state and the mentally ill. Similarly, none were involved in any kind of social pressure groups.

None of the chaplains I interviewed were involved in organisations fighting for changes in the Mental Health Act and for the maintenance or improvement of patients' conditions and rights. That is to say that none of them belonged to MIND or the National Schizophrenia Fellowship. At a recent conference organised by the former organisation on "The Future of the Mental Hospital" (October 1980), only one clergyman was present, according to the list of participants, and this particular man was chaplain to psychiatric services rather than being the chaplain of one of the large old psychiatric hospitals whose future was under consideration at this conference.

Within the hospitals themselves chaplains do not seem to have been prominent in attempting to gain greater influence for patients and their relatives in the running of the institution and in matters of treatment. Although one hospital I visited did have a patient-staff committee which provided some form of official channel for patients to have an effect on the hospital, none of the other hospitals possessed such a body and chaplains seemed largely indifferent to this fact. While sometimes recognising that there were groups whose voice was unheard in the hospital, e.g. junior staff and patients, chaplains did not seem to be unduly concerned about the situation or regard it as their responsibility to try and amend it.

Chaplains seem to sit light to their opportunities for influencing policy in the hospital, eschewing the membership of committees and other similar bodies in favour of being involved in other activities. They also betray a bias in their interests and work towards the acute sectors of their hospitals. This can be seen, for example in Grainger's book where little mention is made of the old and the chaplain's

role in relation to them as opposed to dealing with those patients who are younger. Similarly, the account of Law's work above shows that the chaplain involves himself mainly in the admission units of the hospital rather than dealing with the half of the hospital population who have little future and little influence in society and who enjoy the worst conditions in the hospital. It seems, then, that most chaplains, in company with the other professional personnel in the hospital, including the doctors, prefer to devote their energies to those who are already receiving most in the hospital while neglecting those who are neglected by everyone else anyway. Chaplains naturally gravitate to the acute sector where they can exercise an active therapeutic role and not to the place where perhaps they are needed more.

In this connection, attention should be given to the therapeutic methods and activities espoused by chaplains. It has been shown that many chaplains have a strong interest in therapeutic techniques used in small groups of four individuals. Psychotherapy and counselling often form part of a chaplain's role in the psychiatric hospital. Browning has pointed out that such methods originated among the articulate middle classes and depend heavily on the ability to verbalise, be introspective and to gain insight (42). By their very nature these methods exclude members of the lower classes who have urgent needs but whose needs cannot be met by these means because of a lack of insight, verbal ability and so forth. It may be argued, therefore, that the therapeutic techniques favoured by chaplains have a built-in class bias and will tend to draw them to working more with individuals of higher rather

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(42) See Don S. Browning, 'Pastoral Care and the Poor', in Howard J. Clinebell, ed., Community Mental Health Nashville : Abingdon, 1970), pp.110-18.

than lower social classes. Similarly, these therapeutic techniques are of little use with the old and demented and so will tend to reinforce the propensity of chaplains to concentrate their best efforts in the acute sector of the psychiatric hospital (43).

Perhaps the most devastating example of chaplains failing to act in ways which promote justice and equality in the hospital is to be found in their response to demoralised and potentially abusive situations in their hospitals. Some ten mental illness and mental handicap hospitals have had incidences of demoralisation and abuse which have led to official investigations (44). It is apparent that abuse and demoralisation is likely to be a frequent occurrence in every large psychiatric hospital with an elderly or long stay population for reasons which have been explored above. Despite the prevalence of this sort of situation,chaplains seem to have remained almost totally passive in regard to them. In no case has a chaplain played a prominent part in exposing abuse, demoralisation or inadequate facilities. In only one of the enquiries cited above (South Ockenden) did a chaplain give evidence at the enquiry proceedings. It appears that chaplains have given no support to junior members of staff who have complained about conditions in their wards and so they have been left unsupported to run the gauntlet of the displeasure of their colleagues and superiors almost alone (45).

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(43) For further discussion of differences in linguistic usage between classes and the effect of these on therapeutic relations see above, p. 279.

(44) See Beardshaw, Conscientious Objectors at Work, pp.84-8, for summaries of all the enquiries which have been published.

(45) Beardshaw, op.cit., pp.24ff. for descriptions of the experiences of different nurses.

It seems that after more than ten enquiries into mental illness and mental handicap hospitals over the last decade or so, few lessons have been learned either by the N.H.S., the hospitals or their chaplains. This may be more understandable in the case of part-time chaplains spending a limited amount of time in the hospital, but seems inexcusable in the case of full-time chaplains who have a great deal of time to get to know what is happening in the back wards of their hospitals if they want to. Sadly, I have to report that two of the hospitals whose chaplains I interviewed have subsequently featured in the national press (46). At both places I was assured by the chaplains that they knew of no disquieting practices in their hospitals. At the second hospital I was assured that morale was good. In the case of the first hospital, only two months after my visit it was acknowledged by the A.H.A. that long-stay patients were being over-medicated due to shortages of staff. This fact had been exposed by a concerned social worker. At the second hospital, following the suicide of a nursing officer, it was alleged by his trade union that the management structure of the hospital was in ruins and an official enquiry was called for (47). It may be added that chaplains are not deliberately callous, uncaring, cowardly or indifferent, though some may fall into one or two of these categories. They are simply blind to the realities of the socio-political context in which they function and so fail to act in an appropriate way.

I shall later go on to outline a model of chaplaincy which incorporates the type of socio-political awareness of

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(46) Specific reference to press articles and to the names of hospitals and chaplains has been omitted here to preserve confidentiality.

(47) This second incident took place about six months after my visit.

which I have written above. The next stage is, however, to enquire into the function of the chaplain and his ideology from the Marxist perspective and to try and elucidate the factors which make this function appropriate to chaplains.

CHAPTER XVIII

THE ROLE OF THE PSYCHIATRIC HOSPITAL CHAPLAIN FROM A MARXIST PERSPECTIVE

One of the distinctive features of liberation theology, it may be recalled, is its realisation that all institutions and ideologies have a particular social and temporal context which determines their shape. All religious ideas and institutions serve a socio-political purpose. The liberation theologians, using a Marxist analysis of society, believe that the purpose served by these institutions and ideologies in Latin America has been to serve, albeit unconsciously, the interests of the ruling capitalist class. It is now necessary to undertake the same kind of analysis on the role of the chaplain in the psychiatric hospital in this country. Although the analysis presented here may sound simple and dogmatic, the relations between particular individuals and groups and society as a whole is a very complex one and it is important to remain mindful of this. Nonetheless, such an analysis, however crude or over-simplified, can be of value in considering chaplaincy praxis today.

I will engage in the proposed analysis firstly by looking at the Marxist critique of the place of the church and religious belief in society in general. I shall then consider the place of the clergy in capitalist society. Finally, I shall examine the socio-political function of psychiatric hospital chaplains specifically.

Marx himself devoted comparively little of his time and energy to the critique of religion and religious institutions. Following Feuerbach, he dismissed the ideology of religion with its belief in a transcendent God as a feature of man's alienation from his own essence and predicted its demise with

the end of the capitalist system. With reference to religious institutions in society, Marx saw these as essentially allied with the ruling classes in the nineteenth century Europe and therefore as part of the capitalist superstructure which would ultimately be overthrown (1).

Subsequent Marxist criticism of the place of religion in capitalist society has been sparse also, and has reflected the basic views of Marx. For the most part it has focused on the place of the church as an institution in capitalist society. Miliband sees the church in contemporary British society as one of the organs whereby the ideological hegemony of the ruling class is maintained and legitimated (2). He notes, "In their political competition with the parties of the Left, the conservative parties have always derived a very notable amount of direct or indirect support and strength from the Churches" (3). While the churches maintain that they are politically neutral and non-partisan, like the other organs dominated by and serving the ruling elite, they support the capitalist system,

> Organised religion, in most of its major manifestations, has played a profoundly 'functional' and 'integrative' role in regard to the prevailing economic and social system, and... to the state which has defended the social order (4).

Miliband further comments,

> It would not seem unfair to suggest that the reason why the Churches in advanced capitalist countries have been so willing to serve and support

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(1) For more on Marx's attitude to religion see e.g. Lochman, Encountering Marx, especially Ch. 3, D.W.D. Shaw, The Dissuaders, (London : S.C.M., 1978), Ch. 2, Peter Hebblethwaite, The Christian-Marxist Dialogue.

(2) See Miliband, The State in Capitalist Society.

(3) Miliband, op.cit., p.178.

(4) Ibid., p.181. Emphasis original.

> the state is not ... so much because of its 'democratic' character, but because the governments which have represented it have had an ideology and political bias broadly congruent with that of the Churches themselves (5).

In the specific case of the Church of England it should be noted that links with the State are still formalised to a high degree. The majority of diocesan bishops sit in the House of Lords and all ordained clergy take an oath of allegiance to the head of the church who is the sovereign of the country. It is within this broad view of the church as a legitimating institution for the ruling class that I shall examine the role of the clergy in the Church of England.

A number of factors would seem to legitimate the assertion that clergy essentially form a dependent class of the ruling class in English society and therefore act in ways which are generally consistent with the interests of that class. Firstly, the majority of the clergy come from the higher and middle social classes, while only about 5% come from social class 5. No less than 49.1% come from managerial or professional backgrounds and 34.9% attended public schools (6). Amongst the leaders of the church, of the diocesan bishops in 1960 72% came from backgrounds in the professional and ruling classes. In 1969-70, 88% of the diocesan episcopate had been educated at "Oxbridge", a further indicator of upper class origin (7). Secondly, the professional nature of the clerical occupation suggests that clergy will share many of

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(5) Ibid., p.184.

(6) For these figures see Stewart Ranson, Alan Bryman and Bob Hinings, Clergy, Ministers and Priests (London : R.K.P., 1977) pp.28-9.

(7) For these figures see Kenneth Thompson, 'Church of England Bishops as an Elite', in Philip Stanworth and Anthony Giddens, eds. Elites and Power in British Society (Cambridge : C.U.P., 1974), pp.198-207, pp.199,201.

assumptions and behaviour patterns of professional groups as a whole. These, as has been argued in the case of doctors, will generally be congruent with the interests of the upper rather than the lower classes in society. Those clergy who come from lower class backgrounds are educated in theological colleges to accept for the most part these same norms, assumptions and behaviour patterns.

It is helpful, in looking at the relationship between clergy and society, to follow Gramsci in suggesting that clergy should be regarded as 'organic intellectuals' of the bourgeois class. That is to say that clergy disseminate ideas and practices which broadly buttress the interests of the ruling class and which make its claims to rule seem legitimate. They must be seen as a dependent group upon the ruling class in terms of their ideology and practice (8).

If the assertion that clergy serve as part of the ideological hegemony-promoting apparatus of the ruling class in contemporary society seems unlikely and arbitrary the history of the clerical profession should be recalled. In the eighteenth and early nineteenth centuries, Anglican clergy, then associated more directly with the landed classes, often served as J.P's and were a powerful force of social

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(8) For further information and discussion of Gramsci's views on the role of intellectuals in the class struggle see James Joll, Gramsci (Glasgow : Fontana, 1977) Ch. 9, and Corrigan and Leonard, Social Work Practice Under Capitalism, op.cit., p.151ff. In the latter, social workers are similarly designated as organic intellectuals of bourgeois hegemony. It is interesting to note that Gramsci first became interested in the place of intellectuals in society by observing the role of the Italian clergy in preserving the established social order in Italy.

control in English society. At the same time many clergy were active politicians, usually on the side of the Tory party and were regarded as bastions of the established order over against the revolutionary ideas percolating into England from France in the latter part of the eighteenth century. While later in the nineteenth century clergy ceased to play such an overt role in politics and the judicial system espousing the ideal of neutrality associated with professionalism, their work in education and poverty relief enabled them to remain effective agents of social control on behalf of the ruling classes (9). With a few notable individual exceptions, there is no evidence to suggest that clergy are more critical of the established order of capitalist society now than they have ever been. It seems safe therefore to assume that clergy as a whole are essentially propagators of the status quo rather than its detractors in contemporary English society.

This general statement is specifically validated in the case of chaplains in psychiatric hospitals. By asserting their independence, universal concern and availability chaplains avoid confronting real differences in class, status and power and so allow the established order to continue as it is. By attempting to remain neutral, chaplains are siding with the powerful against the powerless and continue to exercise a social control function for the ruling class (10). This siding with the powerful becomes overt in situations like strikes where chaplains are forced to choose what they will do. In

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(9) For all the above see Antony Russell, The Clerical Profession (London : S.P.C.K., 1980), especially Chs. 11, 12, 13, 15 and especially p.228.

(10) For neutrality as siding with the powerful against the powerless, cf. Paulo Freire, 'Education, Liberation and the Church' in Alistair Kee, ed., A Reader in Political Theology (London : S.C.M., 1974), pp.100-106, p.100.

the case of three of the chaplains I interviewed in 1980 they refused to support strike action in their hospitals by nurses and ancillary workers even though they admitted the justice of the cases which these workers presented. 'Neutrality' in this instance ultimately led to crossing picket lines and strike-breaking activities.

The focus on individuals and small groups prominent in the work of many chaplains may also be seen as a way in which chaplains act to affirm the status quo and the power of the people who already have power both in the hospital and society. By emphasising the locus of pathology as lying within the individual or in his family or small group relationships, chaplains fail to focus attention on the larger social structures in capitalist society and in the hospital and so implicitly affirm the established order, formed and maintained by the capitalist socio-economic system(11).

Chaplains who emphasise the importance of the spiritual, transcendent and liturgical may be regarded as deflecting attention away from the ills of the present with their historical and social causes to a transcendent realm where historical conditions of suffering and pain are relativised, individualised and abstracted from any kind of historical struggle for justice and equality. The liberation theologians have pointed to this trait in the context of Latin America where they believe the sacraments have been used ideologically to devalue the importance of historical activity (12).

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(11) Similar criticisms have been made of other professional groups in society, e.g. social workers. See further e.g. Corrigan and Leonard, Social Work Practice under Capitalism.

(12) See e.g. Segundo, The Liberation of Theology, Ch. 2.

Balasuriya, from a Sri Lankan perspective, demonstrates how the eucharist which expressed Christ's mission of human liberation and opposition to oppression and injustice has become socially conditioned by the dominant groups in the church so that it is a tool of social domestication which by its other worldly emphasis allows unity at any price (13).

Chaplains function as part of the hospital's apparatus of legitimation, both to the patients and to the outside world. Their presence is reassuring to society as a whole, making it look as if nothing could be very profoundly amiss in the psychiatric institution (14). Vis a vis the patients, the

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(13) See Tissa Balasuriya, The Eucharist and Human Liberation (London : S.C.M., 1979) especially Ch. 1. He similarly condemns the individualisation and privatisation of the sacraments, affirming their communal nature.

(14) See Appendix 1 of Barbara Robb, Sans Everything (London : Nelson, 1967). This contains a speech by Lord Strabolgi in 1966 in the House of Lords. The speech, on the appalling conditions of old people in mental hospitals was interrupted by the Bishop of Lichfield who was keen to assert the fact that each hospital has a chaplain in the face of an accusation that few ministers visited in hospital, thus contributing to the poor state of affairs suffered by the elderly. Appendix 2 containing a letter to the Catholic Herald from Daniel Woolgar, O.P. points out that with other commitments, many clergy have not got time to visit the elderly in hospitals regularly even if they are hospital chaplains. This state of affairs illustrates the ideological function of the chaplain very well. On the one hand, every hospital can say that it has a chaplain, thus reassuring the public, while on the other it can remain unchanged as the chaplain will not be able to have a significant effect on the institution because of lack of time.

chaplain can help convince them that they should recognise and submit to the authorities in the hospital. This legitimating, or apologetic function in relation to patients is overt in the writing of Grainger, "From the point of view of the hospital, he (the chaplain) justifies his place within the institution as its advocate and interpreter, explaining the hospital to the patient"(15).

The chaplain's palliative or analgesic function is connected with his function of legitimation. Simply put, this is the function of simply making people feel a bit better about the situation in which they find themselves so that they will not attempt to change it or leave it. The chaplain can act as an 'oiler of the machine' so that people do not get so frustrated or angry that they demand major changes for themselves and others. The chaplain can in this way help to make the intolerable acceptable and the insufferable bearable. He may exercise this function with all types of groups in the hospital and may conceive it to be a function of reconciliation rather than of anaesthesia.

Halmos would describe this palliative function as one of therapy. By this he means to designate that function whereby individuals are adapted and changed to suit social rules, norms and roles rather than the rules, norms and roles being changed which he would see as political activity (16).

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(15) Grainger, Watching for Wings, p.3.

(16) See Paul Halmos, The Personal and the Political (London : Hutchinson, 1978), Ch. 2.

Halmos points out that the personalist, therapeutic orientation in society is very different from the political, reformist orientation. More radical theorists have gone on to warn that the whole concept of 'care' in relation to individuals can be implicitly politically conservative because of its individualist nature, focusing on the changing of individuals rather than the changing of society (17). As I have argued above, many of the therapeutic methods used in psychiatric hospitals are compatible with or legitimate a view of adjusting the individual and not wider society. Chaplains often utilise the same sort of individualistic personalistic therapeutic methods and concepts, e.g. those of psychotherapy, thereby throwing their weight and influence firmly behind the status quo in social and political terms.

It must be said at this point that chaplains are not bound to function in this way and that not everything they do affirms the status quo. It may be, for example, that counselling activities which build up the confidence and strength of individuals may ultimately have a political effect. In any case, not all work with individuals and small groups is de facto conservative, and the care of individuals who have been irreparably damaged must be recognised as valid. However, the general assertion that chaplains perform a broadly conservative function within psychiatric hospitals in capitalist society still stands. Psychiatric hospital chaplains, in common with military chaplains and prison chaplains, continue to be a welcome addition to the State apparatus of social control under capitalism.

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(17) See e.g. Mike Simpkin, Trapped Within Welfare (London : Macmillan, 1979) pp.103, 107.

CHAPTER XIX

THE SOCIO-POLITICAL DIMENSION IN PASTORAL CARE

In the two previous chapters, socio-political awareness in the literature relating to pastoral care in psychiatric hospitals specifically was examined. It was found that there was little evidence of consideration of this dimension in terms of either practice or theory. At the same time, it has been argued that many of the problems facing patients and staff in psychiatric hospitals demand a species of political awareness and action if they are to be resolved and if suffering is to be alleviated. The next chapter will set out some proposals for a socio-politically informed and committed pastoral care in the psychiatric hospital. The present chapter, however, sets out to examine the Christian pastoral care tradition in general. After considering some contemporary perspectives on pastoral care which focus on the individual and psychological reality, modern writers who have demonstrated a concern with the wider corporate dimension within pastoral care are considered. After this historical traditions are scrutinised. It will be suggested that these traditions contain an important element of socio-political awarnesss and action and that modern individualistic definitions of pastoral care are somewhat arbitrary. Finally, a definition of pastoral care will be proposed which permits the inclusion of the kind of pastoral action which will be outlined in the next section. The purpose underlying all this is to show that socio-politically informed and committed pastoral care can reasonably be described as pastoral care without doing violence to the pastoral care tradition. Indeed, the definition of pastoral care which will be proposed will demand the inclusion of this dimension at certain times and in certain circumstances.

It is surprising how few writers on the subject of pastoral care define what they mean by the term 'pastoral care' (1). For the most part, it is assumed that readers will share a common understanding and so the writer turns immediately to matters of particularity and practicality, perhaps with relation to pastoral counselling or some other technique. Here some typical modern definitions of this activity will be considered.

In one modern American definition of pastoral care, it is defined as consisting of "helping acts, done by representative Christian persons, directed towards the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns"(2). Hulme, another American has written more recently that pastoral care is "a supportive ministry to people and those close to them who are experiencing the familiar trials that characterize life in this world, such as illness, surgery, incapacitation, death and bereavement"(3). These definitions are compatible with British assertions

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(1) In this connection it is interesting to note also the inadequacy of the theological basis for pastoral care displayed by most writers on the subject. In a previous article on hospital chaplaincy (Stephen Pattison, op.cit.,) one of the common denominators among all the writers considered was found to be a lack of any adequate theological understanding for pastoral care. Pastoral care has thus remained a praxis without an underlying theological theory to a large extent. This concentration on the particular practicalities of ministry effectively divorced from theology has sometimes been designated the 'hints and tips' approach.

(2) William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (New York : Jason Aronson, 1975), p.4. Emphases omitted. This definition is substantially based on the ideas of Hiltner, although it is more comprehensive. See Hiltner, Preface to Pastoral Theology.

(3) William E. Hulme, Pastoral Care and Counselling, (Minneapolis : Augsburg, 1981), p.9.

concerning the nature of pastoral activity. Autton lays heavy emphasis on the priest's ministry to individuals:

> As we read through the Gospels we find that over and over again our Lord's attitude to the individual is stressed. He always treated people as being each one uniquely important. In his busy life he always had time to devote to their needs. To help people individually may seem to so many slow, tedious and time-absorbing - and indeed it is! - but it is the primary charge laid upon every priest at his ordination (4).

In a recent work, Wright, an English writer, shows considerable awarnesss of the need to recognise the socio-political dimension in pastoral care. He recognises that "the temptation of the pastorally-inclined ... is always to exaggerate the extent to which individuals can be helped, regardless of the circumstances in which political, social and economic realities place them" (5). Furthermore, it is stated that "there is ... a prophetic concern in the pastor's task, a social commitment..." (6). Wright affirms the role of the pastor as one who sustains a vision of the Kingdom of God, which is social as well as individual, by preaching and teaching (7). Ultimately, however, Wright gives primacy to the personal and individual in pastoral care: "Under the compulsion of the Kingdom, the pastor will never settle for the impersonal, but always seek the true welfare of the person. There, at least is pastoral distinctiveness"(8).

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(4) Autton, Pastoral Care of the Mentally Ill, p.21.

(5) Frank Wright, The Pastoral Nature of the Ministry (London : S.C.M., 1980), p.66.

(6) Op.cit., p.70.

(7) See ibid., p.71.

(8) Ibid., p.73.

In socio-political terms, pastoral methods can only go as far as being "the silent midwife of the revolution" (9). The pastor must not abandon his concern for individuals to become a political activist and people must always be treated as individual ends in themselves now (10).

Campbell, in a still more recent book, also exhibits a primary concern for the individual in pastoral care. He focuses on the qualities and characteristics desirable in pastors and seeks to prescind from issues of quasi-professional training and technique in the pastoral relationship. While this may be seen as a worthy political end in itself, it undoubtedly fails to address wider socio-political questions. Campbell does not provide an overt definition of pastoral care beyond stating that it is "a relationship founded upon the integrity of the individual" (11). It is interesting to note, however, that his later assertion that "what people are seeking from pastoral care is liberation from the cavern of sin and companionship on the journey of faith" would permit a wider interpretation of this activity which might incorporate a socio-political dimension (12).

Several factors may have contributed to what I shall call the individualist and psychological encirclement of pastoral care evident in the writings cited above. Firstly, the theory and practice of psychodynamic psychology has had

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(9) Ibid., p.73.

(10) See ibid., p.71.

(11) Alastair V. Campbell, Rediscovering Pastoral Care (London : D.L.T., 1981), p.37.

(12) Op. cit., p.65. Emphasis original.

an enormous influence on the development of modern ideas about pastoral care. Thus Clinical Pastoral Education (C.P.E.), the most widely used pastoral training method, has derived much of its theory from humanistic psychology and its insights have spread throughoughout the Western world. It may be noted that Hiltner evolved his concepts of pastoral theology in part to meet and integrate the contemporary challenge of psychology in the U.S.A. of the 1950's (13). Many other writers like him responded to this challenge, encouraged in their endeavours by the influence of individualistic existentialism dominant in theology itself at that time. Essentially , despite the advent of forms of therapy other than those based directly on psychoanalysis, pastoral care remains heavily indebted to this fundamental influence even now and no movement or practice has had anything like the same influence.

A second factor in the popularity of individualistic and psychological conceptions of pastoral care may be the fact of secularisation. As formal religious institutions have withdrawn from having any formal influence on society and religion has become a private matter for the individual, there has been less and less scope for the churches to attempt to influence larger social structures. One of the responses to this has been to seek to minister to individuals only and to abandon the secular order. A form of individually-oriented psychologically-informed personal intervention provides a meaningful way for pastors to seek to order their existence in the face of a total lack of political influence and the massive indifference of society at large to formal religious

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(13) See further e.g. Hiltner, Preface to Pastoral Theology, especially pp.24-9, Day Williams, The Minister and the Cure of Souls, especially Ch. 1.

institutions (14).

Related to the secularisation factor may be a sense that political solutions to human woes have been discredited. Halmos suggests that we are living in a post-political society where social and political reform are rejected because of factors such as the complexity of social issues and the size of the task in trying to explore them, the disillusion with double-think and intellectual half-truths which pervade modern life, the desire to express compassion in personal problems, the wastefulness of human sympathy in political action, the idea that to be politically involved means to be hard and impersonal, the stereotyping of politics, and the loneliness of man in mass society. All these factors have, in Halmos' opinion, led to the growth of the individual counselling movement where people feel they can contribute something of worth to their fellows (15). It seems reasonable to suppose that these factors have influenced pastors as much as any other group in society, and certainly the last two decades have seen a burgeoning of courses and institutions which train ministers for a counselling ministry of some sort.

The adoption of a professional role model by the clergy has probably also exerted an influence. Russell has traced the history of the clerical profession and shows clearly the way in which, during the last century, clergy came to specialise more and more in overtly 'religious' and ' 'spiritual' matters, forsaking other aspects of their work

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(14) For more on secularisation see e.g. Peter L. Berger, The Social Reality of Religion (Harmondsworth : Penguin, 1973), Michael Hill, A Sociology of Religion (London : Heinemann, 1973), Chs. 11 and 12.

(15) See Paul Halmos, The Faith of the Counsellors (London : Constable, 1965) Ch. 2.

which were being taken over by emergent professional groups like doctors and teachers. At the same time, clergy themselves adopted many of the appurtenances of other professional groups - specialised training, professional journals, etc. Among the professional features adopted was an emphasis on the relationship between the individual professional and his client. It can be seen therefore that the one to one professional relationship, coupled with an emphasis on the personal and private nature of religion forms an important predisposing influence for a species of pastoral care which is psychologically, spiritually, and individually oriented (16).

Behind and beyond any of the factors mentioned so far is the nature of the socio-economic order of Western capitalism. For various reasons this order has placed enormous emphasis on the importance of the 'atomised' individual as opposed to the wider social group. These reasons include the necessity of individuals being able to enter freely into contractual relations in the market and the need to disguise the existence of classes in society (17). The dominance of an individualistic approach in medicine and psychiatry under capitalism has been described and accounted

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(16) See further, Russell, The Clerical Profession, Ch. 8.

(17) See Corrigan and Leonard, Social Work Practice under Capitalism, pp.109ff. See also Gough, The Political Economy of the Welfare State, p.25: "The existence of classes is hidden by the individualisation of all operations within the capitalist market ... the political process, with its rights of citizenship and individual ballots, also masks the class structure of capitalist society." Steven Lukes, Individualism (Oxford : Basil Blackwell, 1973), explores the concept of individualism at some depth.

for elsewhere. Sölle describes the effect of individualism on religion as follows,

> We Protestants reduced our symbols and confined them to ourselves, to our personalities. We used religious concepts and images for one purpose only: they had to serve the supreme value of middle-class culture - individualism. When the beginning of all modern economic growth is the private initiative of the individual employer, and when collective forms of co-operation and shared property disappear through the economic process, then the prevailing religion is assigned the task of blessing this process. Religion becomes a tool of the ruling classes, and only continues to function in order to comfort the sad, enrich personal life, and give the individual the feeling of significance. Sin then becomes personal transgressions... .The cross then becomes my unique suffering, and the resurrection my individual immortality (18).

Individualism and individualistic Protestant religion permeates North American society. It is not surprising, then, that the pastoral psychology movement emanating from the U.S.A. is saturated with a primary concern for the individual. Purves has pointed out how well this concern dovetails with capitalist social policy and philosophy in the U.S.A.(19). Since the pastoral psychology movement has had enormous influence in this country, the same perspective on the individual applies here too.

The prevalence of the individualistic psychological

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(18) Dorothee Sölle, Choosing Life (London : S.C.M., 1981), p.82.

(19) For the dominance of the individualist ideal in America see especially Andres Purves, 'Political Theology and the Theology of Pastoral Care : A Comparative Study with Special Reference to Jurgen Moltmann and Seward Hiltner', Unpublished Ph.D. Dissertation, University of Edinburgh, 1978, pp.313-4, Lukes, op.cit., p.26ff.

models of pastoral care must be compared with criticism both from within the modern pastoral care tradition itself and from a historical perspective on pastoral care. Campbell writes of the "politics of pastoral care", by which he refers to the "idea of broadening the context of pastoral care to include the communal aspects of human experience" (20). He recognises the psychological captivity of pastoral care:

> The literature of pastoral care becomes largely a re-stating of the tenets of good counselling in a religious context; the activities of the pastoral carers become narrowed down to the refinement of one-to-one and small group interactions; the development of the individual's capacity for self-determination according to the values he chooses for his own life become the epitome of the Gospel hope and promise. Somewhere in the by-going the prophetic edge of Christianity is lost and the pastoral care movement becomes dangerously like a new version of Marx's "opium of the people" - only in this case the people are articulate, highly self-conscious, middle class Westerners (21).

Campbell follows Lambourne in advocating 'we-formation' and political responsibility. He also calls for prophecy and the ministry to structures, while warning against conscience driven activism.

Leech shares some of the same concerns shown by Campbell in this area,

> Christian theology needs to ask questions about the politics of therapy and counselling. What are therapy and counselling actually doing about the problems confronting human society? Are they in fact simply helping people to be well adjusted in a society whose fundamental values and assumptions remain unquestioned? (22).

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(20) Alastair V. Campbell, 'The Politics of Pastoral Care', Contact, 62, 1979, 2-15.

(21) Op. cit., p.6.

(22) Kenneth Leech, The Social God (London : Sheldon, 1981), p.80.

He cites Heasman's definition of pastoral counselling as "a relationship in which one person endeavours to help another to understand and to solve his difficulties of adjustment to society" and asks whether this is not a highly dubious goal for the Christian (23). He comments,

> It does seem, in fact, that therapy and counselling have one of the lowest levels of political awareness among the various disciplines ... .There seems to be a growing danger of the misuse of therapy and counselling in order to dodge and evade fundamental social and political issues ... .It is at this point that the Christian prophetic tradition of asking fundamental questions about justice in society is extremely important (24).

It is regrettable that Leech has not seen fit to pursue this line of questioning with relation to pastoral care and counselling further in his essay.

Faber has written on the relationship between C.P.E. and social structures. He points out that

> C.P.E. has been from the start and has remained a movement for the improvement of pastoral care, of the work of ministers in face to face relations. Here lies our indisputable strength, but ... our weakness also. With our accent on personal pastoral care we have been inclined to forget the social structures ... we have perhaps even strengthened social structures, which should have been weakened (25).

The American writer, Bonthius, has written a very important article on the need for 'Pastoral Care for

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(23) Op.cit., p.80.

(24) Ibid., p.80.

(25) Heije Faber, 'C.P.E. and Social Structures',(unpublished paper, Tilburg, n.d.),p.4. A second paper by the same author, promisingly entitled 'The Prophetic Role in Pastoral Care' (Heije Faber, 'The Prophetic Role in Pastoral Care', Pastoral Psychology,29, 1981, 191-202), refers however exclusively to the role of the counsellor in the one to one therapeutic encounter.

Structures - As Well as Persons'(26). Writing from the perspective of trying to improve community mental health, Bonthius notes that "Unfortunately, the term 'pastoral care' is synonymous with ministry to individuals and their families and to members of the congregation or to needy individuals in the community" (27). He asserts that ministers should also be concerned with maximising communal well-being by appropriate social action and writes,

> As long as mental health could be interpreted in purely individualistic terms ... it was possible to rest easy with the notion that a pastor was performing his work faithfully - if not well - by paying attention to persons. I for one would not say that this is not important. I do contend that it isn't enough. You cannot take good care of persons without doing something about the environment which makes them what they are .... My thesis is that pastoral care for structures is fully as important as ministry to persons. Indeed, that unless a clergyman is giving 'equal time' to changing structures, he is just as surely neglecting his pastoral duties as when he fails those who can use pastoral counselling (28).

He goes on,

> Now we are open as never before to a reform of the idea of pastoral care. In one sentence, the situation as we see it is that persons are so much products of structures that we must change structures in order to help persons ... .In Christian terms it is a 'structure', an ideal community, that we are taught to pray for and asked to work for. Ministry to structures is not simply subordinate to ministry to persons. It is not even, strictly speaking, 'for the sake of' persons. Ministry to persons is ultimately for the purpose of enabling them to serve a structure: the Kingdom of God (29).

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(26) Robert H. Bonthius, 'Pastoral Care for Structures - As Well As Persons', Pastoral Psychology, 18, 1967, 10-19.

(27) Op.cit., p.15.

(28) Ibid., p.10.

(29) Ibid., p.11.

Bonthius concludes,

> It is not a matter of choice for clergy whether they will or will not assume the sociological role of pastoral activity. To the extent that a clergyman chooses not to be an agent at this end of the mental health continuum, he sides with the status quo, and therefore supports existing systems in their demonic effects on some individuals. The true choice for the clergyman is what kind of agent he will be in his pastoral activity: whether he will act with insight and effectiveness on the environment, or whether he will act in ignorance and prejudice or simply by default, to oppose necessary social change (30).

Bonthius' criticisms of pastoral care without a social dimension arise out of his experiences in urban ministry in the 1960's. His concern is echoed by other writers of the time in Pastoral Psychology. Two issues of that periodical are devoted to pastoral care of the poor and reflect a pastoral concern for large segments of society rather than simply for the individual (31).

Browning, the editor of the two issues of Pastoral Psychology which deal with pastoral care of the poor contributed a significant article to a symposium on the church's role in community mental health (32). In it, the failure of the modern pastoral psychology movement to address the needs of the poor, i.e. those without money or power, is faced:

> To raise the question of the pastoral care of the poor at this point in history is something of an embarrassment to the pastoral psychology movement. To raise this question now necessitates the confession

(30) Ibid., p.19. Emphasis original.

(31) Pastoral Psychology 19, March 1968 and 20, November 1969.

(32) Don S. Browning, 'Pastoral Care and the Poor', in Howard J. Clinebell, ed., Community Mental Health (Nashville : Abingdon, 1970) pp.110-18.

> that the pastoral psychology movement has not heretofore adequately given it the attention it deserves (33).

It is because this movement has had its genesis in the middle class sector of society that it has become alienated from the needs of the lower classes. The companion disciplines of pastoral psychology tended to be

> primarily clinical psychology, psychiatry and social work, and pastoral psychology itself soon took on the trappings of quasi-professionalism with its emphasis upon the white collar, appointments, structured interviews, and so forth. Much of this was good, but it unwittingly led the pastoral psychology movement to isolate itself from the lower classes (34).

The methods of pastoral psychology gleaned from the principles of individual and small group therapy emphasise "talk", "insight" and structured interviews. Such methods are inappropriate in attempting to meet the needs of the poor or lower classes who are less verbal, introspective and abstractive and who are orientated more towards concrete action. Browning emphasises that "... this (does) not mean that the poor (cannot) be helped; it simply (means) that help (has) to come in a different form than most psychological, psychiatric, and pastoral counsellors (are) accustomed to providing" (35). In the light of this situation Browning advocates some principles and strategies for pastoral care with the poor which take these factors into account and which aim to integrate the poor into society and to enable society to respond to and encourage the contribution of the poor. In particular, behaviour and ego-building therapies are suggested as being suitable for this kind of work.

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(33) Op.cit., p.110.

(34) Ibid., p.111.

(35) Ibid., p.113.

Hulme has published one of the few articles to appear on this subject over the past two decades in the Journal of Pastoral Care, the journal of the American Association for Clinical Pastoral Education (36). In this article, the author admits that C.P.E. has failed to take account of the importance of social structures and advocates a ministry which is both priestly, i.e. to do with the care of individuals, and prophetic, i.e. to do with changing structures which act on the lives of individuals.

The work of Seifert and Clinebell, as well as that of Kemp, again flows from the challenge of social conditions to urban ministry in the late 1960's and early 1970's. In Personal Growth and Social Change, Seifert and Clinebell attempt to integrate the prophetic and pastoral aspects of ministry. While maintaining that "the overarching goal that points the direction for change is self-actualization for all persons in relationship to both immediate and ultimate reality, to both their society and their God" (37), they reject the retreat of the church into a new pietism in an age of psychology with its focus on individuals to the exclusion of "the bleeding wounds of our communities" (38). They assert that individuals must be helped to grow not only by the overcoming of inner conflicts, but also by combating outer injustice (39). They note that social problems breed

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(36) William E. Hulme, 'Concern for Corporate Structures or Care of the Individual?', Journal of Pastoral Care 23, 1969, 153-63.

(37) Harvey Seifert and Howard J. Clinebell, Personal Growth and Social Change (Philadelphie : Westminster, 1969) p.11.

(38) Op.cit., p.12.

(39) Ibid., cf., p.13.

individual problems "like a stagnant swamp breeds insects" (40), but that reciprocally "individual problems collectively feed and undergird social problems" (41). Commenting on the relationship between the sociological and the psychological, Seifert and Clinebell write,

> God created man in community. There is in the Biblical tradition both an intense individualism and an intense communitarianism. Every person stands in personal responsibility before God. Yet we are also members one of another. This dynamic unity of person and group is also reflected in the conclusions of the behavioural sciences. Society is always composed of individual units, and the social environment is shaped by personal action. On the other hand, human personhood is not achieved apart from the nurturing group. There is no self other than a self in relationships (42).

They go on to outline a system for personal and social growth and change, some of whose features have been touched on above. Seifert and Clinebell describe their model of social change as a liberal radical one. That is to say that, as liberals they advocate change, and as radicals they advocate, not disruptive revolutionary behaviour or counterproductive extremism, but rather "a speeded-up gradualism" (43).

Kemp's work on pastoral care with the poor also advocates a species of social action for ministers working in poor areas of America (44). Kemp emphasises the importance of ministers being prepared to improve their skills as social change agents and warns that the shepherd must be careful lest his pastoral work is a means of hiding from being a

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(41) Ibid., p.15.

(42) Ibid., p.30.

(43) Cf. ibid., p.162.

(44) Charles F. Kemp, Pastoral Care with the Poor (Nashville :Abingdon, 1972).

prophet (45). He maintains that pastoral care leads to social action, "The concerned pastor, the faithful shepherd, must also throw the full weight of his influence on the side of justice and change"(46). Having recognised the value of Kemp's work, it is important to mention also that, like many of the other writers considered here, he has no coherent socio-political analysis or programme. In fact he rejects a technical analysis of poverty (47), and his book contains no proper analysis of society as a whole. It seems likely that such analysis is necessary if social action is to have any sense of direction beyond piecemeal opportunism.

Lastly, in this connection, the work of two British psychiatrists specialising in Pastoral Studies at Birmingham University must be mentioned. The first of these is the late R.A. Lambourne who throughout his writings maintained an acute consciousness of the social and political nature of human existence and devoted a good deal of his writings to ensuring that the pastoral care tradition should become aware of this dimension. In his early work, Community, Church and Healing, Lambourne explores the hypothesis that both sin and sickness are symptoms of communal disorder, exploring the nature of mental health as an example of the way in which sickness is caused by communal factors (48). He goes on to

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(45) See op.cit., p.86.

(46) Ibid., p.87.

(47) See ibid., p.21.

(48) See R.A. Lambourne, Community, Church and Healing (London : D.L.T., 1963), Ch. 2. Lambourne does not use the kind of socio-political critique and analysis which I have outlined above, perhaps because the kind of evidence which I have cited was not available to the same extent as it is now when Lambourne was writing this particular work.

investigate the communal nature of Old and New Testaments, emphasising in the latter case that the work of Christ in healing was not simply "a private work between man and God, an individual spiritual test and reward for a sick person", but rather a "public effective sign" of the breaking through of the power of God and of the Kingdom. Healing acts were acts of judgement and healing for the communities in which they took place and not simply for individuals (49). Lambourne develops the practical implications of a corporate view of healing and wholeness for church and community at large in the remainder of the book.

In subsequent work Lambourne continued to criticise medicine and pastoral care from a corporate perspective. In 'Personal Reformation and Political Formation in Pastoral Care' (50), he sets out to "narrow the gap between the private and the political models used in pastoral care and urban renewal respectively by offering a personal-political model for pastoral care" (51). He suggests that, essentially, pastoral care is concerned with "the radical, progressive formation of the behaviour and conscience of the church fellowship as it exercises its corporate responsibility in being a holy servant people", that it is concerned with "we-formation" for "we-responsibility" to Christ who is present in all men (52). He believes that as this formation occurs

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(49) See op.cit., p.36ff.

(50) R.A. Lambourne, 'Personal Reformation and Political Formation in Pastoral Care', Journal of Pastoral Care 25, 1971, 182-87.

(51) Op.cit., p.182.

(52) See ibid., pp.183-4.

it will be realised that "personal salvation and political righteousness are indivisible"(53).

In his paper, 'With Love to the U.S.A.' (54), Lambourne explores, amongst other matters, the apparent split between those teaching pastoral care and counselling through C.P.E. programmes and those teaching through field work in depressed urban situations. He points out that the former group have based their practice on the psychoanalytic model of Freud and have thus unwittingly imitated the exclusive ghetto situation which conditioned Freud's own practice in Vienna and forced him to develop his work in the form of encounter between individuals in the consulting room. He notes this has led to "the separation of the theory and art of loving from the theory and art of justice" (55). Lambourne further comments,

> The Rogerian school of non-directive counselling.. exhibits the same ghetto situation in which a highly intelligent, privileged, and relatively affluent group developed a theory and practice of counselling in an isolated situation where problems of cultural relativity, stupidity, poverty, physical coercion, and so on could be ignored, and thus encourage the participants to foster the delusion that they were engaged in a universal process to which problems of justice and power were either secondary or even irrelevant (56).

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(53) Ibid., p.187.

(54) R.A. Lambourne, "With Love to the U.S.A.', in M.A.H. Melinsky, ed., Religion and Medicine (London : S.C.M., 1970), pp.132-45.

(55) Op.cit., p.135.

(56) Ibid., p.136. Lambourne's criticisms concerning the split between the community and the hospital are picked up by Lyall who argues that the clinical pastoral model of education for ministry can be adapted for use in the depressed urban ghetto situation. See David Lyall, 'The Clinical Pastoral Model : In Hospital and Community', Contact 56, 1977, 23-7.

This type of criticism is continued in Lambourne's 'Objections to a National Pastoral Organisation' (57), where the author rejects the notion of professionalised, individualised care offered by pastoral experts modelling their practice on psychotherapy in favour of pastoral care which is "lay, corporate , adventurous, variegated and diffuse" (58). He asserts that American pastoral care organisations "though sophisticated and enlightened are trapped in their history of having been formed, and having flourished under the pressure of clinical psychotherapy in a highly individualistic society" (59). Referring to the effect that this has had specifically upon hospital chaplaincy, Lambourne writes:

> In my opinion, in the U.S.A. for two decades the too close identification of the hospital chaplain with clinical pastoral care of a counselling oriented type was a great weakness. It produced a stereotype, robbed the hospital of theological prophecy and contributed to the notable failure of the U.S.A. health care deliverance system. It constitutes now the gravest threat to hospital chaplaincy in developing countries (60).

Perhaps the clearest exposition of Lambourne's socio-political concern is to be found in his concepts map describing the effective concepts used in medical education. This is to be found in the paper 'Towards an Understanding of Medico-Theological Dialogue' (61). It locates disease and its healing

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(57) R.A. Lambourne, 'Objections to a National Pastoral Organisation', Contact 35, 1971, 24-31.

(58) Op.cit., p.26.

(59) Ibid., p.28.

(60) Ibid., p.31.

(61) R.A Lambourne, 'Towards an Understanding of Medico-Theological Dialogue', in M.A.H. Melinsky, ed., Religion and Medicine 2 (London : S.C.M., 1973), pp 12-23.

within its total environmental context. The same paper contains a warning against an uncritical acceptance of medicine and the deliverance model which it offers by theologians. A second paper in the same volume also bears on the present theme. 'Mental Health, Christian Medical Mission and the Future Concept of Comprehensive Health Care' explores the philosophy of personal and political behaviour implicit in modern medicine. The integration of justice and health over against the individualistic acute emphasis of much modern Western curative medical practice is demanded here (62).

From the point of view of the modern British tradition in pastoral care, Lambourne must be seen as the most important single thinker. His acknowledgement and continuing awareness of the corporate and socio-political dimension of human existence in his writing is highly original and has proved to be seminal for the work of others like Wilson. It is doubtful whether, even now, Lambourne's ideas have been developed to their furthest extent. However, it must be acknowledged that the breadth of this writer's concern has in some ways limited the depth of exposition he was able to give to it. Thus, although Lambourne obviously had a great concern for the socio-political dimension of existence and the way in which it was endangered by an unrealistic individualism, he made no systematic examination of that dimension using the tools of politics and the social sciences. The concept 'political' refers in Lambourne's usage to "the network of management, organisations,

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(62) See R.A. Lambourne, 'Mental Health, Christian Medical Mission and the Future Concept of Comprehensive Health Care' in M.A.H. Melinsky, ed., Religion and Medicine 2, (London : S.C.M , 1973), pp.24-34.

sanctions, etc., which are to be found in any society." (63). This definition is extraordinarily generalised and reflects Lambourne's unwillingness to address specifically matters of analysis, conflict, and the distribution of power. Such matters would seem to be of vital importance if the socio-political realm is to be examined or, more significantly, changed. Wilson is therefore right to conclude that Lambourne was a generalist seeking a balanced overview and attempting to rectify distortions of reality by seeking conceptual equilibrium (64). Within a generalised framework of attempting a conceptual repentance, Lambourne was highly successful. The debt owed to him on this count is enormous. However, in terms of the present work, he went neither far enough nor deep enough into the socio-political dimension of human existence.

James Mathers, the second of the two psychiatrists specialising in Pastoral Studies to whom I shall refer here, has written of his view of the pastoral role (65). Mathers traces the history of the pastoral role. He points out that in the Israel of O.T. times, the pastoral role was associated with the rulers of the nation and focused on public and corporate problems (66). The priestly function was an entirely separate one and related to the preservation and teaching of the religious tradition (67). In the early Christian

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(63) Lambourne, 'Mental Health, Christian Medical Mission and the Future Concept of Comprehensive Health Care', p.34.

(64) See Michael Wilson, 'Repent : Change your Point of View'.

(65) James R. Mathers, 'The Pastoral Role : A Psychiatrist's Perspective' in M.A. H. Melinsky, ed., Religion and Medicine 2, (London : S.C.M., 1973), pp.82-93.

(66) Cf. e.g. the shepherds of Ezekiel 34.

(67) See op.cit., p.82.

church, the pastoral function was linked to the community in general and, again, was not a part of the priestly role. From this data Mathers concludes:

> There is very slender historical warrant for the present-day notion that the professional healers of disease, whose special concerns seem still to be individual and private rather than public and corporate, have anything to contribute to the understanding of the pastoral role (68).

He distinguishes between the prophetic and priestly tasks whose essential nature is one of leadership and the pastoral task which is one of caring for the flock. He asserts that

> There are good grounds for giving priority to the leading rather than to the caring function whenever there is doubt - so to speak, the priestly or prophetic function should take precedence over the obviously pastoral - because in the long run this is more likely to preserve the flock (69).

Mathers cites Moses as an example of one who was in fact a very effective pastor to his people while he was far from being a kindly one. In the light of these reflections, Mathers warns against the dangers of pastors focusing on individualistic methods of care derived from other professional disciplines:

> There is a tendency for clergy, seeking to improve the quality and effectiveness of their pastoral work, to study the methods of caseworkers and psychotherapists, which have grown up, like curative medicine in general, by intensive study of the individual, isolated from his social context. This has been particularly true in America, and we should be warned by their experience (70).

Picking up on Lambourne's insights into the corporate nature of health and salvation, Mathers claims:

> Whatever individualized care he may receive, the single man will only be able to reach his best

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(68) Ibid., p.83.

(69) Ibid., p.84.

(70) Ibid., p.85.

> possible health, his optimum, inasmuch as he is a participating member of a community or organism of which the morale is good. Without this context, the best that can be offered him is the mediocre, average condition which medical science so often takes as its norm - the mere absence of disease... . Robbed of his social context and sense of common purpose, it is unlikely -that a man will stay free of disease for long. Conversely, of course, morale in the community is likely to be adversely affected if there is frank neglect of the care of the individuals composing it (71).

From the account above it can be seen that there is, within the modern pastoral care tradition, a certain amount of material which points to the importance of the social and the political in pastoral care. It must, however, be said that this awareness seems generally to have had little influence in pastoral practice. Furthermore, none of the writers cited have developed any kind of explicit or coherent socio-political analysis. On the whole, their awareness of socio-political reality is of a generalised nature.

Finally, it is interesting to note that those who have been most incisive in the area of the corporate and socio-political dimension of pastoral care in Britain have been medical doctors rather than pastors (72).

Turning from modern to more ancient sources in the history of pastoral care, it is clear that there is a much greater diversity of pastoral practice and a much broader

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(71) Ibid., ''.86-87.

(72) Lambourne, Mathers and also Michael Wilson who, as I showed above, gives more attention to the hospital as an institution than any of the other writers on hospital chaplaincy, are all medically qualified.

conception of pastoral care than is apparent in the definitions of this activity cited earlier from modern authors. Visiting the poor and sick, consolation, preparation for sacraments, and spiritual direction all fall within the ambit of pastoral care historically. Two elements are especially prominent in historical pastoral care; the overcoming of sin among the faithful and church discipline (73). It can be argued that both these elements have strong corporate overtones, being more to do with building up the body of Christ and enabling it for its missionary function in the service of the Kingdom of God than simply with the relief of individual suffering and existential problems. In the words of Lambourne (following Thurneysen), "Pastoral care ... is concerned with church discipline" (74).

Clearly there has often been in the pastoral care of the church an important element of political involvement for the sake of maintaining the Body and for the sake of bringing those outside the realm of salvation within it. This can be illustrated with two examples, those of Augustine and Calvin. As Bishop of Hippo in the fourth century, Augustine evolved a doctrine of coercion by the civil authorities in order to draw the schismatic Donatist sect back into the Catholic church, seeing this as an integral part of his duties as a bishop and pastor (75). Calvin, in sixteenth century Geneva

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(73) This assertion is based on evidence from John T. McNeill, A History of the Cure of Souls (New York : Harper and Row, 1977) and Clebsch and Jaekle, Pastoral Care in Historical Perspective.

(74) Lambourne 'Personal Reformation and Political Formation in Pastoral Care',p.183

(75) For more on Augustine's attitudes to the Donatists see W.H.C. Frend, The Donatist Church (Oxford : O.U.P., 1952), Ch.15, and Peter Brown, Augustine of Hippo (London : Faber, 1969), Ch. 21.

devoted a good deal of his energy to writing pastoral letters to rulers in "an attempt to reach the conscience of the man, while suggesting the policy of the ruler"(76). These examples are amplified by, and bring to mind, the perception of Mathers that in the Biblical tradition the pastoral task was linked with the political task of rulers and his assertion that ultimately the function of leadership must take precedence over that of pastoral care in a narrow individual sense for the sake of allowing the flock to survive. In this context then it could be said that there are grounds in the Christian tradition for maintaining that, in at least some circumstances, only appropriate political action is truly pastoral care.

Further examples of the ways in which pastors have exercised an overtly socio-political function, which they presumably saw as in some sense part of their cure of souls or pastoral care are to be found in Russell's account on Anglican clergy in the eighteenth and nineteenth centuries. Apart from their liturgical and preaching functions, parish clergy were officers of law and order, almoners, teachers, officers of health (this included acting as physicians where no others existed), and politicians (77).

In looking at the historical diversity of what may loosely be labelled 'pastoral care', an attempt is not being made to justify the assertion that chaplains should be politically aware and active in the pursuit of pastoral care. Rather, it is hoped that it will be recognised that (a) there is a great variety of pastoral practice upon which to draw in the Judaeo-

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(76) McNeill, op.cit., p.201.

(77) See Russell, The Clerical Profession, Chs. 8-15.

Christian tradition, that (b) by implication, in terms of the tradition in pastoral care, the narrow modern definitions cited at the beginning of this section are somewhat arbitrary, and that (c) socio-political activities are at least one element in the pastoral care tradition, and are not entirely alien to it as they might seem on first sight. Clebsch and Jaekle themselves admit that Christian pastoral care defies neat classification and systematisation (78). They furthermore assert that pastors today cannot be bound by the methods and aims of pastoral care in the past (79). This is a judicious assertion, not least because it is consistent with the methodology of the liberation theologians who see the traditions of the past as permissive rather than normative. In the present context this makes it possible to argue that pastoral care must be determined by the needs of the people of God in the present and not by the definitions of the past. This being the case, a definition of pastoral care which is very broad, permitting ministry to individuals and wider society within which it is possible to adopt an essentially socio-political stance will now be proposed.

Pastoral care must be seen as having two main elements. Firstly, it is activity directed towards the fight against sin and sorrow in the lives of human beings, however this sin and sorrow appears and whatever causes it (80). It should be noted in this connection that sin and sorrow are not caused by or suffered by atomised individuals alone. Collectivities

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(78)Clebsch and Jaekle, op.cit., p.2.

(79) Ibid., pp.2-3.

(80) Cf. McNeill, op.cit., p.330 for this characterisation of the cure of souls.

of individuals can suffer, and they have a far greater potential for sin and destruction than any individual could ever have. Thus Davies writes,

> To be set free from sin is not to be understood in terms of individual, personal and private sin ... freedom, if it is to be anything other than private self-adulation, has to be embodied in corporate life (81).

Secondly, pastoral care is that activity which is oriented towards presenting all people perfect in Christ to God (82). It should be recognised that the fullness of humanity and growth is also a corporate experience. Jenkins writes,

> The process of the growth of the image out of the potentialities of the image towards the fullness of him who is imaged is not an individual process. Indeed, I am increasingly of the view that 'the individual' is a myth and a dangerously dehumanizing myth. We are not individuals, we are persons ... The process of the development of the potentialities of the image of God which is the process of being and becoming human is the process of the development of community ... We cannot be human until all are human (83).

Several significant features of this definition of pastoral care should be noticed. Firstly, an open ecclesiology is implied in it. That is to say that pastoral care is directed towards all people and not only towards those who would see themselves as members of the Christian church only. This assertion is consistent with the insights of the liberation theologians who reject the division between the realm of salvation, the church, and the realm of human history. God's saving activity then occurs in the world and the task of pastoral care offered by representative Christian persons

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(81) J.G. Davies, Christians, Politics and Violent Revolution, (London : S.C.M., 1976), p.102.

(82) Cf. Col.1.28.

(83) Jenkins, The Contradiction of Christianity, p.102. Emphasis original.

extends beyond the bounds of the church.

It is also consistent with the actual experience of pastors who find that, pragmatically, they cannot confine their energies only to members of the church, but must offer service to all those who need and will accept it. If Hiltner's notion that operation-centred theology derived from practical experience in the past is accurate (84), it would seem that the experience of pastors is indicating a modification in the corpus of theology as a whole to the effect that salvation, history and pastoral care are one and that exclusiveness is neither permissible nor actually possible in being faithful to God (85).

A second feature of this definition of pastoral care is that it permits a positive and preventive approach to pastoral care which is oriented towards growth in the future

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(84) For Hiltner's operation-centred theology see Hiltner, Preface to Pastoral Theology.

(85) Examples of incipient universalism in pastoral praxis can be found in much of the chaplaincy literature cited above. None of the chaplains to whom I have spoken would advocate a ministry only to the faithful and many defined 'the people of God' in non-ecclesiastical terms. It must be admitted that in advocating a pastoral care which is extra-ecclesiastical as well as intra-ecclesiastical, conventional theories of this activity are being transcended. Campbell has pointed out that both Hiltner and Thurneysen adopt an essentially intra-ecclesiastical definition of pastoral care and in general pastoral theory has held to this kind of narrow definition. See Alastair V. Campbell, 'Is Practical Theology Possible?', Scottish Journal of Theology, 25, 1972, 217-27.

and the prevention of suffering rather than simply towards a post hoc therapeutic role in binding up injuries which must occur again and again unless fundamental changes beyond the individual are made. Finally, this definition allows pastoral care to escape from the psychological and individual encirclement which I described earlier. It permits approaches which are oriented towards communities, institutions, and perhaps even whole societies when this seems the most appropriate way of eliminating sin and sorrow and encouraging growth into the fullness of humanity to which all people are called in Christ.

It is necessary at this point to emphasise that while it is being maintained that socio-political action on the part of pastors can legitimately be construed as pastoral care, it is by no means being suggested that the care of individuals is not an equally legitimate part of valid pastoral praxis. The care of individuals is, and will remain, a very important part of pastoral care, for reasons which will be explored shortly. However, the notion that only the care of individuals or small groups constitutes authentic pastoral care, especially when that care is exercised without any regard to the socio-political context of carers and those being cared for, is rejected. Such practice opens the way for uncritical, therapeutic quietism which almost invariably maintains the status quo in political terms and may be at odds with the claims of social justice. Ironically, those who would focus exclusively on the individual and reject socio-political action may ultimately fail to help that individual to the extent that they might because they fail to alter structures which will affect the futures of all individuals. Honouring the individual in the end requires the possibility of socio-political as well as personal

involvement (86). While it would be wrong to deny that there are real difficulties in values and orientation facing the pastor in coming to terms with both the 'personal' and the 'political' (87), there can be little doubt that some kind of principle of equilibrium is necessary in pastoral care whereby the political and individualist orientations are able to inform and assist one another (88).

It has already been stated that the individual is, and should remain, a proper object for pastoral care. The reasons for this assertion must now be expounded. In the first place, while it is true that many of the cases of suffering have a very important socio-political component, there are some features of human existence which cannot be dealt with by socio-political action. This is recognised, for example, by radical social workers:

> Although the oppressive and dehumanizing elements in the capitalist system affect every facet of our lives, some experiences of pain and suffering are

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(86) Lukes makes a similar point in arguing that if individualism is taken seriously as a value, the only way it can become a reality for all people is through a humane form of socialism. See Lukes, Individualism, p.157.

(87) These difficulties are explored by Halmos who compares the features of mutuality, particularism, aspiration to value neutrality, tentativeness, lack of certainty and rejection of violence which tend to be inherent in the personalist orientation with the segmantalisation one-sidedness, universality, partisanship, forcefulness cognitive certainty and implicit violence inherent in the political orientation. See Paul Halmos, The Personal and the Political (London : Hutchinson, 1978), Ch. 6.

(88) See Halmos, op.cit., Ch. 7, for a model of 'symbiosis' of the personal and political which draws out the common ground between the two orientations.

> inseparable from human life, including those associated with loss, bereavement, ageing and death. A radical perspective which ignores or argues away the psychological effects of experience and the need to respond to these effects individually ... is in danger of failing to consider others as whole persons, of perpetuating, in another form, a fragmented, dehumanized view of men and women. Radical social work must therefore encompass direct work with individuals and families as well as with the wider groups and collectivities to which they belong, and must seek to relate organizational and individual action (89).

Secondly, and equally pragmatically, individually-oriented pastoral care will allow the growth of mutual trust and affection between pastor and community which will enable corporate action for change in society to take place (90). Personal relations can facilitate socio-political change. Thirdly, and more idealistically, it must be recognised that individuals are rational and moral beings, transcending their social context in some sense, and worthy of recognition and care as ends in themselves. While this seems uncomfortably idealistic, it is a necessary principle if moral discourse of any kind is to be possible, and this includes moral discourse concerned with the shape of the political order (91).

In this chapter it has been argued that a socio-political model of pastoral praxis is compatible with, and may validly be called pastoral care. This is possible because there is

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(89) Peter Leonard, 'Towards a Paradigm for Radical Practice' in Roy Bailey and Mike Brake, eds., Radical Social Work (London : Arnold, 1975), pp.46-61, p.51.

(90) See Seifert and Clinebell, Personal Growth and Social Change, pp.135f. and 73f. for more about this.

(91) For more on these points see Raymond Plant, Social and Moral Theory in Casework (London : R.K.P., 1976) pp.13ff.

a socio-political tradition in the historical practice of pastoral care, as well as in the modern pastoral tradition, and because the narrow modern definitions of pastoral care focusing on the individual are themselves somewhat arbitrary - an opportunistic pragmatic response to sin and sorrow and the need for growth in the society in which they evolved - and none the worse for that. It has been argued that individualistic definitions of pastoral care cannot be regarded as in any sense authoritative or binding and a new definition of pastoral care which is compatible with elements in the Christian tradition which allows the possibility of socio-political theory and action to take its rightful place, where circumstances demand that this should happen has been outlined. At the same time it has been asserted that this does not mean abandoning the importance and care of the individual. However, it does appear that pastoral care has become so obsessed with the individual that a good case could be made for a great deal more time and effort to be spent on developing a new praxis and theory which focuses mainly on the social and political factors surrounding individuals beset by corporate sin and sorrow and stunted in their growth towards each other and towards God by the social circumstances and socio-economic order in which they live.

Having considered the pastoral care tradition and the place of the socio-political dimension within it, it is now possible to move on to outline some principles for a socio-politically aware and committed pastoral care, especially in psychiatric hospitals. These form the conclusion of the present work.

C O N C L U S I O N

CONCLUSION

The present work took as its starting point some of the insights and methods of a particular form of political theology, liberation theology. From this a method was outlined whose purpose was to identify inequality, injustice and oppression in the socio-political context of one specific mode of pastoral care, that exercised by chaplains in English and Welsh psychiatric hospitals. Using a basically Marxist perspective, it has been possible to show that social inequality, injustice, oppression and conflict of group interest impinges upon the incidence of mental disorder and the treatment of the mentally disordered in our society. Furthermore, it was recognised that there is little awareness of this dimension amongst pastors working in psychiatric hospitals. This lack of awareness leads, it was suggested, to pastoral practice which, albeit unwittingly, affirms the power relations and inequalities which are present in the hospital in particular and in society in general. Thus it was asserted that pastors exercise a form of pastoral care which is essentially conservative and which maintains the present status quo. Against this 'a-political' and basically conservative role for pastoral care, it was argued that the socio-political dimension of human existence must find a place and that this can be seen as an integral part of the Christian pastoral care tradition. A definition of pastoral care was proposed which allowed and affirmed the validity of socio-politically informed and committed pastoral activity alongside other aspects of this activity. It was further suggested that appropriate modes of pastoral care must be determined by contemporary needs for freedom from sin and sorrow and for growth. In the case of the mentally disordered in contemporary British society, it has been seen that there are social and political factors involved in incidence.

recognition and treatment and this suggests that pastoral care of this group should encompass social and political action of some sort in the interests of alleviating and preventing suffering and of promoting positive growth.

This concluding chapter sets out to outline some general principles for a socio-politically aware and committed pastoral care and then to relate these more specifically to factors uncovered by the analysis of the psychiatric hospital and the situation of the mentally disordered. Having outlined these principles and their specific application, I shall return to the question, enunciated at the beginning of this work, namely how far the insights and methods of the theology of liberation illuminate and provide a basis for an evaluation of the theology and practice of pastoral care in this country.

There are six fundamental general principles for a socio-politically informed and committed pastoral care. These are as follows:

1) It must be based on a thorough analysis of the socio-political context in which pastoral care is exercised.
2) There must be an option for the oppressed.
3) It demands that pastors should become 'organic intellectuals' of oppressed groups and should exercise an educative, consciousness-changing role.
4) It requires membership of, and co-operation with, groups working for desired social change.
5) It requires an 'unfinished' model for social and political action.
6) It does not preclude appropriate individual pastoral care.

Each of these principles will now be expounded and discussed.

Analysis of the social and political context of pastoral care

If pastoral care is to be socially and politically aware as well as committed, a priority is the need for careful analysis of the socio-political context of this activity. This analysis will make clear who the oppressed are in a particular situation and will help in the identification of appropriate modes of action for desired change. Almost certainly, a failure to undertake detailed analysis will result in the inappropriate selection of groups by pastors and may well result in equally inappropriate or ineffective action.

The analysis contained in the second and third parts of the present work which anatomises the broad context and the socio-political factors surrounding the psychiatric hospital may be seen as paradigmatic of the type of activity which is advocated here. It is to be hoped that it reveals the value of such analysis while it also illustrates the difficulties inherent in it. It is important to realise that, while analysis of the socio-political factors and structures of another type of institution might demand the use of different tools and sources of information than the ones used here, the exercise itself cannot be avoided.

A similar assertion to this one is made by Bailey and Brake in connection with the practice of social work. They define radical social work as "essentially understanding the position of the oppressed in the social and economic structure they live in" (1). It seems appropriate to apply a similar

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(1) Roy Bailey and Mike Brake, 'Social Work and the Welfare State' in Roy Bailey and Mike Brake, eds., Radical Social Work, (London : Arnold, 1975), pp.1-12.

principle, that of understanding the position of the oppressed in the context of their social and economic structure, to the practice of a socio-politically aware and committed pastoral care.

The option for the oppressed

It may be recalled that one of the most prominent features of the theology of liberation is its assertion that the starting point for theological reflection should be a concrete option for the oppressed (2). A concrete and conscious option for the oppressed should also be a starting point for a socio-politically informed and committed pastoral care, whether in society in general or in the hospital in particular (3). In any situation where there is a conflict of interest between groups or individuals, or where there are substantial and influential disparities of power, it is suggested that the pastor should in general opt for the weaker side.

This assertion is based on the assumption that in a situation of conflict it is in fact impossible to preserve a neutral stance: "Political neutrality, as the Marxists know well, really favours one side rather than another and far from being neutral is unavoidably partisan (4). Freire puts

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(2) See above Ch. 1, especially p.30ff.

(3) Although the option for the oppressed is referred to in the singular here, it must be recognised that within the basic preliminary desire to be on the side of the oppressed denoted by this term there are in fact many specific options for identification and action. The broad concept of the option for the oppressed talked of here indicates the need to escape from conscious or unconscious collusion with the powerful or oppressors.

(4) Davies, Christians, Politics and Violent Revolution, p.30.

the same point in rather stronger terms: "'Washing one's hands' of the conflict between the powerful and the powerless means to side with the powerful not to be neutral" (5).

There are a number of difficulties, both practical and theoretical, consequent on asserting that pastors should make a deliberate option to side with the powerless and oppressed. In the first place, prevalent conceptions of reconciliation have to be altered. There is a long tradition in the church and among its pastors of attempting to bring together groups and individuals which are in conflict with one another. Underlying this work of reconciliation is the notion that in Christ all people are united and that therefore all division and disunity is contrary to will of God. Generally, pastors have attempted a role of reconciliation on the basis of neutrality and mediation. It was noted above how great a value psychiatric hospital chaplains, for example, put on preserving neutrality and a non-partisan stance within the hospital, and this is at least partly motivated by the need to exercise a ministry of reconciliation. It may appear that the notion of reconciliation in ministry is being forfeited in advocating that pastors should be prepared to take a partisan stance in conflict. It can be maintained that this is not in fact the case. The end of seeking to unite people remains the same in a socio-politically aware and committed pastoral care. It is the means which differ. A partisan stance is recommended because it is realised that apparent harmony and reconciliation is often based on what is effectively a defence of the status

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(5) Paulo Freire, 'Education, Liberation and the Church, in Alastair Kee, ed., A Reader in Political Theology (London : S.C.M., 1974), pp.100-06, p.100.

quo with its implicit injustices and inequalities. True reconciliation can only be achieved from this perspective by the pursuit of liberty, justice and equality for all people. Where this does not exist it is necessary to strive actively for it and this may mean actively siding with an oppressed group to help achieve basic equality. It is not a question of loving the oppressed and hating the oppressors. The true freedom and reconciliation of both groups will be found only when the oppressed are freed. This point is neatly encapsulated by Davies: "Liberation ... has to take place before reconciliation of the two sides is possible - without liberation there is not reconciliation but conciliation (6).

A second problem which must be confronted in advocating an option for the oppressed on the part of pastors is that of actually perceiving who the oppressed are in a particular situation. The foregoing analysis of the psychiatric hospital and its social and political context revealed many different levels and types of powerlessness, inequality and injustice. It was seen, for example, that the psychiatric sector of the National Health Service is under-financed and neglected. Within the psychiatric sector itself it was noted that different groups have different amounts of power and influence ranging from doctors with a great deal of autonomy to patients who were found to be relatively impotent within the psychiatric hospital. The complexity of this situation precludes naive over-simplification and demands two things of the pastor who desires to put himself at the disposal of the powerless. Firstly, he must be prepared to undertake a proper, thorough analysis of the society and the institution in which he functions without minimising the ambiguities and complications which this exposes. Secondly, in the light of such an analysis,

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(6) Davies, op.cit., p.184.

he must attempt to develop a differentiated response to the various injustices and inequalities of power and resources which are exposed. Thus, it might happen that while in the context of the hospital ward the chaplain of a psychiatric hospital sought to enhance the autonomy and power of patients and junior staff over against that of the medical profession, at an extra-institutional level, say that of the District, the chaplain might seek to co-operate actively and closely with doctors to obtain a better deal in terms of the psychiatric sector from the National Health Service.

The third problem associated with a basic option for the oppressed concerns the pastor's relationship with the institutional church and with his fellow-ministers. Matheson argues that the most common relationship between the church and the State has been that of assimilation in which Christianity has been used to legitimise the political establishment (7). While Matheson argues that this relationship is now in decline, there can be little doubt that a residuum of this remains, perhaps especially in established churches such as the Church of England whose Supreme Governor is also the head of State. This means that even today this church and its leaders tend, by and large, to adopt a fairly positive attitude to the existent social order and to eschew radical social change. This inherent conservatism is also nurtured by the professional ideal of neutrality adopted by many clergy. Russell notes that

> The notion that the clergyman is 'above politics' may be taken as a significant indicator of the degree to which clergy (have) accepted (the professional) ideal; for the concept of

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(7) See Peter Matheson, Profile of Love (Belfast: Christian Journals Limited, 1979), pp.34-7.

> neutrality - affective, emotional and political - is of central importance in the professional model (8).

Neutrality can be, and in the case of clergy often is, a covert form of conservatism and a means of maintaining the status quo without actually appearing to do so. The point that is being made here is that pastors are members of an institution and of a profession which has taken a positive, or at least a neutral view of the social and political order as it is presently constituted. Those who would attempt to challenge that order, to take a critical active social and political stance with the oppressed may not receive a great deal of acclamation or support from their ecclesiastical superiors or their colleagues in the ministry. It must be clearly recognised that socio-politically informed and committed pastor must take the risk of finding himself alienated to an extent from the institutional church and from his peers, as well as from certain powerful groups within the N.H.S.

Pastors as 'organic intellectuals' of oppressed groups

This principle embodies the insight of the Italian Marxist thinker Gramsci that clergy as intellectuals legitimate the rule of the powerful in society but can choose to eschew this role in favour of putting their intellectual and ideological resources at the disposal of oppressed groups. As educated professionals, clergy often have considerable resources in terms of both understanding and the ability to manipulate information which can be of great use to those who feel that they have few or no tools for understanding or changing their own situation in the face of the forces

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(8) Russell, The Clerical Profession, p.228.

which are ranged against them.

To some extent the mere fact of having been educated to a high degree furnishes clergy with the equipment they need for this role. However, it is also desirable that they should receive specific training in the social sciences if this role is to be enhanced and made more valuable. Theological training can also make a contribution to the pastor's understanding of the situation of those whom he seeks to serve in this way. A consideration of political theology and more specifically of the theology of liberation has already revealed that there are aspects of the Christian tradition which contribute valuable ideological insights into social and political reality and into situations of injustice and inequality.

In using general, sociological and theological intellectual skills and insights to help the powerless to articulate and understand their position more clearly, pastors can act as effective catalysts for desired social and political change (9).

Co-operation with other groups

Throughout this work the emphasis has been on the importance of wider social and political groups and structures. Clearly an individual acting on his or her own can have only a limited impact for change on such structures. Pastors seeking social and political amelioration for those in their care must therefore be prepared to work closely with others to attain mutually desirable ends. This principle applies at all levels of the pastor's activity and concern.

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(9) For this role in general see further Peter Leonard, 'Toward a Paradigm for Radical Practice' in Roy Bailey and Mike Brake, eds., Radical Social Work (London : Arnold, 1975), pp.46-61.

Unfortunately, such a principle challenges one of the key characteristics of contemporary clerical practice. Unlike other professional groups, clergy have adhered closely to an individualistic model of operation. Even today, the normal pattern is for clergy to work on their own in a parish and to exercise a great deal of autonomy over their own activity (10). Close co-operation with other groups which might demand the surrender of a degree of autonomy is therefore alien to the orthodox clergy. This might not be the case to quite the same degree in the particular case of hospital chaplains where the notion of the 'therapeutic team' with its emphasis on interdisciplinary co-operation may have served to break down the importance of clerical autonomy to some degree. However, it is a factor which should not be ignored or minimised in considering this aspect of socio-politically informed and committed pastoral care.

Clearly, not all the groups with which the pastor co-operates to bring about desired social and political changes in a particular context will consist entirely or even predominantly of practising Christians. It may be necessary to work with secular pressure groups and movements to achieve a wider end which is mutually desired. This should not deter the pastor, for if the insights of the theology of liberation are correct, it is not only members of the churches or self-confessed Christians who are used by God to make real his Kingdom on earth.

An 'unfinished' mode of social and political action

I have argued that the root of much sin and sorrow is to be found in social and political structures. The relief

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(10) See further Russell, op.cit., Chs. 17 and 18.

and prevention of this therefore depends on some kind of action to change those structures. Clearly this action must often be oriented towards long-term change and its execution may take a long time to get under way. If major social changes at a national level are required many years may elapse before any significant change is apparent. At the same time however people will continue to have short-term needs and will experience the effects of the way things actually are at the present. The pastor is thus confronted with a number of dilemmas. Should he avoid short-term ameliorative action in order to concentrate on long-term aims? Should he work for small, immediate reforms or look towards the radical transformation of the whole social order in the future? This may be polarised as the dilemma between 'reform' and 'revolution'. (11).

In this connection Cohen's 'unfinished' model of social action for change is helpful and illuminating. Cohen argues that it is necessary to obtain both short-term reforms within the present social order and long-term change in the totality of that order. He suggests that it is unhelpful and wrong to opt entirely for one mode over against the other. This is because the option for future total change alone leads to the neglect of the immediate needs of those who are oppressed and suffering while the choice of immediate reform can easily lead to effective co-option to the status quo and the loss of long-term solutions. This model is of great utility to pastors who seek to sort out priorities and appropriate action in the context of a socio-politically

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(11) The dilemma between reform and revolution is by no means exclusive to chaplains or pastors. Other groups, e.g. social workers and doctors share this problem.

informed and committed pastoral care (12).

Pastoral care of individuals

It is important to emphasise that there is still room for the pastoral care of the individual within the socio-political model of pastoral care advocated and outlined here. Individuals remain ends in themselves and will continue to have needs which can be met in an essentially individualistic way. The skills and insights of individually oriented pastoral care remain of lasting value to the pastor and the care of individuals as an important pastoral task is not in question here. It is, however, questionable whether individually-oriented pastoral care should dominate the work of pastors to the extent which it has in recent times in Western society.

It should be acknowledged that individual pastoral care enables the pastor to keep in touch with the constituency which he seeks to serve. It helps him to reflect more accurately their needs and desires and also reduces the potential suspicion and distrust which might come into existence when a pastor undertakes social and political action which might tend to alienate some individuals.

Finally, it should be noted that while social and political action might alienate pastors from some individuals, it will almost certainly open up the way to individual pastoral care of others. It is surely correct that political activism may tend to estrange pastors from some members of the Christian

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(12) For a longer exposition of Cohen's 'unfinished' model of social action for change see Stanley Cohen, 'It's All Right For You To Talk : Political and Sociological Manifestoes for Social Work Action' in Roy Bailey and Mike Brake, eds., Radical Social Work (London : Arnold, 1975) pp.76-95.

community (13). On the other hand, it may draw pastors closer to those who had previously rejected the ministrations of the church in their quest for social justice. In this context there are many wounds to be bound up and there is much growth to be nurtured. For this reason it is erroneous to equate social and political action for change with a total denial of the need for individual pastoral care. Individual care remains even though the constituency of the 'flock' may change (14).

Having outlined six general principles for a socio-politically aware and committed pastoral care, it is necessary to exemplify and be more specific as to how these principles might be applied in the particular situation of the psychiatric hospital.

It has already been indicated that an option for the oppressed, the first principle under consideration here presents a number of problems, both practical and theoretical. It is important that the reality of these difficulties should not cause pastors to cease to try and identify the oppressed and to work for and with them. It has been suggested that a graded response is necessary in this connection. The psychiatric hospital chaplain must try and identify oppression at all levels, from that of the health sector as a whole down to the ward level. He must then decide in the light of this

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(13) For more on this see Gill, Prophecy and Praxis, Ch. 4.

(14) An interesting and instructive parallel example in considering the relationship of individual care against socio-political action is that of medicine. This discipline manages to address both individual and social needs by splitting itself into clinical and community medicine specialities. Perhaps a similar division of interest and labour should be introduced into pastoral care.

to what extent he can act effectively in his particular situation, given his own strengths and weaknesses and the opportunities, or lack of them, that the situation provides. The suggestions which follow should therefore be treated as exemplary rather than prescriptive.

The analysis of the psychiatric sector above indicated clearly that ultimately the least powerful group and that which suffers most under the present order is that of the patients. This suggests that the socio-political activity of chaplains should be shaped by the final end of changing the factors which allow this to be the case. An option for the patient group in the hospital will require spending time with them, coming to understand their perspective on the hospital and the way it works, and working for and with them to achieve a greater equality of power and influence. This might mean trying to ensure that structures in the hospital come into existence which reflect the views of the patients and where patients can have representation, e.g. on patient care groups or on staff-patient groups. It could mean defending or advocating the patient's point of view when a particular decision is being made about that person's future, e.g. when compulsory treatment under the Mental Health Act or the taking of children into care is mooted. As it was shown above, it is easy for staff to arrive at an opinion of the patient and what should be done for him without the patient himself having his own perspective taken seriously. The negative effects of this situation can be far-reaching and permanent. I would suggest that chaplains might like to take a particular interest in the most demoralised sectors of the hospital where voicelessness and lack of resources, human and other, are especially prominent features. This is often the case in the sectors of psychiatric hospitals which care for the very old and demented. Doctors and others tend to

spend a disproportionate amount of their time working with the acutely ill, to the neglect of the psychogeriatric population in the hospital. It may be that chaplains would wish to adopt a precisely contrary bias in their work and allocation of time. Work in this sector presents several difficulties, the chief of these being that the very old and demented cannot, even with help from others, speak for themselves. A commitment here on the part of the chaplain would require close co-operation with patients' relatives and the staff on the ward to achieve amelioration of conditions there.

Another group within the hospital which may be regarded as in some sense oppressed is that of junior nurses and unqualified staff. Once again, it may be possible for chaplains in psychiatric hospitals to consider this group and to work towards a greater integration of its perspective within the institution. Frequently people working at the bottom of the nursing hierarchy feel unable to make an impact on the hospital. A pastor working outwith the nursing hierarchy can do much to aid the transmission of their views and to encourage junior staff to retain a sense of vision in circumstances where the odds are against them.

A graded response to the different situations of oppression and inequality encountered in the psychiatric sector as a whole demands that in certain circumstances chaplains should co-operate with all those working in the sector to ensure that adequate resources are devoted to it. However, chaplains will need to be careful in their relations with powerful groups in the hospital. It is easy to accept the definition of the situation put forward by groups such as doctors because they can articulate their position so well. It is therefore important that pastors should remain

critically aware of that which may be implicit in the 'official explanation' for actions or states of affairs within the hospital. There has been a tendency among chaplains to join the 'therapeutic team' within the hospital and to co-operate closely with those who have power. This involvement has taken place for the best of motives, the amelioration of the patients' suffering. My analysis of the psychiatric hospital suggests that too ready involvement in the 'therapeutic' process may not in fact always be the best way for chaplains to help the patients and staff in their care.

Little more need be said about the particular application of the general principle of analysis in the context of pastoral care in the psychiatric hospital. Much of the present work has been devoted to this and it has been seen what a range of tools and sources are needed to undertake this process in anything like a thorough and comprehensive fashion. One element which is almost entirely missing in my analysis of the psychiatric hospital is the voice of the patients and staff of the hospitals. This perspective is very difficult to come by in literary sources but it is vital if the chaplain is to gain a full understanding of the socio-political context in which he is required to function. An important task of any pastor seeking to implement the general principle of analysis in a particular situation will be to spend time with, and to listen very carefully to, the views and opinions of those working in particular hospitals. These will give valuable information on matters of inequality and powerlessness and will suggest ways in which those matters should be dealt with in practical terms.

The chaplain's role as an intellectual in the broad sense of the term and as a catalyst to changing of perspective in the psychiatric hospital should not be minimised. One who

has undertaken a thorough analysis of the social and political structure of the hospital and of the psychiatric sector such as the one above can contribute a great deal to patients and staff alike in helping them to come to a realistic appraisal of their situation within the system. It is vital that people should have a realistic appraisal of the social system in which they find themselves and the location of power within that if they are even to begin to try and change it for the better. A broadening of perspective and a proper understanding of the situation as it exists at the present time is the sine qua non for social and political action.

It was suggested as a general principle of socio-politically aware and committed pastoral care that co-operation between chaplains and other groups seeking common ends is of the essence if desired social change is to be accomplished. In the context of the hospital this may mean working with groups of patients, of like-minded fellow-workers, with unions and with hospital committees and sub-committees. There are a number of organisations outside the hospital which also seek to work for beneficial change. These include MIND, National Schizophrenia Fellowship and Mental Patients' Unions. Pastors often have an entrée to church groups whose interest and resources can be mobilised in the interests of the psychiatric sector. Little has so far been done to try and interest the church outside the hospital to bring its corporate weight to bear on the neglect of the mentally disordered in our society and this would be an avenue worth exploring at local, diocesan and national level. The potential of the Hospital Chaplains' Fellowship and the National Association of Whole-time Hospital Chaplains could function as pressure-groups for desired change in the psychiatric sector. In the analysis of the socio-political context of the psychiatric hospital undertaken above, I tried to make clear the connections between

the whole social order and the psychiatric hospital, modes of treatment etc. In the light of this relationship, it is important for chaplains to consider whether or not they should try and become involved in the wider political process of society. In this connection they might contemplate membership of a trade union or of a political party in the interests of influencing, however infinitesimally, the whole social order.

The principle of adopting an 'unfinished model' of social and political action in the context of ministry in the psychiatric hospital requires little further exposition. The chaplain must be prepared to be flexible in his quest for social change and his response must not become totally predictable in every situation. Obviously the points at which the chaplain will compromise and accept reform and those where he refuses to do so will be determined by particular circumstances. An example of the sort of situation in which this kind of dilemma arises can be given however. Clearly, there are many psychiatric hospitals in this country which are outdated and grossly under-resourced. In this circumstance it is necessary for the individual chaplain to decide whether he can do more for the mentally disordered and those who work in the hospital by staying and working alongside them in the psychiatric hospital within the existent framework or by withdrawing himself from it and campaigning for its closure. A refusal to lend legitimation to an intolerable situation may in the end be a more effective act of pastoral care than trying to obtain piecemeal reforms, desirable as these might be in themselves. There are no cut and dried answers in this matter, but the psychiatric hospital chaplain should be careful not to reject the option for radical change as one possible response to the need to alleviate suffering and to nurture growth.

The chaplain in the psychiatric hospital who endeavours to practice a socio-politically informed and committed pastoral care will find that there is no shortage of work to be undertaken with individuals. As people in the institution come to realise that he is 'on their side' they will be prepared to open up and receive his ministration as they have done with few other chaplains in the past. The task of working for change is a difficult and painful one which leaves many wounds. Pastors in this context can sustain and support, nurture and encourage and build up links between those who had previously thought that they were all alone in their perceptions and concerns. The care of the individual will inform and deepen the quest for social and political change, both within the hsopital and outside it. Activities like ward visiting therefore remain an integral part of the pastoral task.

The starting point for this work was the hypothesis that some of the methods and insights of Latin American theology of liberation can illuminate the practice, theory and theology of pastoral care in this country, especially that undertaken in psychiatric hospitals. A critical evaluation of the validity of this hypothesis is now both possible and necessary.

In general terms, the hypothesis proposed has been vindicated in the foregoing. An approach derived from the methods and insights of the theology of liberation has indeed cast new light on the practice, theory and theology of pastoral care, both within psychiatric hospitals and beyond them. This approach has raised many new questions and insights for pastoral care and for ministry and its common assumptions generally. It has, for example, shown that an exclusively individualistic outlook in pastoral care is not adequate in the face of the socio-political causes and effects of human suffering and

needs for growth. Indeed, undue preoccupation with the individual or small groups may actually contribute de facto to the persistence of some types of suffering. The approach illustrated here, based on the methods and insights of the theology of liberation has succeeded in broadening the perspective within which pastoral care is exercised and in pointing up the importance of social and political factors in this as in all other aspects of human existence. It has brought matters of social and political order, conflict, injustice, inequality and impotence to the fore in pastoral care. This is a much-needed corrective in Western society where love for the afflicted individual independent of his social context has tended to be the focus of pastoral care in recent times. In addition, this approach has broadened theoretical resources and tools which may be used to understand pastoral problems and situations. Instead of leaning only on psychology for an understanding of human beings, other social sciences such as political science, sociology, social administration and economics have been utilised and brought into play. Finally, this way of looking at pastoral care has led to the suggestion of some principles for a socio-politically aware and committed pastoral care. These principles allow a re-orientation of pastoral practice to absorb and concretely test these new insights. In many ways then, this approach has been illuminating and invigorating in considering the state of pastoral care in this country today.

There have been, however, some negative factors and difficulties associated with this enterprise. Many of these flow from the difficulty of attempting to transpose analytic methods, theories, insights and concepts from one highly specific context to another. For example, although the use of a basically Marxist perspective in social and political analysis of the context of pastoral care in this country was

substantiated , it is clear that the social order here is different and more complex than it is in Latin America. There subsistence and gross disparities of wealth are apparent. In Britain, on the other hand, disparities of power, wealth and the like are disguised and modified by a democratic social order and by the existence of social institutions such as the welfare state. Perhaps most significantly, people in Britain do not die of starvation. All this is by way of noting that the apparently cut and dried approach of the methods derived above from those of liberation theology can seem over-simplistic and somewhat arbitrary when applied in this particular social context. Similarly, the absolute and dogmatic tone often inherent in the insights of liberation theology worked out in the context of a literally life and death struggle can jar on the ears of people in this country accustomed to the notions of liberal democracy and tolerance. These difficulties are compounded by the fact that the methods and insights of liberation theology have been applied to a particular small-scale situation of pastoral care in psychiatric hospitals and they were not, of course, originally developed to be used specifically in this context. It is not surprising then if there is sometimes a feeling that the shoe does not fit the foot, that the theory and analysis does not exactly fit the situation concerned (15). This might also explain a tendency to grandiosity and ponderousness which might seem gratuitous in the context of pastoral care. If this is the case, it must be regarded as a necessary, if

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(15) It was found, for example, that there are a number of powerless groups in the hospital whose interests and needs conflicted and who were separated from each other by the 'staff-patient divide'. Although it was possible to locate these groups in the wider social and economic order, it has to be acknowledged that they do not conform precisely with the Marxist paradigm of two classes successfully utilised by the theologians of liberation in Latin America.

undesirable, bi-product of the enterprise as a whole. Finally, it must be acknowledged that an approach to pastoral care based on some of the methods and insights of the theology of liberation is inevitably one-sided. It is but one way of looking at this activity; a way of seeing, but also a way of not seeing reality. It is my hope that it has been worth pursuing a one-sided approach as this is more likely to yield a clear cross-section of reality than an approach which is even more even-handed. The nature of the reality which has been exposed has been significant but it must be recognised that other approaches and analyses, undertaken on the bases of different theological methods are possible and valuable also. At the very beginning of the present work it was recognised that problems of content, method and pre-supposition are inherent in the theology of liberation itself. While maintaining the value of the present method, it is essential to admit that it has its weaknesses, blind-spots and narrownesses which make it only one of the many ways of obtaining a full and accurate understanding of the reality of the practice, theory and theology of pastoral care in Britain today.

To conclude: Despite its acknowledged difficulties and weaknesses, an approach to pastoral care based on some of the insights and methods of the theology of liberation is a valuable and worthwhile one. It reveals much that was formerly hidden and which implies considerable modifications of pastoral practice, specifically that in psychiatric hospitals. Indeed, if what has been discovered and suggested using the methods herein is even approximately accurate, it would seem that social and political analysis, reflection and action must lie near the heart, and not on the periphery, of any comprehensive and effective pastoral care in contemporary Britain.

A P P E N D I X

SOCIAL CLASS AND MENTAL DISORDER

It has long been recognised that social factors play a large part in the incidence and prevalence of mental disorder. Hare, for example, showed that social isolation played a part in the incidence of schizophrenia in Bristol (1). Brown and Birley have shown that crises and life changes can precipitate attacks of schizophrenia (2). Brown, Birley and Wing have demonstrated that a high degree of expressed emotion is an index of characteristics in relatives of schizophrenics which are likely to cause a relapse into florid schizophrenic symptoms (3). Brown, Harris and others have identified vulnerability factors such as not having an intimate relationship with a husband or buy friend, not being employed, having three or more children under the age of 15 years at home, and having lost a mother before the age of 11 as influential in the origins of depressive disorders among women. They further noted the importance of severe life events in determining when depression occurs, seeing these as provoking agents of this disorder. Past losses of close relatives, largely in childhood or adolescence, were seen to act as symptom-formation factors, influencing the type and severity of the symptoms experienced by the women investigated. Indeed the degree of social influence discovered in examining depression among women has led Brown to assert that 'depression

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(1) E.H. Hare, 'Mental Illness and Social Conditions in Bristol', Journal of Mental Science, 102, 1956, 349-57.

(2) George W. Brown and J.L.T. Birley, 'Crises and Life Changes on the Onset of Schizophrenia', Journal of Health and Social Behaviour, 9, 1963, 203-14.

(3) George W. Brown, J.L.T. Birley and John K. Wing, 'The Influence of Family Life on the Course of Schizophrenic Disorders', British Journal of Psychiatry, 121, 1972, 241-58.

is essentially a social phenomenon' (4). The findings of Wing and Brown concerning the influence of social factors on hospitalised schizophrenics have been noted elsewhere (5). Finally, Brenner has noted the significant relationship between mental disorder and unemployment (6).

The studies mentioned above are a sample of those which indicate the decisive part which social factors play in the incidence and prevalence of mental disorder. Having acknowledged the importance of social factors, I will focus more narrowly on the specific social factor of social class and its relationship with mental disorder.

Dohrenwend writes: "The most consistent demographic finding reported in the social psychiatric field studies is an inverse relationship between social class and psychological disorder"(7). Fried, reviewing 34 studies on the relationship between social class and psychiatric disorder on both sides of

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(4) George W. Brown, 'Depression : A Sociological View', in David Tuckett and Joseph M. Kaufert, eds., Basic Reading in Medical Sociology (London : Tavistock, 1978), pp.225-34, p.225. See also George W Brown and Tirril Harris, Social Origins of Depression (London : Tavistock, 1978), and George W Brown, Maire Ni Brolchain and Tirril Harris, 'Social Class and Psychiatric Disturbance Among Women in an Urban Population', Sociology, 9, 1975, 225-254 for fuller accounts of this research.

(5) See Wing and Brown, op.cit.

(6) M. Harvey Brenner, Mental Illness and the Economy, (Cambridge : Harvard University Press, 1973).

(7) Bruce P. Dohrenwend, 'Social Status and Psychological Disorder', American Sociological Review, 31, 1966, 14-34, p.15.

the Atlantic, concluded that 29 confirmed the general finding that the lowest status groups in society enjoyed the highest proportion of psychosis and hospitalization (8). Most reviewers would agree with the assertion of Turner and Wagenfield that "there is little doubt that a disproportionate number of schizophrenics are in the lower socio-economic strata" (9). This observation would be equally applicable to specifically depressive disorders also.

Before considering a sample of the vast numbers of studies which consider the inverse relationship between social class and mental disorder, it is important to consider some of the problems, methodological and other, which dilute the cumulative value of this work. Fundamental here is the basic point that many of the studies are not directly comparable because they share no common methodology, sampling technique, terminology or scale of measurement. Thus, for example, a 'case' of schizophrenia may mean very different things in different studies. Certainly, when considering the relationship between British and American studies, there are probably considerable differences in diagnostic definition. British researchers tend to use 'schizophrenia' as a diagnostic term in a far narrower sense than their American counterparts, and this difference was very significant during the 1950's and 1960's when most of the research into mental disorder and social class was undertaken. Similarly, class may be defined in different ways, ranging from strict adherence to the British Registrar General's classification by occupation

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(8) Marc Fried, 'Social Differences in Mental Health' in J. Kosa and I.K. Zola, eds., Poverty and Health (Cambridge : Harvard University Press, Revised Edn , 1975), pp.135-92.

(9) R. Jay Turner and Morton O. Wagenfield, 'Occupational Mobility and Schizophrenia : an Assessment of the Social Causation and Social Selection Hypotheses', American Sociological Review, 32, 1967, 104-13.

to more wide-ranging indices used by researchers like Hollingshead and Redlich who built up a classification system based on education and place of residence as well as occupation. Some of the studies consider urban population while others consider rural ones; here again there are significant differences. Some include members of different ethnic groups while others do not. Different age and sex groups are considered in different studies. While some of the studies attempt to sample the population randomly, and so to identify untreated and possibly unidentified disorder, many only consider those cases which have already been identified and are already being treated. Selection of treated or hospitalised cases introduces a significant bias, as there is evidence that lower class individuals use the treatment services in different ways from those in higher classes. Studies which concentrate only on cases treated in hospital record only the prevalence of treated mental disorder and not the incidence of disorder in the community as a whole. Similarly, prevalence studies of the community may show little about the incidence of mental disorder which is useful in considering its relationship to social class as there is evidence that lower class cases of disorder take longer to recover, so, once again, bias is built in to these studies. Only new cases can effectively indicate incidence. Taking all these factors into account reduces the apparent weight of the evidence concerning the relationship between mental illness and social class. Mishler and Scotch write:

> It is not difficult to criticise the state of the field - few (methodologically acceptable) studies are available, concepts and methods are unclear and unstandardized, findings are inconsistent, and speculation abounds in the absence of reliable

empirical knowledge (10).

Kohn echoes this in writing that "all together, the results of the studies of class and schizophrenia are hardly definitive". He goes on, however to assert that the studies do "probably point to something real"(11). It is in the belief that, on aggregate, the studies of social class and mental illness do point to "something real" that I now proceed to a closer examination of some of them.

I noted above that research into social class and mental disorder has taken place on both sides of the Atlantic. I propose to consider only one American study here to give a flavour of the kind of investigation which has taken place there and I will then turn to a much more comprehensive account of the British evidence concerned with this topic.

The American study chosen for further consideration is Hollingshead and Redlich's classic Social Class and Mental Illness (12). This is a comprehensive account of research in New Haven, Connecticut, into treated cases of mental disorder. The study was conducted in 1950. Among its findings were that a definite inverse relationship existed between treated mental disorder and social status, that the number of cases of mental disorder in the population increases as social status decreases and that there is a greater proportional concentration of cases in class 5 than in any other class in

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(10) Elliot G Mishler and Norman A. Scotch, 'Sociocultural Factors in the Epidemiology of Schizophrenia', Psychiatry, 26, 1963 315-351, p.340.

(11) Melvin L. Kohn, 'Social Class and Schizophrenia; A Critical Review and Reformulation' in P M. Roman and H. M. Trice, eds., Explorations in Social Psychiatry (Philadelphia : F.A. Davis and Co., 1974), pp.113-37, p.121.

(12) August B. Hollingshead and Fredrich C. Redlich, Social Class and Mental Illness (New York : John Wiley, 1958).

society. It was also discovered that social class position was significantly correlated with the type of mental disorder experienced by people. Psychoses were proportionately far more common among members of social classes 4 and 5 than among members of higher classes. The latter experienced more neurotic disorders. Hollingshead and Redlich also considered the relationship between social class and treatment but these findings are more appropriately considered below.

No British study, until that of Brown et al., has been as comprehensive as that of Hollingshead and Redlich. However, such studies as have been undertaken have shown similar results to those of Social Class and Mental Illness. Goldberg and Morrison, studying a sample of 353 male schizophrenics on first admission to hospital in England and Wales found that there were over 100% more from the Registrar General's class 5 than would be obtained if the distribution was even through all classes (13). Although, as was noted above, the study of treated mental disorder may reveal more about reactions to disorder than it does about incidence insofar as it seems likely that lower class people are more likely to extrude the disordered into hospitals than those of higher classes, and may delay in seeking treatment so that disorders become more severe and so must be treated in hospital, the figures presented by Goldberg and Morrison still suggest an increased rate of incidence of mental illness among the lower classes of some size (14).

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(13) E.M. Goldberg and S.L. Morrison, 'Schizophrenia and Social Class', British Journal of Psychiatry, 109, 1963, 785-802.

(14) See Hollingshead and Redlich, op.cit., Ch.11, for more about working class reactions to mental disorder and their response to the disordered.

Brook's figures for first admissions of male schizophrenics to hospitals from 1949-1953 also show a vastly disproportionate concentration of psychotic disorder among the members of social class 5. The figure of 229 class 5 admissions per 100,000 of the population is greater than the combined rates of classes 3 and 4 together. This latter figure stands at 196 admissions per 100,000 of the population (15).

Stein, in a study comparing first admissions for all mental disorders to psychiatric hospitals in two London boroughs in 1954-5 also demonstrated a clear social class gradient in the incidence of treated mental disorder. Her research emphasises that factors other than social class were also important in the aetiology of mental illness (16).

The most recent, and methodologically most acceptable, major study of social class and mental disorder is that of Brown et al.which has already been mentioned (17). In this work, which set out to study the incidence of clinical depression among a sample of 458 randomly selected women in South London from 1969-1975, it was revealed that the incidence of depression is inversely related to social class. Lower class women were found to be much more vulnerable to depression than women in higher classes. Brown and Harris record: "Psychiatric disorder, and depression in particular,

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(15) These figures quoted in J.N Morris, 'Health and Social Class', Lancet, 1, 7.ii.59, 303-5 .

(16) Lilli Stein 'Social Class Gradient in Schizophrenia', British Journal of Preventive Social Medicine, 11, 1957, 181-95.

(17) See Brown and Harris, op.cit., for a complete account of this study.

is much more common among working-class women: 23% were considered cases in the three months before interview compared with only 6% of middle class women" (18). Furthermore it was demonstrated that prevalence of chronic cases of depression lasting for a year or longer is five times greater among working class than among middle class women (19).

It is not enough simply to take note of the evidence for an unequal distribution inversely related to class amongst the population. Some attempt must be made to explain why mental illness and social class are inversely related and to account for the intervening variables in society which are active in the relationship. There exist no completely satisfying explanations for this, but some informed notions have been advanced.

The first issue to be tackled here must be the direction of causality in the relationship between social class and mental disorder. Some writers have argued that there is that in the social situation of the lower class members of society which actually provokes, or helps to provoke mental disorders e.g. stress. These critics believe therefore that in some sense, social class helps to cause mental illness. Others reject this hypothesis and suggest that the reason for the disproportionate distribution of mental illness amongst members of the lower classes is that the illnesses themselves cause downward social mobility 'downward drift'. "In its broadest formulation", Kohn writes,

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(18) Brown and Harris, op.cit., p.151

(19) Ibid., p.195.

> the drift hypothesis asserts that high rates of schizophrenia in the lowest social strata come about because people from higher social classes who become schizophrenic suffer a decline in social position as a result of their illness (20).

Evidence for the social drift or social selection hypothesis is equivocal. Turner and Wagenfield conclude from their research that the balance lies on the side of social selection rather than social causation in the relationship between social status and mental disorder. Goldberg and Morrison produce evidence which also favours the social selection hypothesis although they do conclude that "occupational factors, yet to be defined clearly, appear to exert some influence on the course of the disease (schizophrenia)" (21). Kohn, however, concludes that "it can be tentatively concluded that, despite what Goldberg and Morrison found in England and Wales, the weight of the evidence lies against the drift hypothesis providing a sufficient explanation of the class-schizophrenic relationship" (22).

Brown et al.concur with Kohn's judgement in the case of depression and assert the casual effectiveness of social class as a significant and independant variable in the causation of mental disorder. At the same time, they resist any attempt to oversimplify the nature of causality by social class or to be dogmatic as to the exact relationship between it and mental disorder. I will go on to expound the models offered by Kohn and by Brown et al.to account for the

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(20) Kohn, op.cit , p.117.

(21) See Godlberg and Morrison, op.cit., p.802. Emphasis added.

(22) Kohn, op.cit , p.119.

intervening variables in casual relationship between social class and mental illness.

Both theories are quick to emphasise the multifactorial nature of the variables intervening between social class and mental disorder. Kohn argues that genetic predisposition, due perhaps to the lack of upward mobility of previous generations may be one very important such intervening variable. Stress, i.e. externally induced pain, may be another. Kohn argues that it is probably not so much stress in itself which is greater in lower class life situations (although he does indeed believe that the lower classes do experience more stress), but rather that lower class people have fewer resources, institutional or internal for dealing with stress. Kohn emphasises the importance of the internal resource factor, suggesting that the view of reality internalised in lower class culture tends to be rigid, limited, and conservative and so disfunctional under stress. This prevents lower class people from being able to deal resourcefully with problems which confront them. Because such people are insufficiently educated, work at jobs of little substantive complexity under conditions of close supervision with little leeway to vary their routine flow of work, their sense of social reality tends to be limited and they have little awareness of their own personal efficacy or power. This minimises internal resources and flexibility.

To sum up Kohn's model: it is suggested that genetic predisposition, greater stress in lower class life, diminished internal and external resources and a narrow, inflexible view of social reality conditioned by the circumstances of lower class life go some way towards explaining the significant relationship between social class and schizophrenia.

Brown et al. expound a model which has some similarities

to that of Kohn. Again the emphasis is on the intervening variables between social class and mental disorder, specifically depression. Essentially, this model sees episodes of depression as being triggered by severe life events and difficulties, e.g. the death of a near relative. However, the provoking or triggering agent is only one factor in the development of depression. Vulnerability factors greatly increase the chances of breakdown in the presence of a provoking agent. Brown et al. argue that severe life crises or difficulties are more prevalent among lower class women and that they are also exposed to a greater prevalence of vulnerability factors (23). Of the four vulnerability factors identified by the study, three, namely lack of intimate relationship with a husband or boy friend, three or more children under the age of 15 years at home, and the loss of a mother in childhood were more common in the lower classes. Only unemployment was equally shared with middle class women. Brown et al. interpret the significance of the effect of provoking agents and vulnerability factors as revolving round the notion of hopelessness. Depression is seen to depend on a sense of hopelessness in the subject and so it is argued that provoking and vulnerability factors induce in some way a loss of hope.

Implicit, though not explicit, in this analysis is the idea that the circumstances of lower class life engender a greater sense of hopelessness and impotence than the circumstances of middle class life. Once again, then, a theory of lack of internal and external resources engendered by the particular situation to be found among members of a certain social class is required. Brown and his colleagues concede that there are issues of social injustice and inequality

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(23) See Brown, Ni Brolchain and Harris, op.cit., p.243.

arising from their findings:

> Certain groups of women in our society have a significantly greater than average risk of suffering from depressive conditions. To the extent that the unequal distribution of such risk is the result of more widely recognised inequalities within our society ... we believe that it constitutes a major social injustice (24).

However, they do not provide a thorough socio-political analysis of the situation. This is a point which will be more fully considered when the effects of social class on prognosis have been documented.

The relationship between social class and the incidence of mental disorder and the exact nature of the direction of causality in this relationship has provoked much controversy. No less important, but apparently much less controversial have been the findings of researchers looking at the relationship between social class, prognosis and treatment in mental disorder.

Cooper examined social class and prognosis amongst 219 male schizophrenic patients who became long stay cases. He discovered that whether or not patients became long-stay was significantly related to class in that lower class patients tended to stay longer in hospital than higher class patients. The mean duration of stay of patients in hospital was longer for lower class patients and it was found that lower class patients responded considerably less well to treatment in the hospital judging by rate of discharge and the condition of patients on discharge. In addition, 40% of class 4 and 5 patients were compulsorily admitted, while only 4% of class 1 and 2 patients were admitted involuntarily.

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(24) Brown, Ni Brolchain and Harris, op.cit., p.248.

This suggests that lower class patients may well be reluctant to accept and co-operate with treatment (25).

In a follow up study of 192 male schizophrenic patients, Cooper showed that there was a significant inverse relationship between social class position and the success of rehabilitation in the first year after discharge. It was also found that social class and successful return to a former occupation were significantly related, lower class people having less success than higher class counterparts. Patients' levels of social adjustment and self-care were also related to class. While social class position did not affect a patient's likelihood of being re-admitted, it was revealed that lower class patients spent more time in toto in hospital than higher class patients. Cooper concluded:

> Prognosis in schizophrenia is directly related to social status. Patients from the upper social classes, with high occupational prestige and good employment records, carry a good prognosis: conversely patients from the lower social classes with low occupational prestige and poor employment records have a correspondingly poor prognosis... (26).

Cooper's findings are compatible with those of Hollingshead and Redlich whose investigations revealed that social class and the number of years spent undergoing treatment were significantly and inversely related (27).

The causes of the poor prognosis of lower class cases of schizophrenia are not fully understood. The work of Hollingshead

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(25) See B. Cooper, 'Social Class and Prognosis in Schizophrenia - Part I', British Journal of Preventive Social Medicine 15, 1961, 17-30.

(26) B. Cooper, 'Social Class and Prognosis in Schizophrenia - Part II', British Journal of Preventive Social Medicine 15, 1961, 31-41, p.40.

(27) Hollingshead and Redlich, op.cit , p.296.

and Redlich suggests that lower class cases are allowed to develop to a much more advanced state before help is sought than those occurring among higher classes. This means that a chronic condition which is more difficult to treat can develop. Factors such as the lack of understanding of mental disorder and lack of appropriate treatment facilities in predominantly lower class areas may also be significant in this process. Differential treatment in hospital and negative attitudes to it on the part of patients may be influential also.

In the U.S.A., a substantial amount of research has been conducted into the relations between forms of treatment and social class. Myers et al. have shown that as the social class of patients becomes higher, they are less likely to remain in hospital. Conversely, the lower the social class position of patients, the less likely they are to receive outpatient treatment in clinics (28). This phenomenon may be explained by differential access to outpatient departments, by a reluctance on the part of lower class families to retain a disordered relative in the community, or by the severity of the disorder afflicting lower class people due to a reluctance to recognise psychological disorder which would enable it to be treated at an early state (29). Probably all these factors and others contribute.

Several American studies have demonstrated that psychotherapy is more likely to be used with upper rather than

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(28) Jerome K. Myers, Lee L. Bean and Max P. Pepper, 'Social Class and Psychiatric Disorders - A Ten Year Follow-up', Journal of Health and Human Behaviour, 6, 1965, 74-79.

(29) See Radke-Yarrow et al. op.cit., for this latter point.

lower class patients (30). It has been noted elsewhere that psychotherapy is not commonly available in British N.H.S. facilities so this evidence is not directly of great use here. However, if psychotherapy is seen as being the most prestigious and valued form of treatment in American psychiatry at the time of the studies mentioned above, it may be regarded as, to some extent, an indicator of the differential distribution of precious resources. In this way, it may be suggested that psychiatrists tend to give their greatest efforts and most valuable resources to members of their own class i.e. the upper class. There is no reason to suppose that contemporary British psychiatrists do not act in the same way so that members of the lower classes may well receive less care and treatment than members of the higher classes.

Finally, something must be said about the relationship between social class and the type of hospital into which patients are admitted. Hollingshead and Redlich and other American researchers have shown that lower class patients are treated primarily in public hospitals while higher class patients are treated in private hospitals with lower bed numbers, better

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(30) See Hollingshead and Redlich, op.cit., Ch. 9, Robert A. Moore, Elissa P. Benedek and John G. Wallace, 'Social Class and the Psychiatrist', Journal of Psychiatry, 120, 1963-4, 149-154, Norman Q. Brill and Hugh A. Storrow, 'Social Class and Psychiatric Treatment', Archives of General Psychiatry, 3, 1960, 340-44, David W. Rowden, Ronald C. Dillehay, Jerry B. Michel and Harry W. Martin, 'Judgements about Candidates for Psychotherapy : The Influence of Social Class and Insight Verbal Ability', Journal of Health and Social Behaviour, 11, 1970, 51-58, Jerome K. Myers and Leslie Schaffer 'Social Stratification and Psychiatric Practice : A Study of an Out-Patient Clinic', American Sociological Review, 19, 1954, 307-10.

patient-staff ratios etc. to a greater extent (31). In Britain, where there are ostensibly the same facilities available for all members of the population equally, the differential hospitalisation of patients is less apparent. However, there is some private hospital treatment available and this is presumably available only to those who can pay for it themselves, i.e. the higher class members of British society. Even in public facilities, it seems possible that higher class patients are treated in better and more prestigious facilities than members of the lower classes.

On the basis of the evidence cited, it is possible to maintain that prognosis, treatment, and facilities are all inversely related to social class. In all these areas, the lower the class position, the worse prognosis, treatment and facilities become. Unfortunately, the exact reasons and mechanisms of this relationship have not been thoroughly researched and accounted for.

Brown et al., in their discussion of social class and psychiatric disturbance among women in an urban population, write: "While there is unanimity about the correlation between class and rates of psychiatric disturbance, nothing has convincingly been established about causality or the meaning of the social class differences"(32). Although it has been possible here to argue with a fair degree of certainty that social class is related significantly to incidence, prevalence prognosis and treatment, accurate interpretation of this correlation proves nearly impossible. Marxist analysis, so helpful in dealing with the general structure of society, runs

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(31) See Hollingshead and Redlich, op.cit., Ch. 9.

(32) Brown, Ni Brolchain and Harris, op.cit., p.226.

into the sand when confronted with particularised correlation between social class and mental disorder which has its locus in the individual. A few tentative clues have been given as to how this relationship might fit into the wider structure of late capitalist society. Kohn, for example, has suggested that the mode of production in capitalist industry tends to encourage a narrow and rigid world view and a sense of personal ineffectiveness which saps individuals of the ability to deal with stress appropriately. Brown et al. in their study imply that the whole position of women in the present socio-economic order needs to be examined. Essentially because of their secondary role in production, women are nurtured in an environment of personal ineffectiveness and hopelessness and are not encouraged to master their environment or to develop their powers. Feminist writers have exposed the way in which the role of women as housewives and mothers is exploited in the capitalist economic order (33). Helplessness and hopelessness engendered by insignificance and narrowness which allows capitalism to continue may well form part of the precondition for an increased incidence of depression amongst women.

Other factors which help to bring about mental disorder, e.g. stress inducing factors such as economic hardship and bad housing, can clearly be seen as a function of the main class division in society which distributes hardship and resources unequally in the community so that the weight of the burden falls on the less powerful, the lower classes. Similarly, the absence of appropriate treatment facilities for the lower classes may be regarded as related to the class divide in society. While all these notions sound possible as starting

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(33) See e.g. Anne Oakley, Housewife, (Harmondsworth : Penguin, 1976), Juliet Mitchell, Woman's Estate (Harmondsworth : Penguin, 1971).

points for further exploration into the relationship between the wider socio-economic order and class-related nature of mental disorder, they are somewhat speculative and leave many aspects noted above unexplained. Why, for example, do lower class people resist identifying their relatives as mentally ill so that their disorders persist and become more severe than those of members of higher classes? Although the answer to this question may well be linked with the nature of capitalist society as a whole, so far no proper analysis of this kind of phenomenon has taken place.

In the last analysis, only generalisations can be made about the connections between social class, mental disorder and the wider socio-economic order. It is true to say that there must be factors in lower class life in Western society which lead to a greater incidence and prevalence of mental disorder. These factors are apparently not present in higher classes in society. So, at the very least, it can be said that there exists a fundamental injustice and inequality in the distribution of circumstances which minimise mental disorder in society. Further, it can be stated that only with a wider reformation of the socio-economic order will mental illness cease to be inversely related to class and be reduced, or at least more evenly distributed, among the members of the population. Thus, although analysis of the relationship between mental illness and social class in Marxist terms produces little concrete evidence concerning the factors intervening between mental illness, and the wider socio-economic order, it does point once again to the necessity for a perspective on mental disorder which extends far more broadly than that of the individualistic medical model. It also reveals the need for changes in the social and economic order of an absolutely fundamental kind if mental disorder is to be equalised or prevented.

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