WORK AND MADNESS: THE RISE OF COMMUNITY PSYCHIATRY
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NAME OF AUTHOR/*NOM DE L'AUTEUR* Diana Sharon Ralph

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NAME OF SUPERVISOR/*NOM DU DIRECTEUR DE THÈSE* W. P. Livant

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WORK AND MADNESS: THE RISE OF COMMUNITY PSYCHIATRY

A Thesis

Submitted to the Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

for the Degree of

Doctor of Philosophy

in Psychology

Faculty of Arts

University of Regina

by

Diana Sharon Ralph

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April, 1980

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SUMMARY OF THE THESIS

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DIANA SHARON RALPH

B.A. (Wayne State University, Detroit)

M.S.W. (Columbia University School of Social Work, New York)

M.A. (University of Saskatchewan Regina Campus)

June, 1980

Committee in Charge.

R.E. Johnson (Department Head)
W.P. Livant (Supervisor)
L. Elkin
S.D. Heeren
S. Rands
J.K. Roberts
R.M. Stirling
C. W. Blachford (Dean of Graduate Studies and Research)

External Examiner:

P. Marchak, Associate Professor of Anthropology and Sociology
University of British Columbia
Vancouver, British Columbia

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THESIS

WORK AND MADNESS:
THE RISE OF COMMUNITY PSYCHIATRY

Community psychiatry emerged soon after World War II, in many Western nations as well as in a number of Third World Countries Under community psychiatry, the proportion of people treated for emotional problems has expanded dramatically, chronic mental patients have been deinstitutionalized, and techniques and programs to treat non-psychotic people have proliferated

The purpose of this study is to investigate why and how community psychiatry developed and to examine its social implications

The literature contains three broad, conflicting theories about why community psychiatry developed. the benevolent government theory, the mental health lobby theory, and the social control theory. All three assume that community psychiatry evolved directly from clinical psychiatry, and they largely confine their analyses to the internal motives and politics of the mental health system. In spite of some important contributions by each of these theoretical approaches, this limitation results in too narrow a perspective to analyze adequately the historical and social context within which community psychiatry developed As a result, they are all unable to explain the massive scope and the particular features of community psychiatry.

This study proposes an alternative hypothesis — the labour theory, which suggests that

- Community psychiatry serves primarily to control labour alienation and to increase the reliability and productivity of workers.
- Its historical roots lie far more in industrial psychology with its emphasis on employed workers than they do in public, clinical psychiatry with its focus on custodial care of the unemployed.
- Community psychiatry emerged so suddenly after World War II largely because rising labour alienation threatened not only particular businesses, but the political and economic stability of Western countries.

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By tracing the histories of labour-management relations and public mental health services since 1900, the study provides evidence that the major theoretical and technical innovations of community psychiatry developed in industrial psychology and not in clincial psychiatry These innovations frequently emerged as direct defenses against labour militancy and other threats to corporate profits. Since World War II, community psychiatric policy and programs have continued to be dominated by business and state needs for a reliable work force

This analysis has implications for mental health workers, for their clients, and for working people in general In an era of economic crisis and a rising threat of war, it is likely that government efforts to enforce industrial discipline through community psychiatry (as well as through other social services) will intensify and become increasingly coercive At the same time, budgets for care of unemployable people, including chronic mental patients, are likely to shrink Mental health work for both employable and unemployable people is becoming increasingly Taylorized — that is, de-skilled, impersonal, alienating, and pressured Nevertheless, the study demonstrates the consistently defensive nature of community psychiatry and the potential of organized labour and client groups to oppose oppressive policies

BIOGRAPHICAL

DIANA SHARON RALPH

1965 - 66	Alpha Kappa Delta Award, Wayne State University, Detroit, Michigan.
1966	Bachelor of Arts in Sociology, Wayne State University, Detroit, Michigan
1966 - 74	Social Worker, New York, Buffalo, Washington, Maryland, Regina
1967 - 68	National Institute of Mental Health Graduate Scholarship, Columbia University, New York, New York.

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1968	Master of Social Work, Columbia University School of Social Work, New York, New York
1970 - 76	Sessional Lecturer, University of Regina, Regina.
1974	Master of Arts in Psychology, University of Saskatchewan Regina Campus
1975	Special Lecturer, University of Regina, Regina
	Province of Saskatchewan Graduate Scholarship and Graduate Summer Scholarship, University of Regina, Regina
1976 - 78	Canada Council Doctoral Fellowship, University of Regina, Regina
1978 - 79	Assistant Professor in Psychology, Huron College, Huron, South Dakota

PUBLICATIONS

The madness industry and control of workers *The Psych Agitator*. Spring, 1979, pp. 11-14

Shrinking to fit in Saskatchewan *State and Mind*. 7(2), Spring, 1979, pp 21-24

The business of madness: Saskatchewan's case history *Next Year Country*, 5(2), 1978, pp. 11-14.

Youth: Potential power *Colloquy*, 1970, 3(10), pp. 32-35

Racism in mental health. A case study *The Advocate*. 1969, 2(4), pp. 1-4.

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FACULTY OF GRADUATE STUDIES AND RESEARCH

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We, the undersigned, certify that Diana Sharon Ralph

candidate for the Degree of Doctor of Philosophy in Psychology

has presented a thesis on the subject Work and Madness: The Rise of Community Psychiatry

that the thesis is acceptable in form and content, and that the student demonstrated a satisfactory knowledge of the field covered by the thesis in an oral examination held on July 14, 1980.

External Examiner M. Patricia Marchak
Dr. P. Marchak, Professor of Anthropology & Sociology, Univ. of British Columbia

Internal Examiners Steve Heeren

[signatures]

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ABSTRACT

Community psychiatry emerged soon after World War II, in many Western nations as well as in a number of Third World countries. Under community psychiatry, the proportion of people treated for emotional problems has expanded dramatically, chronic mental patients have been deinstitutionalized, and techniques and programs to treat non-psychotic people have proliferated.

The purpose of this study is to investigate why and how community psychiatry developed and to examine its social implications.

The literature contains three broad, conflicting theories about why community psychiatry developed: the benevolent government theory, the mental health lobby theory, and the social control theory. All three assume that community psychiatry evolved directly from clinical psychiatry, and they largely confine their analyses to the internal motives and politics of the mental health system. In spite of some important contributions by each of these theoretical approaches, this limitation results in too narrow a perspective to analyze adequately the historical and social context within which community psychiatry developed. As a result, they are all unable to explain the massive scope and the particular features of community psychiatry.

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- Community psychiatry serves primarily to control labour alienation and to increase the reliability and productivity of workers.

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- Its historical roots lie far more in industrial psychology with its emphasis on employed workers than they do in public, clinical psychiatry with its focus on custodial care of the unemployed.

- Community psychiatry emerged so suddenly after World War II largely because rising labour alienation threatened not only particular businesses, but the political and economic stability of Western countries.

By tracing the histories of labour-management relations and public mental health services since 1900, the study provides evidence that the major theoretical and technical innovations of community psychiatry developed in industrial psychology and not in clinical psychiatry. These innovations frequently emerged as direct defenses against labour militancy and other threats to corporate profits. Since World War II, community psychiatric policy and programs have continued to be dominated by business and state needs for a reliable work force.

This analysis has implications for mental health workers, for their clients, and for working people in general. In an era of economic crisis and a rising threat of war, it is likely that government efforts to enforce industrial discipline through community psychiatry (as well as through other social services) will intensify and become increasingly coercive. At the same time, budgets for care of unemployable people, including chronic mental patients, are likely to shrink. Mental health work for both employable and unemployable people is becoming increasingly Taylorized -- that is, de-skilled, impersonal, alienating, and pressured. Nevertheless, the study demonstrates the consistently defensive nature of community psychiatry and the potential of organized labour and client groups to oppose oppressive policies.

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PREFACE

This study presents an historical analysis of the social causes of community psychiatry. The formative stages of community psychiatry are roughly parallel throughout the countries of Western Europe and North America. However, this work focuses mainly on specific examples and details from the United States. I have done this primarily because the United States largely led the community psychiatry movement, imposing its model on other nations. Its particular history, therefore, is more germane to the study than that of other countries. Wherever possible, I have tried to note major contributions by other countries and to describe different national trends in labour relations and mental health services. However, it is beyond the scope of this work to analyze events in all Western countries in great detail. Whenever the context is unspecified, I am referring to tendencies dominant in the United States and in most other Western countries.

I refer in this study to a number of concepts which either have no consistent label or which have several similar names. I have tried to use only one consistent name for each concept, but this requires me to use labels in a broader sense than they are sometimes understood. The definitions below describe the boundaries of these concepts as I have used them.

1. *Community psychiatry* includes "community mental health," "preventive psychiatry," and "community psychology." It refers to the

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publicly-funded preventive or treatment programs for mental illness which have developed primarily in Western capitalist countries since World War II. It includes work done by psychiatrists, as well as by other professionals and non-professionals who receive public funds for treating emotional problems. It may also include indirectly subsidized private psychiatric services, such as nursing homes which have taken over care of chronic mental patients and general practitioners who prescribe mood-altering drugs.

2. *Taylorism* is synonymous with "scientific management." It refers to Frederick Winslow Taylor's theories about how to improve management control over the work process. For a more detailed definition and discussion, see Chapter IV, section 2.

3. *Industrial psychology* encompasses research and programs directed at improving worker cooperation with management and labour's willingness and ability to produce more. This general field includes "industrial psychiatry," "occupational psychology," "human engineering," "mental hygiene of industry," "vocational testing," "organizational psychology," "management training," and "human relations of industry." Industrial psychology as a field includes work done by psychologists, sociologists, anthropologists, psychiatrists, and other specialists who are employed either directly by management or indirectly through private grants to universities to study or treat labour-management issues. Industrial psychology activities are usually funded privately. But there has been some overlap with the public sector since the advent of community psychiatry, for example, in government-run alcoholism treatment programs for industry. I do *not* intend

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consumer or marketing psychology to be included in this concept.

4. *Social classes* are defined for this study in terms of one's way of making a living (or, in Marxist terms, one's "relationship to the means of production"). This definition has little in common with the allocative model of social class common in Western sociology, which defines upper, middle, and lower classes by how much wealth, status, and education they have. The classes I mention in this work are "business," "labour," "petit-bourgeois," and "unemployed." "Business" refers to large corporations and financial institutions: those extremely wealthy groups and individuals which employ large numbers of workers. "Business" is synonymous with the Marxist term, "bourgeoisie." (I decided not to use this latter term, since its more common usage in English means "middle class.") "Labour" refers to all people who work for an employer for a wage or salary. I specifically intend it to include salaried white-collar and professional groups which are increasingly facing job-degradation and production pressures formerly limited to industrial workers. The term is generally equivalent to "proletariat." "Petit-bourgeois" refers to self-employed professionals or businessmen who do not themselves employ more than a few people (e.g. farmers, shop keepers, and doctors). Finally, "unemployed" includes both people who are permanently unemployable (such as chronic mental patients), and those who are temporarily out of work or only marginally employed. Although both categories of people are included in the "unemployed" category, their relationship to business is quite different. From the perspective of business, unemployable people are useless but harmless, while able-bodied unemployed people are useful as a reserve labour pool, but also

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dangerous because of their link with labour (see Chapter III, section 3.2).

I have published portions of the last chapter before (Ralph, 1979).

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My supervisory committee is composed of Bill Livant (supervisor), Stan Rands, Joe Roberts, Bob Stirling, Steve Heeren, and Lorne Elkin. It would be hard to imagine a more helpful, responsible, and co-operative committee. They allowed me to work at my own pace, on the topic that I chose, and they made no demands on me to adopt their values or priorities. Instead, they flexibly adapted themselves to the changing focus of my research. They went out of their ways to be available for me to discuss difficult issues, to refer me to helpful sources, and to offer practical help. They read my drafts carefully, and promptly, making exceptionally insightful suggestions and comments. I especially appreciate the high level of respect and co-operation they showed both to each other and to me. This sense of common purpose and comradeship is not common in the university, where faculty often insulate themselves from each other and jealously haggle over petty differences, at the expense of the student. In spite of their ideological variation, the committee members all share a strong commitment to doing socially relevant, useful work and a deep sense of unity with oppressed and exploited peoples. More than anything else, the example they provided in their own work has helped me to treat my research, not as an isolated academic exercise, but as one contribution among many to social progress.

Bill Livant has been a remarkably conscientious supervisor and

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a good friend for many years. Most helpful intellectually has been his creative, ground-breaking insights into dialectical-materialism and its application to a variety of social phenomena. He is gifted in his ability to see the crucial division of a problem, and many times, when my analysis got tangled, Bill helped to suggest the shift in emphasis which resolved the confusion. In addition to being a good supervisor, Bill has been a real friend. When I got discouraged, he helped me to put my concerns into perspective and to figure out how to handle them. Through times of his own difficulties, Bill has been consistently supportive, generous, and helpful. I am grateful that, in addition to risking a number of other pro-student stands, Bill agreed to supervise me when no one else could or would.

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invaluable. In a confusing sea of conflicting perspectives, Joe was a balanced, accessible, and friendly navigator. In spite of his busy schedule, Joe always read my drafts promptly, and, with his ear for clear English, he provided excellent editorial suggestions.

Bob Stirling spent two years of painstaking effort trying to help me to gain access to a uniquely useful data file. He wrote letters, made long distance phone calls, submitted detailed funding applications, and spent hours training both me and potential programmers to handle the cumbersome data. Although, so far, we have not managed to get the file in hand, we are close. Even though all that effort was not used in this dissertation, it will be a valuable resource for students and researchers in the future. I appreciate the great patience and kindness Bob showed in helping me to develop both the original empirical methodology and the revised historical one which was used in this work.

Steve Heeren and Lorne Elkin each made helpful editorial suggestions and referred me to useful sources of information.

Ruth Ralph, my mother, a skillful general semanticist, trained me in basic principles of clear, simple writing and thoroughly edited my drafts. In the process, we transcended the mother-daughter relationship and became even closer friends.

Doris Rands, my dear friend, has been an emotional buoy for me throughout the long process of writing. She fed me, bedded me down, cheered me up, partied me, nursed me through illnesses, and baby-sat for my son so often that I feel like a member of the family. At times I would have given up if it hadn't been for her

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support and ready smile.

Mike Fitzgerald read the draft in its early stage and gave me very helpful suggestions and useful references.

Linda Mahler did an excellent job of typing the final draft in record time. Marion Lake, Robert Franks, and Jim Hemiset, librarians at the University of Regina and at Huron College in South Dakota, patiently processed my endless stream of interlibrary loan requests.

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1. INTRODUCTION

1.1 The scope of community psychiatry

In the past twenty-five years, many Western countries including Canada have adopted a "community mental health" model of psychiatric treatment. This model has ushered in dramatic shifts in the philosophy, scope, techniques, and staffing of psychiatric services. The medical model of psychiatric care emphasizing individual cures has given way to a public health model aimed at mass behavioral management (Bloom, 1973; Expert Committee, 1953; Felix, 1961; Lieberman, 1975; McKerracher, 1966). The scope of psychiatric jurisdiction has widened to include virtually any "behavior" which poses a problem for individuals or for the social institutions with which they come in contact (Dinitz & Beran, 1971; Lennard & Bernstein, 1973; Wagonfeld & Robin, 1976). Long-term custodial care and psychotherapy has been superseded by quick, cheap treatment in community-based programs (Ahmed & Plog, 1976; Bellak, 1964; Bennett, 1973; Greenblatt, 1976). Technological advances such as psycho-active drugs, brain implantations, computerized recordkeeping, and various behavior modification techniques have vastly increased the speed of treatment and reduced the skills necessary for mental health work (Cooperstock, 1977; Crawford, Morgan & Gianturco, 1974; Johnson, Giannetti & Nelson, 1976; Laska & Bank, 1975; Schrag, 1978). As a result, auxiliary workers can handle all the routine aspects of patient

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care while psychiatrists act as administrators (Albee, 1959; Arnhoff, Rubinstein, Shriver & Jones, 1969; Davidson, 1970; Douglas, 1971, pp. 17-19; McKerracher, 1966; Reiff & Riessman, 1964; Robertson & Shriver, 1964).

All of these changes have basically amounted to industrializing the psychiatric system. Its management has been centralized, its technology automated, and its work force Taylorized (See Chapter IV, section 2). Through massive public investments, its services and products have been packaged and marketed to be as available as your local mental health clinic, family doctor, or drug store.

The main target of these expanded services is the active and the potential labour force. In the 1940's, less than half of one percent of the Canadian and U.S. populations were treated for mental disorders, mostly unemployable people who were considered severely disturbed, retarded, or aged (D'Arcy, 1976a; Deutsch, 1949, pp. 455-456; McKerracher, 1966, p. 7; Richman, 1966, pp. 58, 116-121). By the 1970's, about fifteen percent of the populations of Canada and other Western countries were receiving explicit psychiatric treatment each year, and at least twice that number -- one-third of the total population -- were using some mood-altering prescription drugs (Altman, 1971; Balter, Levine & Rubinstein, 1972; Cooperstock, 1977; D'Arcy, 1976b, p. 2; Doig, 1978; Harding, Wolf & Chan, 1978; D. Lamb, 1978; Lennard & Bernstein, 1973; Pflanz, Basder & Schwoon, 1977; President's Commission, 1978, Vol. 2, p. 16; Waldron, 1977). The overwhelming majority of these patients are working-aged employees and housewives who are treated for relatively mild, stress-related

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"problems of living" -- neuroses, psychosomatic illnesses, and personality and behavior disorders (D'Arcy, 1976b, pp. 219-220; Mental Health Statistics, 1966, p. 8; Meyer, 1973; President's Commission, 1978, Vol. 2, p. 990; Szasz, 1960).

While psychiatric treatment of employable people has mushroomed, the number of people treated for psychotic and organic disorders and the per capita expenditures on their care have declined precipitously (Ahmed & Plog, 1976b; D'Arcy, 1976b; Love & Hobbs, 1971; Murphy & Datel, 1976; Sharfstein & Nafziger, 1976). In the early 1960's Western governments almost simultaneously began a massive effort to deinstitutionalize chronic mental patients. Although this policy was billed as a humanitarian gesture to re-integrate the mentally ill into "the community," there is evidence that the move was motivated at least as much by the dramatically lower cost of boarding and nursing home care (Cassell, Smith, Grunberg & Boan, 1972; Expert Committee on Mental Health, 1953; Fein, 1958; McKerracher, 1966, pp. 14-15; Murphy & Datel, 1976; Scull, 1977, pp. 134-153). Recent studies indicate that in many cases the "decarceration" movement has merely dispersed institutionalizing conditions less visibly, that significant proportions of community placements are inadequate, and that ex-mental patients are often more isolated than they had been in the hospitals, with fewer activities, less care, and more limited freedom (Allodi & Kedward, 1977, pp. 223-224; J. Anderson, 1978, 1979; Cumming, Coates & Bunton, 1976; H. Lamb & Goertzel, 1971; Murphy, Pennee & Luchins, 1972; Robbins & Robbins, 1974; Robitscher, 1976; Santiestevan, 1976; Swann, 1973). In effect, the community psychiatry movement has abandoned, as much as possible, its role in

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custodial care of unemployable people, and simultaneously vastly expanded its treatment of the labour force.

Community psychiatry is not alone in experiencing these trends. Both the police (criminal justice) and education systems have undergone developments similar to those in psychiatry. Public expenditures for all three areas have risen steeply since World War II, particularly since 1960 (Center for Research on Criminal Justice, 1975, p. 7; Martell, 1974, p. 5). Like community psychiatry, the education and police systems have centralized their operations and funding, and they now depend far more on federal direction and money (Center for Research, 1975; Martell, 1974; National Advisory Commission on Criminal Justice, 1973). They also, like community psychiatry programs, have automated their technologies, allowing for cheaper, faster processing of cases, and the "rationalization" of their work forces (Carnoy, 1974; Elliott, 1973; Gay & Schack, 1977; Gumbert & Spring, 1974; Lenard & More, 1974; Martell, 1974; Munro, 1976; National Manpower Survey, 1978, p. 18). There are extensive parallels between the deinstitutionalization movements of prisoners and of mental patients. Since the late 1960's, courts have diverted and deinstitutionalized as many relatively harmless convicts as possible (Bakal, 1973; Empey, 1973; Scull, 1977, pp. 134-150; Vorenberg & Vorenberg, 1973), and shifted the emphasis of their programs to "community service."

As in the case of community psychiatry, the major impact of this industrialization of the police and education systems has been a vast increase in the number of working class people they contact.

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Between 1920 and 1973, the proportion of 18-21 years olds who were attending post-secondary educational institutions increased from twenty to fifty percent (U.S. Bureau of Census, 1973), with most of that increase occurring in vocational schools, community colleges, or two-year Associate of Arts degree programs (Bowles & Gintis, 1976, pp. 201-223). This growth occurred as corporate and federal funding has been progressively withdrawn from private colleges whose programs are geared toward training professionals (Schecter, 1977). Similarly, the growing crime statistics numbers of prisons, and number of prisoners reflect a portion of the increased police contact with working class people (Census of Jails, 1979; Grieco, 1979). In addition, police are increasingly active in intelligence operations, investigations of white-collar crime, anti-union activity, and control of Third World communities (Center for Research, 1977, pp. 93-124; Stotland, Walsh & Weinberg, 1977). The expanded "community corrections" programs, with their lengthy parole periods and behavior sanctions for relatively minor offenses, in effect, extend the time individuals are under surveillance and significantly broaden the number of people who can be processed through the criminal justice system (Cohen, 1979; Greenberg, 1975).

In addition to showing similar growth patterns, these three social services also have tended to merge since the 1960's, sharing technological knowledge, personnel, and sometimes programs. In spite of some jurisdictional boundary tensions, this tendency reflects their mutual social functions (Abramson, 1972; Allmand, 1973; Arboleda-Florez, 1975; Dinitz & Beran, 1971; Goldman, 1977; Hartt, Lamer, Mohr & LaForest, 1976; Monahan, 1976; Newell, 1979; Salutin,

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1975; Shah, 1976; Wagenfeld & Robin, 1976).

Other social services, such as unemployment insurance, medicare, welfare, and workman's compensation evolved primarily as "social wages," i.e., as benefits granted in response to popular or labour demands which expand purchasing power by covering basic necessities. To the extent that these services are paid out of corporate profits (rather than indirectly by workers themselves through taxation), they are only reluctantly supported by business and they frequently face cutbacks during economic crises or periods of labour complacency (Finkel, 1977). Nevertheless, they also have been organized as social control agencies and have undergone some of the same changes in scope and organization as community psychiatry, education, and criminal justice (H. Allen, 1975; R. Bailey & Brake, 1975; Mandell, 1975; D. McLean, S. Smith & Hill, 1975; Piven & Cloward, 1971).

1.2 Purpose and methodology

The purpose of this study is to explain why community psychiatry developed, and to examine its implications for workers, potential workers, and unemployable people. In addition, because trends in community psychiatry closely parallel those in other social services (see pp. 4-6), this study may serve as an example of the functions and dynamics of other growing social services.

The facts that community psychiatry has grown so rapidly, that it was adopted almost simultaneously across the Western world, and that the pattern of its growth is so similar to other social services (see Section 1.1), all imply that broad socio-political

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forces stimulated its creation. However, although the literature contains diverse attempts to explain the rise of community psychiatry, there have been very few efforts to place it within a wider social and economic framework.

Chapter II critically analyzes the alternative theories of why and how community psychiatry developed. Three conflicting theories dominate the literature on this question: the benevolent government theory, the mental health lobby theory, and the social control theory. Benevolent government theorists argue that community psychiatry is the latest in a progressively enlightened and humane evolution of psychiatric services. The mental health lobby theorists propose that professional interest groups, motivated to build personal power and wealth, pressured governments to finance community psychiatry. The social control theorists divide into two wings, antipsychiatric and Marxist. Antipsychiatry theorists believe that community psychiatry is primarily a technological extension of psychiatric oppression which has consistently characterized public mental institutions. Marxist theorists, with the exception of Scull (1977), have not yet addressed the issue of community psychiatry in any depth. Scull argues that community psychiatry represents a government attempt to cut expenses on care of unemployable people. All three types of theorists assume that community psychiatry evolved from traditional clinical psychiatry with little qualitative change in policy. From their perspective, it simply became more benevolent, more powerful, more oppressive, or cheaper.

In spite of making some significant contributions, none of these

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theories explains the dramatic shift in emphasis from pre- to post-World War II public psychiatry which characterizes community psychiatry. In particular, none of them explains why community psychiatry would slash programs for unemployable mental patients while geometrically expanding treatment of relatively normal, employable people. Nor do they explain why this new policy should suddenly spread through most Western public psychiatry agencies just after World War II.

To adequately explain the rise of community psychiatry, a theory must account for these major issues. That requires us to transcend the narrow disciplinary boundaries of clinical psychiatry, and to venture into political, economic, and historical fields. Specifically, a useful theory of community psychiatry should address the following questions:

(1) Does community psychiatry have a history before World War II? Viewed from the blinkers of the psychiatric discipline, the innovations of community psychiatry appear as ahistorical "inventions" after World War II. However, few phenomena spring full-blown into existence, least of all those which involve multi-million dollar budgets on an international scale. We would expect that community psychiatry does have a history, if not in clinical psychiatry, then elsewhere. Because it focuses on treating employable people, it seems logical to investigate the history of treatment of workers' emotional or behavioral symptoms.

(2) What impact did economic and political pressures have

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<u>on the formation of community psychiatry?</u> Because community psychiatry treats primarily employable people, it is important to investigate trends in labour relations and their impact on national and international policies. Wars, economic fluctuations, and the vicissitudes of labour militancy all strongly influence business and government relations with workers (as well as with unemployable people). The rise of community psychiatry must be analyzed in the context of these broad social pressures.

(3) <u>What influence have changes in the scope and functions of the state had on community psychiatry?</u> Community psychiatry is overwhelmingly government financed and it operates under the policies and priorities of government agencies. We need, therefore, to analyze it in the context of the expanding scope and the changing functions of the state in Western countries. In particular, a theory of community psychiatry should take into account the general relationship of the state to different social classes, and especially to labour and to the unemployed.

The theory which I evolved as a result of investigating these issues may be termed the "labour theory." Briefly summarized, it proposes that Western states have produced the mass psychiatric industry largely to control the effects of worker alienation on productivity. It suggests that community psychiatry's consistent function has been

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to produce a compliant, reliable work force, and a passive, flexible supply of unemployed labour. According to this perspective, community psychiatry represents a major qualitative policy shift from the pre-World War II focus on custodial care of unemployable people, to an emphasis on mass treatment of workers and potential workers. Rather than growing out of clinical psychiatry, this theory proposes, community psychiatry's roots lie far more in industrial psychology's tradition of labour regulation. Chapter III outlines this theory and its implications in detail.

Hypotheses

If this "labour theory" is sound, the following hypotheses should hold true:

(1) We will find that many of the significant "innovations" of community psychiatry were widely adopted before World War II (i.e., before community psychiatry) in the practice of industrial psychology. This would imply that community psychiatry has major roots in industrial psychology, and that methods and policies which we now identify with community psychiatry were originally developed primarily to regulate labour's behavior in the interests of management. Central "innovations" of community psychiatry which differentiate it from pre-World War II public psychiatric services include:

- Shifting from an individual clinical model to a mass public health conception of its mandate
- Expanding the definition of mental illness to include

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many more non-psychotic behavioral and personality disorders

- Emphasizing far more treatment of non-psychotic disorders

- Deinstitutionalizing and cutting expenses on services to chronic mental patients

- Instituting preventive consultation with community groups, organizations, and businesses

- Emphasizing cheap, accessible, short-term outpatient therapy techniques primarily for non-psychotic patients

- Counselling families and involving families in patient care

- Developing new mental health professional and sub-professional specializations

- Actively involving general practitioners in early psychiatric treatment and referrals

These "innovations" are discussed more specifically in Chapter I, Section 1 and Chapter II, Section 1. See also Bloom (1963), Bellak (1969), N. Hobbs (1964), and Terhune (1948).

(2) Conversely, we would *not* expect these innovations to have figured prominently in the policies and practices of clinical psychiatry, and particularly of public mental health services before World War II. If supported, this hypothesis would suggest that community psychiatry was not rooted in clinical psychiatry, and that, on the contrary, it represented a major shift from the pre-World War II concept of mental health services.

(3) If community psychiatry "innovations" were motivated by business and state needs to control labour, we would

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expect to find that these innovations were generally adopted during periods when businesses required greater labour productivity (such as before and during wars) or more control over workers (as a result of labour militancy).

(4) Conversely, during economic recessions particularly when labour is docile, we would expect *few* of the innovations of community psychiatry to emerge. During economic recessions, management's problems with labour are minimized because unemployment increases the supply of available workers, deflates wages, and weakens labour's bargaining power. In addition, because there is little demand for products then, employers become less concerned with improving worker productivity. If community psychiatry was oriented primarily to control workers, we would expect to find little investment in its innovations during these periods. On the other hand, if community psychiatry were motivated by benevolent concern for the mentally ill, we would expect to see most innovations during these humanly stressful times, when emotional problems increase (Brenner, 1973, 1976; Buck, 1972; Reid, 1961; Schwab & Schwab, 1978, pp. 304-308; Tiffany, Cavan & Tiffany, 1970; Weiman, 1977).

(5) We would expect to find corporate leaders and industrial psychologists explicitly indicating that they adopted these innovations (before the creation of community psychiatry) primarily to increase management control

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over labour productivity and labour unrest. Such statements would strongly imply that community psychiatry's "innovations" were created *intentionally* to increase industrial discipline.

The first four hypotheses reflect a structuralist philosophy. That is, they are based on the assumption that social forces (e.g., economic pressures, class relations, international conflicts) cause social institutions, relatively independently of the motivations or wills of individuals. The fifth hypothesis, on the other hand, is based on an instrumental approach, in which one must demonstrate the conscious intention of actors who occupy positions of power to create these social institutions to serve their own interests.

Although, at times, these two approaches have been considered contradictory (e.g., Miliband, 1972; Poulanzas, 1972), they actually complement each other. The structuralist method lays out the material foundation of causation, while the instrumental method analyzes the way people act on it and in terms of it.

Considered alone, structuralism threatens to lapse into a reified conception of causation, into "super-determinism" (Miliband, 1972, p. 259). Social forces alone do not make social institutions: People, albeit constrained by their particular social situations, make policy and have a certain degree of choice about their actions. To demonstrate that objective social forces made it in the interests of the state to create community psychiatry does not prove that that is why it was created. To conclusively demonstrate that community psychiatry was created to enforce labour discipline, we should also

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be able to show that both business leaders and government policy makers were aware of the labour control aspects of the innovations of community psychiatry, and that they supported them because of those aspects.

On the other hand, we need the structural evidence to ground the instrumental approach. Unless we can demonstrate that objective social pressures led to community psychiatry we are left without a framework within which to evaluate the statements of people in power about community psychiatry. Taken alone, the intentional aspect of causation is even more problematic than the structuralist method. For example, it raises issues such as lying (which statements one is to believe), self-deception (whether policy-makers are aware of their "real" intentions), and power (whether the actors have the means to carry out their stated intentions). In terms of this study, for example, we find business leaders and policy makers claiming all sorts of benevolent reasons for their actions, and asserting that their techniques have great power to solve problems for both labour and capital. In order to sort out these statements, we need an analysis of the structural position of these people and its impact on their definition of the problem. More fundamentally, we need both the structuralist and the instrumental hypotheses to analyze and explain the relationship between the actors' intentions and their position within a social structure (Poulanzas, 1972, pp. 238-243).

Methodology

To test this theory, I traced the histories of both public

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mental health programs and of industrial psychology since 1900, and examined their relationships to labour relations and to economic and political trends.

I relied primarily on original documents by:

-Management representatives (e.g., Ford, 1946; Lewisohn, 1926; Rockefeller, 1917; Sligh, 1956)

-Industrial psychologists (e.g., Argyris, 1957; R. Baker, 1920; Bingham, 1931; Mayo, 1930, 1933; A. McLean, 1967; Southard, 1920a, 1920b; Taylor, 1911)

-Government policy makers (e.g., B. Brown, 1973; Felix, 1947, 1961; Hargreaves, 1959; Kennedy, 1963; McKerracher, 1966; Rees, 1959, 1966; Yolles, 1967, 1969, 1975)

-Public hearings, legislative debate, and commissions of inquiry (e.g., Expert Committee, 1950, 1953; Frazier & Pokorny, 1968; Hincks, 1946; House Report, 1945; Hoxie, 1918; Joint Commission, 1961; President's Commission, 1978)

-Labour spokespersons (e.g., Barkin, 1956; Fountain, 1945; Glasser, 1967; Gomberg, 1957; Meany, 1956; Santiestevan, 1975)

-Annual reports and publications of private national and international mental health organizations (e.g., National Committee for Mental Hygiene, 1941, 1944; Tyhurst, Chalke, Lawson, McNeil, Roberts, Taylor, Weil & Griffin, 1963)

-Public statistical data on economics, labour trends, and mental health services

This original material is supplemented by an extensive review of secondary analyses of trends in labour relations, economics, mental health policy, and international relations, as well as by professional and lay reports on psychiatric innovations. The results of this investigation are discussed in Chapters IV and V.

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The limits of the study

Data for this study are limited to broad trends in community psychiatry and labour-management relations in developed Western countries. Its central purpose is to explore community psychiatry's roots in industrial psychology and to examine its possible function as an agency of labour regulation. In pursuing this main question, it does not deal in depth with: (1) the stylistic variation among community psychiatry programs of Western countries, (2) the history of community psychiatry in under-developed countries, or (3) secondary contradictions within labour and management groups. These omissions may be justified as follows:

(1) *Variations among Western community psychiatry programs*

The particular history and situation of each nation colors its public psychiatry programs. For example, German psychiatrists emphasize both genetic and psychoanalytic research, while Italian psychiatrists tend to focus on neurological malfunctions and to ignore psychoanalysis (Cerletti, 1961, pp. 189-198; Hoff & Arnold, 1961, pp. 63-86). Europeans give more attention to existential issues than do Canadians or Americans who tend to be more behavioristic (Bellak, 1961, pp. ix-x). These philosophical differences spill over into the treatment of patients, as Hoff and Arnold (1961) point out:

> If a schizophrenic lives in a certain part of the world, it is unlikely that he will escape with an intact forebrain; if he happens to live in another part of the world, he will not be declared mentally ill, but rather, disturbed in his relationships to his environment. In one locale he will become the subject of the most diverse laboratory examinations;

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> in another, his utterances will be stifled immediately by electro-shock. (p. 109)

However, these stylistic differences have become rather secondary since World War II. Since 1945, most Western countries have widely adopted the innovations and principles of community psychiatry (Cloutier, 1966, pp. 79-83). Partly, this is because the United States used its enormous post-World War II influence to impose its model of community psychiatry on other countries (David, 1966; Lin, 1961; see also Chapter V). For example, Langfeldt (1961) reports that in Scandinavia, U.S. psychiatric influence had been virtually non-existent before the war, but:

> This state of affairs has changed completely since 1945. In post-war years the majority of leading Scandinavian psychiatrists and neurologists have had one or more courses of study in the United States. This has been made possible, to a great extent, by generous American scholarships, especially from the Rockefeller Foundation, and by the Fulbright grants. At the same time, authorities in the Scandinavian countries have recognized the advisability of providing instruction in American psychiatric theoretic and therapeutic principles. (p. 220)

On the other hand, since World War II, most developed countries have faced similar problems of political and economic instability and of rising labour alienation (Rees, 1966, pp. 14-16). The same social forces which encouraged the United States to adopt a community psychiatry model, therefore also made it an attractive model for other countries. For example, Soviet psychiatric programs have independently adopted many aspects of community psychiatry since the war (Aronson & Field, 1964). Because of the overriding influence of community psychiatry throughout Western psychiatry, I have not explored the variations which remain, however secondarily, among

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psychiatric programs in different developed countries.

(2) *Community psychiatry in under-developed nations*

This study focuses only on developments in industrially developed Western countries, and it does not examine the history of community psychiatry in Third World countries. However, general trends in psychiatric programs for developing nations indicate that for them, too, community psychiatry may serve primarily to control labour alienation.

Before World War II, underdeveloped countries had few public psychiatric services or trained personnel (Expert Committee, 1950, pp. 6-7; Sangsingkeo, 1966). An early priority of the United Nations was to establish community psychiatry programs in all nations, including those in the Third World (Chisholm, 1948, p. 47; Expert Committee, 1950, pp. 8-12). Rather than focusing on improving clinical services to the seriously disturbed, the explicit U.N. policy for developing nations was to emphasize preventive programs oriented to treating non-psychotic children and urban workers (Expert Committee, 1950, pp. 6-18). Specific U.N. priorities for mental health programs included training managers in industrial psychology techniques, treating "antisocial deviants," and studying the effects of rapid industrialization on mental health (Expert Committee, 1950, pp. 18-20, 29-30). These priorities define the problem of "mental illness" as the threat of revolution and lack of control over workers (Rees, 1966, p. 16):

> If development and human resources [in developing countries] are to be encouraged, psychiatric programs must receive more attention. Psychiatric illness must be recognized in terms

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> of such effects on the social system as unemployability, absenteeism, lack of motivation, delinquency, crime, drug addiction, and alcoholism, as well as susceptibility to revolution, violence, and social turmoil. (Argandoña & Kiev, 1972, p. ix)

Third World countries had little voice in approving these policies. For example, of the 2,065 members of the influential International Conference on Mental Hygiene in 1948, over 1,900 represented developed Western nations, and 1,440 of those came from England and the United States (International Congress, 1948, Vol. 1, pp. 120-122). The membership of the World Health Organization's policy-making Expert Committee on Mental Health was similarly dominated by the United States and Britain (Expert Committee, 1950, p. 2; 1953, p. 3). By 1950, the World Health Organization, UNESCO, the United States government, and private American foundations (particularly the Rockefeller Foundation) had all established extensive grants and fellowships to help Third World countries train mental health personnel and set up community psychiatry programs (David, 1966). United States mental health experts consulted extensively with Third World governments, especially for those headed by United States-supported dictators, to set up community psychiatry programs there (Bordeleau & Kline, 1962; Kline, 1963; Lin, 1961; Maguigad, 1964).

(3) *Internal conflicts in labour and management*

This study also does not address a number of issues in labour-management relations. For example, it does not discuss the consequences of internal labour divisions (e.g., craft vs. industrial unions, national vs. international unions, or union leadership vs.

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memberships). Nor has it dealt with the effect of racism or sexism on the labour movement and on industrial relations. On management's side, it does not explore the competing factions within business leadership (e.g., domestic vs. absentee owners, large vs. small manufacturers, financial vs. manufacturing sectors, or conservative vs. liberal political orientation).

These are all important issues. The conflicting factions in organized labour directly affect the direction and effectiveness of labour struggles. For example, U.S. based international unions have tended to sacrifice the interests of their Canadian affiliates, and to expel dissident, communist-affiliated unions (Brooks, 1971, pp. 223-242; Lipton, 1967, pp. 266-349; Scott, 1978). How workers resolve these internal struggles will strongly influence the effectiveness of their external struggles with management and government.

Racism and sexism under capitalism consistently have been used by management to break workers' unity and to divert workers into struggles among themselves. Racism and sexism also permeate community psychiatry. For example, women receive proportionally far more mood-altering drug prescriptions than men, and minorities -- particularly low income minorities -- tend to receive the most directive and least personal forms of therapy (Cole & Pilisuk, 1976; Harding, Wolf & Chan, 1978). For both women and minorities, therapy tends to enforce "better adjustment" to oppressive conditions. Sexism and racism in therapy directly reinforce oppressive relationships at work (including housework) making women and

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minorities more manageable. These problems, therefore, are intimately related both to the regulation of labour and to the organization of mental health services.

Similarly, business is far from a monolithic entity. The politics of contending factions within business have had a major impact on both labour-management relations and on social services (including community psychiatry) (Finkel, 1977; Schecter, 1977; Swartz, 1977; Wilcock, 1961). Basically, community psychiatry reflects the victory of liberal, international monopoly capital over conservative, domestic capital and over petty-bourgeois professional psychiatric interests. Those less dominant factions, however, continue to exert pressure. For example, right-wing politicians (backed by conservative employers) frequently agitate against funding progressive aspects of community psychiatry programs such as grants to Black youth groups or community controlled mental health centres (Chu & Trotter, 1974; Ehrenreich & Ehrenreich, 1970, pp. 77-94; Kovel, 1976, p. 33; Persky & Brunet, 1975; Repo, 1961). Psychiatric lobbyists were able to claim the largest proportion of N.I.M.H. training funds and to institute regulations that all United States community mental health centres should be directed by psychiatrists (Ralph, 1969).

Nevertheless, for the central question of this study -- why community psychiatry developed -- these issues are all relatively secondary. No prior research has postulated an intimate relationship between labour relations and community psychiatry, and the focus of this work is to examine this basic link. If this "labour theory" can

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be supported, future research on the impact of these secondary conflicts can be placed in better perspective.

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II. WHY COMMUNITY PSYCHIATRY? LITERATURE REVIEW

2.1 The benevolent government theory

It is appropriate to begin this survey of theories about why community psychiatry developed with the perceptions of those who created and now support community psychiatry. Almost without exception, they explain community psychiatry with what could be called a "benevolent government" theory. Advocates of this approach assume that the government is a neutral dispenser of services for the benefit of all. This assumption steers its spokesmen toward an apolitical, technological explanation of community psychiatry. They perceive its growth as a consistent advance in a series of ever more enlightened scientific progressions toward "the goal of making high quality public and private mental health services available at a reasonable cost to all who need them" (President's Commission, 1978, Vol. 1, p. viii). For them, the sole motive for this "third revolution in psychiatry" (Bellak, 1964) is the welfare of the current and potentially mentally ill (Bloom, 1973; Ewalt, 1975; Ganser, 1975; Hirschowitz & Levy, 1976; Kennedy, 1963, p. 13; Mechanic, 1969; C. Smith, 1974; Yolles, 1969, 1975).

Community psychiatry developed, these theorists propose, because government leaders became more aware of mass psychiatric problems developing as side-effects of progress, and of the institutionalizing effects of mental hospitals. For example, the

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first director of the U.S. National Institute of Mental Health proclaimed that community psychiatry had a mandate to both improve care of chronic mental patients and to prevent mental illness in general:

> We have long since learned that the problem can never be solved simply by building more institutions for those persons whose abnormal behavior can no longer be ignored or neglected. Our goal must be not merely to press for better care of those mentally ill persons for whom we have failed to provide adequate treatment in time. Rather, we must adopt the positive aim of utilizing our talents and energies to prevent such illnesses and to improve the mental health of the nation. (Felix, 1947, p. 364)

Lawson (1958), one of the pioneers of Canadian community psychiatry, echoed similar sentiments:

> The older concept of the mental hospital as an asylum where the mentally ill could be stored out of harm's way is no longer acceptable. The mental hospital must be one of the tools used to restore the mentally ill to their place in the community and in the words of Florence Nightingale a hospital must at least "do the sick no harm." We must go further than this in our modern conception of the mental hospital for it must not or[illegible] do no harm but must actively assist in the pat[illegible]t's cure and rehabilitation. (Lawson, 1958, p. 186)

A burst of demographic studies were funded during the 1950's and early 60's which graphically demonstrated that the prevalence of mental illness is related to social stress and that many more people are ill than are treated in mental hospitals (Hollingshead, Ellis & Kirby, 1958; Hollingshead & Redlich, 1953, 1954; Langner & Michael, 1963; Srole, Langner, Michael, Opler & Rennie, 1962). At the same time, Goffman's (1961) exposé of the debilitating effects of mental institutions received enthusiastic and extensive recognition. These findings became the empirical justification for policy decisions already made (Expert Committee, 1953; Felix, 1947; Preston, 1947;

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Rennie & Woodward, 1948; see also Chapter V). The inmates of mental hospitals were to be freed, and returned to the healing, normal environments of their own communities, while all other emotional casualties of "progress" were to receive cheap, accessible treatments to cure them before they needed to go into an institution. Everyone would benefit -- the mentally ill, the taxpayers, and the businesses, as services to the already mad improved and the costs of future madness to society were averted.

This perspective has some validity. Certainly a large number of liberal, humanitarian professionals have been attracted to community psychiatry out of genuine concern for mad people, and with honest hopes of righting the injustices and inadequacies in their treatment.

However, as an explanation for why community psychiatry developed, this theory is extremely weak. In some ways, this is understandable since its spokespeople are usually administrators of or lobbyists for community psychiatry, and their interest is, therefore, more in promoting than in critically analyzing its growth. Nevertheless, the benevolent government theory suffers from multiple blind spots and inconsistencies. Among other things, it fails to address questions like:

- Why was there such a sudden international upsurge of benevolent concern for the mad just after World War II? If professionals and administrators had these charitable urges earlier, what kept them from expressing them?
- Who else had a stake in community psychiatry besides the insane?
- How did all that charitable feeling alone motivate massive spending on psychiatric programs, when other serious social problems were neglected?

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It does not analyze why so many Western governments almost simultaneously adopted community psychiatry programs. Each country's theorists suggest local reasons, such as Kennedy's retarded sister (U.S.) (Bloom, 1973), the Swiss "democratic tradition" (Benedetti & Müller, 1961), and exposure to welfare state policies in Britain and Norway (Bennett, 1973; Bremer, 1961). But this massive international phenomenon demands deeper economic and political motivation than personal interests, democratic traditions, or habit.

Nor does it examine the stake that groups other than the "mad" may have had in creating community psychiatry. The mental patients themselves and even their families never actively lobbied for these programs. In fact, polls showed that most people preferred to have mentally ill family members treated in distant mental hospitals rather than nearby, and a number of community groups protested against de-institutionalizing chronic mental patients (Badgley, C. Smith & McKerracher, 1966, p. 250; Burrows, 1969, p. 109; Citizen's Medical Reference Board, 1946; Frazier & Pokorny, 1968). On the other hand, corporations, insurance companies, military leaders, and some medical groups did vociferously support community psychiatry funding (See Chapters III, IV and V).

The benevolent government theory also ignores the links between trends in psychiatry and in other social services. These links imply a consistent, wider stimulus for community psychiatry than simple concern for the mad. A theory of charitable intentions falls most short when it tries to account for community psychiatry's tendency to slash budgets and services to the chronically mentally

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ill (Hersch, 1968; Santiestevan, 1976). These theorists are left claiming that any inadequacies in services to ex-mental patients are local "mistakes" (Deinstitutionalization, 1978; Doll, 1976; H. Lamb & Goertzel, 1971; NIMH Report, 1977).

Finally the benevolent government theorists' claim that community psychiatry is primarily a technological advance as a result of new mood-altering drugs is unconvincing, since deinstitutionalization of chronic mental patients and expansion of programs for workers began well before the drug technology was invented (Love & Hobbs, 1971; Scull, 1977, pp. 79-89).

Underlying all these weaknesses is the blindness of the benevolent government theorists to the class nature of psychiatric services. As a result, this theory leaves out a central question: For whom is the high incidence of "mental illness" a problem and why is it a problem for them? The "problem" of mental illness as it is defined now is quite different from its definition thirty years ago. The large majority of mental patients now are diagnosed for disorders which were scarcely treated and sometimes not even labelled as mental disorders before 1945 (International Classification of Diseases, 1957, 1965; D'Arcy, 1976b). These include transient situational disorders, most personality and behavior disorders, unaddicted and nonpsychotic drug and alcohol "abuse," neurotic depression, and a variety of psychosomatic illnesses. At the same time, the number of people treated for chronic mental disorders such as organic brain damage, mental retardation, and functional psychoses has declined precipitously as a result of the decarceration movement. It is easy

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to see that the decline of treatment for chronic mental illness has nothing to do with a decline in the incidence of these illnesses, but only with their changing definition from psychiatric to non-psychiatric problems (D'Arcy, 1976a). But it is harder to see the social production of the rising treatment statistics. The rise in psychiatric treatment appears on the surface to be a response to the growing "real" incidence of mental illness in the population.

We have been trained to assume, particularly in the social services, that problems exist independently of their treatment, and that the incidence and prevalence of a problem can be objectively measured. As a result, there are many attempts to study the "true" incidence of poverty (as opposed to numbers being served by welfare), crime (as opposed to numbers of convictions), unemployment (as opposed to numbers receiving unemployment insurance), and so forth. Similarly psychiatric epidemiologists have devoted impressive energy to discovering the "true" incidence of various psychiatric disorders. With widely divergent results, these studies have "confirmed" the high incidence of untreated mental illness particularly among the poor and the oppressed.

But the measurement and the treatment of social problems are intimately related. As Dorothy Smith (1975) points out, "when you seem to be counting people becoming mentally ill, you are in fact also counting what psychiatric agencies do. The two aspects can't be taken apart. The figures can't be decontaminated" (p. 88). Diagnosing -- labelling -- is a central function of psychiatric treatment, as well as of all other social services. It is the criterion by which clients' eligibility for or requirement of service

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is determined. The difference between actual treatment statistics and "real" incidence rates is primarily a difference in the definition of the problem, a difference between those who are treated and those who the definers of the problem believe should be treated (Kelman, 1975). We can see the underlying political nature of the "true" incidence problem in the debate over who is to be considered "unemployed." The measured rate of unemployment can vary over three hundred percent depending on what definition one employs and how rigorously one looks for cases (Kouri & Stirling, 1979; Livant, 1978). Since the resulting number of people defined as unemployed has serious consequences, these definitions are hotly contested.

"Problems" reflect primarily the concerns of the definers, rather than of the people who are defined as having the problem. To be labelled and counted (and eventually processed through some official treatment), one has to pose a problem for the people who finance the labelling and treatment. For example, we get regular government reports on the incidence of crime, inflation, union organizing, and unemployment (as it affects business), but we can not get any official statistics on the incidence of dangerous employers, un-employers, union busters, incompetent doctors, scabs, spies, and other dangers to workers.

Of course, often the people who are labelled do experience real problems, but these are not necessarily the problems that they are defined as having. Some of the miseries people experience are relatively ignored as social problems worthy of treatment, for example, malnutrition and infant mortality among native people and mothers' economic powerlessness in the absence of adequate day care. Other

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sources of unhappiness are explicitly not defined as problems, as in adoption of "acceptable" exposure levels to radiation, pollution, and noise. And some problems people experience are actively caused and supported by government policies, as, for example, when people are deported, drafted, denied welfare, or arrested. In all of these examples, the official definition of "problem" fails to include, or explicitly excludes the individual's experience of unhappiness or discontent. On the other hand, many problems which people do not have are defined as social problems, such as the "need" for wage-controls, better police intelligence operations, and treatment of "minimal brain dysfunction" in bored children, addicts, and thieves (Bellak, 1969; Schrag & Divoky, 1975). As we shall see, the new treatments of the new "mental" illnesses combine both types of error -- by treating people who have real social problems for psychological problems they do not have, and often by producing more of the real problems they do have. It is significant that the recent U.S. President's Commission on Mental Health (1978), while noting that poverty, racism, sexism, and alienation psychologically damage over one-third of the population, failed to propose any action to attack these problems. Instead, it only urged that psychiatric programs be expanded to "reach these underserved populations" (Vol. 1, pp. 2-10).

The rising "incidence" of new forms of "madness" corresponds closely to the problems these people pose to business and the state. The fastest-growing diagnoses -- neuroses, alcohol and drug "abuse," and "personality disorders" -- are all social diseases (to the extent that they are valid descriptions of symptoms and not just pejorative labels): reflections of alienation, hopelessness, frustration, and lack

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of dignified, useful options in life. The symptoms of these diagnoses are simultaneously evidence of personality damage and of personality repair. That is, they represent ego defenses against unbearable reality. In a sense, the "problem" for these people, is not nearly so much their behavioral "symptoms" as it is the social stresses which require this distorted behavior. People drink and take drugs largely to cope in soul-destroying situations. They repress their awareness of reality and develop "personality problems" because that is the only way they can continue to do what they must do -- work or be unemployed. But for business and for government, the psychiatric diagnoses _are_ the main problem, because they pose a serious danger to profits and social order. People with these symptoms don't produce as much as they could, and they are unreliable, impulsive, and prone to accidents, work disruptions, and absenteeism. As Bertram Brown (1973), ex-director of NIMH, pointed out: "Mental illness is without a doubt the nation's costliest health problem and constitutes an enormous drain on the country's energies and resources" (pp. 10-11). This sentiment echoed the earlier statement by two prominent industrial psychologists: "The cost to industry of disruption resulting from emotional disturbance ... runs into hundreds of millions of dollars annually." (A. McLean & Taylor, 1958, pp. 30-31). In other words, community psychiatry _defines_ potential disrupters of work and social order as "mentally ill" and as "emotional contaminants" (Bellak, 1969, p. 253) who are likely to infect others. The definition of this new "problem" is part of the effort to control it, i.e., to eliminate the

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danger it poses to capitalist order (Kelman, 1975). Many of the treatments which have been developed under community psychiatry -- the mood-altering drugs, methadone, behavior modification techniques, and brain surgery -- primarily are oriented to merely produce more reliable and controllable emotional repressors of consciousness than the alcohol, drugs, and ego defenses they "treat."

The benevolent government theory of community psychiatry basically expresses the voice of progressive business leaders under monopoly capitalism (Miliband, 1969, pp. 108-116; Navarro, 1976b, p. 445). Assuming that what is good for business is good for people leads these theorists naturally to applaud policies to adjust people to the needs of business "for their own good." If one accepts the maddening conditions of capitalist society, the only humane thing to do is to "help" people to be happy in those conditions. As Shagass (1971), a prominent community psychiatrist, explains:

> The explicit value system [of community psychiatry] is that measures which permit people to feel comfortable, to work and to study more easily, and to get along better with others are 'good.' (p. 4)

The only remaining issue is how to do that most efficiently and effectively -- i.e., technological issues.

While these theorists offer little in direct analysis of the evolution of community psychiatry, their work is useful in clarifying the philosophical assumptions of its founders. Basically they represent well-intentioned reformers who want "the best" for people, but they are constrained by their ideologically conditioned assumptions to define both problems and goals in terms of the priorities of an unequal social system.

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2.2 The mental health lobby theory

Mental health lobby theorists focus on the role of psychiatrists and other mental health professions in pressuring governments to expand psychiatric services. Their perspective reflects a pluralistic, democratic conception of politics in which relatively equal, competing interest groups vie for power and money. Community psychiatrists, like other interest groups "growing out of the liberal social programs of the 1960's" (Chu & Trotter, 1974, p. 6) capitalized on national concern over social problems and managed to convince their respective governments that they could prevent and cure mental illness (Steinhart, 1973). Other psychiatrists "followed their noses to the federal money and defined large portions of their function in the areas of community psychology and psychiatry" (Magaro, Gripp & McDowell, 1978, p. 12). Before long, community psychiatry took on the quality of "another bandwagon" (Burrows, 1969) as psychiatrists faddishly sacrificed judgment for prestige and money (Fischer & Weinstein, 1970). The result, they claim, has been "innovation without change" (Graziano, 1969); bureaucratic empire building and politicking at the expense of patients, their communities, and nonprofessional mental health workers (Ryan, 1969; Chu & Trotter, 1974). "'God is dead,' one has been told; 'try NIMH'" (Burrows, 1969, p. 112).

By and large these theorists are not as concerned with analyzing the causes of community psychiatry as they are with criticizing it. Therefore, they offer little detailed investigation of the actual mechanisms by which community psychiatry managed to win

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such massive political influence so suddenly and so simultaneously in many countries. Rather, they tend to avoid macro-economic and political analyses and to focus instead on the immediate political machinations of psychiatric interest groups and on the personal motivations of their leaders to expand their empires. For example, Chu and Trotter (1974) explain the growth of the N.I.M.H. like an AVIS RENT-A-CAR ad.

> Although NIMH soon became the largest and fastest-growing component institute in NIH [National Institutes of Health], it was never completely content within the NIH fold. In part, its discontent reflected the independent leadership of Dr. Robert Felix, director of NIMH from 1949 to 1964, who was not always willing to follow the policy decisions set forth by the NIH director. But more than the conflict of personalities, NIMH's uneasiness within NIH reflected psychiatry's precarious position within the medical fraternity during the late forties and early fifties. Due to a number of factors ... psychiatry had long been viewed as the 'cinderella' department of medical schools. In a similar way NIMH felt something like a second-class citizen within NIH. Perhaps fearful that psychiatry would receive short shrift within any medical agency and convinced that the rest of the medical community would not mightily promote a mental health institute, NIMH always seemed to try harder than the other institutes of health and incessantly strove to increase its own power within NIH, even after the prestige of psychiatric medicine became great. (Chu and Trotter, 1974, p. 7)

This theory that "trying harder" will reap political rewards typifies these theorists' view that growth is a result of individual decisions of psychiatrists and agencies rather than a response to social and economic pressures.

The mental health lobby theorists fall generally into two categories: (1) conservative psychiatrists whose professional fiefdoms are threatened by community psychiatry's industrialization and state intervention (Burrows, 1969; Dingman, 1976; Fischer & Weinstein, 1971; Magaro, Gripp & McDowell, 1978; Robbins & Robbins, 1974; Steinhart, 1973), and (2) liberal social scientists who basically approve of

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community psychiatry, but who bemoan its unequal distribution by race, geography, and income (Chu & Trotter, 1974; Connery, 1968; Persky & Brunet, 1975; Willie, Kramer & B. Brown, 1973). The conservative wing complains that community psychiatry causes too much change, and guts professional standards, while the liberals complain that little has changed, that community psychiatry is merely traditional psychiatry cloaked in new rhetoric. But both factions agree that the professionals single-handedly created community psychiatry by legislation and clever public relations work.

This approach is useful in clarifying the internal politics of competing professional groups and their relationship to state legislative and administrative bodies. However, it fails to deal with historical or class issues, and as a result, it explains little about the wider forces molding community psychiatry or about its broad social impact. Focusing on formal administrative and bureaucratic policies, the mental health lobby theorists ignore the far greater impact of private, non-legislative forces on community psychiatry. The public sector of community psychiatry is only one highly specialized wing of a much broader and more complex phenomenon. Public mental health programs in Canada treat less than a quarter of those receiving psychiatric diagnoses (D'Arcy, 1976b, p. 162), and less than one-eighth of those who received mood-altering drug prescriptions (Harding, Wolf & Chan, 1978).

We can see, therefore, that the mental health lobby theory produces a highly skewed perspective on the dynamics of community psychiatry. It recognizes only petit-bourgeois lobbyists and state policy-makers, ignoring both the impact of corporate demands and the

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power of labour actions in causing those demands.

As a result, these theorists are unable to explain what made the psychiatric lobby, or indeed any other petit-bourgeois lobby, powerful. Clearly the power was not inherent in the profession itself, as we can see by the rising and falling budget appropriations for community psychiatry. From 1945 to 1970, funding for psychiatric programs rose almost geometrically in the United States and Canada (Arnhoff, Rubinstein, Shriver & Jones, 1969). But beginning in 1970, mental health-related grants were frozen or cut, while criminal justice programs proliferated (Chu & Trotter, 1974; Center for Research, 1977, pp. 7-9). The mental health lobby has demonstrated little power which is independent of its ability to adapt itself to state, and ultimately to business, interests.

Like the benevolent government theorists, the lobby theorists do not address issues like: (1) the simultaneous international upsurge of community psychiatry; (2) the relationship of community psychiatry to other social services, or (3) the state's motives for responding so generously to the mental health lobby. As a result, they offer little insight into the causes of the evolution of community psychiatry.

They do, however, perform a useful role in discrediting the theory of the disinterested benevolent government. By analyzing the petty squabbling among professional lobby groups and by exposing the inequalities in the distribution of community psychiatric services, these theorists lay bare some of the failures of community psychiatry in its own rhetorical terms. It remains for the social control theorists to make sense of this apparent failure.

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2.3 The social control theories

Social control theorists explain the rise of community psychiatry as part of the broader expansion of the social regulation of citizens. Unlike either of the other theoretical positions, they tend to discount the government's claims about its benevolent motivations toward mental patients. They view community psychiatry as an active threat to the interests of its clients, which operates "directly to enforce oppressive sex and class roles, to reinforce individualism, and to promote the idea that however oppressive your situation is, your problems are 'all in your head'" (Ehrenreich & Ehrenreich, 1975, p. 140). As a result, far from lobbying for more and better programs, or even for services which are more available to poor and working-class people, social control theorists oppose community psychiatry in general:

> Who wants a community mental health center, even an attractive and well-staffed one, if its ultimate prescription for mental health is acquiescence to oppression? (Ehrenreich & Ehrenreich, 1975, p. 139)

For the social control theorists, mood-altering drugs are not a therapeutic advance, but rather a sinister progression from physical to psychological restraint of civil liberties (Brandt, 1975; Lennard & Bernstein, 1973; Scheff, 1976; P. Schrag, 1978). The widening net of psychiatric services implies for them, not improved accessibility of care, but rather forbodings of fascism (Brandt, 1975; M. Brown, 1968; Keniston, 1968; Leifer, 1966). Szasz (1970), for example, perceives community psychiatry as advocating an ideology that:

> ... the individual should be allowed to exist only if he is socially well adapted and useful. If he is not, he should

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> be "therapized" until he is "mentally healthy" -- that is, uncomplainingly submissive to the will of the elites in charge of Human Engineering. (p. 224)

For them, "deinstitutionalization" is an ironical hypocrisy, in light of the rapidly increasing number of people who are hospitalized and the equally institutionalizing conditions of many "community" placements (P. Allen, 1974; Ehrenreich & Ehrenreich, 1975; Leifer, 1969, pp. 221-222; Scull, 1977; S. Spitzer, 1975). The social control theorists divide into two schools of thought on the causes of community psychiatry, antipsychiatric and Marxist. Anti-psychiatrists emphasize the internal politics of therapist-patient relations, while Marxists focus on external social and economic influences on community psychiatry.

2.3.1 The antipsychiatry theory

The antipsychiatry perspective grew out of the mental patients' rights movement, and it tends to reflect the specific concerns of its members, primarily ex-mental patients and liberal mental health professionals. It focuses on the problems of those labelled psychotic, on their treatment in and out of mental hospitals, and on professional power of therapists over their patients (D. Cooper, 1967, 1979; Szasz, 1960, 1970, 1978; Brandt, 1975; Leifer, 1966, 1967, 1969). The antipsychiatry theorists believe that community psychiatry is simply an expansion of a consistently oppressive psychiatric system, and they do not recognize any fundamental shift in emphasis from unemployed, chronic patients to active workers.

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> The chains are gone, the beatings are less frequent and more secretive, the locked doors have been opened in many institutions, and the interior decorations have been improved. However, mental hospitals are still used primarily to confine disruptive members of the lower classes. The chains are chemical and legal, the beatings are psychological, and the locks have been replaced by members of the mental health team who guard the open doors. The rapid discharge rate, far from being an index of the "progress" of medical psychiatry, is evidence of an increased efficiency in influencing and controlling throught and behavior. (Leifer, 1969, pp. 98-99)

Antipsychiatric theorists perceive the medical establishment and particularly psychiatrists as the principal forces for expanded social control of deviants, and they fear the threat of medical dictatorship over everyone (Illich, 1975; Szasz, 1970).

> We shall have solutions for our human dilemmas proposed to us in the language of medicine, in terms of techniques for combating mental illness and promoting mental health, so that we cannot disagree unless we are wicked or mad. This can serve only those in power, who will promote their causes under the banner of medical progress. We shall have been bewitched by "experts" about our nature and our destiny. And this bewitchment will be eagerly sought by its victims -- and justified and exalted "In the Name of Mental Health." (Leifer, 1969, p. 242)

Their attitude toward the non-psychiatric population is ambivalent. On the one hand, they see community psychiatry as endangering the civil liberties of everyone, and particularly of the oppressed. But on the other, they view all non-mental patients as the ultimate enemy, since they believe mass intolerance of deviant life-styles is the source of psychiatrists' power (Scheff, 1968, 1976; Szasz, 1978; Leifer, 1966). From this perspective, community mental health centres are "instruments of the state employed for the involuntary confinement of persons who have offended the public sense of behavioral propriety" (Leifer, 1969, p. 99). This leaves mental patients and their allies alone in a struggle against everyone else:

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> It would be a shame if the ex-patient groups now in existence lost sight of their actual political goals and adopted the line which strict Marxists like Michael Glenn ... are pushing on them. ...Mental patients [should] see the real oppressor as being the mental health system and its practitioners.... It is not the ruling class which is the enemy of mental patients. It is the community. The people who hate and fear mental patients the most are the people who insist on a system of strict controls for them, the very "masses" Glenn would have them ally with. (Brandt, 1975, p. 272)

The antipsychiatry theory offers major advantages over the benevolent government and the lobby theorists. First of all, it identifies the conflict of interests between the servers and the served in community psychiatry. Where the other theories treat all "services" as benefits, antipsychiatry theorists point out that many psychiatric "services" serve primarily the interests of the powerful and of the professionals, while they often restrict the freedom and rights of those "served." This opens up the internal politics of community psychiatry in a way that the mental health lobby theory could not. It allows antipsychiatry theorists to provide a wealth of detailed evidence on the specific mechanisms by which social control is imposed on those labelled insane. Finally, the antipsychiatry theorists offer useful descriptions of how community psychiatry helps to enforce oppressive social relations by invalidating the feelings of women, minorities, and the poor, and by treating these groups with more coercive methods.

Nevertheless, the antipsychiatry theorists offer a weak tool for explaining the rise of community psychiatry. Their emphasis on hospitalized mental patients limits their ability to examine the dramatic shift of mental health services under community psychiatry away from public, psychotic and toward private, non-psychotic treatment.

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Far from explaining the rise of community pschiatry, therefore, they hardly recognize it. Focusing on the internal dynamics of therapist-patient relations, they tend to ignore wider economic and political forcės impinging on community psychiatry, and to ascribe more independent power to psychiatrists than they actually have. This leaves antipsychiatry theorists without a framework to analyze the purpose of the social control of mental patients, why this control should expand so rapidly since 1960, and who controls the psychiatrists. As Scull (1977), a critic of antipsychiatric theory, explains:

> Almost exclusive attention to the impact of organizations on the individual results in only passing attention to the structure of the organizations themselves and in almost total neglect of the overarching structural context within which particular agencies of social control operate. In turn, this narrowness of vision inevitably leads to work which depicts social control as arbitrary. For want of a larger perspective, the actions of the agencies come to be seen either as free-floating and apparently perverse, or as determined simply by the immediate interests of the first line controllers [psychiatrists]. (pp. 9-10)

One serious consequence of this omission is the tendency of anti-psychiatrists to separate mental patients from the practical situations which may have caused their deviant behavior. Antipsychiatry theorists begin their analysis at the point of deviant labelling, ignoring and sometimes explicitly denying the existence of madness -- i.e., being out of touch with one's own feelings and situation. They often treat those who are labelled insane as independent spirits or even as revolutionaries who are simply trying to do their own thing. "All madmen are political dissidents" (D. Cooper, 1979, p. 15). This romanticizing of madness fragments mental patients from their social

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relationships. As one ex-mental patient points out:

> But most of us ... were being broken down by social conditions in our personal lives before psychiatry identified us as "deviants." Returning to those lives (trying to reconstruct them) has placed many of us back in the frying pan -- back in living situations in which we are lonely, poor, treated with no respect, and denied decent food, housing, work, and companionship. Racial and sexual discrimination are additional burdens for many of us -- they are daily realities, not abstract political ideas. (Latz, 1979, p. 5)

This asocial perspective leads antipsychiatry theorists to view non-patients as potential enemies, and to blame psychiatric power on the mass's fears of deviancy. It is difficult, however to reconcile this position with numerous studies which indicate that: (1) the lay public has always defined madness much more narrowly than psychiatrists do, recognizing only extremely bizarre behavior as mental illness, and (2) in spite of massive, government education efforts to widen popular "awareness" of the new, expanded psychiatric diagnoses, the public's definition of madness has remained remarkably consistent (D'Arcy & Brockman, 1976, 1977; Rabkin, 1972; Turner & Spivak, 1974). In other words, although mass fears of severely psychotic people may have contributed to the creation of mental institutions, they cannot explain either the geometrical expansion in the scope of treatment for non-psychotic diagnoses or the decline in treatment of psychoses which characterizes community psychiatry. Although it provides some worthwhile analyses of psychiatric treatment -- particularly treatment of psychoses -- the antipsychiatry theory fails to provide a coherent explanation for the rise of community psychiatry.

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2.3.2 Marxist theories

By contrast, Marxist theorists have recently begun analyzing the nature and functions of public social services. Few of these studies focus directly on community psychiatry, but their findings imply possible answers to some of the questions surrounding the rise of community psychiatry, which were not addressed by the other approaches. They provide particularly useful insights in three areas: (1) clarifying possible social control functions of community psychiatry, (2) explaining the economic and political pressures which may have motivated the rise of community psychiatry since 1945, and (3) describing how these pressures may have contributed to the tendency of community psychiatry services to industrialize their methods and to shift from a public to a private emphasis of services.

(1) *Social control functions of community psychiatry*

Marx and his followers propose that the capitalist state exists to protect the interests of big business (Marx & Engels, 1972, p. 33; Lenin, 1939, 1971, 1972, 1973; Sweezy, 1942). ["The state" as used here includes the central government, the legislatures, the civil service, the military, public corporations, central banks, the judiciary, and provincial and local governments (Miliband, 1969; Panitch, 1977).] In addition to mundane, relatively apolitical housekeeping functions like providing roads, currency, and sanitation services, the state must actively control any behavior of other classes, and particularly of labour, which conflicts with business interests. These social control functions include: (1) co-opting mass grievances

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in order to prevent unrest and revolution, (2) using force to prevent and control "anti-social" behavior (for example through the police, the military, the legal structure, and bureaucratic rules), (3) ideologically conditioning people to co-operate with the wishes of business (for example, through the public educational system and regulation of the mass media), and (4) molding the current and potential labour force to fit the requirements of the job structure (Bowles & Gintis, 1976; Navarro, 1976a, 1976b, 1977; Panitch, 1977). Community psychiatry fulfills each of these functions to some extent.

Community psychiatry services, such as mood-altering drugs, counselling, and consultation, do help to make alienating work and living conditions bearable, and thus to co-opt labour militancy. This co-opting role of community psychiatry was explicitly recommended by a number of management and military representatives who advocated its establishment (see Chapters IV and V).

Community psychiatry operates to physically control trouble-makers directly through its powers of involuntary hospitalization, and indirectly through computerized psychiatric data on individuals and groups. It also uses psychological technologies in prisons, in police intelligence operations, and in the military (Crabtree, 1973; K. Cuthbertson, 1979; Hint, 1973; Laska & Bank, 1975; Levy, 1978; Planondon, 1973; P. Schrag, 1978; Schuchman, 1975; Shah, 1976; Task Force on Privacy and Computers, 1972).

Along with other health services, community psychiatry encourages people to perceive their problems as individual and irrational, and to see their psychiatrist's advice to adjust as based

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on scientific authority (Berliner, 1977; Navarro, 1977, Shatan, 1969; Szasz, 1978; Ziola, 1978).

Finally, and most importantly, social services in general have emerged as powerful tools in adapting workers to the faster, more degraded form of work under monopoly capitalism. Although this point has been well-documented in the education, welfare, and police systems, little work has yet been done to apply this concept to community psychiatry. That aspect is the central focus of this study (see Chapters III, IV and V) (Bowles & Gintis, 1976; Cohen, 1979; Mandell, 1975; Martell, 1974; Piven & Cloward, 1971).

Marxist theorists argue that it is not necessary to postulate that anyone consciously conspires to create these multiple social control functions. Rather, they propose, capitalist state organization implicitly assumes, depends on, and enforces capitalist values such as the "virtue" of private property, the "right" to make a profit, and the public's "need" for enlightened management. As Ehrenreich and Ehrenreich (1975) point out:

> To analyze something as a system of social control is not to view it as a conspiracy. We are not arguing that the health system is consciously designed to exercise social control, or that the social control functions of the health system somehow explain its structure and dynamics. To the contrary, we explain the social control functions as themselves a result of the institutional structure, organization, and economics of the health-care system. (p. 141)

Nor do social control functions depend on malevolent motives of individuals in power, as Navarro (1977) explains:

> To see these policies as a result of malevolence of individuals or the manipulation of government by certain economic groups is ... limited and erroneous. Such policies respond to the need perceived by those governments that the economy, to whose health we are all supposedly tied, has to be straightened out

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> before we can think of "other matters." And it is this behavior, and not the specific motivation of individuals or manipulation of groups, which establishes those policies as capitalist policies. (p. 63)

Panitch (1977) adds:

> The problem is not that political and bureaucratic officials decide to favor capitalist interests in case after case; it is rather that it rarely even occurs to them that they might do other than favour such interests. The problem is indeed a systemic one. (p. 14, original emphasis)

Social control is not exercised uniformly on all members of a society, but rather its purpose and form are conditioned by the client's relationship to the bourgeoisie. Steven Spitzer (1975) and the Ehrenreichs (1975) make a useful distinction between control of those excluded and those included in the labour force (in Marxist terminology, respectively the lumpen-proletariat and the proletariat). From the point of view of business, the unemployable are "social junk," i.e., unproductive burdens on the economy.

> The discreditability of social junk resides in the failure, inability or refusal of this group to participate in the roles supportive of capitalist society. ... Since the threat presented by social junk is passive, growing out of its inability to compete and its withdrawal from the prevailing social order, controls are usually designed to regulate and contain rather than eliminate and suppress the problem. Clear-cut examples of social junk in modern capitalist societies might include the officially administered aged, handicapped, mentally ill and mentally retarded. (S. Spitzer, 1975, p. 645)

Social services, including mental health services, directed at the unemployed tend to exercise "disciplinary social control" (Ehrenreich & Ehrenreich, 1975, p. 146). This form of social control is unpleasant, punitive, and exclusionary, designed to discourage workers from joining the unproductive.

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> At times, it has been used quite consciously to maintain industrial discipline in the work force. Foucault describes the combined poorhouses/insane asylums of eighteenth- and nineteenth-century Paris and London. These were maintained as public spectacles to remind the populace of what awaited them if they opted to drop out into pauperism or madness. (Ehrenreich & Ehrenreich, 1975, pp. 146-147)

This analysis helps to explain the "failure" of the decarceration movement to provide community placements for unemployable, chronic patients which are any less degrading than mental institutions (Crane, 1973). Disciplinary social control of the unemployed still requires that "social junk" be processed in the cheapest way while at the same time discouraging productive workers from dropping out.

By contrast, from the viewpoint of business, workers and potential workers threaten to become "social dynamite" -- that is, to "call into question established relationships of production and domination" (S. Spitzer, 1975, p. 645). To the extent that these people are alienated, dissatisfied, and organized, they pose a much more active threat to capitalist order than does "social junk." Yet, they are necessary for the success of business. (This is true for the working class as a whole, of course, since capital depends on labour to produce surplus value. But even on an individual basis, it is expensive for employers to replace and retrain employees or to compensate for the unreliability and lower productivity of "disturbed" workers, and for their impact on the morale of other workers.) "Behavior problems" among these people tend to be subject to a quite different form of social control -- "integrative" (S. Spitzer, 1975, p. 648) or "co-optative control" (Ehrenreich & Ehrenreich, 1975, p. 147). "Co-optative control," unlike disciplinary social control, is

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attractive, accessible, and non-stigmatizing, aimed at recruiting all with "problems" "into the fold of professional management of various aspects of their lives" (Ehrenreich & Ehrenreich, 1975, p. 147). It is this aspect of community psychiatry -- the expanding, dominant sector -- which the antipsychiatry theorists cannot explain, because it is neither punitive, exclusive, nor stigmatizing, and as the overwhelmingly voluntary use of these services indicates, it is also not coercive. The routine, co-optative control techniques refuse to fit neatly into the paradigm of conspiracy-based, disciplinary control which the antipsychiatry theorists discuss.

The precision with which this approach differentiates the types, targets, and purposes of social control is still in an early, relatively underdeveloped stage (Navarro, 1977, p. 61; Panitch, 1977, p. 5). Little of this work deals explicitly with community psychiatry. But it already suggests more useful analytical tools for explaining community psychiatry than the other approaches can offer.

(2) *Economic and political causes of community psychiatry*

The massive centralization of capital and proletarianization of the labour force, since World War II has required increased state involvement in regulating the labour force, in guaranteeing profits in all sectors of economic life -- including the social services, and in repairing or muting the damaging effects of work on labour (Navarro, 1976b, pp. 450-451; Panitch, 1977, pp. 20-21; Armstrong, 1977, p. 290). State intervention is "now immeasurably greater than ever before, and will undoubtedly continue to grow; and much the same

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is also true for the vast range of social services for which the state in these societies has come to assume direct responsibility" (Miliband, 1969, p. 10).

The social services which constitute the "welfare state" improved the living conditions of poor and working-class people, and represented concessions to mass demands. But they were organized in a way which promoted the interests of business, and they were actively supported by business leaders (Finkel, 1977, p. 352; D. McLean, S. Smith & Hill, 1975; Piven & Cloward, 1971). For example, workman's compensation serves to transfer workers' anger over unsafe working conditions to a neutral government agency and to set limits on the liability of any particular business (D. McLean, S. Smith & Hill, 1975). Welfare benefits vary in direct relation to corporate needs for surplus labor (Piven & Cloward, 1971; Ritti & Hyman, 1977). Public education "is used to infuse the dominant values and ideological outlook of society," and "to meet the manpower requirements of private profit making industry" (Deaton, 1973, pp. 24-25).

Community psychiatry was one of the best examples of this expanding intervention of the state. Federal and international government mental health agencies were spawned immediately after World War II and equipped with rapidly growing budgets and expanded legal and bureaucratic jurisdictions (Appley & Rickwood, 1967; Birnbaum, 1974; Bremer, 1961; Connery, 1968, pp. 21-22; Ewalt, 1975; D. Goldberg, 1971; MacClay, 1961). Until the mid-1950's the number of both psychotic and the new non-psychotic mental patients rose

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dramatically (Mental Health Statistics, 1966; D'Arcy, 1976b; Scull, 1977). These theorists presumably would argue that during this era, there was sufficient revenue and also sufficient demand to treat both "social junk" and "social dynamite."

However, they also believe that this ever-increasing need for state intervention, particularly in light of the growing international pressures on capitalist economies, has become too expensive for the productive capacities of capitalist societies (Scrivener, 1974).

> The era of cheap raw materials from Third World nations, of cheap labor in the passive colonies of major capitalist powers, and of undisturbed international relations between American and European sectors of capital is now coming to an end. As Third World nations begin to put pressure on the American capitalist class, as the price of oil and energy rises, as these same nations begin to do their <u>own</u> producing (thus beginning to compete with us), and as the socialist nations develop their own trade relations, American capitalism comes under pressure. (Krause, 1977, pp. 320-321)

As a result, a constant fiscal crisis of the state has developed, as governments are unable to finance the still increasing demands on them for services (Deaton, 1973; O'Connor, 1973). To stave off economic collapse, some Marxist theorists propose, the state responds by cutting all expendable social services (those least useful to business), demanding increased efficiency and productivity of those remaining (by speeding up and automating civil service jobs), and by transferring programs to private, profit-making agencies both as a way of shifting their costs on to clients and of bolstering business profits (Deaton, 1973; Navarro, 1976b, pp. 452-453; Obers, 1979; Patry, 1978; S. Spitzer & Scull, 1977).

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(3) *Impact on community psychiatry*

All of these responses characterize trends in community psychiatry since 1960. The expense of services to unemployable mental patients has been slashed as much as seventy-five percent through the decarceration movement (Cassell, C. Smith, Grunberg & Boan, 1972; Murphy & Datel, 1976; Scull, 1977, pp. 144-148). Psychiatric treatment has been automated with computers capable of cheapening all aspects of patient care from admission, through diagnosis, therapy prescription, drug monitoring and dispensing, and discharge, not to mention payroll, record keeping, and accounting (Laska & Bank, 1975; J. Johnson, Giannetti & Nelson, 1976). Mood-altering drugs vastly cheapen the process of therapy: Lengthy psychotherapy by specialists can be replaced with a five-minute prescription by a general practitioner (Brill & Patton, 1961; Cooperstock, 1974; Doig, 1978). These technological inventions make possible massive Taylorization (see Chapter IV, Section 4.2) of mental health manpower, by reducing the need for skilled therapists and expanding the "productivity" of unskilled and semi-skilled mental health workers (Bullough & Bullough, 1974; Epstein, 1962; Patry, 1978). Explicit governmental policy decisions have reorganized the structure of mental health manpower to cheapen the costs of processing patients most efficiently, (Albee, 1961; Davis, Arrill & Sharfstein, 1975; McKerracher, 1966; Robertson & Shriver, 1964).

> Under the guise of mounting a total crusade against illness, what does the community mental health movement really offer as a replacement for the clinical, humanistic emphasis on the unique value of each individual? <u>The assembly-line techniques</u>

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> <u>of industry</u>. Assembly-line techniques borrowed, not from a therapeutic model, but from the industries they are designed to serve. Assembly-line techniques which, as presently applied, must lead to the <u>industrialization and dehumanization of the mental health professions</u>. (Shatan, 1969, p. 319)

Community psychiatry has also tended to expand primarily in the private, profit-making sector. The decarceration movement has moved ex-mental patients <u>en masse</u> from free, public institutions (however bad), into private nursing and boarding homes which operate at high rates of profit and cost to patients (Extendicare, 1975; Prewst, 1979; Santiestevan, 1976). In effect decarceration "transforms 'social junk' into a commodity from which various 'professionals' and entrepreneurs can extract a profit" (Scull, 1977, p. 150). More significantly, the overwhelming bulk of growth in community psychiatry has occurred in private, out-patient care of non-psychotics, resulting in massive profits for doctors, construction companies, and especially the pharmaceutical industry (D'Arcy, 1976c; Doig, 1978; Mintz, 1967, pp. 185-213; Moody's, 1960; Silverman & Lee, 1974, pp. 327-329). The priority which government places on these profits, sometimes (often?) at the expense of patients' best interests, is indicated by a British M.P.:

> But a prosperous pharmaceutical industry does not merely help a national economy by ensuring lowered absenteeism, shorter stays in hospital and increased ability of general practitioners to treat sickness in their patients' homes. It also makes a direct contribution as a producer of wealth. This role would obviously be diminished if a harsh or unskilled curb were to be put upon its activities or doctrinaire purposes. ... Overall, these companies contributed £ 35 million in foreign exchange in 1963.... (Davies, 1967, p. 199)

Under medicare drug plans in Canada, England, and other countries, the government explicitly subsidizes and supports the pharmaceutical

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companies' promotion of mood-altering (and other) drugs both locally and in Third World countries (Honey, 1977; Waldron, 1977).

The Marxist theories reviewed above, thus, help to situate the political and economic functions, causes, and consequences of community psychiatry. They suggest that it may be primarily a co-optative social control movement aimed largely at active workers, ("social dynamite") which was motivated by the needs of business under monopoly capitalism for a reliable work force. As a result of the fiscal crisis of capitalist states since the mid-1950's, community psychiatry appears to have largely jettisoned its responsibilities for unemployable patients, industrialized its operations, and built up profit-making aspects of their programs as much as possible. To interpret these events, these theorists explain that we need to distinguish among the different possible types of social control functions (e.g., co-optative, disciplinary, and ideological), and the different target populations (employable vs. unemployable), and that we must place these considerations in their historical setting.

Although these Marxist theorists have suggested, in broad outline, directions to explore in seeking the causes of community psychiatry, none of them has provided a satisfactorily detailed analysis of the community psychiatry movement in particular. The most thorough work to date is Scull's (1977) book, *Decarceration*. Although it is an excellent exposition of the deinstitutionalization aspect of community psychiatry, it virtually ignores the much larger problem of the geometrical expansion in the numbers of non-psychotic

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people who get processed through community psychiatry programs. This leads Scull into some awkward blind alleys. For example, since he argues that decarceration was a money-saving effort resulting from the fiscal crisis, he can only explain the continuing rise in government spending on mental health as evidence that bureaucratic staffs are struggling against official policy (pp. 143-144). On the contrary, there is strong evidence that expanding services (and therefore expenses) are official policy, and that Scull has neglected to divide the different forms of social control aimed at unemployed and at employed target populations. Although the theory of the fiscal crisis of the state may help to explain the move to decarcerate mental patients, it fails to explain why the state suddenly adopted such expensive psychiatric services for workers.

2.4 The missing link: Industrial psychology

Something is missing in all these explanations. All four types of theorists assume that community psychiatry evolved directly from clinical psychiatry, and that its particular features first appeared after World War II. The benevolent government, the lobby, and the antipsychiatry theorists all ignore the wider social and economic context within which community psychiatry developed. This leads them to "explain" the rise of community psychiatry internally, as an invention of psychiatric professionals and administrators. However, as we have seen, this emphasis produces serious gaps and contradictions in their analyses.

The Marxist theorists do better, since they tend to deal with social services in general in a broad social context. This allows

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them to analyze the economic and political pressures impinging on social services and to trace their evolution long before World War II. But, in this early stage of work, Marxist theorists have not yet defined the particular relationship of community psychiatry to these social forces. Those few who do address topics in community psychiatry directly, such as Andrew Scull (1977) and the Ehrenreichs (1975) do a good job of analyzing programs for unemployable patients. But, because of their (apparently obvious) assumption that community psychiatry evolved from clinical psychiatry, they tend to over-generalize from that traditional function of public psychiatric care. Thus, for example, the Ehrenreichs (1975) propose that the expanding number of community mental health centres are designed to control unemployed poor people (p. 162). In fact, however, community mental health centres for low-income and ghetto areas are proportionally under represented and under funded (Chu & Trotter, 1974; Office of Program Liaison, 1969; Persky & Brunet, 1975; Ralph, 1969). Steven Spitzer's (1975) only direct reference to community psychiatry in his important paper, "Toward a Marxian theory of deviance," deals only with decarceration of chronic, unemployable, mental patients (p. 649).

The largest and most rapidly growing services of community psychiatry bear little resemblance to the public, psychiatric services before World War II. Community psychiatry ushered in the first public investment in massive emotional treatment of "normal," employed or employable people. With the exception of mass psychiatric screening of soldiers during the World Wars, public clinical psychiatry by

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and large had confined itself to custodial care of unemployable psychotics and retarded people. Clinical psychiatric practitioners before World War II had focused on improving services to chronic and psychotic patients, and had showed little interest in preventive programs or in treatment of non-psychotic people (see Chapter IV). Under community psychiatry, these traditional clinical services to unemployable people have been phased out as much as possible (the "decarceration movement"). This evidence strongly suggests that community psychiatry did not evolve from clinical psychiatry.

But if it did not, where did it come from? The missing link may be the field of psychology which has addressed workers -- industrial psychology. Industrial psychology since 1900 has specialized in improving worker adjustment and productivity. The next chapter (Chapter III) outlines an alternative theory, "the labour theory," which proposes that community psychiatry evolved directly from industrial psychology. This theory is an extension from the Marxist theorists discussed in this chapter, and it treats community psychiatry as an example of the functions and growth of social services.

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III. THE LABOUR THEORY OF COMMUNITY PSYCHIATRY

3.1 The labour theory of community psychiatry

Work is almost invisible as a topic in clinical psychiatry. Abnormal psychology texts hardly note where or whether "cases" are employed, much less if their jobs contribute to their problems. A recent list of mental health research grants funded in the United States includes fewer than one percent which deal with work or occupational mental health (ADAMHA, 1974). Work is scarcely mentioned at all in the major policy documents of community psychiatry (Chrichton, 1973; Expert Committee, 1953; Fein, 1958; Joint Commission, 1961; Kennedy, 1963; P. Martel, 1973; McKerracher, 1966; President's Commission, 1978; Richman, 1966; Tyhurst, Chalke, Lawson, McNeil, Roberts, Taylor, Weil & Griffin, 1963). It is understandable, therefore, that work and labour regulation have been ignored in efforts to explain the rise of community psychiatry.

Nevertheless, this study will propose that the organization of work and workers has had a profound impact on community psychiatry's development (as well as on the emotional condition of workers and their dependents). In contrast to the approaches described in Chapter II, this study presents a "labour theory" to explain why community psychiatry developed. This chapter outlines this labour theory and analyzes its advantages over the other theoretical approaches to this issue. The following chapters (Chapters IV and V) lay out the

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detailed historical documentation on which the labour theory is based.

The labour theory proposes that community psychiatry developed primarily to control the productivity-damaging side-effects of worker alienation. It suggests that the major innovations of community psychiatry have been motivated by management's fears of labour militancy on the one hand, and worker breakdown on the other. According to this theory, neither the welfare of mental patients nor the power of mental health professionals has motivated mental health policy decisions, although they have provided some secondary direction. Rather, the definition and treatment of mental illness depends primarily on the economic and political priorities of Western business interests.

The labour theory suggests that community psychiatry's roots grow far more from industrial psychology than from public clinical psychiatry. Public psychiatry before World War II had little direct relationship to employable people. Before 1945, public psychiatric care was generally limited to isolated large mental institutions which specialized in treating patients whose employability was, at best, marginal (Deutsch, 1949, pp. 228-230; Edginton, 1973; Foucault, 1965; Giberson, 1942, p. 1987; Rothman, 1971; Tuke, 1885). Although mental hospital administrators in the 19th and early 20th centuries certainly hoped to rehabilitate some of their patients, the curable patients were far outnumbered by unemployable aged, retarded, brain damaged, and psychotic individuals (Deutsch, 1949, pp. 229-271; Edginton, 1973; Hurd, Drewry, Dewey, Pilgrim, Blumer & Burgess, 1916,

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pp. 234-236, 258). The coercive and sometimes brutal treatment of these chronic patients also may have been intended marginally to deter workers from "mad" behavior (Tuke, 1885, pp. 8-15). But this function was minor compared to the simple custodial care of chronically unemployable people (Deutsch, 1949, pp. 230-271; Scull, 1977, pp. 64-66). Brenner's (1973) longitudinal data indicate that mental institutions consistently have served as dumping grounds for the unemployable; their admissions rising during economic slumps and falling during periods of high employment when either the patients or their families could find work to support them.

By contrast, industrial psychology, which developed early in the twentieth century, has focused on increasing worker productivity by eliminating "the problems of restriction of output, lack of cooperation, apathy, and worker-management conflict" (Bucklow, 1976, p. 389). Industrial psychology, like community psychiatry, has focused consistently on treating employed workers and their families, using largely non-coercive methods. Many of the innovators of community psychiatry techniques -- Carl Rogers, Kurt Lewin, Raymond Cattell, Rensis Likert, and others -- developed their methods under generous corporate funding and used them in industry long before they were generally applied to public clinical psychiatry (Bingham, 1931; Bucklow, 1976; Ianoco & Bellelli, 1972; Lewin, 1935, 1936, 1948, 1951; Mindus, 1953, pp. 63-70; Rogers & Roethlisberger, 1956; Tatham, 1964). The use of the "mental health team," mass psychological testing, non-professional counsellors, family involvement, and preventive psychiatry all originated in industrial psychiatry, to be later incorporated as central elements of community psychiatry (Bloom, 1973; Collins &

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Klemes, 1956; A. A. McLean, 1969; Rennie, Swackhamer & Woodward, 1947; Southard, 1920a, 1920b; see also Chapter IV).

During World War II, industrial psychologists provided much of the research toward developing minor tranquilizers and mood-altering drugs designed explicitly to increase "working capacity" under stress (Brady, 1968; Evans, 1968, 1971; Evans & Kline, 1969; Greenburg, 1957; Hoch, 1957; Janke & Debus, 1968; Landers, 1978; Lehmann, 1960; McGuire & Leary, 1958; Rogg & Pell, 1963). Prominent industrial psychologists developed a variety of other short-term therapies for use in the military which were later adopted as standard treatment for civilian employees (Deutsch, 1949, pp. 458-482; Yolles, 1969). They also expanded the range of symptoms defined as mental illness (Deutsch, 1949, pp. 472-482). This new classification gave far greater emphasis to inefficient or disobedient, non-psychotic behavior (R. Spitzer & Wilson, 1968; Yolles, 1969, p. 10).

These links between industrial psychology and community psychiatry are not accidental. In large measure, community psychiatry represents nationalized industrial psychology. Operating at public expense, under a more neutral cover than management-run mental health programs, community psychiatry has the resources to mass produce and market industrial psychological techniques and to treat the labour force as a whole. According to this perspective, community psychiatry's central task is identical with that of industrial psychology: to "help" workers and their dependents to adjust to increasingly alienated, degraded, and pressured conditions, in order to prevent labour unrest.

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Although individual corporations benefit from and support community psychiatry (Habbe, 1960; Rennie & Woodward, 1948, pp. 300-302; Yolles, 1967), it would not be accurate to conclude that businesses conspired to foist community psychiatry on a reluctant government. Rather, industry has functioned more as an advisor than as a lobby to government (Follman, 1976; Yolles, 1967, p. 43).

> Since World War II, business and industry have afforded somewhat of a laboratory for social psychiatry. Intensive and extensive studies in the area of human relations in industry have yielded a body of data of importance to the general mental health field. Community mental health workers, military leaders and leaders of any human organization are looking to industry as pioneers in the area of applied action. (Butler, 1957, p. 231)

Business did not have to conspire to "trick" public leaders to support community psychiatry, because the goals and fates of business and government have always been intimately meshed. They have become increasingly more entwined since World War II, as industry has become much more centralized, and as the state has intervened increasingly in regulating both the economy and labour-management relations (Gold, Lo & Wright, 1975; Gonick, 1976, pp. 23-32; Panitch, 1977; Wolfe, 1977). With this growing interdependency, threats to business profits (through labour militancy or individual worker breakdowns) menace the stability of governments, and conversely, political instability threatens business profits (Block, 1979). In self-defense, governments (with the blessings of business) have tended to expand their role in the direct production and regulation of the entire labour force. In a speech to the National Association of Manufacturers, the Director of the U.S. National Institute of Mental Health (NIMH) spelled out this mutual alliance:

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> Since we live in a working society, in the largest sense, all our mental health is "occupational" mental health. It is to our mutual advantage [business and government] to promote the mental health of our population.... Our motives may stem from compassion or from a need for human productivity, but our success will profit all of us. (Yolles, 1967, p. 47)

Since 1900 -- and particularly since 1945 -- competition among Western businesses has grown increasingly fierce as industries, nations, and international power blocs compete in cut-throat struggles for survival and dominance (Baran & Sweezy, 1966, pp. 82-88; Kristjanson, 1977; Lenin, 1939; Paget, 1979; Scrivener, 1974; Thomson, 1973, pp. 70-71). At the same time, it has become much riskier for Western businesses to count on exploiting Third World labour and resources. Under these dual pressures, they have relied more and more on increasing the profit extracted from their "own" national employees.

However, workers resist these management pressures to raise their profitability through speed-up or automation. They realize that however attractively it is packaged, ultimately higher productivity means stress, proportionally lower pay, loss of jobs, and less bargaining power (J.A.C. Brown, 1954, p. 14; Bramel & Friend, 1978; Marx, 1967, pp. 390-507; Matles & Higgins, 1974; Selekman, 1947; Trice, Hunt & Beyer, 1977, p. 106). For employers, this resistance is a serious problem:

> One of the most baffling and recalcitrant of the problems which business executives face is employee resistance to change. Such resistance may take a number of forms--persistent reduction in output, increase in the number of "quits" and requests for transfer, chronic quarrels, sullen hostility, wildcat or slowdown strikes, and of course, the expression of a lot of pseudological reasons why the change will not work. Even the more petty forms of this resistance can be troublesome. (Lawrence, 1956, p. 343)

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Even when they do not actively resist, workers break down emotionally (and physically) under the pressure, and exhibit a variety of "behaviors" which foil production goals. They get ulcers, headaches, and insomnia; they have accidents, stay home, drink, get irritable, daydream, and sometimes go raving mad, all of which is very costly to management (Aldridge, 1970; Auster, 1967; Colligan, M. Smith & Hurrell, 1977; Collins, 1962; Follman, 1976; Gadourek, 1969; Gravley, 1963; Katz, 1964; Kohn & Schooler, 1973; McCallum, 1979; R. O'Connor, 1958; Ralston, 1977; Ross, 1963; Rushing, 1971; Scher, 1973). Much of the behavior associated with either organized resistance or individual breakdown is now defined as "mental illness."

Since World War II, the economic consequences of this "mental illness," measured in lost production, property damage, and social service costs, have reached a level which threatens not only corporate profits, but also the entire economy (Alix & Boudreau, 1975; Brenner, 1976; B. Brown, 1973; Chafetz, 1974).

> Alcoholism has been recently estimated ... to cost the American economy in excess of $25 billion annually. Of this amount, over $9 billion is in lost production, over $8 billion is health and medical costs, and over $6 billion results from motor vehicle accidents. These estimates are considered conservative. (Follman, 1976, p. 20)

> Mental illness is without a doubt the nation's costliest health problem and constitutes an enormous drain on the country's energies and resources. Consider the following facts:
>
> 1. Accidents, low productivity, and high personnel turnover are concrete industrial problems significantly related to mental health and mental illness.
> 2. Emotional problems are responsible for approximately 20 to 30 percent of employee absenteeism.
> 3. Personal factors cause 80 to 90 percent of industrial accidents. (sic)
> 4. It is estimated that from 15 to 30 percent of the work force are seriously handicapped by emotional problems....

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> 5. At least 65 and possibly as much as 80 percent of the people who are fired in industry are dropped from their jobs because of personal rather than technical factors.
>
> 6. Although exact dimensions are unknown, there are considerable data which suggest that drug abuse and addiction is emerging as a serious and major problem in many work settings. (B. Brown, Former Director NIMH, 1973, pp. 10-11)

As Lillian Rubin dryly points out: "When absentee and turnover rates rise, when wildcat strikes occur with increasing frequency -- in short, when productivity falls off -- the alienation of workers becomes a focal concern for both industrial managers and government." (Rubin, 1976, p. 159)

Equally serious is the threat which this rising alienation poses to social order. When over one million U.S. World War II army recruits were found emotionally unfit to serve, the U.S. government felt justifiably vulnerable (Connery, 1968, pp. 16-17; Deutsch, 1949, p. 464; House of Representatives Report #1445, 1949, p.13). Even more unsettling was the rising labour militancy following the war (Hutt, 1975, pp. 170-174; R. Johnson, 1950, p. 1; Swartz, 1977, p. 320).

> 1946 was the peak year of stoppages in our whole industrial history. ... By the very contrast with the productive potentialities of American industry, labor relations appear a Pandora's box continually spilling forth new vexations--smoldering hostilities, suspicions, and fears; high turnover, absenteeism, and strikes; discontents with wages that are the highest in the world; restrictions on output by men who are the most mechanically minded in the world--seemingly an incessant, seething ferment of dissatisfaction and discord. (Selekman, 1947, pp. 2-3)

Government fears of this rising labour resistance were reflected in a rash of anti-union and anti-communist legislation and police actions following World War II (Barkin, 1975, pp. 3-5; Brooks, 1971, pp. 223-227; L. Brown & C [illegible]a, 1973, pp. 87-95; Huberman &

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Sweezy, 1955; Lamont, 1956; Rayback, 1966, pp. 394-409; Selekman, 1947, pp. v-ix; Watkins, 1973, p. 183). Leading industrial psychologists pointed in alarm to "the obvious national dangers which may result from the lack of proper safeguards and controls for maladjusted emotions" (Giberson, 1942, p. 1085).

> Collaboration [between worker and management] in an industrial society cannot be left to chance--neither in a political nor in an industrial unit can such neglect lead to anything but disruption and catastrophe. ... had not the emergency of the war been compelling and of personal concern to every last worker, it is questionable whether the technicians could have achieved their manifest success. ... There is no active administrator of the present who does not fear that peace may see a return to social chaos. (Mayo, 1946, pp. 9-10, His emphasis).

In this embattled context, community psychiatry was born, soon after the war, amid a flurry of legislation, international conferences, and U.N. resolutions (Allodi & Kedward, 1977; Bloom, 1973; Bremer, 1961; Connery, 1968, pp. 15-21; Expert Committee, 1950; Fraser, 1947; International Congress, 1948; McKerracher, 1966, pp. 5-18; Nationaal Congres voor de Geestalijke Volksgezondheid, 1947; National Committee, 1944, pp. 35-36; 1946, pp. 17-18; Rees, 1959). The philosophy of these midwives to community psychiatry was well summarized by Terhune (1948):

> War and various forms of inter-social conflict are not the result only of environmental conditions, but are largely due to the mass instability of the individuals who make up society. The hope of mankind lies in stabilizing the people who compose our society so that dissatisfaction may not spread to the point of igniting general conflagration. Psychiatry ... can do much along these lines. (p. 106, emphasis added)

In the years since 1945, labour force alienation has remained a serious problem for business. A Harvard Business Review survey found that U.S. industrial job satisfaction has declined steadily and steeply

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since the war (M. Cooper, Morgan, Foley & Kaplan, 1979). Trade union militancy and wildcat strikes grew rapidly throughout the West after 1960, spreading to public service employees and white collar occupations (Brecher, 1972, pp. 264-293; Roberts, Okamoto & Lodge, 1979, p. 21). The Trilateral Commission, representing some of the largest business interests, reported recently:

> Over the last twenty years, all the European countries have witnessed similar developments. Trade unions have been encouraged by legal protection and have grown stronger; old divisions between labor organizations have become less significant, if not entirely eliminated. Collective bargaining has become more decentralized and wider in the scope of decisions covered. Management has been compelled to be less authoritarian, to disclose more information and to limit "managerial prerogative" (to decide on issues of concern to employees without consultation or negotiation) to an ever-decreasing range of decisions. (Roberts, Okamoto & Lodge, 1979, pp. 85-86)

Each increment in labour intransigence has been accompanied by pressures on government to control it (see Chapter V).

In response, community psychiatry has expanded geometrically, along with other social (control) services. In a speech promoting community mental health centres as an "alternative to chaos," the then-Director of NIMH voiced government fears of mass alienation:

> People ... who feel helpless to accommodate to or change an unacceptable world consciously choose to alter their own; their experience tells them that the future may be unknown but it is certainly horrible. This rejection of many goals of society makes urgent the development of new approaches to bridge these gaps. If this is not done, and if we do not focus on and try to solve the root causes of alienation, there is serious danger that large proportions of current and future generations will be embittered toward the larger society, unequipped to take on parental, vocational, and other citizen roles, and involved in some form of socially deviant behavior. (Yolles, 1968, pp. 17-18)

The labour theory suggests two major functions of community

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psychiatry. Like its antecedents in industrial psychology, community psychiatry exists primarily to increase workers' tolerance for ever more alienated and pressured work, and to reduce their (and their families') resistance against these alienating situations. Secondarily it serves to pacify displaced workers and potential workers such as housewives, adolescents, and minorities, without rendering them permanently unemployable. These two population groups -- the employed and the potentially employed -- receive the vast bulk of and the most expensive treatment, while unemployable people have been largely diverted to the cheapest care available. The central achievement of community psychiatry has been to develop the technology and organization to put industrial psychology on a mass basis.

3.2 Advantages and implications of the labour theory

The labour theory of community psychiatry offers several advantages over the approaches which are reviewed in Chapter II. First of all, it situates community psychiatry in its historical and social context. As a result, it is able to correct the assumption that community psychiatry's roots lie exclusively in public clinical psychiatry. In fact, it demonstrates that community psychiatry owes far more to industrial psychology than it does to clinical psychiatry. Unlike the other theories, its historical rooting allows it to explain the political and economic dynamics which created such strong international investment in community psychiatry after World War II, and why the most dramatic expansion of services has been aimed at employed and employable people.

Secondly, the labour theory extends the analysis of community

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psychiatry beyond the issue of the personal motivations of its planners and practitioners (whether benevolent, megalomaniac, or malevolent). Instead, the labour theory suggests that corporate pressures leading to community psychiatry simultaneously created the opportunities for well-intentioned reformers to close the "snake pits," for mental health professionals to build empires from government grants, and for psychiatrists to expand their technological control over their clients (i.e., the benevolent government, the mental health lobby, and the antipsychiatry theories). Although all three of these theories accurately describe aspects of community psychiatry, the labour theory implies that they are all effects, rather than causes of the phenomenon. We can see their contingent quality by noting that these same corporate pressures have closed other options. For example, it is difficult to get funding for either lengthy treatment programs or programs for those considered psychotic or mentally retarded (Arnhoff, Rubinstein, Shriver & Jones, 1969; Elkin, 1972; Goebel, 1976; Segal, 1975, pp. 330-331). Instead, the labour theory suggests that community psychiatry was motivated primarily by business's expanding post-War problems with labour alienation, and that it is employed only those professionals and programs which offered cheap solutions.

One important corollary of this point is that mental health workers are neither independent, powerful experts, nor pawns of an evil conspiracy as the other theories imply. Rather, they are employees in an active labour-management relationship with the government. Like other workers, they vary in their commitment to their jobs and to the goals of "management." Most are able to reconcile

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themselves to the adjustment functions of community psychiatry, although not without some personal conflict (Cherwiss, Egnatics & Wacker, 1976). For example, R. Bailey and Brake (1975) found that the majority of social case workers broke regulations to help their clients. Mental health workers, as employees of a social control agency, are restricted by both formal and informal pressures from providing either intensive, insight therapy or social advocacy. Caseloads are simply too heavy and meaningful social action programs are too likely to lose their funding (Chu & Trotter, 1972, pp. 174-182; Perskey & Brunet, 1975; Ralph, 1969). At the same time, however, mental health workers have been subjected to many of the same alienating trends as other workers. Psychiatry has become Taylorized (See Chapter IV, Section 1) with the creation of numerous gradations of auxiliary professional, sub-professional, and non-professional "careers," all of which are increasingly subjected to production and efficiency ratings (Albee, 1959; B. Bullough & V. Bullough, 1974; Epstein, 1962; Kowaluk, 1975; Mitchell, 1969; Ontario Council of Health, 1973; Ostrom, 1976; Patry, 1978; Riessman, 1964; A. Schrag, 1956; Sobey, 1970; Ultimate psychiatrist, 1965). As a result, mental health workers, particularly those at the bottom of the hierarchy, often find themselves in a situation similar to that of their clients: overworked, trapped in dead-end jobs, pressured to increase their "productivity" and to cut their wage demands, and subjected to job insecurity as a result of funding uncertainties (Ehrenreich & Ehrenreich, 1970, pp. 77-90).

> Today health workers have reluctantly concluded that deinstitutionalization means "closures, speed-ups, unemployment, and patient neglect," in the words of AFSCME President Jerry Wurf. (Santiestevan, 1976, p. 16)

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Frustration and exhaustion as a result of these pressures have become so common as to earn a label, "professional burnout" (Cherniss, Egnatios & Wacker, 1976; Family Weekly, 1978; Pearlin, 1962; Teed, 1979). This conflicted position has caused both mental health worker-client alliances and union organizing among professional and non-professional mental health workers (B. Armstrong, 1976; P. Brown, 1974; Chu & Trotter, 1974; D. Cooper, 1979; M. Glenn, 1974).

An additional advantage of the labour theory is that it helps to reconcile the controversy over whether or not madness is real. Benevolent government theorists generally argue that mental illness indicates a flaw in the individual, and that the individual, and not his situation, must be changed. Conversely, antipsychiatry theorists insist that madness does not exist as an internal property of individuals, and therefore that psychiatric labelling and treatment are oppressive violations of patients' civil liberties. The labour theory, instead, argues that both these views are partially correct: Real emotional damage does indeed occur (as does physical damage), but it is caused not nearly as much by individual weakness as it is by social and occupational stress. Although genetic make-up, childhood socialization, or existential factors may influence which particular individuals break down, the consistent strong relationship between social and economic stress and emotional breakdown (regardless of individual traits) indicates that environmental pressure explains madness far better than the theory of individual flaws (Faris & Dunham, 1967; Hollingshead, Ellis & Kirby, 1958; Hollingshead & Redlich, 1953; 1954; Kohn, 1968; Kohn & Schooler, 1973; Langner & Michael, 1963;

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Mishler & Scotch, 1965; Segal, 1975, p. 176; Srole, Langner, Michael, Opler & Rennie, 1962). Even those who assume that genetic flaws predispose people to break down emotionally concede that "as industry speeds in ever increasing modern technological advance, the hereditable nature of stress disorders will ensure a concomitant increase in a population sensitive to these conditions" (Collins, 1962, p. 608). As early as 1917, Thomas Salmon (1917), Medical Director of the National Committee for Mental Hygiene, eloquently pointed out:

> Unemployment, overwork, congestion of population, child labor, and the hundred economic factors which contribute to the stress of living for the poor are often contributing factors in the production of mental disease. Weaknesses in constitutional makeup are discovered under the stress of such conditions, that might have remained undiscovered under happier circumstances. (pp. 352-353)

This is particularly true of the newer non-psychotic diagnoses (Segal, 1975, pp. 186-201). Work-related stresses, in particular, cause mental breakdown. Numerous studies document the emotional damage caused by job dissatisfaction, hazardous work, competitive environments, lack of autonomy in decisions, task ambiguity, isolation, shiftwork, job insecurity, economic worries, unemployment, and speed-up (Brenner, 1973; Brook, 1976; Buck, 1972; Grinker & Spiegel, 1945; Jaco, 1958, 1970; Kahn, 1973; Kohn & Schooler, 1973; Kornhauser, 1965; Laforest, 1968; Lazarus, 1966; Levine & Scotch, 1970; Mott, Mann, McLoughlin & Warwick, 1965; Reid, 1961; Rushing, 1971; Schuckit & Gunderson, 1974; Tiffany, Cavan & Tiffany, 1970; Wall, 1959; Weiman, 1977; Zaleznik, Lets de Vries & Howard, 1977). These occupational stresses affect a large proportion of workers. For

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example, a 1964 nationwide survey of American workers found that:

> 48 percent of workers often found themselves trapped in situations of role conflict, 45 percent complained of work overload, and 35 percent were disturbed by a lack of clarity about the scope and responsibilities of their jobs. These perceived environmental factors were found to be related to a variety of signs of psychological strain. (Gavin, 1977, p. 198)

Since the mid-1950's there has been a steady rise in stress-related pathology among working aged adults in Canada, the United States, and many Western European countries (Eyer & Sterling, 1977, pp. 26-27). In other words, the emotional damage--madness--is quite real, but the cause of this breakdown is not flawed people, but intolerable social and economic stress.

Finally, and most importantly, the labour theory reveals the defensive nature of community psychiatry. The other approaches all portray the patients and potential patients of community psychiatry as passive -- either as beneficiaries or as victims of governmental and professional initiatives. The labour theory, however, argues that community psychiatry developed (along with other social services) in reaction against labour's very active role in resisting alienated and oppressive working conditions. Like the Taylorism, the mental hygiene, and the human relations movements before it (see Chapter IV), community psychiatry was created largely out of fear of labour initiatives.

This fear includes more than organized union militancy. Most symptoms of the new psychiatric diagnoses reflect, at least in part, active (though not necessarily conscious) resistance on the part of the individuals who are labelled. Drinking, drug use, quitting without

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notice, calling in sick too often, talking back, and engaging in pranks can all result in psychiatric labels -- respectively, "alcoholism," "drug dependence," "occupational maladjustment," "antisocial personality," and "explosive personality" (DSM-II, 1968). Although these actions obviously have many motives (and psychologists are fond of analyzing the irrational ones), they serve primarily to make life more tolerable and to protest non-verbally against lousy working conditions. Barbara Garson (1975) for example, describes workers she interviewed:

> Whether they work in factories or offices, whether their jobs are light or heavy, they toil like horses wearing blinkers. Their vision of the beginnings and the ends of their work is deliberately restricted....
>
> In this situation the most common way of fighting back or at least retaining sanity, seems to be to develop false or sub-goals within the job that is otherwise meaningless. That's the way I eventually came to understand the pastimes and oddities I encountered, like collecting dark meat from the tuna fish, working with your eyes closed, playing rhythm games with other key-punchers, or letting a line pile up so you can race to overtake the backlog. These games may in fact be essential for the flow of modern industry. For without some measureable unit of accomplishment, it is possible that leaden depression would progress to total paralysis. Indeed, it does happen from time to time that a job is so designed that it becomes too fast for the human nerves, too insulting to the human spirit, or just too meaningless for the brain to comprehend. (p. 218)

Similarly, Judson Gooding's (1970), study of blue-collar workers, dismisses psychological explanations of absenteeism: "By staying out they are saying they don't like the job" (p. 71). Even symptoms which primarily reflect emotional damage and stress -- for example, depression, ulcers, and phobias -- are not simply passive illnesses. They all include an inarticulate, internalized rebellion against

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intolerable reality.

It is this potentially explosive rebellion which both employers and government fear, because of its immediate damage to productivity, and because of the long-range threat that workers may politically unite and rebel against their maddening work conditions. The rising tide of labour militancy and individual "behavior disorders" following World War II has posed a menace which industrial psychology, divided among separate and competing companies, was inadequate to control (Slotkin, Levy, Wetmore & Runk, 1971, pp. 1-2). This threat, far more than any intentions of psychiatrists or government bureaucrats, has motivated the development of community psychiatry.

The next chapters trace in more detail the history of corporate interest in employee mental health and the continuing role of business in shaping community psychiatric policy.

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IV. THE INDUSTRIAL PARENTAGE OF COMMUNITY PSYCHIATRY

4.1 Introduction: Labour-management relations

At the heart of capitalism is the contradictory relationship between labour and capital. The interests of employers and workers are mutually dependent but also fundamentally in conflict. Workers depend on employers to provide jobs (when self-employment options are destroyed), and employers depend on workers to produce goods and services which can be sold at a profit. To a certain extent, therefore, "what's good for GM" is also good for its employees. When business is booming, more workers tend to be hired and at higher wages, and when businesses fold, workers face hard times (Bramel & Friend, 1978, pp. 1-3; Marx, 1933, pp. 31-33). Similarly, businesses prefer to keep their employees relatively content, and therefore they share some (limited) concern for worker welfare (Rockefeller, 1923; Traves, 1979, pp. 86-90). It is this unity of interests to which employers appeal in urging worker cooperation.

But underlying this surface commonality is a much more fundamental conflict of interests between employers and workers, which revolves around the division of the value which workers add to the things they work on. In general, the price of a commodity reflects the cost of labour-power expended in producing it, and variations in supply and demand tend to average out over time to this basic value (Marx, 1965, pp. 32-42). Although some employees may at particular times

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buy raw materials unusually cheaply or sell their products unusually dearly, in general they cannot count on making profits from capital expenses or sales. The price of capital expenditures is relatively fixed (in relation to other employers) (Marx, 1967, p. 209; Sweezy, 1942, p. 62). The only reliable source of profit is the value which workers add to materials by turning them into products. Both profits and wages ultimately come from this added value (Marx, 1967, p. 534; Lenin, 1970, pp. 19-34). Because wages and profits are both drawn from the same source, they are inversely related: One cannot rise without the other falling (Marx, 1933, pp. 36-38). This creates an implicit and irreconcilable conflict between management and labour.

To raise their profits, employers may cut directly into the workers' share by lowering wages and by hiring cheaper workers (e.g. women, children, and immigrants). Or they may increase the productivity of workers (and thereby multiply the value each one creates while working for about the same wage) by lengthening the work day, by enforcing a "speed-up," and by mechanizing the job.

Both wage cuts and higher productivity reduce the share of added value which labour receives, at least relative to the share capital takes, and frequently in absolute terms. Wage cuts and increased productivity generally are not separate options, but two aspects of the same process. By using division of labour and mechanization, employers can simultaneously boost productivity and replace skilled workers with fewer and lower-paid employees (Braverman, 1974, pp. 70-84, 184-235; Engels, 1968; Marx, 1933, pp. 39-48, 1967, pp. 336-507). Often only current employees who are

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not displaced receive any pay increases for the resulting higher productivity, and even these raises tend to disappear as the higher output becomes general throughout the industry. In any case, the raises rarely equal the additional value workers produce (since that would not be "cost-effective" for the employer). In addition, higher productivity that is consonant with maintaining control over labour is often achieved by making the work less tolerable; more dangerous, pressured, monotonous, and out of the worker's own control (Braverman, 1974, pp. 228-232; Garson, 1975; Sass, 1979).

It is in the workers' interests, therefore, to resist management efforts to raise profits. Workers fight to raise their pay and they fight against productivity increases because the value of their extra output generally is stolen from them and used against them (for example, to lay off redundant workers, to buy machines to automate away more jobs, or to hire extra supervisory staff) (Serrin, 1979; Sykes, 1965).

Work does not have to be organized so that higher productivity makes conditions worse, rather than better, for workers. But capitalist relations, in which employers struggle with workers over the ownership of the value workers create, do produce that form of organization (Gordon, 1976a). As Barbara Garson (1975) points out:

> This way of organizing work is not the result of bigness, or meanness, or even the requirements of modern technology. It is the result of exploitation. When you're using someone else for your own purposes, whether it's to build your fortune, or to build your tomb, you must control him. Under all exploitative systems, a strict control from the outside replaces the energy from within as a way of keeping people working. The humiliating and debilitating way we work is a product not of our technology but of our economic system. (pp. 211-212)

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This conflict of interests between employers and employees is an inherent characteristic of capitalism, which intensifies, rather than declines, as businesses become larger, capital more concentrated, and exploitation more global (Greene, 1970, pp. 200-215; Lenin, 1939; Marx, 1933; Sweezy, 1942, pp. 285-328). Employers temporarily can provide "progress" for some groups of workers by exploiting others even more (e.g., creating the differences in standards of living between Hong Kong and Toronto, or even between Quebec and Ontario) (Sweezy, 1942, pp. 291-292). But as the more exploited groups rebel, and as competition among economic power blocs increases, employers are forced to shift the pressures for ever-higher productivity and profits back to the relatively advantaged workers (Bird, 1977; Byron, 1979; Douty, 1977; Kerr, 1979; Kristjanson, 1977; Paget, 1979).

This chapter traces the intimately entwined history of labour-management struggles and of corporate interest in employee mental health. It demonstrates that management's problems in forcing workers to produce more have stimulated virtually every innovation of community psychiatry. It also demonstrates the strong impact of industrial psychology and business priorities on commmunity psychiatry.

4.2 Taylorism and the rise of industrial psychology (1900-1919)

With the advent of monopoly capitalism in the last quarter of the nineteenth century, worker solidarity and resistance became a major problem for Western employers (Lenin, 1939; Rayback, 1966,

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pp. 187-193). Dramatic increases in industrial mechanization allowed stronger businesses to absorb weaker ones. Competition among the surviving businesses raged on a vastly expanded scale, creating tremendous pressures on employers to find ways to boost worker productivity (and therefore profits). "Between 1870 and 1900 the production of bituminous coal increased five times, of crude petroleum twelve times, of steel ingots and castings more than 140 times" (Hofstadter, 1963, pp. 1-2). By 1886, this drive for greater productivity through division of labour and mechanization had already relegated three-quarters of the workers to unskilled or semi-skilled jobs, and had made factory working conditions scandalous enough to prompt national protests (Brooks, 1971, pp. 84-97; Hofstadter, 1963; Rayback, 1966, p. 159; Sinclair, 1905; Spargo, 1963).

Labour reacted with militant organization. The number of unionized workers in the United States jumped over 700% in one year between 1885 and 1886, and strikes, boycotts, and labour-run producers' co-operatives proliferated (Rayback, 1966, pp. 162-174). To control this labour upsurge, business resorted to force, using Pinkerton police, imported strikebreakers, state militia, black lists, labour spies, lock-outs, yellow-dog contracts and injunctions (Brooks, 1971, pp. 98-123; L. Brown and C. Brown, 1973; Pinkerton, 1878; Rayback, 1966, pp. 159-186). Although these techniques succeeded in temporarily breaking the militancy of the labour movement (aided by the depression of 1893-1897), the power which labour had demonstrated seriously alarmed business. In addition, individual and group resistance to productivity hikes through "soldiering" (intentional

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restriction of output) caused more immediate profit loss than that caused by strikes (Hoxie, 1918; Jarrett, 1920).

At the turn of the century, even work labelled "unskilled" required practical knowledge and skill which the employer did not possess, and this gave employees some control over when and how the work would be done (Braverman, 1974, pp. 90-91; A. McLean, 1969; Stone, 1973). In the absence of intimate knowledge of and control over the work process, employers had relatively weak leverage to enforce worker discipline. Relying on brute force was unsatisfactory because, at best, it won only grudging compliance from workers, it often disrupted production and, worst, it strengthened the solidarity of labour against employers. As Henry Ford II later explained:

> If we cannot succeed by cooperation, it does not seem likely that we can succeed by any exercise of force. We cannot, for example, expect legislation to solve our problems. Laws which seek to force large groups of Americans to do what they believe is unfair and against their best interests are not likely to succeed. In fact, such legislation can lead to exaggeration of the very problem it is designed to solve. (Ford, 1946, pp. 49-50)

Without ruling out the use of force, business leaders felt they had to find a more effective way to prevent and control workers' resistance to raising their output. They adopted a succession of techniques of worker control and pacification which together constitute industrial psychology.

One of the first and the most influential of these techniques was Taylorism. Taylorism, or scientific management, refers to Frederick Winslow Taylor's (1911) theories on how to reorganize work to give management control over each step of the labour process and how it is performed. Taylor argued that, since it is not in the

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workers' interest to raise their output, they will exercise any discretion they have to produce as little as possible. Therefore, he proposed, management must remove all discretion in the work process from the workers.

Under Taylorism, management divides skilled work into its elementary component parts and re-distributes it among a number of less skilled workers each of whom performs only limited tasks in ways rigidly defined by management (or indirectly defined by controls built into the machines they operate). In this way, Taylor demonstrated, management could command workers to produce many times more, and at the same time prevent them from controlling or even understanding how the work is done. Rather than exercising complex skills, workers under Taylorism just follow orders. As a result, knowledge about and control over the work process becomes the exclusive property of management, which is explicitly withheld from workers (Braverman, 1974, pp. 85-123).

Taylorism offers three major advantages to management: (1) It increases the dependence of workers on management (and therefore the "mutuality" of their interests), since the boss now owns not only the capital necessary for production, but also the skills and knowledge to put it in operation; (2) It dramatically lowers the cost of labour both because unskilled workers replace skilled, and because the control over how work is done allows management to speed up each worker's output sometimes many times over; and (3) It weakens organized labour's bargaining power by giving management greater power to set production standards and by making it easier for it to replace troublemaking workers (Braverman, 1974, pp. 85-139;

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Ehrenreich & Ehrenreich, 1976; Stone, 1973).

Enthusiastically adopted by industries throughout the West between 1890 and 1920, Taylorism and its progeny have continued to spread to newly industrializing occupations (Garson, 1975, pp. 215-216; Geller, 1979, pp. 40-42; Tannenbaum, 1966, p. 16). Taylorism now characterizes virtually all industrial work and an increasing proportion of clerical, service, and professional occupations (Braverman, 1974, pp. 293-409; Bullough & Bullough, 1974; Epstein, 1962; E. Glenn & Feldberg, 1977; Greenbaum, 1976; Noble, 1977, p. 264; Ostrom, 1976; Patry, 1978).

For workers, Taylorism has been a serious blow, robbing them of freedom to decide how and when to work, speeding up the pace of work to health-damaging levels, weakening job and income security as higher productivity allows management to lay off workers and downgrade pay, and threatening to make each worker, in the words of Taylor himself, "a mere automaton, a wooden man" (F. Taylor, 1967, p. 125). For many, work has become a daily struggle to maintain sanity and health (Connell, 1978; Garson, 1975; Matles & Higgins, 1974; Navarro, 1976c; Sinclair, 1905; Special Task Force, 1973, pp. 76-92; Stellman & Daum, 1973; Wallick, 1972). As union representatives explained in a brief to the United States Commission on Industrial Relations (Hoxie, 1918):

> "Scientific management" ... is a device employed for the purpose of increasing production and profits; and tends to eliminate consideration for the character, rights and welfare of the employees.
>
> It looks upon the worker as a mere instrument of production and reduces him to a semi-automatic attachment to the machine or tool.

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> In spirit and essence, it is a cunningly devised speeding-up and sweating system, which puts a premium upon muscle and speed rather than brains; forces individuals to become "rushers" and "speeders"; ... drives the workers up to the limit of nervous and physical exhaustion and over-speeds and over-strains them; ... tends to displace all but the fastest workers; ... is destructive of mechanical education and skill....
>
> It tends to lengthen the hours of labor; shortens the tenure of service; lessens the certainty and continuity of employment; and leads to over-production and the increase in unemployment.
>
> It condemns the worker to a monotonous routine; tends to deprive him of thought, initiative, sense of achievement and joy in his work; dwarfs and represses him intellectually; tends to destroy his individuality and inventive genius; increases the danger of industrial accidents; tends to undermine the worker's health, shortens his period of industrial activity and earning power, and brings on premature old age. (pp. 15-17)

The stress, meaninglessness, and damage to self-respect of Taylorized work spills over into the workers' private lives, affecting their entire families (Meissner, 1971; Seeman, 1967; Sennett & Cobb, 1972; Special Task Force, 1973, pp. 29-30).

> In fact, any five-year-old child knows when "daddy has had a bad day" at work. He comes home tired, grumpy, withdrawn, and uncommunicative. He wants to be left alone; wife and children in that moment are small comfort. When <u>every</u> day is a "bad day," the family may even feel like the enemy at times. But for them, he may well think, he could leave the hated job, do something where he could feel human again instead of like a robot. (Rubin, 1976, pp. 160-161)

This spillover of tension is reflected in rising rates of alcoholism, car accidents, family violence, suicides, and violent crime (Brenner, 1976, pp. 5-9; C. Cooper & Marshall, 1976; Eyer & Sterling, 1977; Segal, 1975, pp. 129-130). [I am not suggesting that all cases of these social pathologies are directly work-related. Under capitalism, the quality of social life in general deteriorates, disintegrating families and communities, debasing culture, polluting

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the environment, and so forth (Amin, 1974; Eyer & Sterling, 1977; Sennett, 1976). It is interesting to note that even outside of work, Taylor's principles have been applied. We are now witnessing Taylorizing of consumption in the form of self-service banks, gas stations, and restaurants, which require us to labour in rigidly defined ways in return for small price discounts, and which, at the same time, replace or degrade the jobs of people formerly employed in these service industries. Self-service is one of the biggest tools for raising productivity in the service industry (Lovelock & Young, 1979).].

In addition to its impact on individual workers, Taylorism also gave management a potent tool to use against organized labour. Organized labour's initial reaction to Taylorism was intensely and universally hostile (Braverman, 1974, p. 136; Hoxie, 1918, pp. 14-17, 169-177; Stone, 1973, pp. 58-60). Taylor, himself, even complained of "not being able to look any workman in the face without seeing hostility there, and ... feeling that every man around you is your virtual enemy" (Taylor, cited in J. Brown, 1954, p. 14). But as new, unskilled workers replaced the craftsmen who had experienced the degradation of their jobs, Taylorized work became accepted as routine (Braverman, 1974, pp. 135-136; Garson, 1975, p. 97). By giving employers monopoly over planning, Taylorism gave business a powerful tool to second-guess worker negotiations:

> The workers' struggle to get ahead of production pressures is unending -- and one-sided. No victory is final. Production standards are set by engineers for management; the workers can challenge these only after they have been put into effect. If the worker and/or his union manages to score a point, management remains free to introduce still

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> another set of production standards. Since the workers are not privy to the planning processes, they are ... continually off balance when it comes to protecting their interests. "You can strike one week over standards," ... reports a leader of the United Auto Workers ..., "and the next week they'll introduce new standards." (Brooks, 1971, pp. xiv-xv)

By collapsing skilled jobs, Taylorism also made it easier for employers to eliminate troublesome workers. Many of the skilled workers displaced by Taylorism were active union members, whose passing has left unions defensively trying to "construct an ever stronger umbrella over a shrinking total number of jobs" (Brooks, 1971, p. viii; Rayback, 1966, p. 304).

From business's perspective, the pain Taylorism causes individuals is irrelevant, and the weapon it provides against organized labour is all to the good. But, for business, the main drawback of Taylorism was that it alienated workers from their work so much that profits suffered.

On the one hand, it was too successful in turning workers into passive tools. As initiative, skill, and knowledge were drained from workers, they became unable to adapt to changing job requirements. That is, they became incapable of applying the human judgment which made them necessary to employers in the first place (Braverman, 1974, p. 55; Garson, 1975, p. 219). As Peter Drucker (1954) explains

> Traditional Scientific Management ... always increases the worker's resistance to change. Because he is being taught individual motions rather than given a job, his ability to unlearn is stifled rather than developed. He acquires experience and habit rather than knowledge and understanding. Because the worker is supposed to do rather than to know -- let alone to plan -- every change represents the challenge of the incomprehensible....
>
> It is an old criticism of Scientific Management that it can

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> set up a job so as to get the most output per hour but not so as to get the most output per five hundred hours. It may be a more serious and better-founded criticism that it knows how to organize the present job for maximum output but only by seriously impairing output in the workers' next job. Of course, if the job were considered unchangeable, this would not matter. ... But we know that change is inevitable; it is, indeed, a major function of the enterprise to bring it about. (pp. 285-286)

On the other hand, because workers are not machines, under the regimentation of Taylorism, they do not act like the passive automatons they are expected to be. They exhibit epidemic levels of "behavior management problems" such as "absenteeism," "alcoholism," "accident-proneness," and "personality disorders." Even worse, by increasing the workers' sense of exploitation, Taylorism actually drives workers to organize against management.

The first two decades of the century were marked by severe labour unrest which rose in intensity during World War I. In order to keep pace with war-time productivity demands, employers invested heavily in finding ways to patch up these "side-effects" without sacrificing Taylorism itself.

Two of the earliest techniques were corporate welfarism and the company union. In 1915, John D. Rockefeller Jr. had been attempting to mollify national protest over the "Ludlow massacre" of striking miners and their families at one of his Colorado plants. He hired W. L. Mackenzie King, Canada's Minister of Labour and later Prime Minister, to come up with a plan to pacify labour (Bernstein, 1960, pp. 159-160). The resulting "Rockefeller Plan" couched minor concessions to workers (particularly management-run company unions) in a rhetoric of "human relations" between management and worker:

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> This plan in substance aims to provide a means whereby the employees of the company should appoint from their own number as their representatives men who are working side by side with them, to meet as often as may be with the officers of the corporation, sometimes in general assembly, where open discussions are participated in and any matters of mutual interest suggested and discussed; more frequently in committees composed of an equal number of employees and officers, which committees deal with every phase of the men's lives -- their working and living conditions, their homes, their recreation, their religion, and the education and well-being of their children. (Rockefeller, 1917, p. 78)

The tactics of allowing some (highly-controlled) form of worker representation through the company union and of giving paternalistic corporate welfare programs were designed to convince workers that there is no conflict of interests between them and management (Rockefeller, 1923, pp. 90-106). This tactic worked remarkably well at Rockefeller's Standard Oil plants, preventing any serious labour disputes there for over thirty years (Thirty years, 1946).

By the mid-1920's the Rockefeller Plan, and its British variant, the Whitley plan, had become the dominant corporate ideology of American, Canadian, and British industry (Bernstein, 1960, p. 165; G. Cole, 1948, p. 368; Lewisohn, 1926, pp. 24-25; Rayback, 1966, pp. 304-306; Traves, 1979, p. 88; Young, 1968, pp. 125-126). As Sam Lewisohn (1926), Chairman of the American Management Association explained, this policy was entirely compatible with management interests:

> A large measure of autonomy and self-expression for workers in industry is not only compatible with efficiency but actually conducive to efficiency, as many experiments in employee representation and management-union co-operation have demonstrated. The point is, however, that this factor of efficiency ... must be the most prominent if not the determining consideration in evolving new principles of organization. (pp. 24-25)

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These ideas were later incorporated into industrial psychology by Elton Mayo (see pp. 98-105).

In addition to supporting company unions, Western employers also invested heavily in two aspects of industrial psychology. On the one hand, they funded research in ways to refine Taylor's techniques to develop the job organization and working conditions under which the human-machine would produce the most efficiently. These studies yielded the fields of "human engineering," "job analysis," and psychological testing (for vocational and military selection) (Bass & Barrett, 1972; Iacono & Bellelli, 1972; Münsterberg, 1913; H. C. Smith, 1964, p. 352; Spring, 1972, pp. 80-81; Super & Crites, 1962). All of these approaches assume that workers are a passive "factor of production" equivalent to the machines they operate (Braverman, 1974, p. 51). This mechanical conception of the worker is an enduring trait of both employers and industrial psychologists, which permeates even the most "humane" approaches.

On the other hand, employers developed ways to directly prevent industrial unrest. In the United States, this research was strongly supported by the National Committee for Mental Hygiene. Originally a minor, low-budget lobby group for preventive psychiatry and reform of insane asylums, the National Committee had little money or influence (Beers, 1908; Deutsch, 1949, pp. 310-314; National Committee, 1929). However, as strikes spread during World War I, the Rockefeller Foundation and other private philanthropies began providing substantial funding to the organization, and it suddenly leaped into national prominence (Brecher, 1972, pp. 102-103; Deutsch, 1949, p. 314; Hutt, 1975, pp. 69-84; National Committee, 1921, 1940,

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p. 24). The National Committee led a highly influential lobbying and research program whose explicit goals closely resembled those later adopted in community psychiatry:

> To work for the protection of the mental health of the public; to help raise the standard of care for those in danger of developing mental disorder or actually insane; to promote the study of mental disorders in all their forms and relations and to disseminate knowledge concerning their causes, treatment, and prevention; to obtain from every source reliable data regarding conditions and methods of dealing with mental disorders; to enlist the aid of the Federal Government so far as may seem desirable.... (Deutsch, 1949, pp. 314-315)

Although these overt goals, like those of community psychiatry, are worded benignly, the central concerns of the National Committee were to control labour militancy, to improve worker productivity, and to prevent crime. As a spokesman for the National Committee explained:

> Mental hygiene ... presents many wider aspects. Industrial unrest to a large degree means bad mental hygiene. The various antisocial attitudes that lead to crime are problems for the mental hygienist. Dependency, insofar as it is social parasitism not due to mental or physical defect, belongs to mental hygiene. But mental hygiene has a message also for those who consider themselves quite normal, for by its aims, the man who is fifty per cent efficient can make himself seventy per cent efficient.... (Bromberg, 1939, p. 217)

These concerns were all strongly reflected in the publications of the National Committee (R. S. Baker, 1920, pp. 208-218; Campbell, 1921; Cobb, 1919; Jacoby, 1919; Jarrett, 1917, 1920; National Committee, 1929, pp. 32-45, 1945; Pruette & Fryer, 1923; Rockefeller, 1917; Salmon, 1919; Tead, 1918).

This pioneering work by the National Committee and its grantees laid much of the foundation for the philosophy and methods of community psychiatry. It emphasized the need to isolate and treat malcontent or misbehaving workers, to train management in conciliatory

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skills, and to provide workers with an outlet to talk out their grievances to sympathetic-sounding listeners. Following its lead, employers began hiring psychiatrists in industry as early as 1915 specifically to control "these grudge-bearers, agitators, drinkers, fighters and lazy persons" who threaten profits (Southard, 1920a, p. 557).

World War I, with its attendant demands for higher industrial production, for mobilizing effective armies, and for assuring labour co-operation, provided the impetus to turn industrial psychology into a full-fledged discipline (Gavin, 1977; Ianoco & Bellelli, 1972; A. McLean, 1969; Rennie, Swackhamer & Woodward, 1947). For the first time, Western governments became actively involved in trying to "apply psychiatry on a mass basis to the armed forces" (Giberson, 1942, p. 1088). In the United States, the federal government and the Rockefeller Foundation jointly funded the National Committee for Mental Hygiene to organize "neuropsychiatric units" to screen and later to treat combat soldiers (P. Bailey, Williams & Komora, 1929). As Deutsch (1949) pointed out, the motivation for this massive psychiatric mobilization was "not to make robust citizens, to be sure, but to make more efficient fighting machines of their soldiers, present and potential" (p. 317). Because they were treating primarily non-psychotic illnesses, the military psychiatric programs made extensive use of both the insights and the personnel of industrial psychology (Deutsch, 1949, pp. 317-320; Southard, 1920a). And conversely, these industrial psychologists employed by the military had an ideal laboratory in which to study large numbers of people in

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a completely controlled environment (Giberson, 1942, p. 1088). As a result, the war catalyzed significant progress in industrial techniques for treating masses of non-psychotic people (Yolles, 1969, p. 7). On the one hand it spurred refinements in Taylorism by promoting efficiency studies on the relationship between men and their machines and especially by encouraging the use of mass psychological testing for military selection:

> The personnel work of the psychologists in the American army and the elimination, by neuropsychiatrists supported by psychologists, of the feebleminded from the army have settled for all time the question of the applicability of skillfully (sic) and specially devised mental tests to groups of men.... This kind of mental-measurement psychology has come to stay. Even if we limited consideration to the personnel work of the Secretary of War's office alone, or to the work of the nervous and mental division of the Surgeon General's office alone, we should be able to demonstrate the value of these methods. ... <u>Here was large-scale production with a vengeance. It takes but half an eye to see that many of the methods and some of the conclusions of military psychology can be carried over with due modifications into industry</u>. (Southard, 1920a, pp. 47-48, my emphasis)

On the other hand, by requiring both government and business to control the rising tide of labour unrest in reaction against the war and to maintain military discipline, the war itself spawned dramatic advances in psychological techniques of labour pacification (Bercuson, 1974, p. 4; Brecher, 1972, p. 102; Hutt, 1975, pp. 163-172).

In the post-war period, these advances were <u>not</u> applied to public psychiatry, which remained almost entirely custodial, but they <u>were</u> used extensively in industry (Giberson, 1942, pp. 1088-1089; Noble, 1977, pp. 276-320), to be incorporated into community psychiatry after World War II.

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4.3 Labour militancy and industrial psychology (1919-1939)

Immediately after World War I, the problem of labour alienation became even more critical for business. The end of the war was accompanied by an unprecedented wave of labour militancy and unity. Membership in unions grew dramatically, and in the first year after the war, one-fifth of all industrial workers in the United States, both organized and unorganized, went on strike (Jamieson, 1957, p. 38; Rayback, 1966, p. 279; The labor situation, 1946, p. 121). Emboldened by the successful Russian Revolution, communist movements and militant action flourished in the West (R. Baker, 1920, pp. 3-25; T. Buck, 1967, pp. 49-69; G. Cole, 1948, pp. 382-384; Haider, 1968, pp. 24-27; Rayback, 1966, pp. 280-282; Renshaw, 1967). There were general strikes in Winnipeg and Seattle in 1919, and many other major strikes across Canada, Britain and the United States (Bercuson, 1974, p. 28; G. Cole, 1975, pp. 84-100; Jamieson, 1976, pp. 181-182). Authorities in the United States and England feared a revolution (R. Baker, 1920, pp. 3-25; Hutt, 1975, pp. 84-101). Riding this tide, workers won significant gains:

> By mid-1920 hours had been reduced to the point where ... the [U.S.] nation's work week averaged fifty hours; real wages of persons engaged in manufacturing and transportation were 35 per cent higher than before the war. Politically the advance was recorded in legislation for women, improvements in workingmen's compensation, and a restrictive immigration policy. (Rayback, 1966, p. 279)

In addition to these threats to profits by organized labour, employers found the alienation of individual workers a major barrier to raising productivity. Burlingame, in a 1916 study, discovered that workers' feelings of alienation "toward their employment, their

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foreman and the machines were responsible for a greater loss in dollars and cents than accidents and contagion" (Rennie, Swackhamer & Woodward, 1947, p. 67). Other studies claimed that between 20-25 per cent of all employees were "problem workers" (V. Anderson, 1929; Bingham, 1931; Giberson, 1942, pp. 1099-1100; Jarrett, 1920).

Needing to re-establish control to keep up with the business boom, business and government responded to this labour threat with strong anti-union and anti-communist measures, as vicious as those of the McCarthy era, which effectively broke the tide of worker's progress (G. Cole, 1948, pp. 418-424; Greene, 1970, pp. 88-89; Rayback, 1966, pp. 280-303).

To complement this use of force, businesses began investing even more heavily in research on psychological techniques to win the co-operation of workers (Burlinghame, 1946; Deutsch, 1949, pp. 327-328). Industrial psychologists began "to appear as essential factors in industrial organization" (R. Baker, 1920, p. 67). In England, the Industrial Health Research Board and the National Institute of Industrial Psychology were established (R. Baker, 1920, p. 69; Bingham, 1931, p. 52). In Germany:

> There is scarcely an engineering college ... without its elaborately equipped psychotechnical laboratory. Governmental agencies have been active. The tramway companies, the state railways, the great steel works, the dye industries and many factories have their own psychological laboratories.... (Bingham, 1931, p. 52)

In the United States, Thomas Edison exulted: "A great field for industrial experimentation and statesmanship is opening" (1920, p. 4). The industrially-backed mental hygiene movement boomed, acquiring affiliates in thirty countries (Deutsch, 1949, pp. 328-329).

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The most prominent psychiatric researcher of the post-World War I era was E. E. Southard (Deutsch, 1949, pp. 295, 328). A leader of the mental hygiene movement who had consulted for the Army during the war, Southard received generous funding (both private and public) to develop techniques to control industrial unrest (Rennie, Swackhamer & Woodward, 1947, p. 67; Southard, 1920b). Southard's research resulted in several major technical innovations for industrial psychology. He instituted the first use of family therapy, of out-patient treatment for non-psychotic patients, and of the mental health "team" (composed of a psychiatrist, a psychologist, and a psychiatric social worker) (Southard, 1920b; Southard & Jarrett, 1922, pp. 510-516, 552-562).

In fact, with his associate, Mary Jarrett, Southard coined the term "psychiatric social work" and created it as a new profession (Deutsch, 1949, p. 321; Southard & Jarrett, 1922, pp. 517-521). As the first auxiliary mental health workers, psychiatric social workers were the earliest stage in Taylorizing psychiatry. They were assigned highly stratified and specialized roles, were given detailed instruction cards similar to those Taylor used on industrial workers, and were required to submit lengthy reports on their activities (Southard & Jarrett, 1922, pp. 525-533). The idea of the mental health team was quickly adopted both in industry and in the social services:

> Thus a working party, composed of psychiatrist, psychologist, and social worker, can already be found in advanced juvenile courts, and even in certain courts for adult cases.... Again, in schools and in various institutions for the care of children, this combined insight would penetrate many a dark corner. But industry seems to be the nearest problem

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> to-day to the hand of mental hygiene. One is impressed by the readiness of industry for such working parties in mental hygiene. (Jarrett, 1920, p. 872)

More important than his technical innovations, Southard contributed to the policy of treating problem employees on a mass basis. He pointed out that employers as a class have a mutual self-interest in treating, rather than firing, the "mentally ill" (by whom he meant people who, for example, "did not like supervision," who "resented criticism," who found the "work too hard," or who were "agitators," "drinkers," "too slow," or "insubordinate") (Southard, 1920b, p. 556). For, he argued, when each employer fired its own troublesome employees, they were all as a group actually only circulating, rather than curing, industrial unrest, since discharged workers are re-hired elsewhere (Southard, 1920b, p. 557). Employers have now generally accepted this principle of corporate self-interest in treating their own "mentally ill" employees (Committee on Occupational Psychiatry, 1965, p. 2; Levinson, 1960, p. 206; A. McLean, 1967). Both Southard's technical innovations and his emphasis on a unified national mental hygiene program were highly influential and they were later incorporated as central parts of community psychiatry.

Nevertheless, Southard's vision was limited by his assumption that industrial unrest is an irrational flaw of individuals, rather than a reasonable reaction to oppressive conditions. His definition of irrational feelings was quite broad:

> The great majority of the causes of industrial unrest ... have their root in certain psychological conditions. Among these may be mentioned lack of confidence in the government, feeling of inequality of sacrifice in army and industry, ...

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> feeling of unreliability of certain trade union officials, and feeling of the uncertainty of the whole industrial future. (Southard, 1920b, p. 558)

This conceptualization of the problem led Southard to exclude any analysis of organized resistance by groups of workers:

> That portion of the unrest problem which depends not upon group experience, but upon individual experience, not upon group thought, but upon individual thought, and finally not upon group action, but upon individual action, is the proper topic for the psychiatrist. (Southard, 1920b, p. 561)

Management did not seriously address this issue of group influences on labour unrest or on productivity for more than a decade. By the mid-1920's labour militancy had declined in the United States, Canada, and Britain (at least in part because union leaderships there resisted rank and file militancy) (Bernstein, 1960, pp. 334-390; Hutt, 1975, pp. 98-130; Lipton, 1967, pp. 237-254; Rayback, 1966, pp. 290-313). In the years before the Great Depression, inventories mounted, industrial productive capacity went unused, and businesses had difficulty selling their stock (Bernstein, 1960, pp. 47-82). As a result, both government and employers grew less interested in funding new industrial psychology research either to boost worker productivity or to prevent labour unrest. Although industrial psychologists were hired at more companies during the period from 1924-1932, they generally merely applied old techniques (Bingham, 1931; Burlinghame, 1946; Giberson, 1942, p. 1090).

By 1934, however, rising labour militancy and communist organization in reaction against the Depression again began to threaten employers in the United States, England, and Canada (Bernstein, 1960, pp. 416-455, 1969; G. Cole, 1948, pp. 444-445; Hutt, 1975, pp. 130-137;

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Lipton, 1967, pp. 256-260; Piven & Cloward, 1971, pp. 61-77; Rayback, 1966, pp. 316-329). This militancy was particularly evident in the United States. Between 1934 and 1938, a series of major strikes swept across the United States as workers defied armed attacks on them by National Guardsmen and police (Brecher, 1972, pp. 158-177). The C.I.O., formed in 1936, provided a forum for more militant organization than had been possible under the A.F.L., and by 1939, a larger proportion of the U.S. nonagricultural labour force was unionized than ever before (Cochran, 1968, p. 75). As a result of this militancy, the New Deal administration in the United States conceded significant powers to labour, including collective bargaining rights, social security, the right to picket, minimum wages, unemployment insurance, and social welfare (Bernstein, 1969; Piven & Cloward, 1971; Rayback, 1966, pp. 339-340). Although these programs were organized in a way which protected business interests, they were, nonetheless primarily social wages granted in response to labour militancy (Finkel, 1977, pp. 350-352). In Canada and Britain, where strikes and union militancy were smaller during the late 1930's, similar programs were not established until the 1940's (G. Cole, 1975, pp. 443-450; Finkel, 1977, pp. 350-352; Jamieson, 1976, pp. 278-279).

To supplement their use of forc gainst workers through the courts, the military, and both public and private police, U.S. employers were anxious to develop new techniques to prevent labour unrest. In response to this wave of labour militancy, management interest in industrial psychology re-emerged with new urgency.

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Clearly the old methods of industrial psychology had proved inadequate to control worker unrest, and some new approach had to be developed to win "the loyalty of the worker away from the union" (Bernstein, 1969, p. 790).

Into this gap stepped Elton Mayo, an Australian industrial psychologist who had been brought to the United States by the Rockefeller Foundation (J. Brown, 1954, p. 73). Mayo had just published the results of his research at the Hawthorne plant of the Western Electric Company (1933). His central conclusion was that workers function in groups and not as isolated individuals. He argued that management can only hope to counter worker solidarity against management by exploiting this "eager human desire for co-operative activity" (1946, p. 20). Mayo pointed out that earlier industrial psychologists, beginning with Taylor, had tried to break worker solidarity and treated workers individually. But, Mayo argued, this tactic is self-defeating:

> In industry ... the administrator is dealing with well-knit human groups, and not with a horde of individuals. Wherever it is characteristic ... that by reason of external circumstances these groups have little opportunity to form, the immediate symptom is labor turnover, absenteeism, and the like. ... Any disregard of [man's need to work in groups] by management or any ill-advised attempt to defeat this human impulse leads instantly to some form of defeat for management itself. (Mayo, 1946, p. 111)

Mayo's Hawthorne plant research had, he believed, provided conclusive evidence that "friendly supervision" causes greater productivity gains than either pay incentives or improved working conditions. In fact, he claimed, under friendly supervision, worker productivity continued to climb even when working conditions

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benefits and pay incentives were removed. This "Hawthorne effect" occurred, he believed, because management had overcome the work group's psychological conflict between loyalty to the company and loyalty to the working group by convincing them that higher productivity was in both management's and the worker's interests, and also by giving them the feeling that their ideas and comfort were important to management.

> Informal organization in any organized human activity serves a very healthy function. ... It gives people a feeling of self-respect, of independent choice, of not being just cogs in a machine. Far from being a hindrance to greater effectiveness informal organization provides the setting which makes men willing to contribute their services. Informal organization cannot be prevented; it is a spontaneous phenomenon necessary wherever co-ordinated human activity exists.... Too often management has mistakenly opposed -- or what is worse -- ignored this. (Roethlisberger, 1945, p. 299, my emphasis)

Mayo believed that the "Hawthorne effect" demonstrated management's power to win worker co-operation on a group basis, without having to concede any costly improvements in wages or working conditions (Bramel & Friend, 1978; J. A. C. Brown, 1954, pp. 73-83; Fruitful errors, 1946; Mayo, 1930, 1933, 1937, 1946; Rennie, Swackhamer & Woodward, 1942, pp. 68-70; Roethlisberger & Dickson, 1949). Mayo claimed that he had discovered a "new method of human control" (Roethlisberger, 1941, p. 16).

As it turned out, the Hawthorne effect was not valid. Mayo's conclusions were based on research methods which have since been widely criticized as inappropriate, inadequate, and shoddy (Bramel & Friend, 1978; Carey, 1967; Gilbert, 1940; Landsberger, 1958; Sykes, 1965). Data which supposedly demonstrated the Hawthorne effect

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were based on an unrepresentative sample of only five workers, and two of those were replaced eight months into the experiment, when their productivity failed to increase, by workers whose productivity was from the start (i.e., before any exposure to "friendly supervision") much higher than any of the remaining subjects (Carey, 1967). Working conditions, pay incentives, and supervision styles were haphazardly varied, and the impact of the workers' social situation outside of the isolated work area -- particularly the Depression and Western Electric's anti-union spying -- were ignored (Carey, 1967; Gilbert, 1940). Most importantly, even under these poorly controlled experimental conditions, the data still failed to support Mayo's contention that friendly supervision alone causes productivity increases. Bramel and Friend (1978) demonstrate that the data actually indicate that: (1) "Friendly" supervision had negligible impact on productivity, and in fact that "'friendliness' of the supervision ... was probably as much an _effect_ as a _cause_ of increased productivity" (p. 12, their emphasis); (2) Hourly productivity dropped dramatically when rest pauses were eliminated, and only punitive, hard-line supervision kept it from falling even further (p. 14; Carey, 1967); and (3) The highest increases in productivity occurred in response to pay incentives (p. 19; Carey, 1967; Sykes, 1965).

However, hardly anyone challenged the myth of the Hawthorne effect until the 1950's. Mayo's "discovery" of the power of "human relations" reverberated throughout the business community. It was hailed as "the single most important social-science research project

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ever conducted in industry" (Jackson, 1928, p. 289), as "the first effective challenge to the prevailing theories of individual and organizational behavior" (Whyte, 1956, p. 125), and as providing "the key to industrial peace" (Fruitful errors, 1946, p. 181).

Actually, Mayo's theory was not new. It came straight from John D. Rockefeller Jr. (see pp. 86-87):

> The heart of the Rockefeller philosophy was what he labelled "human relations," understanding by managers that their employees were "human beings" and by workmen that managers and investors were also "human beings." Conflict, as he saw it, was both undesirable and wicked. He found it "wantonly wasteful"; both parties and the innocent public were losers. "To say that there is no way out except through constant warfare between Labour and Capital is an unthinkable consel of despair."
>
> The alternative in his view was a "harmony of interest," that employer and employee must "join hands and recognize that their interest is a common interest." Each was indispensable to the other in the development and sharing of the earth's riches. "Co-operation of Labor and Capital may well be regarded ... as the most vital problem of modern civilization." (Bernstein, 1960, pp. 164-165)

The Rockefeller "human relations" ideology was particularly strong at General Electric (of which Western Electric's Hawthorne plant is a subsidiary) (Noble, 1977, pp. 278-279). In 1919 Mackenzie King had helped General Electric to establisn a company union and to set up a corporate welfare program, to avoid the threat of labor organization (Bernstein, 1960, p. 168; Rennie, Swackhamer & Woodward, 1942, p. 70). The Western Electric Company, alone, reported spending $25,825.76 for labour spies between 1933-1936 (Gilbert, 1940, p. 100).

In other words Mayo provided a "scientific" justification for what had already become general corporate policy. Originally funded by the Rockefeller Foundation and employed by Western

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Electric, he produced the expedient "discovery:"

> The essential ideas, as well as the very name of the [human relations] movement, were those Rockefeller had laid out in 1915: human understanding, the undesirability and eradicability of conflict, harmony of interests in the shop community, and improved communication. The only basic change was the gradual replacement of Christ by Freud, the sloughing off of the Christian ethic and the substitution for it of a sort of group psychoanalysis. (Bernstein, 1960, p. 169)

Inadvertently, however, Mayo did make one independent discovery which had enormous impact on both industrial psychology and community psychiatry. In attempting to accurately survey workers' feelings and concerns, Mayo and his associates invented the non-directive interview. Rather than asking leading questions, interviewers were instructed just to listen attentively and to comment only for clarification (never to argue or to advise) (Mayo, 1946, pp. 73-74). The workers (apparently) responded enthusiastically to this approach, pouring out their resentments and problems in a flood that went well beyond the original purposes of survey research:

> Such comments as "This is the best thing the Company has ever done," or "The Company should have done this long ago," were frequently heard. It was as if workers had been awaiting an opportunity for expressing freely and without afterthought their feelings on a great variety of modern situations, not by any means limited to the various departments of the plant. To find an intelligent person who was not only eager to listen but also anxious to help to express ideas and feelings but dimly understood -- this, for many thousand persons, was an experience without precedent in the modern world. (Mayo, 1946, pp. 74-75)

Mayo was astute enough to recognize that the non-directive interview could be used as a potent "emotional release" of worker resentments (Mayo, 1945, p. 84). He and his associates cited case after case in which workers' grievances evaporated after the interview even

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when nothing practical had been done about the problem.

> The interview has demonstrated its capacity to aid the individual to associate more easily, more satisfactorily, with other persons -- fellow workers or supervisors -- with whom he is in daily contact. ... it also develops his desire and capacity to work better with management. ... This is the beginning of a necessary double loyalty -- to his own group and to the larger organization. (Mayo, 1946, p. 84)

The non-directive interview was the main practical discovery to emerge from Mayo's research (Roethlisberger & Dickson, 1939, pp. 590-604; Tannenbaum, 1966, p. 103; Whyte, 1956, p. 126). Mayo and his associates organized a massive "personnel counselling" program at the Hawthorne plant, which interviewed 20,000 employees in just its first two years of operation (it lasted fourteen years) (Bramel & Friend, 1978, p. 32; Mayo, 1946, p. 78). They trained a large number of nonprofessional "counsellors" in non-directive interviewing skills and assigned them to interview workers whose productivity or attitude was a "problem" (Roethlisberger & Dickson, 1939, pp. 590-604). However, the workers were not supposed to realize that the interviews were prompted by management's concern for productivity, and so sometimes counsellors were instructed to first conduct decoy interviews with non-problem workers (Roethlisberger & Dickson, 1939, pp. 594-595). Management made being interviewed as convenient as possible. Workers were paid regular wages during their interviews, and were explicitly not treated as if they were mentally ill. Rather, they were told they were merely suffering from "a defect or distortion of attitude" which could be cleared up through "communication" (Mayo, 1946, p. 78).

Although this interviewing technique was labelled "non-

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directive," it contained a strong, although covert, directiveness. Interviewers were instructed to concentrate on "each worker's personal situation" (Mayo, 1946, p. 78, his emphasis), and to "clarify" workers' complaints in terms which implied that the problem stemmed from the worker's unique situation rather than from valid grievances which are shared by many workers (Bramel & Friend, 1978, p. 34; Marcuse, 1964, pp. 108-114; Wilensky & Wilensky, 1951). By personalizing the worker's grievances, the "counsellor" effectively isolated the worker's problem from its class situation, and thereby established a false unity between the worker and management and a false division between the worker and other workers. Marcuse (1964) brilliantly illustrated the co-opting power of this operation, using an example from Mayo's associates (Roethlisberger & Dickson, 1939, p. 267):

> "A worker B makes the general statement that the piece rates on his job are too low. The interview reveals that "his wife is in the hospital and that he is worried about the doctor bills he has incurred. In this case the latent content of the complaint consists of the fact that B's present earnings, due to his wife's illness, are insufficient to meet his current financial obligations."
>
> Such translation changes significantly the meaning of the actual proposition. ... the untranslated statement established a concrete relation between the particular case and the whole of which it is a case.... This whole is eliminated in the translation.... The worker may not be aware of it, and for him his complaint may indeed have that particular and personal meaning which the translation brings out as its "latent content...."
>
> The translation ... stops at the point where the individual worker would experience himself as "the worker," and where his job would appear as "the job" of the working class. ... The worker B, once his medical bills have been taken care of, will recognize that, generally speaking, wages are not too low, and that they were a hardship only in his individual situation (which may be similar to other

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> individual situations). His case has been subsumed under another genus -- that of personal hardship case. He is no longer a "worker" or "employee" (member of a class), but the worker or employee B in the Hawthorne plant of the Western Electric Company. (Marcuse, 1964, pp. 109-111)

In addition to the counselling program, Mayo recommended that Western Electric improve individual (i.e. non-union) channels of worker-management communication, train supervisors to treat workers "like human beings," and give employees back minor control over their work process (e.g., the right to decide when to take a break) (Mayo, 1946; Rennie, Swackhamer & Woodward, 1942, p. 70). As Bramel and Friend (1978) point out:

> It is not difficult to see that the purpose of the program was to mute conflict in the plant by presenting to workers a friendly, paternalistic side to management (the illusion that "something is being done") while at the same time drumming in the point of view that the factory is a co-operative enterprise in which "teamwork" and loyalty are in the common interests of all concerned. (p. 34)

The political content of this entire human relations program (both Rockefeller's and Mayo's) was to break worker unity by building ties between individual workers and management, and where worker unity could not be broken, to use "friendly supervision" to win their joint co-operation, without making any tangible concessions. Workers were to be induced to perceive their grievances as unique personal problems, unions as anti-social, and management as their best ally.

The "human relations" philosophy had a tremendous impact on both industrial psychology and community psychiatry. The Rockefeller and Ford Foundations enthusiastically picked up the counselling idea and generously funded Carl Rogers to refine the technique of non-directive interviewing for general use in industry (Mindus, 1953, pp.

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63-65; Rogers & Roethlisberger, 1956). Many corporations, already attuned to "human relations" by Rockefeller and King's earlier campaigns, enthusiastically adopted Mayo's ideas:

> Mayo's system, often in vulgarized form, appealed to many employers. The levers remained solely in the hands of management; industrial conflict was condemned and avoided; government regulation was denigrated; and the level of discussion was shifted from wages to non-economic "satisfactions." Best of all, the union was eliminated. In one form or another, many American employers opted for Elton Mayo. (Bernstein, 1969, p. 791)

The human relations movement dominated industrial psychology throughout the 1940's and early 1950's, as human relations schools and training programs proliferated in the United States, Canada, and England, as well as in some areas of Europe (H. Baker, 1944; Bladen, 1949; Bursk, 1956; Butler, 1957; Ferguson, 1964; Fruitful errors, 1946; Hincks, 1945; Likert, 1967; Nasatir, 1940; Schoen, 1957; Selekman, 1947; Stephanson, 1966; Tannenbaum, 1966). Lewin's concepts of management training, Bion's theories of "work enrichment," and diverse varieties of group-based wage incentive and profit-sharing schemes all rely to varying degrees on Mayo's concepts (Argyris, 1957; Bion, 1961; Bucklow, 1976; Clegg, 1960; Lewin, 1948; Trist & Bamforth, 1951; Whyte, 1956). Although refined and expanded, Mayo's strategy remains a dominant management tactic of industrial relations -- to humanize Taylorism.

This corporate interest in human relations, in turn, directly influenced the philosophy of community psychiatry. Its ideological assumptions could have been written by Mayo himself:

> Among the important ethical beliefs of community psychiatry are:
>
> 1. <u>Good mental health services should be available</u>

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> to all those who need them....
>
> 2. Each person should control his own destiny to the greatest extent possible. This concept of personal freedom envisions that individuals and groups of individuals will make decisions about allocation of their own resources....
>
> 3. Close, long-term human relationships, particularly those within small groups, are valuable and to be fostered.
>
> 4. The strength which comes from humans banding together in social groups is to be prized and utilized. ... In clinical community-oriented treatment ... group therapy and the therapeutic community are major elements. So too are the emphasis on understanding and treating families, treating patients where they work and live, and helping the patient by changing his group or his place in the group, not by changing him or removing him from a natural group.
>
> ... The belief in the unconscious and in the powerful, long-lasting effect of childhood experience upon later life are not essential elements of community psychiatry. (Zusman, 1975, pp. 25-26, his emphasis)

The entire humanistic wing of clinical psychology closely resembles Mayo's approach, particularly in its emphasis on feelings to the exclusion of practical changes, on its pseudo-equality between therapist and client, and on its concept of positive mental actualization (as opposed to curing mental illness) (Back, 1972; Ewalt, 1975; Maslow, 1962; Zusman, 1975). Non-directive interviewing by non-psychiatrists has been institutionalized as a major counselling technique in public community psychiatry programs.

It is important to place the human relations movement in its social context. As the Western powers geared up for World War II, U.S. and Canadian employers once again needed to boost productivity to keep up with the booming sales. But they encountered a labour force far stronger than at any earlier point in history. Unions were larger, more militant, and better protected by legislation (Bernstein, 1969, pp. 768-791; Lipton, 1967, p. 259; The labor situation, 1946).

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In other words, the human relations movement was a defensive response by employers to labour strength. Forced to concede that unions and collective bargaining are here to stay, management opted for the soft sell (while maintaining the power to back up their demands with force) (Bernstein, 1969, p. 791; Selekman, 1947, pp. 2-3).

> The rise of the "human relations movement" among managers coincided with the declaration by the Supreme Court of the constitutionality of the Wagner Labor Act. Management now _had_ to bargain collectively with labor unions. Good human relations was seen as offering potential support for continued management control. (Bass & Barrett, 1972, p. 10)

Human relations techniques gave employers a "carrot" with which to cheaply "buy" worker co-operation. But, since employers are unable to abandon their claim to profits at the expense of workers' wages and working conditions, it was a relatively weak "carrot" in comparison to the attractions of union benefits. Workers were not nearly as easily fooled by the benign rhetoric of "human relations" as employers hoped they would be (Baritz, 1960, p. 144; Bramel & Friend, 1978; Fountain, 1945; Gomberg, 1957; A. McLean, 1969, p. 30; Whyte, 1956). As one disenchanted union representative commented:

> Traditionally, a personnel program is simply one of management's tools for the control and direction of the enterprise. Like the others, it seeks greater efficiency and higher profits....
>
> This "humanistic" or "human relations" approach has no appeal for the trade unionist. He starts with the proposition, formulated by Emil Durkheim and popularized by the Harvard group of industrial researchers, that our society does create "a disordered dust of individuals." He goes on to seek a remedy, however, not from the open or disguised bounty of the employers but through the formation of trade unions. (Barkin, 1956, pp. 362-363)

By the mid-1950's (when business's position was stronger), employers were more willing to scoff at "the almost panicky fear of the labor

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union that runs through the entire work of the original Human Relations School at Harvard University" (Drucker, 1954, p. 279). But during the period 1936-1953, human relations was among the best alternatives available to employers.

In contrast to the significant expansion of industrial psychology programs, public treatment of unemployable psychiatric patients languished during this period. During the Depression, the budgets of mental hospitals were slashed throughout the West (Deutsch, 1949, p. 446). At the same time, mental hospitals were forced to accommodate many more patients -- the direct and indirect casualties of the Depression. Mental hospitals became depositories for unemployable sick, aged, and retarded people who could no longer be supported by their families, as well as for people driven mad by the economic stresses (Brenner, 1973; D'Arcy, 1976a). As the Superintendent of Weyburn Psychiatric Hospital in Saskatchewan reported:

> Relatives have not always been able to take the patient home, or perhaps had no work for the patient if taken home, and in the case of patients who have no near relatives we have at times hesitated to turn them loose on recovery, realizing that parole without the prospect of employment would probably be detrimental and result in their early return to the institution. (Saskatchewan Department of Public Works, 1933, p. 60)

Overcrowding and inadequate funding became epidemic, destroying whatever therapeutic programs the hospitals had been providing (National Committee, 1941, 1942, pp. 11-12). The mental hospitals never recovered. In spite of new economic growth in the late 1930's governmental priorities had shifted away from chronic care, and policy-makers explicitly opposed increasing institutional funding (National Committee, 1942, p. 27; Rothman, 1972, pp. 8-9; Talbott, 1978, pp. 165-168). By 1945, the mental hospitals had deteriorated

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to the point that they "rivaled the horrors of the Nazi concentration camps" (Deutsch, 1949, p. 449).

> Hundreds of naked mental patients herded into huge, barnlike, filth-infested wards, in all degrees of deterioration, untended and untreated, stripped of every vestige of human decency, many in stages of semi-starvation. (Deutsch, 1949, p. 449)

> The Weyburn hospital stunk like something out of this world.... It was crowded and all the whole basement area was a shambles, naked people all over the place, lying around, incontinent. There was a lot of seclusion in use, and mechanical restraints. (Kahan, 1965, p. 21)

Innovations during the 1930's which were directed at chronic or psychotic patients were almost all intended to cheapen, rather than to improve their care. By 1935, many local government units in Western countries were beginning to support plans to place manageable patients with private families (Deutsch, 1949, p. 447; Dorgan, 1958, p. 413). To the extent that the National Committee for Mental Hygiene (an increasingly influential, business-financed lobby) addressed the problem of mental hospitals, it favored cutting costs of patient care by discharging them into the community (National Committee, 1942, pp. 27-28). In contrast to the benevolent rhetoric of the 1960's decarceration movement, these plans were explicitly intended only to save money and to ease overcrowding for the remaining patients without additional expense.

To facilitate the management and discharge of chronic mental patients, Western governments supported research on a variety of technological innovations, "notably insulin therapy by Sakel in Vienna, convulsion therapy by means of drugs by Meduna in Budapest, electrical convulsion treatment by Cerletti and Beni in Rome, and the

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operation of prefontal leucotomy by Egas Monez in Lisbon" (Rees, 1959, p. 355). Generally, these biological treatments were not combined with any personal counselling or psychotherapy, and after discharge, these patients were generally ignored. These treatments are all hazardous to patients, resulting in high rates of brain damage, spinal fractures, and even death. Their primary benefit was to cheaply and quickly make patients more manageable (Friedberg, 1976; Segal, 1975, pp. 337-338).

Thus, we see that in the period between World War I and World War II, psychological treatment of employed people expanded dramatically, while care of unemployable mental patients deteriorated. Treatment innovations for employable people occurred consistently in periods of economic booms (World War I and the build-up period in preparation for World War II) and of high labour militancy (1915-1921; 1934-1939). Industrial spokespersons made it explicit that the purpose of these innovations was to combat labour militancy and individual worker resistance to productivity demands. As a prominent Canadian industrial psychologist pointed out, "psychiatry in industry is no mere accident" (Giberson, 1938, p. 401).

> Its purpose is to preserve the individual while adjusting him to the central effort.... It is almost axiomatic that an employee's value to his organization is in direct relation to the calm adjustment of his day to day existence. (p. 401)

As World War II began, industrial psychology had already developed many of the central innovations which now characterize community psychiatry; mass psychological testing, the mental health team, auxiliary non-professional counsellors, family and out-patient

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therapy, non-stigmatizing counselling methods, and psychiatric consultation to organizations. Although these advances were primarily funded privately, Western governments had begun to establish Industrial Hygiene offices which supported programs and research in industrial psychology for both civilian and military workers (Bingham, 1931; Giberson, 1938).

The next chapter will describe how these industrial psychology programs were transformed into community psychiatry and how they largely replaced the traditional public psychiatry focus on custodial care of unemployable people.

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V. THE NATIONALIZATION OF INDUSTRIAL PSYCHOLOGY

5.1 World War II (1939-1945)

Like the First World War, World War II posed serious labour problems for the United States and its allies. During the Second World War, organized labour in those countries was in a stronger position than ever. Employers had been forced to recognize the legitimacy of unions and of collective bargaining (G. Taylor, 1948, p. 7). Booming war-time production and military mobilization created labour shortages, and this gave workers greater bargaining power. This new strength won labour grudging recognition as a "partner" in Allied war production (Bailey & Brake, 1975, pp. 7-8; Brooks, 1971, pp. 194-208; G. Cole, 1948, pp. 456-457; Finkel, 1977, pp. 357-361; Hutt, 1975, p. 144; Rayback, 1966, pp. 373-379; Swartz, 1977, pp. 320-321). During the war, union membership in the United States and Canada more than doubled, and in Britain, it increased by a third (Anatomy, 1946, p. 130; Cochran, 1968, pp. 170-175; G. Cole, 1948, p. 455; Finkel, 1977, pp. 357-359).

Under broad government assurances that its interests would be protected, labour generally united behind the war effort and workers accepted wage restraints, longer hours, and speed-up to raise productivity for the war effort (Brecher, 1972, p. 223; G. Cole, 1948, pp. 452, 456; Jamieson, 1957, p. 24). In Britain, workers even demanded changes in industrial organization to increase productive

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efficiency (Hutt, 1975, pp. 151-152). This labour effort was decisive in winning the war:

> In spite of shortages and maldistributions of manpower, production of war goods reached record proportions. By the war's end, man days of labor [in the United States] increased by 50 per cent over 1939; output increased nearly 100 per cent.... It was this production which was the greatest single factor in winning the war. (Rayback, 1966, p. 377).

However, this co-operation did not at all imply the passive acceptance of employer benevolence which Mayo had advocated. Rather, it was based on labour strength and on its own commitment to defeat fascism, which was at times even stronger than that of business (Hutt, 1975, pp. 139-140; Lipton, 1967, pp. 264-265). Labour leaders agreed to no-strike pledges and wage restraints only in return for business and government promises of significant concessions, such as full employment after the war, maintenance of membership clauses, and price controls (Brooks, 1971, pp. 280-288; Hutt, 1975, p. 146; Lipton, 1967, pp. 267-269). Toward the end of the war, to enforce these concessions, waves of strikes grew in the United States, Canada, and England (Brecher, 1972, pp. 223-224; G. Cole, 1948, pp. 454-455; Lipton, 1967, p. 268). In the United States, there were more strikes in 1944 than ever before in American History (Brecher, 1972, p. 224).

As a result, in addition to the challenge of mobilizing an effective fighting force, the Allies also had to find a way to maintain worker co-operation -- or what is euphemistically called "home front morale" -- while conceding as few benefits as possible (Deutsch, 1949, pp. 460-461; Hincks, 1945, pp. 92-94; Rennie, Swackhamer & Woodward, 1947, pp. 77-80). Under these dual pressures,

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Western businesses and governments invested heavily in industrial psychology:

> The impact of World War II, with its tremendous production demands, the shortage of labor, and a consequent use of hordes of individuals not usually considered employable in factory work ... enormously accentuated interest in the psychiatric approach. The problems of absenteeism, accidents, psychosomatic illness became more acutely significant, and the auditing of jobs in terms of personality requirements and vice versa was subjected to new analysis. (Burlingame, 1946, p. 550)

Fritz Roethlisberger, Mayo's chief associate, was appointed to "help set up the Training Within Industrial Service of the War Manpower Commission whose goal was to 'secure maximum co-operation' from workers in essential industries" (Bramel & Friend, 1978, p. 25). His influence there helped to expand "human relations" programs in American industry (H. Baker, 1944; Halsey, 1953, p. 196). The National Committee for Mental Hygiene worked with government agencies to set up services to promote "citizen morale" and to treat civilian employees on an out-patient basis (National Committee, 1942, pp. 12-20). The out-patient "community clinics" which they established were the forerunners of the community mental [illegible]th centres under community psychiatry.

To help build an effective military force, the National Committee for Mental Hygiene and prominent industrial psychologists played a major role in selecting and treating soldiers. Luther Woodward, of the National Committee, was appointed to set up a massive psychiatric screening program for draftees (Deutsch, 1949, p. 463; National Committee, 1941, pp. 7-9, 1944, p. 12). This program was far more detailed and exclusive than the selection procedures

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of World War I, as a spokesman explained:

> Few people realize how different our handling of personality placement is from that of the world war [I] conscription. They don't understand that we were then sorting out people suffering severe mental disorder, the gravely feeble-minded, and those with functional disorders which would cause them to collapse at the battle line. We are now sorting into the army with as great care as possible the people who seem peculiarly well suited to meet the demands that are necessarily associated with combat troops. We are not merely eliminating those already broken down, but attempting to build up the armed forces from people who can scarcely be broken down by any strain they may encounter. (National Committee, 1942, p. 9, emphasis added)

This new sorting procedure, therefore, implicitly extended the definition of "mental illness" to include potential, as well as actual, symptomatology.

The National Committee also helped to recruit psychiatrists, psychiatric social workers, psychiatric nurses, and ward attendants to treat emotional problems among the troops and among employees in community clinics (National Committee, 1942, pp. 11-12). These mental health workers were drawn primarily from the staffs of public mental hospitals, thus further diluting the personnel available to treat chronic mental patients (Forley, 1975, p. 4).

> The maintenance of state mental hospitals ... is now threatened by the diversion of professional personnel from civilian positions to service with the armed forces, and by the loss of artisans attracted to industrial defense centers. ... This will add to the already excessive burden borne by our state mental hospitals in caring for the increasing number of cases among the general population. (National Committee, 1941, p. 11)

William C. Menninger and Francis J. Braceland, both industrial psychiatrists, were recruited to direct respectively the U.S. Army and the Navy psychiatric programs (Braceland, 1945, 1955; Deutsch, 1949, pp. 466-468; Menninger, 1952; Menninger & Levinson, 1954).

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Menninger and Braceland were members of the new Group for the Advancement of Psychiatry within the American Psychiatric Association, which lobbied for expanding preventive and community psychiatric services (Foley, 1975, p. 4).

In addition to expanding direct services to employed people, the war also stimulated research to develop new techniques of industrial psychology for both military and civilian use. Organized by the National Committee for Mental Hygiene, the research directors of "seven of the country's leading industrial organizations" worked together pooling their resources "for joint action in the interests of medical and industrial research" (National Committee, 1941, pp. 16-17). At the same time, industrial psychologists, working for the military, studied soldiers' efficiency under varying conditions of stress, and used their findings to produce many innovations which were later incorporated into community psychiatry.

For example, under Menninger's direction, the American Psychiatric Association adopted a new classification system for psychopathology which gave far more emphasis to the neuroses and behavior disorders which plagued both the military and industry (Deutsch, 1949, p. 580; Giberson, 1942, pp. 1099-1100). This new system became the model adopted by the World Health Organization which has been retained ever since (with minor modifications) (R. Spitzer & Wilson, 1968).

With inadequate staffs to handle the epidemic of combat fatigue, neuroses and psychosomatic illness among soldiers, the military psychiatrists tried out a variety of new therapeutic methods

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which were fast and cheap, and which did not require professional psychiatrists as therapists (Menninger, 1946, p. 576). They also applied these methods to treat the similar stress-related symptoms in the civilian population (Giberson, 1942; Rennie & Woodward, 1948, pp. 276-280). These techniques became the technological foundation for community psychiatry, as a former Director of NIMH explained:

> During the war, military medicine seized its opportunity to advance the knowledge and use of a variety of short-term therapies and this experience provided a sound basis for further development of the concepts and practice of community psychiatry..... (Yolles, 1969, p. 10)

Among the war-spawned therapy techniques which have become standbys of community psychiatry were group therapy, brief talking therapies, modified electro-convulsive treatments for non-psychotic patients, and psychotropic drugs (amphetamines, narcotics, and barbiturates) designed explicitly to improve the working efficiency of normal people under stress (Barten, 1969; Care & Turner, 1939; D. Cuthbertson & Knox, 1947; D. Davis, 1947; Deutsch, 1949, pp. 479, 501; Evans, 1948, 1971; Graf, 1950; Ivy & Goetzl, 1943; Newman, 1947; Ruitenbeek, 1970, pp. 21-22; Sargent & Blackburn, 1936). These diverse methods all were oriented to treat non-psychotic, rehabilitable people on a mass basis (Deutsch, 1949, p. 492; Giberson, 1942). Although these methods later filtered into the treatment of chronic mental patients, they were first developed to improve the efficiency of the armed forces. For example, German Luftwaffe pilots and Japenese war factory workers were given amphetamines, and when the Allies uncovered the reports of their improved efficiency, studies were quickly funded to duplicate and extend the Axis drug technology to Allied soldiers (Bylinsky, 1978, p. 4; Evans, 1968; Graf,

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1950).

To staff these new therapies, both military and industrial psychiatric programs expanded the mental health "team" to include many more types of specialized mental health workers (Deutsch, 1949, p. 481; Gregg, 1947, p. 218; Rennie, Swackhamer & Woodward, 1947, pp. 81-84). By far the most important staffing innovation was to train general practitioners to detect early signs of emotional upset (which was defined, as in the past, as poor adjustment to work demands) (Deutsch, 1949, p. 481).

> Lowered efficiency, dissatisfaction, spoilage, vandalism, horseplay, increased labor turnover, high accident rates, continued absenteeism, excessive fatigue ... these call for a general casting about for maladjusted personalities. (Giberson, 1942, p. 1097)

Under community psychiatry, the role of general practitioners has expanded to constitute the key link for early detection, treatment, and referral of mental patients (Albee, 1959, pp. xiii-xiv; Robertson & Shriver, 1964).

As labour unrest increased toward the end of the war, U.S. military, business, and political leaders began to press the government to establish a national program to treat the "mental illness" of non-psychotic employees. The problem of this "mental illness" had reached a "scale far beyond the reach of private philanthropy" (National Committee, 1944, p. 36), and, as a psychiatric historian argued:

> In the 1940's it was clear to psychiatric leaders in the armed forces and their Congressional allies that there was a need to develop and to organize the capacity and willingness of all relevant decision-makers ... to cooperate in a broad society-wide effort to ... develop new technological skills in the research and care of the mentally ill. (Foley, 1975, p. 1)

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The National Committee for Mental Hygiene, backed by business funding, lobbied extensively for a "National Neuropsychiatric Institute" (National Committee, 1944, p. 36).

Thus, we see that the war "called dramatic attention to the problem of mental disorders [among soldiers and employees], pointing up the need for a national mental health program" (Foley, 1975, p. 4). By contrast, facilities to treat chronic mental patients had, by the end of the war deteriorated even more than they had during the Depression. The stage had been set for public community psychiatry to supplant custodial care of chronic mental patients.

5.2 The birth of community psychiatry (1945-1953)

If the strength of labour during the war alarmed business and government leaders, post-war labour relations appeared even more frightening to them. A frequent topic of high-level policy discussions was how to avoid revolutionary labour unrest after the war, when employment levels would drop and workers would have less patriotic incentive to curtail their demands (Deutsch, 1949, pp. 474-475; Finkel, 1977, p. 361; Giberson, 1942, p. 1085; Rayback, 1966, pp. 387-388; Swartz, 1977, p. 320). In the years following the war, these fears appeared well justified. Waves of strikes of unprecedented size swept the Western countries, (Brooks, 1971, pp. 210-223; Burlingame, 1946, p. 550; Center for Research, 1977, p. 43; Selekman, 1947, pp. 2-4).

> [U.S.] labor quickly chucked the no-strike pledge. In the last four and a half months of 1945, man-days lost due to strikes shot up to ... more than double the war-time peak of 1943, when the coal strikes wracked the nation. This was but

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a prelude to the great strike wave of 1946.

> That year set the nation on the collective-bargaining road to a new corporate welfarism. Over four and one half million workers marched on the picket lines in 1946, a half million more than the previous peak, in fateful 1919. ... Nationwide strikes halted production in coal, auto, electric, and steel industries; maritime and railroad transportation ground to a halt. (Brooks, 1971, p. 210)

With memberships covering the entire work forces of many basic industries, unions wielded enormous power. As one industrial psychologist pointed out:

> Certainly, none can deny the strategic power of unions speaking as sole representatives for workers in basic industries -- coal, oil, steel, rubber, power, transportation, and so on. In our interdependent economy an industry-wide strike in any of these becomes, sooner or later, the equivalent of an uncalled general strike, an immediate or creeping paralysis. (Selekman, 1947, p. 5)

The power of organized labour extended to the political arena. In 1945, English workers elected the first Labour government (Pelling, 1972, pp. 226-229). Strong labour unions in Denmark, Norway, and Sweden had maintained social democratic governments since the 1920's (Willis, 1968, pp. 267-275). In Canada, the social democratic CCF party, with labour support, gained strength, winning one-third of the votes in Ontario in 1943, and electing a government in Saskatchewan in 1944 (Swartz, 1977, p. 320). Although these social democratic parties were not revolutionary, by any means, they forced through important social legislation, and demonstrated the potential for workers to organize for more fundamental change. By 1944, for example, Canada's Mackenzie King "could argue that class conflict had reached such a point that social legislation was the only alternative to socialism" (Finkel, 1977, p. 361).

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Communist parties also increased their power in European and Third World countries. In Italy, in the wake of "the turbulent round of strikes, agitations, and demonstrations of the period of late 1945 and early 1946," communists gained control over the Italian General Confederation of Labour and won almost a third of the seats in the 1948 elections (Horowitz, 1963, pp. 204, 213). In France, "in the fall of 1947, and again in the autumn of 1948, a strike wave of such intensity welled up as to suggest civil war rather than the give and take of industrial relations" (Shorter & Tilly, 1974, p. 137). Communists won representation of more than one-quarter of the electorate and challenged the rule of De Gaulle (Dunan, 1964, pp. 386-387; Willis, 1968, p. 185). A communist government took power in Yugoslavia, and would have in Greece if the British had not forcibily intervened (Dunan, 1964, pp. 388-389). This surge of international labour's power, combined with a perceived threat of Soviet expansion and of revolutions in China, Korea, and Vietnam combined to seriously menace the viability of capitalism, and particularly of U.S. power:

> There was a real danger that the United States might be left as an isolated island of capitalism, in a world "gone socialist." Her capitalist system, now expanded into a global empire, could not survive as an island in a non-capitalist world. Both her capitalist allies and enemies were virtually bankrupt or on the brink of collapse. Unless help was given to them quickly, to enemies and friends alike, America would herself face a massive economic depression and the peoples of these countries might well seek a solution in some form of socialist economy. (Greene, 1970, pp. 113-114)

In addition to these organized labour actions, more individual workers than ever were passively resisting management productivity

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demands, causing a threat to profits severe enough to weaken national economies. In England, an extensive survey of industrial workers found that 30 percent "suffered from some form of neurosis" which damaged their productivity (Aldridge, 1970, p. 84; R. Fraser, 1947). Absenteeism and rapid turnover of miners in the newly nationalized British mines (largely as a result of a new Taylorized work organization) were so pervasive that military draftees had to be sent there to supplement the employed work force (Trist & Bamforth, 1951; Willis, 1968, p. 269). In the United States, industry spokesmen claimed that productivity per industrial worker had declined more than 34 percent between 1940 and 1945 (Brecher, 1972, p. 226; Ford, 1946, p. 49). Specific personnel problems such as alcoholism, psychosomatic reactions, "accident proneness," "absenteeism", and "habitual rule infractions" soared (Rennie & Woodward, 1948, pp. 286-287; A. McLean, 1969, p. 23; Selekman, 1947, pp. 2-3).

Both business and governments recognized that the labour force had to be brought under control quickly in the United States and capitalist Europe. As they had in the past, Western businesses and governments reacted to this wave of labour unrest with strong anti-labour measures, including the use of police to break strikes, anti-union and anti-communist legislation, red-baiting, union spying, and vigorous public relations campaigns to discredit unions (Brooks, 1971, pp. 223-230; Center for Research, 1977, p. 43; Industrial Relations Committee, 1967; Rayback, 1966, pp. 394-401). This use of force limited new labour organization and in the U.S. forced unions

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into defensive battles to protect rights previously won, such as the closed shop, union discipline of its members, and maintenance-of-membership clauses (Brooks, 1971, p. 226; Jamieson, 1957, pp. 27-28; Rayback, 1966, pp. 398-416).

With the inauguration of the Cold War in 1946, attacks against communists began in earnest, sponsored by government, business, and conservative labour leaders (Jamieson, 1957, pp. 47-52; Rayback, 1966, pp. 407-408). Communist parties were forced out of the cabinets of Austria, Belgium, Finland, France, and Italy, and the influence of social democratic parties outside of Scandinavia dropped as they lost seats and soft-pedalled any relationship to Marxist class struggle (Barkin, 1975, pp. 2-3). Red-baiting witch hunts throughout the West destroyed communist-dominated unions and forced left-wing labour leaders, intellectuals, performers, and politicians out of their jobs (L. Brown & C. Brown, 1973, pp. 87-97; Brooks, 1971, pp. 227-229; Lamont, 1956; Red Strip, 1954; Wilson & Glickman, 1954). As Huberman and Sweezy (1955) argued, the central function of this red-baiting campaign was not nearly as much to insure internal security, as it was to impose "thought control" over the entire labour force:

> Once we adopt this hypothesis, everything immediately falls into place. From the point of view of effective thought control, what is needed is not the limitation of the system to areas of necessary secrecy, but on the contrary its expansion to the widest possible sector of the total employment field. What is needed is not criteria of trustworthiness, but criteria of self-regimented robotcy in the service of the status quo. (p. 86)

As in the past, industrial psychology programs to control labour unrest were developed to complement these hard line coercive

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measures. But this time, business leaders demanded that they be generated largely by government, rather than by private sources. As Rep. Priest successfully argued in his bill for a national mental health program, the problem of emotional control had become too large and complex for separate industries to handle:

> The mental health problem is so great that it requires the type of coordinated action by the Federal Government, the States and communities, and the professions and institutions, which has been so effective in other fields of public health. Despite the contributions of public and private organizations and of individuals, the Nation has not yet made real progress toward the goal of mental health because these efforts have been limited and have lacked coordination. (House Report #1445, 1945, p. 3)

In 1946, the United States passed the National Mental Health Act. This act established the National Institute of Mental Health with massively increased federal funding for basic research, training of psychiatric personnel (including general practitioners), and most important for establishing out-patient clinics specifically geared to treat non-psychotic adults (Deutsch, 1949, pp. 513-514; Connery, 1968, pp. 16-20; House Report #1445, 1945). The act explicitly <u>excluded</u> any aid for mental hospitals or their patients (Bloom, 1973, p. 8; Connery, 1968, p. 19). Instead, it focused squarely on the problems of working-age adults:

> The seriousness of the mental health problem has been brought to our attention very sharply by the experiences of the Selective Service System and the armed forces during the war. The Director of Selective Service testified that about 1,767,000 men were rejected for military duty because of mental or neurological diseases or defects....
>
> The experience of the armed forces is limited largely to the male population between the ages of 18 and 37. ... A much larger number of people, although not hospitalized, suffer because of what their minds or emotions subtract from

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> their otherwise normal existence or performance....
>
> ... Unless prompt and vigorous action is taken, the Nation has reason to expect during the postwar period a material increase in the volume of delinquency, suicide, homicide, and alcoholism -- all of which are commonly symptoms of psychiatric disorder. (House Report #1445, 1945, pp. 3-4)

Industrial and military influence dominated the formation of NIMH. The act was drafted in close consultation with "the chief psychiatrists of two military services: Dr. William Menninger, army; Dr. Francis Braceland, navy: and Dr. Jack Ewalt, who was consultant to the air force" (Foley, 1975, p. 4). Administrators of state mental hospital services were not consulted. Testimony supporting the act came primarily from military and industrial sources. The three key witnesses were General Lewis B. Hershey, director of the Selective Service System, G. S. Stevenson, medical director of the National Committee for Mental Hygiene, and Burlingame, a prominent industrial psychiatrist (Connery, 1968, pp. 16-17; National Committee, 1944, pp. 35-36). Business control over NIMH was institutionalized in the National Advisory Mental Health Council, the policy-making overseer of the Institute. Of its first six members, at least three were industrial psychiatrists (two of whom had directed the U.S. wartime psychiatric program), and two were leaders of the National Committee for Mental Hygiene (Connery, 1968, p. 16; Deutsch, 1949, pp. 325, 466, 472; Tallman, 1943, 1944a, 1944b). Far from being a rubber-stamp, the National Advisory Council "over the next decade ... assisted, checked, and in at least two instances ... directed Dr. Felix [Director of NIMH] to adopt programs that he initially did not favor: the development of pharmacology and the psychiatric training

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program for general practitioners" (Foley, 1975, p. 5). In addition to this formal authority, business interests worked behind the scenes to direct the focus of NIMH (Foley, 1975, pp. 6-9):

> Key bargains struck with Mary Lasker [a philanthropist who was prominent in the National Committee for Mental Hygiene] and Mike Gorman [a lobbyist supported by the National Committee and Lasker] were necessary to obtain increased appropriations.
>
> Lasker pushed NIH directors to translate basic research into applied services. The fact that Felix [NIMH Director] designed and maintained a psychiatric organization that promoted applied research and demonstration services was consistent with her desires. Gorman was also sympathetic to Felix's revulsion toward traditional care in state mental hospitals. "My hidden agenda," he said recently, "was to break the back of the state mental hospital." (p. 8)

These business interests, over Felix's objections, won Congressional appropriations of two million dollars in additional funds for psychopharmacology, and over the protests of the American Psychiatric Association, won funding for training psychologists, nurses, psychiatric social workers, and general practitioners (Foley, 1975, pp. 8-9).

Following the lead of the United States (and in many cases, at its urging) many other Western countries inaugurated similar national mental health programs, which were also oriented to treating primarily non-psychotic, working-age people (Allodi & Kedward, 1977; Bremer, 1961; Chrichton, 1975; Expert Committee, 1953; Hincks, 1945; McKerracher, 1966, pp. 5-18; Rees, 1959; Schumacher, 1948; Stogdill, 1949). As in the United States, business and military leaders played a major role in both promoting and shaping these programs. The industrially financed International Committee for Mental Hygiene (an offshoot of the National Committee for Mental

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Hygiene) created the World Federation for Mental Health in 1948 to work closely with the World Health Organization (Deutsch, 1949, p. 330). Brock Chisholm, former Director of the Canadian Army General Medical Services, was the General Secretary of the WHO at the time, and he strongly supported this alliance (Chisholm, 1948, pp. 47-48; Deutsch, 1949, pp. 516-517). J. R. Rees, wartime chief of the British Army's psychiatric service, was elected as the first president of the World Federation (Deutsch, 1949, pp. 330, 517). G. R. Hargreaves, a leader of British industrial psychiatry, co-ordinated the WHO's Expert Committee on Mental Health (Expert Committee, 1953; Mindus, 1953, p. 17).

In Canada, C. M. Hincks, founder and director of the Canadian National Committee for Mental Hygiene (an affiliate of the U.S. National Committee), strongly influenced public mental health policy. In 1946, he advised the Saskatchewan government to set up a public community psychiatry program similar to the U.S. model (Hincks, 1946). This consultation became a major stimulus for the Saskatchewan Plan for Mental Health, which, in turn, served as a model for national Canadian mental health policy (Lawson, 1967; C. Smith, 1974, pp. 13-14). The psychiatry departments at McGill University and the University of Toronto, during the post-war years, showed "great interest in the mental health problems of industry," and worked closely with industrial relations departments of private companies, for example running training conferences for managers and supervisors (Mindus, 1953, p. 19).

The new community psychiatry programs drew heavily on the

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innovations of military and industrial psychology. They emphasized early diagnostic testing and brief individual or group talking therapies (often combined with shock therapy), which were conducted in outpatient clinics or general hospitals, and staffed by multi-disciplinary mental health teams (Expert Committee, 1953; Love & Hobbs, 1971; Maclay, 1961; Ozarin, 1962; Stogdill, 1949). They also provided extensive free consultation to private businesses, and welcomed referrals of problem employees for treatment (Yolles, 1967).

As public community psychiatry programs took over many industrial psychology functions, the number of private industrial psychology programs fell after the war (A. McLean, 1969, p. 23). But private industrial research still created many of the remaining major technological innovations of community psychiatry. The Dupont and Eastman Kodak Companies, for example, launched the first alcoholism treatment programs during the early 1940's, developing methods which have since been incorporated into public alcoholism programs (D'Alonzo, 1961; Levinson, 1957; Occupational, 1973, p. 5). Group therapy techniques were refined by Kurt Lewin to help train business supervisors in human relations skills (Bucklow, 1976; Lewin, 1948). And most important, private drug companies in France, Belgium, Switzerland, and the United States developed the technology of mood-altering drugs (Caldwell, 1970, pp. 23-56; Ey, 1962; Segal, 1975, p. 333).

In contrast to this booming treatment of non-psychotic, ambulatory clients, few of these programs, either public or private, paid more than lip service to improved care of institutionalized

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psychotic, aged, or retarded patients. The new community mental health centres were explicitly designed to exclude chronic patients, and to treat only those who could benefit from outpatient therapy or brief hospitalization (Expert Committee, 1953). By the early 1950's momentum was building to move chronic patients into even cheaper, non-psychiatric facilities (Dorgen, 1958; Fein, 1958; Love & Hobbs, 1971, p. 81; Maclay, 1961; Rothman, 1972; Scull, 1977). The vast majority of chronic patients, throughout the West remained seriously neglected. In England, Hargreaves (1959) reported that mental hospitals:

> all remain geographically separate, and often remote from other medical activities. They inherit buildings and equipment which would not be tolerated in general hospitals. The staffing ratios are far worse than even the chronic general hospitals and ... some regional hospital boards ... give the impression that they set themselves much lower standards for their mental hospitals than they do for any other medical institutions. (p. 358)

In Canada, Richman (1966) echoed this testimony:

> It was the day of the "snake pit" hospital -- bars, locks, restraints, "herding" and all the rest.
>
> In 1948 almost all treatment of severely ill psychiatric patients was conducted at provincial mental hospitals, often located in isolated areas. Patients were denied any legal process and retained in locked wards. Because of under-staffing and lack of funding, the emphasis was on custody rather than therapy. Patients and their families used the hospital only as a last resort. (p. 34)

To summarize, both during and after World War II, labour unrest and alienation was so severe that it threatened the economic and political future of capitalism. The problem was too widespread, and labour too well organized for separate employers to be able to contain it. In self-defense, the Western governments dramatically

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expanded their involvement in controlling and regulating the labour force, a function, which until then had been by and large the domain of private employers (with government support in emergencies). One of the products of this trend was community psychiatry. Relying heavily on the leadership and insights of industrial psychology, the early community psychiatry movement had very little concern with or impact on unemployable, institutionalized populations. Instead, it addressed the task of reducing the discontent of active and potential members of the labour force.

5.3 Technological innovations (1954-1962)

By 1954, the organizational foundations for community psychiatry were well established. Government agencies had been created to conduct research, train personnel, and set up out-patient and short-term hospitalization treatment. New legislation had facilitated voluntary admissions to psychiatric treatment and increased the power of mental hospitals to discharge chronic patients (Ozarin, 1962; Rees, 1959; Yolles, 1969).

The next task was to create a technology capable of effectively treating the 30 to 40 percent of the labour force which was estimated to have (or to cause employers to have) problems (J. Brown, 1954, pp. 265-266; Cruickshank, 1955, p. 475; Gadourek, 1969, p. 195; Plumb, 1954). [Note that this estimate is double the proportion of disturbed workers reported in 1919 (see p. 93). This increase may be attributed both to the more destructive pressures of work (see p. 148) and to the expanded definition of mental illness (see p. 117)]. As a prominent industrial psychologist

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explained:

> Large numbers of persons once classified as merely socially hazardous (to themselves and/or to others) have now been formally added to the ranks of the sick. This is a major advance, but [it] will not achieve its full meaning until these cases elicit ... the same types of research effort which has brought other forms of illness within range of effective prevention and treatment.
>
> To be satisfactory, treatment for these persons ... should be capable of large scale application with personnel and physical facilities which are available or easily developed. No existing method of therapy for these persons fully meets these requirements. (Kolb, 1968, p. 335)

All the treatment methods for non-psychotic emotional problems developed by 1953 required lengthy contact with trained therapists. Although both the length of treatment and the amount of training required of auxiliary workers had been significantly reduced during the war, talking therapies were still prohibitively expensive and too labour intensive to use on a mass basis. As one industrial psychiatrist complained, talking therapies just "do not lend themselves to assembly line methods" (Levinson, 1960, p. 207). Mindus' (1953) survey of international industrial psychology programs documented that, even with extensive government support, "psychiatric treatment is still very expensive and can seldom be given to low salaried workers" (p. 3). Industrial and government authorities bemoaned the monumental expense and personnel required to treat all those who "needed help" (Albee, 1959, 1961; Fein, 1958; Kline, 1957, p. 208; Munden, 1960; Levinson, 1960).

Furthermore, the results of these talking therapies were far from reliable. After all, it is hard to keep convincing people that their problems are irrational and that they must adapt, if their "symptoms" occur precisely because they have been pushed past

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the tolerable range of adaptation. Union members were becoming even more hostile to industrial psychology programs, which they justifiably suspected of attempting to subvert grievances and of co-opting the union's advocacy role (Collins, 1956, pp. 546-547; Gomberg, 1957; Labor looks, 1954; Mindus, 1953, p. 3; Stagner, 1963; Wade, 1956; Whyte, 1956). And at the same time, workers were reluctant to use the new public psychiatric clinics because of the stigma associated with public psychiatry (D'Arcy & Brockman, 1976; Foley, 1975, p. 14; Goffman, 1963).

As a result, during the 1950's both business and government invested heavily in research to develop methods to treat large masses of people cheaply and in more neutral settings. Between 1948 and 1960, NIMH's budget increased almost fifteen-fold, from $4.5 million to $67.4 million (Connery, 1968, p. 22). Military spending on psychiatric research also boomed (Bylinsky, 1978, pp. 5-7; Delgado, 1969, p. xx; Langer, 1968, p. 128). The Ford Foundation committed fifteen million dollars for research on mood-altering drugs, and other private foundations followed suit (Fifteen million granted, 1955; Gravley, 1963; Levinson, Price, Munden, Mandl & Solly, 1963, p. viii). Pharmaceutical companies, for reasons of self-interest, also invested significant amounts in developing mood-altering drugs (Silverman & Lee, 1974).

From this effort, two therapeutic innovations emerged in the mid-1950's which together created the technological foundation to put therapy on a mass basis: behavior modification and psychopharmacology.

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Behavior modification is based on the assumption that people can and should be made to adapt to a relatively unalterable "reality" (Eysenck, 1960; Ferster & Skinner, 1957; Mikulas, 1978; Skinner, 1971; Skinner & Lindsley, 1954; Wolpe, 1969). Patients receive reinforcements for "appropriate" behavior, and are not reinforced and sometimes are punished for "inappropriate" behavior. Standards of desirable behavior are external and arbitrary, entirely under the control of the therapist. It is a model taken almost directly from Taylorized industrial labour relations, where arbitrary production methods and goals are set by the employer, and workers are paid ("reinforced") for meeting them, and are docked wages (not "reinforced") or reprimanded ("punished") for under-producing or breaking company rules. From the perspective of employers and administrators of institutionalized populations, behavior modification was a godsend; cheaper, faster, and more reliable in eliminating "symptoms" than the earlier therapy methods. Training in behavior modification is relatively easy, so "therapists" can be produced quickly and cheaply (Ayllon & Michael, 1959). In fact, "therapy," can be fully automated, and performed entirely with tapes (Migler & Wolpe, 1967; Slack, 1960). Unlike insight or client-centered therapies, behavior modification requires no trust or intimacy between therapist and client, and does not aim to improve either the patients' insight or their happiness. Instead, obedience is its only criterion of "improvement." It is an ideal management tool.

As a result, behavior modification quickly grew popular, dominating all other talking therapies. For example, in 1957, NIMH

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devoted only 8 percent of its "psychosocial" (i.e. talking) treatment research to behavior modification; but, by 1973, its share had grown to 55 percent (Segal, 1975, p. 329). The impact of behavior modification has been particularly strong on those defined as having "behavior disorders." In addition to prisoners and delinquents, unreliable workers have been singled out as a prime target group (Follman, 1976; Gravley, 1963; Lotterhos & Waldrop, 1972; Masi & Spencer, 1977; McCallum, 1979; Ralston, 1977). Although some voluntary behavior modification programs exist for middle class patients (such as smoking and phobia clinics), the majority of behavior modification programs are coercive and involuntary, designed to increase the obedience of unruly populations (Behavior modification case study, 1979; Behavior modification in prisons, 1979; Holland, 1975; The resistable rise, 1977).

Mood-altering drugs have been even more influential than behavior modification in putting psychotherapy on a mass basis. Since World War II, Western researchers had been exploring the idea of using these drugs both as weapons and as tools to improve workers' (and soldiers') stress tolerance and working capacity (D. Cuthbertson & Knox, 1947; D. Davis, 1947; Evans, 1968, p. 1004; Ey, 1962; Graf, 1950; Hauty & Payne, 1958; Hersh, 1968; Ivy & Goetzl, 1943; Joyce, 1968; Langer, 1968; Newman, 1947; Rothschild, 1964). This research was oriented explicitly to treat "normal" subjects.

The U.S. military and the CIA were "among the first large-scale users of mind-influencing drugs" (Bylinsky, 1978, p. 5). Their priorities included: (1) finding ways to improve the efficiency and reliability of military personnel, (2) developing hallucinogenic,

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incapacitating, fear-inducing, and pacifying drugs for use as weapons and as espionage tools, and (3) creating antidotes to these mind-altering drugs as defenses against both Soviet drug weapons and accidental exposure of U.S. troops (Bylinsky, 1978, pp. 5-8). As early as 1953, the military and the CIA had experimented with inducing LSD psychoses in normal people (often without their knowledge or consent), and they encouraged research to develop chlorpromazine, the first major tranquilizer, as an antidote to LSD (Bylinsky, 1978, pp. 152-154; Caldwell, 1970, pp. 35, 79; Evans, 1971, p. xix; Schwarz, Bickford & Rome, 1955). During the late 1950's, the U.S. military Chemical Corps waged a hard-sell campaign to win public acceptance (and more funding) for research on mood-altering drugs:

> In one four-month period in 1959, at least nine major newspapers and magazines carried lengthy feature articles or series on the CBW [Chemical and Biological Warfare] program. Other pro-CBW articles were published in medical journals, Sunday supplements, and ... periodicals. ... In addition Chemical Corps officers appeared before a closed Congressional hearing and later made dozens of speeches, all aimed at extolling the virtues of the psych-chemicals, and the notion that they could lead to humane warfare. (Hersh, 1968, p. 54)

In other words, much of the initial impetus for developing mood-altering drugs (including those which were used primarily to treat chronic mental patients) grew out of military interest in their use as social control agents. By 1959, the investment had paid off. Tranquilizers, barbiturates, amphetamines, anti-depressants, anti-convulsants, hormones and a number of other categories of mood-altering drugs were being used to treat both chronic mental patients and non-psychotic, ambulatory workers. (Davidoff, Best & McPheeters,

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1957; H. Fraser, 1958; Holliday & Dillie, 1958; Lehmann, 1960; Marquis, Kelly, Miller, Gerard & Rapoport, 1957; McGuire & Leary, 1958; Norbury, 1957; Paredes, Gogerty & West, 1961).

The mood-altering drugs provided the major technological solution to community psychiatry's two problems; on the one hand, cutting public responsibility for chronic mental patients; on the other establishing emotional regulation of the labour force on a mass basis. Mental hospital administrators quickly recognized the potential usefulness of the major tranquilizers, chlorpromazine and reserpine ,to make psychotic patients far easier to manage (Furman, 1955; Laurence, 1955; Weaver, 1955). These two drugs immediately halved the labour costs of in-patient, chronic, psychiatric care:

> Agitation, irritability and quarrelsomeness, Dr. Salinz reported, disappeared within six to twenty-four hours after the drug had been given. As a result of the therapy, he said, the man-hours spent by psychiatric aides, nurses and doctors on such [chronic] patients was decreased by an average of 50 per cent. (Laurence, 1955)

More important, the major tranquilizers made possible massive discharges of formerly unmanageable, chronic mental patients (Brill & Patton, 1957, 1959, 1971; Furman, 1955; Laurence, 1955; Weaver, 1955). In Canada, the United States, England, France, and Sweden, the number of patients resident in mental hospitals dropped abruptly in 1955 when the major tranquilizers were introduced (Allodi & Kedward, 1977, p. 221; Brill & Patton, 1961, p. 434). It is important to emphasize that these drugs were not the "reason" for this trend. Rather they were tools to implement an already existing policy of phasing out chronic psychiatric care (D'Arcy, 1976a; Dorgan, 1958; Kramer, 1977; Love & Hobbs, 1971; Scull, 1977, pp. 139-151;

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see also pp. 110-111, 127). Nor were they intended to improve patient care, as much as to cut costs (Brill & Patton, 1957, 1979; Furman, 1955; Laurence, 1955; P. Schrag, 1956; Scull, 1977, pp. 139-151).

Although the major tranquilizers made patients more manageable, few claimed that they cured them or even made them happier. These drugs show high rates of seriously debilitating or fatal side effects (R. Bell, 1958; Chandler & Sallychild, 1977; Crane, 1973; Mintz, 1967, pp. 194-196; Norris, 1971; Silverman & Lee, 1974, pp. 271-274). Even the "main" intentional effect of the major tranquilizers addresses the patients' manageability far more than their recovery (Janke & Debus, 1968, p. 326). As John Gillis (1975) pointed out:

> Chlorpromazine [Thorazine] ... may generate a kind of "cognitive dampening," a diminution in the recipient's ability to bring cognitive functions effectively to bear on any complex learning situation, whether it is social or interpersonal..... On any view of psychotherapy various kinds of interpersonal learning must be involved. One member (the patient) is expected to learn something _from_ the other (the therapist) about how to conceptualize, react to, or cope more effectively with his environment.... The implication is straightforward -- some, at least, of the psychoactive chemicals appropriately used to control psychotic _behaviors_ ... may nevertheless render [the patients] less susceptible to other forms of treatment.... (p. 183)

Mark Vonnegut (1975) eloquently describes the resulting dehumanizing experience of taking these drugs:

> The side effects were bad enough, but I liked what the drug was supposed to do even less. It's supposed to keep you calm, dull, uninterested and uninteresting. ... What the drug is supposed to do is keep away hallucinations. What I think it does is just fog up your mind so badly you don't notice the hallucinations or much else....
>
> On Thorazine everything's a bore. Not a bore exactly. Boredom implies impatience. You can read comic books and "Reader's Digest" forever. You can tolerate talking to jerks forever. Babble, babble, babble. The weather is dull, the flowers are dull, nothing's very impressive. Muzak,

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> Bach, Beatles, Lolly and the Yum-Yums, Rolling Stones. It doesn't make any difference. (pp. 252-253)

At the same time, the minor tranquilizers -- meprobamate (Equanol, Miltown) and later chlordizopoxide (Librium) and diazepam (Valium) -- were revolutionizing treatment of employable people. In comparison to earlier drugs for non-psychotic people (e.g., amphetamines, barbiturates, and narcotics), the minor tranquilizers relieved tension and anxiety with far less damage to the patient's alertness, intelligence, concentration, or motor skills (R. Bell, 1958, p. 587; F. Berger & Potterfield, 1969; H. Fraser, 1958, p. 567; Hoch, 1957, p. 415; Larned, 1975; Lehmann, 1960, p. 526).

With these drugs, the stress-related symptoms of workers and potential workers could be controlled on a mass basis, cheaply, quickly, and in the neutral setting of the doctor's office. They seemed the ideal treatment for making workers more efficient and less unhappy. A prominent Army researcher explained:

> It can be demonstrated that we can improve human efficiency and sense of well-being by the administration of psychotropic drugs. These facts lead to the possibility of reducing variations in efficiency of the <u>normal</u> human to a minimum around a point of optimal functioning and well-being by the use of the correct psychotropic agent or combination of agents. Possibly, the time may even come when chemicals .:. will be able to raise this optimal level.... (Evans, 1968, p. 1007, original emphasis)

Other researchers predicted even more dramatic results:

> Those of us who work in this field see a developing potential for nearly total control of human emotional status, mental functioning, and will to act. These human phenomena can be started, stopped, or eliminated by the use of various types of chemical substances. (Bylinsky, 1978, p. 4)

Employers' interest in applying this new drug technology to workers boomed in the 1950's. Many articles appeared exhorting

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managers that "emotions can be dangerous" (Spriegel, 1956), and looking hopefully to drugs to minimize "the impact of emotions on production and safety" (Drucker, 1954; Ewalt, 1960; Felix, 1956; Industry is, 1956; Janke & Debus, 1968; Lehmann, 1960; MacIver, 1962; MacIver, A. McLean, Herzberg, Burling & Roethlisberger, 1962; A. McLean, 1969, p. 26; McMurry, 1960; R. O'Connor, 1958; Singer, 1960; Whitney, 1960). Entire issues of industrial journals were devoted to this problem and there were many conferences among major corporate executives to discuss the mental health of their workers (Collins, 1962, p. 604; Habbe, 1960; A. McLean & Wohlking, 1962). The number of U.S. company-run mental health programs jumped to over four hundred by 1963 (Gravley, 1963).

The U.S. government co-operated with business in speeding tranquilizers onto the market. The Food and Drug Administration relaxed regulations requiring safety and double-blind studies, and allowed the pharmaceutical companies to mount a massive publicity campaign which made highly inflated claims about the appropriate use and safety of tranquilizers (Mintz, 1967, pp. 186-295; Silverman & Lee, 1974, p. 292; Waldron, 1977). In 1959, NIMH set up a psychiatric training program for general practitioners aimed at making mood-altering drug prescriptions by family doctors the main source of treatment for employable people (Robertson & Shriver, 1964, p. 926).

Under these pressures, the number of people who received mood-altering drugs increased almost geometrically. In 1957, U.S. patients received 35 million prescriptions for mood-altering drugs

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(Kline, 1957, p. 211). By 1968, the number had risen to 160 million, and by 1976 they accounted for 250 million prescriptions per year (Kline, 1968; Pekkanen, 1976, p. 14; Silverman & Lee, 1974, p. 293). By 1972, Valium and Librium, two minor tranquilizers, were respectively the first and the third most frequently prescribed drugs in the United States (Waldron, 1977, p. 38), and psychotropic drugs as a class accounted for almost 30 percent of all U.S. drug prescriptions (Muller, 1972, p. 488). A 1978 national survey in the United States revealed that:

> 31 million U.S. women, or 42%, have used tranquilizers, compared to 18 million, or 27% of men.
>
> Sedatives have been prescribed for 21% of all women, or 16 million, compared to 17% or 11 million men.
>
> 12 million women, or 16%, have been prescribed stimulants, twice as often as the 5 million, or 8%, of men receiving such drugs. (D. Lamb, 1978, p. 11)

Similar trends have been found in other Western countries (Cooperstock, 1973; Harding, Wolf & Chan, 1978; Rogg & Pell, 1963; Silverman & Lee, 1974, p. 293). Most of these drugs are prescribed by general practitioners without any additional psychotherapy (D'Arcy, 1976c; Waldron, 1977, p. 39).

The largest category of mood-altering drugs, the tranquilizers, are designed specifically to treat normal people "who are only temporarily disturbed by stressful environmental conditions" (Berger & Potterfield, 1969, p. 38; Evans & Kline, 1969, 1971).

Like the major tranquilizers, these minor tranquilizers do nothing to cure the underlying causes of patients' symptoms. Instead, their function is uncomfortably close to that which William Saroyan satirically attributed to aspirin:

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> It *is* helping to keep people going to work.... It *is* sending millions of half-dead people to their jobs.... It *is* deadening pain everywhere. It isn't preventing anything, but it is deadening pain. (Saroyan, quoted in Kline, 1957, p. 208)

Like the major tranquilizers, they cause a number of serious side-effects, including dizziness, blurred vision, lowered blood pressure, liver damage, blood diseases, hallucinations, nausea, rashes, and acute rage (Larned, 1975, p. 27; Doig, 1978; Norris, 1971; Silverman & Lee, 1974, p. 273).

In addition to behavior modification and psychotropic drugs, the 1950's saw refinements in electro-convulsive therapy and psychosurgery which made these treatments safer, cheaper, and more applicable to depressed or anti-social, non-psychotic patients (Balasubramanian, Kanaka & Ramamurthi, 1970; B. Brown, Wienckowski & Bivens, 1973; Crow, Cooper & Phillips, 1963; Fulton, 1951; Kalinowsky, 1961; Lindstrom, 1954; Lindstrom, Moench & Rounanek, 1964). Although electro-convulsive treatment is used to treat depression, many theorists deny that it has real therapeutic value, other than inducing forgetfulness and docility, and they point out that shock therapy causes serious brain damage and permanent memory loss (Friedberg, 1976; Network, 1977; Weitz, 1979). Under the original ("unmodified") method of ECT, patients frequently experienced compression bone fractures and were unable to speak coherently afterward. The refinements consisted primarily of giving sedatives and muscle-paralyzing drugs and only shocking the right (non-verbal) side of the brain. Although these modifications did eliminate fractures and babbling, brain damage to the non-verbal side of the

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brain is as severe as ever, and patients die more often from cardiac shock and failure to breathe (Friedberg, 1976; Kalinowsky, 1961). Many patients testify that the treatments either way are terrifying and that the memory loss is debilitating and upsetting (Network, 1977).

Psychosurgury operates by destroying the capacity of portions of the brain to respond emotionally. It is used particularly on prisoners and other "socially hazardous" people as an explicit social control mechanism, with hardly any pretense of being "therapeutic" (E. Baker, Young, Gauld & Fleming, 1970; Balasubramanian, Kanaka & Ramamurthi, 1970, B. Brown, Wienckowski & Bivens, 1973; Delgado, 1969; Delgado, Mark, Sweet, Ervin, Weiss, Back-y-rita & Hagiwara, 1968; Kohler, 1976; Newell, 1979).

All of these therapeutic innovations treat patients as flawed objects requiring external control; as "emotional contaminants" whose "behavior" threatens social order (Bellak, 1969). Nowadays, anyone who regularly or deeply feels unhappy, anxious, angry, or anti-social, no matter how valid these feelings, is considered "ill" and urged to get treatment. These treatments do nothing to help people deal more realistically with their alienated situations. Rather than offering either practical help or personal insight, they are designed only to minimize the "symptoms" as quickly and as cheaply as possible. At best they only patch patients up enough to allow them to go on coping at work, behaving at school, or putting up with the tension and emptiness of unemployment and isolated child-care.

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It is debatable whether these forms of treatment can properly be considered "therapy." "Therapy" which damages our ability to perceive anxiety, pain, tension, and anger ultimately reduces their ability to defend themselves from the social causes of their feelings. Substantial research has demonstrated that suppressing stress-related symptoms may precipitate even more emotional and physical damage in the long run (without even considering the direct side-effects of these treatments) (Caligari, 1978b, 1979; Eyer & Sterling, 1977, p. 35; Lennard & Bernstein, 1973; McGuire & Leary, 1950, p. 503; Melzack, 1961). Treatment which adapts us to damaging situations is not therapeutic, but only anaesthetic. As Eyer and Sterling (1977) conclude:

> It seems just plain inappropriate to view these [psychogenic] diseases as mere technical defects in the body's machinery rather than as dramatic evidence of the fear and pain pervading people's lives. Even if technical advances can be developed cheaply, they are not an appropriate response. ... What sort of society ... deals with the problems of 9 million people by destroying their capacity to *feel* tension and anxiety? (pp. 34-35)

In summary, we see that during the period from 1954-1962, public agencies and private industrial psychologists co-operated to develop a technology which could control the emotional symptoms of both working class and unemployable people. Innovations in treating chronic mental patients were oriented primarily toward reducing the costs of their care and toward discharging them from public responsibility. On the other hand, the new treatments for working class people were designed to increase their (short-term) tolerance for stressful working conditions. They markedly increase worker productivity by cutting down on absenteeism, alcoholism, and

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interpersonal friction (Alcoholism, 1960; Gravley, 1963; Masi & Spencer, 1977; McCallum, 1979; Ralston, 1977). Counselling and drugs make workers more tolerant of dangerous working conditions and help them adjust to near-accidents (Felton & Wilner, 1969, pp. 213-215; Modlin, 1976; R. O'Connor, 1958). Most important, they mute labour militancy (Ross, Powles & Winslow, 1965). By anaesthetizing workers individually, the new treatments prevent them from collectively recognizing problems and acting on them. They only "help" workers to bear their "madness" -- alone.

Unlike earlier periods of psychological innovation in treating workers, this surge of research did not occur as a result of either high productive demand or labour militancy within the United States. In the wake of anti-labour and anti-left repression, labour militancy in the United States (as well as in Britain, France, and Canada) was relatively low from 1954-1962 (Hutt, 1975, pp. 196-215; Lipton, 1967, pp. 301-317; Shorter & Tilly, 1974, p. 410). The AFL and the CIO merged in 1955 under a conservative union leadership committed to expelling "communists" and co-operating as much as possible with management (Rayback, 1966, pp. 413-434). As George Meany (1956), then President of the AFL-CIO, explained:

> In the final analysis, there is not a great difference between the things I stand for and the things that NAM [National Association of Manufacturers] leaders stand for. I stand for the profit system; I believe in the free enterprise system completely. I believe in the return on capital investment. I believe in management's right to manage.
>
> ... no union can gain anything -- I am speaking now of American unions, not a Communists-controlled [sic] union -- no union can gain anything by putting the fellow out of business who fills the pay envelope. The interests of the

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> worker and the employer must be identical ... because they have both got to get their livelihood from whatever is produced by the industry.
>
> I feel that unity of American labor, under the new AFL-CIO, presents no threat ... to American management. (pp. 10-11)

As the AFL-CIO shied away from organizing new workers, the proportion of non-agricultural workers who belonged to unions dropped from 34.7 percent in 1954 to 28 percent in 1966 (Brooks, 1971, p. viii; Handbook on labor statistics, 1968, p. 300). Strikes during this period were fairly mild and involved less than five percent of the U.S. labour force (Handbook on labor statistics, 1968, p. 301). The resulting weakness of labour's influence was reflected in its failure either to elect the pro-labour Stevenson or to get the Taft-Hartley Act repealed (Rayback, 1966, pp. 413-434).

Nor was this period one of particularly high productive demand in the United States. During the 1950's the U.S. productive growth rate slackened in comparison to other industrial countries and also in comparison to growth rates in the previous decade (Derber, 1970, p. 425; Indexes of output, 1972, p. 1; Kuznets, 1964, p. 98). The United States suffered recessions in 1953-1954 and in 1957-1958, and unemployment rose from 3.1 percent in 1952 to 5.5 percent in 1959 (Derber, 1970, pp. 424-425).

However, this divergence from the tendency of community psychiatry innovations to occur in response to labour militancy or high productive demand does <u>not</u> imply that their social control function had ended. During the 1950's the United States was establishing itself as the dominant world imperialistic power.

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> U.S. direct foreign investments alone increased more than sevenfold between 1946 and 1966 -- from $7.2 billion to $54.6 billion. By 1964, sales of U.S. goods abroad had tripled since 1950, and the size of the foreign market for U.S.-owned firms in 1965 was equal to approximately 40 percent of the domestic U.S. output of farms, factories and mines. Indeed, U.S. firms abroad constituted the third largest economic unit after the U.S. and Soviet domestic economies. (Horowitz, 1969, p. 232)

Between 1949 and 1959 alone, U.S. companies more than doubled their investments overseas from $11 billion to $30 billion (M. A. Brown, 1972, p. 83).

As a result, the labour force of U.S. business expanded to encompass workers and peasants in many other countries. In large measure, corporations financed the relative prosperity of U.S. workers during the 1950's (which contributed to their passivity) by "superexploiting" workers in the Third World and unorganized workers in developed countries (e.g., women, immigrants, and minorities) (Amin, 1980, pp. 21-22). As David Horowitz (1969) points out, this policy was adopted deliberately to protect capitalist stability:

> In the calculations of U.S. leaders -- from William McKinley to Franklin Roosevelt, from Woodrow Wilson to John F. Kennedy and Lyndon Johnson -- the preservation of American prosperity and institutions and of "the American way of life" has been predicated on the preservation and extension of U.S. control of foreign markets, and thus the inevitable expansion of U.S. power overseas. Viewed in this perspective, the cold war can be seen as the U.S. ruling class evidently sees it, namely, as a war for the American frontier. (p. 234)

To squeeze high profits from these Third World workers and to prevent them from revolting, the United States financed both overt military and police expansion and covert methods to condition and pacify workers on a mass basis (R. Brown, 1979; J. Henderson & R.

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Cohen, 1979). The innovations of community psychiatry developed largely in this context.

Nor had community psychiatry's social control functions ended even for U.S. industrial workers. Although, during the 1950's, both labour unrest and productive demand were relatively lower than during the 1940's, they still remained significant. Most major U.S. industries recorded large increases in productivity in this decade (albeit smaller than the increases in countries recovering from World War II devastation) (Indexes, 1972; Kuznets, 1964, pp. 99-100). For example, steel workers increased their productivity-per-man-hour by one third and iron workers increased theirs by two-thirds between 1949 and 1961 (Indexes, 1972, pp. 7, 59). This increased productivity was won at the expense of workers' job security and working conditions. During the 1950's automation and Taylorization became far more intense in established industries, and spread to white collar sectors of the labour force (Braverman, 1976; Brooks, 1971, pp. 263-286; Meltz, 1969). By the mid-1950's, evidence had begun to accumulate that workers were becoming less satisfied with their jobs and were reflecting this dissatisfaction in alarmingly high rates of "behavioral disorders" (Eyer & Sterling, 1977, p. 26; Illson, 1955; Plumb, 1954). The dramatic increase in the number of corporate mental health programs during this period reflects the importance placed by business on controlling these reactions. Under the growing pressures of post-war Western economic competition, massive Soviet economic and military strength, and the threat of revolution in Third World countries, businesses became even more

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committed than in the past both to intensifying the Taylorized organization of work and to expanding the technology with which to control the resulting dissatisfaction of workers (Ferguson, 1964; Geller, 1979, p. 42; Horowitz, 1969, p. 208).

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5.4 Community psychiatry in a threatened empire (1962-1980)

The U.S. Empire threatened

Since 1962, the United States has faced growing challenges to its pre-eminent position as the major world power. The Soviet Union has posed a rising military threat, spreading its own sphere of influence into what the United States has considered "its" sphere of influence, beginning with the Cuban missile crisis in 1962, and extending into South America, Western Europe, the Middle East, Africa, and Southeast Asia. Though offering no direct military threat, China's successes in developing a socialist society also worried U.S. leaders, since, as the U.S. Joint Chiefs of Staff explained:

> The dramatic economic improvements realized by Communist China over the past ten years impress the nations of the region greatly and offer a serious challenge to the Free World. (Cited in Chomsky, 1972, p. 6)

Third World revolutionary movements have flourished in spite of massive military and economic attacks by the United States. With the U.S. defeat in Vietnam, and its subsequent losses in Angola, Mozambique, Zimbabwe, Nicaragua, Iran, and elsewhere, the U.S. hold over the Third World -- with its markets and cheap labour -- has slipped seriously.

The United States has also become increasingly vulnerable in its relations with other developed capitalist nations. The value of the U.S. dollar -- and the political influence its wields -- has been undermined by higher productive growth in Japan and Europe and by the creation of the European Common Market and OPEC (Organization

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of Petroleum Exporting Countries) (Red Star Collective, 1978, pp. 10-12; Peterson, 1971; Rostow, 1978, pp. 248-249). Unprecedented levels of military spending, deficit financing, corporate tax subsidies, and the expansion of consumer credit all helped to stave off economic crises, but since 1966, the U.S. economy has grown dangerously unstable (Huberman & Sweezy, 1967, p. 4; Red Star Collective, 1978, pp. 9-10). The United States managed to export some of its economic weaknesses to Europe through the 1944 Bretton Woods agreement which established the U.S. dollar as the international currency, but this system collapsed during the late 1960's, when Europe refused to support the U.S. dollar any longer (Sweezy, 1974, p. 7). Nevertheless debt financing of its military expenses and capital expansion has threatened not only the U.S. economy but also that of all other capitalist countries (Sweezy, 1979). Since 1974, the economies of major Western nations have become unstable, characterized by "stagflation," public fiscal insolvency, and resource crises (Dowd, 1976; O'Connor, 1973; Rostow, 1978, pp. 250-259, 358-362).

To shore up its fortunes, U.S. business and government have turned increasingly to the domestic labour force both to man the armed forces necessary to wage its counter-revolutionary battles, and to produce more profits to stabilize the economy at home and support military expenses abroad. But getting workers' cooperation has become even more difficult.

During the 1960's, militant movements among working class people re-emerged with new vigor. The conservative AFL-CIO leadership and business tried to confine labour struggles to narrow

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economic issues, but the civil rights, the anti-war, the women's and other grassroots movements generated massive political influence, which won progressive concessions and contributed to the U.S. defeat in Vietnam (Brooks, 1971, pp. 267-304; Center for Research, 1977, pp. 44-49). As Sweezy pointed out, "Vietnam has shown that the people of the United States are simply not prepared to support counter-revolutionary wars, nor are conscripted armies willing to fight them" (1974, p. 7). During the 1960's civil unrest, riots, and wildcat strikes rose in all the major Western countries, exploding in 1968 in a flood of militancy which rocked both political and economic stability (Piven & Cloward, 1971, p. 196; Shorter & Tilly, 1974, pp. 316-317).

> From 1968 until at least 1971 almost every country in Western Europe experienced its own milder variation of the turmoil that plagued French industrial relations after the student demonstrations there almost provoked a revolution.
>
> ... all saw some of their long-established institutions challenged. ... the unions were as much the subject of these challenges as any other bodies. ... It is not surprising that both unions and employers were driven to explore new ways of conducting their relations in the face of everything from unofficial and unauthorized wildcat strikes, through plant sit-ins and work-ins to enterprise seizures. (Crispo, 1978, pp. 8-9)

Like their European counterparts, many American workers carried their protests into their work places, challenging both management's authority to run its plants and the co-opting role of union labour leaders (Brecher, 1972, pp. 264-266).

In addition to these organized actions, the rising alienation and anomie of American workers has been expressed in mushrooming rates of individual absenteeism, alcoholism, drug use, sabotage, and other

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"behavior disorders" (M. Cooper, Morgan, P. Foley, & Kaplan, 1979; Follman, 1976, pp. 16-25; MacIver, 1969; Navarro, 1976a, pp. 87-88; Salpukas, 1972; Scher, 1973; Serrin, 1979; Sheppard & Herrick, 1972; Special Task Force, 1973, pp. 10-12, 29-75). Between 1965 and 1972, absenteeism and labour turnover more than doubled in the auto industry (Salpukas, 1972, p. 34). Nationwide, the incidence of people considered alcoholic in the United States more than doubled between 1963 and 1974, and employees with "an alcohol problem" now make up about ten percent of the work force (Follman, 1976, pp. 19, 79; Masi & Spencer, 1977, p. 20; Ralston, 1977, p. 51). The cost of alcoholism to "the American business community" has jumped from $2 billion a year in 1967 to $12.5 billion in 1976, and the cost of alcoholism to the American economy as a whole exceeds $25 billion (Follman, 1976, pp. 20, 81-82). Since 1960, government authorities report, drug addiction "has probably trebled or quadrupled" (Scher, 1973, p. 8). Among auto assembly-line workers, 15 percent were estimated to be addicted to heroin (Special Task Force, 1973, p. 86). Epidemic alcohol and drug addiction rates in the military have called into question the effectiveness of the U.S. armed forces (H. Foley, 1975, p. 128).

Corporate response

In view of the growing vulnerability of the U.S. economy and the instability of its political empire, neither business nor government could accept this level of "wasted" potential labour-power. As a Vice-President of ALCOA explained:

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> We have found it harder and harder to make a return on invested capital that will assure the company's continued capacity to serve people's needs for our product. Like many other industries, we are squeezed by the rising costs of labor, energy, materials, and services. To us, this underscores the importance of using wisely every resource we have, especially people.
>
> It is costly when an employee cannot do his job properly because of an emotional problem. In effect, we have lost part of an employee that we are paying for. (Fleming, 1976, pp. 57-58)

We should note that this concept of "wasted" production assumes that workers have not already been driven beyond the productivity that they can tolerate, and that it is only some perverse flaw in their constitution which prevents them from turning out what employers demand of them.

In the early 1960's businesses began to invest much more money in programs to treat the "emotional problems" of their workers (A. McLean, 1969, pp. 26-29). The dividends of these programs in reduced absenteeism and higher productivity were significantly higher than the costs of the programs themselves (Auster, 1967, p. 71; Gravley, 1963). A large proportion of what passes as treatment in these programs is simple coercion, based on the threat of job loss or disciplinary action (Franco, 1973; Masi & Spenser, 1977, p. 22). As one Navy expert explained: "Managers have to learn that early intervention using job threat to create motivation, and monitoring of recovery are extremely cost-effective business practices" (Pursch, 1979, p. 3). A high proportion of employee "alcoholism" programs are not limited to drinking problems, but treat "everyone with a deteriorating job performance" (Masi & Spenser, 1977, p. 22). The procedure described

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below, for example, is typical:

> The employee who has done a poor job, gone against plant policy, is always late, or has a poor attendance record would be put on record by his supervisor as being in work difficulty. Under this job threat, he would agree to see the more neutral employee assistance counselor. A psychiatrist would then determine the kind of treatment most likely to improve the employee's adjustment, whether it be ... lithium for hypomanic swings, an alcohol program with in-patient and out-patient therapy, or short-term individual psychotherapy to help him stop a pattern of reacting to work supervisors as to his despised father. ... The counselor would assist the troubled person to accept the proper treatment; he could even use some "constructive coercion" by reminding the employee of the supervisor's warning. (Myers, 1976, pp. 33-34)

By 1977, almost all of the 50 largest U.S. industrial corporations had established employee emotional treatment programs, and many other major employers had followed suit (McCallum, 1979; Ralston, 1977, p. 51).

Community psychiatry programs of the 1960's

Even more far-reaching than these direct employee treatment programs, has been business influence over public community psychiatry policy since 1960. Business leaders recognized that more essential than rehabilitating the particular emotional casualties of each business, was the need to establish a broad national program which could treat all workers -- both active and potential. For the welfare of particular businesses was becoming much more dependent on the political stability of the government and on the ability of the United States to mobilize effective armed forces. Much of the unrest of the 1960's emerged from populations which had not been part of the traditional industrial working class -- women,

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minorities, adolescents, university students, and the urban poor (Hymer, 1978, p. 28). Similarly, military draftees and recruits were drawn largely from low income, minority youth. These populations, relatively untouched by the employee mental health programs of large corporations, also had to be controlled. To provide "an alternative to chaos" (Yolles, 1968), industrial and military leaders began to press for a significantly expanded federal program of community psychiatry.

In 1960, the National Association for Mental Health (the new name of the National Committee for Mental Hygiene) successfully pressured the Democratic Party to include a plank in its platform promising to provide "greatly increased Federal support for psychiatric research and training and community mental health programs" (H. Foley, 1975, p. 31). Through Mike Gorman, "the spokesman for the philanthropists" (H. Foley, 1975, p. 53), the National Association convinced President Kennedy and the U.S. Congress to support legislation which would "federalize" U.S. mental health care, and, for the first time, involve the national government in directly providing psychiatric treatment (H. Foley, 1975, p. 142).

We should note that there was no corresponding initiative on the part of the federal government to directly treat other health problems of the general population, in spite of the high rates of infant mortality, heart disease, cancer, and occupational illness which reflect the U.S. "failure to institute simple public health measures" (Eyer & Sterling, 1977, p. 1). Medicare and Medicaid legislation passed in 1965 only subsidized existing medical treatment, and -- unlike community mental health centres -- did not

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provide new federally-funded treatment facilities. Similarly, there was no powerful lobby which favored new funding for mental hospitals or for their unemployable clients, in spite of their well-documented inadequate budgets (Talbott, 1978). In fact, against the recommendation of the Joint Commission for Mental Illness and Health (1961), military, political, and business leaders explicitly opposed extending any federal support to state mental hospitals (H. Foley, 1975, pp. 35-37; 59-65). In contrast to these areas of obvious social need, there was little mass demand for community mental health centres, and in fact, there was considerable union and community suspiciousness toward them (Follman, 1976, p. 107; Frazier & Pokorny, 1968; Glasser, 1967; Korman, 1971, p. 6; Santiestevan, 1975; Weiner, 1967). In other words, the high priority which government placed on community psychiatry was based neither on social need nor on popular demand, but rather on the priorities of business and military leaders.

The resulting Community Mental Health Centers Act of 1963 authorized NIMH to: (1) provide direct Federal funds for building and operating a national network of community mental health centres, (2) more than triple federal training grants for mental health personnel, especially for auxiliary workers, general practitioners, and non-professionals, (3) increase support for mental health research on social problems and ways of treating them, and (4) "eliminate, within the next generation, the state mental hospital as it then existed" (H. Foley, 1975, pp. 40-70; Segal, 1975, pp. 13-17).

In effect, this legislation provided the vehicle to carry

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out the earlier mandate of NIMH to shift the focus of public psychiatric treatment from chronic mental patients to "the population of entire communities" (Yolles, 1975, p. 157).

> The essence of the [community mental health centre] program has always been and will continue to be summarized in one objective: to remove the locus of care and treatment of the mentally ill from large, custodial institutions to acute treatment in community-based facilities. (Yolles, 1975, p. 154, original emphasis)

The Act allowed the federal government to coerce and bribe the states to phase out chronic patient care and to establish facilities to treat employable, ambulatory patients. This "preventive" focus (i.e. on treating employable, non-psychotic people) of the Act, was a prerequisite for its winning Congressional support (Yolles, 1969, pp. 13-14).

In the wake of the 1963 legislation, state mental hospitals were encouraged to discharge as many unemployable, aged or chronic patients as possible, causing the decline of resident patients to accelerate dramatically (Ahmed & Plog, 1976; P. Brown, 1979, p. 646; D'Arcy, 1976b; C. Smith, 1971, p. 65). Many of these patients were discharged before any alternative plan had been formulated for their care "in the community," and, as a result, instant "psychiatric ghettoes" sprang up in slum districts (World Health Organization, 1978, p. 21). Outraged relatives, staff members, and community leaders testified that the hospitals "had adopted a policy of discharging patients no matter what the situation, the patient's condition, etc.," that "social workers had a 'quota' of discharges to fill, at all costs," and that "they chalk up each discharge as if they were shooting down fighter planes" (C. Smith, 1971, p. 68;

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A. Stewart, LaFave, Grunberg & Herjanic, 1968, p. 123, original emphasis). This decarceration movement, in large measure, transferred the costs of caring for unemployable mental patients from the government to the patients, their families, and their local communities. Even in countries with "socialized" medicine, such as Canada, this trend holds. Although government Medicare continues to cover direct medical expenses, it does not support the costs of housing, food, maintenance, and non-nursing supervision for a large proportion of those who would have received these services free in mental hospitals. Aside from welfare and old age assistance, many of these patients are forced to rely on their own savings or on their family's generosity. For example, a Saskatchewan study of ex-mental patients who have returned home found that half of the families sampled had to keep a wage-earner home to care for the patients, and that almost 80 percent reported other serious economic and practical consequences of caring for them (C. Smith, 1969, pp. 97-103).

Policy makers indicated that they supported decarceration at least as much because it reduced the costs of caring for chronic patients, as for any humanitarian motives (Cassell, C. Smith, Grunberg & Boan, 1972; Fein, 1958; McKerracher, 1966, pp. 14-15; J. Murphy & Datel, 1976; Scull, 1977, pp. 134-135). Generally, patients were placed in nursing homes, boarding homes, or back with their families which had not been able to handle them in the first place. In most cases, their only treatment "in the community" (to the extent that they can be considered "in" it) consists of mood-altering drugs, and occasional check-ups to see that the dosage

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is correct and that the patients are behaving (Hoffer, 1979). The mental health centres which were supposed to pick up their care have not had either the resources or the incentive to meet their needs adequately (P. Brown, 1979, p. 648; General Accounting Office, 1977).

As it was divesting itself of responsibility for most chronic patients, the U.S. government mobilized its resources to expand the treatment of employable people. In addition to funding community mental health centres -- which account for about one-quarter of mental patient care (Yolles, 1975, p. 179), the government encouraged general hospitals to provide short-term psychiatric treatment -- accounting for one-half of psychiatric admissions (Yolles, 1969, p. 17) and urged general practitioners to treat an increasing proportion of people with "emotional" problems (Proposed legislation, 1979, p. 12). Fifty-four percent of those who seek emotional help now are treated by general practitioners (Proposed legislation, 1979, p. 12). Between 1962 and 1972, the NIMH research budget jumped from $50 million to $112 million (Segal, pp. 21, 65). Its research priorities emphasized socially disruptive populations (juvenile delinquents, alcoholics, drug abusers, and urban residents), and methods of treating them (primarily more sophisticated mood-altering drugs and behavior therapies) (Segal, 1975, pp. 15-21).

As social unrest mounted near the end of the 1960's Congress massively increased NIMH funding for programs to treat "crime and delinquency," "alcoholism," "minority group mental health," and "narcotic addiction and drug abuse. (Segal, 1975, p. 20). The government explicitly defined community psychiatry as a solution to

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social unrest:

> The national community mental health program is providing a basic framework for intervention -- not only to treat and control the mental illnesses, but to extend the scope of mental health to all aspects of the human condition -- in an effort to identify and ameliorate the root causes of stress and alienation and to understand the mental health implications of a wide variety of social phenomena. (Yolles, 1969. p. 5)

In order to attack these social problems most efficiently, the U.S. government invested heavily in improving the technology of treatment and in further Taylorizing the nature of mental health work. Many of the resulting new techniques were designed to increase control over "disruptive" behavior. For example, methadone keeps addicts off the streets, under surveillance, and dependent for life on government suppliers. Antabuse (a drug which makes people nauseous if they drink alcohol), brain implantations, and aversive conditioning impose internal biological or psychological constraints on drinking and aggressive behavior. Lithium salts, ritalin, and other mood regulators are prescribed on a long-term basis to stabilize moods at a level consistent with efficient, routine (but not creative) work.

NIMH also has played a major role in both helping and requiring mental health agencies to computerize their operations (J. Johnson, Giannetti & Nelson, 1976).

> For many years, the Institute has required that the various states and federally funded community mental health centers submit statistical data which are then integrated by computer into reports describing national trends.
>
> In addition, NIMH provides financial support to a number of research and development projects in the automation of psychiatric records with the objectives of providing tools for improved patient care and more efficient use of personnel,

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> developing institutional management information systems, building research data bases, and facilitating the reporting of data useful for state and national program planning and evaluation. (Laska & Bank, 1975, p. 42)

Computers significantly aid large government agencies in monitoring trends and potential problem areas quickly and accurately. As one authority pointed out:

> Equipped with these data magnifiers, the social psychiatrist of tomorrow will be able to forecast the demographic and epidemiological characteristics of the behavior of populations at different risks. This is the wherewithal to create a dynamic early-warning system that can tackle the problem of primary prevention. (Editorial, 1970, p. 94)

Computers also allow the government to compile detailed data on particular potentially troublesome individuals. With current levels of technology, computers not only can track patients through their psychiatric treatment, but also can link them with data related to welfare, private medical diagnoses, and potentially, with income tax data, census records, and police files (Laska & Bank, 1975; Secretary's Advisory Committee, 1973, pp. 243-246; Schuchman, 1975). Any two or more computer files technically can be combined. All that protects confidentiality now is legislation, and laws are vulnerable when powerful interests are threatened. As Laska and Bank (1975) concede, "even though computerized administrative systems are usually planned with the best of democratic intentions, they do furnish the framework for mechanisms of totalitarian control in the hands of antidemocratic forces" (p. 369). A recent study of government computer systems indicates that there is already considerable violation of confidentiality:

> The files at present contain too much information and are accessible to too many agencies, including private business

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> concerns. Few safeguards protect legitimate rights of personal privacy or prevent use of the information in a discriminatory manner. ...The potential harm that they could inflict ... is made even more critical by (a) the coincident development of new state-level intelligence files on civil disorders and dangerous persons that are maintained by the same agencies that administer the information files and that are accessible to participants in the national system, are (b) the rapid expansion of computerized records on individuals maintained by welfare, health, education and other public and private agencies that can be (and have been) readily interfaced with the criminal offender files. (Secretary's Advisory Committee, 1973, pp. 243-244)

In addition to increasing control over patients, the new techniques also cheapen and expand control over mental health workers. They eliminate many of the remaining skills that go into treating and maintaining patients. [I do not intend "skills" to be equated necessarily with training which benefits the clients. For example, before the advent of major tranquilizers, mental health aides had to be "skilled" in forcing violent patients into strait jackets. Business and a fiscal conscious capitalist government perceive "skills" primarily in terms of cost and not of usefulness to the patient.] The new methods allow general practitioners, nursing home aides, non-professional mental health workers, and family members to replace expensive psychotherapists. As Obers (1979) explains:

> Psychoactive drugs ... are chemicals whose effects are intended to replace the labor that would be involved in emotional support, education, job training, or natural healing. "Cost effectiveness" has become an increasing factor in medical treatment and health care organization, at times involving needless risks. (p. 28)

Similarly, although computers eliminate some routine, clerical tasks, their main cost-benefit is in replacing skilled labour and in increasing management control over the pace and quality of work:

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> Computers in psychiatry have played a role in simulated interviews and in administering, scoring, and standardizing intelligence and personality tests.... In terms of service delivery in mental health, computers function in the realms of data collection, psychiatric/medical record keeping, psychotropic drug monitoring, evaluation of patient treatment and goal attainments, and in the establishment of a total mental health information system. (Laska & Bank, 1975, p. 18)

During the 1960's, under pressure from business lobbies, and their representative, the National Association for Mental Health (and in opposition to the AMA), NIMH expanded its training program from funding only professional graduate level studies, to supporting training for general practitioners, occupational and recreational therapists, clergy, and non-professional psychiatric aides and mental health attendants (H. Foley, 1975, pp. 11, 66-68). Under ever more Taylorized working conditions, mental health work has become increasingly sub-divided (Epstein, 1962; Sobey, 1960, p. 41). For example, a recent report lists 27 separate mental health occupations with education requirements minutely graduated from more than six years of graduate school to grade ten of high school (Ontario Council of Health, 1973, pp. 34-37). Psychiatrists have taken on more administrative functions delegating actual patient contact to auxiliary mental health workers (Yolles, 1969, p. 18).

> Someone else will see the patient and the psychiatrist will become an assembler of reports. He will, of course, continue to do research, to teach, to advise social agencies, and to talk to probation officers, first aid squads, industrial leaders, clergymen, judges, lawyers.... (The ultimate psychiatrist, 1965, p. 196)

Auxiliary professions, such as psychiatric nursing, psychiatric social work, and psychology, have been sub-divided into a wide range of skill levels from Ph.D.'s to one year certificate programs

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(Bullough & Bullough, 1974, pp. 292-299; Kowaluk, 1975). General practitioners, with minimal psychiatric training and with their power to prescribe psychotropic drugs, have been encouraged by NIMH to replace lengthy and expensive forms of psychotherapy (Robertson & Shriver, 1964). And finally, during the middle 1960's, the U.S. government encouraged social service programs to use "indigenous non-professionals" (low-income, mostly minority group, local residents) as a buffer between professionals and their low-income clients (Reiff & Riessman, 1964; Sobey, 1970). In spite of well-publicized "new careers" and "career-ladders" for these workers, non-professional mental health workers generally have been confined to dead-end, low-paying, routine work (P. Brown, 1979, pp. 647-649; Riessman, 1964). Under strong government incentives, the number of mental health workers in the United States since 1963 has increased over 250 percent while the number of health workers only rose by 30 percent (H. Foley, 1975, p. 11).

The impact of this concerted public investment in community psychiatry has been widespread. About 15 percent of the U.S. population -- overwhelmingly composed of employable people -- receive an explicit psychiatric diagnosis each year, and twice that number receive psychotropic drugs (Altman, 1971; Balter, Levine & Rubinstein, 1972; Cooperstock, 1977; Doig, 1978; President's Commission, 1978, Vol. 2, p. 16; Waldron, 1977). Other major Western countries quickly adopted policies similar to those in the United States, resulting in parallel decarceration movements and rapidly rising rates of treatment of employable people (D'Arcy, 1976b, p. 2;

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Harding, Wolf & Chan, 1978; Lennard & Bernstein, 1973; McNair & Barnes, 1970; Pflanz, Basder & Schwoon, 1977; World Health Organization, 1978, p. 15).

The anti-community psychiatry movement

By attempting to treat the social forces which threatened business on a mass scale, NIMH was forced to take an ever higher profile as a social control agency, and thereby to become embroiled in the very disputes it hoped to solve. By the late 1960's, labour, community, and ex-mental patient groups for the first time began to attack federal mental health programs in their own right (Hersch, 1968). Unions of mental health workers organized to attack the excesses of the decarceration movement and to defend both their own job security and the welfare of chronic patients (Armstrong, 1976; McFadden, 1972; Santiestevan, 1976). Non-professional minority workers at the prestigious Menninger Clinic and the Lincoln Hospital Mental Health Service staged effective work-ins and strikes to demand real career ladders, improved care for patients, and action against injustices in their communities (P. Brown, 1979, pp. 647-648). A militant black gang used its NIMH funds to buy guns, sparking a scandal that jeopardized Congressional appropriations to NIMH. Militant groups took over the podiums of professional psychiatric conferences to protest coercive, racist, and sexist psychiatric practices (Miranda & Kitano, 1976). And a growing "antipsychiatry" movement, composed of over forty groups of ex-mental patients, mobilized to oppose oppressive psychiatric practices (Ralph, 1979, p. 15).

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Government agencies managed to repress, divide, placate, and co-opt some of these protests by giving small grants to militant groups for innocuous self-help projects, and by making small concessions such as creating study groups on the ethics of brain surgery and tightening the limits on involuntary psychiatric hospitalization. Nevertheless, by 1970, community psychiatry programs had generated so much controversy in the United States that the Nixon administration severely cut back NIMH funding, dismissed the director of the Institute, and tried to phase out the community mental health centres program (H. Foley, 1975, pp. 127-133; Segal, 1975, pp. 21-22). As one opponent of the program explained:

> The CMHC [Community Mental Health Centre] has little or no expertise at its disposal that it might usefully apply to direct action in the vast sphere of urban problems....
>
> Moreover, as the CMHC has moved into the social action sphere, it has become increasingly the object of political maneuvering and confrontation. Its agenda is thus frequently perverted by the agenda of interest groups.... (Leopold, 1974, pp. 187-188)

Since 1970, NIMH has retrenched into less controversial areas under a much more restricted budget. Business and political leaders recently have been pressing (so far successfully) to transfer community mental health centres to the jurisdiction of Health Maintenance Organizations (HMO's) and to "re-integrate psychiatry into medicine" (Leopold, 1974; Muszynski, 1976). The purpose of this move is to transfer an even greater proportion of psychiatric care from public to private control, increasing the role of general practitioners and private hospitals, and putting psychiatric care on a more profitable "cost-efficient and manageable"

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footing (Muszynsky, 1976, p. 399). As Phil Brown (1979) explains:

> Health Maintenance Organizations (HMO's) are highly favored by corporate interests since they promise a type of health delivery which receives guaranteed payments that can be made more profitable (or, in the case of nonprofit concerns, can be made to better realize and circulate profit to the actual profit-making sectors). This increased profitability comes from cost cutting (e.g. restricting patient usage, employing many nonphysicians in primary care) and from the monopolistic expansion of a single HMO to cover a huge population. (p. 655)

Under restricted funding and regulations, community mental health centres -- the most controversial and visible portion of the NIMH program -- have drawn back from social intervention, to focus on handling more severe emotional problem populations -- the aged, psychotics, youthful offenders, minorities, addicts, and people with deep depressions (B. Brown, 1977, p. 473; Segal, 1975, pp. 25-26). While mental health centres treat less profitable cases, private doctors tend to handle employable patients with milder symptoms (D'Arcy, 1976b). Most of these "private" patients (their fees are often paid with public funds) just get a prescription for mood-altering drugs from their family doctors along with a brief lecture on reducing life stress. Those who are admitted for in-patient treatment generally get little more than perfunctory visits by their doctors and stronger doses of the drugs with or without shock treatments. Unlike the politically visible and volatile community mental health centres, treatment by private doctors is virtually immune to public scrutiny, protected from demands for community control and social responsibility.

Although the community mental health centres were forced to withdraw from blatant social intervention, other, less visible,

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NIMH programs have become more explicitly coercive. During the past ten years, community psychiatry programs have tended to merge with criminal justice agencies and corporate mental health programs. Mental health personnel consult for law enforcement agencies, prisons, and businesses, helping them to apply the most up-to-date psychiatric techniques to control "anti-social" behavior (Abramson, 1972; Allmand, 1973; Arboleda-Florez, 1975; Monahan, 1976; Newell, 1979; Salutin, 1975). Prisons are taking in a rising proportion of ex-mental patients who are too disturbed to remain in the community, but who are now barred from mental hospitals (Hoffer, 1977, 1979). The National Insitute on Alcohol Abuse and Alcoholism (NIAAA) and the National Council on Drug Abuse, both offshoots from NIMH, work closely with corporate and military mental health programs, providing funds, consultants, and statistical data services (HEW's Califano, 1979; Scher, 1973). The more direct social control functions of NIMH have been transferred to the Law Enforcement Assistance Administration (LEAA). At a time when the NIMH budget was being cut back for the first time (along with other social services), LEAA's funding rose more rapidly than almost any other federal agency from $63 million in 1969 to over a billion dollars in 1976 (Center for Research, 1977, p. 50). Unfettered by either the benevolent ideology of public health or by the militant constituency of community psychiatry, LEAA operates as an explicit agency for social control.

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Summary

Under the pressure of economic and political instability during the past 18 years, business pressured the government to simultaneously slash its care of chronic mental patients (the "decarceration movement"), and to expand programs to treat a large proportion of employable people -- particularly those who threatened to become socially disruptive. In taking on this more direct role in mass social control, community psychiatry itself became a target of mass protests and it ultimately constituted a political liability. As a result, NIMH assumed a lower profile, and drew back from attempts to deal with explosive populations. It has shifted control over its programs to the private, profit-making sector, and to public agencies with less public accountability (especially LEAA and NIAAA). Under corporate and military pressures to assure an efficient labour force and a reliable pool of potential workers, the United States (followed, in large measure, by other Western countries) has increased funding substantially for programs to control inefficient or disruptive workers and potential workers.

In essence, the past twenty years has accelerated the consistent direction of, first, industrial psychology and, since World War II, community psychiatry. Many more employable people are being treated for a much broader range of "mal-adjustments" in increasingly coercive ways and at a far greater public expense. At the same time, the cost of services for chronic mental patients are being shifted to the patients, their families, and their local communities, and their care is being transformed into a private

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profit-making commodity. As capitalist powers become more economically unstable and politically vulnerable, we can expect these trends to escalate, unless they are actively opposed. The next chapter will discuss the implications of commmunity psychiatry for workers and strategies for future.

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VI. DISCUSSION

6.1 Is the labour theory valid?

To explain why community psychiatry developed, this study postulates a "labour theory," which proposes that community psychiatry is a nationalized form of industrial psychology, and that, like industrial psychology, its central function is to minimize the effects of worker alienation on productivity. Unlike traditional public clinical psychology, which emphasizes care of unemployable people, community psychiatry focuses on treating workers and potential workers. Because other theories on the nature of community psychiatry fail to make this distinction between "social dynamite" (employable people) and "social junk" (unemployable people) (Spitzer, 1975), they do not highlight the qualitative change in the character of public mental health programs since World War II. Instead, they see commmunity psychiatry as merely more and better (or worse, depending on the theory) clinical psychiatry.

If the labour theory is valid, it would correct some of the gaps and inconsistencies in these other approaches. But, more important, it also has major implications for predicting future trends in psychiatric treatment of both employable people and unemployable people, and for suggesting strategic actions by working class people.

In light of the historical material described in Chapters IV

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and V, we can evaluate the extent to which the evidence supports the original hypotheses (see pp. 10-13) on which the labour theory rests.

(1) We will find that many of the significant "innovations" of community psychiatry were widely adopted before World War II (i.e. before commmunity psychiatry), in the practice of industrial psychology. As World II began, industrial psychology had already developed many of the central practices which later characterized community psychiatry. During World war I, mass psychological selection and treatment methods were developed for soldiers which were also incorporated into industrial practices. Industrial psychologists have always defined "mental illness" more broadly than pre-World War II clinical psychiatry, focusing on behavior which has since become the emphasis of community psychiatry (e.g. drinking, disruptive behavior, and low work efficiency). As early as 1917, Rockefeller argued that industrial leaders should consult with community leaders and involve them in helping to prevent labour unrest. This policy was the forerunner of the preventive consultation program which has become a central feature of community psychiatry. During World War I and soon after, Southard and Jarrett popularized the industrial concepts of treating non-psychotic workers on an out-patient basis, of involving their families in counselling, of developing sub-specializations of mental health work, and most important, of developing a national program to treat inefficient or disruptive workers. Mayo and his followers extended these concepts by using non-professional counsellors to provide free, accessible, short-term therapy to problem employees. Since 1935, the business-

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dominated National Committee for Mental Hygiene had advocated cutting costs of chronic mental patients care by discharging them into the community (Deutsch, 1949, p. 447; National Committee, 1942, pp. 27-28). Under community psychiatry, these principles and techniques became central to public psychiatric care.

(2) Conversely, we would *not* expect these innovations to have figured prominently in the policies and practices of clinical psychiatry, and particularly of public mental health services before World War II. Clinical psychiatry, both public and private, has never focused on working class people. Private clinical psychiatry before World War II was strongly influenced by Freud, and its practitioners tended to treat well-to-do patients on an individual basis, over extended periods of time. Because private therapy was something of a status-symbol, there was little incentive to speed up therapy or to make it available on a mass basis with Taylorized mental health workers. Similarly public psychiatric care provided little leadership in developing the innovations of community psychiatry. It changed little between 1900 and World War II, consistently focusing on the most severely disturbed chronic mental patients (less than one-half of one percent of the population), in programs isolated from the patients' communities and families (D'Arcy, 1976a; Deutsch, 1949, pp. 455-456; Richman, 1966, pp. 58, 116-121). What treatment the mental hospitals did offer, aside from custodial care, was provided by psychiatrists, more than by sub-professionals, on a long-term basis. During the Depression, mental hospitals faced severe budget cuts and overcrowding, which grew worse even after the

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economy recovered, as public psychiatry was relegated further and further back in the government's priorities. Between 1935 and 1940, new methods of treating chronic patients (insulin coma, electroshock, and lobotomies) helped the mental hospitals to discharge more manageable patients (Dorgen, 1958, p. 413; Rees, 1959, p. 355). But the impetus for these new methods came at least as much from business interests as from leaders in public psychiatry (National Committee, 1941, pp. 11-12). In general, clinical psychiatrists have preferred to promote better institutional care rather than to discharge patients en masse, and many of them continue to oppose the decarceration movement and wholesale drugging of chronic patients (Ahmed & Plog, 1976; Burrows, 1969; Hoffer, 1977, 1979; Steinhart, 1973).

(3) If community psychiatry innovations were motivated by business and state needs to control labour, we would expect to find that they were generally adopted during periods when businesses required greater labour productivity (such as before and during wars) or more control over workers (as a result of labour militancy), and (4) Conversely, during economic recessions -- particularly when labour is docile -- we would expect few of the innovations of community psychiatry to emerge. Almost all of the innovations of community psychiatry developed during periods of rapid productive growth and/or during periods of high labour unrest. Table I summarizes the co-incidence of psychiatric innovations with periods of high GNP growth and work stoppages. Gross National Product and work stoppages are relatively crude indices of trends in productivity and labour unrest. For example, Gross National Product neither

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TABLE I

U.S GNP per capita (1958 dollars), Work stoppages,

Psychiatric innovations, 1914-1970.

(Source: U.S. Bureau of the Census, 1975, pp. 125, 179)

Year	GNP dollars per capita (change from previous years)		Work Stoppages	Psychiatric Innovations
1914	1267		1204	
1915	1238	(- 29)	1592	
1916	1313	(+ 75)	3789	
** 1917	1310	(- 3)	4450	Rockefeller Plan (1917) Preventive consultation (1917) Mass testing and treatment (1917)
* 1918	1471	(+161)	3353	
1919	1401	(- 70)	3630	
1920	1315	(- 84)	3411	Mental health team (1920) Psychiatric social work (1920) Out-patient treatment (1920) Policy of treating workers (vs. firing them) (1920)
1921	1177	(-138)	2385	
* 1922	1345	(+168)	1112	
1923	1482	(+ 37)	1553	
1924	1450	(- 32)	1249	
* 1925	1549	(+149)	1301	
1926	1619	(+ 70)	1035	
1927	1594	(- 25)	707	
1928	1584	(- 10)	604	
1929	1671	(+ 87)	921	
1930	1490	(-181)	627	
1931	1364	(-126)	810	
1932	1154	(-210)	814	

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	Year	GNP dollars per capita (change from previous years)		Work Stoppages	Psychiatric Innovations
	1933	1126	(- 38)	1695	Human relations in industry Non-professional counselling Free, accessible, non-stigmatizing treatment (1933)
	1934	1220	(- 6)	1856	
	1935	1331	(+ 11)	2014	First decarceration plans (1935)
*	1936	1506	(+175)	2172	
**	1937	1576	(+ 70)	4740	
	1938	1484	(- 90)	2772	
*	1939	1598	(+114)	2613	First out-patient clinics for workers
*	1940	1770	(+122)	2508	Expanded definition of mental illness
*,**	1941	1977	(+257)	4288	Brief therapies
*	1942	2208	(+231)	2968	Sub-specialization of mental health work
*	1943	2465	(+257)	3752	Plans for NIMH (1940-1944)
*,**	1944	2611	(+146)	4956	
**	1945	2538	(- 73)	4750	
**	1946	2211	(-327)	4985	NIMH formed (1946)
	1947	2150	(- 61)	3693	
	1948	2208	(+ 58)	3419	
	1949	2172	(- 38)	3606	
*,**	1950	2342	(+178)	4843	
*,**	1951	2485	(+143)	4737	
**	1952	2517	(+ 38)	5117	First major tranquilizers (1952)
**	1953	2587	(+ 60)	5091	Behavior modification (1953) Shock and psychosurgery for non-psychotics (1953)
	1954	2506	(- 81)	3468	Minor tranquilizers (1954)
*,**	1955	2650	(+144)	4320	Other mood-altering drugs (1954)
	1956	2652	(+ 2)	3825	
	1957	2642	(- 10)	3673	
	1958	2569	(+ 27)	3694	
	1959	2688	(+ 59)	3708	
	1960	2699	(+ 11)	3333	

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Year	GNP dollars per dapita (change from previous years)		Work Stoppages	Psychiatric Innovations
1961	2706	(+ 7)	3367	
1962	2804	(+ 98)	3614	
* [1963]	2912	(+108)	3362	Community mental health centres (1963)
				Decarceration of chronic patients (1963)
				Expanded training of G.P.'s and auxiliary workers (1963)
* [1964]	3028	(+116)	3655	Methadone, Lithium, Antabuse, Computer technology advances (1964-1966)
* [1965]	3180	(+152)	3963	
*, ** [1966]	3348	(+168)	4405	
** [1967]	3398	(+ 50)	4595	
*, ** [1968]	3521	(+123)	5045	
** [1969]	3580	(+ 59)	5700	LEAA formed (1969)
** [1970]	3555	(- 25)	5716	NIAAA formed (1970)

NOTE: * = increase in GNP greater than 100
** = more than 4,000 work stoppages
Bracketed years = war or major military conflict

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differentiates between primary and secondary industries nor between productive and service industries. Similarly, reporting the total number of work stoppages does not describe the severity or duration of those strikes. For example, 1919, which was a year of severe labour unrest characterized by major strikes involving one-fifth of all industrial workers, had fewer total "work stoppages" than 1950, a relatively tame year for labour relations. Nevertheless, Table I illustrates several important tendencies.

First of all, we see that many of the major psychiatric innovations occurred during wartime (1914-1919, 1939-1945, 1950-1953, and 1963-1970). During wars, the state intervenes more directly in labour force regulation. In effect, the state itself becomes a massive "employer" of soldiers and an influential "consumer" of the weapons and military supplies produced by industrial workers. At the same time, wars intensify the problems of controlling workers. Labour shortages engendered by diverting workers into military service, and the urgency of raising production rapidly to mount an effective war effort make war a time of relative labour strength. As a result, during wars, both business and government invest heavily in new methods to control labour. As Marx points out:

> The history of the army brings out more clearly than anything else ... the connection between the productive forces and social relations. In general, the army is important for economic development. (1977, p. 21, original emphasis)

Secondly, community psychiatry innovations also tend to occur during periods of high labour unrest. 1919, 1933, and 1946 were all years when business feared that there might be a revolution. In 1919 and 1946, record numbers of workers went on strike, and

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demonstrated their power to threaten both the economic and political foundations of capitalism (see pp. 92-93, 120-123). Similarly, Elton Mayo's Depression-era psychiatric innovations also occurred in response to the rising threat of labour unrest. The number of work stoppages doubled between 1932 and 1933, and they were supplemented by militant organizations of the unemployed and of World War I veterans (see pp. 96-109).

Finally, in the 1950's and 1960's we see a growing link between U.S. efforts to control its domestic labour force and its repression of Third World revolutions. The technological innovations of the 1950's (mood-altering drugs, behavior modification, psycho-surgery) occurred in the context of both McCarthy era repression of American workers and the U.S.-led war against Korea (see pp. 135-149). Between 1963 and 1970, U.S. leaders faced both effective resistance by the Vietnamese and rising domestic unrest largely in reaction against the war in Vietnam. In response, both business and the government invested far more money to expand psychiatric controls in order to treat the entire labour force -- both active and potential. As labour unrest continues to rise, both in the United States and in the Third World, these community psychiatry measures have become more overtly coercive and more directly linked to both the police and the military (see pp. 150-170).

(5) <u>We would expect to find corporate leaders and industrial psychologists explicitly indicating that they adopted these innovations (before the creation of commmunity psychiatry) primarily to increase management control over labour productivity and</u>

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labour unrest. Corporate leaders and industrial psychologists were explicit in the years before World War II that their innovations were designed to maximize production and minimize labour unrest. Frederick Taylor openly advocated Taylorism as a management weapon against labour intransigence (1911). The Rockefeller Plan expressly aimed to reduce industrial conflict by making management appear humane (Rockefeller, 1917). E. E. Southard described himself as a "modern specialist in unrest" (1920b, p. 550), and Ray Baker offered "reasons and remedies" for "the new industrial unrest" (1920). Elton Mayo offered his theories to management as an explicit "new method of human control" (Roethlisberger, 1941, p. 16).

When unions became stronger and more openly hostile to these methods of control, business and government leaders became more circumspect about announcing that new programs were designed to make employable people produce more and protest less. They adopted euphemisms like "prevention" (meaning to treat employable normal people), "behavior disorder" (meaning disruptive behavior), and "aversive therapy" (meaning punishment). But even so, policy makers have indicated fairly clearly that community psychiatry innovations are intended to control social unrest and as "an alternative to chaos" (House Report, #1445, pp. 3-4; Yolles, 1968). Business representatives have been more open than civil servants about the productivity-enhancing focus of community psychiatry programs (see pp. 139-140, 154-155).

In other words, this historical analysis supports the

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conclusion that: (1) Community psychiatry grew out of industrial psychology, and not from clinical psychiatry; (2) Its central innovations generally emerged only during period of high productivity and/or high labour unrest; and (3) Both business and government policy makers have more or less openly announced that they adopted these innovations primarily to make workers produce more and conform better.

6.2 Implications of community psychiatry for different populations

On the surface, community psychiatry appears to be a relatively inoffensive and benevolent service, helping people who really are having trouble coping in a world of rising stresses, rescuing mental patients from the "snake pits," and generally increasing knowledge about how people tick and how to make them happier. Most people seek its services voluntarily (although often under informal duress from employers, family, and the courts), accepting the freely dispensed treatment to dull their pain. Most of us view instances of over-zealous decarceration, drug side-effects, and homeless psychotics wandering the streets merely as correctable excesses of a policy which, on the whole, is a "good thing." After all, workers have to keep coping to earn a living, and frequently they have no practical way out of the maddening tension. So drugs which relieve anxiety, shocks which drive away the blues, and counselling which lets them blow off steam do help to make it all bearable. If all these treatments are only "band-aids," we may reasonably argue, it isn't fair to expect psychiatry to change the world -- at least they help them feel better.

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This superficial perspective contains three errors. First of all, it assumes that community psychiatry is oriented to solve, rather than to cause, the problems workers experience; that if it only had the techniques, money, and manpower, community psychiatry *would* try to change the world for the better. However, as we have seen, the innovations of community psychiatry are precisely those which management adopted in order to speed up work and "cool out" protest. In other words, these innovations were not designed to improve things for workers, but on the contrary, they were powerful tools in making working and living conditions so stressful in the first place.

Secondly, this benign interpretation assumes that anesthetizing the reaction to oppression is helpful for people. If a patient has painful, terminal cancer, we see little wrong with drugs to take away the pain. But the analogy only applies to community psychiatry if we view ourselves as terminal -- that is as passive, beaten, and hopeless. In order to fight oppressive conditions and change things, we need our wits about us. We need to feel inside what is dangerously stressful and to feel also the anxiety, aggression, and anger which give us incentive to fight those conditions. Rather than "letting off steam" individually in counselling, we need to let it erupt in collective militant action.

And finally, it assumes that psychiatric treatments at least make patients feel better in the short run. As we have seen, since the late 1960's community psychiatry has been becoming more overtly coercive and punitive, particularly in "treating" disruptive workers and Third World people.

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Community psychiatry has very little to do with curing rising alienation and stress-related problems. But that is not what it was intended to do. Its primary function is to create an efficient alienation-control apparatus, through which patients efficiently flow in and out for periodic "repairs" and "adjustments" like products on an assembly line. With the community focus, the whole concept of being a "mental patient" and being "discharged" from care has evaporated: We are all always potential patients.

The community psychiatry system is set up in such a way that it provides different specialized treatments to the various sectors of the population, depending on whether they are unemployable, marginally employable, or actively employed. (By and large, it does not treat the wealthy.)

Those who are unemployable -- that is, those who can not be "repaired" cheaply (e.g. aged, psychotic, and retarded patients) are disposed of efficiently in nursing, boarding, or group homes where, despite the dedicated efforts of (underpaid and overworked) staff, they fall apart in poverty. Many have been simply discharged with no place to live at all (Anderson, 1978; Hoffer, 1979). Major tranquilizers make them manageable enough to eliminate staff attendants, and if the social service budgets get cut or if the nursing home profits are not high enough, administrators simply raise the doses and make the patients more manageable (Chandler & Sallychild, 1977; Santiestevan, 1976). The resulting epidemic of tardive dyskinesia (a severely debilitating syndrome involving permanent brain stem damage) and other side effects generally have been ignored (Caligari, 1978b; Crane, 1973, pp. 126-127):

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> The side effects of these drugs are frightening. A short list includes: Parkinsonism, hypertension, jaundice, excessive weight gain, lupus, edema, breast engorgement, EKG abnormalities, seizures, amenorrhea, blindness from retinitis, and even "sudden death."
>
> Tardive dyskinesia is possibly the most alarming of these side effects since it is so prevalent. This degenerative and irreversible disease produced by phenothiazines [major tranquilizers] involves loss of muscle control, especially of the face. Tardive dyskinesia was known to the psychiatric profession two decades ago but was largely ignored. Only in the last few years have the psychiatric journals "discovered" and discussed the problem. Recent studies have shown that as many as 56 percent of inpatients show some form of tardive dyskinesia, and among outpatients who have been on phenothiazines for over one year, 43 percent have the disease. (P. Brown, 1979, p. 653) .

R. D. Laing captures the blithe inhumanity of this attitude toward unemployable mental patients:

> The trouble with you
> 's you've lost a screw
>
> I'm sorry it's you
> but there's nothing to do
>
> There'll be no abatements
> there are no replacements
>
> don't make a to-do
> just say toodle-oo
>
> I'm sorry I can't help you
> you'd cost too much to redo
>
> you'll have to be abolished
> report to be demolished
>
> (1976, p. 47)

Potentially employable people include those who are largely "apartheided" from mainstream jobs with adequate pay, such as women, adolescents, displaced men over 45, members of minority groups, and moderately handicapped people. These people receive slightly better

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treatment than unemployable populations, since their ability to work has to be maintained so that employers and the military can draw them in and out of the labour force fairly flexibly.

Psychiatric treatments for them fulfill four main functions: (1) Mood-altering drugs (minor tranquilizers, anti-depressants, stimulants and barbiturates) numb their emotional reactions to poverty and discrimination. For example, women -- especially housewives -- tend to receive far more of these drugs than comparably-aged men (Harding, Wolfe & Chan, 1978; Lamb, 1978; Larned, 1975; Mostow & Newberry, 1974; Radloff, 1975, p. 249); (2) Counselling at mental health centres socializes them to "adjust" to their situation and to blame themselves for it. The following ideology is typical:

> The great portion of the unemployed ... show avoidance behavior patterns or what has been referred to as "work inhibition," which implies that they are physically capable of work but are prevented from working because of psychological disabilities. The work-avoidance behavior patterns constitute personal obstacles to employment. The individual has developed these behavior patterns to defend himself [sic.] from all the experiences associated with the ethic "to work." (Tiffany, Cavan & Tiffany, 1970, pp. 14-15)

(3) "Life skills" programs provide training in "proper" work attitudes (e.g. punctuality, deportment, neatness, etc.) without providing any substantive preparation for skilled work; and (4) Methadone maintenance programs, aversive conditioning, psychosurgery, and behavior modification coercively try to prevent people from committing "anti-social" behavior. These coercive programs constitute a large proportion of what passes as "treatment" for adolescents and adults who run afoul of the law.

Active workers also receive large quantities of mood-altering

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drugs, victim-blaming counselling, and -- when they act up, or fall down on the job -- coercive "therapies." But programs oriented to treat employees focus on improving their productivity under stress, rather than merely maintaining minimal coping skills. Corporate counselling programs have to justify their expense to employers in dollars-and-cents savings. Basically, they achieve these savings by elaborating on industrial psychology methods developed before 1945.

First of all, they screen job applicants with sophisticated psychological tests to select "people who can scarcely be broken down under any strain they may encounter" (to paraphrase the military testing procedure on which these methods are based) (National Committee, 1942, p. 9). (Whether workers should be exposed to severe strain is an issue primarily for workers, and not a serious concern of management.)

Secondly, corporate mental health programs provide an elaborate network to channel workers into "counselling" whenever their work deteriorates. Frequently, employers try to recruit union representatives to take on the chore of convincing or forcing workers to seek "help" (Alcoholism, 1960; Trice, Hunt & Beyer, 1977; Slotkin, Wetmore, Levy & Runk, 1971; Weiner, 1967; Weiner, Akabas & Sommer, 1973). At best, this technique of using union representatives encourages the targeted employees to trust that the treatment is in their interests, and minimally, it lines up the union with management and against the workers' wishes.

Treatment may be provided either by the company or by a public mental health service to which the company refers the worker. The government programs work in explicit "partnership" with corporate

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programs (HEW's Califano, 1979, p. 1), and therefore, either way, workers are under heavy pressure to cooperate with the prescribed treatment and to "improve" (i.e. to produce more efficiently and to stop any disruptive behavior). Treatment is usually some form of mood-altering drug designed specifically to improve "working capacity." These therapies rarely explore the valid causes of the workers' diminished productivity, but only treat the specific behavioral problem:

> Working capacity is determined by four factors: action potential on the physical level, motivation on the level of aspiration, integration potential on the cognitive level, and control on the emotional level. The central representative of these four factors in the brain is partly cortical and partly subcortical. Three emotional conditions can exercise a profoundly disorganizing effect on a person's working capacity. These are anxiety, depression, and indifference. Different psychoactive drugs influence these emotional conditions in different ways. (Lehmann, 1960, p. 527)

There are three serious dangers associated with these treatments. First of all, the mood-altering drugs all cause varying degrees of side-effects. For example, lithium carbonate, a popular treatment for employed "manic-depressives," has a "therapeutic" level which is extremely close to the toxic level. Since the quantity of lithium in the body fluctuates constantly, patients frequently are poisoned, experiencing kidney damage, disorientation, convulsions, and even death. In addition to clear cases of poisoning, sub-clinical lithium toxicity causes permanent physical damage and can make workers act confused (which leads their friends and themselves to believe that they are indeed insane) (Caligari, 1979). Equally serious side-effects accompany the other mood-modifying drugs. For workers, even mild side-effects such as dizziness, blurred vision,

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and indifference can lead to dangerous accidents.

More serious than the danger of the drugs' side-effects is the way that they mask workers' awareness of occupational hazards. The drugs are used to "help" workers adjust to near-accidents and dangerous working conditions (Felton & Wilner, 1969, pp. 213-215; Modlin, 1976). For example, the Medical Director of U.S. Steel, cited as signs of mental illness the following complaints by workers:

> At one time four people came to me ... in the course of two days, all from one section, each requesting a change of job for medical reasons. One said he couldn't stand the noise on his job; it was making him tense and nervous and he couldn't sleep at night. Another said the job was too heavy; at the end of the day his back and legs were aching. Two of them said the odors of solvents on the job were making them nauseated; they couldn't eat their dinner at night. (R. O'Connor, 1958, p. 1)

In that era before the wide-spread use of minor tranquilizers, O'Connor "treated" the patients by counselling them to understand that their "real" problem was with their foreman, and not the noise, the over-heavy loads, or the solvents. Since then, drugs have made this sort of treatment easier. For example, in 1971, a group of electrical workers in Saskatchewan accidentally discovered that they all had been experiencing similar symptoms of irritability, insomnia, and shakiness for years. Because of these symptoms, they each had seen their family doctors separately and had been given tranquilizers (as well as lectures to cut back on their drinking and on union activities). However, once they got together, the workers were able to figure out (in spite of company attempts to cover up the evidence) that they were all suffering from chronic, job-related, mercury poisoning, to get appropriate treatment (as opposed to tranquilizers), and, after another three years of fighting, to win an award from

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workmen's compensation (G. Smith, 1978).

Many other substances that workers commonly are exposed to also cause serious psychiatric symptoms; for example, insecticides, formaldehyde, heavy metals, carbon disulfide, methyl bromide, pentaborane, and solvents, (Formaldehyde, 1977, p. 7; Gershon & Shaw, 1961; Sutton, 1969). Masked by mood-altering drugs, and dismissed as individual madness, the symptoms of this organic poisoning are made inaccessible and unintelligible to the worker. Employees are frequently barred from knowing the dangers of chemicals they work with, or even what chemicals they are exposed to (Kinnersly, 1973, pp. 95-120).

Other occupational hazards, such as noise, speed-up, shift work, and vibration also cause both emotional strain and long-term physical damage (Stellman & Daum, 1973; Wallick, 1972). Often the very symptoms for which workers are treated reflect the fact that their work makes dangerously severe demands on their tolerance. To the extent that community psychiatry treatments "help" workers to return to these conditions, they are likely to precipitate even more serious long-term damage.

Most important, community psychiatry poses a serious threat to workers as an entire class. It amplifies the effectiveness of traditional industrial psychology techniques, allowing management to speed up production, to "cool-out" protests, and to defuse "trouble-makers." The easily available mood-altering prescription encourages workers to seek individual relief from their family doctors, rather than to organize collectively to change their working

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conditions. The psychiatric (and criminal justice) computer technology has invaded fields which have traditionally been confidential. It is entirely possible that employers and the police can be given access to psychiatric files for "sanity checks" just as we now have credit checks done on us without our authorization. Treatment is becoming more coercive and compulsory, and the range of "behavior" labelled deviant is broadening.

There is one final category of people who are targets of psychiatric innovations: Third World workers in liberation movements. The U.S. military, police, and the CIA have adapted knowledge about brain functions and psychological techniques to forge a horrifying arsenal of weapons for espionage, torture, and social control. Pilisuk and Ober (1976), describing U.S.-directed torture training in many countries, persuasively argue that torture and genocide are becoming major "public health" problems for the world's people:

> Scientific research in which doctors must necessarily have participated has made it possible to identify the maximum suffering that the various systems of the body can endure without resulting in death.
>
> ... In Montevideo, Uraguay, an entire ward has been set aside for the administration of pharmacological torture. ... In Northern Ireland, the application of a form of sensory deprivation to IRA prisoners is producing the severe cognitive deterioration, hallucinations, and anxiety states that psychologists understand well.
>
> ... In most instances, the torture seems intended less to protract a confession than to produce conformity through fear and the complete destruction of will. (Pilisuk & Ober, 1976, pp. 389-391)

In other words, for all four groups -- for the unemployable, the marginally employable, and the employed peoples of the developed Western nations, and for Third World freedom fighters -- community

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psychiatry is not only not helpful; it is actively destructive. In return for quick, addictive "fixes" to ease our tensions and depressions, we pay dearly, in reduced personal and class awareness, in debilitating side-effects (and main effects) of treatments, in the neglect of "disposable" friends, relatives, and sometimes ourselves, in the "mad" labels we get for behavior never considered crazy before, in taxes and fees to feed the hungry madness business, and in the threat of severely authoritarian social control and torture in the future.

On the whole, the techniques of community psychiatry represent methods to extend corporate social control and profits, without consideration for either the wishes or long-term well-being of those who are treated. Electroshock, aversive conditioning, psychosurgery on prisoners, mass drugging of chronic patients, coercive alcohol and drug abuse treatment, and torture have very few redeeming qualities. They were invented solely for the benefit of those in power. Other techniques have some, limited, legitimate uses. Low doses of mood-altering drugs can help frantic people enough so that they can discuss their problems realistically. In China, for example, psychotics are sometimes treated with short-term, low doses of tranquilizers, in combination with lots of practical help, discussions, exercise, and good food (Livingston, 1974, pp. 75-80). Behavior modification has some limited uses in self-administered situations such as in relaxation training, phobia release, and smoking clinics. Non-directive counselling, and encounter groups, employed in a sympathetic, unmanipulative manner, can sometimes lead to insight and greater self-acceptance. However, under most community

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psychiatry programs -- particularly those for working class and unemployed people -- these therapies tend to <u>substitute</u> for helping patients' practical situations or personal insight. They are used instead as "a valuable aid in controlling patients" (Kahan, 1965, p. 21).

6.3 Community psychiatry as a locus of class struggle

We have seen that community psychiatry is intimately implicated in the class struggle between workers and business. Since the early 1900's, its methods have served management in their efforts to control labour. Industrial psychology was "nationalized" into community psychiatry after World War II, because it was essential for U.S. business to extend its control over a wider proportion of the domestic labour force, as well as over workers in other Western countries and in its Third World empires. The technology of community psychiatry has evolved to a point where it constitutes a serious danger to working people throughout the capitalist world. It is important, therefore, for workers to develop strategies to oppose community psychiatry.

To do that, it is useful to review both the history of labour-management relations and the history of opposition to industrial psychology and community psychiatry. On a world scale, labour has come a long way since 1900. A large proportion of the world's people have succeeded in freeing themselves from or resisting, first, overt British and European imperialism and, later, Western economic imperialism: There is a strong "socialist" bloc now,

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whatever its flaws and internal differences. Labour movements in the developed countries have forced employers and the state to recognize the legitimacy of labour unions and labour's right to strike, to bargain collectively, and to have basic civil liberties and social services. In many European countries, labour has won a major voice in determining how work is organized and in developing economic and social welfare policies.

This does not imply either that the basis of class struggle is declining or that workers will easily win new concessions (or even maintain old ones) without fighting and eventually overthrowing the capitalist system. On the contrary, as the genocidal U.S. policies toward the Third World and the growing neofascist trend in the developed world vividly demonstrate, the struggle has escalated in both scope and ferocity.

But reviewing the history of labour victories does show that the capitalist class is vulnerable. Indeed, during periods of high labour unrest, business and political leaders have only managed to prevent revolution by making major concessions and by using every military, economic, and ideological weapon at their disposal.

In large measure, industrial psychology and its descendant, community psychiatry, represent defensive rather than offensive, capitalist tactics. In virtually every instance, new psychological techniques to control workers emerged in response to the threat posed by high labour militancy. And each successive innovation was required because the previous ones had failed to keep the lid on labour unrest.

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Community psychiatry is an escalating technology because the scale of labour organization and struggles is escalating.

In the years before World War II, unions had opposed industrial psychology techniques; protesting against Taylorism, rejecting company unions, and refusing to participate in human relations style counselling and co-optation ventures. Since industrial psychology programs before the war were run directly by the managements of each separate business, it was easy for workers to see that their function was anti-labour, and to incorporate actions against these programs in their general bargaining strategy.

It was more difficult, at first, to perceive that community psychiatry programs also were designed to maintain social control. And so, although labour did not especially support community psychiatry (it was scarcely consulted), it also did not oppose it. By the 1960's, however, with the decarceration movement, the expansion of community mental health clinics, and the growing use of coercive psychiatric techniques, the groups that were most directly affected began to organize to attack community psychiatry programs.

The first to organize were ex-mental patients, who protested against inhumane treatments, pejorative labelling, and denial of mental patients' civil liberties. They were joined by newly organized unions of mental health workers, who demanded job security, career ladders, controls on over-drugging of patients, and adequate staff-patient ratios both in mental hospitals and in community facilities so that they could provide responsible care. By the late 1960's a

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broader range of affected groups had joined the movement. Minority group organizations in areas where community psychiatry programs were imposed staged effective protests against the fraud of "community participation," the victim-blaming medical model of treatment, the dependency and addiction caused by methadone maintenance programs, and government complicity in maintaining oppressive social conditions. "Indigenous non-professional" mental health workers went on strike to protest many of these same issues. Militant black, Latino, anti-war, women's, and gay groups denounced community psychiatry programs as sexist, racist, and oppressive (Office of Program Liaison, 1969).

As a result of these movements, NIMH lost much of its credibility as a benevolent, neutral, progressive agency. It was forced to abandon its most visible forays into low-income communities, to guarantee some degree of job security to mental health workers, to set higher standards of ethical behavior toward patients and research subjects, and to grant some basic civil liberties to mental patients. Although these accomplishments did not alter the basically oppressive nature of community psychiatry, they did represent real victories.

It is important to note that these victories were won by a relatively small and unorganized assortment of separate groups. Since 1970, the anti-psychiatry movement, representing mostly ex-mental patients, has grown stronger and better organized, unified under the international umbrella organizations, NAPA (Network Against Psychiatric Assault) and MPLF (Mental Patients Liberation Front). The women's, gay, and minority group movements also have matured, and they have continued to win concessions from the psychiatric

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establishment.

However, the groups which have been most active in opposing community psychiatry, by and large, represent marginally employed populations and low-income mental health workers. Their isolation from broader political and labour struggles limits both their base of support and their political analysis. They tend to view community psychiatry as the main enemy, leading to distorted theories that psychiatrists run the government in a "therapeutic state." They confine their protests to its particularly objectionable specific practices, and their programs to self-improvement through Zen, natural food, and peer support. As a result, a number of their struggles have been easily co-opted or defeated by bureaucratic red-tape and the government's ability to pit groups against each other in competition for funding.

Mainstream labour groups have not yet seriously addressed the threats of community psychiatry, largely because the psychiatric programs directed at workers are well camouflaged. Much of the treatment of workers takes place outside the workplace -- in the offices of family doctors, and in public mental health centres, mental hospitals, and drug and alcohol treatment programs. The stigma associated with mental illness (not to mention the threat it poses to employability) keeps workers from discussing their emotional symptoms openly, especially when there are so many places where one can get "help" without others knowing. Management-run treatment programs appear on the surface to have little to do with these non-job-related psychiatric treatments (although they are heavily subsidized with public funds and expertise), and so whatever protests

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workers wage against psychiatric treatment tend to focus only on the local occupational program (Trice, Hunt & Beyer, 1977). In addition, employers often have been able to slip mental health "services" into a broad occupational health package, and thereby to put workers in the position of accepting them as part of a benefit for which they fought. However, many unions have managed to see through this stratagem:

> The development of multiple issue employee assistance policies (often called "broadbrush" programs) has stirred up considerable union resistance. Such broadbrush programs, encompassing a variety of behavioral problems under one program, are viewed by many union officials as extending management's option to deal with mental health, an area of traditional union suspicion. Such a broadbrush program can be viewed as an open-ended device for management control of practically any form of dissent. (Trice, Hunt & Beyer, 1977, p. 110)

We can expect, however, that as economic conditions deteriorate further, employers will intensify the maddening aspects of work -- speed-up, job insecurity, occupational hazards, and attacks on wages and benefits. And we can also expect that the government will subsidize further expansions of community psychiatry to counteract both the psychological breakdowns resulting from work pressure and the rising militancy of workers in struggling against those pressures. Battles directly against community psychiatry may well become an arena of struggle in store for workers.

If this struggle is to be effective, there are several strategic points which emerge from this study as crucial. First of all, workers need to be clear about what the enemy is and about who their friends are. The "enemy" is no longer just the specific employer, but the entire capitalist class and its state. As

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community psychiatry now exists, employers can manage quite well without actually running their own private treatment programs by referring "problem" employees to outside treatment by HMO's (Health Maintenance Organizations), private doctors, and public mental health programs. They have access to public computer records and publically-funded research and training programs. To effectively prevent psychiatric social control of workers, all of these programs must be attacked.

For friends, workers need to ally with a broader population than just the members of their own union locals. In addition to other labour organizations, workers can well co-operate with the other populations which are also protesting psychiatric oppression -- ex-mental patients', mental health workers', women's, prisoners', and Third World liberation movements.

An additional area of common concern is with parents of school-age children. From the perspective of business, children represent the future labour force, and therefore children tend to be subjected to psychiatric innovations similar to those of their parents. This practice has a long history dating to the early days of the National Committee for Mental Hygiene and the child guidance clinics it organized (National Committee, 1929). Since then, the link between public education and community psychiatry has grown even more intimate. Children are exposed to personality and intelligence tests, vocational tracking, "non-directive" counselling (as well as highly directive coercion), and, most recently, sophisticated behavior modification programs and psychotropic drugs. A detailed analysis of this process is beyond the scope of this study. But as a strategic question, it is important to recognize

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and fight the powerful tools that these techniques give business in preparing children to become subservient, other-directedly productive, and anti-revolutionary workers.

And finally, workers might do well to remember that community psychiatry has consistently been a defensive weapon against the power of united labour unrest. Viewed in isolation, community psychiatry's expansion may seem intimidating. But in the context of its direct response to labour unrest, we can see that community psychiatry's development derives largely from the vulnerability of business. Although the weapons of community psychiatry have grown more sophisticated and have spread to treat an ever larger proportion of the world population, the labour force which it addresses also has grown in size, sophistication, and militancy. During this period of economic instability and preparation for war, we can expect community psychiatry to become more extensive and more coercive. But, as in the past, workers can mobilize to fight back effectively, because they are not passive victims but active combatants.

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