Editorial:
The Medical Means of Repression

Psychiatry and psychology have long been in vogue among liberal intellectuals as particularly humane disciplines. In the forties and fifties it was Dewey’s educational psychology with its progressive schools and Play-Art toys and Gestalt psychology with its dynamic, multi-dimensional view of human experience. In the sixties it was Reich and his sexual politics, Marcuse and his dialectical psychology, and Laing and his existential psychiatry. For some liberal and New Left intellectuals, understanding of the individual psyche has seemed to open the doors to new, humane ways of “treating” those incapacitated by mental illness, and to new tolerance of non-conforming thought and behavior.

But while liberals were finding visions of liberation in psychiatry and psychology, the society around them was learning to exploit the darker sides of these disciplines. Psychology and psychiatry are increasingly used for purposes ranging from selling deodorant to isolating and repressing those who “step to a different drummer” (or worse yet, have visions of a better society).

For starters, psychiatry is used directly to incarcerate people who can’t get along with society. A variety of civil commitment procedures and commitment methods tied to the criminal courts, presided over by psychiatrists, serve this end. Parents have “difficult” children committed to mental institutions. Relatives sign in their “cankerous” aged dependents. Police whisk “disorderly” people off to Bellevue for a few days’ observation rather than bothering with courts and elaborate legal procedures. Prosecutors seek to have defendants against whom they have flimsy evidence declared “incompetent” and committed. In some cases, of course, the person sent to a mental institution may be deeply troubled and seriously in need of help. In many others, however, they may merely be someone whom parents, relatives, cops, or courts can’t get along with and want to get rid of. In either case, his fate is imprisonment. Patients in mental hospitals get, at best, comfortable custodial care and an inadequate level of treatment. At worst (and very commonly) they are brutalized, dehumanized, physically mistreated, and kept too doped up with drugs to resist. For all the rhetoric about how we have learned to give the mentally ill humane treatment, in fact mental institutions only provide a more or less humane facade behind which we “put away” those whose minds we can’t control.

Psychiatrists and psychologists also serve as part of the repressive apparatus within such conventionally repressive institutions as prisons and the armed forces. In these institutions, total obedience without question is demanded. Many methods, from persuasion to isolation to physical punishment, may be used on recalcitrant prisoners (or soldiers). The psychiatrist or psychologist is just a more refined instrument for obtaining absolute submission. His therapy or counselling serves one end alone—to break the resistance of those on whom other, more direct, methods have failed and to ease the way to “adjustment” (i.e., submission) for all.

Even the police use psychology as one of their weapons. Increasingly, police departments are allying themselves with academic departments of psychiatry for assistance in dealing with individual offenders, crowd control, and “conflict resolution.” The use by the police of methods other than the gun and the club, of course, does not change the social function of the police. The only sense in which it can be seen as a humane advance is that it enables the police to do their repressive jobs while breaking a few fewer heads.

Psychiatry and psychology are thus used as direct instruments of coercion against individuals. Under the guise of “medical methods,” people are pacified, punished, or incarcerated. But psychiatry and psychology are also used more generally as an instrument of pacification and control of our entire society. They have become a central ideological instrument for obscuring people’s understanding of their experience and for preventing their recognizing the social bases and collective nature of their oppression.

The central mechanism by which psychiatry...
try and psychology achieve this is to reduce all collective experience to a sum of individual experiences, to reduce all social grievances to individual pathology. Psychiatrists are trained to try to impose the responsibility for a patient's problems on the patient him or herself, rather than on the patient's experience or environment. The March 1970 issue of Transaction reports on an article by Thomas J. Scheff on this process: "Most psychotherapists have been trained to view patients as favorable candidates for psychotherapy if they have 'insight into their illness' - which is to say that they accept, or can be led to accept, their problems as internal" [Emphasis ours]. Scheff gives an example from the pages of a textbook on psychiatric practice: A women is irritable, tense, and depressed because of her alcoholic, abusive husband. The therapist is supposed, according to the text, to 'reject' that explanation of her troubles. But when the patient finally states her problem in psychiatric terms, saying that she came to him because "Maybe I could get straightened out" [Emphasis ours], he should now, according to the text, sound "interested": "And you don't regard your husband as being the difficulty? You think it is within yourself?" When the patient replies: "Oh, he's a difficulty all right, but I figure that even had it been other things, that this state would've come to me," the therapist should, "eagerly now," begin to question her on "the factors within yourself."

One of the most pervasive uses of this kind of psychiatric ideology is in supporting the continued oppression of women. A woman's failure to accept her prescribed roles as housekeeper, nursemaid, and husband-pamperer is explained to her as resulting from her own psychological inadequacies as mother and wife rather than from flaws in the institutions of marriage and the family and in the roles defined within them. If she fails to wipe Con Ed's soot off the window sills every day, she is a "bad" housekeeper; if her child uses dope to escape the emptiness and despair of the streets, she is a "bad" mother. Whether delivered in person by her psychiatrist, or through the mass psychotherapy of Abby, Ann Landers, Rose Franzblau, and the Readers Digest, the message is clear: your oppression as a woman is your fault, not a social problem; hence it must be met individually (and by changes in yourself), not collectively.

Another use of the psychiatric ideology has been in "explaining" the rise of dissident political movements. Thus, psychiatrists and psychologists have sought to explain the rise of the New Left to the American people in terms of the psychology of the dissenters. Vietnam, racism, poverty, imperialism disappear save as triggers of latent psychopathology. Bruno Bettelheim, the well-known psychoanalyst, describes the new radicals, in a widely quoted interview, as "paranoids," the necessary outcome of the "permissive" child-rearing practices of Dr. Benjamin Spock. More recently, the New York Times called in psychiatrist David Abrahamsen, a specialist in the study of violence, to explain the politics that led up to the recent rash of bombings. The bombers need not be psychotic, he said. They may be "dissatisfied persons with a grudge . . . some hurt, some loss, disharmony in the family, disappointments, personal grudges." Somehow the bomber "twists his own personality conflicts into believing something is wrong with society . . . " Bombing is a way to call attention to oneself: "And so, while his inner conflict is personalized, he directs his aggression at society to displace his anger." These psychiatric descriptions have found expression in the plans of the Nixon Administration for increased surveillance and repression of the Left. One "highly placed Nixon assistant" described extreme radicals thus: "It wouldn't make a bit of difference if the war or racism ended overnight. We're dealing with the criminal mind, with people who have snapped for some reason."

The Daily News turns it into laymen's language—"spoiled, self-centered brats" who "hate everything decent and good" and who

Much Madness is divinest sense
To a discerning eye—
Much sense the starkest madness,
'Tis the majority
In this, as all, prevail.
Assent and you are sane;
Demur, you're straightaway dangerous
And handled with a chain.
—Emily Dickinson

have an "urge to destroy." The psychiatrists give the same theme the respectability of science. Widely publicized in the mass media, their views help shape the public's consciousness of the movement. They help insulate the good TV-watching, Life magazine-reading citizens from understanding what the movement is all about, how it relates to the forms of oppression he feels in his own life, and why he should take it seriously on its own terms.

Many other examples of the repressive ideological role of psychology and psychiatry can be given. Black riots come from the "instability of the Negro family" according
to presidential advisor Daniel Moynihan, not from poverty and racism, hopelessness and anger. Absenteeism among the blacks and Puerto Ricans in low-paying dead-end jobs is due to inadequate socialization in the virtues of promptness and perseverance not to the inhumanity and pointlessness of the job itself. Acceptance of the status quo is normal and healthy; deviance in thought or behavior, whether individual or collective, is pathological. People are taught to think of themselves and to think of the deviations and dissenters of others in these terms. A sick society is transformed into nothing more than a collection of sick individuals. Conceived of in scholarly journals, boiled down by pop psychiatrists and advice columnists, in our society psychiatry and psychology have become the pseudo-scientific underpinning for a repressive ideology which promotes alienation, from oneself, from others, and from reality.

Do not Pass GO, go Directly to Jail . . .

Back in the 1950’s and early 1960’s, mental health vied with fluoridation as a pet peeve of the far right. For a bunch of psychiatrically trained “intellectuals” to have the power to put people away for something as undefined as “mental illness” seemed an assault on the moral character of America and an intolerable infringement of personal freedom. Liberals regarded the right-wing anti-mental health buffs as “crackpots.” To the liberals, hospitalization for the mentally ill seemed to be a humane alternative to more conventional punitive measures taken against those who commit anti-social acts because of mental disability. The liberal tradition honored the efforts of private and public institutions to look out benevolently for the welfare of those who were unable to make it in society (“whether due to joblessness, age, or insanity”). But the right-wingers, regardless of their reasons for opposing the mental health movement, may not have been entirely wrong. Both criminal and civil law relating to mental health provide ample opportunity for the suppression of those who behave in ways alien to society or profess a different life style—the criminal, the hippie, and the political dissenter.

In New York State, a recently proposed recodification of the State Mental Hygiene laws has presented the Legislature with a “reconciliation” of the State Mental Hygiene laws. The new law is really more of a revision than a recodification. It amends the state alcoholism, narcotics, mental retardation, and mental illness laws and puts them all under the jurisdiction of the Department of Mental Hygiene. The bill is currently before the Joint Legislative Committee on Physical and Mental Handicaps, but there are indications that an effort will be made to jam it through the Legislature before more opposition mounts. Governor Rockefeller’s Department of Mental Hygiene is the leading protagonist of the bill, because the bill provides a major increase in its power over a diverse set of programs. Other backers of the measure include New York City’s Department of Mental Health (see May, 1969, BULLETIN) and the New York Association for Mental Health. The psychiatric and psychological professional societies are opposed, largely because the bill contains provisions expanding the powers of the State to license, regulate and investigate private psychiatric practice.

The portions of the proposed law relating to involuntary commitment to mental institutions are especially threatening, adding a new vagueness, looseness of language, and lack of concern for civil liberties to the existing civil commitment procedures (which themselves have been attacked on civil liberties’ grounds). Some features of the proposed law (some of which are carryovers from the current law) are:

- The definition of mental illness is purposefully vague. “Mental illness,” says the law, is “an affliction with a mental disease.” (Got that?) Involuntary long-term commitment to a mental institution requires that the person committed be “dangerous to himself or others,” but no overt act or threat justifying the allegation of danger is required. (In...
California, by contrast, an "imminent threat of substantial physical harm to others," demonstrated by an overt act or threat of an act of violence in the immediate past is a prerequisite to commitment.) The Department of Mental Hygiene is reportedly pressing to have even this vague wording changed, so that it would be possible to commit a person "for his own welfare or the welfare of others."

The law permits, in effect, preventive detention of a person who may be dangerous, if (and only if) he is mentally ill. "Our society," the New York Civil Liberties Union points out, "is remarkably, though properly, reluctant to confine persons solely because of what they might do in the future." The Civil Liberties Union adds that an estimated 50 to 80 percent of ex-felons will commit future crimes, and members of other groups such as ghetto residents and teenaged males are much more likely to commit a crime than the average member of society. By contrast, mental patients with no prior arrest records have an arrest rate after release which is less than one-twelfth of that of the general population. Nevertheless, "of all the identifiably dangerous groups in society, only the 'mentally ill' are singled out for preventative detention, and they are probably the least dangerous, as a group, of the groups here mentioned."

A person can be committed to a mental institution, under the proposed law, for three days (Sundays don't count), for examination, merely upon the allegation—by anyone—that he is mentally ill and requires observation, care or treatment "for his own welfare or the welfare of others." In particular, a policeman can commit a person who "appears to be mentally ill" [to the policeman] and who is "conducting himself in a manner which in a sane person would be disorderly." The distinction between a sane person who is acting disorderly and an insane person who is acting like a sane person acting disorderly—makest the mind to reel and the brain to boggle. Political demonstrators, watch out! (There are similar provisions in the current law.)

After the three days, the person can be held further on the signature of two physicians or one psychiatrist. (It's at this step that the "dangerous" provision applies.) Sometime before five days have elapsed, he must be informed that he is being involuntarily held (in case he hadn't noticed it) and that he has certain rights. (Again, Sundays are days only to the confined man, not to the course of justice.) The patient then has 60 days to ask that the court review his case. If he does not request a hearing, the hospital can ask the court to order a six month confinement without further ado; there is no absolute requirement for a hearing before commitment or confinement. If the patient, however, does request a hearing, it can be put off for five days, and possibly, at the request of the hospital and with the consent of the court, for a longer time.

At the court hearing, the patient can be committed to the hospital for up to six

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After a fruitless appeal for change to the Center's administration and to the brass in the State Narcotics Commission, two of the six counselors who complained were dismissed, and the other four were threatened with transfer. (The entire counseling staff consists of seven people.) Dr. S. Seymour Joseph, associate commissioner of the State agency, denied the allegations of the dissidents and said: "The counselors will be replaced with individuals who are more concerned with the rehabilitation of addicts and less with their own personal ambitions." (One of the counselors' many demands was that one of their own members be promoted to a policy-making position. The other demands all concerned improved care for the addicts.) A press release issued by the therapeutic staff March 10, just before the Joseph edict, said:

"There are over 200 people, mainly Blacks and Puerto Ricans, locked up in a prison right behind us. According to the State of New York as manifest in the New York State Narcotic Addiction Control Commission they are being rehabilitated mainly through the use of therapy. The therapeutic staff demands that the people of this state regard it as a jail. Mental Hygiene is reportedly pressing to

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months. The court is required to explain in writing the reasons for its decision, if it decides to release the patient, but no explanation is required if it orders his incarceration continued. At the end of six months, similar proceedings can result in additional one and two-year sentences. (The words “incarceration” and “sentence” are used advisedly. State institutions for the insane are notoriously brutal and “anti-therapeutic.”) A 1960 article in the American Journal of Psychiatry observed: “There is repetitive evidence that once a patient has remained in a large mental hospital for two years or more, he is quite unlikely to leave except by death.”

- The court “may determine the need, if any, for the appointment of counsel for the patient” [emphasis ours]. He has no guaranteed right to counsel. Moreover, his lawyer, if he has one, cannot get access to the patient’s records except “on the consent of the commissioner [of Mental Hygiene] or on an order of a court of record.”

- The patient has no right to confidentiality or privacy. State Mental Hygiene officials can freely examine him in private (he has no right to have a lawyer or his own doctor present), and are authorized to inspect his clinical records and personal possessions.

- Involuntary commitment gives the State extraordinary powers over the confined person. It can subpoena a patient’s personal books and papers; fingerprint and photograph him; take away permanently a child born to a patient in the mental hospital; seize the patient’s funds or other personal property up to $2500 and sell them for his support; regulate his communications with non-patients; and even open his letters to friends or his lawyer.

- Consent is required for surgery on a committed person. From the wording of the law it appears that consent is not required for electroshock therapy, drug therapy, etc.

Mental health laws, in New York and elsewhere, are unparalleled in their delegation of arbitrary power to a single group of people—the psychiatrists, who, of course, are subject to all the political and social prejudices of our society. In a 1969 Florida case, for example, two psychiatrists testified that a “self-proclaimed ‘hippie’ who believed in love, non-violence, and the use of hallucinogenic drugs” was on these grounds alone mentally ill and in need of confinement. This particular hippie was luckier than some: his lawyers found a psychologist to take issue with the psychiatric judgment and the appellate court set aside an order of commitment. If someone can be threatened with civil commitment merely because of his life style, then those whose behavior and attitudes are more directly threatening to the established order might well watch out. Perhaps never in United States history has a law threatened such severe punishment for ideas and attitudes as the proposed New York law. And, according to the law, it’s all in the name of “the protection and promotion of the mental health of the people of the state.”

The criminal courts have also used psychiatry as a tool of repression through rulings of incompetence to stand trial and acquittal by reason of insanity. Hearings on incompetence to stand trial are held on the motion of either the prosecution or the defense before a criminal trial. The hearing is held before a judge without a jury. Although the exact legal definition is in some dispute, findings of incompetence to stand trial are based on the policy that a criminal defendant should not have to go to trial if he is unable to assist his lawyer in preparing the defense. This legal standard of incompetence is often confused by the courts and psychiatrists, however, with a more general medical standard of mental illness. A court psychiatrist not infrequently will testify that a defendant is incompetent based on a finding of some form of mental illness, without investigating further whether this will incapacitate the defendant in assisting his attorney. For example, a psychiatrist might testify that an overly paranoid defendant is incompetent because he is mentally ill. However, this paranoia may equip a defendant with precisely those insights that most assist his attorney, e.g., a minute by minute diary of his life. This confusion between the legal standard and a medical standard of mental illness can result in a defendant’s being institutionalized in a hospital for the criminally insane for the rest of his life without ever being tried for the criminal act in question.

Often it is the prosecution which seeks to have a defendant found incompetent, although theoretically it should be the defense attorney who makes this decision, because it is he who must be satisfied or not satisfied with the defendant’s ability to help prepare the case. Sometimes the prosecution desires to have the defendant ruled incompetent because it is unwise to amass evidence to support its case. Bruce Ennis of the New York Civil Liberties Union’s Project on Mental Illness reports a case in which the district attorney asked a court psychiatrist to testify to a defendant’s incompetence because the state “wasn’t ready to try him.”

“Incompetence” can easily become a vehicle for handling the political defendant. Given the availability of established psychiatrists who are willing to testify to the “paranoia” and “schizophrenia” of dissidents, the court would have no difficulty declaring the political defendant incompetent and having him institutionalized for an indefinite period. Activists who make “political defenses” might be another target. For example, recently a militant black was arrested for allegedly assaulting a court officer at a trial of one of his friends. When he became unruly at his own hearing, the prosecution had him sent to Bellevue Psychiatric Hospital to determine if he was competent. The court psychiatrist testified for the prosecution that the defendant suffered from severe depression. After a lengthy hearing the New York Civil Liberties Union was finally able to persuade the prosecution to withdraw its motion and admit
Psychiatrists: the new Custodians

The form of this article departs so strikingly from that of previous BULLETIN articles that a word or two of explanation is in order. The author wrote an earlier version from his cell in Lewisburg Penitentiary Farm Camp. At that time he was less interested in describing prison psychiatry (e.g., number of psychiatrists per 1,000 prisoners, hours and types of psychotherapy offered, etc.) than he was in exploring and analyzing the relationships and interaction of the psychiatrist and the prisoner, and, more specifically, the political prisoner. This approach was adopted because he hoped to show a contradiction of serious consequence between the psychiatrists' benevolent aspirations and the real role required of him by prison authorities.

The essay was written in an effort to satisfy a pragmatic need and not as an academic exercise. At the time of the writing, political prisoners in the camp were divided in their evaluation of the role of the prison psychiatrist. Some prisoners felt that prison mental hygiene clinic personnel were basically allies; other prisoners felt the opposite. The first group of prisoners cooperated with the mental hygienists; the latter did not. It was hoped that a political/psychological delineation of the psychiatrist's role in a prison setting might help resolve these polar views.

P risons are, to use Erving Goffman's term, "total institutions," meaning "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." It should be clear that institutions other than prisons can be thought of as "total institutions." Indeed, the term was first applied to State mental hospitals. One could also consider monasteries, chronic disease hospitals, high schools, colleges and medical schools to be various degrees of total institutions. Insofar as these organizations are total, or at least, "subtotal" institutions, some of the conclusions reached with regard to prison psychiatrists may also be applicable to psychiatrists practicing in them.

One particular institution, the military, offers striking parallels with regard to the role played by psychiatrists. Not only are prisons and the military total institutions, they are,
authoritarian institutions. Of the two, prisons are, of course, the more total and more authoritarian. But both prisons and the military have their chains of command, consisting of lieutenants, captains and commanders/war­ dens. Prisoners, like soldiers, are given or­ ders which demand unswerving and unques­tioned obedience. In both systems, behavior is controlled and directed by a system of re­ wards and punishments. In both systems, reality is defined within a frame of reference which includes only the total institution but which ignores the existence of the larger so­ ciety. Behavior is evaluated in similar fash­ ion. Naturally, "adjustment" is encouraged; "maladjustment" discouraged. However, ad­ justment or maladjustment are evaluated only with reference to the needs and de­ mands of the institution in question; the re­ quirements of the wider society are excluded from consideration. Thus the individual who confines his conduct within the limits set by the authorities is said to be "well adjusted," and is rewarded for his behavior. Those whose behavior strays outside the bounds set by the authorities are said to be "malad­ justed" and are punished for their "failure to adjust."

The analysis in this essay is based upon the proposition that psychiatrists play an essential role in, firstly, defining standards of behavior which serve the needs of repressive institutions and, secondly, in enforcing ad­ herence to these standards. The psychiatrist is then very much a part of these repressive institutions. These institutions, of course, do violence to their victims' freedom. They aim at the destruction of their victims' very being and personality matrix. They are, then, in their essence, anti-mental health.

The question is why and how the psychia­ trist, in particular the prison psychiatrist, contributes to, indeed serves, a pivotal role in the destruction of the mental health and well-being of so many countless victims. We must, in the course of this analysis, explore the psychological/political interplay between the victim and the psychiatrist.

For the captured victim, two alternative strategies present themselves: He may 1) passively accept the assaults hurled upon him, or, 2) he may choose to resist. The first response is by far the most common. His­ torically, the oppressed often consent in their own oppression. While there are undoubted­ ly many explanations, suffice it for our pur­ poses to say that the victim's resignation is due to the rewards which will be offered in payment for his capitulation. The compliant victim is less harassed, humiliated and phy­ sically brutalized. If he is a prisoner, the car­ rot of parole is constantly dangled in front of his eyes. The compliant victim, the one who obligingly accepts his "fate," is allowed to melt into the woodwork and is essentially forgotten. In totally acquiescing, however, a steep price is paid. The institution has been permitted to achieve its total domination over the victim's life. The end result is that the victim becomes part of a homogenized mass of humanity, cut off not only from the larger society but even from itself, blending indistinguishably into the concrete walls. In the process of adapting to his environment, the victim sacrifices his self-image and self-conception; he ultimately renounces his self­ dignity and manhood. He is emasculated, debased and dehumanized.

The victim does have another alternative; he can resist. He can do so by using many forms and methods. He may choose a collec­ tive political approach, or, under less favor­ able conditions, may resist individually. He may resist for very conscious political rea­ sons or simply because his sense of rage will not permit his jailors to imprison and annihi­ late his mind as well as his already shackled body. The effort to survive imprisonment is a life-and-death struggle. The longer a man is exposed to the dictates of his captors, the less likely it will be that he will survive with his mind and body functionally intact. In such a setting, one cannot carp too harshly about the politics of the victims' survival methods. The fact is that every act of re­ sistance in prison is a political act.

We need not concern ourselves with an ex­ tensive recital of the exact methods of prison resistance used. They vary from the complete and total non-cooperator, who refuses to eat, dress, shave, shower, work, etc.; to the man who smuggles books, political tracts and let­ ters into and out of prison; to prison organ­ izers who struggle for the day when the en­ tire prison population will be united to wreak vengeance upon their jailors while toppling the prison walls. The victim realizes that, by resisting, he can attain a measure of free­ dom despite his imprisonment, and, by so doing, he can prevent or at least delay his self-deterioration. And, if worst comes to worst, and, despite his valiant resistance, he is finally defeated, he will have succeeded in giving a historical and personal dimension to his defeat. The legacy of past resisters lingers in the dank cells and corridors of prison and helps fortify the next crop of con­ demned men.

The resistor will be met by institutionally-imposed counter-resistance. Initially, these measures include verbal chastisement and denigration. During this process the resistor is for the first time labelled by his captors. He is called a "kook, malcontent, eccentric, sub­ versive or pinko." He is not "a part of the team;" he is an "oddball and troublemaker." While still relatively benign, the insidious character of these tactics must not be under­ estimated. Their intended end result is the acquiescence of the prisoner's spirit in its own destruction. The worth and value of the individual is brought into question; the re­ sistor is being emotionally isolated and quar­ antined from the larger prison community.

Later, when the initial verbal chastisement tactic fails, the resistor will be administrative­ ly punished. He will be denied privileges (e.g., use of the library or recreation field); he might be placed in solitary; and he may
be placed on a restricted diet. Eventually, if these measures still do not succeed in quelling his urge to resist, physical brutality will be added to the emotional violence which has already been imposed upon the victim-resistor.

Throughout the attempted “breakdown” process, the resistor is offered “benevolent” advice. He is told that he is “making things hard on himself.” He is advised that the institution is designed to “rehabilitate” him, and that he should gratefully cooperate in this endeavor. Prison officials act as if the victim owes them a vote of thanks for their efforts. Of course, the prisoner owes his jailors nothing; they owe him his freedom. And, as far as rehabilitation is concerned, prisons are anti-rehabilitative in the extreme.

The victim-resistor is striving purely and simply after self-preservation. This is true of every resistor: the politically-inspired resistor, however, adds another ingredient—he seeks to destroy the system that is oppressing himself, his brothers and sisters. Even if the actors are not political, success cannot be insured because pitted against the victim-resistor is the prison Establishment. The victim-resistor must be suppressed because if he is permitted to survive, the institution perishes, or, contrariwise, for the institution to flourish, the victim-resistor must be sacrificed. To understand why so massive and awesome a counter-resistance is mounted, it is only necessary to point out that prisons are ultimately the defenders of an entire oppressive State and society. The victim-resistor’s demise must be achieved because his survival necessarily would compromise the power of society’s vehicle of oppression. To do so comes very close to challenging State power itself.

Psychiatric science buttresses and stabilizes this repressive apparatus. In not a few instances, the institution’s counter-resistance fails to silence the victim-resistor. The initial measures—persuasion, chastisement, mild administrative punishments—foil because the hostility of the institution’s personnel is too overt and their duplicity all too evident for them to be convincing. As a matter of fact, not only do these tactics often fail, but, not infrequently, the individual’s determination to resist may be strengthened rather than undermined. At this critical juncture, the forces of science are called upon. The heavy artillery is moved into position—an appointment is arranged with the psychiatrist.

The victim-resistor is interviewed in the mental hygiene clinic and shortly thereafter a new, medically-sanctioned and therefore “legitimate” label is affixed to the resistor. He is no longer merely a “kook” or “malcontent” but is instead a “passive-aggressive” or “immature personality.” But the fundamental thrust of these labelling devices is the same: They aim to convince the individual that he, and he alone, is responsible for his “aberrant” behavior. The labelling device exonerates the institution and its personnel.

**BRUTALITY IN THE CLINIC CELLAR**

It is no secret in Washington Heights that if you can afford it and if you have an interesting medical case, Columbia’s Presbyterian Hospital will provide the best medical care that money can buy. But those who rely on Vanderbilt Clinic (Columbia’s outpatient community facility) confront an enormous, impersonal institution—waiting in line for hour after hour: unconcerned, if not arrogant, medical staff; and, increasingly, police violence in the bowels of the clinic.

On the evening of February 24, Ira Heller, a 42-year-old salesman and a community resident, went to Vanderbilt Clinic’s 24-hour emergency room to have a particle removed from his eye. He waited over an hour to be told by the medical resident on duty at the screening desk that he would have to wait to be seen by an ophthalmologist. Another hour ticked by and still no ophthalmologist appeared. (It is not clear whether an ophthalmologist was even on duty.) Heller complained to the screening doctor about the wait and was told that if he didn’t like it he could leave. He did not leave but insisted emphatically that it was his right to be seen by a doctor. At this point the screening doctor lost his patience and called in three security guards to remove Heller from the clinic.

The following discription of the events that ensued has been pieced together from Heller’s account, the accounts given by community people and medical students from the Upper Manhattan Coalition for Community Health who rushed to the scene to interview other patients and clinic workers who were eyewitnesses, and from the report of a doctor in the community who examined Heller later that evening.

Three security guards, one armed with a pistol and the others with night sticks, seized Heller and dragged him into an elevator which opens into the clinic waiting room. (No given location in the street-level waiting room is more than 30 feet from the doors leading to the street.) “They began working me over— with gloved fists, billy clubs, kicking, . . . . They knew exactly where they were taking me. When the elevator got to the basement, they took me into a room and locked the door behind us and continued working me over. They said, ‘We’ll show you how we treat troublemakers.’ When they finished, they pushed me out through Harkness Pavilion (an adjacent hospital for doctors’ private patients) and threw me into the street. They warned me that if I came back again. ‘We’ll put a bullet through ya.’”

According to people who work in the clinic, this incident was not the first of its kind. The only thing unusual about the beating was that the victim was a white man. According to a worker who heard the screams from the
from any and all culpability.

The prisoner is especially likely to succumb when, as they always do, the psychiatrist professes impartiality and remoteness from the institution. Generally, the psychiatrist goes even further to court the favor and earn the confidence of the victim-resistor; he accepts the grievances of the victim and pretends to identify with his efforts at overcoming his tribulations.

But the commiseration is a sham. The victim is vulnerable. He's vulnerable because he is love- and reinforcement-starved and in such circumstances even a sham-love and sham-reinforcement is better than nothing. The strong victim-resistor who was able to accept his own resistance, begins to wonder when he is himself vulnerable. He's vulnerable because he is love- and reinforcement-starved and in such circumstances even a sham-love and sham-reinforcement is better than nothing.

"You rebel because of certain unresolved psy­tor to continue his resistance. "The reason

trist goes even further to court the favor and

accepts the grievances of the victim and pre­

assists those needing help" as, assisting the

the victims of prisons to "adjust" to an ad­mittedly unnatural environment. It should be stressed that if "adjustment" is the goal, they do meet with a certain measure of success. And this precisely is the evil, for to be "ad­justed" to one's own imminent destruction is to promote the cause of one's self-victimiza­tion; it invites the victim's mind suicide. The psychiatrist's role is to destroy any remnants of the prisoner's resistance, and this is profoundly antithetical to any meaningful concept of mental health.

It is a rare man, indeed, who can freely and openly admit to serving inglorious and evil designs. Evil men can do so, but evil men are themselves hard to come by. The men of whom I write are not evil; they do, however, serve evil designs. But, since they conceive of themselves as being essentially good, it is painful for them to acknowledge the legitimacy of an indictment which insists upon judging all acts in terms of the totality of the City—the City Department of Hospitals said Vanderbilt was not a City facility, and therefore not a responsibility of the City—and State Senator Sy Thaler (whose major con­cern has been the conditions that exist in New York's Municipal health facilities) didn't return the call.

Heller, who has received several phone calls threatening his life if he doesn't drop the case, plans to press criminal charges against the Vanderbilt security guards, as well as bringing a civil suit against Presby­terian Hospital. He does not view his case as an isolated one, however, but as a symptom of a much larger problem. He says:

"I've seen both sides of Columbia—my children were born there, I've been a patient at Harkness and my daughter had an eye operation at Harkness . . . but it's a different story if you're poor, or black or Puerto Rican.

. . . The Columbia administration doesn't acknowledge the community it is situated in. Not only has there been no community in­volvement in deciding what services the hos­tial offers, but they act as if they're doing the community a favor by occasionally treat­ing them. They only take the cases they are interested in. . . . The guards must have felt their actions were condoned by the adminis­tration, or they wouldn't have beaten me. . . . The only way to change such attitudes is to make Columbia and the hospital answerable to the community."
of the design these acts serve. Thus, to maintain his own self-image, the psychiatrist must and does interpose rationalizations and other defensive postures between himself and the indicator. In this way, he tries to justify his actions and extricate himself from a morally ambiguous predicament.

One such rationalization goes as follows: “Even if I help only a single individual, I am justified in serving the institution.” To begin with, there is a serious question whether prison psychiatrists are able to help even single individuals, given the way they define “help.” But this rationalization collapses of its own weight in any case, when it is remembered that for every one individual “assisted,” the psychiatrist helps to destroy one thousand others.

A more sophisticated second rationalization is often offered: “By infiltrating the institution and initiating reforms to make it more humane, I can change the system and alleviate the distress of all prisoners.” But the unwillingness of the psychiatrist to accept the notion that the prime initiator of reforms is actually the agitation produced by prisoner-resisters. Unfortunately, while psychiatrists claim they are reforming and even destroying the institution, it is obvious that, in fact, the psychiatrist’s main role is to undermine the efforts of those victims who have the nerve and strength to resist of their own accord. In order to safeguard his own privileged sanctuary, the doctor contributes to the sacrificing of the system’s victims. Thus his medical and humane rationalizations are untrue and are politically dangerous.

A conversation with a prison psychiatrist during my own incarceration perhaps reveals most clearly that naked cynicism and self-interest is the only real explanation of the functioning of the prison psychiatrist. I asked a psychiatrist whether he had ever thought of his office as a fireproof sanctuary protected from the roaring prison flames outside. He said he hadn’t but that he could agree with the analogy. Nonetheless, it was clear that he felt no regrets and no responsibility for helping to consign men to the prison inferno. This particular psychiatrist’s motivation for serving as a prison doctor was simple. By his own repeated admissions, he had joined the Public Health Service to avoid military service. He was then a draft-dodger, and, paradoxically, was assigned to the job of subjugating draft-resisters and other political prisoners who chose to confront the State directly instead of opting out for an easy draft deferment.

One more point of rebuttal to the sympathetic, rationalizing psychiatrist must be added. Mental hygiene clinics are important substantiations of the claim that prisons “rehabilitate.” The existence of the mental hygiene clinics are used by legislators and prison administrators to justify these thoroughly unjustifiable institutions to the public. Therefore, whether willingly or otherwise, the would-be psychiatrist-subversive lends stability and support to these institutions, and, in so doing, subverts his own would-be goals.

Actually, the psychiatrist should be asking himself these questions: “What is this institution and what is my role in it? Is the sick one the man who enters my office seeking help, or is the sick one the institution which pays my salary, gives me a uniform to wear, and provides me with a set of rules and regulations I’m asked to obey?”

The answers to these questions are rather obvious. The institution is the patient, and the victims who seek the doctor’s assistance are the “disease.” In particular, the victim-resistor is the most virulent disease infecting the institution and upsetting its homeostasis. The psychiatrist serves his true patient well indeed. He is asked to combat the infectious agent and he does. Instead of antibiotics, however, words and tranquillizers are used to arrest the causative agent—victim-resister. It is to be anticipated that, were the words and pills to fail, the knife would be tried next. By one means or another, the disease—the victim-resistor—must be extirpated.

The psychiatrist knows quite well that for him to act other than as an agent of the prison, would be to run the risk of endangering himself. Prison psychiatrists are unable to envision any alternatives, not because they are so difficult to conceive, but because the psychiatrist is too frightened to even speculate about what those alternatives might be. As one prison psychiatrist told me: “Let’s face it, I’m a coward.”

The victim-resistor knows that the psychiatrist is not an “objective” therapist; rather he is a frightened therapist. The victim-resistor further knows that because of his fear, the psychiatrist performs acts which make him equally culpable as the institution itself. Rather than admit the accuracy of this indictment and thus compromise his own ego image, the psychiatrist ultimately projects his own inadequacy back upon the victim. The combination of fear, self-protection, and the entire thrust of American psychiatric training facilitates the psychiatrist’s adopting the institution’s original line of reasoning, lock, stock and barrel: ‘The fault rests with the victim-resistor and his failure to ‘adjust’.‘

The institutional psychiatrist may be the possessor of limited power, position and privilege. He is not, however, the possessor of his own freedom. Although the victim-resistor is infinitely more victimized than the psychiatrist, the latter, too, is a victim of the system.
Both victim-resistor and victim-doctor are trapped by forces felt to be outside themselves—forces which instill fear and deny both victims their freedom. But it is the psychiatrist who is the more alienated of the two victims since his very power, position and privilege prevents his attaining full consciousness of his own imprisonment. And, psychologically, insofar as his victimization is not fully conscious, he is the less free of the two victims since he is not yet even in a position to formulate the means by which he might resist. Thus, we have come full circle.

Insomuch as the therapist is afraid to grasp the totality of the system and confront that system, he becomes, as one commentator has phrased it, the “New Custodian.” The psychiatrist who cannot free himself becomes an instrument for the imprisonment of others. The “New Custodians” mold men’s behavior to fit the imperatives of institutions, and, in so doing, mold themselves to the same institutional shape. Even the psychiatrist’s power is illusory and will be taken away from him as soon as he takes his first tentative steps towards freedom.

What might these first tentative steps be?

To begin with, the prison psychiatrist must declare his allegiance unequivocally to the victim-resistor as well as all other prisoners. Once having done so, he must manifest that allegiance in concrete acts. Such acts could include the use of psychotherapy to strengthen, rather than weaken, the will of the resistor. It might include the smuggling of political materials into and out of prison—letters, pamphlets, magazines and books. And the psychiatrist could and should publicly expose the realities of prison life, including the utter hypocrisy of the theme that prisons “rehabilitate.”

Every victim-resistor is fighting to free all victims everywhere. That struggle has been in progress for centuries. Were the psychiatrist ever to decide to do these things, he would also truly liberate himself. At that point he would be welcome to the larger liberation movement. To do so, however, the psychiatrist must be willing to yield his privilege. Until he does so, however, the victim-resistor has no choice but to regard the “New Custodian” for what he really is—a policeman. The victim is entitled, and in fact, has no other option than to take whatever action may be appropriate in dealing with this enemy.—Howard Levy, M.D.

Cops:
From Clubs to Couches

With a little help from psychiatry, the long arm of the law may become the velvet fist of justice during the 1970’s. Increasingly, mental health professionals and cops are getting together to consider more “humanized” ways of dealing with troublesome city dwellers and, in the course of it, are developing more subtle forms of social control. Mental health techniques in the hands of the cop, as in the hands of the mental health professional, deal with the disruptive citizen on an individual basis—by helping him to “adjust” or “communicate” more effectively with the authorities. Though such programs may be more humanitarian than billy clubs, they fail to understand what is justifiable anger at an oppressive system—especially as experienced by the black and brown communities. Sensitive to growing complaints of old-fashioned brutality, urban police forces are arming themselves with more acceptable, but equally repressive techniques borrowed from the mental health professions.

In response to the many “movements” for social change in the 1960’s, police began dabbling with the ideas coming out of the community mental health “movement.” With the guidance of mental health professionals, local law enforcement agencies began to launch experimental programs—special training courses in riot control and handling strikers, special recruiting and training programs for teenage policemen, weekends in the country for police officers and juvenile delinquents, sensitivity sessions between police and community leaders and encounter therapy between community militants and cops. Financing for such experiments was assured by the passage of the omnibus Crime Control Act of 1968 and the subsequent establishment of the Law Enforcement Assistance Administration as part of the Justice Department.

The attraction of mental health professionals to fighting “crime in the streets” was predictable. Those in the forefront of the community mental health “movement” were using group therapy in their offices as a means of resolving conflict. By working with the police, they could not only examine the dynamics of conflict in small groups, but might gain insight into conflicts and antagonism between entire segments of the American society. And, in the eyes of the more idealistic, if they were successful, perhaps they could resolve grave social conflicts such as those which exist between the police and the ghetto dwellers.

Police/community pilot projects are proliferating and the mental health professionals are refining the techniques as they go. One of the early, more primitive techniques—the “encounter”—is being pushed in city police departments throughout the country. In the State of Illinois, for example, some enterprising professionals from a private consultant firm, Ebony Associates, have sold the idea to a score of troubled municipalities. Ebony, headed by a black, University of Illinois psychologist, has as another executive a black ex-cop who uses his seat on the State Commission on Human Rights to extol the virtues
A couple of years ago, Ebony convinced the police of East St. Louis, Illinois, that an encounter session would help the local police better understand the local black militants. As in traditional encounters which seek resolution of conflict through open, non-violent confrontation, the program directors set up a weekend meeting for cops and militants in a motel on the edge of town. CBS later immortalized the encounter with an hour-long television documentary entitled the "Battle of East St. Louis." After hours of head-on verbal collisions, each participant began to see both his "enemy" and himself as a "human being" with problems. And once he accepted individual responsibility for attitudes and actions, he could begin taking individual steps toward resolving the conflicts which had built up over the years. The camera crews revisited participants a few months later and found that the weekend encounter probably changed the attitude of several cops who participated. The blacks of East St. Louis report that certain cops who were considered sadists by the community are no longer using third-degree tactics at the station house. However, critics of the mental health approach point out that in a town like East St. Louis—a primarily black community which is ruled by a totally white power structure—the problems go deeper than individual antagonisms. The encounter group leaders, they report, not only did not bring up, but openly discouraged discussion of the role of the police force in the black community.

In New York City, encounter therapy has played a relatively minor role in mental health projects being devised for cops and community. In the past, if trouble arose in a community, the local police precinct captain—if he sought counselling at all—would most likely call in a psychologist or psychiatrist on a one-shot consulting basis. Now, mental health professionals from both the universities and the medical institutions are working with the New York Police Department to set up joint mental health demonstration projects.

Two programs to sensitize policemen have been designed by the Department of Psychiatry at St. Luke's Hospital. The first is a "people who play together, stay together" style program in which a cop can take a kid to camp for a weekend. At camp (an abandoned army camp in Queens) "dialogue" is stressed in a professionally designed program which provides for both play therapy and for a series of T-group sessions. In the summer of 1968, 35 two-day periods were scheduled with 10 policemen and 30 youths taking part each weekend with expenses paid by the Law Enforcement Assistance Administration and Mayor Lindsay's Urban Task Force. Though the directors of the program feel that a lot has been accomplished so far as changing attitudes (many youths subsequently expressed an interest in joining the police force), the mental health professionals say the program could be even more effective if they had more control of it. For example, the professionals would like the participants to represent a broader spectrum of youth and the cops who actually work on the beat. Unfortunately, they say, the police control the recruiting and they tend to choose only kids who are "troublemakers" and cops who are already specialists in "community relations" rather than ordinary patrolmen.

St. Luke's second program, and the one which seems to have taken root and is now being looked to as a prototype for dealing with ghetto youth, provides ongoing training for young police recruits. A little over a year ago—faced with increasing hostility from minority youth—the police department began recruiting 17- to 21-year-old trainees into its Precinct Service Officer program. The recruits are trained to relate to their peers and their problems, often those which are rooted in drug usage. Of the 46 young men in the program, only about one third are black or Puerto Rican. For the New York Police Department, however, this is a high proportion of the total. The recruits go through police academy training and upon reaching 21 become regular patrolmen.

At St. Luke's, the trainees are required to read such books as Soul on Ice and to contemplate such heady subjects as: conflict between blacks and Puerto Ricans, the hostility displayed to policemen by militants and SDS, violence and the psychology of extremism, alienation from "the establishment," the generation gap, youth power, student power, police and urban community conflict and the role of the police in community change. One young trainee who was attempting to absorb all this psycho-social theory requested that the experts clarify and elaborate on the following:

"I would like to talk about how to relate to a Hard Core Child . . . I figure this will be very valuable to me in the field [placement] period. By Hard Core I refer to a Cop-Hater, or one who dropped out of school and is using drugs. From what I see these types usually have a big following of young impressionable children. I feel if they see their 'leaders' turn to the police, instead of against, they will also follow. [The psychiatrist] was a tremendous help in the past and I feel he can clear my mind on this subject."

At the same time that community mental health professionals have been tutoring the New York police force, their counterparts in the university have laid more elaborate plans for extending psychology's impact out of the hallowed halls and into the streets. The Psychological Center at City College, under the directorship of Dr. Morton Bard, for example, is heading aggressively for the frontlines. Dr. Bard says that "careful evaluation of the realities of modern social existence suggests that law enforcement and mental health are not such strange bedfellows after all . . . In these days of increasing social tension, increasing crimes (particularly of violence), increasing mental health manpower short
agencies, and increasing need for a university-community dialogue, novel approaches to these problems are necessary . . ." The Psychology Center, which is located in West Harlem, has launched a research-oriented "community action" program in which mental health professionals work with and train the local police.

The Center is currently focussing on the New York Housing Authority police, who are employees of the Police Department possessing the same powers as regular city police. (There are 1400 housing police patrolling 152 public projects with a total of 600,000 tenants.) This demonstration training program, which involves policemen from three housing projects, is an extension of an earlier project which trained policemen for crisis intervention during family disturbances. On the basis of the successful crisis intervention experiment, the psychologists developing the housing police project are asking: "[Can] the methods of the demonstration [crisis intervention] be successfully extended to human conflicts which do not involve family members? [Can] there be a precise measurement of impact upon the community?"

Already, community people have been surveyed for their attitudes toward police so that the researchers can measure changes of attitudes produced by the latest police training program. They hope that, eventually, changed attitudes will be reflected in increased utilization of the police force and a decrease in the incidence of "malicious mischief and vandalism . . . which often reflects a passive-aggressive citizen response toward an authority structure that is seen as wholly repressive and insensitive rather than reasonable and helpful."

Conflict resolution is the goal of the City University program. In a paper presented last month to the annual National Symposium on Law Enforcement Science and Technology, Dr. Bard asserts:

"To some observers [conflict] is a disruptive and deviant form of behavior which needs to be treated as if it were a disease: to others, conflict is a form of socialization which has positive and constructive aspects. In either case, it is for each society to define the tolerable limits of conflict and to contain those conflicts which go beyond acceptable limits. . . . Virtually everywhere, it is the police who have been assigned the responsibility for monitoring the dimensions of conflict and for checking excesses. . . . Unfortunately, it may be that the failure to properly acknowledge the increasing importance of these highly complex conflict resolution functions [of police] has been partially responsible for the deteriorating effectiveness of the police as a system of social regulation."

How do the mental health professionals or academicians fit into the picture? Read on, Dr. Bard: " . . . the present experiment [housing police] suggests further the viability of a collaboration between the social scientist and the police. The action-research model embodied in this experiment is clearly to the mutual advantage of both. For the police, the relationship holds promise of affording insights into dimensions of complex social processes of which they are the lonely arbiters and from which can flow their increased safety and job satisfaction. For the social scientist, the association provides an avenue to human interactional data not available to naturalistic study in any other way. And for society, the collaboration holds promise for contributing somewhat to improving the conditions of life in these confused and complicated times." [Emphasis ours.]

The mental health professionals—whether entrepreneurs pushing encounter sessions in motel rooms or academicians reading to recruits from Soul on Ice—all seem to have a mental block when it comes to recognizing oppression. They have yet to ask the right questions: Will a predominantly white occupying police force ever find the struggle of minority groups (no matter what the means) for self-determination to be anything other than hostile? And when the role of the occupying police force is to protect the property of the privileged classes, can the occupying force also provide "equal protection" to the citizens of the occupied community? Or will the kind of protection that the black and brown communities need—from drug pushers, greedy landlords and exploitative businessmen, for example—be provided only when the community controls its own police force?—Maxine Kenny

NYU - NY Times:
What News is fit to Print?

When NYU appointed CBW expert and former Pentagon advisor Ivan Bennett to the post of Dean of the School of Medicine, the medical students used every means possible to make their objections known—leaflets, letters and even a protest demonstration. The NYU administration had more dignified means of communication at its disposal. On April 9, NYU printed its rebuttal to the student protestors—in the form of an editorial in the New York Times. (NYU and the Times have always been very close. Howard Rusk, director of the NYU-affiliated Rusk Institute, serves as a Times columnist and medical consultant: see the February, 1970, BULLETIN.) Just in case any of the students might have missed the Times editorial, NYU reprinted it and distributed it to all the medical students.

Below we have reprinted the Times editorial and a rebuttal written by a fourth-year
NYU medical student in the form of a letter to the editors of the Times. (The student’s letter was never printed by the Times): April 9 Times editorial, entitled “McCarthyism from the Left”: McCarthyism—this time emanating from elements of the New Left instead of the Old Right—is beginning to reappear on some college campuses.

A particularly dismaying case in point is the current offensive against the distinguished medical scientist, Dr. Ivan L. Bennett Jr., who is New York University’s vice president for health affairs and dean of its medical school. Charging that Dr. Bennett once did research on diseases that are included in the spectrum of biological warfare weapons, a group of NYU faculty members and students is now demanding his ouster.

The charge in Dr. Bennett’s case is ludicrous in light of his major contribution behind the scenes toward persuading the Nixon Administration to abandon biological warfare techniques and to destroy existing stocks of disease organisms. Opponents of biological warfare should be honoring Dr. Bennett for his effectiveness in pressing their cause, instead of attacking him . . .

This nation, still remembering the damage done by McCarthyism in the early 1950’s, is not going to embark upon any such massive irrationality and injustice in the early 1970’s.

April 10, letter from David Mendelson to the New York Times: Your invocation of “McCarthyism From the Left” is both a serious misrepresentation of the facts in the Bennett case, and also a poor historical analogy. First, the charges against Dr. Bennett are in several different areas. Chemical-biological warfare (CBW) is one; another is the involvement of the community in the selection and control of the position he has recently assumed. You insist that we object to him because of his past work in CBW; we do, but we also object to his present stance. He so-called “attempts toward persuading the Nixon Administration to abandon biological warfare techniques and to destroy existing stocks of disease organisms” are motivated less by considerations of morality than by military tactics. He stated in November at the University of Pennsylvania, “When you examine the concepts of biological warfare closely, you see they don’t offer much militarily . . .

The same can’t be said of chemical weapons.” Indeed, he lauded the use of the tear gas CS as a weapon in Viet Nam; and declared his opposition to Secretary-General U Thant’s call to abandon “all chemical, bacteriological and biological agents (including tear gas and other harassing agents),” saying that “any move that might be interpreted as taking an effective weapon away from our forces would surely carry domestic political risks.” And to go even further, the July, 1969, report of the UN Commission on Biological and Chemical Weapons (on which he served), attempted to reclassify bacteriological toxins as chemicals, thus exempting them from a possible ban on biological weapons.

President Nixon several months later termed the Commission’s statement an “administrative oversight.” This is absurd; a person with Dr. Bennett’s expert background in politics and pathology simply does not make “administrative oversights.”

We also oppose him because his dual role as Dean of the Medical School and Director of the Medical Center represents a dangerous concentration of power, without accountability to the medical school faculty or student body, let alone to the Medical Center workers and members of the community the Medical Center serves.

McCarthy, by using smear techniques, sought to destroy people on the basis of prior associations, of past history and of past involvements which had no immediate relevance to the issues at hand. We seek to remove Dr. Bennett because of his present positions and his present involvements. His past work is significant only in that it has brought him to his position of power today. His present views on the use of chemical and bacteriological warfare render him morally unfit to direct our medical center, and to direct the education of generations of young physicians. His appointment was based on considerations of power. This appointment must be reversed.

The New York Times is to be criticized for supporting Dr. Bennett without a clear understanding of the issues involved, and for invoking the spectre of McCarthyism, which is totally irrelevant to this entire situation.

OUT OF THE STIRRUPS: In a major breakthrough in doctor-patient communications, Women’s Liberation and the Women’s Health Collective invaded the Sixth World Congress of Gynaecology and Obstetrics on April 16. Demands for free admission and participation in the Congress as well as immediate public support for free safe abortions on demand, free and open communication of medical information, and an end to two-class medical care brought a surprisingly sympathetic response—the Congress, which had previously conceded only 12 admission passes, “found” time for the women to speak at the inauguration of the new president. Hotel Americana officials, however, had other ideas and tried to keep the women out. After several attempts, the women made it—just in time for the end of the inauguration. While the academic-robed doctors marched solemnly off the stage, the women stole the show by raising their signs and marching once around the room and on to the stage. After some further discussion with interested doctors and with Congress officials, the women were granted time during the afternoon sessions to present their analysis of women’s medical care and their demands for changes.