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Correspondence

THE SEEBOHM REPORT

DEAR SIR,

The significant fact about the Seebohm Report was that it raised the issue of distribution of power and authority between social scientists on the one hand and various levels of medical professionals on the other, concerning certain areas of social pathology. At least Dr. McDowall (*Journal*, October 1970, p. 413) and I are in agreement that this is where the argument lies. But the Seebohm Report went on to recommend in effect an extension of the areas of autonomy for social scientists, with a consequent limitation or reduction of medical control. It is this second point that Drs. Pilkington (*Journal*, April 1970, p. 457) and McDowall refute. Dr. McDowall chides me for failing to state the grounds on which I base my views that social scientists should have equal influence with psychiatrists and community physicians in the management of welfare services and development of policy. But correspondence columns are hardly the appropriate media for this purpose, and in any case I have already done so elsewhere (1, 2).

But this central dialogue, which is by far the most important one in pragmatic terms, has become complicated and confused by other factors in our exchanges:

(a) I chose to illustrate my charges of professional resistance to change by quoting your review of Goffman's *Asylums*. This seemed to recommend itself because it was located in the *Journal* within two pages of Dr. Pilkington's defence of the RMPA position. The reviewer was discussing Goffman's concept of total institutions without really examining the serious reasoning it contained. This seemed a neat and immediate instance of the attitudes that dismay me, i.e. medical chauvinism—one of our besetting and most socially alienating characteristics—and a significant, if possibly (and damningly) unconscious, explanation of our rejection of Seebohm (and of Green Paper One and Green Paper Two incidentally). Dr. Osmond (*Journal*, November 1970, pp. 607–8) believes that *Asylums* does not have much relevance for psychiatric hospitals and that Goffman's analogies can be quickly destroyed. One knows that Dr. Osmond has been around psychiatric hospitals for a few years. Is he not struck with the similarity between Goffman's ideas and those put forward at an earlier date in books about mental hospitals by British psychiatrists like Freeman and his colleagues (3) and Russell Barton (4)?

(b) A second confusing issue appears to have been the use of the Chadwick case as an historical model for the Seebohm position. Here, as it happens, I am obliged to Dr. Osmond for correcting Dr. McDowall's simplistic interpretation of *The Times* quotation—Chadwick really was utterly socially discredited for many years and later vindicated. It was much more than a journalistic misjudgement; it was a societal misjudgement. But I cannot wholly accept Dr. Osmond's explanation of Chadwick's vindication on the grounds of the advance of medical science alone. There is a little more to it than that. Chadwick's famous report of 1842 led to the Health of Towns Commission in 1844, and to the first Public Health Act of 1848. Five years later Act and Chadwick came down together. But Chadwick's ideas persisted, and a turning point in the State's commitment to Health and Welfare occurred in 1875 when a definitive Public Health Act enjoined Local Authorities to accept responsibility for some health matters and to appoint MOHs—considerably *before* Koch's major discoveries of the 1880s. If social insights have antedated medical confirmation in the nineteenth-century why not in the twentieth?

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PSYCHOTHERAPY WITH FAILURES OF PSYCHOANALYSIS

DEAR SIR,

The recent paper by Dr. Schmideberg on 'Psychotherapy with Failures of Psychoanalysis' (*Journal*,

February 1970, pp. 195–200) suggests several implications to me. First, despite the fact that Freud recognized the role of constitutional, developmental and current factors in influencing the formation of neurotic symptoms, contemporary psychoanalysts tend to emphasize the first two factors exclusively and to ignore the third. One of the few analysts who took the current reality situation seriously was Herzberg with his concept of 'tasks', but this notion has not found acceptance by most therapists. His belief in the value of self-esteem acquired through acquisition of skill has received detailed examination in the past few years in America as a result of the work of Robert White on 'competence.' A psychotherapeutic approach which emphasizes infantile urges, personal weakness, incompetence, helplessness, dependency and impulsiveness cannot help build realistic self-esteem. This is especially true for the increasing numbers of people who nowadays enter into analysis with low self-esteem and low ego-strength at the very outset.

A second point implied by Dr. Schmideberg's paper concerns the nature of professionalism. The basic question is: Is the current system of private practice for the delivery of mental health care (1) efficient, (2) effective, or (3) ethical? Although it may be argued that the few cases presented by Dr. Schmideberg are isolated exceptions and untypical, the fact remains that there is no good evidence on this point. We do not, in fact, know what per cent of analytic patients are failures in the senses described in the paper. We have few data on the actual effectiveness of psychoanalysis for 'curing' symptoms or for producing long-lasting personality changes. It almost seems, from a perusal of the contemporary scene, that the therapeutic gains expected from psychoanalysis go down as the length of the treatment goes up.

Another aspect of this question concerns the efficiency of the treatment. By this I mean the benefits in relation to the costs. Analysis has become so expensive at the present time that it is perfectly fair to ask whether the presumed benefits are worth the time and money which will be expended. Any prospective patient is surely entitled to ask (himself at least) whether five or ten thousand dollars plus five or ten years of therapy time could not be more profitably put into such things as getting an education, providing a dowry, going on an ocean cruise, buying a new car, taking tennis, golf, skiing, painting, or sculpture lessons, or loafing on a Caribbean island.

My final point concerns the ethics of private practice. We are all aware of the abuses of the relationship that can and do occasionally occur in the privacy of the analyst's office. But here too we have no way of knowing just how untypical these exceptions really are. In addition, the analyst's fallibilities, his biases and his tendency to play God can remain unobserved and unchecked in the private practice setting. It would be better to remove the source of temptation than to assume all men can remain saintly.

What I should prefer to see, in contrast to private practice, are small and large clinics widely distributed among communities. The advantage is obvious. Costs can be reduced, more adequate records kept, and there would be constant professional interaction to prevent the blindspots which each analyst has from exercising an undue influence.

I think we should feel grateful to Dr. Schmideberg for directing our attention to the kinds of issues raised here.

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THEMES IN A THERAPEUTIC COMMUNITY

DEAR SIR,

I was interested in the article by D. H. Clark and Kenneth Myers in the October 1970 issue of the *Journal*, pp. 389–95. I would like to make a couple of points, not so much criticism but perhaps enlargement.

I was fortunate enough, while recently seconded to Fulbourn, to spend a few weeks in Hereward House, and it was generally a very stimulating experience. I would certainly agree, firstly, with the authors that the 'flattening of the authority pyramid and blurring of roles' is a very worthwhile goal—but in practice I felt that a certain degree of leadership is still needed, and I think that the tension and uneasiness that was present in the 'ward' while I was there was, at least in part, attributable to the absence of this. Residents, when unable to solve problems collectively, still seem to look to the 'professional' for certain guidance and modification. This group anxiety seems to accumulate and, ironically, to interfere progressively with genuine attempts to reduce it.

Again, though the therapeutic community has indisputable assets, it seems to have limited rehabilitative value.

In the first place, the kind of frank and immediate expression of feelings which the therapeutic community seems to involve is not often possible in the normal community. Invariably—perhaps unfortunately—for the sake of tact and generally successful interpersonal relationships, greater suppression of