Antipsychiatry in Australia: Sources for a Social and Intellectual History

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Antipsychiatry as a European, British and American phenomenon has been well documented by historians, yet almost nothing has been written about antipsychiatry in Australia. Milton Lewis’ study Managing Madness (1988) only glances at this matter and, seemingly, no other historians have tackled the problem. It is timely, then, to introduce and to outline some sources from which such an account could be compiled. In this article, four interconnected aspects of the history will be examined. I begin by regarding antipsychiatry itself—as an intellectual entity and as an approach to the treatment of mental illness—and then briefly assessing the state of Australian psychiatry in the years after World War II. Introducing Australian antipsychiatry proper, I examine the ‘pseudopatient’ studies commissioned by the Sydney-based radical psychologist Robin Winkler in 1973, and analyse the controversial student activism of that year that found full voice in the nationally distributed student newspaper, National U. Finally, the ‘Liberation Movements and Psychiatry Conference’ of August 1973 is explored.

Antipsychiatry in Anglo–American context

One of the archetypal social and intellectual movements of the 1960s, antipsychiatry—as promulgated by the British-based practitioners R. D. Laing and David Cooper, French thinker Michel Foucault, and the Americans Erving Goffman, David Rosenhan and Thomas Szasz, among others—offered a full-bloomed, indeed, in its strongest form a wholly transformative, re-evaluation of psychiatric theory and practice. Antipsychiatry entailed two thematically interrelated lines of approach. One strand of thought, championed by the Scottish psychiatrist R. D. Laing, questioned whether mental illness (typically, schizophrenia) was indeed an illness at all. If schizophrenia lacked a firm somatic aetiology and hence could be analysed in terms of the subject’s response to external criteria—if madness was a product of political and interpersonal processes rather than medical ones—then
in a mad world might the schizophrenic be more authentically sane than the so-called ‘normal’? Might the psychiatric ‘breakdown’ be better regarded as a psychic, even mystical, ‘breakthrough’?".

This characteristically romantic epistemology of madness was fortified by the emergence of an equally romantic historiography of insanity. Most famously, Michel Foucault’s *Histoire de la Folie à l’âge Classique* of 1961 (translated and truncated as *Madness and Civilisation* in 1965) proposed that madness was a historical category, the development of which was linked to the needs of the modern capitalist state. Where, prior to the Age of Reason, madness and sanity interacted in a kind of dialogue concerning spiritual salvation and the experience of the noumenal, after the Enlightenment the insane were ‘literally shut up’ in houses of confinement, and metaphysically ‘shut up’ via Reason’s hegemonic usurpation of transcendental experience. In the modern world, Foucault argued, the mad were silenced where once they had an authentic voice of their own.

The second line of antipsychiatry interrogated particular structures, like the mental hospital, for their roles in the creation and maintenance of mental illness. The environment of the mental hospital actively sent its inmates mad: the process of being inducted into the world of the ‘total institution’ entailed the systematic stripping-away of the patient’s rights as a citizen, and the reformulation of the subject as a sick person who needed, above all, to acquiesce to the rules of the establishment in order to be adjudged cured. Similarly, ‘labelling theory’ and its cognates proposed that mental illness maintained no intrinsic psychological reality of its own; rather, insanity comprised a form of social deviance the character of which was imposed by others. It was not that abuses ruined the hospital’s curative potential, but that the psychiatric institution’s ‘moral architecture’ was essentially pernicious—mental hospitals produced mental illness.

In the clinical setting, the two strands of antipsychiatry—the critique of psychiatric knowledge and the radical reformulation of its practice—were never completely distinct. The more vocal proponents of deinstitutionalisation tended to walk hand-in-hand with those who called for the reconfiguration of psychiatric epistemology and practice. For example, having wondered how much of the behaviour witnessed on the wards was, in fact, caused by ward life, many psychiatrists and allied professionals found themselves questioning the extent to which psychiatric illnesses were as immutable as had been previously imagined. And, correspondingly, learning to communicate with mental patients in ways that did not denigrate the patient’s ‘voice’ encouraged reflection on the hierarchical nature of the mental hospital’s moral structure. Thus, many antipsychiatrists did not so much demand the end of psychiatry, as call for its renovation. Their radical status within the.
profession entailed a certain contrariness, but not as much as was often believed. As the late British commentator Peter Sedgwick noted, antipsychiatrists like Laing seemed to abjure psychiatry ‘only in the sense that the Anti Popes were rivalling the Popes’.8

For many radical critics from outside the profession—student activists, as well as paraprofessionals, such as social workers and psychologists—antipsychiatry tended to entail a much more robust rejection of psychiatry. Lay activists who denied the legitimacy of psychiatric diagnosis and the efficacy of its treatment remained quintessential outcasts. Where their professional counterparts were able to manipulate structures from within, and hence tended not to run to the extremes of radicalism, by contrast unaccredited would-be therapists (or ‘antitherapists’) were characteristically more disposed to reject psychiatry out of hand. As one Sydney radical proposed, ‘it’s a real fallacy to think that psychiatry can help you’.9 The notion that psychiatry was irredeemably and universally debased gained considerable support among Australian and international lay antipsychiatric activists.

Accurately or misleadingly, the semantically slippery term ‘antipsychiatry’ came to be associated with the stronger forms of the emergent critiques, and, as such, was easily converted to a calumny directed by the ‘insiders’ against the putative interlopers. Yet much of both the professional and lay critiques of psychiatry had evolved from a common stock of ideas in the first place, and many nominally antipsychiatric ideals maintained impeccably orthodox pedigrees.10 As Adelaide psychiatrist Dr Issy Pilowsky was to complain, ‘the antipsychiatry crowd carried on as though they had discovered something. We have been struggling with this thing for years and years.’11 In 1970s Australia, the question of who owned antipsychiatry was implicitly more worrying to many psychiatrists than were the specific works and claims of the movement itself. Indeed, it was debatable that antipsychiatry was constituted as a genuinely singular movement. As Sedgwick showed, left- and right-wing antipsychiatric positions—characteristically, Laingian romanticism as contrasted against Szaszian libertarianism—were often confused by contemporary observers, who tended to imagine that Szasz was of the left.12 Precisely how antipsychiatry was to be defined was every bit as hot a topic as was its putative log of claims against the profession.

For it was part and parcel of deinstitutionalisation that actors external to the profession—such as social workers, psychiatric nurses, psychologists, educators, and (not least) student radicals—were claiming authority to discuss, interpret and treat mental illness. An additional factor governing the reception of antipsychiatry in Australia in 1973 was the proposed introduction of socialised medicine—that is, Medibank—a side-effect of which was that patients would now have
the means to shop around for medical services. While prospective users of psychiatric services, like clients of general practice, were to be empowered by a greater array of choices in the medical marketplace, many doctors interpreted the planned changes as a challenge to their clinical autonomy. As this article shows, the promise (or threat) of socialised medicine inflected the course of the debate concerning psychiatry.

Psychiatry in Australia

There is solid evidence showing that, at least until the 1960s, Australian asylum-based psychiatry languished in forlorn decrepitude. Reflecting in the 1980s, senior practitioners painted a bleak picture of their profession’s recent past. In 1983, New South Wales’ director of Mental Health, William Cramond, conceded that:

I doubt if any College Fellow or Member under the age of 40 can have much idea of what the closed institutions were really like... it is difficult to describe adequately the hellishness of the worst... appalling standards of care were widespread throughout the Commonwealth only 20 years ago.

Mental hospitals were overcrowded, treatment was desultory and piece-meal, and staff–patient relations were punitive and adversarial. Rates of long-term incarceration were high, filling hospitals with large numbers of ‘institutionalised’ patients and absorbing staff time in the care of chronic cases. The use of electroshock therapy and psychosurgery was widespread and, at times, indiscriminately administered.

Prevailing community attitudes were hostile to sufferers of mental illness, and suspicious of the professions that treated them. South Australian psychiatrist John Cawte remembers that a ‘public dread of lunacy, and of psychiatry and of those who practised it, saturated society’. The Freudian revolution did little to soften this opprobrious atmosphere. Whereas in the United States, especially after World War II, the middle and upper classes were broadly receptive to an increasingly popular tradition of psychoanalysis, in Australia the bulk of the middle class remained hostile to, or ignorant of, the psychoanalytic shift. Many Australian psychiatrists themselves viewed psychoanalysis with suspicion.

Moreover, there was a lack of public discussion about mental health in Australia. Debates in the pages of the Medical Journal of Australia (MJA) occurred from time to time, but these tended to reflect occupational politics, rather than engagement with public opinion. Views from outside the profession were rarely solicited. Within the Royal
Australian psychiatrists in their professional lives and in their daily interactions with patients and their families. In the mid-1960s, there were only some 500 qualified practitioners in the nation, roughly a quarter of the figure who would be practising by the 1980s. Patients and their families were quieter: ‘consumer advocacy’ was largely the product of a later era.

Furthermore, psychiatric education was problematic. General medical education took small account of psychological training needs prior to the 1960s, a situation that contributed to the professional isolation of psychiatry from the rest of general practice. Newcastle academic psychiatrist David Maddison remembered that within general hospitals from the late 1950s, psychiatry was marginalised to the extent that ‘it was almost unheard of for a psychiatrist to be invited by a non-psychiatrist to collaborate from the beginning in patient management’. Much of the hostility towards psychiatry was directed against the idea that many forms of illness could have a psychological component. Until the later 1960s, psychiatric medicine was taught only at a handful of medical schools across the nation, with many Australians continuing to receive their psychiatric training in the United States and Great Britain. What psychiatric education could be had in Australia was heavily biased towards somatic medicine, with very little training in psychoanalysis, psychodynamics, or even interpretative psychology, available locally.

Perhaps surprisingly, the relative paucity of a psychological tradition within Australian psychiatry was, from the mid-1960s onwards, set in the context of a heightened interest in various forms of social psychiatry. In its milder manifestations, social psychiatry called for attention to be paid to the demographics of mental illness and for community-based intervention programs. More boldly, however, psychiatric practitioners and academics, like Stanley Gold and Herbert Bower, argued that Australian psychiatrists needed to take account of, and comment authoritatively on, broad social concerns like drug use, homosexuality and crime. But because these strands of social psychiatry too easily degenerated into a medicalisation of deviance—by failing clearly to delimit where sickness was to be distinguished from badness, or mere difference—many within the profession baulked. For example, in 1972 Bower was derided by his colleagues for calling for psychiatrists to have a role in assessing the mental fitness of politicians. In 1975, West Australian academic psychiatrist G. Allen German urged that the prospect of an unfettered expansion of social psychiatry was a ‘dangerous development’: ‘David Frost and Germaine Greer do the job much better.’ For most Australian practitioners, however, there was nothing intrinsically misguided or debased about social psychiatry.
try, and few rejected it out of hand. Rather, the risk was in the profession overextending itself, by taking on roles outside its brief to treat sick people. The proposed incursion of social psychiatry into the political sphere also threatened to diffuse the RANZCP’s already-troubled public image, by moving away from its medical mandate. Given the difficulties the college had experienced in gaining respect and credence within the medical profession in particular, and society at large in general, this was no small problem.

Thus, the profession of psychiatry in Australia seemed to be caught at an unenviable historical juncture. On the one hand, it remained fused to the unwieldy apparatus of the vast long-stay hospitals, in which environment it would be difficult to manage large-scale institutional and administrative upgrading. On the other hand, the forces of progressivism were indeed beginning to spread their wings, in the form of the emergence of social psychiatry and a heightened sensitivity to the peculiar concerns of psychiatric patienthood. Added to this turbulent atmosphere was a new awareness of the abuse of psychiatry as an instrument of overt political repression in the Soviet Union and China, and the controversial fact that, as recently as 1972, homosexuality was still listed in the Diagnostic and Statistical Manual (of Mental Disorders) as a psychiatric illness. Elsewhere in the world, psychiatry had been the object of much public critical scrutiny: by the early 1970s, Australia’s turn had come.

Robin Winkler’s pseudopatients

In 1973, a Stanford University professor of law and psychology, David Rosenhan, commissioned a study of psychiatric hospitals using ‘pseudopatients’. In a famous paper entitled ‘On Being Sane in Insane Places’, Rosenhan described how university students pretending to be insane gained entry into a range of American psychiatric facilities on the basis of faked symptoms, such as hearing voices saying ‘empty’, ‘hollow’ and ‘thud’. Once admitted, the pseudopatients ceased feigning madness and resumed normal behaviour. They found, however, that because hospital staff acted on the received wisdom that the pseudopatients were mad, all their purportedly normal behaviour was taken to indicate insanity. For example, some pseudopatients took extensive notes on their experiences on the wards, which was often ‘seen as an aspect of their pathological behaviour: “Patient engages in writing behaviour” was the daily nursing comment’. Rosenhan argued that, in light of his findings, ‘it is clear that we cannot distinguish the sane from the insane in psychiatric hospitals’. Hence, a sociological model of insanity was to supplant both medical and psychological ones:
psychological categorisation of mental illness is useless at best and downright harmful, misleading and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of the observers and are not valid summaries of characteristics displayed by the observed.  

Inspired by this boldly iconoclastic piece of research, the Australian academic psychologist Robin Winkler borrowed the ‘pseudopatient’ technique in a study that formulated the basis of (nominally) antipsychiatric activism in this country. Winkler’s work was ultimately presented formally in two separate papers published simultaneously in the MJA in September 1974. The first of Winkler’s papers reported the findings of pseudopatients who had visited general practitioners claiming to suffer depression, while in the second article the infiltrators had themselves admitted to psychiatric hospitals. In both cases, the pseudopatients, who were university students, were carefully trained to present with realistic case-histories. Those who visited general practitioners (twenty-five GPs were each visited by two researchers) examined prescription practices, education concerning side-effects of medication, and the use of counselling and referral. The report argued that, in general, medication rates were high, while counselling and referral rates were low. This being regarded as unsatisfactory, Winkler concluded that ‘a permanent body should be established with the co-operation of medical, research and consumer organisations, to report regularly on health care services as evaluated with pseudopatient observations’. 

The imminent arrival of Medibank, offering government-funded healthcare services that would undermine market-driven private medical practice, would set the highly politicised context in which the pseudopatient studies of the practices of GPs were conducted. Specifically, Winkler’s project, with its free-ranging undercover reporters, threatened to expose the medical marketplace to a new and vigorously intrusive form of scrutiny. Winkler’s team was clearly sensitised to the issues surrounding their own work in relation to the introduction of Medibank, and they sought to identify practitioners’ own views of the forthcoming changes by examining the use of political comments made by doctors in the clinic. Pseudopatients reported encountering nine practitioners who maintained largely negative attitudes to Medibank, for example, in the form of signs proclaiming ‘Say “No” to Nationalized Medicine’ being displayed prominently in the surgery. Thus, the research into general practice, focusing on the relatively straightforward matter of patient–doctor relations in the few minutes of the medical consultation, offered a detailed account of the broader context to the clinical interaction.
In the psychiatric hospital studies, by contrast, Winkler’s chief aim was to:

help to validate the experience and observations of patients in their own eyes, and in the eyes of mental health professionals so that criticisms can be taken as serious statements and not as evidence of pathology.35

On the wards, a sense of boredom was among the researchers’ first impressions; monotony was pandemic and was ‘capable of producing behaviour normally labeled “ill”’.36 The pseudopatients found that, as Rosenhan predicted, ‘normal’ manners were suspended on the wards. Those who asked uncomplicated questions about their treatment were answered as though they were infants; if they became upset they were ‘disregarded and disparaged by [the inference] that the complaint indicate[d] irrationality’.37 At one hospital patients were obliged to wear pyjamas following admission, or as punishment for various misdemeanours, ‘to make them realise they’re sick’.38

Ultimately, Winkler’s desideratum—a Rosenhan-inspired respect for the slippery problems of patient subjectivity—was clearly linked to plans for future radical action:

Public awareness of what pseudopatients observe in psychiatric hospitals is capable of pressuring hospitals to change more rapidly and more appropriately than they have been, to raise public debate about the need for alternative resources and to assist in developing a more discerning attitude in prospective patients with respect to the way in which the mental health system handles them.39

For Neil McConaghy, psychiatric affairs editor at the MJA, the ‘decision to publish [Winkler’s studies] in a scientific journal was a difficult one’, justified only by the publicity Winkler had already received.40 McConaghy’s major complaint was that Winkler, like Rosenhan, had failed to account for observer bias (acknowledging their own prior hostility to psychiatry) in the formulation of the findings. Nevertheless, he felt that the pseudopatient technique was an innovation of lasting influence and that it had an authentic utility. Paramount was the need to wrest the method from forces external to psychiatry: ‘the fact that studies using pseudopatients as a means of evaluating health services have until present been poorly conceived, should not blind us to the possible values of this technique’.41 However, McConaghy also suggested that:

The medical profession has a long tradition of maintaining the ethical standards of its members... If medical practitioners are to retain the privilege
of controlling such standards, evidence must be publicly available that they are doing so effectively, and that they are enthusiastically guarding the interest of their community of patients. Techniques such as the use of pseudopatients may be of value in this respect, but not if they result in pressure on medical practitioners to treat patients according to authorised opinion rather than with scientifically established methods.\textsuperscript{42}

Others, by contrast, were not so hopeful for the program’s possible benefits. Denis O’Brien, corresponding with the MJA, criticised the methodology on the reasonable grounds that doctors ought not to be spending time trying to catch out liars.\textsuperscript{43} Less appealingly, he rejected with a chill brusqueness the charge that mental hospital patients were bored, disempowered and misinformed about their treatment:

\begin{quote}
Surely, these findings apply to almost any hospital, certainly to any army, and... to life in General Motors, Ford or any other industrial corporation... these findings express what it is like to be at or near the bottom of a bureaucratic pyramid.\textsuperscript{44}
\end{quote}

Support for Winkler came from one G. B. Chesher, an academic pharmacist at the University of Sydney. Chesher denied that Winkler’s study was crippled by its author’s observer bias, and he convincingly rebutted the charge that Winkler thoughtlessly denigrated the efficacy of medication. Most tellingly, however, he upbraided McConaghy’s hostility to the broad acceptance among scientists of (particularly Rosenhan’s) pseudopatient studies, by pointing out that conceivably, ‘it is the views of your Journal and not those of the rest of the world that are “out of step”’. Ultimately, Chesher argued, McConaghy’s bluff style was too much:

\begin{quote}
I feel that the emotional and condemnatory tone of your editorial is unfitting to the Journal. Perhaps it betrays a very considerable editorial anxiety and reflects the Association’s resistance to the proposed changes in health care delivery.\textsuperscript{45}
\end{quote}

The exchanges between McConaghy, O’Brien and Chesher in September 1974 illustrate the adversarial environment in which Winkler’s pseudopatient experiments were conducted and debated. They also mark the end of the discussion about the matter in the 1970s, at least as far as can be determined. The close (if such it was) of the debate has been put towards the front of the discussion in order to clarify and contextualise the preceding events: we are now in a position to outline how Winkler’s student radicals set about their activism in 1973.
National U and student activism

The now defunct nation-wide student newspaper National U provided the setting for Robin Winkler’s pseudopatient activism to be disseminated to a wide audience. The edition of 30 April 1973 was wholly given over to a discussion of institutional psychiatry.\(^{46}\) As a number of writers contributed to the edition, Winkler’s precise role in the work is difficult to gauge. However, he took no editorial responsibility nor did he explicitly acknowledge his participation in its writing.\(^{47}\) The antipsychiatry edition contained an informal account of Winkler’s pseudopatient research, as well as other essays and interviews. Authorship was not directly credited on any of the pieces, but a small announcement listing the publisher’s, editors’ and writers’ names was tucked away in the body of the paper. Disaffected former student psychiatric nurse and memoirist David Close asserted that National U would publish ‘almost anything’ on antipsychiatry.\(^{48}\)

The informality of the National U reports notwithstanding, it seems certain that already bands of pseudopatients were infiltrating Sydney hospitals. Advice to prospective pseudopatients suggests that the program was up and running, if informally so:

Using pseudonyms is not illegal per se. Your name and address (be it inpatient or outpatient treatment) will be forwarded and recorded in the central Dept. of Health register. What happens from there is anyone’s guess.\(^{49}\)

The paper also printed hints for coping on the wards, seemingly being directed both to pseudopatients and to authentic ones alike:

Ask your therapist what he plans to do? What are the drugs he is giving you, what are their side effects? You might check out whether he is giving you drugs when you don’t need them, e.g. by going off them for a little while and you don’t feel worse, tell him [sic].\(^{50}\)

For the most part the tone was more defiant:

* Rearrange the furniture, inspect all equipment such as switchboards, fire extinguishers, fire hoses.
* Nurses particularly will want everything to be in its place so move everything, adjust windows, lighting, make yourself at home and don’t feel obliged to fit in if there is anything that can be altered for your convenience.\(^{51}\)

Unsurprisingly, in light of the spectre of unrestrained activism on hospital wards, the backlash was not long in coming, and ‘a number of hospitals... directed restricted access to university students’ fearing that
they would ‘interfere with the treatment of patients’. The problem of precisely how the pseudopatients would interact with staff and other patients in terms of their therapy was never properly addressed by either Winkler or the activists. Neither was it clear how authorities intended to distinguish pseudopatients from real ones, if the former were to be denied access to hospitals. Perhaps worst of all, there was no acknowledgment made by Winkler that his pseudopatients were themselves at risk due to their exposure to psychiatric institutions.

The National U activists failed to provide sophisticated explanations or analyses of the techniques and practices they sought to examine. The activism was piecemeal and ad hoc, and no systemic, articulated program of change was advanced; rather, emotional condemnation took the place of rational analysis. A subsequent edition of the paper contained several letters expressing concern at the representations of psychiatry and of mental illness. One unnamed correspondent (‘Research Fellow, Royal Melbourne Hospital’) likened the problem to

publishing articles detailing all the side effects and complications of the treatment of leukaemia, without giving any rational or scientific argument as to whether leukaemia should even be treated or not.

Perhaps worse, individual psychiatrists, some of whom had unwittingly ‘diagnosed’ and ‘treated’ the pseudopatients, were identified by name by their anonymous adversaries and pressed into service as exemplars of psychiatric opprobrium. Thus, Doctors Ellard, Lush, Pilowski, Guile, Smallman, Morris, Maddison, Bennett, Wright-Short (called ‘a shit’), and Freeman were rendered objects of public suspicion and ridicule. The only factor mitigating this apparent impropriety was psychiatry’s long history of guarded, secretive institutional practice. The 4 June 1973 editorial asserted that it was

easy for the ‘pedants’ to sneer and accuse the group of irresponsibility. The industry is working from within a safe (for them) and empirical [sic] empire. Their security is built upon order and restriction.

For another of National U’s informants, however, there was

little point singling out a couple of shrinks for target practice. All shrinks working within the system—the psych machine—are all categorically harmful—some may be more human than others.

The National U activists, then, seemed not to appreciate the irony in expressly nominating a few practitioners as being unworthy if, as they charged, an encompassing and systematic malaise was at work.
The diffuseness and the lack of clear direction in the activists’ program was a sticking point, but not only for those within orthodox psychiatry. One correspondent to the 4 June edition charged Winkler with neglecting to deliver a sufficiently thoroughgoing antipsychiatry:

Failing to produce a coherent account of anti psychiatry, [instead delivering] a mixture of personal grievance and hostility, give[s] the reader no chance of seeing alternative frameworks, only the option of a witch hunt.57

For their part, some psychiatrists felt that the article and the style in which it was presented was ‘unnecessarily aggressive’, and that ‘they had been expecting a very documented report [of Winkler’s research] and didn’t get it’.58

The Sydney activists did, however, succeed in making the issues of, firstly, patient subjectivity in psychiatric institutions, and, secondly, psychiatric thought and practice, objects of public attention. Mainstream journalistic receptions of the affair were surprisingly sympathetic towards the activists. The Bulletin was cautiously critical of psychiatry, suggesting that ‘proclaiming “PSYCHIATRY IS EVIL” may be over-reacting [but there was room to be] doubtful about the methods, the underlying attitudes and the growing influence of psychiatry’.59 The radical weekly Tribune reported the National U allegations and took up with the theme of ‘psychiatry as an institution... exist[ing] under capitalism to “help” people to “adjust” to life in society’.60 The National Times reported the pseudopatient allegations briefly, and gave only scant discussion to the presence of ‘underground’ ‘movements’ concerned with ‘creative psychiatry’.61 The Australian media showed considerable interest in antipsychiatry, but the timing was wrong for a full-scale public debate. Internationally, the Watergate scandal became headline news, and at home interest in public health matters was sated by discussion about abortion law reform.

Liberation movements and psychiatry: the profession responds

Even before the publication of the National U antipsychiatry edition, the profession of psychiatry recognised in Winkler’s bold work a challenge that required an institutional response. The biannual Geigy conference of August 1973 was given over to a series of discussions on ‘liberation movements’, which included antipsychiatry but also feminism and abortion, homosexuality, and pornography. The ‘Liberation Movements and Psychiatry’ symposium, as it was dysphemistically titled, was the object of controversy for months before it was convened.
Psychiatrists themselves organised the conference, selecting who would attend and what topics would be addressed, and their retention of control angered many activists, most notably the homosexual lobbies. The symposium was convened by academic psychiatrist and practitioner of aversion therapy for homosexuals, Dr Neil McConaghy, Winkler’s adversary at the MJA.

Trouble was expected from the outset. For some five years previously, gatherings of psychiatrists and activists abroad had been volatile affairs, and Australian psychiatrists had witnessed such scenes: John Cade was at the APA/ANZCP Congress at San Francisco in May 1970 when that gathering was ‘heavily and at times noisily picketed by students’. An American radical psychiatrist had moved that the entire schedule be suspended, and that debate might instead begin on ‘the burning issues of the day... to the dismay of many, he received considerable support from the body of the hall’. At the same conference, McConaghy was presenting a paper on the use of electric shocks and nauseant agents as tools of aversion therapy when the eruption started. A dozen Gay Liberation Front members shouted ‘torture!’ and ‘barbaric!’ and ‘Gay is good!’... then raised a shouting storm of protest over what they called a ‘tool of fascist psychotherapy’.

The Sydney activists were aghast at McConaghy’s role in the symposium and dismayed at the sponsorship provided by the Geigy pharmaceuticals corporation (‘not our favourite institution’). Activist groups were not invited as such (invitations were sent to individuals), hence plans for ‘a consensus of tactics [to] be employed to present a unified front’ were, as the activists perceived it, thwarted from the beginning. Also, ‘notably not invited [were] psychiatric patients, blacks, and Robin Winkler, noted Sydney opponent of psychiatry’. The activists felt that the symposium was organised around a ‘structure that best protects the vulnerability of psychiatry’, and reasoned that ‘unless a radical change occurred in the presentation of the Conference, we [do] not want to be involved’. The homosexual lobbies CAMP Inc. and Gay Lib flatly boycotted the gathering. The hundred or so members of the NSW branch of the Australian Association of Social Workers, who were reported to have been planning to meet in May 1973 to discuss concerns illuminated by Winkler’s work and the role of social workers in redressing the problems raised by it, were also excluded from the symposium.

The antipsychiatry section of the conference was the last to be held and comprised submissions from six individuals, four of them psychiatrists. One of Winkler’s pseudopatient studies was formally presented here under the title ‘Psychology as Social Action’. But Winkler’s
paper can have held few surprises for an audience familiar with his work.

The other non-psychiatrist to contribute to the section was academic psychologist and Sydney Push habitué Elizabeth Fell, who summarised the stance of the Socialist Patients Kollective (SPK), a University of Heidelberg-based group ‘committed to radical antipsychiatry using a Marxist dialectical anthropology’. This entailed viewing the experience of madness as a form of rebellion: ‘Symptoms are the factual expression of people’s lives—they express inhibition of protest against life as well as the potential for protest.’ Fell’s relationship with the Sydney Push suggests further lines of enquiry.

At least two psychiatrists who spoke to the antipsychiatry section made mischievous use of that malleable rubric. Victorian psychiatrist Wallace Ironside utilised the term to refer to the various hostilities ranged against the ‘reality’ described by socio-psychological aetiologies. For Ironside, ‘the most potent and persistent antipsychiatry process of our time’ was the suspicion directed at psychiatry from general medicine. A second antipsychiatry was to be found within the profession itself, in the ‘tough headed’ psychiatrists who attacked their ‘soft headed’ colleagues for their ‘total abandonment of the canons of scientific reasoning, with a heavy reliance on a primitive and anecdotal type of evidence’. The ‘soft heads’ were ‘concerned with the problems of living... and practice psychotherapy and family therapy rather than use psychopharmacology, ECT etc’. This hostility was characterised as a

medical antipsychiatry attitude directed especially towards the study of and understanding of the feelings, phantasies, desires, psychic controls, and their complex determinants that can be lumped under the heading of human motivational psychology.

Thus, the long-standing suspicion of psychological interpretations of mental illness was invoked within an affirmative, if capricious, rendering of antipsychiatry’s significance for the profession.

Ironsie proceeded to endorse, partially at least, antipsychiatric claims about psychiatry’s troubled history of practice:

the contemporary antipsychiatry movement cannot be wholly misguided. In it is a core of well justified concern for the person in his or her own right as man, woman, or child whose psyche, development, personality and liberty can be profoundly affected by what is imposed on them in the name of psychiatry and mental health.
But Ironside’s allegiances were with his profession not with notions of its dissolution. For him, psychiatry remained ‘the best way... to acquire the skill to help with the problems... that challenged most’. He found it ‘foreign when contemplating it... that I was... an ephor of an authoritariansociety’.76

The paper by South Australian academic psychiatrist Claude Barrow similarly contributed to the discussion of professional politics, but did so within a more conventional vision of antipsychiatry. Thus, while his assertion that ‘all roads in the contemporary antipsychiatry movement lead to Laing’ misinterpreted both Laing and antipsychiatry, his paper nonetheless touched on some interesting issues.77 Barrow identified a destructive, almost Oedipal undercurrent: ‘The antipsychiatry movement is characterised by an intense identification with the underdog (patient) and an equally intense hostility toward the topdog (psychiatrist or institution).’78

Such an identification was, within Barrow’s psychoanalytic reading, an act of transference undertaken by the activist and was aimed at negotiating the path from helplessness to autonomy:

Under the guise of apparent concern for the handicapped, and identification with the underdog, comes frustration and rage that a person should need to be dependent on and attached to another helping person. This is particularly crucial for the adolescent who is trying to separate himself from his parents... there is magical thinking in it, too—if you can denigrate the helper enough, then the need for help may somehow seem to disappear.79

Like some others, Barrow did not completely condemn antipsychiatry; for him it displayed ‘some highly constructive aspects’.80 He identified a central concern in the manifest need for change, both in the organisation of mental health services and in the social structures that disenfranchised the mentally ill. But Barrow’s faith in the profession’s capacity to chart its own course through these waters was undiminished. ‘It all boils down to whether we feel the change must come via evolution or revolution’, he urged, ‘some of us simply prefer to be tortoises rather than hares.’81

Psychiatrist Hugh Freeman’s reading of Barrow’s psychoanalytic account of antipsychiatry pointed to the apparent incommensurability of the ‘medical model’ (in which ‘ambivalence’ about the world is interpreted in terms of categories of illness), and antipsychiatry’s phenomenological models of behaviour and adaptation wherein the same ‘ambivalence’ is viewed as a wholly valid perception of reality. Freeman’s ‘Revisionist Anti psychiatry’ proposed that, in regarding either medical models or antipsychiatric models, it must be realised that ‘the use of a particular model poses on the user a particular definition of real-
ity’. Thus, there was a pressing need for a reconfigured account of the ontology of patienthood (and of the doctor’s role):

This whole conference is really about consciousness-shift: the consciousness-raising process which occurs when a new model is introduced to enable us to look at data in a different way. As a psychiatrist I am interested in raising consciousness about the ‘sick-role’.

However, Freeman did not seek to trouble psychiatry’s claim to be the proper agency to treat the mentally ill: ‘I do not think I could still operate as a doctor unless [the medical model] was the model I used most of the time in “being a doctor in the world”’. Thus, Freeman’s was a partial capitulation to antipsychiatry’s critique of medicine’s epistemological certitude, but one that retained medicine’s authority to diagnose and treat mental illness.

How might historians of antipsychiatry assess the ‘Liberation Movements and Psychiatry’ symposium? It seems clear that the debate was tightly controlled and delimited by the profession of psychiatry itself. Lay contributors were regarded with hostility and suspicion, and were all but excluded from the symposium. The purpose of the gathering was indeed, as Hugh Freeman observed, to negotiate a ‘consciousness shift’, by providing a forum for the profession of psychiatry in Australia to reassert its claim to retain occupational control. The conference emphatically was not an open exchange of ideas; rather, it was an instrument of professional suasion designed to mediate the importation of a set of techniques that were perceived to threaten psychiatry’s occupational autonomy.

The Sydney activists accurately charged that the conference was organised so as to ‘best protect the vulnerability of psychiatry’. The pseudopatients’ work was arguably the single most significant reason for the conference to incorporate discussion of antipsychiatry in the first place. The fact that the activists were subsequently isolated from the gathering fortifies the assessment that the conference was an exercise in occupational politics. If certain antipsychiatric ideas were held to be useful, even necessary, additions to a mature understanding of mental health provision in Australia, their adoption was contingent on the profession of psychiatry retaining the mandate to assess and delimit the process of their incorporation. In short, there could be no question of activists ‘giving’ psychiatrists ideas. Rather, I have shown (albeit only in outline form) that Australian psychiatrists cautiously utilised only those notions which conformed to a vision of mental health services that retained their supervisory role.
Conclusion

The history of antipsychiatry in Australia is a fascinating topic that has been examined only in a tentative and partial manner in this article. There is much ground yet to cover for future researchers. It will be fruitful to pursue the debates which emerged, particularly in the early 1980s, about the ‘medical model’. Precisely what did psychiatrists think that they were doing when they practised their profession? How did sociological and psychological approaches mesh with somatic ones? Was psychiatry best seen as art or science, or as an amalgam of the two? Questions like these were prompted by the self-examination which antipsychiatry encouraged. More broadly, it will be useful to examine how antipsychiatric activism was related to 1960s and 1970s radicalism in general. A reappraisal of how antipsychiatric ideals question and influence late twentieth-century writing of the history of psychiatry, and medicine in general, would establish the highly politicised context. An extended project could also profitably examine the many issues raised by the interactions between pseudopatient activists, hospital staff and patients, for example, in the form of an oral history project. Another line of attack will be to examine the as-yet untold history of clinical experiments in antipsychiatric practice, for instance, at the Melville Clinic in Melbourne. The undertaking will be a vast one: in the absence of a full-scale narrative of deinstitutionalisation in Australia, it may have to wait.

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16. ibid., p. 3.


27. Dr John Ellard, operator of a large private clinic in Sydney, denigrated public education on matters psychiatric as mere propaganda, and rejected community mental health initiatives as utopian nonsense. For a discussion see Lewis, *Managing Madness*, p. 89.


30. ibid., p. 257.
31. ibid., p. 251.
32. For an excellent, concise overview of Winkler’s career, see Peter Wilson, ‘In Memory of Robin Winkler: His contribution to behaviour modification in Australia’, Behaviour Change, vol. 4, no. 3. 1987, pp. 3–10.
35. Winkler, ‘Research into Mental Health Practice’, p. 399.
36. ibid., p. 400.
37. ibid., p. 401.
38. ibid., p. 403 The extent to which psychiatric therapy entails the patient’s acknowledgment of their own illness suggests a complicated problem. For example, in contrast to the example listed above, psychiatrist John Cawte observes that one patient who hallucinated the presence of enemies could find physical restraint comforting: the straitjacket ‘seemed to remind him that he was under care, in hospital, and not in the deranged massacre that he envisioned’, The Last of the Lunatics, p. 134
41. ibid.
42. ibid., p. 385.
44. ibid.
47. ibid. The paper had been ‘totally produced’ by a group of 14 ‘and many others’; the 14 included ‘Phil, Kate, Robin, Jon, Ponch’, ‘Robin’ being Winkler.
50. ibid.
51. ibid.
53. ibid., p. 2.
54. ibid., 30 April 1973, pp. 2–8.
56. ibid., 30 April 1973, p. 6.
61. If some ‘underground’ methods were ‘quite good’ in the opinion of Dr Francis McNab, other professionals were concerned about recent developments: “Concerned is hardly the word for it”, says Mr R. C. King, general secretary of the [Australian Psychological] Society. “We are more concerned at this than at so-called distortions of orthodox psychiatric methods”.’ National Times, 21–26 May 1973, p. 19.
65. ibid.
66. ibid.
67. ibid.
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71. ibid.
73. ibid., p. 135.
74. ibid., p. 136.
75. ibid., p. 134.
76. ibid., p. 133.
78. ibid., p. 127.
79. ibid., p. 128.
80. ibid.
81. ibid.
83. ibid., p. 141.
84. ibid., p. 140.