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# **AN INVESTIGATION OF THE RELATIONSHIP OF SOVIET PSYCHIATRY TO THE STATE**

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Based on Research Conducted at The Institute Of Russian and East  
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## **ABSTRACT**

### **AN INVESTIGATION OF THE RELATIONSHIP OF SOVIET PSYCHIATRY TO THE STATE**

This thesis examines how Soviet psychiatry took the particular form that it did and how it had a historically specific relationship to the state. Psychiatry in the USSR was used by the state against those who opposed the regime. In particular it was used after the death of Stalin against a dissident intelligentsia.

Chapter One examines the legal position of the Soviet psychiatric patient with relation to the political economy of the USSR. The legal position of the psychiatric patient was a precarious one because the absence of private property meant there was no basis for law. It was possible to co-opt doctors as repressive agents of the state because they were dependent on it in a way in which their counterparts in the West were not.

Chapter Two examines the historical development of Russian and Soviet psychiatry and assesses the importance of its development under tsarism. The point at which Soviet psychiatry became differentiated from world psychiatry is located in the Stalin period.

Chapter Three examines the role played by Soviet psychology and the supposed influence of Marxism-Leninism in shaping psychiatry in the USSR. It is argued that Soviet psychology owed nothing to Marxism but that it was distorted in a similar way to other branches of science.

Chapter Four discusses the defective nature of Soviet psychiatry and shows how Soviet political economy led to archaic practises in psychiatry. All Soviet medicine was similarly defective and this had serious consequences for the Soviet population as a whole.

Chapter Five examines the role that psychiatry played in repressing the dissident movement in the 1960s and 70s. Psychiatry was used as an ameliorated form of the labour camp at a time when mass killings and labour camps were less useful to the elite. Psychiatry played this role from about 1953 until 1988 and was used mostly against the intelligentsia.

**‘And further, by these, my son, be admonished:  
of making many books there is no end;  
and much study is a weariness of the flesh.’**

**Ecclesiastes 12:12**

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Paddy's ability to ask the right questions and to encourage me was also vital and no post-graduate can have had my good fortune in having two supervisors with whom I had such a good working relationship. I would also like to thank Paddy for help in securing the financial assistance for my second fieldwork trip from Glasgow University Psychology Department. On the subject of money, I must also acknowledge the Economic and Social Research Council for supporting me for three years and funding fieldwork and conference trips. Glasgow University's Wellcome Unit for the History of Medicine has also financially supported me by giving me a job and for this I have to thank the enlightened and benevolent management style of Dr. Malcolm Nicolson.

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## INTRODUCTION

### THE PROBLEM STATED

The final years of the USSR saw a heated controversy regarding Soviet psychiatry. Writers in the USSR and other countries exposed the Soviet State as using psychiatry as a form of repression. It was used against religious and political dissidents and for the extra-judicial punishment of those deemed a threat to the status quo. A number of well researched and remarkably consistent accounts of psychiatric abuse were published in the West throughout the 1960's, 70's and 80's. Many of the informants had managed to publicise the problem through 'samizdat' publications. Some contacted Western researchers who took up the issue of human rights abuse in the USSR and published their findings outside the USSR. This was known colloquially in the USSR as 'tamizdat'.

The exposure of psychiatric abuse performed an invaluable service to the dissidents involved. Pressure was placed on the Soviet regime and their plight was brought to the attention of campaigners for their release. However, the whole debate took place against the background of the Cold War. This necessarily distorted many of the accounts of the problem. The complaints were inevitably used to make a political point which went far beyond the abuse of psychiatry. The political right took up the issue in order to demonstrate that brutality, repression and the wholesale disregard for human dignity was in some way inextricably connected to socialism. The political left, which was Stalinist or influenced by Stalinism, either denied the problem existed, made excuses for the USSR, or suggested that the question was only one of degree. It was argued that psychiatric abuse happens everywhere and the USSR is no different to the West and in some ways may be better.

Those on the left who claimed a Marxist heritage hostile to Stalinism often took the reactionary position of supporting the USSR because the political right was attacking it. Groups that claimed that the USSR was only a distorted form of capitalism found it difficult to explain why psychiatry was so different in the USSR. After all, if the USSR were capitalist, albeit modified with the adjective 'state', then why would Soviet psychiatry be different at all? One would then be left with an attempt to explain it in political terms or to say that it is not different. In other words, supposedly Trotskyist

parties ended up in a position, which was similar to the position of the USSR's apologists. In short, they had little to say on the matter.

## **THE CHARACTERISATION OF THE USSR**

There were a variety of different explanations for why Soviet psychiatry took the form it did. All these explanations were, in the last analysis, shaped by their characterisation of the USSR. The political right tried to explain the nature of Soviet psychiatry on the basis of the USSR's supposed allegiance to Marxism-Leninism. The works of Marx, and in particular Lenin, were trawled to find quotes, which showed that socialism was inherently anti-democratic and likely to lead to the type of state that would always interfere in matters of science. Therefore, it is argued, socialism necessarily leads to a brutal form of psychiatry. The lack of individual rights in the USSR was cited as further evidence, if any were needed, that Soviet psychiatric abuse follows naturally from Marxism.

Those that characterised the USSR in terms of 'totalitarianism' tended to see the absence of liberal-democracy as the problem. For these commentators Russia is seen as having always been undemocratic. The main issue is the absence of structures which guarantee the inviolability of the person. This includes the absence of the formal mechanisms, which would guarantee the rights of the mental patient. These mechanisms include an independent medical profession, legal statutes and a parliamentary system of government. The tendency of such an approach is to see an unbroken chain of psychiatric abuse from Tsar Nicholas I to Gorbachev.

The aim of this thesis is to examine the explanations for Soviet psychiatric abuse. Some of these offer an insight but usually only a partial understanding of the problem. It will be argued that this follows from a failure to properly understand the nature of the USSR. The explanations may well be put forward in all sincerity but are often formulated to serve a particular political perspective which was shaped by the demands of the Cold War. As a result the focus of attention was on the punitive and politically motivated treatment of dissidents. It will be argued that, while such treatment is a particularly disgraceful episode in the history of psychiatry, it was only the tip of the iceberg. Whilst the number of dissidents involved were relatively few the overwhelming majority of Soviet psychiatric patients suffered as a result of the very nature of the Soviet regime and continue to suffer as the economy declines.

The initial impetus for my research stemmed from a critical appraisal of explanations of Soviet psychiatric abuse. However, this thesis is also concerned with the more wide ranging problems of Soviet psychiatry, many of which continue to today and appear to be worsening. The other aim of the thesis is to test what might be called the 'Ticktin Thesis'. That is, to see whether Hillel Ticktin's particular characterisation of the USSR has any explanatory capacity with regard to Soviet psychiatric abuse. I was little acquainted with the journal *Critique* at the start of his study and even less so with Ticktin's analysis of Soviet political economy. However, in the course of fieldwork in Moscow, Petersburg, Riga, Zelenograd, Suzdal' and Magnitogorsk the Ticktin thesis held up better than any other.

If there is one conclusion of which I am certain as a result of this research it is that Soviet psychiatry was qualitatively different to anything I saw as a psychiatric nurse in Britain. If the USSR was some sub-species of workers' state then it is not clear why Soviet medicine in general and psychiatry in particular was so awful. The extent to which a theory can be put to the test must depend upon its capacity to explain given social phenomena. Ticktin's particular characterisation of the political economy of the USSR can be measured against other explanations and has proved more robust than others. Those who argued (and sincerely believed) that the USSR was socialist or 'progressive' are now left in disarray. Many now take comfort in post-modernist discourse or the defence of Cuba. Those who maintained that the USSR was a workers' state and declared that it ceased to be so when Boris Yeltsin took office are left with the difficulty of explaining what the difference is between the pre- and post-Yeltsin regime apart from the rhetoric and the badges on the soldiers' caps.

## **METHODOLOGY**

As the topic was a sensitive one for Soviet psychiatrists they were, at times, reticent. Sometimes notes had to be compiled soon after the event and on occasion, covertly. There were difficulties involved in gaining access to Soviet psychiatric hospitals. However, I did manage to talk to a number of medical workers over the course of my research. My first fieldwork trip lasted ten months and began a few days after the coup that toppled Gorbachev. During this time I was mainly getting to grips with Russian life in general and improving my knowledge of the language at the Pushkin Institute of Russian Language. Through good luck and useful contacts I managed to become the first researcher from a capitalist country to be allowed access to the Serbsky

Institute. However, this was limited to the library and hospital grounds. The librarian was distinctly suspicious of me and disapproved of my attempts to browse the shelves rather than ask for things from the catalogue. However, I was able to talk to a number of the psychiatrists. This experience shaped my view of Soviet psychiatry and provided the framework for subsequent investigation.

When I talked to psychiatrists there were things that I wanted to find out about but it was not always possible to broach certain subjects. I had to feel my way and probe the boundaries of what doctors were prepared to say. Many people told me things over dinner which they would not have said in a formal setting. Others made it clear what it was that *they* wanted to talk about. That too was valuable. Therefore, my research has been something of the nature of an ethnographic study.

Another valuable experience (although that was not how it felt at the time) was my own admission to a Soviet hospital. While I lay in Infectious Diseases Hospital Number One in Moscow's *Sokol* district for ten days I gained a valuable insight into Soviet general medicine.

During my second field work trip, lasting six weeks in 1994, I managed to get onto the wards for a day in Magnitogorsk. Doctors were still suspicious, often feeling that anything they said would be used in evidence against them. Once they were reassured that I did not hold the view that Soviet psychiatrists were themselves to blame I found that I received a great deal of co-operation. There was a genuine wish to foster academic links and a general sense of goodwill towards foreign academics. I spent a good deal of time in the library of the Kashchenko Psychiatric Hospital Number One, in Moscow. I also went to work for the day with Moscow's psychiatric ambulance service, which was made possible by the help of Aleksei Nikolaevich despite the personal risk to himself. In fact, he was dismissed as a result of helping me.

Apart from my own observations and discussions with medical workers I have drawn materials from as many Soviet journals as I could. Some of these are unavailable in Britain but were kindly given to me by psychiatrists in Moscow. Although this thesis is concerned with Soviet psychiatry it inevitably suffers from the grave weakness of being almost wholly focused on Russian psychiatry. Russian, as the *lingua franca* of the USSR, dominated all Soviet journals and textbooks. Arguably, this is a feature of the cultural hegemony of Great Russia that was exacerbated by Stalinism. This is an extremely important issue but is not discussed in this thesis. A line has to be drawn somewhere. It would be extremely valuable to find out what happened in Soviet Central

Asia but this is beyond my linguistic capabilities and deserves separate treatment. Russian textbooks were widely used in other republics and the same political-economic system was in force throughout, notwithstanding local differences. I therefore acknowledge the difficulty involved in generalising from Russian sources to the USSR as a whole.

When this project started there was still a Soviet Union, which was formally still 'socialist'. Its demise opened up many opportunities for research but has given me a problem of nomenclature. Throughout I have used USSR and 'Soviet' as shorthand terms to apply to all of those countries that used to make up the USSR. At other times I have used the shorthand of the Former Soviet Union (FSU). Some of the topics discussed do not apply to the whole of the FSU. For example, the Russian Law on Psychiatric Care of 1992 is neither Soviet nor does it apply to other independent countries of the FSU. My only defence is that my object of study is Soviet psychiatry and while that geo-political entity no longer exists all of its former constituents were shaped by it. By discussing the mental health law of the Russian Federation a useful comparison is made between the Soviet and post-Soviet periods. Although the Russian mental health legislation of 1992 is not part of Soviet psychiatry it is undoubtedly derived from it. I have tried to illustrate changes that have taken place in psychiatry in the FSU but the bulk of the thesis is concerned with the Soviet period.

## **THE CHAPTERS**

Chapter One attempts to uncover one of the root causes of the problem of Soviet psychiatry. It is argued that, because of the nature of Soviet political economy, strictly speaking, law did not exist in the USSR. This had the effect of negating the rights one would normally expect of citizenship. The absence of commodity production led to a level of dependence of the Soviet citizen unprecedented in Western Europe. This meant that the ability of the physician to arrive at an independent diagnosis, motivated solely by the interests of the patient, was severely compromised. The absence of commodity production also meant that private property did not exist and this extended to the ownership of oneself. It follows that the rights of the citizen were extremely restricted. This is because such rights are dependent on the social relationship of free individuals who confront one another in the market as commodity owners. In effect, instead of law, there were only thousands of contradictory rules and regulations that could easily be circumvented by the psychiatrist. The patient had no other body to whom he could

appeal. The various attempts to introduce legislation from 1988 to 1993 are examined and there are three appendices to this thesis in connection with Chapter One. The first is a copy of the 1988 decree of the Supreme Soviet on psychiatric care that was previously published elsewhere. Appendix two is my translation of the 1990 Soviet mental health draft legislation, which was originally published in *Meditsinskaya Gazeta*. Appendix Three is my translation of the 1992 mental health law of the Russian Federation.

Chapter Two looks at the historical development of Russian and Soviet psychiatry in order to explain some of the possible reasons why psychiatry in the USSR was different to the West. The point at which Soviet psychiatry became differentiated is located in the Stalin era. Chapter Two also examines the proposition that Soviet psychiatric abuse is something that stems from the lack of a liberal democratic tradition in Russia. It is accepted that, unlike Britain, there was no independent medical profession either in tsarist Russia or in the Stalinist USSR. However, the assumption that it is the lack of liberal professions *per se* that has led to psychiatric abuse is questioned. It is argued that although doctors under tsarism did not have the kind of independent professional status of their Western colleagues this could not explain the subsequent abuse of psychiatry. Their position of dependence was far worse under Stalinism. The fact that, in 1917, doctors supported the February but not the October Revolution is evidence that psychiatrists did not support the regime under Stalin and, where possible, opposed it. However, by the time that Brezhnev took power at least some in the intelligentsia had aligned themselves with the elite and psychiatrists were among their number. Some psychiatrists were even part of the elite and as such were willing to support the regime by using a punitive form of psychiatry.

Chapter Three examines the role of Soviet psychology in shaping Soviet psychiatry. It is argued that the development of psychology in the USSR owes more to a mechanistic rather than dialectical materialism. One of the explanations for why psychiatry took the form it did was that Marxism-Leninism shaped psychological science and this had a detrimental effect on psychiatry. It will be argued that few, if any, of the principal theoreticians of the communist movement had a particular 'line' on the nature of a putative Marxist psychology. The call for the development of a specifically Marxist psychology is something which evolved from a Stalinist perspective. The form of psychology that developed was quite specific and, ironically, it is close to Western behaviourism. Soviet psychology was far removed from what a Marxist psychology might be, even if we assume that such a concept would make sense.

Chapter Four examines the defective nature of Soviet medicine in general and Soviet psychiatry in particular. The provision of free medicine was one of the gains of the October Revolution which was retained until recently in a distorted form. However, like virtually all other Soviet products the health service was defective. The USSR produced not commodities but defective use values and this included the commodity of labour-power, which affected medical workers no less than any other occupational group. The USSR always used crude quantitative indicators of health as evidence that the USSR was 'catching up with the West'. These included an increasing life expectancy, a free and expanding health service, an increasing number of psychiatric beds while psychiatric hospitals in the West were being closed down and a high ratio of doctors to the general population. It will be shown that such indicators served merely to disguise the fact that the health of the population was worsening and the health service was of very poor quality. Soviet psychiatry was as defective as any other Soviet product.

Chapter Five investigates the complaints against Soviet psychiatry as a repressive force used against political and religious dissenters and those attempting to emigrate from the USSR. It investigates the recent history of how psychiatry came to be used in this way and against whom. It will be argued that psychiatry was used mostly against a dissenting intelligentsia who wanted a political-economic transition to capitalism. The abuse of psychiatry took place from after the death of Stalin and reached a peak under Brezhnev. The number of dissenters incarcerated was not great but was highly indicative of a far greater problem. Chapter Five also examines the way in which the disclosure of psychiatric abuse was discussed in the West and in the USSR and discusses some of the reasons for particular areas of controversy.

The overwhelming majority of the psychiatrists I met were kind, professional, underpaid and dedicated to the care of their patients. They knew that their patients deserved better and they longed for an end to economic crisis, uncertainty and poverty. They did not support the regime that had brought calumny on their profession and suspicion of their personal integrity. Under the influence of the Cold War, Soviet psychiatry was subject to intense scrutiny. Now that the FSU has formally embraced the market it seems likely that the problems which affect the mentally ill are only to be the subject of rueful silence, humiliating and woefully inadequate 'humanitarian aid' or the advice to trust in *laissez faire* capitalism under which Western drug and private health companies can find a market among the newly rich, many of whom were previously in the Stalinist *nomenklatura*. Arguably, the market has already failed and will continue to

fail and this will lead to even greater pressures being placed on the people of the former USSR. The mentally ill tend to be one of the most vulnerable in any society and it is likely, therefore, that they will suffer even more than the general population. However, such suffering is not likely to receive the same attention as the dissident intelligentsia received in the Cold War.



# CHAPTER ONE: SOVIET PSYCHIATRY AND LAW

## INTRODUCTION

At the heart of the debate around Soviet psychiatric abuse there is the controversial question of how was psychiatry turned to the direct and explicit service of the state? Furthermore, why was it a relatively simple matter to undermine the rights of the individual in the USSR? It will be argued that neither the characterisation of 'totalitarianism' nor the commonplace that the USSR was repressive offers an explanation. Furthermore, it will be shown that the psychiatric patient occupied a tenuous legal position. This was a reflection of the nature of Soviet political economy, namely, a position of dependence due to the absence of private property that undermined the very basis of law. The absence of private property meant that the juridical subject did not exist as it does under capitalism and therefore the legal status of the citizen was negated. For much of its history there were no laws regulating the confinement of mental patients in the USSR. Instead of law there were thousands of contradictory rules which I shall refer to as bureaucratic regulation.

It will be necessary to discuss briefly the nature of Soviet political economy in order to demonstrate how it differed fundamentally from capitalism and yet bore no relationship to socialism. This is not just a scholastic distinction but vital to understanding why the widespread abuse of psychiatry in the USSR took place. Those who argue that the USSR was a sub-species of capitalism find it difficult to explain why, appearances notwithstanding, Soviet law had a different form and content from bourgeois law.

It will be argued that, from a Marxist perspective, socialism would entail not only the 'withering away' of the state but also rights and law. Those who argued that the USSR was socialist or some form of Workers' State find it difficult to explain why Soviet law took an even more brutal form than its bourgeois counterpart and indeed retained the appearance of bourgeois law. In order to contrast the legal status of the Soviet psychiatric patient with his Western counterpart it will be necessary to make some general observations on law under capitalism.

The absence of abstract labour meant that production in the USSR was not of commodities and furthermore the Rouble was not money (Ticktin, 1992: 12-13). It also meant that the universality of rights under capitalism was compromised in favour of a

highly specific form of quasi-legal particularity. The absence of private property meant that, whether mentally ill or not, the person was not inviolable, as he did not even own himself. There was no distinction between the state and civil society. Consequently, the intrusion of the state into every sphere of life meant that even psychiatry's position of being a private matter between doctor and patient was subject to state interference. The absence of private property also meant that the psychiatrist was utterly dependent on the state in a way that his Western counterpart never was. This put him in a precarious position and made it difficult for him to avoid being forced into a repressive role.

## **POLITICAL ECONOMY AND LAW**

Every form of production creates its own legal relations and form of government (Marx, 1973: 88). The term law is often used to describe juridical relations in a wide range of societies and this may mask the historical specificity of legal relations in commodity production. Under capitalism, the very atom of jurisprudence is the citizen, the legally free individual who, above all, owns his or her self (Pashukanis, 1989: 109). Only such an individual can enter the market bearing rights. Each citizen is recognised as a property owner and therefore the owner of his labour-power, as soon as he enters the market. Labour-power is the only commodity the overwhelming majority of people do own. Private property implies mutual recognition of oneself by others as a free and rational being, which is expressed in the form of the contract (Fine, 1984: 53). With the development of capitalism the citizen becomes the bearer of rights rather than customary privileges. The feudal distinctions between individuals based on rank and hereditary privilege are replaced in favour of an objectified and universal social relationship between citizens. The fact that the citizen bears rights makes law possible, even in the absence of formal statute. Written laws forbidding arbitrary arrest and imprisonment are important but their existence presupposes the existence of the citizen, which exists logically and temporally prior to the statute. A statute declares what law is, it does not create it (Fine, 1984: 20). The inviolability of the person is enforceable because it is intrinsic in the very nature of the contract, which is guaranteed by the state as a 'third force'.

Feudal law, which undoubtedly shares common elements with bourgeois law, has no such third force. It is characterised by customary privileges and duties supported by violence which is the prerogative of manorial power. Under feudalism, control of the labouring population was external and coercive. One consequence of this was that

the exploitative nature of the relationship between lord and serf was transparent. That is not to say there was no ideological justification for manorial power but it was limited in how far it could mask the fundamental relationship between lord and serf. 'The alienation of the person must have a limit in time, so that something remains of the 'totality and universality' of the person. If one were to sell the entire time of one's concrete labour, and the totality of one's produce, one's personality would become the property of someone else; one would no longer be a person and would place oneself outside the realm of right' (Marcuse, 1955: 195). A slave or serf cannot freely enter into the labour contract, which is the basis of surplus value production.

## **CAPITALISM AND LAW**

Under capitalism, the extraction of a surplus from the labouring population is on the basis of a contract freely entered into. Exploitation is obscured and becomes mystified whilst the value of the commodity takes on the appearance of being a natural feature; rather like its weight or colour (Marx, 1954: 76-87). The contractual form of human relations presupposes the separation of subjects. Relationships between subjects are not direct but mediated through the contract and underpinned by the state as guarantor (Kay & Mott, 1982: 3). Under such conditions all relations between people are as between things whilst relations between things assume a reified character. The product of human labour, such as capital, relates to other elements of capital in the same way as subjects; it assumes a legal persona. The whole area of company law is concerned with relations between companies, which relate to one another as subjects.

A Marxist approach to law aims to uncover the essential categories of bourgeois jurisprudence. It is not concerned with simply showing '...that juridical concepts are consciously manipulated by bourgeois publicists in order to browbeat the workers (which is indisputable), but to show that in them - in these concepts - social reality takes on an ideological form which expresses certain objective relationships arising from the social relations of production and stands or falls with them' (Pashukanis, 1989: 11). Pashukanis regarded law as a specific transitory form associated with class antagonism. He rejected the notion of 'proletarian law', other than as a temporary feature of society in transition to communism. Since Pashukanis treated law as an historical form which achieves fullest expression in the bourgeois epoch and which is tied closely to the commodity form, he opposed the pseudo-radicalism that talks of the overthrow of bourgeois law and its replacement by proletarian law. Such a line is

implicitly conservative since it accepts the form of law as supra-historical and capable of infinite renewal (Arthur, 1989: 18). Obviously, this calls into question the assertions of those who try to argue that the nature of Soviet psychiatry is explicable by its having a system of proletarian or socialist law (Wortis, 1950: 209-225).

Pashukanis' argument against 'proletarian law' cost him his life. The continued existence of forms which would have no place in socialist society such as law, money or a professional standing army, requires explanation. The Stalinist assertion of the possibility of socialism in one country must necessarily lead to the assertion of the feasibility of socialist or proletarian law. Once it has been asserted that the USSR is building socialism in one country then it follows that the laws of that country must be socialist even if this is hedged with the assertion that these represent some sort of transitional form.

Pashukanis also rejected the Stalinist assertion that law belongs to the realm of ideology and therefore confined to the 'superstructure'. Law is not just a set of ideas existing in the heads of jurists or merely a 'reflection' of material conditions but is an expression of real material conditions. One can draw an analogy with commodity fetishism. The existence of commodity fetishism as a 'commodity oriented ideology' did not mean in any sense that commodities do not really exist. A characterisation of law as 'merely ideological' creates a false dichotomy between 'base and superstructure,' a distinction which became a defining feature of Stalinism.

It is only under specific historical conditions that the regulation of social relations assumes a legal character. Legal relations between juridical subjects are historically specific and inextricably linked to private property. 'There is no denying that there is a collective life among animals too, which is also regulated in one way or another. But it would not occur to us to assert that the relations of bees or ants are regulated by *law*. Turning to primitive peoples, we do see the seeds of law in them, but the greater part of their relations are regulated extra-legally, by religious observances for instance' (Pashukanis, 1989: 79).

Pashukanis distinguished between law, which is a specific transient feature of class society and reaches its highest point under capitalism, and technical rules, which imply no antagonistic relationship. 'Human conduct can be regulated by the most complex regulations, but the juridical factor in this regulation arises at the point when differentiation and opposition of interests begin. [...] In contrast to this, the prerequisite for technical regulation is unity of purpose. For this reason the legal norms governing

the railway's liability are predicated on private claims, private, differentiated interests, while the technical norms of railway traffic presuppose the common aim of, say, maximum efficiency of the enterprise. To take another example: healing a sick person presupposes a set of rules, for the patient as well as for the medical personnel. In so far as these rules have been prescribed for the express purpose of rehabilitating the sick person, they are technical in nature. The enforcement of these rules can be associated with some degree of constraint on the sick person. So long as this constraint is viewed from the standpoint of a goal which is the same for the person exercising the coercion as it is for the person coerced, it is a technically expedient act and no more. The content of the regulations is specified within these limits by medical science and undergoes change as medical science progresses. The lawyer has no place here. His role begins at the point where we are forced to leave this realm of unity of purpose and to take up another standpoint, that of mutually opposed separate subjects (Pashukanis, 1989: 82-3).

The emphasis placed by Pashukanis upon the importance of the juridical citizen would appear to be wholly consistent with Marx and indeed Hegel. 'Hegel argued that private property implies recognition by others of oneself as a free human being. When others respect your property by not trespassing on it, they respect you as a human being. Private property represents a mutual recognition of people as free and rational beings, expressed in the form of the contract whereby 'the parties entering it recognise each other as persons and property owners' and recognise each other's right to buy and sell as they choose without constraint' (Fine, 1984: 53). The state and the legal form have their material basis in commodity production. It follows that the absence of the legal subject compromises law. It also means that as there was no private property and no juridical subject, neither law nor rights existed in the USSR. However, the continued existence of regulations with the appearance of law points to the continuity of exploitative relations of production. People in the USSR worked under conditions of semi-forced labour and did not own themselves. There was no abstract labour as the Soviet worker did not sell his labour-power but alienated it in a historically unique way. Furthermore, production within the USSR was not for exchange and therefore the Soviet economy did not produce commodities but defective use values (Ticktin, 1992: 134-6).

For Hegel, private property was not just a means of satisfying needs but was an end in itself, the embodiment of citizenship and therefore, freedom. He argues 'All men

are rational, and the formal side of this rationality is that man is free; this is his nature, inherent in the essence of man' (Hegel, 1985: 75). For Marx, the free association of individuals in society is what it is to be truly human; it is man's 'species activity'. The movement to such a society constitutes the telos of humanity. Private property, therefore, is not the final embodiment of freedom but a transitory moment in its development. Humanity's freedom is not realised through private property but by its transcendence. This implies that in socialist society relationships between people would be direct, personal and unmediated by the contract and the legal form.

For Pashukanis, as for Lenin, the state only exists in so far as there are antagonistic interests between the individual and social interests and between antagonistic classes. Production and appropriation do not occur socially as they do in a primitive communist society but by means of exchange among isolated individuals which is all that binds people together under conditions of commodity production (Jakubowsky, 1978: 41). Thus, antagonism is the very basis of the state and law. It follows that just as the withering away of the state is a logical consequence of communism then so must the withering away of law be. In the transition to communism, the narrow horizon of bourgeois right would be confined to its lower phase, when distribution would be according to the principle of 'from each according to his ability, to each according to his labour.' The transcendence of private property would entail the end of right in favour of human need when society can inscribe on its banners: 'From each according to their ability, to each according to their need' (Marx, 1978: 17-18). The point is that the Stalinist assertion of 'proletarian law' had no basis in Marxist theory, was entirely inconsistent with it and served only to mask the growing Thermidorian reaction within the USSR. It also illustrated the contradiction between form and content in what passed for law in the USSR.

Fine argues that Pashukanis' strength is that his criticism of law uses Marx's method. However, he asserts that it is not the legal subject but private property which is the elementary category of jurisprudence. According to Fine, Pashukanis was mistaken and his assertion of the primacy of the legal subject means that he derived the state and law from exchange rather than production relations. The primacy of private property means that law and the state are derived from relations of production and not those of exchange, which Fine asserts is the logical consequence of Pashukanis' argument. Fine goes further and suggests that Pashukanis' 'ultra-critical view' of law led to his 'political failure' to understand the democratic nature of Marx's critique of bourgeois

legality. Fine also argues that Pashukanis' distinction between law and 'technical control' was uncritical of bureaucracy and made him temporarily useful for the development of Stalinism. This, he argues, '...exemplifies the dangers besetting 'left' Marxism' (Fine, 1984: 8).

Fine seems to ignore the fact that Marx is concerned with the historical specificity of private property. The object of Marx's study is capitalist relations of production, their coming into being, laws of motion and eventual transcendence. Marx's starting point is with real historical subjects and not private property. In order for private property to come into being it is necessary that the worker be the acknowledged owner of himself. Private property presupposes an owner whose right of ownership is acknowledged even before he enters the market and this is as true if the only commodity owned is labour-power. This is the result of a historical process where, initially, exchange begins at the margins of society. Far from Pashukanis' assertion being an expression of ultra-leftism it seems perfectly compatible with Marx's approach to the question of exchange.

## **ABSTRACT LABOUR**

Under capitalism the value of a given commodity is determined by an aliquot part of socially necessary labour. It is this *abstract* labour which determines the value of commodities. Abstract labour is homogenised in the market and differentiated only quantitatively. This stands in contradiction to individual concrete labours, such as the factory worker, circus clown or contract researcher, which produce individual use values differing from one another only qualitatively. The consequence of abstract labour is that the product and the labour-power of every worker are rendered commensurable with every other in the market. This is the basis of the universalism, general atomisation and economic exploitation of capitalism. It also forms the basis of rights and equality before the law. However, the principle of legal subjectivity is an advance over feudal particularity. Under feudalism there was no '...notion of a formal legal status common to all citizens [...]. Personality never had the same content universally. Rank, property, occupation, religious denomination, age, sex, physical strength and so on generated such extensive inequality of legal rights that people could not see past the concrete differences to the constant elements of personality' (Pashukanis, 1989: 119). In that sense, law reaches its most developed form under conditions of commodity production. Each citizen is subject to the same laws. The

contract, which takes place between free citizens, has to be on the basis of the exchange of equivalents as measured by the value of commodities. Equality before law is the juridical counterpart to the exchange of commodities in the market place.

The contract treats individuals as free and equal and considers each not in his contingent particularity but in his universality, as a homogenous part of the whole. However, force and the threat of force stands behind every contract and binds the individual to it. The contract contains the contradiction between the individual and society at its heart (Marcuse, 1955: 82). The independence that is a feature of capitalism is an expression of the inter-penetration of the atomised individual and society. Under capitalism this contradiction is expressed as an antagonism of the abstract rights of the individual and the laws of society. It is because of this contradiction that the state assumes its importance. The state protects the antagonistic relations which are expressed through law and upon which capitalism is based.

Abstract labour is neither a heuristic device nor an 'ideal type' which one finds, for example, in the work of Max Weber, but has a material basis in society. We can illustrate such an abstraction by considering the example of graphite and diamonds. Both are made of carbon although neither is carbon in the abstract. Yet no one denies that both graphite and diamonds have the properties that they do because of the particular arrangement of carbon molecules. Similarly, in their finished form as commodities, jewels and pencil lead, diamonds and graphite are not only examples of carbon but of individual concrete labours on the one hand and repositories of value on the other. One cannot take a cut diamond to a laboratory and find the abstract labour in it but the fact that it bears a definite amount of exchange value testifies to it embodying a distinct amount of congealed labour time. In a Weberian 'ideal type' there is no suggestion that it is ever an expression of the essence of a given phenomenon. Weber's book *The Protestant Ethic and the Spirit of Capitalism* never intended to suggest that the influence of Calvinism is anything other than one of a number of contingent factors. An essentialist explanation is excluded a priori and the ideal type in question is acknowledged as having no material existence.

For Marx, as for Hegel, the universal exists. Abstract labour exists and is discoverable through the influence it exerts and scientific investigation. The effect it has on the universalism that characterises bourgeois society 'becomes obvious when contrasted with modern authoritarian ideology in which the reality of the universal is denied, the better to subjugate the individual to the particular interests of certain groups



that arrogate to themselves the function of the universal. If the individual were nothing but the individual, there would be no justifiable appeal from the blind material and social forces that overpower his life, no appeal to a higher and more reasonable social ordering. If he were nothing but a member of a particular class, race, or nation, his claims could not reach beyond his particular group, and he would simply have to accept its standards' (Marcuse, 1955: 126). Rights apply to individuals in so far as they are universal; they are not possessed because of any particular accidental qualities. This means that he who possesses right does so as the 'individual in the form of the universal, the ego *qua* universal person,' and that the universality of right is essentially an abstract one. The rule of law applies to the 'universal person' and not the concrete individual (Marcuse, 1955: 207). Right formally expresses freedom but in practice it is based upon wage slavery and almost universal poverty, which is a necessary feature of capitalism. It is this that Rousseau understood when he asserted that; 'Man is born free; and everywhere he is in chains' (Rousseau, 1973: 165).

Abstract labour means that the various different forms of concrete labours take on a social character and that the labour of different individuals is equalised. The qualitative differences between concrete labours vanish in favour of homogenised labour time embodied in commodities. 'The individual, by virtue of his labour, turns into a universal; for labour is of its very nature a universal activity: its product is exchangeable among all individuals' (Marcuse, 1955: 77). Commodities differ from one another only quantitatively as 'congealed labour time.' By contrast, use values differ from one another only qualitatively. Their equivalence is expressed in their relation to a 'universal equivalent' - money. When Marx was writing, the universal equivalent was usually in the form of precious metals. Whilst money is now no longer based on precious metals, under capitalism the money form is still dependent on abstract labour.

'Lastly, it is a characteristic feature of labour which posits exchange-value that it causes the social relations of individuals to appear in the perverted form of a social relation between things. The labour of different persons is equated and treated as universal labour only by bringing one use-value into relation with another one in the guise of exchange value' (Marx, 1971: 34). The particular object becomes a universal one in the process of labour; it becomes a commodity. The universality also transforms the subject of labour, the labourer and his individual activity. He is forced to set aside

his particular faculties and desires. Nothing counts in the distribution of the product of labour but 'abstract and universal labour' (Marcuse, 1955: 77).

## **CAPITALISM, ATOMISATION AND INDEPENDENCE**

The consequence of abstract labour is human atomisation and alienation. Humanity is separated not only from nature and from its own product but also from what it is to be truly human. Capital, the product of human labour, rises over man and dominates him. Although the degree of independence is far greater than feudal society there is also a far greater degree of alienation as man is separated from the means of his subsistence and is dependent upon the sale of his labour-power. The separation between human needs and capacities is the necessary outcome of commodity production and means that the state must play a crucial role in maintaining relations of production (Kay and Mott, 1982: 3).

The citizen has a two-fold character. There is a contradiction between the biological human being and the abstract citizen, which is a historically specific social formation. The citizen on the one hand is a natural human being and on the other hand is a juridical subject. These are the interpenetrating opposites that constitute the individual in bourgeois society. A human, in nature, is no more a citizen than he is a king or prostitute. Citizenship expresses bourgeois relations of production as absolute monarchy expresses the relations of production of declining feudalism. The extent to which all citizens are rendered equivalent to one another is a reflection and consequence of abstract labour where qualitatively different human beings undertaking qualitatively different concrete labours are rendered equal by their labours being part of social, abstract labour. Just as the product of individual concrete labours are use values distinguished from one another only qualitatively, human beings are distinguished from one another only by natural personal qualities. The citizen, the abstract human being, is not distinguishable from any other citizen in a formal legal sense. However, citizens become distinguishable from one another in a quantitative sense as the sellers of labour-power. Different commodities are distinguished from one another only quantitatively through the particular product of abstract labour the amount of embodied value. Citizens are distinguished from one another in the labour market by the amount of labour required to reproduce that human being and citizen. This manifests itself in varying values and prices of labour-power; wages.

## PSYCHIATRY AND LEGAL RELATIONS

Under capitalism, the rights of the mentally ill are limited in so far as they can not enter into contracts if they cannot understand the consequences of their actions. One has to own one's own property in order enter into contracts and be able to dispose of it consciously with a full understanding of the consequences of one's actions. Reason is an essential prerequisite for contractual relations. The legal position of the mentally ill is analogous to that of a minor (Foucault, 1988: 254). A mentally ill person is assessed for his ability to enter into contracts; the most important of which may well be his consent to treatment or remain in hospital. The mentally ill, similarly, are not always assumed responsible for criminal acts, as reason is also an essential prerequisite of the violation of the contract. Reason entails being able to understand the consequences of the contract one is about to enter or violate.

Where the psychiatric patient is unfit to enter contracts it is possible to have a designated proxy. Reason then becomes invested in a third party who is deemed to have the patient's interests at heart. This can be the nearest relative, a social worker or a designated agent of the state such as the Public Trustee. The fact that even the most intimate personal relations assume a contractual form under capitalism is illustrated by the fact that sexual relations among those who may not enter fully into contractual relations are regulated by statute such as those governing sexual offences against minors, the mentally ill and handicapped. In Britain the Mental Health Act (1983) sets out under what conditions the psychiatric patient may be confined against his will. Even where the psychiatric patient is confined or treated against their will this is done within a framework of law which presupposes that the patient remains the owner of himself. The state, as the guarantor of the contract, protects the legal persona of the mental patient. However, even without the Mental Health Act the existence of common law would circumscribe the conditions under which a patient may be confined.

The Mental Health Act includes the right to appeal against confinement to a formally independent Mental Health Review Tribunal. Officially, a similar right existed in the USSR but there was absolutely no guarantee of the independence of any judicial body, particularly in the face of a psychiatrist who was a General in the KGB, as was the former Director of the Serbsky Institute, Georgii Morozov (Buyanov, 1992: 19). The extent to which one could formally appeal was irrelevant as judges were as constrained

by the same dependence to which all persons in the USSR, including psychiatrists, were subject.

If any further proof is needed of the association between psychiatry and private property then one only needs to consider the way in which separate legal treatment of the insane was confined to the wealthy from the reign of Edward II until 1744. The so-called Chancery Lunatics had a special status by which the state took over and administered the estates of the wealthy insane. The aim was to protect the estates of the wealthy from dissipation by a mentally ill owner thus preventing their inheritance by the legal (and mentally healthy) heir. Under such circumstances the estate could be placed under the direct authority of the crown until such time as the heir could inherit his property. As is well known, vagrancy laws, the Poor Law or criminal law dealt with the poor insane (Jones, 1955: 221-3). It was capitalism which extended property rights to all even if the majority of people own only themselves. A good deal of the Mental Health Act is concerned with the administration of the property of the mentally ill.

It has been argued there is little difference between Western and Soviet psychiatry. Moreover, apologists for Soviet psychiatry are seen by some as essentially the same as advocates of Western psychiatry (Szasz 1974: xiv). Szasz does not deny that there is mental anguish or suffering that requires intervention, or that most of those seeking psychiatric help do so voluntarily. However, he argues that mental distress should be regarded as another 'problem of living.' Where it leads to anti-social behaviour it should be regarded as social deviance. Szasz regards the use of the term illness as an obfuscating justification for repressive measures against those we call mentally ill. Therefore, he suggests, there is no need for mental health legislation at all. Moreover, the term 'mental illness', as it is used in mental health law, is not even the name of an identifiable disease but serves only to conceal the nature of repression. There is no perceived need for a special law regulating peptic ulcers: why then, he argues, should there be special law regulating the treatment of schizophrenia?

This part of his argument ignores the fact that there have been laws specifically aimed at somatic medical conditions. Laws have existed to prevent the spread of syphilis, which in the eighteenth and nineteenth centuries compelled prostitutes to undergo health checks. More recently some countries have introduced legislation making it a criminal offence knowingly to spread the human immuno-deficiency virus. Moreover, there has been a great deal of public health legislation to ensure building and sanitation is of a standard which does not damage health.

Szasz argues that psychiatrists, East and West, play a repressive role. From his right-wing libertarian perspective, the state is the problem and therefore the difference between the USSR and the West is only one of degree. He approaches the question from the point of view of the inviolability of the person and regards any state interference with the freedom of the individual as repressive. Consequently, Szasz sees no difference between Soviet and Western psychiatry. Both confined people to hospitals against their will using dubious diagnostic categories as a justification. However, Szasz's argument is internally contradictory. The universal free citizen that Szasz wishes to defend is a historically specific feature of commodity production. As we have seen, the social relations of commodity production could not exist without the state. In that sense he is attacking the very institution which acts as the guarantor of the social relations he wishes to defend. Such a view cannot account for any differences between Soviet and Western psychiatry.

Whilst we may acknowledge the problematic nature of applying the term 'illness' to mental disorders, Szasz seems to ignore the fact that to be 'mentally ill' is a legal status as well as a description of particular signs and symptoms. Such a status implies that a person is not fit to dispose of his property, as he does not understand the consequences of his own actions. This includes the right to dispose of his body into the care of those who may help him. Most people with peptic ulcers are thought to be able to make such decisions but occasionally they cannot. For example, if a person collapses from blood loss from their peptic ulcer and is unable to signal his consent to an emergency operation, then his reason, like that of a psychiatric patient, is invested in a proxy. This too is usually the nearest relative or, in an emergency, the surgeon himself. To acknowledge that specific laws on mental illness are based on private property would place Szasz's argument in an awkward position. He would have to accept that the manic patient who orders a car he has no hope of keeping up the payments for, or the person with Alzheimer's disease who is tricked into selling his home for a nominal sum, are entering valid contracts and should be held to them. Mental health legislation exists not to negate the liberal principle of the rights of the citizen but to define and protect them. A great deal of the work of the Public Trustee, through the auspices of the Court of Protection, is concerned with administering the property of the mentally ill who have no other reliable representative. Their role is an extension of the mediaeval Chancery applied to universal property owners. It was precisely such mechanisms which were absent or ineffectual in the USSR. Therefore, Szasz is mistaken when he

equates the abuse of Soviet psychiatry with the confinement of the mentally ill in the West.

It could be argued that psychiatry like somatic medicine does play a role in controlling the working population in capitalist countries. However, rather than being a state sponsored confinement of healthy dissidents it has a totally different mechanism. The person who is suffering from anxiety, depression or psychosis has their symptoms defined as a medical problem. The problem is that of the sufferer himself. It is a disease to be treated in an isolated individual. It could be argued that a good deal of illness, somatic and psychiatric, is due to poverty, bad housing and alienation. Evidence for this can be seen in empirical work on inequalities in health. Almost every physical and mental disorder affects people to a greater degree in the lower social classes (Townsend & Davidson, 1982). The definition of a problem in medical terms has the effect of deflecting criticism away from the political economic system that guarantees scarcity and this was as true in the USSR as it is in the West. The implication is that poor health is a technical problem to be solved by improvements in medical science or health education. The way is then clear to offer reformist solutions. In so doing, any suggestion that ill health can only be conclusively addressed by the transcendence of private property is ignored.

Many of the great advances in health have not been the result of medical innovation, such as vaccination, but the result of public health measures which have led to better housing, nutrition and birth control. Tuberculosis, for example, declined greatly before vaccination became available (Kennedy, 1983: 19). By focusing on disease rather than the nature of society a possible focus for popular discontent is diffused. Capitalism leads to widespread illness in the working population. This is not the place to debate this point fully but it is worth remembering that in Britain during 1970-2, if the death rates for people in social class I had applied to classes IV and V then the lives of 74,000 people under seventy-five would not have been lost (Townsend & Davidson, 1982: 15). As capitalism declines, measures such as free medical treatment, provided according to need, and better housing are no longer affordable. The result has been that the emphasis has shifted away from public health measures to the personal lifestyle of the sick and 'risk taking behaviour' such as smoking and drinking. As a result, the blame for widespread ill health is placed at the door of the sufferer.

From a Marxist perspective it could be argued that a good deal of mental illness is the result of alienation which is particularly acute under conditions of commodity production. Scull argues that the transition from feudalism to capitalism is marked by an increase in mental illness (Scull, 1989: 76-7 et passim). The defining feature of modern psychiatry is the movement away from the physical restraint of the patient to his internal and moral control. Under capitalism the ideological control of the working population is through the mystification of social relations through commodity fetishism. At the same time, the role of medicine in general and psychiatry in particular is obscured by the same mechanism. The patient usually sees the psychiatrist on the basis of a contract, which is voluntarily entered. Moreover, the problem is the patient's and not that of the society that is based on a separation between the person's needs and the means to satisfy them. The result is that the controlling feature of psychiatry is mystified and internalised in a way analogous to the control of the working population. Aside from the fact that, under capitalism, the state provides most of the psychiatric services, the relationship of psychiatry to the state is neither direct nor obvious.

Within Soviet medicine in general and psychiatry in particular similar debates took place around questions of public health. As we shall see, the Soviet responses had much in common with capitalist countries but the rate of ill health was higher and the medical and public health response was poorer and less effective.

## **CAPITALISM, MORALITY AND PSYCHIATRY**

Psychiatry assumes its modern form with the development of industrial capitalism. One of the distinctive aspects of modern psychiatry is the development of 'moral control'. Instead of the forcible restraint of the insane, as in the mediaeval Bedlam, the emphasis shifts to one of moral restraint that must come from within the patient. Moral being is a necessary complement of legal being. It amounts to the fact that man does 'freely', out of inner conviction, that which he would be compelled to do in the sphere of law. 'Where there is a close emotional tie blurring the limits of the individual self, the phenomenon of moral obligation cannot occur. If one wants to comprehend this category, one must start out, not from the organic bond that exists, for example between the mother animal and its young, or between the clan and each of its members, but from the condition of *isolation*. Moral being is a necessary complement of legal being; they are both modes of intercourse utilised by commodity-producers'

(Pashukanis, 1989: 155). In other words moral control relies on an internalisation of the sanction which accompanies the violation of a contract. A society where the bonds between humans were not contractual but human would mean that the contradiction between individual and society would vanish. 'If the living bond linking the individual to the class is really so strong that the limits of the ego are, as it were, effaced, and the advantage of the class actually becomes identical with personal advantage, then there will no longer be any point in speaking of the fulfilment of a moral duty, for there will then be no such phenomenon as morality' (Pashukanis, 1989: 159). A genuinely socialist society would entail free labour and not labour as the only alternative to poverty and supported by the internalisation of the contractual relation between worker and his employer.

In the USSR, where the relationship between the classes was antagonistic and at the same time transparent, this meant that there was neither a sense of 'moral duty' to work well nor any idea that the advantage of the class had any relationship to personal advantage. As a result the working class was atomised by fear and unable to see any relationship between personal advantage and the advantage of the class. Consequently, Soviet relations of production led to fear and atomisation. Moreover, the working class could not come into being as a class and could only act politically in an atomised, individual way.

The control of the working population under capitalism is not, as it was under feudalism, direct and coercive. Modern proletarians are controlled by commodity fetishism and the reserve army of labour. Exploitation appears to be on the basis of a free and fair contract and scarcity appears to be a natural and unchangeable feature of society. Just as the control of the working population under capitalism takes an internalised form, so does the role of psychiatry. The patient is usually the voluntary client of the psychiatrist or general practitioner.

This is important because in the USSR, where there was no commodity production, commodity fetishism exerted no control over the working population. The exploitative nature of production relations was transparent and there was no effective ideological control. Soviet citizens, in the absence of contrary evidence, assumed that their government was not telling the truth. The tendency was to 'read between the lines' of every official pronouncement and in some cases to invert the official line and assume the opposite to be true. This had its counterpart in psychiatry. Where the role of psychiatry was coercive and in the interests of the elite it was also transparently so.



Under capitalism inner freedom does at least reserve to the individual a sphere of unconditional privacy with which no authority may interfere, and morality does place him under some obligations (Marcuse, 1955: 199). In the USSR the entirety of the person became a political object and privacy was abolished.

## LAW AND SOVIET POLITICAL ECONOMY

In the USSR the worker did not sell his labour-power but alienated it in a historically unique way (Ticktin, 1992: 84). He was compelled to work but had a good deal of control over the labour process even if this took a negative form. He could not be sacked without the employer finding him another job. Effectively, workers were paid whether they worked well or badly. The result was that almost the entire product, including labour-power, of the USSR was defective. This manifested itself in very poor quality goods in the shops and equally poor services. This was just as true of medical services in general and psychiatry in particular. To illustrate this one only need to point out that pyrogenic therapy and insulin coma therapy were still in use at least until 1992 (Malin, 1992: 81-5).

The system of semi-forced labour and the absence of a labour market meant that abstract labour did not exist. Consequently, the basis of commodity production was absent as well as the basis of legal universalism. Effectively, there was no law. It also meant that there was no relationship between prices and values. All prices were set by the central authorities that, in the absence of a market, had no means of rationally calculating the value of goods. Many goods and services, such as housing, medicine and transport, were distributed outside of even the semblance of market relations. At the same time it was obvious that the elite lived a far better life and therefore the exploitative nature of the system was clear to all (Ticktin, 1973: 20-41).

As law did not exist in the USSR its place was taken by thousands of contradictory rules supported by violence or the threat of violence. The Soviet '*Sobranie deistvuiushchego zakonodatel'stva SSSR*' consisted of over 10,000 pieces of legislation and this does not include the incalculable number of semi-legal instructions and statutory instruments (Buxbaum & Hendley, 1991: ix). The total print run of the '*Sobranie*' was only 18,000 copies, which was not even sufficient to reach all agencies concerned with enforcing the law, let alone individual lawyers. (Loeber in Buxbaum & Hendley, 1991: 3). Because of the contradictory nature of Soviet laws the

implementation of legislation took on an arbitrary character.<sup>1</sup> Each judge, party official, army officer or psychiatrist interpreted the rules more or less as they wished. The individual became the subject of arbitrary expropriation, imprisonment or treatment and the recourse to an independent judiciary was limited. These rules were as imperfectly administered as any other aspect of Soviet society. More often than not, the rules handed down from the centre were so numerous and so contradictory that interpretation became a localised and bureaucratised process. For the Soviet mental patient, this meant that, notwithstanding pronouncements regarding human rights and 'laws', his protection was in the hands of the psychiatrist who was the final arbiter of the patient's fate.

An example of this in Soviet mental health law is the right in Chapter 33 of the RSFSR Code of Criminal Procedure to challenge the expert opinion regarding a person's legal imputability. 'As often happens in Soviet law, this provision is rendered, in many cases, practically meaningless, because another article states that the investigating agency, which is under the supervision of the procuracy, does not need to inform the charged person about the psychiatric commission's opinion or even about the fact that his mental health has been called into question...' (Lapenna, 1986: 18).

Psychiatrists, whether in the USSR or in the West, are in a position to transform their opinion into a social reality because they are, in both cases, supported by the state. In the West the opinion of the professional is enhanced by a monopoly of expertise in his particular field. It also depends on a very effective and credible form of ideology. The diagnostic categories psychiatrists use tend to be accepted. However, in the USSR the abuse of psychiatry to silence a dissident was not particularly effective because of the transparent nature of the regime and the absence of a credible ideology. The tendency among many Soviet people was to disbelieve, and sometimes simply invert, the official pronouncements of the state. Therefore, in the absence of solid evidence to the contrary, even a dissident who was unwell would probably be presumed well by the public.

## **SOVIET ATOMISATION AND DEPENDENCE**

In societies without private property relations, such as primitive communism, relations between people are direct and personal. Such societies are characterised by

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<sup>1</sup> I am indebted to Hillel Ticktin for this point.

personal interdependence for the most basic necessities of life. They are also dominated by nature and usually have a precarious existence where the social surplus is small.

The dependence of the serf on the lord is mitigated by the difficulty the lord has supervising his vassals and the fact that the serf also has a customary access to the means of subsistence. Under capitalism the proletarian may sell his labour-power to whomsoever he pleases, providing he sells it to someone. It is this freedom and money, which is derived from abstract labour, which forms the basis of the independence one has under capitalism. The worker is free but a precondition of his freedom is that he does not have access to the means of subsistence. One might have nothing else but one does have the right to work. What one does not have is the right to a job, an income or to have one's needs met.

A developed socialist society would imply the interdependence of all but unlike primitive communism would make use of advanced technological development to ensure abundance. In so doing, the meeting of human need would replace the concept of right. In place of the right to work and meet one's needs indirectly, all production would be solely to meet human needs. The independence that money and the market seem to offer would be replaced by the real independence associated with abundance and the abolition of wage labour. The inviolability of the person that rights seem to confer would be replaced by the only other social guarantee available, the direct, participative democracy of all working people. The state and law would wither away and all that would remain is technical regulation that does not imply antagonistic interests.

The Soviet system had the worst of all worlds. The Soviet people were in a state of complete dependence. In fact, in the absence of private property, they were not citizens at all. They did not own themselves. It was illegal not to have a job and therefore people were subject to semi-forced labour. As a result, rather like feudalism, the relations of production were transparent. No one was under any illusion that the elite lived better than the working class or that they did so at the workers' expense. Furthermore, everybody was utterly dependent upon the state and their position in society. Dissent could result in the loss of one's job, home, car, degree or even life. Whereas atomisation under capitalism is on the basis of abstract labour, in the USSR it was on the basis of fear and the ubiquitous presence of the KGB, which extended its influence into every sphere of life.

The dependence and control under which the Soviet psychiatrist operated meant that the compliance of at least some psychiatrists was guaranteed when it came

to confining the political or religious dissident. Dependence and control were the direct result of the widespread surveillance of the general population, and its subsequent atomisation. They were also due to the absence of money and the direct distribution of those privileges which were always more important than money. For example, the psychiatrist who refused to certify a dissident as insane could lose access to higher education for his children. Just as this points to the direct and transparent nature of exploitation in the USSR so is it the case that the use of psychiatry took a transparently repressive form.

A psychiatrist in Britain, after the initial training, is well paid and quite independent. He can work more or less where he chooses and although he is usually little more than salaried employee he can work privately or even be the owner of a private clinic which employs staff who realise a profit for him. In extreme circumstances he can give up medicine or choose not to work while his savings last. After the consolidation of Stalinist power, the ordinary Soviet psychiatrist was never more than a low paid, salaried employee. In the absence of private property, the psychiatrist could lose everything if he fell out of favour with the elite. We need only remember that Dr. Semyon Gluzman, who publicly announced that the dissident, Major General Grigorenko, was sane, was sentenced to seven years in a labour camp and three in exile as a result (Bloch and Reddaway, 1978: 235).

In the USSR the form of atomisation was different to that in the West. Under capitalism the atomisation which results from abstract labour is mitigated by the independence that goes with it. It is also mitigated by the possibility of the political association of workers that can assume revolutionary significance. Atomisation in the USSR had no such mitigating factors. In fact the attempts to overcome its worst effects led to dependence on a network of friends, colleagues, work mates and so on. Even securing enough to eat might depend on neighbours telling one when scarce foodstuffs were available. Obtaining a place at a good school often depended on 'favours' from someone who worked there. My access to The Serbsky Institute, Kashchenko Hospital and Psychiatric Hospital Number One, in Magnitogorsk, were only possible through 'contacts' and the obligations that resulted from them.

'So long as value relationships are absent, it is only with difficulty that the economic activity is distinguishable from the aggregate of life functions which constitute a unitary whole. With the gradual emergence of commodity relations, and especially with the advent of the capitalist mode of production, economic life becomes

a separate structure without any admixture of kinship systems, political hierarchies or whatever, and its form must be understood in terms of a set of concepts specific to it' (Arthur, 1976: 33). The fact that Soviet society relied on such a network of particularities testifies to a level of atomisation which was more far reaching than anything under capitalism.

## **IDEOLOGY IN THE USSR**

For ideology to have any effect it has to have some relationship to reality. If a capitalist says that he can't afford to increase workers' wages as this will lead to his company being uncompetitive this is believable because within the capitalist framework it is often true. The resultant fear of redundancy is frequently enough to control the workers and the call to 'open the books' to scrutiny may simply reveal that the capitalist is telling the truth. In the USSR the discontinuity between the state's official pronouncements and the day-to-day reality experienced by Soviet workers was so great that there was no credible ideology. We have already seen how commodity production supplies capitalism with a ready and effective form of ideology. In the USSR that was absent and exploitation was transparent. In addition, virtually every official pronouncement by the Soviet State was contradicted by everybody's experience.

The USSR claimed to be socialist but, in fact, had glaring inequality. It claimed to be internationalist but actually institutionalised chauvinism internally and expressed it further in its foreign policy. It claimed to have a comprehensive range of health care services that compared well with any in the world but in fact most ordinary Soviet workers dreaded going to doctors or to hospital as they knew that the service was extremely poor. Similarly, the controlling property of psychiatry was as manifest as exploitation under Soviet production relations. No one was in any doubt about the role of a psychiatric service with a significant KGB presence.

## **THE COMPARISON WITH FASCISM**

I have tried to argue that the abuse of psychiatry in the USSR is not explicable solely with reference to the absence of liberal democracy. It may be objected that there are other historical examples of psychiatric abuse, such as fascist Germany, which share common features with the USSR. This tends to be the perspective of those who characterise both regimes as 'totalitarian'. Among the

problems with the concept of 'totalitarianism' is that it tends to generalise over the whole historical period of the USSR and ignores the very important differences between the USSR and Nazi Germany.

The differences between Germany and the USSR are well illustrated by the treatment of the mentally ill and handicapped. The case of Nazi Germany deserves fuller treatment in its own right but it is important here to differentiate between the legal rights of the mental patient in the USSR and Nazi Germany. It is argued that the USSR and fascist Germany, as totalitarian regimes, both abused the rights of the mentally ill. It is well known that in Nazi Germany the mentally handicapped and chronically mentally ill were gassed in concentration camps along with the millions of other victims. On the one hand this leads to favourable comparisons with the USSR where there is no evidence of such systematic murder of the mentally ill and handicapped. On the other hand the abuse of rights is seen as being the inevitable outcome of regimes in which the state interfered in scientific matters, made academic appointments on political grounds and denied the rights of the mentally ill and others.

Whilst some of these comparisons are perfectly valid the differences were so great that closer inspection is required. In Nazi Germany, although thousands of mental patients were killed, the killings in many cases were stopped as a result of widespread resistance from ordinary German citizens, the church and legal challenges (Weindling, 1989: 550). This illustrates some of the essential differences between German fascism and Stalinism. Unlike the USSR, law continued to have some basis in Germany even if it was in a grossly distorted form. The very basis for law, the juridical citizen and private property continued to exist. Furthermore, the state retained some independent existence apart from the Nazi Party. Obviously, the status of 'law' under the Nazis is very far removed from bourgeois liberal democracy. No one would argue that there was the kind of abstract universal citizenship that characterises capitalist society. Large sections of the population had their rights as citizens withdrawn. Interestingly though, this was often done under the guise of formal legislation, such as the infamous Nuremberg laws forbidding sexual relations between Jews and non-Jews.

In the case of the mentally handicapped many of the killings took place furtively and were couched in euphemistic terms. Parents were informed that their mentally handicapped child had died and the fact that a doctor killed them was

withheld. Curiously, even the killings were undertaken in a quasi-legal way. Often the medical decision to kill a mentally ill or handicapped person was undertaken by a commission of doctors, including at least one psychiatrist, and the 'euthanasia' was recorded as 'treatment'. Occasionally, such euthanasia even included the 'patient' having to sign a consent form (Lifton, 1986: 46-7).

Forcible sterilisation of the mentally handicapped and ill was also widespread although it was not confined to Nazi Germany. It was not uncommon in the USA and, as recent press revelations have shown, even took place in Sweden controlled by the Social Democratic Party (Freedland, 1997: 1-2). In Germany this also took a quasi-legal form, even in the concentration camps. People, even those who had been formally deprived of German citizenship, forced to undergo sterilisation and other life-threatening medical experiments, were often compelled to sign consent forms (Poller, 1962: 129).

How is one to account for these apparent paradoxes? German fascism itself grew out of capitalism and moreover a capitalism in decline. Under normal circumstances such abuses of rights would not have been acceptable to the bourgeoisie. However, under conditions where the bourgeoisie could lose everything to what would be regarded as a worse enemy, a socialist-inclined proletariat, the bourgeoisie were prepared to support Hitler and the petite bourgeoisie providing that the Nazi Party did not threaten German private property. Accordingly private property remained largely intact in Germany (Neumann, 1942: 48). Excluding Jews, the haute bourgeoisie remained practically inviolate and the working class continued to be the owners of labour-power, which they sold for wages. They therefore had some incentive which Soviet workers did not. Private firms continued to exist and worked on the basis of profit, which they were able to accumulate (Ticktin, 1992: 26). For all of these reasons Nazi Germany remained capitalist however qualified this is with reference to interference with the free market and the role of the Gestapo. Hence, there were very important differences with the USSR.

In other words, Nazi Germany contained significant contradictions. A good example of this is the fact that the State and Party existed side by side as parallel powers. Party officials enjoyed privileges and freedom from prosecution similar to German civil servants (Neumann, 1942: 73). However, although many in the judiciary supported the Nazis, they were still formally separate and had a degree of independence. Notwithstanding the fact that patients were killed illegally, in the face

of objections from relatives about the neglect of mental patients, the courts were compelled to uphold the letter of the law. The use of consent forms and quasi-legal tribunals under such circumstances can then be seen as a means by which doctors could defend decisions which they knew were sanctioned by the Party but proscribed by the state.

The position of doctors under the Nazis and in the USSR was also quite different. In Germany and Austria, doctors retained a degree of independence. Jewish doctors, who were fortunate enough to have the means to leave, could do so as the emigration of Sigmund Freud shows. Doctors in the USSR however were, as we have seen, dependent upon the state and could not even emigrate easily. Many Soviet doctors did not support the Stalinist regime. Under Stalin many used their position to help opponents of the regime avoid the camps and firing squads by describing their charges as unfit to plead and confining them to hospital instead. In Germany, however, doctors were disproportionately represented in the Nazi Party and in many cases lent their active support to racial policies.

The Nazi Physicians League had 2,786 members by the beginning of 1933, which represented six per cent of the entire German medical profession. Doctors joined the Nazi Party in greater numbers than any other professional group. Only 2.3 per cent of engineers joined by 1933, whereas by the end of 1933 11,000 physicians had joined. As many as 45 per cent of physicians may have joined the Nazi Party at some time. Around 26 per cent joined the Brown Shirts while as many as 7 per cent joined the SS (Proctor, 1988: 66-7). Such figures support the view that the Nazi Party was a party of the petite bourgeoisie (Trotsky, 1989: 259). Another interesting aspect is that the Jewish population of Germany was less than 1 per cent but the proportion of physicians who were Jewish was 13 per cent. In the cities the proportion of Jewish physicians was much higher. It has been estimated that the proportion of Jewish physicians in Berlin was around 50 per cent. It is tempting to conclude that in supporting the Nazis the German physicians were creating valuable career positions for themselves at the expense of their Jewish colleagues (Proctor, 1988: 69-93).

The contradictory nature of Nazi Germany found its expression in a number of ways. For example, as private property continued to exist, so did the juridical citizen as its owner, which meant there was a basis for law. The fact that law took a distorted form was inevitable given that the bourgeoisie had allowed a distorted form of capitalism rather than lose everything. The consequences for the mentally ill and



handicapped were tragic. The motivation for the neglect, and later murder, of mental patients in Germany was largely financial but justified in eugenicist terms (Proctor, 1988: 183-4). By contrast, provision for the mentally ill and handicapped in the USSR was very limited until after Stalin's death and largely fell upon the family, particularly in rural areas. As we shall see later Soviet psychiatric abuse had quite different origins and therefore took a different form.

## **MENTAL HEALTH LAW 1917-1929**

Law under tsarism had its own contradictions. However, one cannot conclude from this that law had no basis. Notwithstanding the fact that serfdom ended as late as 1861 basic juridical principles regarding the mentally ill were well established even if in practice much of the care of the mentally ill, especially in rural areas, was of a rather primitive nature. The emancipation of 1861 paved the way for the legal universalism which is characteristic of capitalist societies but given the late development of the necessary conditions for bourgeois law it is not surprising that the codification of law took place rather later than elsewhere in Europe. The point is that the Russian mode of production was not capitalist but semi-Asiatic (Trotsky, 1971: 8). This is discussed more fully in Chapter Two. The contradictory nature of this mode of production expressed itself in legal forms. However, it is fair to say that law existed in tsarist Russia in a way that it did not under Stalinism. The legal position of the mental patient in the early Soviet period was practically indistinguishable from developed bourgeois countries.

One of the first textbooks on law and psychiatry in the Russian Empire was *Pravo Estestvenno* written by A.P. Kuntzyn and published in two parts between 1818 and 1820. Kuntzyn was the professor of jurisprudence at the Lyceum and Pedagogical Institute in Tsarskoe Selo. He was influenced by Rousseau and the classical German philosophy of Fichte, Hegel and Kant. This liberal perspective placed Kuntzyn in the circles of the reformers of his time. His book was known to have been read by Pushkin and some of the Decembrists. The general principle that the mentally ill are not responsible for criminal acts was not only well established in law but also Kuntzyn seems to have understood the basis for such non-imputability. 'First of all there is a "basic" foundation of right – the right to oneself. This was understood by A.P. Kuntzyn, as rights to one's own person (individual right). From individual right flowed the essence of right, the right to use one's own force, the

right to achieve happiness. From this flows the right to freedom, that is the right to exist as an independent and the right of every person to exist as a person' (Roytel'man, 1994: 90-1). The point is that although serfdom was not abolished until 1861 the basis for rights was established in the Russian Empire before this. Emancipation was a juridical expression of the fact that the right-bearing citizen already existed. Capitalist relations of production were developing in the Russian empire even before 1861. Or, in other words, the final act of emancipation was the sweeping away of a juridical contradiction that served only to impede the further development of the economy. The fact that fully developed liberal democracy was not as well established in Russia as elsewhere could not explain the subsequent abuse of psychiatry. Although the Bolsheviks inherited a backward system one could not argue that the basis for right was not understood or that this is the reason for subsequent psychiatric abuse.

The provision of specialist facilities for the mentally ill was far behind similar provision in England, Germany and France. Most of the mentally ill were cared for under the provisions made for medicine in the '*zemstvo*'. Medicine was decentralised and subject to wide local variation. The first purpose-built psychiatric hospital with a forensic psychiatric capacity was the Kazan psychiatric hospital, which was opened in 1869 (Gataullin, 1991: 90). Many of the early congresses of psychiatrists and neuropathologists as well as congresses of *zemstvo* doctors featured complaints about the poor state of development of psychiatry in general and forensic psychiatry in particular. Before the revolution psychiatrists were agitating for an expansion of services, a separation of forensic psychiatric care from prisons and the development of laws relating to the confinement of the mentally ill (Morozov, et al, 1976: 117-22).

It is interesting that Morozov's history of the development of Soviet forensic psychiatry divides the history of the Soviet period into three. First from 1919 to 1929 'characterised by the accumulation of experience, the development of new organisational forms of forensic psychiatric expertise and compulsory treatment and the gradual overcoming of erroneous theoretical position of psychiatry and criminal law.' The second stage covering the next twenty years is characterised by 'the organisation of forensic psychiatry into a system of offices of the health service, the expansion of scientific and research work in the field of forensic psychiatry and the preparation of a qualified cadre of forensic psychiatrists.' The third phase

(presumably from 1949) is characterised by the development of 'the modern current and future perfection of socialist, legally ordered,<sup>2</sup> and improved attention to the individuality of the criminal and the legal rights and guarantees of the mentally ill (Morozov, et al, 1976: 129-30). This is the same Georgii Morozov who was a KGB General and head of the Serbsky Institute. One of his co-authors, Danil Lunts, was a KGB Colonel and also a senior figure at The Serbsky Institute. It is probably not accidental that the book was written at the height of dissent within the USSR and the Western criticisms of Soviet psychiatry. The three phases Morozov identified do correspond to distinct periods, first when psychiatry was no different within the USSR to that in any other European country except that it was rather underdeveloped. The latter two periods in which the Stalinist elite established its power base and consolidated it after the death of Stalin.

The Soviet People's Commissariat for Health (*Narkomzdrav*) was established on 11 July 1918. A psychiatric commission was established in May 1918 which was comprised of professors of forensic medicine, psychiatrists, jurists, and pathologists. This acted as a sub-committee of the *Narkomzdrav*. The first act of Soviet mental health law was the instruction 'Concerning the Examination of the Mentally Ill' published in 1918. It laid down guidelines for the assessment of criminal liability and the establishment of trusteeship for those who were to appear before Soviet people's courts. The main focus for reforms was in the prison service and the new reforms were those for which doctors had agitated before the revolution. The People's Commissariats for justice and health were reorganised on 8 of May 1919. A set of 'Regulations Regarding Psychiatric Examination' were published which regulated some aspects of psychiatry, including complaints. It ensured that forensic psychiatric commissions preparing an expert opinion for a court should have at least one psychiatrist present. In 1919 the criminal code was reformed to allow the mentally ill to be transferred from prison to a psychiatric hospital (Morozov, et al, 1976: 131).

Such legal and quasi-legal acts have to be seen in the context of a psychiatric service that was barely developed. In all psychiatric hospitals in the RSFSR on the 1 January 1922 there were only 12,982 patients and a further 1,600 in the Ukraine (Yudin, 1951: 369). Doctors, along with other members of the intelligentsia, were recognised as largely hostile to the October Revolution and concessions were made

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<sup>2</sup> *Pravoporyadka*.

to them. If there had been any intention to use psychiatry for repressive means, for which there is no evidence, then the Bolsheviks would have found themselves obstructed by psychiatrists who had been given a good deal of authority in court cases. They would also have found that there was scarcely any psychiatric service that could be abused. In so far as there was development in psychiatry during this period it was directed toward building new facilities and not in codifying laws for the confinement of the mentally ill.

### **MENTAL HEALTH LAW 1930-1988**

Throughout this fifty-eight year period such regulation as there was did not include a single comprehensive act which resembled legislation in the West. However, there were numerous regulations, instructions and directives concerning the role of forensic psychiatry in relation to the responsibility of persons deemed to be mentally ill before the law. The first criminal code of the RSFSR in 1922 established that 'the medical criteria [of diminished responsibility] included actions committed during a temporary nervous breakdown. However, as before, there continued to exist a generally ill-defined understanding about "such conditions" under which the ability to account for one's actions was excluded. Only in basic criminal legislation of the USSR in 1924 (article 7) was there the first statement which included judicial criteria for diminished responsibility which included an indication that there was the wilful incapacity to "control one's actions". [...] Only in the criminal code of the RSFSR of 1926 was there the first precise establishment of both [judicial and psychological] criteria for diminished responsibility...' (Morozov, et al, 1976: 152). In fact the whole period from 1930 to 1988 included numerous attempts to 'tighten things up' regarding the ability of psychiatrists to have someone acquitted of a criminal offence. However, over the years the provision for the diminished responsibility in the criminal code changed very little. Article 11 of the 1929 Criminal Code states that 'Social protection measures of a legal-corrective character may not be undertaken against a person who, in the act of committing a crime, was in a state of chronic mental disorder, temporary mental derangement, or other condition of illness, if such a person cannot realise the significance of his actions or control them. Equally, a person who, although they carried out their actions in a state of mental stability but at the moment of sentencing becomes mentally ill, may only be subject to social protection measures of a medical character' (RSFSR, 1929: 9-10).

By 1960 this Article had become: 'A person shall not be subject to criminal responsibility who at the time of committing a socially dangerous act is in a state of non-imputability, that is, cannot realise the significance of his actions or control them because of a chronic mental illness, temporary mental derangement, mental deficiency or other condition of illness. Compulsory measures of a medical character may be applied to such a person by order of the court.'

'Also a person shall not be subject to punishment who commits a crime while in a state of imputability but before the rendering of judgement by the court contracts a mental illness which deprives him of the possibility of realising the significance of his actions or of controlling them. Compulsory measures of a medical character may be applied to such a person by order of the court, but upon recovery he may be subject to punishment' (Berman, 1966: 148-9).<sup>3</sup>

There are clear differences between the two codes. The later code specifies that compulsory treatment may be applied. The person who committed the offence may be punished if and when he recovers and in the meantime may be treated. The commission of a crime in the 1929 Criminal Code is replaced by the far looser term of the 'committing socially dangerous acts'. However, it was not the changes in wording which are particularly important over the forty year period but the way in which psychiatry became consciously used as a repressive measure. Another very important change is that by 1955, when psychiatry became part of the state's repressive armamentarium, the composition of the medical profession had changed. In 1929 the state could not have relied on psychiatrists to carry out repressive measures even if it had occurred to anyone to use it in such a way. By 1955 most psychiatrists had trained under Soviet social relations and were dependent for their position on loyalty to the regime. A proportion of these psychiatrists, such as senior figures at the Serbsky Institute, were effectively part of the elite and were willing to implement repressive measures.

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<sup>3</sup> Berman's translation is of the 1964 criminal code, which had some changes from 1960. However, there were no changes between the two codes relating to Article 11. Similarly, the 1929 criminal code was a revised version of the 1926 code to which Morozov et al refer. However, I have been unable to find any revisions to Article 11 between 1926 and 1929.

Until after the Second World War the repeated attempts to prevent psychiatrists from finding so many people non-imputable were often unsuccessful. In 1926, 38 cent of persons referred to the Serbsky Institute were found to be non-imputable. In 1938 of 308 persons admitted to the Serbsky Institute 3.5 per cent were discharged after the first month, 11.4 per cent after the second, 24.1 per cent after the third and 49.8 per cent after the sixth (Morozov, et al, 1976: 146 & 182). Psychiatric hospitals were seen as helping significant numbers of people evade the criminal law by diagnosing them as non-imputable and then either providing asylum or releasing them. Morozov makes frequent reference to the 'mistakes' committed by psychiatric assessments. 'The study of forensic psychiatric clinics permitted to attend the All-Union conference on forensic psychiatry (1948) to lay stress on the question of diminished responsibility during psychiatric illness, difficulties presenting in clinical assessment, in the principles of forensic psychiatric examination and the analysis of assessment mistakes' (Morozov, et al, 1975: 171). It is after 1948 that the directorship at the Serbsky Institute changed and Feinberg was replaced by Morozov in 1950.

The numbers of people found non-imputable in 1926 and 1938 may not be many if one were to make a comparison with a comparable psychiatric clinic in Britain either then or today. However, in 1938 it is tempting to conclude that such figures were very important in the context of the USSR. Meaningful comparisons with the West are probably not possible even if reliable figures were available for the USSR. However, it is interesting that throughout his history of Soviet forensic psychiatry Morozov does not once mention Stalin or the purges during this period. It is hard to avoid the conclusion that up until 1948 it was possible to use psychiatric hospitals to avoid a worse fate in the camps. After 1948 the use of psychiatry to ameliorate more repressive measures was closed off in favour of psychiatry itself becoming a repressive measure as killing and mass deportations became politically, economically and personally intolerable for the Soviet elite and intelligentsia.

Calloway (1992: 203) argues that the USSR had one of the lowest rates of compulsory detention amongst countries with a developed psychiatric service. He states that only about 3% of patients were detained compulsorily as compared with 10% in the U.K. and 25% in the USA, which rises to 50% if one only looks at public hospitals. Calloway cites this information as though it were unproblematic. However, given that until 1988 there was no formal legislation regarding the confinement of the mentally ill it is difficult to know how reliable this is. It may be that such a figure is a reflection of

those patients detained in psychiatric hospitals following a court order and relating to criminal proceedings. There has been a long standing recognition of the category of diminished responsibility in the USSR. Apart from this there were 'various departmental instructions and circulars' which the 1988 decree not only summarised but 'placed anew before society the whole question of the delivery of psychiatric care' (*Meditsinskaya Gazeta*, 27/7/90:1).

By 1977 the increasing dissent in the USSR and mounting criticisms in the West brought matters to a head. The Honolulu congress of the World Psychiatric Association (WPA) publicly criticised the political abuse of Soviet psychiatry. This is discussed in detail in Chapter Five but for now it is interesting to note that Eduard Babayan, who was the leading figure in the judicial aspects of psychiatry in the USSR, gave his paper in Honolulu on 'Legal Aspects of Psychiatry in USSR Legislation.' It was later published in the USSR (Babayan, 1978: 598-604). The article is a defence of the legal position of the psychiatric patient in the USSR. It contains numerous references to 'ukazy' and other administrative measures relating to the procedures for the compulsory treatment of psychiatric patients. It also contained a pointed critique of Western psychiatry by referring to the fact that the USSR restricted the use of ECT to exceptional circumstances and banned the use of leucotomy and lobotomy in December, 1950. Babayan also points out that the use of LSD for treating psychiatric patients was banned in March 1967. However, as we have already seen, it was not the absence of the appearance of formal statutes that was responsible for the abuse of Soviet psychiatry but the absence of the basis for law at all, the juridical citizen.

## **THE 1988 DECREE OF THE SUPREME SOVIET**

It was the failure of the elite's strategy of incorporating the Soviet intelligentsia that led to the need to abuse psychiatry as an ameliorated form of the labour camp. By 1983, following the forced withdrawal from the WPA, it became clear that Soviet psychiatric abuse had outlived its usefulness. It was not withdrawal from the WPA that forced change in Soviet psychiatry but the final decision to abandon the Stalinist regime in favour of the market. Effectively, the dissidents of the 1960s and 70s became the USSR's political heirs. One of the most important symbolic concessions regarding Soviet psychiatry was the drafting of the first comprehensive mental health laws. The first was a decree by the Supreme Soviet in

1988. The second was a draft bill that was published in 1990. However, the USSR collapsed before it could be ratified by the Supreme Soviet and therefore it never formally became law. The third was passed by the RSFSR in 1992 and is now Russia's mental health law. These three acts are included in this thesis as appendices. Here I will discuss the main features of each of them and the reactions they provoked.

On the 5th of January 1988 decree number 8282-XI was passed by the Presidium of the Supreme Soviet 'On the Conditions and Procedures Governing the Provision of Psychiatric Assistance.' It applied to all republics of the USSR and its stated aim was to lay the ground rules for the confinement of the mentally ill, to specify the measures to be taken to protect their rights and legal interests and also what measures should be taken to 'protect society from dangerous acts of mentally ill persons.' It stated that 'Psychiatric treatment is administered observing the principles of democratism, socialist legality, humanism and compassion.' It guaranteed 'free medical treatment by qualified staff and based on modern techniques and medical practice.' Also, 'social and legal assistance, judicial protection, supervision by the Procurator, the help of a lawyer to safeguard their rights and legal interests.' It stated that 'The patient, his family or legal representative may request the inclusion of any psychiatrist employed in an institution of the local health authority in the commission which examines him.' It made the confinement of a person found to be mentally healthy a criminal offence and stated that a person could only be compulsorily confined under the conditions laid out in the statute.

Section four states that the psychiatrist must act independently and be guided only by medical criteria and the law. The decree protects the patient's confidentiality and sets out the responsibilities of soviets in providing facilities for the mentally ill. Article nine states that 'A person whose actions give sufficient grounds to conclude that he is suffering from a mental disorder and which disrupt social order or infringe the rules of the socialist community and also constitute a direct danger to himself or those around him may be subjected to an initial psychiatric examination without his consent, or that of his family or legal representatives on the orders of the chief psychiatrist, or in an emergency, on the orders of a psychiatrist attached to a specialist first-aid brigade or territorial medical-prophylactic institution.' The decree further guarantees the right of appeal to the chief psychiatrist who is then obliged to organise a commission of psychiatrists. However, he must then 'reach his own conclusion on the basis of the



commission's findings.' The basis for compulsory outpatient treatment was also defined.

The consent of the patient's parents was required if the patient was under sixteen. Article 18 states that patients admitted to hospital must be examined by a commission of psychiatrists within twenty-four hours excluding non-working days and holidays. If a patient is admitted with his consent his discharge may be refused if at the time of his application he is judged to be a danger to himself or others. Those who are compulsorily detained must be examined every month to ensure that treatment or detention is still required. Those detained after a court order must be examined every six months.

The wording of the decree shows how it was framed in response to the very sharp criticism both from within the USSR and of course from outside the country culminating in the WPA preparing to expel the USSR at its Vienna General Assembly in 1983. This, as is well known, led to the USSR's withdrawal from the WPA in protest. Outside the USSR and its sphere of influence it is not normally necessary to state in law that patients will be treated using only 'treatment based on modern techniques and medical practice.' Nor is it normally necessary to state that the incarceration of mentally healthy people is a criminal offence. The need to make such a statement is an indication that such basic provisions did not exist in the USSR. In the West even in the absence of formal laws regarding false imprisonment there would be some protection in common law; this might take the form of a writ of Habeas Corpus or some other legal device. Of course, the Mental Health Act is much more detailed than one could envisage in common law and that is why it exists.

One of the interesting omissions of the 1988 decree is the total absence of any provision for the private property of the mentally ill. No 'third force' like the Public Trustee or Court of Protection is established. Instead one has to rely on the service of a lawyer whose means of payment is not specified in the decree. The wording of the decree embodies many of the contradictions of the USSR. The statement that 'psychiatric treatment is based on socialist legality and democratism' from the point of view of a Marxist jurist such as Pashukanis is clearly contradictory and only serves to point out the way in which the USSR was not socialist and therefore not democratic. It quickly became clear that the decree would not be sufficient to stem the criticism from within the USSR and from without.

## THE DRAFT LEGISLATION OF 1990

On the 27th of July 1990 *Meditinskaya Gazeta* published the new draft mental health legislation of the USSR. It said that 'after the appearance of the [1988] decree it became clear that the present quasi-legal act would not be sufficient to address the whole complicated amalgam of problems in this area. The drafting was undertaken by a working party made up of representatives of the leading scientific clinicians from various institutes around the country as well as representatives of interested parties and official departments'. The draft legislation did little more than expand on the provision of the decree and provides more detailed instructions regarding the procedures for the detention of people and their involuntary treatment. Apart from that there were some differences which were important for symbolic reasons. The reference to 'socialist legality' was dropped in favour of one to 'social justice'. Other changes were rather more significant.

The guarantee of free treatment was dropped in favour of a guarantee that there would be a service although how it was to be paid for was not specified. There is a detailed description of the duties of local Soviets (Article 9), which loosely implies state provision, but it does not specify how it is to be paid for either. Among these duties was the obligation to provide sheltered workshops or similar employment as well as housing. Article 15 obliges institutions to provide a range of inpatient and outpatient services as well as ensuring those patients are helped to find work and legal advice. Article 3 guarantees that treatment 'shall be in accordance with established diagnoses of the character of psychiatric disorders and consistent with contemporary developments in medical science.' There was also more emphasis on the provision of out patient care.

There is a distinction to be drawn between the Russian terms *ambulatornoe nabludenie* and *dispansornoe nabludenie*. The former refers to what would be recognised as outpatient care in the West such as going to a psychiatric hospital or other clinic for an appointment with one's psychiatrist. During this time the psychiatrist may review the patient's treatment and ask them to come back at a later date. The latter term is translated in Appendix One of this thesis as 'dispensary observation'. In my experience this often refers to what may be described in Britain as 'day care'. At Psychiatric Hospital Number One, in Magnitogorsk, many of the patients would come to the hospital for the day and return home at night. They may even attend for half a day

and come to the hospital for either the morning or afternoon session and return home afterwards. This was seen by Dr. Larisa Borisovna, who showed me around the hospital, as an effective way of using limited resources for those who needed support but did not require supervision twenty-four hours a day.

The 1990 draft outlined the responsibilities of the psychiatrist and guarantees his independence (Article 10). In Britain such a clause is unnecessary in the Mental Health Act, as the medical profession has been a largely self-regulating profession for most of its history. Although doctors in Britain are guaranteed a monopoly by the state to practice medicine the regulation of the profession is left up to doctors themselves. However, as we have seen the real guarantee of medical independence is money and the market. It is the absence of these factors in the USSR and the whole history of interference by the state and dependence of doctors on the state that necessitates the inclusion of such a clause into mental health law. Throughout the history of the USSR doctors were salaried employees and did not have the professional autonomy of their Western counterparts (Polubinskaya & Bonnie, 1996: 14).

The age of legal responsibility for oneself is lowered to 15 in the 1990 draft legislation from 16 in the 1988 Decree. This may seem to be a minor detail but the extent to which state provision is guaranteed is limited to a few categories of people including minors. Effectively, the number of people the state guarantees to care for was limited by the simple expedient of lowering the age at which one ceases to be a minor.

Article 25 states that those compulsorily admitted as inpatients have to be examined by a doctor within 48 hours of admission, excluding public holidays. The patient has the right of appeal against his compulsory admission and the right to nominate a psychiatrist of his choosing onto the medical commission that will hear his case. Patients confined under court order have to be reviewed no less often than every six months.

The existence of the draft legislation was widely known to the psychiatrists at the Serbsky institute in Moscow when I was there in 1992. However, the fact that it was draft legislation and had not been ratified meant that it probably had little effect. None of the psychiatrists I spoke to at the Serbsky Institute then had a copy and one remarked that the legislation was a 'Soviet law and there is no longer a Soviet Union.' The implication was clear: the doctor did not feel that either the draft law or the 1988 Decree had to be taken into consideration. The librarian of the Serbsky Institute said that she did not have a copy, either, of the draft of the 1988 decree of the Supreme

Soviet. Given that the Serbsky Institute was the premier forensic psychiatric unit for the assessment of offenders in the USSR this struck me as odd. However, it is explicable if one remembers that in the USSR bureaucratic regulations were not law. The 1988 decree was just another contradictory regulation of a defunct political form. The psychiatrists at the Serbsky Institute had never been bound by a Soviet law before; it seemed unlikely that they were going to be in 1992 when the USSR had ceased to exist.

The draft legislation was not particularly controversial among Soviet psychiatrists and there were a number of articles published which supported it. Tatiyana Dmitrieva was appointed as the Director of the Serbsky Institute when Morozov retired in the 1980s. She and I. Ya. Gurovich wrote an article in the Korsakov Journal of Neuropathology and Psychiatry on the importance of 'Patients' Advocates' for psychiatric patients in hospital. They argue that, outside the USSR patients have many positive rights: to refuse treatment, to discharge oneself, to 'informed consent' to treatment and above all to legal representation and redress. The whole article is a call to extend this to the USSR. One of the most important rights, which is, they point out, supported by the United Nations, is that of free legal consultation for those not able to pay for their own legal fees. They favourably describe systems for defending patients' rights in Holland, Canada and the USA. Pointing out that whilst not all the patients' advocates in Holland, for example, are professional lawyers, all Dutch psychiatric patients have recourse to legal assistance whether directly or through the system of patients' advocates. Moreover, they cite with approval the role played by patients' advocates in informing the patient of his legal rights as a matter of course. This extends to the right to complain about treatment. Whilst the article does not directly mention the Soviet draft legislation its tone and concern to address one of the most persistent complaints about Soviet psychiatry are unmistakably supportive of the general position of the new law. The call for such 'patients' advocates' is significant because there was a recognition by some psychiatrists that even if there was a law there was not necessarily a means of enforcing it. Although the draft legislation set out quite detailed instructions regarding involuntary hospitalisation, like the decree it was meant to replace it still did not establish an independent body to which the Soviet psychiatric patient had recourse and this is recognised by Dmitrieva and Gurovich (Dmitrieva & Gurovich, 1991: 1994). The fact that Dmitrieva was one of its authors was highly significant. As the replacement of the discredited regime of Morozov, Lunts and Snezhnevsky she was regarded as a reformer at the Serbsky Institute.

The seventieth anniversary of the Serbsky institute was in 1991. Dmitrieva personally invited me to attend the academic conference and subsequent buffet and party. I had gone to meet her as the result of a contact with a psychiatrist at the Serbsky, Margarita. My initial request of Tatiyana Borisovna was for access to the library, which was granted with no hesitation. The Serbsky Institute seemed very keen to live down its past reputation and the seventieth anniversary was seen as a way of doing this. There were other foreigners at the anniversary celebrations. There was a consultant psychiatrist from the Broadmoor hospital, a Dutch psychiatrist and a German Member of Parliament.

Other letters and articles on the draft legislation queried some of the practical issues involved. For example, Tonkov (1992: 136-7) questioned the practicality the legal right of the patient to invite 'any psychiatrist' to participate in his medical commission, substituting 'any local psychiatrist.' He argued that often 24 hours would not be enough to carry out an initial assessment of the patient's condition and made the interesting observation that in his district of Volgograd it was often difficult to obtain the services of a specialist psychiatrist who was employed at a psychiatric institution, which was specified in the draft law. Apart from a few other details Tonkov was concerned about the patient's right to meet with a lawyer or a priest. The right to a priest was added in the 1990 act. Tonkov's objection was that the psychiatrist should be able to ensure that someone is present in case of an aggressive incident. Despite such minor detailed criticisms of the act there were few substantial objections to the draft. However, before it came into force it underwent a few further changes.

## **THE 1992 RUSSIAN MENTAL HEALTH LAW**

When the USSR withdrew from the WPA the possibility of readmission was left open providing that reforms took place. The 1988 Decree was part of that reform process. After six years the All-Union Society of Neuropathologists and Psychiatrists (VONP) was readmitted to the WPA at the eighth congress in 1989, despite American opposition. Within the USSR the Independent Psychiatric Association (NPA) was formed in 1989; it was also admitted to the WPA and acted as a pressure group for

further reform within the USSR (Kinsey, 1994: 15-16).<sup>4</sup> The 1992 Act (No.3186-I) was ratified by the Supreme Soviet of the Russian Federation and signed by Boris Yeltsin and Ruslan Khasbulatov on the 2nd of July 1992 and came into force on the 1st of January the following year. It differs from the earlier draft in a number of important ways.

It is made quite clear that the role of the state in the provision of psychiatric care is to be a minimal 'safety net.' The state now only guarantees 'emergency psychiatric care, consultation, diagnosis, treatment, psycho-prophylactic and rehabilitative care on an outpatient and clinic basis' (Article 16) and whilst the state guarantees that such care will be provided it does not specify that it will be free at the point of delivery. Not only is there no commitment to free treatment but for the first time there is a legal statement of the role of private medicine. Article 18 states that 'psychiatric care shall be administered by state, non-state psychiatric and neurological institutions and psychiatrists in private practice. The procedure for the issuing of licences to practice in psychiatry shall be carried out according to the laws of the Russian federation.' The reference to licensing relates to changes to the way public health measures are to be funded. However, this, like other reforms, has not been implemented entirely successfully. In 1991 the Medical Insurance Act was supposed to provide a mixed system of public and private medicine. It was to be funded by earmarked payroll taxes levied exclusively on employers. The self employed were to pay their own contributions. Local government was given the task of licensing and accrediting institutions and regulating quality. The licences last up to five years but may be renewed early if the institution wishes to 'diversify its activities.' So far, however, this seems to have been something of a failure. 'The fund raising potential long ascribed to the health insurance did not manifest itself, primarily, because the earmarked contribution rate was introduced on such a miserably low level' (Telyukov, 1993). Article 17 makes it clear that funding is to come from the 'health promotion budget, the medical insurance fund and other sources.'

Whereas in 1988 and 1990 the role of 'Soviets' was outlined in some detail and their role included finding suitable housing and work for the mentally ill, the 1992 Act

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<sup>4</sup> It is not unusual for a country to have more than one psychiatric association affiliated to the WPA. France has four separate associations affiliated (Bloch and Reddaway, 1984: 186).

drops reference to soviets altogether in favour of ‘offices [*organy*] of social security’. All mention of housing is removed although there is still a commitment to finding work for the mentally ill. The age at which one is a minor remains at 15 although when it comes to providing training for young people with some form of mental disorder the state undertakes to provide a place up to 18 years of age (Article 37).

Levels of compensation for a member of the medical staff of a psychiatric hospital being injured or disabled are set by Article 22. Much of the rest of the Act is really an expansion on the procedures set out by the draft. The 1990 draft stated that there is a right to be visited not only by a lawyer but also by a priest. The 1992 law extends this to the right to possess religious artefacts and scripture.

However, one of the most important provisions is that Article 38 provides for the establishment of a state service that has specific responsibility for defending the rights and legal interests of psychiatric patients. Although there is little detail this could be interpreted as the first attempt to establish a ‘third force’ to oversee the rights of psychiatric patients, which is formally independent of the judiciary or other state organs. It is too early to say whether this has been effective but it could be interpreted as the first attempt to establish the equivalent of the British Public Trustee. One of the few guarantees of free state provision is that the ‘cost associated with examining the patient in courts shall be borne by the state’ (Article 48 (3)).

The position of psychiatrists is given a specialised status *vis a vis* other medical specialities. Articles 18 and 19 specify that only psychiatrists should give psychiatric care and other doctors who wish to care for the mentally ill must undergo specialist training. In line with encouraging professional autonomy the practice of ‘professional ethics’ is also included in Article 19. The professional autonomy of psychiatrists is stressed and their professional bodies are given a role not only in regulating themselves but overseeing the implementation of the law (Section Five, Articles 45 and 46). The quest for autonomy similar to their Western counterparts has also led to the Russian Society of Psychiatrists adopting a professional code of ethics. The content of this code would be familiar to virtually any professional body in Britain or the United States. This is not accidental as the code was written by a committee of the Russian Society of Psychiatrists after extensive consultations of the professional codes of conduct of a number of British and American professional organisations and even includes a clause stating that the psychiatrist ‘must always be ready to help every patient irrespective of

his age, sex, race, nationality, social or financial status, religious affiliations, political beliefs or other differences' (Polubinskaya & Bonnie, 1996: 16).

The code of ethics is supposed to be binding on the profession in the same way as the code of ethics of the General Medical Council. It is accepted in British law that the medical profession may discipline its own members. Similarly there is an explicit attempt in the 1992 Law to establish the same relationship between law and professional code. The code, like the law, was widely welcomed and assumed to have drawn a line under the period of Soviet psychiatric abuse. That it has done so is beyond doubt. However, as we have seen, formal rights if they are not the expression of real material relations in society are a poor guarantee. An even worse guarantee is the assertion of a right to help 'irrespective of financial status' if the medical service is moving to one that is entirely dependent upon one's ability to pay. The transition to the market has already had a catastrophic effect upon people's health in the former USSR. The poor state of health, like the precarious legal position of the psychiatric patient, has a history deeply rooted in the nature of the USSR.



## CHAPTER TWO: THE HISTORY OF SOVIET PSYCHIATRY

### INTRODUCTION

Criticisms of Soviet psychiatry often centre upon the differences with Western psychiatry. The differences are explained with reference to the historical development of Russian and Soviet psychiatry. Sometimes the differences between Russian and Western psychiatry are explained in terms of a uniquely Russian development which assumes that the teachings of the Orthodox church shaped a distinctive attitude to the mentally ill. The aim of this chapter is to give an outline of the historical differences and the way psychiatry was shaped by specific factors in tsarist Russia and the USSR. It is important to locate the point at which Soviet psychiatry developed its distinctive character. Some writers on the political abuse of psychiatry locate its origins in the tsarist period (Bloch and Reddaway, 1978: 48-9). They see an unbroken chain of abuse from Nicholas the First to Gorbachev and the incarceration of the philosopher, Chaadayev, as the first act of political abuse. Little distinction is made between the various periods of Soviet history and psychiatric abuse is assumed to have taken place from Lenin onwards. Underlying these assertions are two assumptions. The first is that only fully developed liberal democracy offers a guarantee against political interference in matters of science. The second is that only an autonomous medical profession can ensure that politics does not interfere with the relationship between doctor and patient. These assumptions need to be evaluated.

It will be argued that whilst there are patterns of development specific to Russian and Western psychiatry there are important similarities too. Even after the revolution the extent to which psychiatry was different was limited and the idea that psychiatry should be distinctively Soviet did not emerge until the Stalin period. The development of the professions in Russia will also be briefly examined in order to evaluate the role this played in the subsequent psychiatric abuse. For the sake of comparison it will be necessary to give an outline of the historical development of Western psychiatry. This draws mostly on British and American research but it seems clear that there was an overall pattern of development of psychiatry across Europe from which generalisations can be made (Doerner, 1981: 164).

## WESTERN PSYCHIATRY

Throughout Europe, including Russia, the early history of psychiatry had little to do with a medical specialisation concerned with the treatment of the mentally ill. Often it was as concerned with the control of the poor. The insane in England were not really treated as a separate category or type of deviant much before the middle of the eighteenth century. They were simply part of the larger, more amorphous class of the poor and indigent, a category that also included vagrants and various minor criminal elements. They were a communal and family responsibility and all save the most violent and unmanageable were kept in the community, rather than being segregated and kept apart from the rest of society (Scull, 1979: 13). The Hospital of St. Mary of Bethlehem was founded in London in the 13th century. However, it cannot be regarded as a psychiatric hospital in the modern sense. It is worth noting that, as an institution, its impact on the total population it catered for must have been all but negligible. In 1403-4 the inmates consisted of 6 insane and 3 sane patients. In 1632 it housed only 27 and in 1642 only 44 (Scull, 1979: 19). Even in the 1720s it housed only 150 (Scull, 1989: 221).

It was not until the middle of the nineteenth century that the treatment of madness by physicians became the norm. This does not mean that mediaeval mental hospitals did not cater for the insane or try to cure their charges but that the boundaries between the mentally ill and other inmates were not as sharply delineated as modern psychiatry might lead one to believe. Foucault traces the development of various 'houses of confinement', such as Bridewells, and explores their juridical status with relation to the control of the population. He points out that in England a law of 1575 covered both the punishment of vagabonds and the relief of the poor. From the beginning of the nineteenth century Bridewells began to decline throughout Europe. They were, he argues, a transitory and ineffectual remedy, a social precaution, clumsily formulated by a nascent industrialisation. In other words he sees the movement towards confinement of the poor in the first instance as being a response to the creation of a population moved from the land and the creation of a large and potentially restive proletariat. The separation of the insane from the rest of the poor and vagabonds became an issue of control over the populations of institutions of indoor relief and containment of the poor.

## CONFINEMENT AND CONTROL

The control of the insane in early asylums was external and by force. Manual restraint, physical treatment and, where it was deemed necessary, violence, marked the beginnings of what Foucault has called 'the great confinement'. It reflected the control of the labouring population. Under feudalism, the surplus was extracted from the labouring population by force. As we have seen, one consequence of this is that the exploitative nature of production relations was transparent. As industrial capitalism matured the control over the working class was transformed. The effect of commodity fetishism and the reserve army of labour are that each worker becomes his own slave driver and the social relations of production are rendered opaque. The control of the labouring population moves away from force and the threat of violence and instead takes the form of a fear of poverty and an acceptance that the relations of production are legitimate. The value of a commodity appears to be a natural feature rather than an expression of social relations. The labour contract appears to be entered into voluntarily and therefore the extraction of a surplus from the labouring population seems to be free and fair.

In psychiatry, the reforms, which are credited to Pinel and Tuke, were part of a wider social movement. They constituted a move away from physical restraint to the 'moral control' of the mental patient. In asylums emphasis was placed on establishing a norm of behaviour. Foucault argues that this is no less thorough and even more far reaching than physical restraint and that, 'We must, therefore, re-evaluate the meanings assigned to Tuke's work: liberation of the insane, abolition of constraint, constitution of a human milieu - these are only justifications. The real operations were different. In fact, Tuke created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience' (Foucault, 1988: 247).

Foucault asserts that moral treatment was not an advance over physical restraint. Instead he sees 'moral control' as even more invidious. He sees no underlying historical dynamic in the transition from one form of control to another but argues that it is a self-contained process. This is notwithstanding Foucault's frequent references to 'bourgeois morality'. For Foucault the fact that the insane were confined on a large scale is a particular historical event but apparently one that is not connected to any other historical development, except accidentally or co-incidentally. For example, Foucault argues that the confinement of the mentally ill coincided with the

decline of leprosy and leper houses in Europe. He makes the point that the insane took over the structures of the leper along with poor vagabonds and criminals. He does not evaluate the relationship between these two events or make their relative significance clear despite the implication of a causal relationship (Foucault 1989: 3-9 and passim). If he identifies a social movement at all it is one of ideas. The ideas of bourgeois morality are more pernicious than the physical, explicit and transparent constraint of the *ancien regime*. He argues that society has to be seen in terms of loci of power rather than in terms of antagonistic classes and eschews a conceptualisation of society based on relations of production. Instead the 'discourse' of insanity is seen as performing a functional role within an array of power structures which have no necessary connection to classes or the relations of production. Among the unsolved questions that *Madness and Civilisation* raises is how the effect of 'bourgeois morality' can be asserted without referring to the process which brought the bourgeoisie into being as the ruling class.

Scull, by contrast, sees the historical movement as being firmly rooted in the transition from feudalism to capitalism. He argues that the humanitarianism of the reforms was far reaching and has to be taken seriously. For Scull 'moral treatment' and the internalisation of control were not something imposed from without but were expressions of a real change in human relations. Moreover, he relates this development to the development of capitalism. He says that 'industrial capitalism demands 'a reform of 'character' on the part of every single workman, since the previous character did not fit the new industrial system.' Entrepreneurs concerned to 'make such machines of men as cannot err' soon discover that physical threat and economic coercion will not suffice: men have to be taught to internalise the new attitudes and responses, to discipline themselves. Moreover, force under capitalism becomes an anachronism (perhaps even anathema) save as a last resort. For one of the achievements of the new economic system, one of its major advantages as a system of domination, is that it brings forth a 'peculiar and mystifying form of compulsion to labour for another that is purely economic and objective' (Scull, 1989: 91-2).

Unfortunately, Scull really takes his analysis no further and it remains at the political level. A Marxist account might be expected to draw out the relationship between 'internal control' and commodity fetishism. Sadly, while this is the logic of Scull's argument he does not develop it.

The fact that under capitalism one has to 'become one's own slave driver' is the essence of how psychiatry exerts a controlling function under commodity production. The worker who cannot work owing to the stress of his alienated and atomised life is dealt with by the caring regime of moral control. He is assisted to reintegrate into the working population and at the same time is neutralised as a potential antagonist to the regime. Moreover, this is done in precisely the same atomised way as the conditions he exists under in the world of work. Alienation, the separation of man from his 'species being', is the consequence of abstract labour but has the appearance of a natural relation. It entails the separation of man from nature, from his product and from his fellow man except when mediated through the contract, the 'cash nexus'. The patient's problem is his alone and is dealt with by entering into another contract, the one between doctor and patient.

In Britain the 1930 Mental Treatment Act introduced the status of voluntary patient and made legal commitment to a psychiatric hospital unnecessary for many patients (Jones, 1972: 249-250). From 1959 psychiatric hospitals became institutions where the majority of patients were 'informal', that is, treated voluntarily. The psychiatric hospital population of England and Wales has declined every year since 1953 and since 1979 the programme of closures of large asylums has accelerated. The movement toward 'decarceration' has been attributed to the beneficial effects of increasingly sophisticated psychotropic drugs which are, themselves, a form of internal control.<sup>1</sup> However, asylums began to decline before such drugs were widely available and the real reason for this is the expense of maintaining such large institutions against the background of rising wages of the workers in them. Asylum attendants before the Second World War were paid at a rate similar to agricultural labourers. In a society with full employment such a low standard of living could not be maintained: neither could the spiralling costs of institutional care for the elderly and mentally ill (Scull, 1977: 138-9).

Scull's thesis is that some forms of madness were on the increase while some of the florid manifestations of 'raving and melancholy madness' were becoming more subdued. In other words they were becoming internalised. Scull thus argues that the sort of shocking exhibitions of madness so graphically illustrated by Hogarth in the

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<sup>1</sup> I am indebted to Paddy O'Donnell for this point.

final plate of 'The Rake's Progress' were dying away under the impetus of internalised control which took place in society at large and not just in asylums.

Scull heads chapter two of 'Social Order/Mental Disorder' with the rhetorical question 'Humanitarianism or Control?' In fact, his argument shows that the new regime of modern psychiatry was humanitarianism and control. By the time that psychiatry emerged in its modern form, the role of the church, and to a certain extent the family, was in decline. The manor and the family ceased to be the basis of production. Industrial capitalism heralded a new period of atomisation and isolation as well as a new period of independence for the worker. By the nineteenth century the modern form of psychiatry began to take shape. It came within the remit of the medical profession and the control of the insane, like the control of the proletariat, became internalised.

Initially, psychiatry's role was confined to the wealthy. From the reign of Edward the Second until the 1744 asylums act the only legislation which related specifically to the insane was that which concerned with the property of the wealthy. The Poor Law, criminal law or vagrancy laws dealt with the insane poor. In order that an insane property owner did not dissipate his estate the Crown could administer an estate on behalf of the owner and in the interests of his heirs. These were the so-called 'chancery lunatics'. It was the development of capitalism, which extended the status of property owner to all citizens, even if the only property one owns is one's labour power. In the nineteenth century some psychiatric hospitals, which would be recognisable as such today, were private fee paying institutions whose motives were financial as much as anything else (MacKenzie, 1992). Class segregated the early asylums in the USA in order that the wealthy could 'escape the odour of pauperism'. In the meantime the poor were dealt with alongside the criminal or impoverished. The extension of psychiatry to the poor was the effect of the extension of citizenship to the poor. In other words modern psychiatry was, from its inception, concerned with property rights. As it became clearly established that the worker owned himself as an abstract citizen then it became necessary to differentiate between those who could not work and those who would not work. Under capitalism lunatics, the aged and the sick became a burden to be separated out from productive workers in order that the labourer be free to labour and that the institutions which were founded to provide poor relief were not disrupted by the insane or infirm.

The beginnings of the medical certification of insanity reflected this division. 'Medical certification of insanity (for private patients only) had been required by the 1774 Madhouse Act as an additional security against improper confinement of the sane, and the doctors now sought to clarify and extend their authority in this area so as to develop an officially approved monopoly of the right to define mental health and illness' (Scull, 1989: 147). Unlike Foucault, Scull does not see 'moral control' as simply another species of the genus control. He sees it is a real expression of social relations, which had a practical expression in social policy.

The 1808 County Asylums Act made it a responsibility of county authorities to provide institutional care for the insane. Meanwhile reformers like Tuke were putting into effect their new regimes. Initially the York Retreat was intended for Quakers. However, its regime soon became generalised and taken up as a fitting basis for philanthropic reform. Whatever the regime, the separation of the insane was a necessary consequence of maintaining order in the workhouses, which despite intentions to the contrary, soon became full of the sick and unemployable. Foucault sees it as no accident that the Retreat was originally intended for Quakers. The Quaker world, he argues in a vein not dissimilar to Weber's 'Protestant Ethic and the Spirit of Capitalism', is one where 'God blesses man in the signs of their prosperity: Work comes first in "moral treatment" as prescribed at the retreat.' Work was seen as containing an inherently restraining power superior to physical coercion. The attention required, the regularity of hours and the obligation to produce a result detach the sufferer from a dangerous liberty of mind (Foucault, 1989: 247). Work in the asylum was a moral rule rather than a productive value. It was an important form of rehabilitation entailing submission to order.

The treatment at the Retreat included warm and cold baths and social gatherings at which inmates were expected not only to behave normally but also to put on their Sunday best. The asylum regime 'in practice was no more than a grotesque caricature of the domestic circle: and the insistence on the domestic imagery is the more ironic inasmuch as it coincides with the decisive removal of madness from family life. But certainly insanity now assumed a more placid, less threatening garb, so much so that there were suggestions that insanity has undergone a change and that whilst there is an increase in the number of cases of the disease, there is happily a marked diminution of its most formidable modification, furious mania' (Scull, 1989: 76-7).

The regime of moral control was also moralistic. Except for the set piece social gatherings, which were strictly supervised, sexual segregation was the norm. In some cases segregation even extended to the mortuary. With the development of psychiatry the loss of one's reason renders one less than a citizen, as he could no longer enter into contractual relations, including the labour contract. However, the qualities he lacked might and indeed must be restored in order that he may resume his place as a rational and sober citizen. The inmate remained a human although one lacking in self-restraint and order. This indeed was the aim of moral treatment; it was an instrumental policy with the aim of restoring the person to economic productivity rather than something done for its own sake (Scull, 1989: 88-9).

The establishment of the liberal professions, in particular medicine, was consolidated at about the time that psychiatry emerged as a modern discipline. Tuke himself was a layman with a professed distrust of doctors. The physicians' general monopoly over somatic medicine was not consolidated over their rivals, such as apothecaries, until the 1858 Medical Registration Act. Until the mid nineteenth century doctors certainly had no monopoly in treating madness. The regime pioneered by Tuke and others does not automatically require medically trained personnel. However, the beginnings of a medical monopoly began to emerge early in the nineteenth century. The Madhouse Act of 1828 established a legal requirement for a physician to meet each patient weekly and by 1830 almost all public asylums had a medical director (Scull, 1989: 160). Only later did madness, like much of medicine, become a lucrative province of a developing profession. There is not the space here to discuss the development of the professions in any depth. But it is worth noting that in Britain, and most of Western Europe, the professions developed as occupations with a good deal of control over their own conditions.

After the 1858 Medical Registration Act doctors had an effective monopoly over the practice of medicine. University educated physicians catered mostly for the wealthy and charged a fee for their services. Insofar as they worked in hospitals the appointments were, in the case of the voluntary hospitals, of an honorary nature. In poor law hospitals their fee was paid by the Poor Law guardians (Abel-Smith, 1964: 58). The poor had to rely on folk healers, apothecaries and surgeons who had either a craft training or no training at all. In Britain, after the foundation of the NHS, many doctors effectively became salaried state employees but they retained their right to undertake private work and in the case of general practitioners their formal status as



independent practitioners is preserved even if, in practice, their remuneration does not differ greatly from other well-paid occupations.

Even in the West, sections of the intelligentsia are incorporated into quasi-state roles. For example, doctors, psychiatric nurses and social workers perform tasks that are not dissimilar to judges, prison officers and probation officers. Yet, unlike in the USSR, their role is seen as essentially neutral. The effectiveness of the ideology of commodity fetishism ensures that the relations of production are accepted as legitimate. Even more obviously coercive jobs such as the army or police are not regarded as oppressive except when the controlling function of commodity fetishism begins to break down, for example, during a crisis or a protracted trade dispute. The state role occupied by medical workers is also not new. The *Hopital General* in Paris was not a medical establishment but rather a sort of semi-judicial structure which carried out certain state powers alongside the courts. In the seventeenth century it had its own powers, a 'quasi-absolute sovereignty' (Foucault, 1989: 40).

## **PUBLIC HEALTH IN TSARIST RUSSIA**

Given the crucial interrelationship between the development of psychiatry and the development of capitalist industrial production it is not surprising that psychiatry in Russia had a later start, was instigated directly by the state and was effectively a copy of the psychiatry of Western Europe, notwithstanding its own peculiarities. In Russia, state involvement in all large-scale public health measures was far later than in the West. The state played a larger role in the development of the economy than in many Western countries. At the same time the state consumed a larger proportion of the social surplus than in the West (Trotsky, 1986: 39). The state also played a very important role in developing what medical services there were. Russian physicians in general were never professionally independent in the way their counterparts were in Britain. In the wake of the emancipation of the serfs in 1861 the institutions of local government, the *zemstva*, were established in 1864. These had responsibility, among other things, for rural public health and were funded out of local taxation and central government subsidies. The appalling state of Russian medicine expressed itself in the conditions suffered by the Russian army during the Crimean War (Frieden, 1981: xiv). There were few physicians in Russia and very few psychiatrists compared to Western Europe. Those that there were were poorly paid, largely confined to the towns and had a far lower status than their Western counterparts. For example, in order to become a

medical inspector in a rural district one had to be a doctor of medicine, to have passed specific qualifying examinations and have served at least six years in the government medical service. Yet such inspectors were paid only 1,800 Roubles in 1876 and this had only risen to 2,500 Roubles by 1903. An ordinary *zemstvo* physician earned around 1,200-1,500 Roubles. Because of the difficulty in retaining their services this had risen to 1,500-2,000 by 1911. By comparison, the chief police doctor of Moscow earned 3,600 Roubles. Ivan Pavlov, as a professor, earned 6,946 Roubles in 1904 which would have been considered a good salary even though not by comparison with the 15,195 Roubles paid to the Court Medical Inspector (Hutchinson, 1990a: 16-20).

The *zemstvo* assemblies, dominated as they were by the local nobility, were often in conflict with *zemstvo* physicians. *Zemstvo* physicians played a particular role in debates surrounding the organisation of physicians in Tsarist Russia. During the 1890s the *zemstvo* physicians came to dominate the only Russian medical society of national standing, the Pirogov Society of Russian Physicians (Hutchinson, 1990a: xviii). The Pirogov Society physicians not only tried to further their professional aspirations but also called for reforms such as the extension of *zemstvo* medicine. It was these political and social demands which brought the Society into conflict not only with the *zemstvo* but also with the autocracy. The *zemstvo* wanted to keep taxes down and the autocracy found it impossible to concede even modest reforms and certainly not those which would place an expanding sector in the hands of doctors demanding professional autonomy. In that respect, doctors were denied the professionalism granted to lawyers during the reforms of the 1860s. The result was to produce a medical profession overwhelmingly hostile to tsarism and politicised in a way their Western counterparts were not.

The Pirogov society tended to stress the social and environmental causes of disease, which found little favour with government, local or central. The debates around public health reforms were against the background generally poor health among the population of the Russian Empire at the turn of the century. A 1913 survey for the Pirogov Society showed that 43 per cent of Russia's most populous towns had no civic medical organisation and 63 per cent had no permanent sanitary organisation. Only 219 towns had a piped water supply. There were few public baths or laundries and disinfection facilities were sadly deficient (Hutchinson, 1990a: 116). Compared to Western Europe rates of morbidity and mortality were high. This raised fears of social unrest associated with very poor health provision. There was also unease about the

effect that poor health had on military recruitment and the productivity of peasants and workers alike. Epidemics of cholera, typhoid and typhus were frequent and devastating. However, unlike expenditure on police and law enforcement, which was obligatory, expenditure on health and medicine was optional (Hutchinson, 1990a: 3).

There was little central administration or co-ordination of health care. Such as there was came from the Ministry of Internal Affairs which was responsible for epidemic control through its anti plague commission. Most of the important ministries had their own health departments. Some civil medical establishments came under no ministry at all, such as the Medical Department of the Institutions of the Empress Marie, which was part of the tsar's Imperial Chancellery (Hutchinson, 1990a: 5). Those physicians who were directly employed in the government service were often engaged in forensic duties or other police work such as the inspection of brothels. However, most *zemstvo* physicians were regarded as generalists who consciously eschewed narrow specialisation.

## THE DEVELOPMENT OF THE PROFESSIONS

Russian doctors were controlled by the state in a way that British doctors were not. The professional status of Russian physicians was set by law over which the physicians had little control. They had to obtain both a degree and a licence to practice from a local medical inspector. Unlike the British General Medical Council the licensing was granted not by a body controlled by physicians themselves but by a civil servant answerable to the Imperial Chancellery. Doctors also had a legal obligation to attend the sick whenever called upon to do so. Failure in this duty could be punished with fines and imprisonment. Jewish doctors were restricted to the Pale of Settlement (Hutchinson, 1990a: 25-6). By the time that British doctors were salaried employees on a large scale they already controlled the entry into their own profession and carried out the quasi-legal disciplinary regulation that is a familiar feature of many professions in the West. British doctors can restrict the supply of medical practitioners and thus protect their material interests (Johnson, 1972: 57).

During the 1905 revolution many members of the Pirogov Society, which represented the *zemstvo* physicians rather than the St. Petersburg medical establishment, supported some revolutionary demands. Medical students overwhelmingly voted to support striking workers in 1905. Even some eminent Russian doctors, such as the psychiatrist V.M. Bekhterev, publicly supported the

objectives of 1905 although it seems likely that this revolutionary zeal extended no further than the establishment of a liberal democracy. Doctors were critical of a wide range of tsarist institutions and some, particularly in St. Petersburg, organised behind calls for collegiate organisation. However, such calls were quickly overtaken by events. The natural antipathy of the members of the Pirogov society to the autocracy spilled over into militant opposition during the revolution of 1905. They retained their antipathy to incorporation within some kind of state structure and continued to demand professional status but their demands did not remain confined to reformist ones. In St. Petersburg the Hospital Physicians Society organised in the large city hospitals to demand improved pay and conditions but also for the abolition of the post of chief physician and its replacement with an elected council representing the staff and the city administration. In Moscow physicians helped spread revolutionary propaganda and circulate illegal literature notwithstanding the fact that the Bolsheviks had few representatives within the Pirogov society. However, the Bolsheviks that there were played a leading role in 1905 (Hutchinson, 1990a: 42-4). The most important motivating factor was a general hostility to the autocracy that reached a new intensity after the outrage of Bloody Sunday.

The oppositional role of the Pirogov Society achieved its most uncompromising expression in the declaration that was overwhelmingly carried at its March 1905 congress; ‘..the Pirogov Congress declares that it is necessary for physicians to organise themselves for an energetic struggle hand in hand with the toiling masses against the bureaucratic structure, for its complete elimination and for the convocation of a constituent assembly. This assembly should be summoned on the basis of universal, equal, direct and secret suffrage, without distinction of sex, religious faith, and nationality; [its convocation] should be accompanied by a speedy end to the war, the transfer of the police into the hands of public institutions, and the introduction of the principles of the inviolability of persons and property, freedom of conscience, speech, press, assembly, unions and strikes, and the liberation of all those who have suffered for their political and religious convictions.’ Following this, a call was accepted for the formation of an All-Russian Union of Medical Personnel that would organise medical workers across the spectrum of medical occupations (Hutchinson, 1990a: 45-6). The defeat of the 1905 revolution, the subsequent reaction and suppression of the Stolypin period saw the end of medical radicalism and the demise of the Union of Medical Personnel until 1917. The Pirogov Society did not

have another congress until 1907 and it was, by then, chastened and conciliatory. Stolypin's reforms prevented further radicalisation of doctors and even undermined their professional aspirations.

Hutchinson argues that the majority of physicians represented by the Pirogov Society were hostile to the development of a central ministry of health as they saw it as inimical to their uniquely Russian approach to professionalisation. This, he explains, was due to the *Narodnik* traditions among *zemstvo* physicians who were rooted in rural communities. The creation of a ministry of health had been proposed at the outbreak of World War One. However, the war delayed its foundation until the Bolsheviks took power. Doctors opposed the Bolshevik ministry of health as bitterly as the tsarist one. However, by 1918 most of the opposition from leading members of the Pirogov society began to subside and the ministry was headed by some Bolshevik members and some who had opposed both the ministry and the new regime (Hutchinson, 1990b: 21).

Had a ministry of health been established under tsarist rule the plan was to reform the training of doctors. This would have ensured that the state had control over training, recruitment and the structure of the medical profession. A distinction, which already existed between academic and vocational medicine, would have been emphasised. The Pirogov society represented the vocational branch. Under tsarism, medicine as an academic discipline was to be left under the control of the medical faculties while the vocational branch was to be controlled by the state. There was to be a two-tiered degree structure. All would take the initial *lekar'* degree, the requirements of which were to be set by the medical faculties. Those intending to teach would study for the new degree of Candidate of Medical Science. Those planning a vocational career took the shorter *lekar'* degree and would then proceed to the MD degree which would be based on a particular speciality such as surgery. 'Although these studies would be pursued within a medical faculty, the courses would be prescribed by the state [...], and students would be examined by specially appointed State Examining Commissions'. In Russia, only the academic wing of the profession had anything approaching autonomy. (Hutchinson, 1990a: 99-100).

World War One demonstrated again, as had the Russo-Japanese War, that the tsarist regime was totally incapable of providing an adequate medical service. Medical provision remained devolved, uncoordinated and hopelessly inefficient. Civil

medical care remained in the hands of the Union of Zemstvos and the Union of Towns. At the front the army and the Red Cross controlled it.

## ZEMSTVO MEDICINE

Throughout Hutchinson's scholarly account of *zemstvo* medicine there is no convincing explanation of why *zemstvo* physicians took the position they did with relation to the revolution in 1905. Nor does he explain why, in 1917, they should have supported the February Revolution but not the October Revolution. In so far as there is an explanation it is in terms of their '*Narodnism*'. He argues that they were imbued with 'the political and moral values of Russian populism' and that their aim was public service of the needs of rural Russia. However, there is no account of why *zemstvo* physicians should be uniquely possessed of this moral outlook other than the rural nature of Russia itself. If one were to argue that such an outlook were the result of a rural economy then one would have to explain why the same outlook was not equally evident in other agricultural societies. Hutchinson's argument also implies, but does not state explicitly, that *zemstvo* physicians were heavily influenced by the *Narodnik* politics of the time. While this is possible, Hutchinson gives no evidence of this in the political affiliation of *zemstvo* physicians. Most, it seems, were allied to the Kadets, some were Social Democrats of one wing or the other (and probably more Mensheviks) and a few were Socialist Revolutionaries (S.R.s) (Hutchinson, 1990a: 43).

Trotsky gives an illuminating account of the balance of class forces in 1905 that explains the particular position of Russian physicians. The political-economic development of Russia meant that, in comparison with the West, the state played an important role in the development of the economy. Owing to Russia's poor geographical position and the hostility of surrounding nations the Russian State had to force the pace of economic development. The constant necessity to combat the claims on Russian lands and the stranglehold over Russian trade routes by more developed countries meant that the military demands of the Russian state were greater than in comparable nations. Such demands had to draw on an agricultural base that was far less productive than Russia's neighbours. Of the vast land surface of Russia a relatively small proportion of it is productive. Throughout the economic development of Russia the state forcibly procured a large proportion not only of the surplus but even the necessary produce of the peasantry. The alternative was to succumb to the

pressure of the hostile kingdoms of Sweden, Poland and Lithuania. One of the results of Russia's particular development was that the evolution of an independent bourgeoisie was impeded. The cities only developed as productive centres late in Russian history, especially from the end of the seventeenth century, under the impact of state intervention and foreign capital. At the end of Peter the First's reign Russia's urban population was only 3 per cent. By 1812 it was only 4.4 per cent and by 1897 still only 13 per cent (Trotsky, 1986: 46). One result of this was that the development of liberal professions and scientific endeavour was stunted. 'New branches of handicraft, machinery, factories, big industry, capital, were, so to say, artificially grafted on the natural economic stem. Capitalism seemed to be an offspring of the state. From this standpoint it could be said that all Russian science is the artificial grafting on the national stem of Russian ignorance' (Trotsky, 1986: 41). Russian thought developed under the pressure of the more developed thought from Holland, Germany, France and Britain. This is not to say that capitalism was not developing in Russia. In fact the policy of the Russian state was only possible on the basis of a pre-existing transition from a 'natural economy to a commodity economy' (Trotsky, 1986: 42).

Despite the superficial similarity with Western monarchical absolutism Russia's development was quite different. The towns were insignificant not merely because of the small numbers of people living in them but they also did not form the basis for the development of 'guilds, artisans, gentry and a capitalist class' (Ticktin, 1995: 34). Instead the town populations 'consisted of officials maintained at the expense of the treasury, of merchants, and, lastly, of landowners looking for a safe harbour within the city walls' (Trotsky, 1971: 38-9). The basis for an independent artisan middle class was absent in Russia. Instead, Russia had the new middle class, 'the professional intelligentsia: lawyers, journalists, doctors, engineers, university professors, schoolteachers. Deprived of any independent significance in social production, small in numbers, economically dependent, this social stratum, rightly conscious of its own powerlessness, keeps looking for a massive social class upon which it can lean. The curious fact is that such support was offered, in the first instance, not by the capitalists but by the landowners' (Trotsky, 1971: 41). This, rather than Hutchinson's view of the *Pirogovsty* as public spirited semi-professionals imbued with the spirit of Russian *narodnichestvo*, is the real explanation for the political position adopted by Russian physicians.

The Russian intelligentsia was never in a good position to assert its own demands. As a weak and poorly organised section of the population, Russian doctors were first driven into an alliance with the landowners that dominated their major employer, the *zemstvo*. The fact that so many Russian doctors supported the Kadets illustrates this. The Kadet party was, 'by its very origins, a union of the oppositional impotence of the *zemtsy* with the all-around impotence of the diploma-carrying intelligentsia. The real face of the agrarians' liberalism was fully revealed by the end of 1905, when the landowners, startled by the rural disorders, swung sharply around to support the old regime. The liberal intelligentsia, with tears in its eyes, was obliged to forsake the country estate where, when all is said and done, it had been no more than a foster child, and to seek recognition in its historic home, the city. But what did it find in the city, other than its own self? It found the conservative capitalist bourgeoisie, the revolutionary proletariat, and the irreconcilable class antagonism between the two' (Trotsky, 1971: 42). At the height of revolutionary activity the *pirogovtsy* supported the proletariat but their support was hesitant, vacillating and divided. Students were the most revolutionary section, while more senior figures recoiled at the unfolding revolutionary scene. The radicalism of the *zemtsy* and the liberal intelligentsia seldom went further than the aspiration to liberal democracy.

## REVOLUTION, 1917

Members of the Pirogov Society, Russian physicians in general and psychiatrists supported the February Revolution. They hoped that the reforms they had been long agitating for would face no obstacle. However, the Provisional Government's commitment to the war meant that any reorganisation of civil health care or recognition of the *Pirogovtsy* as leaders of the profession took second place to military medicine. Therefore medical matters remained in the hands of the Red Cross, army and the navy.

Some within the Petrograd Soviet had the objective of fully democratising health care in Russia and established a Medical and Sanitary Section by the early summer (Hutchinson, 1990a: 162-3). Among physicians there was little support for the October Revolution as they were afraid of a centralised ministry of health and that they would become salaried employees. Those physicians with professional aspirations feared salaried status whilst the *Pirogovtsy* feared the loss of their autonomy which rested on the basis of the locally administered nature of *zemstvo*



medicine. As we have seen the *pirogovtsy* were allied to the local landlords and their hostility to the Bolsheviks and a central authority was a reflection of this. The revolution in the countryside was undermining the basis of *zemstvo* medicine. Peasants no longer paid taxes and the local legislative functions of the *zemstvo* were undermined by antipathy to the landlords and the pressure to expropriate the land in the interests of the peasants a central plank of the Bolshevik programme.

Those doctors who explicitly supported the Bolsheviks, such as Z.P. Solov'ev who published a radical health journal *Vrachebnaya Zhizn'*, began to take a leading role within the Pirogov Society. However, the Bolsheviks' main support from among the ranks of medical personnel was from the nurses and medical orderlies (*feldshery*), many of whom were, by 1917, trained in the army and came from the same social classes as the majority of Russian soldiery. There had been a long tradition of *feldsher* medicine in Russia before the war. In many areas doctors were not available and the *feldsher* was the only medically trained alternative to traditional folk healers. It was the paramedical occupations, assisted by a few Bolshevik doctors, who were the backbone of the Proletarian Red Cross, established by a nurse, Fortunatova, which operated under the Military Revolutionary Committee of the Petrograd Soviet.

These class-conscious elements of the medical personnel quickly came into conflict with the more conservative Pirogov Society. The Bolshevik physician, Barsukov, and his colleagues planned a Committee for the Protection of Public Health that would oversee the reorganisation of Soviet health care. On the 15th of November 1917 they secured the support of such organisations of revolutionary medical personnel as there were and put their plans before the revolutionary government. Lenin blocked Barsukov's plan because he wished to avoid a head on clash with the Pirogov Society (Hutchinson, 1990a: 175). Lenin wanted to retain as much support as he could from the liberal intelligentsia and 'specialists'. He was acutely aware of the isolated position faced by the Bolsheviks in 1917 and had no wish to alienate the Pirogov Society. Given that the majority of doctors were hostile to the Bolsheviks Lenin actually had little choice. Lenin hoped to retain the support of the left wing of the Pirogovtsy while ensuring that the rest remained at least passive in their hostility to the revolution.

Lenin's caution in the face of the attitude of the Pirogovtsy seems to have been well founded as the Society publicly condemned the October Revolution at its meeting on the 22nd of November. Lenin's attitude to the specialists was spelled out

at the Seventh All-Russia Congress of Soviets when he argued against handing over authority for agriculture, local administration and the Commissariat for health to the *gubernia*. He concluded by arguing; 'Let us try different systems in the different people's Commissariats; let us establish one system for state farms, chief administrations and central boards and another for the army or the Commissariat of Health. Our job is to attract, by way of experiment, large numbers of specialists, then replace them by training a new officers' corps, a new body of specialists who will have to learn the extremely difficult, new and complicated business of administration. The forms this will take will not necessarily be identical. Comrade Trotsky was quite right in saying that this is not written in any of the books we might consider our guides, it does not follow from any socialist world outlook, it has not been determined by anybody's experience but will have to be determined by our own experience' (Lenin, 1962, vol. 30: 243-8). Lenin had to balance the demands of radical elements demanding the extension of workers' control with the practical difficulty of administering a system where the overwhelming majority of the civil service and intelligentsia were hostile to the regime.

Solov'ev's programme was a break with the landlord dominated *zemstvos* and the assertion of the Bolshevik's position of 'all power to the soviets'. The Military Revolutionary Committee of the Petrograd Soviet established a medical-sanitary section on the 25th of October (old style). The committee received little support from physicians although there were some Bolsheviks on the left of the Pirogov Society. Whilst there was only lukewarm support from among doctors, Barsukov and Fortunatova formed the Pan-Russian Federated Union of Medical Workers largely made up of the people who had been in the Proletarian Red Cross (Hutchinson, 1990a: 178).

There was an extraordinary congress of the Pirogov Society from 13-15th of March 1918. This was followed by a congress on professional unity that founded the All-Russian Union of Professional Associations of Physicians. At the same time Rusakov had convened a Congress of Medical Workers. Paramedics of one sort or another dominated the latter. The most staunchly pro-Bolshevik were the *rotnye* *feldshery*. These were the military trained *feldshers* recruited from the peasantry that shared the hostility to the war of the majority of soldiers. The pro-Bolshevik radicalism of the latter congress was contrasted with the more conservative position of the doctors. 'Having quarrelled about the creation of a professional association for

three decades under the tsars, physicians had somehow managed to bury their differences and form such a body less than five months after the October Revolution. It required no great skill to see that the soviets were regarded as a much more serious threat than the tsarist regime' (Hutchinson, 1990a: 182).

The 1918 Pirogov Congress was attacked by I.V. Rusakov, 'who on the 15 of March 1918 addressed a meeting of the Moscow Union of Medical Workers. His theme was the hypocrisy of the pirogovtsy, who had for decades trumpeted their allegiance to the idea of popular sovereignty but who deserted the popular cause during the revolutionary months of 1917. They had revealed their true colours, he claimed, in resorting to a strike: "This weapon, unsuitable for the struggle with the autocracy, was appropriate for the struggle with the proletariat"' (Hutchinson, 1990a: 183).

N.A. Semashko became Commissar of Health Protection at Lenin's insistence in July 1918. 'The Commissariat of Health Protection owed much more to Russian precedent and tradition than to Bolshevik ideology' (Hutchinson, 1990a: 202). This is in the face of immanent epidemics of cholera and typhus and impending civil war. Lenin needed the support of doctors and other specialists. Instead of handing over the control of the health commissariat to *feldshers* and nurses the move was to encourage *feldshers* and other medical workers to enrol in the universities and become doctors. This was part of a wider movement to open the universities partly because of a popular belief that more doctors would mean better health care in country that had very few doctors by world standards. However, the move to open the universities was also inspired by socialist egalitarianism and the need for more specialists who were sympathetic to the revolution.

## PSYCHIATRY IN TSARIST RUSSIA

The development of facilities for the mentally ill in Russia was somewhat later than in Western Europe. This is understandable when one considers the relationship between psychiatry and capitalist industrial production. In Russia, where such economic developments were later and then often instigated by the state, psychiatry expressed this late development. Intellectually, Russian psychiatry was an example of what Trotsky called 'the artificial grafting on the national stem of Russian ignorance.' All of the major influences of Western psychiatry were present in Russia and continued to exert an influence up until the 1930s. Despite being somewhat

backward in the development of facilities for the mentally ill, the development of Russian psychiatry up to the October Revolution and for some time afterwards is similar to Western psychiatry. That is not to say that there were no Russian contributions to psychiatry or that Russian psychiatrists merely copied Western developments. However, there is little evidence of a distinctively Russian cultural influence on psychiatry. Of course, in remote rural areas where peasants were more likely to seek the help of local folk healers the treatment of the mentally ill would have taken a particular local form but that exerted little influence on medical practitioners who led the developing psychiatric profession. This is important as some writers try to assert that the particular orientation of the Orthodox church, as compared to the Catholic church, offers some kind of explanation of a distinctively Russian approach to psychiatry (Anikin & Shereshevskii: 1992: 90) However, there is little or no evidence to support this except for the obvious point that Orthodox monasteries cared for the mentally ill in Russia until the 1880s and that is largely because no other provision existed. The 'holy fool' may well be an important literary motif but that should not be confused with a historical understanding of Russian psychiatry.

Until the reign of Catherine, the mentally ill were likely to be cared for within the family, a monastery, or prison, or be killed or allowed to die. Interestingly enough, the first law relating to the mentally ill in the Tsarist period, as in Britain, seems to have been a law to protect the property of the mentally ill. An act of 1677 allowed the deaf, blind and mute to engage in property transactions but prohibited such transactions by drunks and the feeble minded (Morozov, et al, 1977: 10) In 1706 the Metropolitan of Novgorod, Iov, built a hospital which also took psychiatric patients. This was a religious rather than a medical establishment and, as with Britain's early asylums, there was no sharp delineation between the care of the insane and the poor. Peter the First issued the first ukase that aimed to establish psychiatric hospitals on 16 of January 1721. However the first hospitals, the so-called *prikaz* madhouses, were not built until 1776. The attitude to the mentally ill 'in the Muscovite state of the 16th and 17th centuries was somewhat varied. Some were ascribed a holy status, others became the objects of amusement, some were burnt at the stake, whilst still others were confined to monasteries "to bring them to their senses" and finally, a few of the dangerous and uncontrollable were held in prison. Those whose illness was inoffensive remained at liberty' (Yudin, 1951: 21-6).

In the 1770s the debate regarding who should be responsible for caring for the mentally ill - the church or the medical profession - was decided in favour of medicine. The establishment of the hospital in Novgorod was the first state provision of funds for the care of the mentally ill. Like the York Retreat, many of Russia's first psychiatric hospitals were small country houses that catered for between ten and forty inmates. In Russia, as in the West, the demand for hospitals designated for the mentally ill grew in proportion to the growth of towns. Interestingly, the nineteenth century in Russia also seems to have been a period in which there were a growing number of people who needed psychiatric treatment. I.F. Rula showed that in 1837 there were around 0.65 mentally ill per 1,000 of the population. By the end of the century this had grown by 3.5 times (Anikin & Shereshevskii, 1992: 90) The period from 1776 to the 1820s saw the foundation of a number of psychiatric establishments so that by 1802 there were around eighteen hospitals serving an area from Vilno to Astrakhan. As in the West many of these hospitals were associated with workhouses<sup>2</sup> (Gataullin, 1991: 89). Conditions in them were equally primitive and one observer noted that in a ward for some of the most disturbed patients that 'some were chained to the wall. There were no chairs, tables or beds and they slept on the floor. They were given no knives or forks nor any other thing with which they could harm themselves.' The death rate in one hospital was around 26.7 per cent (Yudin, 1951: 33-7). Throughout the nineteenth century psychiatric hospitals became differentiated from institutional poor relief and grew larger in size.

### **THE PRE-REFORM PERIOD 1775-1861**

Catherine's reign had seen not only the development of the first psychiatric hospitals but also the extension of important rights, even if only to the nobility. 'Through the Charter of 1785 that class's major political aims had been accomplished: exemption from obligatory state service while maintaining a virtual monopoly over it; civil rights, exemption from corporal punishment, right to trial by peers, right to travel abroad freely; and a corporate organisation.' When attempts were made to limit these rights by the Tsar Paul he was murdered by elements of the nobility (Monas, 1961: 3).

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<sup>2</sup> *Smiritel'nye doma*

Tsar Nicholas I is often portrayed as one of the most reactionary autocrats of the Romanov dynasty. However, in a sense, he expressed the contradictions of Russia perfectly. He combined a deep conservatism with a zealous pursuit of rational reform. His reputation for conservatism stems from his well-known hostility to parliamentary government, the role his administration played in formally establishing the *okhrana* and the extremely harsh treatment of the Decembrists. Later, he reserved a special place for himself in the history of Russian psychiatry because of his role in the confinement under 'medico-legal surveillance' of Chaadayev. He is therefore regarded as being the progenitor of psychiatric abuse (Podrabinek, 1980: 55). Given that this assertion is repeated by a number of writers it is worth remembering some details of the Chaadayev case. He published his first 'Philosophical Letter' in the Moscow journal Telescope. Herzen described the letter as 'a shot in the dark night' as it opposed the 'kvass patriotism' of backward Russia and expressed sympathy with the Polish uprising of 1830. Chaadayev also called for an end to serfdom and his opposition to the autocracy was expressed in religious terms by an argument in favour of Catholicism over Orthodoxy (Monas, 1961: 164-70). Chaadayev did little more than argue for liberal democracy. For this reason a parallel has been drawn between Chaadayev and the Soviet dissidents of the 1960s and 70s (Reddaway, 1972: 231). It seems unlikely that either Nicholas or any of the agents of the 'third section of the Imperial Chancellery' actually believed Chaadayev to be insane. It is true that the description of Chaadayev as insane was intended to negate his oppositional statements as those of a madman and make his confinement appear to be solicitude for his welfare. However, any similarity ends there. Nicholas I did not routinely use psychiatric hospitals to detain dissidents. In fact he did not even use one for Chaadayev who was kept under house arrest for a year and visited by a physician daily (Monas, 1961: 172). Interestingly, the transparently exploitative nature of the economic system under Russian autocracy meant that few people believed Chaadayev to be mentally ill and Nicholas' actions were understood as repressive.

Paradoxically, as a young man Nicholas I visited Britain and it is known that the two places he took a particular interest in were New Lanark and the York Retreat. Nicholas was influenced by Western ideas and was keen to force the pace of industrial development. His interest in New Lanark was, like many of his day, not in the developing socialist ideas of Robert Owen but in the enlightened management approach which seem to be able to lead to high productivity and rising living standards. The York

Retreat, like New Lanark, was in the forefront in the enlightened approach to rational, benevolent, paternalism (Monas, 1961: 10), whereas the reforms of Tuke and Pinel were an expression of a broad social movement in the West, the extension of citizenship to the masses. Nicholas' regime carried out similar reforms in a typically Russian fashion. That is the reforms came from the Tsar himself having been influenced by Western innovations and ideas, including the most up to date care of the mentally ill, which he witnessed when he visited The Retreat.

The first half of the nineteenth century saw a large expansion in educational institutes including the university in Kazan, which was founded in 1804. The psychiatric hospital at Kazan was founded in 1869. By the end of the nineteenth century psychiatry had been introduced into the curricula of all Russian universities and the Kazan hospital was seen as a bright new reform on a Western model which would replace the discredited *prikaz* madhouses (Brown, 1990: 28-9).

## PRE-REVOLUTIONARY PSYCHIATRY.

Psychiatrists in the period just before the 1905 revolution were considerably less organised than in Britain. Psychiatry was a relatively recent addition to the medical profession and scarcely had the same prestige as other, older branches. There were tensions in Russian psychiatry concerning their professional organisation. Some psychiatrists would have preferred to organise on a collegiate basis as British psychiatrists had done with the foundation of the Association of Medical Officers of Asylums and Hospitals for the Insane in 1841. However, their weak position led to their organisation under the aegis of *zemstvo* physicians. Psychiatrists did not necessarily regard union or *zemstvo* physicians as appropriate leaders of their cause and indeed may have seen them as a threat to their precarious professional position. After all, like their counterparts in the West, they could not effect even the limited cures that the somatic medicine of the time could claim. The development of large psychiatric hospitals was not as far advanced as in the West and therefore there was not the physical base for their work either in an institutional setting or in private practice using psychoanalytic techniques.

Even by World War One psychiatric facilities were still very poorly developed. 'One informed writer who reviewed the subject on the eve of the war estimated that there were about 500,000 mentally ill people in the empire, of whom at least one-third needed hospitalisation, yet in January 1913 there were only 46,063

beds available in some 170 institutions' (Hutchinson, 1990a: 133). Whilst the Pirogov society had called for an expansion of provision there were conflicts regarding the control over such facilities. In other words psychiatry was not fully recognised as a distinct medical specialism and on that basis somatic physicians saw no reason why they should not control the treatment of the mentally ill. On the eve of the revolution psychiatrists were alienated from the tsarist state and their colleagues in somatic medicine (Brown, 1983: 267-8).

The revolution of 1905 brought psychiatrists into conflict with the autocracy in a similar way to *zemstvo* physicians but with an added dimension. The police brought an increasing number of prisoners to psychiatric hospitals in order to determine whether they were fit to stand trial. The police began to insist on guarding political prisoners in psychiatric hospitals. Psychiatrists protested against being forced to play a state, rather than a medical role at the Second National Congress of Psychiatrists in Kiev (Brown, 1990: 32). The intrusion of the police into the asylums was seen as an attack on the clinical authority of psychiatrists to decide who should be admitted and on what grounds. By 1909 penal authorities and not psychiatrists were given the final say regarding the confinement of prisoners in forensic psychiatric establishments (Brown, 1990: 33).

### **SOVIET PSYCHIATRY 1917-1929**

Workers in the asylums demonstrated similar divisions to those among medical workers in general hospitals with nurses and other health workers taking a militant stance while their physician colleagues were somewhat more equivocal. Along with millions of other workers asylum workers asserted demands for higher pay and better conditions. 'In at least two widely publicised incidents, however, workers in psychiatric institutions augmented their demands for economic change with an insistence on workplace democracy. In asylums in Kharkhov and St. Petersburg, medical directors were physically removed from the premises and the hospital "autocracy" was replaced with a "representative government" consisting of delegates selected by workers in the institution. Psychiatric physicians reluctantly participated in these new administrative organs but did not control them' (Brown, 1990: 38-9). Psychiatrists had no difficulty with the demand for a constituent assembly but balked when workers began to assert the authority of their own soviets on which doctors were no more than equal partners.



In terms of the development of psychiatric facilities the revolutionary period saw important innovations notwithstanding the turmoil and poverty of the civil war. The Bolsheviks established the People's Commissariat for Health (*narkomzdrav*) on 11 July 1918. Psychiatry did not claim the highest priority in the face of epidemics of typhus and endemic diseases of poverty such as tuberculosis. However, a psychiatric commission was established under the aegis of the Russian Union of Psychiatrists (RSP) whose Chairman was P.B. Gannushkin. On the recommendation of the RSP the commission, which began its work in May 1918, included P.P. Kashchenko.

The first All-Russian Neuro-Psychological Conference took place from 1 to 5 of August 1919. Solov'ev, as People's Commissar, opened the conference by stating that 'the conference must consider the broad question of the organisation of neurological and psychiatric care as a new order gives the sick a new possibility. Until now, this question was decided exclusively from the point of view of treatment; however, special attention to neurological and psychological prophylaxis is required' (Yudin, 1951: 368-9). This is a long way from calls for a distinctively Marxist approach which was to be a feature in so many scientific departments by the late 1920s. Indeed, the eclectic and open nature of the conference is illustrated by some of the other papers. Gilyarovskii gave a paper on 'Mental Illness During Typhus', Kashchenko issued a call for separate provision for acutely and chronically mentally ill and Bekhterev gave a paper on 'The Science of Personality from the Point of View of Reflexology' (Yudin, 1951: 369). Reflexology was later to become one of a number of ideological battlegrounds but in the period up until 1925 there was almost no indication of this.

In 1919 an institute was established for handicapped children. In 1920 the rations of medical personnel, including those in psychiatric hospitals, were at the same level as those of soldiers of the Red Army and psychiatric patients received rations of 2,955 calories per day. So, it is fair to say that although the fight against typhus had to take a high priority, the new regime also carried out important reforms in psychiatry and one would search in vain for any overtly ideological component.

There seems ample evidence that there was little or no state interference in matters of science until 1929 (Medvedev, 1979: 14). Despite this there have been assertions that Soviet psychiatric abuse began with Lenin. For example, Podrabinek asserts that the Soviet diplomat, Chicherin, was an early victim. He quotes a memorandum from Lenin as saying, 'I've just received two letters from Chicherin

(January 20 and 22 [1922]). He poses the question of whether we should agree to alter our constitution slightly for a sizeable compensation; namely, in regard to the representation of parasitic elements in the soviets. He proposes this to please the Americans. I think this proposal shows that Chicherin must be 1) immediately sent to a sanatorium; any leniency in this respect, any delay, etc., would be in my opinion, a major threat to the conduct of the talks...' (Podrabinek, 1980: 61-2)

This and a further short memo are cited by Podrabinek as evidence that there is a continuity between the form taken by Soviet psychiatry in the early post-revolutionary period and the 1970s. It has been impossible to verify Podrabinek's assertion as there is no such memo in Lenin's collected works. Moreover, it is clear that Chicherin was still an active member of the politburo on the 23rd of March 1922. On page 410 of Volume 42 of Lenin's collected works (4th edition) there is a reference to a motion for the politburo regarding the Genoa conference drafted by Chicherin. Also, the notes at the end of the volume (p.596) point out that Chicherin read out the corrected motion at the conference on April 10th of that year.

It would also seem strange that Lenin would concern himself with confining dissident members of the Politburo to sanatoria. There are plenty of examples of Lenin being quite forthright in his views, including the sacking of those who proved themselves to be incompetent. Either way, Lenin's entreaty to move Chicherin, if it ever took place, does not seem to have had any dire consequences for him. Many of Lenin's memoranda were peppered with fearsome orders and are not to be taken literally. For example of a note by Lenin 'on polytechnical education' written at the end of 1920 says of Lunacharsky; '...he demands that a programme of 'general instruction' be compiled, including such subjects as: 'communism, history in general, history of revolutions, history of the 1917 revolution, geography literature etc.', and he goes on: 'If there are no such programmes yet, let Lunacharsky be hanged'' (Liebman, 1975: 316). Needless to say Lunacharsky was not hanged on Lenin's instructions but such a memo is an example of the kind of florid invective Lenin was known to use.

Other attempts to implicate Lenin include the assertion that the Left S.R., Maria Spiridonova and the former Bolshevik, Angelica Balabanoff were both 'confined to sanatoria'. Bloch and Reddaway assert that after Spiridonova was arrested in 1918 'The Moscow Revolutionary Tribunal contrived a scheme to resolve the predicament [of what to do with her] – confinement to a sanatorium, a move obviously anticipated by Spiridonova. In a letter smuggled out of prison she wrote: 'I

have a feeling the Bolsheviks are preparing some especially dirty trick for me. It would be difficult for them to kill me, and to send me to prison for a long term would not do either...they will declare me insane and put me in a psychiatric clinic or something like that... they want to strike a moral blow at me. To save their position they resort to every possible means...' Spiridonova was sentenced by the tribunal to be 'banished for one year from political and social life and isolated in a sanatorium where she is to be given the opportunity of health physical and mental work.' (Bloch & Reddaway, 1978: 49-50). The implication is clear. Bloch and Reddaway assert that the Bolsheviks used psychiatry as a means of incarcerating Spiridonova because they were afraid to imprison or execute her. The only source Bloch and Reddaway cite is the biography of Spiridonova written by one of her comrades, I. Steinberg. If however one looks more closely at the text they cite as evidence of psychiatric abuse then a rather different picture emerges. A quote from the same page gives a better idea of why Spiridonova was sentenced to be detained in a sanatorium; 'The short and hasty notes that Spiridonova managed to get through to her friends give some idea of what she underwent: 'March 3, 1919. 'Please send me a thermometer. I feel worse every day. I have to lie down a great deal, but the bed is dreadful. I can hardly lie down with my bad sides and back. 'The tuberculosis is steadily getting worse. It is incredible how quickly I am giving way to it'' (Steinberg, 1935: 242). The only reference to psychiatry is the fear expressed by Spiridonova that she may be confined to a mental hospital. Why she feared such an outcome is not clear, although she would have been as aware of the Chaadayev case as any other middle class Russian of that period would. There is certainly no evidence that she was threatened with such an outcome or that it had occurred to anyone to pass such a sentence. It seems that in suppressing the S.R.s the Moscow Revolutionary Tribunal took account of Spiridonova's tuberculosis and previous revolutionary activity in not sentencing her to prison. She was subsequently detained in the Kremlin guardroom until she escaped in 1919.

Bloch and Reddaway's 'evidence' that the Bolsheviks abused psychiatry for political ends against Balabanoff is even more spurious. They say: 'Her "mental illness" was only hinted at. An influential figure in the Bolshevik Party and international labour movement, she knew, and collaborated closely with, many of the leaders of the revolution including Lenin and Trotsky. In 1920 Balabanoff protested about several mistakes she felt had been made by the revolutionary leadership. She expressed her anger directly to Lenin. This was a period of great danger for the

Bolsheviks: the White Army was advancing on Petrograd, even Moscow was threatened. It was within this situation that Balabanoff was ordered by the Central Committee to enter a sanatorium' (Bloch & Reddaway, 1978: 50-1). As in the Spiridonova case the only evidence cited is a single secondary source, in this case Balabanoff's own book 'My Life as a Rebel.' Far from her mental illness being 'only hinted at' it isn't mentioned at all. Again, all one has to do is read Balabanoff's own account to see that there is no mention of psychiatry. She says that she had a number of disagreements with senior Party figures including Lenin and Dzerzhinsky. 'During those weeks of danger I made an average of five speeches a day, and though I was physically exhausted through lack of food and constant strain (my temperature was constantly below normal) I should have been glad to work even harder.' She was later ordered to take a rest in a sanatorium but refused to go and argues that the objective was to ensure that she was not in Moscow when important international delegations from Britain and Italy arrived. This may well be true as Balabanoff was Secretary of the Communist International at the time and as a skilled linguist might normally be expected to meet with delegates she had previously been acquainted with. When she refused the place in a sanatorium she was asked to take a propaganda train to Turkmenistan.

It seems entirely feasible that the Central Committee wanted Ballabanoff out of the way. She was increasingly critical of the Revolution at a time when it was most in danger and when important foreign delegates were on their way to Moscow. Whether the Central Committee was correct is not the issue here. The fact is that there is absolutely no evidence for the abuse of psychiatry in the very text that Bloch and Reddaway cite as proving that psychiatric abuse began with Lenin. It is not as if the statements in the case of Spiridonova or Balabanoff are ambiguous. In neither case can one arrive at any other conclusion than that Bloch and Reddaway were misleading in the selective quotes from Steinberg and Ballabanoff.

The arguments put forward by Podrabinek and Bloch and Reddaway are less than honest. They attempt to show that psychiatric abuse is a feature of societies that are not liberal democracies. Tsarist autocracy is equated with the USSR from its inception, which implicates Lenin and therefore Marx, and the whole socialist project is discredited. Unfortunately for Podrabinek, Bloch and Reddaway, in the absence of evidence they were forced to use only the most spurious suggestions of impropriety

contained in the ambiguity of the term 'sanatorium'. It is not much on which to base an argument and has easily been refuted.

### **SOVIET PSYCHIATRY 1930-1953**

The period in which Stalin consolidated his power saw a general expansion in medical services and the beginnings of a differentiation between Soviet and Western medicine. As there were so few psychiatric hospitals, very few psychiatrists and the overwhelming majority of doctors were probably hostile to the regime Stalin could not have used psychiatry as a repressive measure even if it had occurred to him. Given the extensive use of prison camps, prisons and murders there is no reason for psychiatry to have been used to control the working population. The first calls for a distinctively Marxist psychology began in 1925 but the amount of influence such debates had on clinical psychiatry is questionable. It is one thing to ensure that the head of an academic psychology department is a political appointee but another to expect that to influence the scattered and underdeveloped psychiatric service.

Psychiatric services also expanded but not as fast as somatic medicine. For example in Bryanskaya Oblast in 1926, the planned expansion of services was supposed to include provision of eight per cent of the health provision for psychiatric disorders. This was to include one hundred places for handicapped children and twenty-five for child psychiatry. By 1929 this had been modified to provision only for the 'acutely deranged' and was to be located on the edge of town. By January 1941 of 558 doctors only 4 were psychiatrists (Shchegolev, 1992: 93-4). So although new psychiatric facilities were being built they, like all other Soviet products, were not necessarily of a high quality. The increasingly oppressive nature of Stalin's regime meant that gradually Russia began to be cut off from Western scientific influences. While this was less so in, for example, pure maths it was far more difficult where the science has a philosophical or political component. Therefore psychology was badly affected. One way in which psychologists dealt with this was by concentrating on less controversial areas such as physiological psychology.

Psychiatrists, many of whom trained in a neurological tradition, found that there was relatively little interference at first. Psychiatrists who were influenced by psychoanalysis were more affected than most as the Russian Psychoanalytic Society was closed down in 1933. Although this was an important event for psychoanalysis it was less important for Russian psychiatry as a whole.

The area in which political interference was felt first of all was forensic psychiatry. The Serbsky Institute was founded in 1921. However, 'In the mid-1920s and early 1930s, virtually the entire staff of the Serbsky Institute was dismissed. The new staff was politically sympathetic to the Soviet regime, and therefore willing to put very sharp limits on findings of *nevmeniaemost*', unchargeability. Only the most extreme cases of insanity were to be given such exculpation; the rest were to be turned over to the judicial system for punishment. By the early 1930s Cecilia Feinberg, the new director of the Serbsky Institute, was boasting that the percentage of psychopaths found to be unchargeable had dropped from 46.5 per cent in 1922 to 6.4 per cent in 1930' (Joravsky, 1989: 416). However, this does not mean that this was a trend across the USSR as there were probably not enough Party place-men among psychiatrists to carry out similar policies. The Serbsky, in that respect, has always had a special place as the heartland of the section of the psychiatric profession that overlaps with the Soviet elite.

The isolation of Soviet psychiatry and its differentiation in this period stem from two factors. First it became increasingly difficult to travel and receive foreign publications and therefore there was a degree of physical isolation from Western medical trends. Secondly, the process by which people enhanced their careers led to psychiatry becoming defective. This is partly due to the state of dependence in which Soviet psychiatrists found themselves and partly because psychiatric education and the content of psychiatric textbooks became increasingly shaped by the Party line of the CPSU. For example, distinctively Soviet diagnostic categories came into being from 1937 (Holland & Shakhmatova-Pavlova, 1977: 277-287). Arguably, this marks the point at which Soviet psychiatry becomes defective, in common with virtually all Soviet products.

In 1932 Soviet psychiatrists held a conference on schizophrenia which is regarded as the last which was fairly open and unhindered by the Party line. This took place against the background of forced collectivisation; rapid industrialisation and a growing urban population placed an enormous strain on psychiatric services. While psychiatric facilities were being expanded it was nowhere near enough to deal with the large numbers needing psychiatric care and this was a time when every available Rouble was being diverted to industrialisation. Very little was left for the expansion of quality services, medical education or even maintaining patients in hospital for very long. Under such circumstances the 'narrow' conception of schizophrenia of Osipov

and the 'Leningrad School' became the dominant approach to nosology. Such an approach tied the diagnosis of schizophrenia to very specific diagnostic criteria. (Joravsky, 1989: 423-4).

Snezhnevskii, who was present at the 1932 conference, did not join the Party until 1945 when he was 41. By 1948 he had begun his rise to prominence at a time when the campaign against 'rootless cosmopolitans' was at its height. Snezhnevskii was not Jewish and the campaign for a distinctively Soviet nosology fitted perfectly with the nationalism of Stalin's final years. By 1950 he had replaced Cecilia Feinberg as Director of the Serbsky Institute but soon moved from there to take over the Central Institute for Post-Graduate Medical Training. The 1950s marked the point at which Pavlov's reputation was pushed ever higher, at least in part as a coded attack on Jewish psychiatrists who until then had held prominent positions (Joravsky, 1989: 425-6). It is Snezhnevskii's nosological categories that have been the subject of sustained criticism for their 'catch-all' quality. Just as the narrow 'Leningrad School' held sway at a time when patients were flooding in to hard pressed Soviet hospitals, now a broad and flexible definition of schizophrenia came to prominence at a time when the Soviet elite needed a new means of control to replace mass killings – the psychiatric hospital.

## **AN INTERIM CONCLUSION**

As the period from 1953 to 1988 is discussed fully in Chapters Four and Five here I will simply make a few observations on the history of psychiatry up until the death of Stalin.

Psychiatry as the recognisable modern specialism within medicine developed later in Russia but followed a line of development that is very similar to Western psychiatry. The Orthodox church's role was an important one in the early care of the mentally ill but that is not psychiatry. The church played a similar role in the care of the mentally ill and handicapped in Britain and the rest of Europe but this role declined in favour of secular, materialist medicine sooner than in Russia. There are no grounds for asserting that Russian psychiatry developed along a unique path shaped by a uniquely tolerant Russian attitude to the insane. As modern psychiatry developed in Russia it took its lead from developments in neurology, psychoanalysis and the Kraepellian system of nosology which it shared with the USA and the rest of Europe. It only became differentiated under Stalin and even that took around twenty

years. The differentiation into a distinctively Soviet psychiatry was the result of particular features of Stalinism that even shaped the nosological categories employed. For example, a narrower definition of schizophrenia was appropriate when there was pressure on the limited numbers of psychiatric beds. A 'catch-all' definition was adopted when psychiatrists needed to be able to admit people at will for political reasons.

The overwhelming majority of doctors in general and psychiatrists in particular were hostile to the Stalinist regime and it took about twenty years until enough psychiatrists who owed their position to the regime were in place before psychiatry could be used by the state for repressive purposes. In those intervening years Soviet psychiatrists expressed their opposition to the regime in the only ways they could. When faced with a prisoner about whom there was a question of his sanity then the Soviet psychiatrist could find him non-imputable. The early Soviet regime, as it expressed itself in the first criminal code, was fairly lenient. Moreover, the leniency was an expression of the concessions granted to psychiatrists. Psychiatrists were given the final say in forensic psychiatric matters, which was one of their pre-Revolutionary demands.

It has to be remembered that one of the demands of psychiatrists under tsarism was for greater independence and the separation of psychiatry from the state. Under the autocracy psychiatrists complained bitterly about being forced into a coercive state role and they resented the presence of the police in their psychiatric hospitals. The concession of greater independence made by the Bolsheviki was only partly due to the need to placate the intelligentsia in the turbulent times following the October Revolution. Revolutionaries too had every reason to agree with the psychiatrists that, in a humane society, questions regarding mental health, even if it is in the context of forensic psychiatry, are better dealt with by doctors than by police officers. When it was used for such purposes it was under particular circumstances.

It is true that Russian doctors in general and psychiatrists in particular were not fully professionalised but this could not explain their later co-option into a coercive role. In the twenty years after the Revolution doctors were independent enough to resist at least some pressure from the NKVD, which is more than many Soviet citizens could do. From the mid 1920s there were a number of attempts to 'tighten things up' and prevent psychiatrists from helping people to escape the camps and firing squads. The fact that eventually psychiatrists were forced into a state role



had much more to do with the position of complete dependence in which *all* Soviet citizens found themselves in a society without private property but without democracy. It is not the status of salaried employee that makes one vulnerable to state interference but the fact that one does not own oneself. When psychiatrists did play a coercive role it was under very specific circumstances.

## CHAPTER THREE: SOVIET PSYCHOLOGY

### INTRODUCTION

It has been argued that a specifically Marxist-Leninist form of psychology shaped Soviet psychiatric practice (Calloway, 1992: 3). It was asserted by Soviet writers on psychology that their approach was distinguished from pre-Revolutionary Russian and Western approaches by their 'dialectical-materialist principles' (Petrovsky, 1990: 7-9). Some writers on Soviet psychiatric abuse have taken this at face value and tried to explain the abuse of the 1960s and 70s by referring to the state imposition of a particular psychological paradigm. This, it is argued, has hindered the development of free scientific enquiry in psychology and psychiatry and it is assumed to stem directly from Marx or Lenin. The abuse of psychiatry, and other forms of science, is then taken as being an inevitable consequence of socialism (Khodorovich, 1976: 131-9). The aim of this chapter is to assess what was distinctive about Soviet psychology and evaluate the claim that it was shaped by Marxism. The objective is to consider the impact that Soviet psychology had on clinical psychiatry in the USSR.

Soviet psychology was, in some ways, different to Western academic psychology. Influential psychological theories such as psychoanalysis were effectively suppressed and a particular *form* of materialist psychology was imposed. Psychologists who wished to retain their scientific integrity had to adapt their studies in various ways. Many were obliged to adopt an Aesopian language or other subterfuges in order to pursue their interests. Still others, who were concerned only with their own advantage, adopted the officially sanctioned school of psychology as a means of furthering their career. What is highly questionable is that Soviet psychology bore any relationship to a scientific approach as defined from a Marxist perspective. Neither psychologists nor psychiatrists were particularly influenced by Marx or Lenin and as we shall see, Soviet psychology had more in common with behaviourism than any other paradigm.

From the first Soviet congress of psycho-neurology in 1923 until 1929 a debate took place concerning the nature of a putative Marxist psychology. Contributions to this debate produced some fascinating insights into social science. However, the victory of Stalinism meant that by 1929 debate was replaced by a stultifying conformity and the end of meaningful research into the issue. The concept of a distinctively Marxist psychology is highly problematic and raises questions regarding the interaction between

science and society. This is not the place for a full investigation of such a topic but some conclusions can be drawn regarding the relationship between Stalinism, psychology and Soviet psychiatry.

## **PRE-REVOLUTIONARY RUSSIAN PSYCHOLOGY**

Before 1929 there is no evidence for a distinctively Russian approach to psychology. All of the trends in world psychology were represented in Russia before the revolution, although some schools of thought, such as Gestalt Psychology and psychoanalysis were, as in the West, not necessarily regarded as respectable, scientific approaches. The development of psychology, like philosophy, had been hindered somewhat by the autocracy and was rather retarded. Under tsarism, even positivist materialism in Russian science had a radical component. In 1850, owing to rebellious movements in the universities, the teaching of philosophy was banned and not restored until 1863. However, logic and empirical psychology were permitted and as a result they became a focal point for students and academics opposed to the autocracy (Joravsky, 1989: 92). However, even a materialist approach to psychology could lead to difficulties with the tsarist censors. The most famous example is the censorship of Sechenov's work. He put forward a materialist approach to human thought which argued that it is a series of brain reflexes. It is important to remember that the movement for a materialist basis to psychology had a history going further back than the Bolshevik revolution and that it was rooted in a positivist tradition.

The radical component in materialism was not merely that there was an absence of any discussion of the soul or attempt to provide a scientific justification for Orthodox Church teaching. Rather, it stemmed from the fact that opposition to the autocracy was extremely widespread, particularly among students and the intelligentsia. Given the difficulty of organising against the autocracy legally, such liberal opponents expressed their opposition in the only ways they could. This could take different forms such as a literary parody of tsarist society or in the form of materialism in science.

When Trotsky argued that tsarist Russia was backward and that 'all Russian science is the artificial grafting on the national stem of Russian ignorance' this does not mean that there were no Russian scientists of note. Clearly the contributions of Lomonosov, Mendeleev and Pavlov broke new ground. However, their work was firmly in the tradition of Western empiricism, which had been established far longer in Holland, Germany, France and Britain than in Russia. The scientific milieu that allowed

such scientists to carry out their research was founded in a conscious effort to keep up with Western developments. The founding of numerous scientific institutes by Peter the First was driven by utilitarian goals of improving Russia's military and naval power in the face of hostile competition from more advanced countries on Russia's borders (Graham, 1993: 17).

The academic psychology there was in tsarist Russia was closer to the positivist study of physiology than anything which might be found in a modern academic psychology department. It has to be remembered that when Pavlov became Russia's first Nobel laureate it was for his work on gastric secretions and not for anything which has subsequently been regarded as Pavlov's important contributions to psychology. Indeed, Pavlov only came to have a positive regard for psychology in his later years. He rejected everything that he regarded as 'metaphysical' in psychological research and seems to have held the view that there was a distinction to be drawn between 'natural scientific thought', which was based on the observable and quantifiable and psychology which is concerned with 'the internal world of man' (Graham, 1987: 161). The point is that the most prominent of Russia's pre-Revolutionary psychologists, who was later to become exalted as *the* paradigm example of a Marxist psychologist, was not only personally hostile to Marxism but was part of a tradition of scientific thought which eschews all metaphysics. The exclusion of metaphysical considerations from science in general and psychology in particular became an important leitmotif of Soviet psychology and, as we shall see, for very good reasons.

## MARXIST PSYCHOLOGY

Marx, himself, only briefly mentions psychology in *The Economic and Philosophic Manuscripts of 1844*. As it is so important to the following discussion it is worth quoting at length. Marx wrote: 'We see how the history of *industry* and the established *objective* existence of industry are *the open book of man's essential powers*, the exposure to the senses of human *psychology*. Hitherto this was not conceived in its inseparable connection with man's *essential being*, but only in an external relation of utility, because, moving in the realm of estrangement, people could only think of man's general mode of being - religion or history in its abstract - general character as politics, art, literature, etc. - as the reality of man's essential powers and *man's species activity*. We have before us the *objectified essential powers* of man in the form of *sensuous, alien, useful objects*, in the form of estrangement, displayed in *ordinary material*

*industry* (which can be conceived as well as a part of that general movement, just as that movement can be conceived as a *particular* part of industry, since all human activity hitherto has been labour - that is, industry - activity estranged from itself).

A *psychology* for which this, the part of history most contemporary and accessible to sense, remains a closed book, cannot become a genuine, comprehensive and *real* science. What indeed are we to think of a science which *airily* abstracts from this large part of human labour and which fails to feel its own incompleteness, while such a wealth of human endeavour, unfolded before it, means nothing more to it than, perhaps, what can be expressed in one word - "need," "vulgar need"?

The *natural sciences* have developed an enormous activity and have accumulated an ever-growing mass of material. Philosophy, however, has remained just as alien to them as they remain to philosophy. Their momentary unity was a *chimerical illusion*. The will was there but the means were lacking. Even historiography pays regard to natural science only occasionally, as a factor of enlightenment, utility, and of some special great discoveries. But natural science has invaded and transformed human life all the more *practically* through the medium of industry; and has prepared human emancipation, although its immediate effect had to be the furthering of the dehumanisation of man. *Industry* is the *actual*, historical relationship of nature, and therefore of natural science, to man. If, therefore, industry is conceived as the *exoteric* revelation of man's *essential powers*, we also gain an understanding of the *human* essence of nature or the *natural* essence of man. In consequence, natural science will lose its abstractly material - or rather, its idealistic - tendency, and will become the basis of *human* science, as it has already become the basis of actual human life, albeit in an estranged form. *One* basis for life and another basis for science is *a priori* a lie. The nature, which develops in human history - the genesis of human society - is man's *real* nature; hence nature as it develops through industry, even though in an estranged form, is true *anthropological* nature.

*Sense - perception* (see Feuerbach) must be the basis of all science. Only when it proceeds from sense - perception in the two-fold form both of *sensuous* consciousness and of *sensuous* need - that is only when science proceeds from nature - is it *true* science. All history is the preparation for "man" to become the object of *sensuous* consciousness, and for the needs of "man as man" to become [natural sensuous] needs. History itself is a *real* part of *natural history* - of nature developing into man. Natural science will in time incorporate itself into the science of man, just as

the science of man will incorporate itself into natural science: there will be *one* science' (Marx, 1970: 142-3 – All emphases are in the original).

Marx's conception of a scientific psychology is one concerned with uncovering humanity's essence. One aspect of such an essence is that man works on and transforms nature and in so doing he transforms himself. It is with that in mind that Marx used the term *industry*: purposeful human labour. Marx was still influenced by Feuerbach in 1844 but it is clear that Marx's discussion of psychology goes beyond an assertion of man's species being as a biological abstraction. Marx decisively 'settles accounts' with Feuerbach in the 'German Ideology' but there is nothing in the quote above to suggest that Marx's conception of man's essence was reducible to biology even in 1844. Man is also a social animal and therefore any attempt to consider man as an isolated individual, abstracted from society, constitutes a failure to understand real human beings. For Marx, physiology alone could not provide a basis for a scientific understanding although it would be an important part. It is not enough to substitute 'abstract matter' for Hegel's 'absolute mind'. As a social being which works upon nature ('the first historical act') man has to be considered in his historically specific context. Marx's critique of Feuerbach is precisely that he was an inconsistent materialist who did not understand human development in its historical context. This does not suggest that humans are infinitely malleable. Marx never asserted that there is no human nature as such (Geras, 1983: 65-6). The assertion that there is *only* historically specific human nature became a hallmark of Stalinism and will be discussed later.

In transforming nature to meet his needs man also creates new needs. For needs to be met in a way that is distinctively human they have to be met on the basis of free creative activity, which Marx regards as humanity's 'species activity'. What makes labour distinctively human is that 'At the end of every labour process, we get a result that already existed in the imagination of the labourer at its commencement' (Marx, 1954: 174). Whilst there can be no separation of matter from mind it is clear that matter which consciously transforms nature and thereby itself is qualitatively different from inanimate matter. The human brain as the most highly developed form of matter is capable of transforming nature and in so doing it develops itself. The question of the interplay between 'mind' and 'body' assumed a particular role in Stalinism and a distinctively Soviet psychology. In the Stalinist formulation thought was reduced to neurological processes. Ironically, by choosing Pavlov as the paradigm example of a Marxist psychologist, the USSR Academy of Sciences selected a fitting example of the

kind of positivist approach to psychology that was as at home in the academic psychology departments of capitalist countries as it was within Stalinist thought. Pavlov cannot be held entirely responsible for the purposes to which his work was put but it is highly significant that an approach to psychology was chosen which was as close as possible to a psychology without metaphysics. More important than that, it was an approach to psychology that, a priori, excludes any consideration of *ideology*. 'For psychological positivism [...] consciousness amounts to nothing: it is just a conglomeration of fortuitous, psychophysiological reactions which, by some miracle, results in meaningful and unified ideological activity' (Voloshinov, 1986: 12). To put it another way, the psychological paradigm put forward by Stalinism was not a break with the positivist materialism of the pre-Revolutionary period but a continuation of it.

Marx, whilst accepting that Feuerbach made an important breakthrough in the critique of Hegel, nevertheless rejected his crude inversion of Hegel. 'Feuerbach regarded man only as a species, a mere product of nature; he clung to a contemplative materialism based on the natural sciences' (Jakubowsky, 1990: 26-7). It is this failure to understand how man is inseparable from society and at the same time transforms society that leads Marx to say of Feuerbach that 'As far as Feuerbach is a materialist, he does not deal with history, as far as he considers history, he is not a materialist' (Marx, 1938: 37-8). Psychology, as it existed in 1844, was an alienated expression of man, as were philosophy and natural science and remain so today. They were seen by Marx as belonging to man's 'prehistory'. In a non-alienated society there would not be divisions within science.

For Marx the breakdown of knowledge into isolated disciplines is '...the result of inconsistencies or even of irreconcilable differences in their fundamental assumptions and methods of enquiring, especially where the subject of human beings is concerned' (Joravsky, 1989: 12). The reduction of the human essence to neurophysiology is homologous to Feuerbach's notion of abstract matter and is far removed from any possible Marxist psychology, notwithstanding the fact that Marx himself hardly discussed a discipline that barely existed. 'If we engage our minds with Marx's actual thought and its continuing impact, we find ourselves struggling with the central defects of the human sciences - incoherence and dehumanisation - not a bogus correction of those defects' (Joravsky, 1989: 36). Therefore, for Marx, social science, speculative philosophy or the fragmented and positivistic natural sciences were all expressions of human alienation and the division of labour. As alienation is overcome

the logical consequence is the emergence of a unified science which is not separated from man in three senses. First, such a science would not have the artificial distinctions between the disciplines, which is an expression of the division of labour. Second, science would not be abstracted from how man reproduces his life by transforming nature. And third, science would cease to be the select pursuit of a privileged section of the community who, as often as not, are separated from the production process. Science would be part of a truly human, free labour which had become man's 'prime want'. Human labour is conscious and is conducted in a truly human way when it is free from compulsion whether from class relations or the satisfaction of one's animal needs.

As human alienation in capitalist society is the product of abstract labour, it follows that the transcendence of abstract labour is a prerequisite for the development of an unalienated science. Abstract labour did not exist in the USSR but the form of alienation was even more thorough than in capitalist society. Instead of the division of labour resulting from the market, in the USSR bureaucratic regulation and state terror enforced it. Instead of selling their labour power soviet workers, including scientific workers, alienated their labour power as semi-forced labour. There was, therefore, no diminution of the division of labour between scientific disciplines, and the nature of Soviet atomisation meant that scientific disciplines with a political content became extremely dangerous areas in which to work. One solution adopted by Soviet psychologists who wished to retain their integrity was to chose a biological area of psychology to work in. As a result some areas of Soviet psychology were quite well developed, at least theoretically. These included developmental psychology (pedagogy) and psychological research into brain injury. Practically, the therapeutic use of the discoveries of Soviet psychology was dependent upon one's position in society.

Areas of psychology, such as psychoanalysis, which has a social theory, integral to it, were effectively excluded from any form of scientific discussion at all. The result was that, far from removing the boundaries of the division of labour in science, the divisions were even sharper, even within a single academic discipline. In Britain, with its long history of positivism, psychoanalysis is not regarded as a particularly 'scientific' or respectable branch of the discipline. Some academic departments of psychology would not necessarily teach it and only a minority of psychology graduates will have even a basic understanding of the fundamental concepts of psychoanalysis. There is not the space here to discuss why this is the case. However, while psychoanalysis is regarded as a fringe subject in British academic psychology, it is still taught. Some institutions, such



as the University of Sheffield, offer master's degrees in psychoanalytic studies. Individual institutions can exploit the general interest in psychoanalysis as a 'niche market'.

This illustrates another distinction between capitalist countries and the USSR. In Britain, for example, although the fragmentation of scientific enquiry is a necessary feature of capitalism, the fact that there is a market which extends to every sphere including education, means that even subjects which do not have a high academic status can be taught. Therefore, they can achieve a degree of integration with more mainstream branches of science. Any appropriately qualified person may also train in psychoanalysis and therefore a link is retained between respectable behavioural science and a branch of psychology which some would argue is not scientific in the positivist sense. As we shall see, this was not the case in the USSR and therefore the fragmentation of science was greater than under capitalism.

The absence of abstract labour also meant that ideology in the USSR was less effective than in capitalist society. This meant that the divisions which existed among scientists took an explicitly political form and one which was as transparent in its political content as the exploitative relationship between the elite and the working class.

### **RUSSIAN PSYCHOLOGY 1905-1929**

There was widespread support among intellectuals for the February Revolution but hostility to the October Revolution. The Bolsheviks had to contend with a good deal of antipathy from intellectuals and specialists. This was no less so with regard to psychologists. Ivan Pavlov, for example, was explicitly hostile to Marxism, and wrote condemning Marxism as pseudo-science. However, this did not prevent Pavlov being maintained in a relatively privileged position. The Bolsheviks were compelled to make alliances with specialists in general. Pavlov, as Russia's only Nobel Laureate, was allowed privileges with regard to research facilities, a raised salary and better accommodation as his emigration would have been a propaganda disaster for the young Soviet republic (Lenin, 1962, vol. 32: 48). However, political expediency alone does not explain the liberal attitude to members of the intelligentsia. In the period up until 1925 there were relatively few examples of people removed from academic positions because of their hostility to the new regime, especially when one considers how widespread such attitudes might have been. It seems likely that among Bolsheviks of

the revolutionary generation there was no intention to impose a rigid Party line on research or academic work.

There are few recorded instances of academic psychologists who in 1917 were active revolutionaries. One was P.P. Blonsky who joined the S.R.s when a student and was imprisoned for various short spells during 1904-6. At the first All-Russian congress of psycho-neurologists he initiated a debate calling for the recasting of psychology on a Marxist basis. This was the first recorded attempt by any political activist in the USSR to issue such a call. Certainly no significant theorist of any major socialist party discusses it and neither is there any detailed discussion of psychology by any major Marxist thinker before the revolution. This is not because there was no interest in the subject. Trotsky took an active interest in psychology when he was in exile in Vienna in 1908 (Trotsky, 1975: 227-8). However, the idea that Marxists should construct a distinctively socialist psychology had not occurred to anyone before the revolution.

In fact, there was no particular line held by any left group regarding psychology. In so far as it was mentioned, it was only fleetingly and usually as part of a polemic against some right wing group who sought to argue against materialism in general and Marxism in particular. For example, Lenin in 'What the "Friends of the People" are and How They Fight the Social Democrats' argues that 'the scientific psychologist has discarded philosophical theories of the soul and set about making a direct study of the material substratum of psychical phenomena - the nervous processes - and has produced, let us say, an analysis and explanation of some one or more psychological processes. And our metaphysician-psychologist reads this work and praises it: the description of the processes and the study of the facts, he says, are good; but he is not satisfied. "Pardon me," the philosopher cries heatedly, "in what work is this method expounded? Why, this work contains 'nothing but facts'. There is no trace in it of a review of 'all the known philosophical theories of the soul'. It is not the appropriate work at all!'" (Lenin, 1960, vol.1: 144-5).

In common with non-Marxist materialists, Lenin, in his early works, can be read as reducing 'mind' or 'consciousness' to the physical action of the nervous system. However, this would be to ascribe to Lenin's statements on psychology a meaning that he never intended. At no point does Lenin claim any expertise in either psychology or philosophy. His objective was simply to criticise anti-Marxists who were influential in Russia at the time. The best example of this is to be found in Lenin's 'Materialism and Emperio-Criticism'. Partly as a response to the defeat of 1905 some Russian socialists,

particularly Bogdanov, and Lunacharsky, attempted to reformulate Marxism in what they felt would be a more popular form. Bogdanov in particular, seized upon the works of Ernst Mach as an approach to materialism that would be more accessible. Mach, himself, had only a passing interest in socialism through his friendship with Victor Adler and was unaware of much of the controversy surrounding his work in Russia until some time after his work had been translated into Russian.

Mach's book, 'Knowledge and Error: Sketches on the Psychology of Enquiry', was dedicated to David Hume, Richard Avanarius and Wilhelm Schuppe and was originally published in Leipzig in 1905. Although Mach's work was influential for a time among natural scientists it was quickly surpassed in its discussion of physics and provided no advance over Kant in terms of philosophy. This did not stop Bogdanov from promoting Mach in Russia, including translating the above work into Russian with a forward written by himself which stressed the importance of Mach for an understanding of Marx (Blackmore, 1972: 235-246).

After Lenin's death *Materialism and Emperio-Criticism* was used as a philosophy text-book in the USSR and used to justify the Party line of the CPSU on a wide range of issues. In particular Lenin's assertion of ideology as a 'reflection' of material reality was used to assert the mechanistic materialism that became a distinctive feature of Stalinism. The notion that a materialist psychology was also reducible to nervous processes was also justified with reference to Lenin's discussion of psychology in 'What the "Friends of the People" Are' (Budilova, 1960: 102-3). However, if one looks at Mach's work and Lenin's critique, it is clear that it is precisely the positivist aspect of 'Machism' that Lenin is most critical of. Although few would argue that '*Materialism and Emperio-Criticism*' is a good exposition of dialectical philosophy it is undoubtedly a defence of dialectics against positivism.

Lenin's own thought underwent considerable change during the time he spent studying dialectics. In the 'Philosophical Notebooks' Lenin shows that his understanding of the dialectical relationship between being and consciousness became far more subtle. It is arguably from this point that Lenin broke with the simplistic philosophical schema of his teacher Plekhanov. In his 1922 essay 'The Significance of Militant Materialism' Lenin argues not just for the propagation of materialist ideas as such but for the propagation of Hegelian dialectics from the perspective of Marxism. From such a perspective, Lenin argues that natural science 'will find a series of answers to the philosophical problems which are being raised by the revolution in natural

science.' Without the emphasis on Hegelian dialectics the militant materialism argued for in the journal 'Pod Znamiem Marxizma' would not be militant at all (Lenin, 1963, vol.33: 227-36).

There has been some suggestion that the psychological writings of Mach influenced Freud although the evidence is largely circumstantial and is derived from his acquaintance with Joseph Breuer. What is clear, though, is that Mach is closer to the classical behaviourism of John Watson than the essentialist account of Freud. However, even the way Mach approaches introspective psychology is positivist. Regarding Mach's discussion of dreams Lenin wrote that 'It is true that not only is the wildest dream a fact, but also the wildest philosophy. It is impossible to doubt this after an acquaintance with the philosophy of Ernst Mach. As the very latest sophist, he confounds the scientific-historical investigation of human errors, of every "wild dream" of humanity, such as a belief in sprites, hobgoblins and so forth, with the epistemological distinction between truth and "wildness"' (Lenin, 1962, vol. 14: 138). It is intriguing to speculate on what Lenin meant by 'the scientific-historical investigation of human errors' that Lenin seems to be defending against Mach's scepticism. It may well be that Lenin was acquainted with Freud's books, 'The Interpretation of Dreams', which was published in 1900 and 'The Psychopathology of Everyday Life', which was published in 1901. It was in the latter work that Freud gave his first account of parapraxes. However, there is little evidence for this and Mach, in his 'Analysis of Sensation', acknowledges no debt to Freud. There is some evidence that Lenin was acquainted with Freud's work, was critical of it and, had he not become ill, had intended to write on the subject (Petrovsky, 1990: 160-1).

It was the formulation of a materialist psychology in terms of neurological processes that became the subject of intense debate. Of course Lenin cannot be held responsible for the use his works were put to later but they do retain an importance. It could be argued that the crude nature of Lenin's discussion of psychology was a measure of the fact that few had even considered the question until then. Moreover, there was no intention to create a distinctive Soviet or Marxist psychology. 'No one has been able to find a single reference to Pavlov or Bekhterev in any pre-Revolutionary Marxist publication. (Many Soviet scholars have searched, since ex post facto they have joined Pavlov to Marx to Lenin in holy trinity.) Such a uniform anomaly could not have been an accident' (Joravsky, 1989: 185-6). Despite certain peculiarities in pre-Revolutionary Russian psychology it was thoroughly influenced by movements taking

place in the West. The idea that the science of psychology would be different in Russia could not have even occurred to anybody prior to the revolution.

Prior to the defeat of the Russian revolution the idea of a Marxist psychology occurred to no one. Those who later rose to occupy high office in the Soviet psychological establishment were invariably wholly integrated within the movements of psychological thought worldwide. Epistemologically, most were influenced by a mechanistic materialism, which was suffused with a radical content in the context of the Tsarist Empire. Positivism and materialism were features associated with the emergence of capitalism in Russia. Many scientists later went on to adopt a Marxist terminology as a means of survival and career advancement. It is true that Lenin can be interpreted as having a conception of materialist psychology that is undialectical and reducible to nervous impulses. In that sense one can detect the influence of the mechanistic materialism of Plekhanov. However, his few isolated references to psychology are almost exclusively confined to the period preceding the 'Philosophical Notebooks'. More importantly, Lenin never claimed any particular expertise in either psychology or philosophy, where as far as he himself was concerned he occupied a place in the 'rank and file'. The explanation for the nature of Soviet psychology cannot lie with Lenin.

The assertion that there needs to be a distinctively Marxist (that is, Soviet) psychology is a logical extension of the assertion of 'socialism in one country'. From a Marxist perspective, psychology, along with other scientific disciplines, would become truly scientific in a socialist society, stripped of the artificial and alienated form of the academic division of labour. This could only take place in an international socialist society. A distinctively Marxist psychology in one country would be as unthinkable as socialism itself being confined to one country. Stalinism as the doctrine of socialism in one country is a nationalist doctrine. The assertion of a distinctively Soviet psychology is a logical extension of that doctrine. It is an expression of nationalism that takes a highly specific form. This can be seen most vividly in the manifest anti-Semitism of the 'Pavlov Sessions' of the meeting sponsored by the Academy of Medical Sciences and the Academy of Sciences of the USSR which was held on June 28-July 4, 1950 (Graham, 1987: 174). Not only was Pavlov held up as the leading representative of Marxist psychology but the same period saw a number of senior Jewish academics either displaced or their work withdrawn from publication (Joravsky, 1989: 376). The work of some Jewish writers could not be published until after Stalin's death. Among

these were two psychologists who were later to occupy a very high status in Stalinist psychological textbooks, S.L. Rubenshtein and L.S. Vygotsky.

## **THE STRUGGLE FOR POWER**

One of the results of the debate concerning the nature of Marxist psychology was that from 1923 it became a defining feature of one's political position. It became a political debate conducted in an Aesopian language where one's loyalty to the regime was at stake. Jobs, and later lives, were lost over debates which seemed doctrinal but were, in fact, the expression of a scramble for positions within the increasingly bureaucratised regime. Chelpanov, who until 1923 was head of the Moscow Institute of Psychology, was removed from his post and replaced with a political appointee, Kornilov. Kornilov, who himself was to lose his position in 1930, set about appointing academics to the Institute of Psychology who held views on psychology consistent with the prevailing line of the regime. At the time, Chelpanov's enemies described him as 'subjectivist' and 'idealist', a charge that was repeated until recently (Yaroshevsky, 1989: 91). However, this is misleading as it implies an ontological commitment to mind or psyche as an immaterial substance to be investigated by psychology and Chelpanov did not require such a commitment of his staff. In fact Chelpanov was probably a relatively open minded liberal academic. S.L. Rubenshtein, who went on to hold high office in the Soviet psychological establishment, approached the reality of Chelpanov's position when he said that 'in general, Chelpanov had no psychological theory of his own'. In the coded terms of Stalinist criticism, it could be argued that this was just a way of saying that Chelpanov was a tolerant eclectic (Joravsky, 1989: 108).

The fact that each of the leading figures in Soviet psychology was utterly dependent upon remaining in political favour is well illustrated by the case of Blonsky himself. Having initiated the call for a Marxist psychology, he fell out of favour in the 1930s and much of his work was only published in the 1950s. He was the subject of posthumous rehabilitation in a lengthy valedictory article in *Voprosy Psikhologii* in 1974. This article emphasised Blonsky's supposed evolution from an idealist to a mechanical materialist and finally to a dialectical-materialist position. The tone of the article has the feel of a coded criticism of the constraints under which Soviet psychology had to work. For example, referring to the supposed transition in philosophical orientation, the author of the article, which celebrated the ninetieth anniversary of Blonsky's birth, wrote: 'It is quite understandable that a sharp transition

in one's ideas could not possibly take place without mistakes and contradictions. The mastery of dialectical materialism was no easy matter for any Soviet psychologist. Originally, like other Soviet psychologists of this period, Blonsky was a mechanistic materialist' (Nikol'skaya, 1974: 3-4).

Within psychiatry, the debate around whether one adopts a 'narrow' or 'broad' definition of schizophrenia was in fact a manifestation of a power struggle between sections of the intelligentsia and the elite and so was the debate concerning the nature of a Marxist psychology. Eventually the elite decided the outcome of the debate. In November 1929 the press reported a purge of 'wreckers' from the Academy of Sciences. Shortly afterwards, the Moscow Society of Neuropathologists and Psychiatrists was forced to drop its previous requirement for membership that one should have published research. A society which had previously numbered about four hundred, including about eighty who had been co-opted, was effectively compelled to elect three hundred new members and a new slate of officers. 'Half were Communists, the other half members of the All-Union Association of Workers of Science and Technology for Aid to the Construction of Socialism'. Over the period 1929-31 most other scientific societies dropped similar requirements and were compelled to accept new members (Joravsky, 1989: 336).

## **PSYCHOANALYSIS IN THE USSR**

At the turn of the century and up until the middle 1920s, psychoanalysis was popular in Russia and Russian psychoanalysts formed an estimated one-eighth of the worldwide membership of the International Psychoanalytic Association. There were about 30 members of the Russian psychoanalytic society listed between 1922 and 1929. First psychoanalysis became the object of scrutiny and some prominent Russian psychologists began a serious debate concerning a possible synthesis of Marxism and psychoanalysis. By 1924 it became the object of suspicion that led to the closure of an experimental home using psychoanalysis in Moscow for the treatment of disturbed children. By 1925 it became the object of attack. Within a few years leading psychoanalysts (Osipov and Wulff) emigrated while others such as A.R. Luria abandoned his psychoanalytic research and moved into experimental and neuropsychology (Miller, 1985: 638-9).

The roots of Russian psychoanalysis go back to 1908 when N.I. Osipov trained under Jung and visited Freud. The Russian Psychoanalytic Society was

established in 1911. It ceased functioning during World War I but was refounded in 1921 by I.D. Ermakov. 'He was instrumental in the establishment of the State Psychoanalytic Institute in that year where he offered courses on the psychology of the creative process. Ermakov also published pioneering psychoanalytic studies of Pushkin and Gogol' and edited a nine-volume series of Freud's work in Russian translation'. This remained the only officially approved translation of Freud in the Soviet era (Miller, 1985: 626). Despite the fact that psychoanalysis was effectively banned by 1933 the library of the Kashchenko Hospital in Moscow had a copy of Ermakov's translation of Freud in 1994.

In 1926, Trotsky in his essay on 'Culture and Socialism' argued that 'Pavlov's reflexology proceeds entirely along the paths of dialectical materialism. It conclusively breaks down the wall between physiology and psychology. The simplest reflex is physiological, but a system of reflexes gives us "consciousness". The accumulation of physiological quantity gives a new "psychological" quality. The method of Pavlov's school is experimental and painstaking. Generalisations are won step by step: from the saliva of dogs to poetry, that is, to the mental mechanics of poetry, not its social content - though the paths that bring us to poetry have as yet not been revealed.' Freud's method proceeds in a different way: 'It assumes in advance that the driving force of the most complex and delicate psychic processes is a physiological need. In this general sense it is materialistic, if you leave aside the question whether it does not assign too big a place to the sexual factor at the expense of others, for this is already a dispute within the frontiers of materialism.' Trotsky criticised Freud and regarded some of his hypotheses as 'sometimes fantastic conjecture' but then asserts categorically that 'The attempt to declare psychoanalysis "incompatible" with Marxism and simply turn one's back on Freudianism is too simple, or more accurately, too simplistic. But we are in any case not obliged to adopt Freudianism. It is a working hypothesis that can produce and undoubtedly does produce deductions and conjectures that proceed along the lines of materialist psychology' (Trotsky, 1973: 233-4). This does not mean that in defending Pavlov, Trotsky did not understand the limitations of his approach, as he made clear in his essay on 'Science in the Task of Socialist Construction' (Trotsky, 1973: 202-3).

Trotsky opposed any attempt to transmute the theory of Marx into a universal master key that ignored other spheres of learning (Trotsky, 1973: 221). His intervention was entirely consistent with the view that a scientific approach to psychology, or anything else, would require a world socialist society, the end of



alienation and the division of mental and manual labour. It was an appeal against dogmatism and for an honest, materialist, investigation that did not try to pre-judge the issue or make the facts fit a predetermined view.

By the time that the Stalinist elite was consolidating its control over academic institutes Trotsky had been expelled from the Party and exiled. The association of Trotsky with psychoanalysis meant that the latter 'became associated pejoratively not only with "bourgeois science" but also with the alleged threat to party and revolutionary unity posed by "Trotskyite deviationism"' (Miller, 1985: 643).

The attempt by Stalinist psychologists, dependent for their position on a system of patronage, to caricature Freud as philosophically idealist is an example of how Stalinist 'diamat' was a parody of Marx's method. The intensity of the debate gives a clue to what was at stake. If, like Marx, one's starting point is that under commodity production there is a separation of man from his essence which is the consequence of class society, then the question of the ownership of the means of production is only one, admittedly vital, aspect of the liberation of humanity. Before socialism can come into being the working class has to take power, but this is not all. Marx opposed Proudhon precisely because of Marx's hostility to a conception of socialism as some sort of 'community of labour'. The aim, for Marx, was the establishment of a truly human society where all production would be to meet human need. Therefore, the whole communist project is an ontological one, the end of human alienation. In such a society abundance can move from a potentiality, as at present, to an actuality. Under conditions of abundance man becomes free to develop himself through free creative labour in any way he chooses. Not only is there an end to the separation of man from his species being but also an end to man's separation from man and from nature. This is the starting point Marx held in the 1844 manuscripts and throughout his life. It also means that humanity has scarcely begun to scale the unimaginable heights of its potential.

In place of this view the USSR's claim to be a socialist society was based purely on the fact that there was no private property and therefore no ruling class as such. This meant that all discussion of human nature, essentialism, and alienation had to be consigned to Marx's 'early' phase. The 1844 manuscripts were disregarded as pre-dating the mature formulation of dialectical materialism from 1845 and 'The German Ideology'. It was asserted that 1845 constituted a decisive epistemological break between the early Marx who was still under the influence of Hegel and Feuerbach and the mature Marx who finally shed the remnants of idealism. Marx's

ideas did develop but his concern with human nature was as fundamental to him when he wrote *Capital* as when he wrote the 1844 manuscripts and there was no such epistemological break.

No one who knew what life was like in the USSR could claim that alienation had been transcended. Therefore any philosophical or psychological system which raised this awkward question had to be suppressed or marginalised. Hegel came to be treated as a historical curio and dialectics assumed only a formal role in Stalinist writing. The school of psychology that was most suitable was that which was most firmly rooted in positivist materialism. Psychoanalysis, in which there is a conception of alienation, had to be suppressed. Obviously, Freud's conception of alienation is quite different from that of Marx. For Freud, humanity's bestial and egoistic drives have to be repressed and it is this repression that is the source of neurosis. Moreover, he regarded such a state of affairs as an immutable feature of the human condition and the price we pay for civilisation. However, for Marx, alienation can be transcended and the end of private property was a precondition for such a transformation. He argued in one of his most 'mature' works, *Capital*, that one must deal '...with human nature in general, and then with human nature as modified in each historical epoch' (Marx, 1954: 571). Marx did not regard human nature as infinitely malleable, which would be a logical implication of the assertion that there is no human nature but only historically specific human nature. At the same time Marx's understanding of the basis of alienation meant that he was not constrained by the ahistoricism that Freud suffered from.

Such glaring evidence of the continuity of alienation in a country supposedly constructing socialism within its own borders was extremely difficult to reconcile with the essentialist perspective of Marx or any other scientist. Instead, the focus was placed on the public ownership, although in fact, it was *the state ownership*, of the means of production and away from Marx's ontological project. In so doing, the emphasis was diverted from the extraction of a surplus from the labouring population. In philosophy, *diamat/histmat* became a mechanical and corrupted rendition of Marxism.

The debates around psychoanalysis in the 1920s were qualitatively different to subsequent discussions of the subject by later Soviet writers. For example, V.N. Voloshinov, who was an associate of M. Bakhtin, published a critique of psychoanalysis in 1927. The first half of Voloshinov's book contains a detailed exposition of the main tenets of Freud's theories (Voloshinov, 1976). One does not have to agree with the critique of psychoanalysis, which makes up the second half of

the book, but it is a scholarly and apparently sincere appraisal of Freud by someone attempting a critique from a Marxist perspective. This stands in stark contrast to the descriptions of psychoanalysis to be found in later books which seem to illustrate only that the author either had not read Freud or was simply engaged in publishing the official line. Those who regarded Freud as a materialist had been 'misled by the pseudo-materialist cover concealing the idealist substance of that theory' (Petrovsky, 1990: 155).<sup>1</sup>

Although Soviet psychoanalysis was suppressed by 1933 the USSR exerted little influence outside its borders on this question until 1948. At about the time of the 'Pavlov Sessions' in the USSR debates began in Western communist parties around the question of psychoanalysis. The Communist Party of France discussed the question and decided that psychoanalysis was incompatible with Marxism as did the Communist Party of the USA (CPUSA). In the USA the imposition of the Soviet line also had the effect of destroying the association of socialist psychiatrists, psychoanalysts and psychologists, The Benjamin Rush Society (BRS).

The BRS was established in the US in the 1930s and took its name from the 'alienist' who was one of the signatories of the American Declaration of Independence. Many of its members were Jewish Marxists who escaped persecution in Germany and Austria and were familiar with the debates surrounding the compatibility or otherwise of a synthesis between Marxism and psychoanalysis. Joseph Wortis (1906-1995) led the BRS Stalinist wing. He was from a New York socialist family and, despite the fact that he had undergone training analysis with Freud, agitated against psychoanalysis within the BRS. He also wrote the first English language account of Soviet Psychiatry, which is simply a description of its subject matter from the perspective of a life-long supporter of the USSR. Later, he went on to write the preface to Paul Calloway's book, which is almost equally pro-Soviet. One of the accusations some in the CPUSA used against psychoanalysis was that psychoanalysts' files were used by the FBI. The attacks on psychoanalysis began at

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<sup>1</sup> Petrovsky's book was originally published in Russian in 1967. His remarks on Freud may, at best, be seen as an improvement on an earlier history of Russian psychology (Budilova, 1960) which does not even mention the existence of a psychoanalytic movement in Russia or feature Freud's name in the index. Petrovsky's book was amended and published in English in 1990.

the end of 1949 and throughout 1950. A combination of the splits that this caused and the intensifying persecution of the left in the USA meant that the BRS folded in 1951 (Harris, 1995: 309-31).

## **THE CASE OF LEV VYGOTSKY**

From his earliest contributions to psychology Vygotsky generated a good deal of interest. After his death from tuberculosis in 1934 his work fell from favour and ceased to be published. Subsequently, after the death of Stalin, he was rehabilitated in the USSR and has become popular in the West among those who argue that Vygotsky is a representative of Marxist psychology. His career is an interesting case study of the history of Soviet psychology. He was born in 1896 in Orsha in Byelorussia and graduated in 1917 from the Law faculty of Moscow University having fought his way into the small percentage of places allowed for Jewish students. There are no accounts of Vygotsky having been active on the revolutionary left but it seems that he had read Marx and Engels prior to 1917. His early works, mostly unpublished at the time, were on literary themes. Vygotsky did not come to prominence as a psychologist until 1924 when, at the invitation of Kornilov, the head of the Moscow Psychological Institute, he read a paper on 'The Methodology of Reflexological and Psychological Research' at the second All-Russian Congress of Psycho-Neurology. At the time there was still considerable diversity within Soviet psychological research but a hegemonic position in favour of biologicistic psychology was quickly established. It had, after all, been the background of the majority of psychologists at the time, some of whom later took leading positions within Soviet psychology.

One of Vygotsky's publications in 1925 was the introduction to the Russian edition of Freud's 'Beyond the Pleasure Principle' which he wrote jointly with Luria. In this short essay Vygotsky and Luria spoke with enthusiastic praise of Freud's work. In 'Beyond the Pleasure Principle', written after World War One, Freud introduced the controversial concept of the death instinct, Thanatos. Vygotsky and Luria passed over the potentially conservative implication of an inherently destructive human tendency in what was, for Freud, a significant departure from some of his earlier theories. Instead, they stressed the dialectical nature of Freud's new formulation of the human psyche as a unity of the dialectical opposites of Eros and Thanatos. Both drives are located in the biology of every cell of every living organism and in that sense, Freud can still be read as remaining firmly in the materialist camp. Furthermore, Vygotsky and Luria may well

have been correct to stress the positive aspect of Freud's new theories. Either way, their introduction was written in the spirit of an open-minded appraisal by scientists prepared to discuss the issues raised. Vygotsky and Luria wrote: 'It is quite unnecessary to agree with every one of Freud's many postulates, and it is not necessary to share all his hypotheses, but what is important is to be able to discover one general tendency within the singular (perhaps not all of them of equal value) notions, and manage to make use of it for a materialistic explanation of the world' (Vygotsky in van de Veer & Valsiner, 1994: 17).

Luria's own history up until this point was firmly in the psychoanalytic camp. While a postgraduate in Kazan Luria came across Freud's work and soon founded the Kazan psychoanalytic group. He continued to be known for his psychoanalytic research until about 1930 (Miller, 1985: 635).

Vygotsky was clearly influenced by Marx. It is also significant that in 1930 he published a paper called 'The Socialist Alteration of Man' in which he quotes approvingly the passage from the 1844 manuscripts where Marx briefly discusses psychology. This essay was written for the journal of the All-Union Association of Workers in Science and Technology for the Socialist Construction in the USSR (VARNITSO<sup>2</sup>). It was clearly a defence of Marx's ontological project by arguing that a socialist society would not merely take control of the means of production but would also result in the transformation of the human psyche itself (Vygotsky in van de Veer & Valsiner, 1994: 175-83). Vygotsky was also aware that there was a contradiction involved in the fact that there was not one single agreed psychological methodology but a series of contending schools in the USSR and elsewhere. This was to be the subject of one of his publications, 'The Historical Meaning of the Psychological Crisis' (Joravsky, 1989: 262-3).

Some of Vygotsky's psychological theories may also be seen as entirely consistent with a Marxist approach. His discussion of what he termed 'the zone of proximal development' could be interpreted as supporting a fundamental position within Marxism, namely, that humans have a vast undeveloped potential and moreover its development is utterly dependent upon social interaction. Furthermore, Vygotsky

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<sup>2</sup> *Vsesoyuznaya Assotsatsia Rabotnikov Nauki i Tekhniki dlya Sodeystviya Sotsialisicheskomu Stroitel'svu v SSSR.*

argues that human learning and development are inextricably linked and he attaches due importance to the child's linguistic development (Vygotsky, 1978: 74-91).

The debate around Vygotsky's Marxist credentials often centres on whether he 'believed in' Marxism or simply used a Marxist terminology in order to fit in with the new regime. However, what makes a scientific approach distinctively Marxist is whether one employs Marx's method. In this respect Vygotsky's position is not entirely clear. For example, Vygotsky himself regarded Spinoza as his greatest influence (Vygotsky, 1982: 14). In later works he and Luria clearly did adapt their writings to fit in with the prevailing line. Of course, this position may be understandable, as one's life could depend upon such adaptation. A good example of this is the contrast between Vygotsky's 1925 essay 'The question of consciousness in the psychology of behaviour' and his joint publication with Luria 'Ape, Primitive Man and Child', originally published in 1930. In 1925 Vygotsky defended the study of consciousness as a vital part of psychology against those who attempted to reduce psychology to the study of conditioned reflexes. He argues that such an approach draws no distinction between animal and human psychology and dissolves sociology into biology and psychology into physiology (Vygotsky, 1982: 78-98). However, by 1930 Vygotsky is arguing that intelligent (human) behaviour arises out of a complex combination of conditioned reflexes. He and Luria are also duly deferential to Pavlov in the manner that was to become typical in Soviet psychology publications (Luria & Vygotsky, 1992: 2-4 and 20).

Luria subsequently recanted his psychoanalytic heresy and concentrated on psycho-neurological research. He also became a very senior figure in Soviet psychology. Vygotsky in his book, *Myshlenie i Rech'*, which was published in 1934 is also critical of Freud and one is left wondering whether this is the result of a reappraisal of his earlier enthusiasm for psychoanalysis or, more likely, he had to adapt his work in order to be published at all.<sup>3</sup> This is more likely as even *Myshlenie i Rech'* also seems to be appealing for an end to the artificial divisions in psychology when he argues that, 'As long as we lack a generally accepted system incorporating all the available

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<sup>3</sup> Vygotsky's title is *Myshlenie i Rech'* - Thinking and Speech. In 1962 this was heavily abridged and translated as *Thought and Language*. The 1962 version is poorly translated throughout. An improved new edition was published in 1986.

psychological knowledge, any important factual discovery inevitably leads to the creation of a new theory to fit the newly observed facts' (Vygotsky, 1962: 10 & 21-2).

Although much of Vygotsky's work was suppressed until after Stalin's death he was not the subject of the same wholesale vilification as Freud, for example. Moreover, Vygotsky's students and associates such as Luria, Bekhterev and Leontiev all went on to hold high rank and status in the USSR under Stalin, Khrushchev and Brezhnev despite their open acknowledgement of their intellectual debt to Vygotsky, whose own collected works were not published in the USSR until 1982-4. Vygotsky's preoccupation with the fact that, in a supposedly socialist society, there continued to be competing scientific paradigms obviously provoked unease in the Soviet elite. It is tempting to conclude that had he not died of TB, Vygotsky probably would have been shot.

After about 1930 it became a standard feature of all psychological writings to include a selection of quotations from one or more of Marx, Engels, Lenin, Stalin and Pavlov. After his rehabilitation psychology publications began to feature quotations from Vygotsky. It seems clear that Vygotsky had 'thoroughly absorbed Marxism' (Joravsky, 1989: 259). Probably because of this, he was also opposed to the notion that one can create a Marxist psychology. Following his rehabilitation, the ritual references to Vygotsky were selective, determined by the censorship and largely concentrated on his later works, which had, themselves, adapted to the censorship (Joravsky, 254-62). Vygotsky's scepticism of the project of constructing a Marxist psychology may also be due to the fact that for him Marx was only one of a number of highly influential thinkers. He was, like many Russian intellectuals of the time, influenced by a wide range of Western European thought including Gestalt psychology and Piaget. In other words, Vygotsky's method was more eclectic than Marxist. His work, like that of any rigorous scientist, is of interest to Marxists. Some of it is exciting and original. However, the attempt to portray him as the paradigm example of a Marxist psychologist should be treated with a good deal of caution.

Since the 1960's a 'Vygotskyian' school has developed in the USA. An example is Newman and Holzman's contribution to the growth area of 'Vygotsky studies' with their book 'Lev Vygotsky: Revolutionary Scientist'. It is a book distinguished by its emphasis on Vygotsky as a Marxist. The authors argue that Vygotsky's contribution went far further than his acknowledged strengths as a critic of the early Piaget and as an innovative psychologist of child development. They attempt

to build a case for Vygotsky as a psychologist whose methodology is wholly consistent with that of Marx. The attempt fails partly because of the inconsistencies in Vygotsky's work but also because Newman and Holzman spend little time demonstrating the interrelationship between the methodology of Marx and Vygotsky. They pay little attention to the period of Soviet history with which they are concerned and their book is part of a long history of trying to formulate a Marxist psychology, a project which Vygotsky himself opposed. Newman and Holzman do not try to address the complex issues involved in what might be meant by a Marxist psychology but instead try to build a case for establishing Vygotsky as a paradigm example of a Marxist psychologist. All Newman and Holzman have done is substitute Vygotsky for Pavlov. Vygotsky's approach to psychology was undeniably materialist (as was Pavlov's) but this alone does not justify the extravagant claims made for him.

Newman and Holzman make a great deal of Vygotsky's critique of Piaget as though there were a great epistemological gulf between them. This is unsupportable as Vygotsky criticised Piaget as one of Piaget's admirers. He was writing at a time when Russian psychology was not separated from the mainstream of world psychology and his critique did not stem from a personal quest to recast psychology in the mould of Marxism. Years later, when an ageing Piaget was made acquainted with Vygotsky's criticisms, he largely accepted them as a valuable addition rather than as an external challenge (Joravsky, 1989: 361). Moreover, whatever criticisms one might have of Piaget one would still have to acknowledge his important contribution to developmental psychology and it is in precisely this spirit that Vygotsky criticised him.

Newman and Holzman portray Vygotsky as untainted by Stalinism. It is noticeable, however, that Vygotsky seems to have taken no position with regard the left opposition. However, there is some suggestion that Vygotsky 'may have consorted with non-Bolsheviks in 1917, for he published in a Jewish periodical and in one edited by Gorky which was critical of the new dictatorship and was soon shut down by it' (Joravsky, 1989: 255). In other words Vygotsky's political perspective from 1915 to 1923 is passed over in silence by all his admirers while his later works give no indication of any active opposition to Stalinism. Of course one cannot convict Vygotsky by association; after all, there is enough evidence to suggest that he was opposed to the direction taken by Soviet psychology after 1930. However, there no grounds for asserting that 'Vygotsky's thinking was [...] not simply radical in the context of the dominant psychology and meta-psychology of his times, but radical within the tradition



of Marxism as well. After all, he engaged consciousness and psychology head on, which Marx hadn't - thereby advancing Marxist methodology itself' (Newman & Holzman, 1993: 16-7).

One of the interesting facts about the attempt to popularise Vygotsky in the USA is that it was undertaken from as early as 1950 by Joseph Wortis who effectively represented the Soviet position within the Benjamin Rush Society. In his book, 'Soviet Psychiatry', Wortis writes approvingly of Vygotsky and is disparaging of psychoanalysis in the manner which was then common place in all Soviet publications on psychology (Wortis, 1950: 20, 40). This does not mean that Vygotsky, or any other Soviet research, should be rejected for not being Marxist or unscientific but it should alert one to the process which is taking place. The imposition of a particular psychological approach led to a defective form of psychology in the USSR with a great deal of research not being done because it raised too many uncomfortable questions as far as the Soviet elite was concerned. Whole areas of investigation became impossible and the development of clinical psychology was seriously retarded to the detriment of psychiatric patients in the former USSR. I have tried to show how this followed logically from a Stalinist perspective and the nature of the USSR itself.

That some Soviet psychologists adapted in various ways is understandable. The alternative was to be killed, be sent to a camp or emigrate. That Western researchers should adopt the same approach as the psychological establishment in the USSR is a measure to which Stalinism exerted a pervasive influence outside the USSR. The clearest example is the role played by the anti-psychoanalysis campaign in breaking up the Benjamin Rush Society in the USA and of colouring all later discussions around the questions of psychology among Marxists. I am not arguing that Marxists have to set about the task of synthesising psychoanalysis and Marxism, as some in the Frankfurt School did. That, too, is a particular effect of the approach of Stalinism towards psychoanalysis. In an effort to rescue some of the richness of Marx's approach some within the Frankfurt school tried to revive Marx's essentialist project by uniting it with a radical appraisal of psychoanalysis. On one level, this performed a useful service. At least some continued to discuss Marx's conception of human nature (Fromm, 1961). On another level it represented an abandonment of a central tenet of Marx's method that the working class is central to historical change.

The approach which makes a particular psychologist the example to follow is one which is derived from Stalinism and that is no less true whether one chooses

Pavlov, Freud or Vygotsky. The role of psychology 'in Marxist theory has been to compensate for the failure of neo-Stalinist political economy. The assumption is that it adds to, explains gaps in, humanises, the over-simplified theoretical concepts of economics. In seeking a psychology to fulfil this function people have latched on to the Freudian tradition. The argument must be stated briefly here that such a function does not do justice to psychology. Despite its partial nature as a science, it represents more than this. The identification of psychology as isomorphic with Freudianism indicates a complete ignorance of the subject. A closer study of its content might eventually produce an organic link with Marxist political economy' (O'Donnell, 1981: 29) One might equally add Vygotsky to O'Donnell's argument. One can assert the importance of a scientific psychology and say that certain features would make it compatible with Marxism. For example, such an approach would be materialist, essentialist and dialectical. However, the debate around whether psychoanalysis or 'Vygotskianism' is *the* form of a Marxist psychology is a sterile one that stems from Stalinism on the one hand and the continued existence of human alienation on the other.

In the early 1950s when the anti-Semitic campaign, which expressed itself in the 'Pavlov Sessions', was cut short by Stalin's death a new concordat between the elite and the intelligentsia began. The killings and arbitrary arrests ended in exchange for support from the intelligentsia to achieve the elite's ends more efficiently. Although there always remained a line which one could not cross, after the death of Stalin the intelligentsia would no longer be imprisoned for not adhering strictly to the ideas of Pavlov or be removed from one's job for being Jewish. Yet, the view that there had to be a distinctively Soviet psychology persisted. Freud was still unacceptable but in order to have any meaningful psychological research (including industrial and social psychology) psychologists had to be permitted to go beyond Pavlov.

Vygotsky fitted the bill. He was undoubtedly a materialist. If one ignored his early works and judiciously edited the rest it was possible to portray him not only as a Marxist but one who had adapted to the Party line of the 1930s and was therefore distinctively Soviet. This is unfortunate for Vygotsky who seems to have been opposed to the direction psychology took in the late 1920s but not so much so as to align him with the opposition. It is more than unfortunate, however, that some in the West took the Soviet portrayal of Vygotsky at face value. It is an error that results in precisely what Marx would have opposed, the fragmentation and negation of science.

## A DEFECTIVE PSYCHOLOGY

From 1953 onwards many restrictions on science and literature were lifted. As this is discussed more fully in Chapter Five I will confine myself here to discussing the influence this had on Soviet psychology. The main effects of 'the thaw' on psychology were that psychologists, such as Vygotsky, could be studied once again. In art and literature it became possible to escape the stifling effects of 'socialist realism.' In psychology it became possible to undertake psychological research which went beyond the neurological. The restrictions placed on psychology still led to a concentration on particular areas, such as developmental and physiological psychology, but it was possible to at least undertake such research without having to fear that suddenly there would be another change of policy and one would end up in a labour camp for writing an article. Generally, the type of psychology that was studied in the USSR was that which was likely to yield rapid results in medicine or industrial psychology. In other words, Soviet psychologists were free to undertake research into psychology which would help the elite achieve its objectives but not free to study psychology which might challenge the elite.

Articles still attacked psychoanalysis as 'idealist' and 'bourgeois' but they did at least begin to discuss such themes again. In other words previously prohibited subjects were now discussed in an Aesopian way. For example, in 1974 an article in *Voprosy Psikhologii* presented a critique of the 'Class Orientation of the Bourgeois Psychology of Abnormal Personality: Freudianism and Neo-Freudianism' (Roshchin, 1974: 36-49). In it Fromm, Marcuse, Freud and Karen Horney are subjected to a critique which is based on the assertion that their theories of personality necessarily reflect their (bourgeois) class orientation. However, in presenting his critique Roshchin also presents an otherwise reasonably accurate account of the theories of the writers he is criticising and thereby giving them a wider audience too. Sometimes approaches to previously banned writers were even more relaxed.

In *Voprosy Psikhologii*, in 1982 an article appeared which gave a historical account of the 'Individual Psychology' of Alfred Adler. Generally, it is a sympathetic exposition without the standard references to Marx, Engels or Lenin. It is noticeable that most of the article references were from Western (mostly German) sources and of course, Adler himself. The criticisms were limited to a few paragraphs and most of those

derived from the discussion of Adler's work by Western psychoanalysts (Bundlus, 1982: 133-9).

By the 1990s the poor state of Soviet psychology was becoming obvious. Articles began to appear which frankly expressed the frustration of Soviet psychologists. Scathing attacks on Soviet psychology were published which were analogous to the kind of open admission of psychiatric abuse, which also appeared in the Soviet press. One writer assessed the situation in Soviet psychology thus: '...thousands of scientists have defended dissertations, hundreds of thousands of articles and books have been published, but – and we must state this with complete candour or there is no way out for us – these have all amounted to playing in our own back yard. In almost no area have we been able to approach the level of universally recognised leaders. Either we descend to a hopeless provincialism and quote one another, isolating ourselves completely from world science – which nonetheless we criticise “on methodological grounds” – or we repeat Western studies after a long delay – for example in cognitive psychology, psycholinguistics, and now in “humanistic psychology” etc. Our development is along the lines of that merciless saying: “We were the first to do this in Asia, not counting, of course, Japan” (Radzikhovskii, 1991: 73).<sup>4</sup>

Underlying the changes in Soviet psychology was a basic fact that there were very few psychologists in the USSR. 'Even by 1991 the USSR had perhaps as few as 2,500 psychotherapists and 1,000 clinical psychologists' (Smith & Oleszczuk, 1996: 69). Under such circumstances it seems highly unlikely that 'Marxist-Leninist Psychology' can be the explanation for the specific form taken by Soviet psychiatry. Firstly, because the notion of a Marxist psychology hardly makes sense at all from a Marxist perspective and secondly, because what passed for psychology in the USSR was a long way removed from any kind of scientific psychology, Marxist or otherwise. In areas that were less controversial or did not entail crossing the line into social theory Soviet psychological research could be of a reasonably high standard. However, the reason why Soviet psychology was largely biological or experimental was not because Soviet psychologists

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<sup>4</sup> This originally appeared in 1989 in *Vestnik Akademii Nauk SSSR* under a title which consciously used Vygotsky's essay title of the same name, *Istoricheskii Smysl Psikhologicheskogo Krizisa*. Part of Radzikhovskii's article was taken up with a critique of Vygotsky for being a Marxist. However, he reserves his bitterest attack for Vygotsky's epigones, such as Leontiev, blaming them for the stultifying nature of Soviet psychology.

were influenced by materialism but because it was practically impossible to do any other type of research. In so far as Soviet psychology was materialist it owed everything to the positivist materialism of pre-Revolutionary Russia and the positivism of Western science and nothing to Marxist dialectics.

As there were very few psychologists at all and those there were played only a nominal clinical role it seems highly unlikely that Soviet psychology could have influenced clinical practice in psychiatry. That doesn't mean that Soviet psychiatrists did not read psychology but often when they did it was in spite of the system of training for psychiatrists rather than because of it.

## CHAPTER FOUR: THE DEFECTIVE NATURE OF SOVIET PSYCHIATRY

### INTRODUCTION

It is well known that the overwhelming majority of Soviet products were defective (Ticktin, 1992: 11). The object of this chapter is to illustrate how this is also the case with Soviet medicine in general and psychiatry in particular. The defective nature of, say, Soviet machine tools, was not accidental but a direct consequence of the system. The same is true of Soviet psychiatry and for similar reasons.

Under capitalism the product takes the social form of the commodity. It is produced only in so far as it can be sold in the market and it can only be sold in so far as it embodies exchange value. The commodity's use value, which it must have, is of secondary importance. It is this contradiction between use value and exchange value that characterises commodity production. Human needs are only met in so far as the commodity embodies value and a surplus accrues to the capitalist. Services that do not produce surplus value, such as education and health care, are able to exist because a part of the social surplus is appropriated by the state and spent on those areas. Therefore they constitute a drain on the social surplus notwithstanding the fact that they perform an essential role in social production. Capitalism in developed countries needs healthy and well-educated workers.

The quality of commodities is controlled by competition in the market and a rigorous discipline over the workforce. If a given commodity is defective it will not be bought in the presence of an alternative and the capitalist may be left with a mass of objects he cannot sell. The capitalist has a good deal of control over the work process due to commodity fetishism and the reserve army of labour. Commodity fetishism ensures that the social relations that exchange value expresses seem a natural part of the commodity. 'As a general rule, articles of utility become commodities, only because they are the products of labour of private individuals or groups of individuals who carry on their work independently of each other. The sum total of the labour of all these private individuals forms the aggregate labour of society. Since the producers do not come into social contact with each other until they exchange their products, the specific social character of each producer's labour does not show itself except in the act of exchange. In other words, the labour of the individual asserts itself as a part of the labour

of society, only by means of the relations, which the act of exchange establishes directly between the products, and indirectly, through them, between the producers. To the latter therefore, the relations connecting the labour of one individual with that of the rest appear, not as direct social relations between individuals at work, but as what they really are, material relations between persons and social relations between things' (Marx, 1954: 77-8).

Exchange value and commodity fetishism are the result of abstract labour whereby all social relations are mediated through the market. The consequences of this are human alienation and a system of exploitation that has the appearance of being an immutable feature of society. Under these circumstances social relations are rendered opaque. The worker is separated from his own product and work becomes a series of meaningless tasks unrelated to the social whole. Another consequence is the atomisation of human society in which the community of labour is obscured. The worker appears to enter into the labour contract of his own free will. The fact that he is separated from the land, nature and his fellow human beings except through the medium of the contract is obscured by the freedom to work for whomsoever he chooses. In an advanced capitalist society, with social welfare provision, there is even the possibility of not working for short periods, providing that one can tolerate the resultant hardship. However, even this concession causes difficulty in that it negates the controlling effect of the reserve army of labour.

## **THE DEFECTIVE SOVIET PRODUCT**

At the heart of the dependency faced by all Soviet workers was the nature of social relations in the USSR. Abstract labour did not exist in the USSR and arguably, still doesn't (Filtzer, 1994: 146). It follows that the mechanisms by which the Soviet working class was controlled were quite different and this had serious consequences for the nature of the Soviet product. Given that it was impossible to dismiss a worker without finding him another job, there was no reserve army of labour and workers had a good deal of control over the labour process. Therefore, control over the working population had to be direct and coercive. For example, the anti-parasitism laws made it an offence not to work. This meant that, except for certain categories of persons such as the disabled or pensioners, employment was semi-forced and the nature of exploitation was transparent (Ticktin, 1992: 133).

Without the market the only other mechanism for the production and distribution of resources is planning. However, for this to exist in the Marxist sense, there would have to be the direct participation of the workers themselves. In other words, it would have required the kind of democracy which would have left absolutely no place for the Soviet elite. As a result of the defeat of the October Revolution the USSR developed into a system that had neither the market nor the dictatorship of the proletariat (Ticktin, 1973: 38). The system of bureaucratic administration that developed after the New Economic Policy (NEP) was profoundly antagonistic to the interests of the working class. It served only the interests of the elite and therefore workers had neither an interest in supporting it nor of working well. Waste and inefficiency became a defining feature of Soviet production.

Managers and workers alike easily subverted the so-called plan worked out by the Soviet elite. For example, if the plan demanded a thousand tonnes of sheet steel at a gauge of 2mm and a factory found it impossible to meet this target it might produce it at a gauge of 2.1mm. As the 'plan' was expressed in tonnes, the factory might well meet its production target but the product was almost useless. However, the plant which received the steel would be obliged to make use of it or face disruption to its own production. This passed on the defect to the finished product, whether that was a consumer or producer good. If the plan were expressed in terms of profit then the steel plant might cut corners on raw materials and the result would be the same. In other words the USSR produced not commodities but defective use values. The contradiction was not between use value and exchange value but between potential and actual use value. This was as true of labour-power as it was of sheet metal, tractors or anything else (Ticktin, 1992: 11-13).

Without abstract labour and a market, prices were decided arbitrarily by the central administration. Often they were set with regard to political objectives. Hence, basic foodstuffs and housing were cheap but were distributed either by direct rationing or by indirect rationing in the shape of shortages, which led to huge queues to obtain many essential goods. Distribution had nothing to do with the market but was much more dependent on contacts or one's place in society. Even when there was direct rationing by means of ration coupons the possession of a coupon did not guarantee that one would obtain the good in question. This meant that there was little incentive to work well as extra cash in a society where there is nothing to buy has no impact. As the Soviet system was manifestly exploitative the worker had no ideological commitment to it and



it is doubtful that there was even the basis for ideology in the USSR. Exploitative relations were transparent and every statement the Soviet State made was contradicted by the workers' daily experience. The threat of force prevented any kind of association among workers or the intelligentsia and prevented anything resembling politics in developed capitalist countries. This reached a peak in the 1930s but the KGB continued to control the population throughout the Soviet period and still plays a role, albeit diminished and with a change of name. As they could not organise collectively, their resistance to the regime could only take an atomised form. The Soviet worker worked slowly, got drunk at work and took time off to find the scarce goods that he would never find if he worked diligently. In other words, the nature of the Soviet system dictated that even labour-power did not exist as a commodity but as a defective use-value (Ticktin, 1992: 11-13).

This was no less true of the labour-power of doctors and nurses. Medical workers were very low paid employees with a low status. Maintaining or improving qualifications was difficult and unrewarding. Hospitals were often buildings of low quality with rudimentary, if not dirty and dangerous, facilities. Promotion within medicine had far more to do with influence than with scientific rigor and nursing was regarded as the kind of dead-end job one took if nothing else was available. Soviet medical workers had no more incentive to work well than factory workers did with the result that Soviet medicine was backward in its techniques and less effective than its Western counterpart. Moreover, for historically specific reasons, psychiatry was particularly badly affected.

Another consequence of the Stalinist system and feature of waste within the system is overstaffing and underemployment. Administrators were neither allowed to dismiss workers without finding them another job nor able to dismiss workers without causing disruption which would affect their own bonuses. Instead, more workers were often taken on in order to compensate for poor working practices. Even new technology tended to have the affect of more workers being employed in order to minimise disruption to production rather than making it more efficient. This worked as a compensation for the deficiencies produced by the system while there was a good supply of labour that could be drawn in from the countryside. As these reserves of labour dried up the crisis in the system deepened until the situation became intolerable (Ticktin, 1992: 138-9). Again, this was as true in medicine as in industrial production. Although medical technology in the West is sometimes credited with being the cause of an

increasing burden on the British NHS in fact, the expenditure on new technology, including pharmacology, can provide savings in the long term. For example, the high cost of developing medication to treat AIDS was extremely expensive but it has recently led to considerable savings in staffing costs as specialist units are now being closed thanks to the success of new treatments (Green, 1997: 1). This is just as true in the field of psychiatric pharmacology. Medicines that are expensive to develop are regarded as being worthwhile if they lead to the closure of psychiatric wards and facilitate 'care in the community'.

## **DEPENDENCY**

Under capitalism a worker or for that matter member of the intelligentsia has a degree of independence although may be dependent in having only labour power to sell and in that sense is dependent upon the capitalist. 'While the worker is compelled to work, the compulsion is neither personal nor direct. He is forced to work because he needs the money in order to survive. He can then, in principle, choose his employer. If he saves money he can choose not to work for a while. He could actually leave the region or even the country' (Ticktin, 1992: 35) This is in contrast to a person under conditions of 'primitive communism' where human dependence is largely upon nature. It is also quite different from the dependence of the feudal serf. The serf is dependent in a direct and personal way on the lord. However, this type of dependence was mitigated by the fact that the lord could not easily supervise his serfs and the serfs had rights of land usage which gave them a degree of security even if it tied them to the land where the exploitative relationship was transparent.

If Marx is correct then a socialist society would see an end to human relations mediated through the market. Interdependence would be direct, personal and total. However, unlike 'primitive communism' humans would be free from the dependence upon nature due to the development of the productive forces begun in class society and infinitely expanded in socialist society. 'Society now permits the individual to take control over itself and himself in two ways. In the first place, the individual now has direct and indirect forms of control over the different units of the society. In the second place, his position is determined by himself alone. He can change his position in the division of labour both hierarchically and horizontally as he sees fit. His consumption, in a society where scarcity is largely or completely abolished, is his own affair. Choice, therefore, has only one interest in relation to other individuals, one of co-operation to

ensure the common individual interest. Humanity through its social forms becomes truly human' (Ticktin, 1992: 35).

In stark contrast, the individual in Soviet society was utterly dependent upon society and every aspect of life was closely regulated. The individual became dependent on the goodwill of his superiors and the help of acquaintances and work mates. A serious infraction of the rules could mean the loss of everything. As the individual did not so much as sell his labour power as alienate it under conditions of semi-forced labour his freedom even in the limited sense of commodity production was severely compromised. As there was no market and prices were arbitrarily determined at the centre money did not really exist. In many respects money was the least important thing that one needed in order to obtain a wide range of goods. For example, in Moscow in December 1991, to buy a bottle of vodka one needed to find the vodka, a ration coupon (talon), an empty vodka bottle, the time to stand in the queue and finally the money. Whilst this is a trivial example it applied to a range of goods and gives an impression of the amount of time it could take to buy anything from bread to furniture. A wide range of essential requirements was distributed directly and at a minimal cost to the consumer. Housing was so cheap as to effectively be free. However, one's place in the housing queue had far more to do with a system of privileges than any genuinely socialist notion of distribution according to need.

Corruption was rife and places in higher education or one's medical degree could be secured by well placed 'presents.' Even this was not necessarily in the form of money. Favours or goods were often more important and they also fitted in better with the established etiquette for accepting bribes. Depending on the circumstances one had to be careful not just to hand over cash. It was far better to make a 'gift' of something or arrange the provision of some scarce service. I have seen workmen paid in brandy for undertaking repairs which otherwise would have been almost impossible to arrange through official channels.

The nature of such a system of dependence, unmitigated by money, was to create a system of contacts that meant that position was far more important than income. Whereas in the West the relatively high pay of doctors and the additional option of undertaking private work gives the doctor a good deal of independence both in terms of the goods he can buy and over where he works, the Soviet doctor was utterly dependent for his position on state patronage.

## SOVIET SCIENCE

Science in general suffered as a result of the Soviet system and this had an effect on medicine. For example, the whole science of genetics, which yields some of the most valuable insights into a wide range of diseases, was effectively forbidden in the years dominated by Lysenko (Joravsky, 1970, Medvedev, 1979). It is noticeable that Stalinism affected some fields of scientific endeavour more than others. Genetics, for example, suffered badly compared to applied physics. Sciences that raised awkward questions about the nature of the USSR such as philosophy, sociology and psychology suffered most of all. For example, sociology was either not studied at all or it resembled American functionalism of the 1950s. The disciplines that suffered the least were those where there was little scope for an ideological interpretation. For example, those related to the military-industrial complex had to rely on a methodology that actually delivered results. Although physics textbooks may have had ritual references to Engel's book, 'Dialectics of Nature', in fact the methodology employed was the same as any Western physics textbook.

The difficulties associated with any ideological component meant that if Soviet psychologists wanted to carry out scientifically rigorous work and retain their personal integrity they often had to work in the field of neuro-psychology. The result was that while this aspect of psychology was reasonably advanced in the USSR other areas which overlapped with philosophy were effectively stunted or could only be discussed in an Aesopian manner.

There was no differentiation between Soviet science and that of the rest of the world until 1929. After 1929 most links with other countries began to suffer. Foreign academic trips became restricted and the development of new technology was stunted. This affected some areas more than others. For example, at the outbreak of World War Two the Soviet aircraft industry was producing 1936 aircraft. The aircraft designer, Tupolev, had to undertake his work under conditions of virtual slave labour (Medvedev, 1979: 32-33).

Certainly by 1929 the denunciation of 'wreckers' affected the intelligentsia directly and the campaign against them was expressed by Stalin in the following terms: 'The sabotage of the bourgeois intelligentsia is one of the most dangerous forms of opposition to developing socialism. Such sabotage is all the more dangerous in so far as it is linked to international capital. Bourgeois sabotage undoubtedly shows that capitalist

elements have far from put away their weapons, that they are gathering strength for another assault against Soviet power' (Stalin, 1949: 14). Until 1929 the USSR Academy of Sciences did not have a single member who was also a member of the Communist Party. From 1929 a series of appointments were made to the various branches of the academy of science not on the basis of any particular expertise but increasingly on the basis of loyalty to the regime.

The differentiation of Soviet science intensified after the Second World War when each area of research had to prove its 'socialist' specificity, a distinction that would separate it from bourgeois 'idealist' science. Each field of natural science had to be based on the principles of 'dialectical materialism' and to use as its fundamental background the ideas of Marx, Lenin and Stalin (Medvedev, 1979: 45). However, the use of selected quotes, usually from Lenin, masked quite a different approach. Often the quote simply served the purpose of getting the paper accepted for a conference or publication. The scientific methodology usually had far more in common with the atomistic materialism of Western science. Indeed, for work to be accepted as based on dialectical materialist principals it could not contain anything that might have been construed as an essentialist approach. The best example of this was in the field of psychology where for a while a materialist approach was synonymous with an account of neurological processes.

The importance of loyalty to the regime led to the promotion of 'vydvizhentsi'; those who had been 'pushed up' from the working class and the peasantry, over scientists who had trained under the tsarist regime. This led to some extraordinary situations. 'The old Bolshevik revolutionary Mrs. O. Lepeshinskaya, who had been known as a "good cook" in a small émigré Bolshevik community in Switzerland between 1910 and 1917, but possessed little knowledge of biology and was already eighty years old, announced the creation of a new field of biology which "closed" cellular biology and declared non cellular "living substance" to be the main structural element of all living systems. She received official recognition, was elected an academician, won the Stalin Prize along with many other awards, and received much publicity' (Medvedev, 1979: 54).

The rise to prominence of pseudo-scientists like Lysenko was possible because of a macabre social mobility by which a person could obtain a position in the intelligentsia by denouncing those above him. This was no less true in the field of psychology and psychiatry. It also meant that organised dissent among scientists was

impossible until after the death of Stalin when an alliance between the elite and the intelligentsia was established.

Not all Soviet scientists were charlatans but the nature of the Soviet system led to extraordinary results even regarding high quality scientists. Under Stalin, Pavlov's theory of conditioned reflexes was made to explain far more than the theory warranted. As a result it 'became obligatory for the explanation of all physiological processes.' This helped to retard, among other things, 'much of the research on endocrinological, metabolic and other regulatory processes.' In turn this 'delayed the development of pharmacology, antibiotics, modern diagnostic methods, and the therapeutic use of endocrinological preparations' (Medvedev, 1979: 55-7). Many branches of science and technology continued to develop slowly and in some very important fields the movement was mostly backward. Rather than progressing, these research areas had been thrown back almost to the end of the nineteenth century. The effect on Soviet psychiatry was that many treatments were simply archaic.

During World War Two, American industrial and technological superiority was demonstrated by the first atom bomb. There were a number of attempts to catch up with Western technological superiority by simply copying it. However, this had the opposite effect. By the time an invention was copied it was already obsolete and the endeavour prevented home-grown innovation (Medvedev, 1979: 60-7). After the period when attempts to copy foreign products had proved a failure there was a switch to production under licence in USSR, including pharmaceuticals. While this proved more successful, the goods produced were still inferior to their imported equivalent. 'This kind of quality difference could be found in the Soviet version of "pure" enzymes, proteins, special chemicals widely used in medical diagnoses such as phytoemoglutenin, and others' (Medvedev, 1979: 114-5). Medvedev explains this inferiority in terms of the absence of competition and scientific isolation but whilst this undoubtedly played a part it takes no account of the affect of Stalinism had on the work process as a whole. As in medicine, the impetus behind many apparent innovations was political rather than the meeting of practical needs. For example, the Soviet space programme was shaped by political rather than scientific considerations.

By the end of 1964 and 1965 attempts were being made to restore genuine genetic and other research. The compromise with the intelligentsia, which was initiated under Khrushchev, eventually faltered by about 1968 and this led to an increase in political dissent. Following attempts to suppress the growing movement, which included

the abuse of psychiatry, 'Top scientists looked for political connections with prominent writers, artists, film directors, actors, and other intellectuals, and this union reacted strongly against attempts of conservative groups to rehabilitate Stalin and reintroduce their ideological dominance' (Medvedev, 1979: 106-7).

Another factor that led to a defective Soviet science was the fact that it took far longer to publish work in the USSR than in the West. This was partly a feature of censorship in the USSR but was also due to the fact that the journals themselves suffered from all the production problems that plagued the rest of the Soviet economy. The delays were compounded by the ban on the publication of preliminary results of research because of the fear that Western scientists would complete the work.

**Table 1: Average Time Elapsed Between Receiving Papers and Their Publication in Comparable Soviet and Foreign Journals in July-September, 1976.**

USSR	Europe and USA
Biokhimiya, 10-11 months	European Journal of Biochemistry, 4-5 months
Molekularnaya Biologiya, 14-16 months	Molecular Biology, 6-7 months
Genetika, 11-12 months	Genetics, 6-7
Zhurnal Evolutsionnoi Biokhimii i Fiziologii, 18-20 months	Journal of Comparative Biochemistry and Physiology, 5-6 months
Ontogenesis, 12-14 months	Journal of Developmental Biology, 5-6 months

(Medvedev, 1979: 154).

'In the social sciences - economics, history, philosophy, and others - the situation was much worse because the political divisions such as "Soviet", "Marxist", and "bourgeois" were still valid here. This made most of the foreign social and political literature as well as history, modern art, and even modern music unavailable for the majority of Soviet scholars and for the Soviet public at large. The foreign mass media, which are an important source of information for social scientists, were also unavailable. Some works and papers could be found in the special collections of large libraries and could be read by a few trusted professionals if special permission was granted for them, but most works were unknown or unavailable even in special collections' (Medvedev, 1979: 120). This was certainly true of the academic library in the Kashchenko

psychiatric hospital in Moscow. The reserve collection was in a corner of the mezzanine floor over the issue desk but by the time I undertook research there in the summer of 1994 the restrictions had been lifted. I was invited to see the collection by one of the librarians. The collection consisted mostly of foreign books and journals. It was hard to see why many of them were there as they were indistinguishable from the large selection of foreign books and journals on open display in rest of the library.

At least some members of the intelligentsia could always read books that were not available to the working class. At the Kashchenko psychiatric hospital I was given completely open access to the hospital library, which has a formidable collection, including publications from the pre-Revolutionary and early Soviet periods. I was shown the special collection and told by the librarian that in the past only certain people within the hospital were allowed to use it. These were on a special list and mostly comprised senior clinical and academic staff. Under ordinary circumstances this excluded junior doctors. It may be that books that were previously unavailable had been put on display since *perestroika*. It was certainly the case that books that I would have expected to be in the special collection were openly on display. These included the works of Freud in Russian, dating from the early 1920's. When I expressed surprise that these had survived I was told that they had been available for some years. The librarian could not remember a time when they were restricted. Unfortunately, there was no one at the library that could say when, if ever, the works of Freud had been in the special collection. They also had a collection of recently published American psychoanalytic journals. It is tempting to conclude that when a writer, such as Freud, was suppressed their works were maintained for that section of the intelligentsia who were trusted enough to have access to them, or librarians found some way to preserve their works until they were rehabilitated. As a post-script to this anecdote, in the library of the Serbsky Institute in 1992, I was amused to find Stalin's Collected Works hidden under some, rarely used, bookshelves.

'In the Soviet Union, the top scientists had often enjoyed practically unlimited freedom and had been in fact members of the ruling group without formal membership in the Politburo or in the government. Igor Kurchatov, in nuclear industry, and Trofim Lysenko, in agriculture, during the post-war decade had much more power than ministers did in these fields. Both Kurchatov and Lysenko were able to force some ministers to resign if they found them inefficient in the management of the "state-important" scientific programs' (Medvedev, 1979: 131). The director of the Serbsky



Institute was also closely integrated with the elite and this partly explains why the Serbsky, in particular, played the role it did in persecuting dissidents after the death of Stalin.

## SOVIET HEALTH AND WELFARE

The defective nature of the Soviet product expressed itself in the health of people, medicine and psychiatry. The USSR, like many other countries, used indicators relating to the population's health as a sign of economic well being, growth or strength of the USSR as a whole. Important indicators such as the infant mortality or average life expectancy rates were used in a comparative analysis to assert political claims for the superiority of the Soviet system. One such indicator was the number of doctors per head of population. For many years the USSR headed this particular league table.

**Table 2: Supply of Doctors in Selected Countries.**

	Year	Number (in Thousands)	Doctors per 10,000 Population
USSR	1986	1,202	42.8
Bulgaria	1985	31.4	35.1
Hungary	1986	34.9	32.9
GDR	1986	51.0	30.6
Cuba	1985	28.2	27.8
People's Republic of Mongolia	1986	4.8	24.7
Poland	1985	90.6	24.3
Rumania	1986	48.1	21.0
Czechoslovakia	1986	56.8	36.5
Yugoslavia	1984	46.7	20.3
Great Britain	1977	102	18.3
Italy	1979	165	28.9
USA	1983	604	25.7

Federal German Republic	1985	178	30.1
France	1984	125	22.9

(Ryan, 1989: 3-4).

Moreover there was a general tendency to increase the proportion of doctors per head of the population throughout the Soviet period.

**Table 3: Supply of Doctors in the USSR, 1950-86.**

At the End of Year	Number (in thousands)	Doctors per 10,000 Population
1950	265.0	14.6
1955 (a)	333.7	17.2
1960	431.7	20.0
1965	554.2	23.9
1970	668.4	27.4
1975	834.1	32.7
1980	997.1	37.5
1985	1,170.4	42.0
1986	1,201.7	42.7

(Ryan, 1989: 4, Note (a) this is Ryan's calculation).

Underlying the apparently inexorable increase in the number of doctors was the propaganda value of being able to claim such a ratio. Whilst this has been used as evidence of a progressive movement in Soviet health care it disguises an unenviable situation in Soviet medicine. Like the hypothetical example of sheet steel there is a reliance on crude quantitative indicators, which masks the qualitative reality. In fact, most Soviet doctors were badly trained and worked in a health service which was inferior compared with most developed countries.

Western academic commentators have tried to explain the shortcomings of the Soviet health service in a number of ways, the most important of which is the absence of the liberal professions on the Western model and the interference in matters of science

by an ideologically driven system. Another approach is that the form taken by the Soviet health service reflects the priorities of a planned system (Ryan, 1989: 5). In common with many Sovietologists, Ryan offers an explanation for the state of Soviet medicine based upon either the absence of 'civil society' or an assumed impossibility of the whole socialist project. For example, he says; 'In a situation of geopolitical isolation, the new regime [of the Bolsheviks] effectively imposed on medical personnel generally and on doctors in particular various defining characteristics which were to differentiate them sharply from their counterparts in the West. [...] First, on an ideological plane, they were charged with the responsibility for helping to create the new socialist society. Secondly, [...] they were effectively deprived of the opportunity to act as members of an influential self-regulating occupational group. It can be argued that the role accorded to them entailed the devaluation - if not the virtual abandonment - of the notion that doctors should be trained to think for themselves, using a rigorous scientific approach and drawing on detailed knowledge of the relevant basic disciplines. In so far as the state insisted on emphasising 'training' at the expense of 'education' the new generation of medical graduates can be plausibly categorised as primarily technicians who had been taught the practical skills thought necessary for the performance of what was perceived as a practical job' (Ryan, 1989: 8).

Ryan argues that the defective nature of Soviet medicine is due to the fact that doctors in the USSR were state employees, rather than the independent practitioners as they are in the West. Even where the state is the largest purchaser of medical services, as in Britain, doctors retain their independence. They formally retain control over entry qualifications, standards of entry into the profession and the basis on which they sell their labour-power to the state. For Ryan this guarantees not only the quality of medical education but also the overall quality of the medical service. It is certainly true that Soviet doctors were far less independent than their Western counterparts. Ryan's book concentrates on medical practitioners and does not take into account the dependence faced by all Soviet workers. Moreover, he sees the lack of professional independence as the main causal feature of a defective Soviet medical system. Whilst Ryan is correct to point out the dependent state of Soviet doctors as an extremely important factor, it could be argued that he has failed to see the broader picture of dependence in the USSR. In other words he sees it as a problem stemming from the lack of liberal professions and not as a direct consequence of the Soviet system. He also fails to take account of the critique of the liberal professions.

Professional codes of conduct and self-regulation have as much to do with defending the interests of the professionals themselves as they do with protecting the interests of 'the public'. The professions are organised as a kind of craft union with a legally sanctioned monopoly over their services: a monopoly they use in their own interests. Arguably, there is nothing inherently in the public interest in having an artificial shortage of doctors or nurses, which is effectively what professionalisation has accomplished (Johnson, 1972).

Ryan's argument implies that only a capitalist system does not interfere in matters of professional autonomy or the application of science and that only such a system can lead to a health service which best reflects the interests of the population. Although Ryan's extremely informative book is correct in its empirical assessment of the problem, the organisation of Western health services is taken for granted as the best and the case against the Soviet system is 'proven' tautologically. He traces the reason for the nature of Soviet medicine back to the early Bolshevik period but later acknowledges that the structure of the present system was laid out in 1934 (Ryan, 1989: 73-4). He sees no contradiction in such an argument as it is taken for granted that there is continuity between the October revolution and the subsequent development of the USSR. In other words, the socialism of Marx and Lenin inevitably leads to interference in matters of science and the only guarantors of a high quality medical service are a free market and a medical profession which is left to regulate itself.

The history of Soviet psychiatry and psychology illustrates the fact that there is no such continuity between the October revolution and Stalinism. The defective forms taken by Soviet science, medicine and psychiatry are the historically specific product of Stalinism. The lack of independence of the Soviet medical profession is important but it cannot explain all that Ryan would wish.

## **STATISTICAL INDICATORS**

The Soviet use of statistics has been highly questionable, as has the accuracy of their compilation. Those that could be construed as showing a favourable impression of the USSR were emphasised and then dropped as soon as the trend reversed (Knaus, 1981: 167, 213). It is certainly the case that a number of statistical indices offer a damning indictment of the Soviet economy and Soviet medicine. One example of this is life expectancy, which following initial improvements, is now deteriorating. This is in contrast to developed capitalist countries. As Table Four indicates, although life

expectancy improved throughout the Soviet period until its high point in 1986, it was consistently poorer than Britain, for example.

**Table 4: Average Life Expectancy at Birth (in years), 1938-39 to 1986.**

Year	Total population	Men	Women
1938-39	46.9	44.0	49.7
1955-56	67.0	63.0	69.0
1958-59	68.6	64.4	71.7
1971-72	69.5	64.5	73.6
1978-79	67.9	62.5	72.6
1983-84	67.9	62.6	72.8
1984	67.7	62.4	72.6
1985	68.4	63.3	72.9
1986	69.6	65.0	73.6

(Ryan, 1989: 133).

Since 1986 the situation has deteriorated. By 1989 the average life expectancy for men had dropped to 64.6 years but continued to rise slightly for women to 74. The gap between men and women has grown wider and is one of the widest of any developed country. By 1992 researchers at the Institute for Socio-Economic Studies of the Population, in Moscow, reported that the death rate had increased by 20 per cent from 1993 to 1994. They also suggested that average life expectancy for men had dropped to 59. Infant mortality rose from 17.4 per 1,000 in 1990 to 19.1 in 1991. 'The average age for death (for men and women) was now...at 66 or lower - the same level as in the early to mid 1960s. In 1993, 1.4m people were born and 2.2m died - although inward migration of Russians from former Soviet republics compensated to some extent, bringing the net fall in population to 500,000 last year'. The worsened death rate for men was attributed 'largely to two causes - a higher rate of coronary disease and strokes, and more violent deaths. Of the total of 360,000 extra deaths in 1993, nearly 50 per cent were from heart and circulatory failure and more than 25 per cent were from violent causes.' Poverty and the state of the post-Soviet health service were described as 'minor causes' of the phenomenon. More significant was what was described as the 'psycho-

social crisis' with greatly rising insecurity. The decline of births was ascribed partly due to shortage of women - but more because women of child-baring age postpone having children or decide not to give birth 'because of the poor situation in the society' (Financial Times, 14/2/92: 1). The infant mortality rate was so poor at one point that it was even suppressed.

**Table 5: Number of Children per 1000 Live Births Dying Before the Age of One Year, 1970-86.**

Year	USSR	Urban Areas	Rural Areas
1970	24.7	23.4	26.2
1980	27.3	32.5	32.5
1981	26.9	22.8	32.7
1982	25.7	22.2	30.7
1983	25.3	21.7	30.6
1984	25.9	21.9	31.8
1985	26.0	21.7	32.0
1986	25.4	21.1	31.4

(Ryan, 1989: 136).

Infant mortality in the USSR compared unfavourably with most other developed capitalist countries and not very well with other eastern bloc countries as the following table shows.

**Table 6: Number of Children per 1,000 Live Births Dying Before of Age One. International Comparisons.**

Country	Year	Deaths of Children Before One Year
Australia	1989	9
Austria	1989	8
Belgium	1987	10
Bulgaria	1989	14
Great Britain	1989	9
Hungary	1989	16
German Democratic Republic	1989	8
Denmark	1989	8

Italy	1988	10
Canada	1988	7
Cuba	1989	11
Netherlands	1989	8
Norway	1989	8
Poland	1989	15
Rumania	1989	27
USSR	1989	22.7
USA	1988	10
Federal Republic of Germany	1989	8
Finland	1989	6
France	1988	8
Switzerland	1989	7
Sweden	1989	6
Czechoslovakia	1989	11
Yugoslavia	1988	25
Japan	1989	5

(Goskomstat SSSR, 1990: 13).

The infant mortality rate also varied between different Soviet republics. Generally it was worse in the central Asian and best of all in the Baltic republics (Goskomstat SSSR, 1990: 10). A number of writers argue that the Soviet health service suffered because the training of doctors was of a very poor quality. In addition, every area of the Soviet health service is similarly defective. This includes buildings, drugs and a level of funding which was declining. The emphasis has supposedly shifted from crude quantitative indicators to an entirely necessary preoccupation with the clinical competence of existing practitioners and of new recruits to their ranks. Relatively little was spent on health care in the USSR and other Comecon countries compared with the developed capitalist countries (Knaus, 1981: 328-9 and Ryan, 1989: 55-6).

**Table 7: Expenditure on Health Care as a Percentage of Gross National Product.**

	1980	1988
Great Britain	5.6	5.9
Hungary	...	3.1

Italy	5.9	6.2
Poland	...	3.8
USA	9.1	10.4
France	8.4	8.7
West Germany	7.8	8.1
Japan	6.3	6.5
USSR	3.1	3.3

(Goskomstat SSSR 1989: 52)

Other features of Soviet medicine were also used as indicators of a 'progressive' system, such as the number of hospital beds per thousand of the population. Whereas psychiatric beds per 1000 of the population have declined in Britain and the U.S. since the 1950s, they continued to increase in the USSR until 1988. This is against the background of the USSR starting from a lower level of inpatient provision and a lower proportion of psychiatric beds to general hospital beds (Calloway, 1992: 63). This is an assertion supported by Ryan who, unlike Calloway, does not assume that this can be equated with an overall improvement. 'Paradoxically, at first glance, the failings of various agencies in this connection have not led to sluggish growth in what is represented as a key indicator of health care development: the hospital bed-to-patient quotient. From the statistical yearbooks it can be seen that the direction of the trend-line is continuously upwards, and that between 1950 and 1986 the quotient more than doubled, rising sharply from 55.7 to 130.1 per 10,000 persons (The current level of provision falls some way short of the optimum of 136.8 per 10,000, which has been envisaged for 1990 by the USSR Health Ministry)'. The increases, like those for the supply of doctors, have been regularly publicised with the evident purpose of creating a favourable impression. The statistical yearbook for 1986 contains an international league table, which shows that the Soviet Union now far outstrips all other countries in the list. To mention just two, Great Britain is recorded as having 76.3 hospital beds per 10,000 persons in 1984, and the USA as having 55.5 per 10,000 in the previous year (Ryan, 1989: 63).

The explanation for this is that in this sector, as throughout the economy, the authorities at lower levels have consistently striven to find easy ways of meeting



quantitative targets imposed on them from above. The normal concomitant was disregard for qualitative aspects, which were irrelevant to meeting the 'planned' quota. For example, among Soviet hospitals 'almost a third of hospital beds have been installed in adapted buildings in defiance of sanitary and hygiene standards' (Ryan, 1989: 63). The elite have very poor information 'and the enterprise salaried personnel being only interested in maximising their own personal welfare will fulfil the formal instruction even if the result is only an absurdity. Faced with a situation where it is to their benefit to maximise an indicator, whether it is called profit or anything else they will wrongly inform the centre as to their potential and produce a product mix most suitable to themselves' (Ticktin, 1973: 32).

### **DEFECTIVE SOMATIC MEDICINE**

The Soviet elite was well aware of the poor state of the health service and the need for change. Criticisms of Soviet medicine were frequent in a wide range of official pronouncements and in the press. A joint resolution of the CPSU Central committee and the USSR Council of ministers of August 1982 as stated that 'The USSR Ministry of Health and local Party and Soviet agencies have not eliminated serious shortcomings in their work with medical cadres. There are cases where medical personnel fail to carry out duties required of them, a matter which gives rise to justifiable complaints from the population' (Ryan, 1989: 15).

Wide discrepancies existed between prestigious surgical units and other neglected hospitals and of course between hospitals and units intended for privileged sections of society, the Nomenklatura, the intelligentsia and foreigners. My experience of Infectious Diseases Hospital Number One, in Moscow's Sokol district, suggests that even the quality of medical care in relatively privileged hospitals compared badly with hospital care in Britain. Whilst the care I received was better than that described by Knaus (1981), it was still extremely poor. For example, during my ten-day stay, there was no bath or shower in operation and only one sink between four patients. No screen was available in order to wash in private.

The food was extremely poor and invariably cold. A typical example of my daily diet was as follows; breakfast consisted of a side-plate of porridge with tvorog<sup>1</sup> and black bread. Lunch was usually a small bowl (about 200ml) of cabbage soup, followed

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<sup>1</sup> A type of cream cheese.

by half a chicken leg, a tablespoon of rice and fruit compote. As with all meals, this was accompanied with the only thing in relatively abundant supply: black bread without butter. The evening meal was the same as lunch (usually identical) but without the fruit juice. At about 8pm there was sometimes a glass of drinking yoghurt, kefir. The food at Psychiatric Hospital Number One in Magnitogorsk was of a similar quality. There was an implicit assumption that relatives supplemented the diet of the sick person and this is also true of psychiatric hospitals. In the reception hall of the Serbsky Institute in Moscow there are detailed instructions regarding the days relatives may bring food and other essential items for the patients. The food in the staff canteen at the Serbsky Institute was not much better than on the wards. It was also invariably cold but as abundant as one could afford.

Visitors were not allowed on the ward where I was a patient and this was ostensibly on the grounds of avoiding cross infection. However, we were allowed to meet on the stairs, where there was little or no heating, which seemed to make the prohibition of visitors rather pointless. On admission all one's clothes were removed and replaced with a thin cotton shirt, dark blue pyjama bottoms and woolly jacket. This is the same hospital 'uniform' common to all state hospitals whether psychiatric or general. When I was in hospital the temperature was minus 20 degrees centigrade outside and the ineffectiveness of the heating necessitated sleeping in clothes brought in to replace the ones taken away on admission. Once confiscated, clothes were not returned until discharge. Blood tests were done on Monday mornings and the results given to the patients promptly. Fortunately, all the syringes and needles were disposable. However, this may have been peculiar to our ward as it was for the treatment of viral hepatitis where the danger of cross infection by improperly sterilised needles and syringes has long been understood.

The winter of 1991-92 saw a good deal of publicity regarding the supply of humanitarian aid supplied to the former Soviet Union. This clearly included food and medical supplies. The food was sold for fairly high prices in the shops and syringes and needles were widely available for general purchase at street corner kiosks for some time.

Average hospital stays are longer in the USSR than in the West and there is a tendency to keep people in a standard length of time irrespective of progress of the disorder. For example, I was told that I would have to stay in for four weeks for a condition which, in Britain, would only rarely be treated on an inpatient basis. I discharged myself after ten days.

## DEFECTIVE TECHNIQUES, MEDICINES AND TECHNOLOGY

There was a perennial problem of obtaining appropriate medication in the USSR. In psychiatry drugs were the main forms of treatment and often in combination with other drugs. The length of average hospital stays in psychiatry also tended to be longer and accompanied by what would be regarded as highly irregular treatments in the West such as sleep deprivation as a means of treating depression. Other peculiar treatments included 'reducing diet therapy' and purgatives followed by the prescription of special diets (Calloway, 1992: 89). Given the state of Soviet hospital nutrition, the notion that someone should be given a reducing diet as a treatment for mental disorder seems extraordinary. However, the claim that special diets are prescribed is quite believable. It was certainly my experience that special and quite incomprehensible dietary restrictions are placed on Soviet hospital patients. For example as part of my treatment for viral hepatitis I was told not to eat carrots. Needless to say, there was no explanation why carrots constituted such a hazard and no such dietary restrictions exist in Britain.

All levels of technology tended to be of a rather basic level. The same tendency of Soviet goods to wear out quicker and perform at a lower standard was common to medicine. For example, the Soviet Health Minister, Evgeny Chazov, pointed out that Soviet scalpels were of poor quality and 'after two operations the surgeon has to sharpen it again himself' (Ryan, 1989: 68).

One glaring example of the extent to which Soviet psychiatry is hopelessly outdated is the extent to which treatments, which were long abandoned in the West, are still being used. One of the best examples of this is insulin coma therapy that was developed in the 1920s as a treatment for schizophrenia. In Britain, 'This form of treatment, which has fallen almost completely into disuse, was once considered by many psychiatrists to be the treatment of choice for the patient with a well-established schizophrenic reaction. The aim was to induce, by the intra-muscular injection of insulin, a coma of approximately one hour's duration each day, up to a total of 30 hours. It was a formidable procedure, with very real risks and potential complications, and most people now believe that there is nothing which can be achieved by insulin which cannot be achieved more easily and safely by electro-therapy and particularly by the tranquillising drugs' (Maddison, et al, 1975: 231).

One only has to compare this with a study in the *Korsakov Journal of Neuropathology and Psychiatry* on 'The Importance of Pyrogenic Therapy in the up-to-date Treatment of Schizophrenic Patients'. The article states: 'The author analyses experience gained with the use of the pyrogenic drugs Sulfazin and Pyrogenal in the treatment of schizophrenic patients. Pyrogenal and Sulfazin were administered to 26 patients with different forms of schizophrenia to overcome psychopharmatherapeutic resistance and to 11 patients to enhance sensitivity during insulin coma therapy. Based on the clinical analysis the author demonstrates the efficacy of the use of the pyrogenic drugs, particularly Pyrogenal, in schizophrenic patients in order to overcome resistance to pharmacotherapy and insulin' (Malin, 1992: 85). The article's opening paragraph acknowledges the controversial nature of the treatments involved. Malin writes, '...in recent years reports in the foreign press have cast the psychiatric use of pyrogenic treatments, and especially Sulphazine, in a critical light. They have been negatively described as 'inhumane acts' or as having a 'punitive aim' for use in behavioural correction' (Malin, 1992: 81).

Pyrogenic therapy does have a place in medical history. Syphilis was once treated in this way, initially by infecting the patient with malaria and later using pyrogenic drugs of which, Malin claims, Sulfazine was one of the earliest. The extremely high temperatures induced by malaria were thought to kill *Treponema Pallidum*, the fragile causal organism of syphilis. There were obvious drawbacks to infecting patients with malaria and compounds of arsenic and bismuth eventually superseded this treatment. In Britain, before World War One, pyrogenic therapy was extended to the treatment of schizophrenia.<sup>2</sup> The suffix, -zine, could lead one to believe that Sulphazine is a tranquilliser of the phenothiazine group. However the Russian pharmacopoeia describes it as a sulphonamide antibiotic (Krylov, 1993: 799).<sup>3</sup> It is not clear why a sulphonamide would produce a high temperature or any anti-psychotic effect. I have been unable to find a suitable explanation for this and I am unaware of an independent chemical analysis of Sulphazine carried out in a

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<sup>2</sup> I am indebted to Dr. F. McKee of the Glasgow University Wellcome Unit for the History of Medicine for this point. Evidence for this was exhibited in Dr. McKee's exhibition, *Out of Mind, Out of Sight*, at the Kelvin Hall Museum, Glasgow, 1995.

<sup>3</sup> *Registr Lekarstvennykh Sredstv Rossii*. The full chemical name of this drug is 4-Amino-N-2-Pirimidinilbenzolsulphonamide.

reputable laboratory. The literature around the use of Sulfazine is puzzling. The Russian pharmacopoeia mentions no role for it in inducing high temperatures nor does it record such a sign as a side effect. Its entry lists its uses as the treatment of, 'Pneumonia, cerebral meningitis, staphylococcal and streptococcal sepsis and other infective disorders.' Its side effects are listed as: 'Occasionally provokes nausea and vomiting and complications of the cardio-vascular system' (Krylov, 1993: 799). None of the people I spoke to in Russia could reconcile the frequent citations in the literature on Soviet psychiatric abuse or pyrogenic therapy and the entry in the Russian pharmacopoeia.

Calloway states that officially pyrogenic therapy has been banned (1992: 92). However, this seems to be contradicted by Malin's article, unless this is another case where in the absence of law, the system of bureaucratic regulations leads to contradictions where on the one hand a practice is prohibited and on the other hand the doctor is effectively free to do as he wishes. Another way of seeing Malin's article is as one of the last assertions of a distinctively Soviet approach to psychiatric treatment. By defending pyrogenic and insulin coma therapy Malin is defending, in an Aesopian way, the position occupied by the section of the Soviet psychiatric elite who coalesced around the Serbsky Institute and the Korsakov Journal.

Having acknowledged that 'the mechanism of therapeutic action of pyrogenic therapy has up until now not fully been researched' Malin goes on to outline some of the uses of pyrogenic treatment today: 'spastic paralysis as it develops from disseminated sclerosis and poliomyelitis, early forms of neuro-syphilis, persistent gonorrhoea<sup>4</sup>, arthritis with a mild [slaboi] inflammatory process, skin disorders...tuberculosis and bronchial asthma.' And in psychiatry, 'There is evidence of the effectiveness of applying pyrogenic preparations in the treatment of slow-flowing schizophrenia, particularly with a florid presentation [so stoikami navyazchivostyami]' (Malin, 1992: 82).

Whilst electro-convulsive therapy is used in the USSR it is not as widely used as in the West. In 1985 around 100,000 people received ECT in the USA. The Soviet Ministry of Health banned psychosurgery in 1954, when it was at its height in the West.

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<sup>4</sup> Literally slow-flow gonorrhoea (vyalotekushaya gonoria). The disturbing image that such a description creates is perhaps dispelled when one realises that such a diagnosis is the result of a distinctively Soviet classification of diseases, which is discussed more fully in the section on Soviet Nosology.

Another example of a treatment that seems to have survived in the USSR despite the fact that it had been discarded as being of little therapeutic use in the West is the use of 'wet wraps'. In some of the literature on Soviet psychiatric abuse this was cited as a form of treatment which had an entirely punitive use (Podrabinek, 1980: 94-5). It is alleged that wet bed linen would be wrapped around the patient that causes pain as it dries and contracts. However, it is also not clear why wet bed linen should contract as it dries. Whilst such a treatment may have been used for punitive reasons the fact that it was used at all probably has more to do with the fact that in the USSR archaic forms of treatment, such as mustard plasters and cupping, continued to exist for a long time after they had been discarded as ineffective elsewhere (Knaus, 1981: 30).

Another explanation is that whereas in the West, physical restraint has declined as a result of smaller wards with better staffing ratios, in the USSR where staffing ratios are poorer the use of wet wraps is one way in which potentially violent and disruptive patients are controlled (Calloway, 1992: 106). Calloway also points out that straitjackets were used in the USSR until recently and that wet wraps were also used in the USA in 1988. However, it could be argued that this explains nothing. The fact that some patients have to be restrained sometimes to prevent them harming themselves or others is widely accepted. That does not explain what the therapeutic effect of wet blankets is supposed to be. The fact that psychiatrists have recently experimented with an archaic treatment in the USA contributes nothing to an understanding of this question even if it is interesting in its own right.

Hydrotherapy has a long history in the treatment of psychiatric and somatic disorders. At one time there were a number of hydrotherapeutic hotels in Scotland offering 'cures' for a variety of ailments.<sup>5</sup> As has been previously mentioned Tuke's Retreat, in York, at the end of the eighteenth century, specialised in the treatment of mental disorders with warm and cold baths. In the USSR there has also been a long history of treating a very wide range of disorders with water, and trips to spas were a feature of standard Soviet medicine, even if access to the best spas was dependent upon one's position in society (Pertsov, 1953: 28-9).

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<sup>5</sup> I am indebted to Dr. James Bradley of the Glasgow University Wellcome Unit for the History of Medicine for pointing this out. He is currently writing up the results of post-doctoral research on this subject.

## SOVIET NOSOLOGY

Much of the criticism of Soviet psychiatry has focused on the peculiar diagnoses used. The argument is that many were so vague as to be open to the widest possible interpretation. Diagnostic categories such as 'slow flow schizophrenia' led to a problem of 'hyper-diagnosis' where a much higher proportion of patients were diagnosed as schizophrenic than in Britain or the USA. Calloway explains this by arguing that Soviet diagnostic categories take a 'longitudinal approach'. That is, in arriving at a diagnosis account is taken of the likely progression and final prognosis of the disease. Therefore, 'slow-flowing' schizophrenia is a descriptive term. Calloway contrasts this with the cross-sectional approach of Western medicine that arrives at a diagnosis on the basis of the signs and symptoms at a given time. What Calloway does not explain adequately is why the USSR should have a classification of diseases so very different to the rest of the world.

In so far as he does try to explain this it is entirely with reference to ideological factors. For example he argues that the early years of Soviet psychiatry 'saw the development of a parallel view of the mind which emphasised social processes and was partly based on Marxist philosophy but also incorporated some psychoanalytic concepts. This was associated with the psychology of Vygotsky, Luria and later Rubenstein' (Calloway, 1992: 2). One could question Calloway's understanding of psychoanalysis when he says that, '...most psychoanalytic writing has been dualist in orientation and has been concerned with things happening in the mind'. The Soviet psychological establishment tended to caricature Freudian psychoanalysis as 'idealist'. The accusation of idealism or dualism is hard to reconcile with Freud's theories that are based on historically mediated biological drives. Calloway doesn't explain what a 'parallel view of the mind' is nor how this might relate to Marxist philosophy. He certainly makes no distinction between the various periods of Soviet history and their impact on Marxism. For Calloway, as a supporter of the USSR, there is an unbroken development from pre-Revolutionary Russian psychiatry to the present with only the ideology of Marxism-Leninism accounting for the differences. As a result, Calloway seems to see little fundamental difference between Soviet and Western psychiatry.

It is true that in the West there are also controversial diagnoses such as 'borderline personality disorder' (American Psychiatric Association, 1994: 650-4). These, it may be objected, are problematic and open to varying interpretations. However,

the criteria set out by the American Psychiatric Association (AMA) are quite precise and the Diagnostic and Statistical Manual (DSM-IV)<sup>6</sup> goes to great lengths to standardise diagnostic terms and link particular diagnoses to observable symptoms. Whilst one may object to the problematic nature of such diagnoses it is impossible to deny that there is a great deal more precision in DSM-IV and the World Health Organisation's International Classification of Diseases (ICD 10) than in equivalent Soviet handbooks. Both DSM-IV and ICD-10 are compiled following some kind of attempt at a consensus on the reviewed literature on the subject.

This contrasts with the kind of criteria that Soviet psychiatric manuals put forward in the USSR. Psychiatric handbooks were often made up only solely of contributions of psychiatrists from the eastern bloc who usually quoted research done in eastern bloc countries. The classification of, for example, schizophrenia was based on the categories set out by Snezhnevsky where the main distinction was supposed to be the emphasis on the outcome of the disorder. Therefore schizophrenia included three main sub-classifications, the continuous, episodic-continuous and recurrent forms (Morozov, et al, 1988: 424). There are also a number of special forms that do not fit into any of the main groups. These include febrile, latent and residual forms of schizophrenia. Slow-flow schizophrenia is listed as a sub-group of the residual form.

The point about the distinctiveness of the Soviet categories is not just that they did not conform to Western conceptions but that came into being in the first place as a result of the kind of political expedient discussed in Chapter Two. They were designed to have an imprecise character which gave almost complete discretion to the psychiatrist, who in the USSR, may not have had any special training or if he had it was likely to be shorter and of an inferior quality to his Western counterpart.

The history of nosology has yet to be written but if one looks at the classification of diseases in the nineteenth century then one sees that there were a number of competing classifications. Cullen's nosology was most widely used in Britain and was clearly based on the classification of 'Classes, Orders and Genera' adapted from the study of natural history (Medical Dictionary, 1820: 602). There were others that were used in France and Germany. However, by 1917 there was a broad consensus regarding

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<sup>6</sup> This is the most up to date version of DSM-IV. It is closely integrated with the World Health Organisation's International Classification of Diseases, the latest of which is Number 10 (ICD-10).



the classification of mental disorders which Russian doctors shared. The process of differentiation in Soviet psychiatric nosology began in the 1930s and under the kinds of political pressures discussed in Chapter Two.

The Snezhnevsky classification 'overextended the diagnosis of schizophrenia' and this was demonstrated by study by Kazanetz (1979: 740-5). The case studies of 700 patients were reviewed and 312 were chosen for the study. The patients were re-diagnosed on the basis of the information of a ten-year follow up and this was compared with the original diagnosis. The study found that schizophrenia had been 'over diagnosed' at a ratio of 3:1. 'Such overdiagnosis was primarily the result of adherence to the kind of criteria [...] applied by the Moscow School for classifying the psychoses'. The patients who were found to have been wrongly diagnosed had returned to work but often '...there was a recurrence of psychological trauma in the contexts of prolonged conflicts and unpleasant living conditions.' Patients whose diagnosis of schizophrenia had been confirmed using ICD-8 criteria were found to have illness that followed a typical course for that diagnosis (Kazanetz, 1979: 743). If such a finding is correct it meant that tens of thousands of people's lives would have been affected by a misdiagnosis of schizophrenia which would have kept them on psychiatric registers for years and prevented them from obtaining a range of jobs or even having a driving licence.

## **MEDICAL AND NURSE TRAINING**

It is clear that in comparison with the West the quality of medical education is inferior. It is as if the same problems which affect all other sectors of the Soviet economy have an exact equivalent in the training of doctors. Ryan argues that a political decision was taken to ensure that large numbers of doctors were trained with little regard to the quality of those who qualified. Moreover this was only possible on the basis of a low paid occupation. 'It can also be argued that the theoretical possibility of reversing the cheap labour strategy receded as the number of doctors continued to rise year after year; plentiful supply and low salaries came to be in an even stronger reciprocal cause-and-affect relationship. An important subordinate point which deserves mention here is that, by the standards of most countries, fully-trained doctors are wastefully deployed, since they are required to undertake at least some of the functions which are performed elsewhere by paramedical and other categories of health service personnel' (Ryan, 1989: 21).

It is to Ryan's credit that at no time does he fall into the trap of taking the USSR's performance indicators at face value. He understands that the quantity of doctors per head of population is no guarantee of those doctors being of a comparable standard to their Western colleagues. Moreover, the number of doctors also does not take into account the possibility that in the USSR nurses were also trained to a lesser degree and that this is one reason why doctors are 'wastefully deployed' in the USSR.

The ratio of nursing staff to patients was considerably worse in the USSR. Typically, there was 3-4 staff to 90 patients in the USSR as opposed to 3-4 per 30 patients in Western Europe (Calloway 1992: 73). This is borne out by my visit to Psychiatric Hospital Number One in Magnitogorsk. Whilst the wards themselves were clean and orderly they were very crowded with little provided to occupy patients. There was no television or radio, which was also true of the hospital in which I was a patient. In Magnitogorsk there was not enough room for a bedside locker between the beds and the patients seemed not to have any personal possessions or their own clothes. There were very few nursing staff and those that there were unqualified nursing assistants [*sidel'ki*] rather than trained nurses. Nurse education too was rather different to that in the West. It took two years from the age of eighteen in a PTU (professionalnoe technicheskoe uchilishche) college and was roughly equivalent of a British enrolled nurse training. That is, it was primarily practical in its orientation. There was no specific qualification for psychiatric nurses and the psychiatric placement during a nurse's training was as little as two or three weeks. The only male nurse I met was not described as a nurse at all but as a doctor's assistant (feldsher). Feldshers train for a year longer and are paid more than nurses. I met no female feldshers. In other words whatever formal notions of equality existed in the workplace it was disguised by the way the work force was structured. Male nurses did a different course and were paid more. The high proportion of doctors to patients in part mitigates the unfavourable ratio of nurses to doctors and to patients. Doctors in the USSR carried out tasks that would normally be carried out by registered nurses in Britain.

Medical education was generally poor and medical schools were more interested in getting people to pass than ensuring a high quality of practice, partly because of how this would reflect on the director. This is also typical of the Soviet system: the quota would be fixed on the basis of the number of graduates rather than their quality. One of the main sanctions against students is the withdrawal of the grant - which given the level of the grant was not much of a sanction. Ryan gives an account of how notwithstanding

a poor medical education Soviet medical students are capable of becoming doctors. Even where a student performs badly in an exam, which in the USSR were usually oral, they need not necessarily fail. Following an embarrassingly bad answer in an exam, 'Such a revelation of ignorance causes embarrassment among the state examining commission and, as a rule, its chairman favours giving a mark of 'unsatisfactory'. However, another member puts the case for passing this young woman: 'the dean steps in and reports that throughout her five or six years she has been a good singer in the choir, has been active in work for public welfare or something of that sort'. In the event, 'Such a line of argument frequently carries the day'' (Ryan, 1989: 10-14).

The inefficient deployment of doctors, of course, also has its direct counterpart in all other sectors of the economy. Like other sectors of the economy gross over-staffing compensates for this inefficient deployment. Hence, we have a picture of large numbers of Soviet doctors who are only half as well trained, badly deployed and producing a product that is as substandard as any other Soviet product and for much the same reason.

### **LOW PAY, LOW STATUS**

Generally speaking, the doctor in clinical practice is poorly paid, usually female and relative to her Western counterpart poorly trained and commands little respect. The wages of medical workers are well below the national average. They have never been more than about 82% of the average and by 1986 it had fallen to 69%. 'The high point in 1965 is explained by reference to the size of increases that were introduced during 1964-65 for some 20 million workers employed in a range of services' (Ryan, 1989: 21). In that respect the divisions in the medical profession are not dissimilar to the divisions that have been shown to exist between the intelligentsia and the elite elsewhere. 'At this point an important qualification should be entered. In respect of remuneration very substantial differences exist between the vast majority of doctors who form the rank-and-file, and the relatively small numbers of leading medical scientists, academics and high-ranking medical bureaucrats. Although published evidence on this matter is sparse, adequate confirmation is provided by a text which cites the salaries payable to senior staff from 400 to 600 roubles per month, deputy directors 320 to 550 and scientific secretaries from 250 to 400. Their exact salary depended on whether their postgraduate qualification was a Candidate of Science degree or a Doctor of Science degree (the highest accolade of scholarship, usually obtained in mid-career); and also on the

category (first, second or third) of the institute in which they were working' (Ryan, 1989: 24).

**Table 8: Average Monthly Earnings in Roubles, 1950-86**

Year	Average for economy(a)	Health care etc.(b)	Health care etc. as percentage of average
1950	64.2	48.6	75.7
1960	80.6	58.9	73.1
1965	96.5	79.0	81.9
1970	122.0	92.0	75.4
1980	168.9	126.8	75.1
1985	190.1	132.8	69.9
1986	195.6	134.9	69.0

Notes: (a) Excludes collective farm workers.

(b) Includes personnel in physical culture and social welfare services.

(Ryan, 1989: 22).

Ryan argues that many middle-grade medical workers undertake part-time posts that are officially advertised as such for the most part to subsidise their meagre income. 'The arrangement, known in Russia as *sovmetitelstvo*, was introduced during the early 1930s (for middle-grade medical personnel as well). The official reasons, as given by a modern source, were the nation-wide shortage of doctors and the need to improve medical care (Ryan, 1989: 23).

The balance between male and female medical graduates shifted to women from about 1923. The low pay received by doctors is in fact a reflection of the low pay and status of women's jobs in the USSR. The USSR portrayed the high proportion of women doctors as being progressive but also explained it in terms of caring role of women in society.

**Table 9: Women doctors, 1950-86**

At end of year	Number (in thousands)	As a percentage of all doctors
1950	204.9	77

At end of year	Number (in thousands)	As a percentage of all doctors
1960	327.1	76
1970	479.6	72
1980	683.1	69
1985	802.4	69
1986	828.3	69

**(Ryan, 1989: 41)**

The kind of vertical segregation of the workforce seen in Britain where women are concentrated in the lower paid and lower status specialities of any given profession is also true in Soviet medicine.

The overall picture Soviet medicine is one of poorly paid, poorly trained doctors who as a result of the Soviet system are compelled to work with out of date techniques. The burden of making such a system operate falls on women. There were additional factors that meant that psychiatry, as a branch of medicine, was particularly defective. We will now look at how and why it was used by the state as a form of repression.

## CHAPTER FIVE: PSYCHIATRY AND DISSENT

### INTRODUCTION

The aim of this chapter is to examine Soviet psychiatry with relation to dissent. Most of the important works about the abuse of psychiatry in the USSR are concerned with the suppression of dissidence by means of incarceration in psychiatric hospital and punitive treatment without a clinical objective. Psychiatric abuse was not, as some have argued, a ubiquitous feature of Russian or Soviet society, but a particular response to circumstances which were rooted in the nature of the USSR. Moreover, it was only one aspect of a much larger problem. The defective nature of Soviet psychiatry was never confined to its political abuse but went far deeper. Most Soviet mental patients, whether dissidents or not, suffered from a poor quality of service and a precarious legal position. The nature of Soviet psychiatry was rooted in the nature of Stalinism in general and its manifestation in the USSR in particular. In other words, in order to understand the reasons for Soviet psychiatric abuse and its relationship to the state it is necessary to understand the essence of the USSR, which includes its political economy.

It will be argued that psychiatry came to be used by the state against a dissenting intelligentsia under Khrushchev but intensified under Brezhnev. The dissidents in question were engaged in a wide range of activities. They included those who were denied permission to emigrate, religious dissenters and critics of the regime, whether from the left or right. Psychiatry was used in this manner until about 1988, when profound political changes meant that repressive psychiatry had outlived its usefulness. The accounts of dissidents incarcerated in psychiatric hospitals were strikingly consistent. Whilst they varied in detail and severity of accusatory tone, the overall picture was quite similar. This was true whether the accounts were written by former patients themselves or by campaigners who set themselves the task of exposing psychiatric abuse. The charges against Soviet psychiatry included the incarceration of mentally healthy people on the sole grounds of opposition to the regime. Spurious psychiatric diagnoses were used which were so vague as to be

almost entirely arbitrary and treatment with drugs or other procedures had a punitive, rather than therapeutic, aim.<sup>1</sup>

Soviet psychiatry was portrayed by some as totally different to Western psychiatry, which was barely criticised at all.<sup>2</sup> Others regarded Soviet psychiatry as the same as Western psychiatry and the only issue was the degree of abuse. In other words, it was argued that there were excesses on either side of the Iron Curtain and therefore there was no major difference between the approaches in the USSR and the West. For example, Szasz (1974) has pointed to the coercive nature of treatment in Western psychiatric hospitals as evidence that things were no better outside the USSR. It will be argued that this misses the point and that Soviet psychiatry played quite a different role to that in the West.

It is true that there was a close relationship between the Special Psychiatric Hospitals and the KGB. An example often cited is the fact that Dr. Daniel Lunts, a psychiatrist implicated in a number of accounts of Soviet psychiatric abuse, was both a senior psychiatrist at The Serbsky Institute of Forensic Psychiatry and a Colonel in the KGB (Fireside, 1979: 36-7). The former Director of the Serbsky Institute, Georgii Vasil'evich Morozov was a KGB General (Buyanov, 1992: 19). This suggests that Soviet psychiatry had a different relationship to the state than in Britain. Moreover, the relationship between psychiatry and the state in the USSR had a more transparent nature compared to its Western counterpart. The relationship of psychiatry to the state was direct and explicit. Soviet psychiatry's repressive role was on the basis of conscious decisions systematically taken by representatives of the ruling elite and, therefore, were not local, isolated incidents.

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<sup>1</sup> 'Doklad delegatsii SshA', in *Psikhiatria v SSSR*, Moscow, 1990. This journal appeared only once and carried the report of the American delegation that investigated the allegations of Soviet psychiatric abuse. It also included the official Soviet response to their report. This was also published in Russian and English in a special edition of the *Schizophrenia Bulletin*, listed below.

<sup>2</sup> Report of the American delegation to the USSR in 1988, to be found in the *Schizophrenia Bulletin* (supplement) Volume 15, Number 4, 1989.

## SOVIET PSYCHIATRIC ABUSE

Many of the accounts of Soviet psychiatric abuse focused on the Special Psychiatric Hospital (SPH) previously called Psychiatric Prison Hospitals. The SPH was controlled by the Ministry of Internal Affairs, unlike General Psychiatric Hospitals (GPH) which were controlled by the Ministry of Health. It has been argued that the very fact that a ministry other than the Health Ministry oversaw Soviet SPHs' led to abuse (Nekipelov, 1980: 26). In itself, this could explain little, as the situation in Britain was not dissimilar. Special hospitals such as Broadmoor used to be controlled directly by the Home Office. In recent years, the Special Hospital Authority has been created to oversee all Britain's special hospitals. Usually, patients in special hospitals require the consent of the Home Secretary before being released. The relationship between the special hospitals and the Home Office is also reflected in the fact that psychiatric nurses who work in them are usually members of the Prison Officers Association rather than one of the health service unions.

Soviet psychiatry was portrayed by most writers as a bleak and unpleasant regime. There were a number of references to treatment with large doses of major tranquillisers, particularly of the phenothiazine group. These are normally used to treat psychotic conditions, particularly those exhibiting symptoms such as delusions and hallucinations. In long term use they can have distressing side effects. These include a kind of pseudo-Parkinson's disease, which has to be treated with separate medication. Worse still are side effects such as blood dyscrasia and the largely untreatable tardive dyskinesia. If good quality phenothiazines can produce distressing side effects then phenothiazines which are of poor quality are likely to be worse. As we have seen, not all Soviet pharmaceuticals were made to a high standard. Particular medicines are singled out for criticism such as Sulphazine. There have been many accounts of this drug producing very unpleasant side effects. These include very high temperatures and muscle necrosis. A number of dissidents allege that it was administered for punitive reasons. Sulphazine is also described as a pyrogenic drug, that is, a drug that supposedly exerts its therapeutic effect by inducing a very high temperature.

Other controversial treatments included insulin coma therapy which was employed in Britain in the 1950s but is now seldom, if ever, used, as it is dangerous and of little therapeutic value. However, there is evidence of its use in the USSR up



until 1992. Aside from its inefficacy, it is alleged that insulin was administered for punitive reasons. As well as punitive treatment it is suggested that physical violence and the theft of patients' belongings were common. An example is Major Leonid Lymits who was formally the head of the 4th unit, the KGB unit of the Serbsky Institute. He ordered beatings for patients who came to him with complaints and called it a "prescription of Kulazine" (Podrabinek, 1980: 41). Kulazine is a play on the Russian word for fist [kulak] and the usual suffix of phenothiazine drugs.

Other complaints regarding treatment include the use of 'wet wraps' - the wrapping of wet linen around a patient which allegedly causes pain as it dries and contracts. That it was used as a treatment is supported by Calloway, a writer sympathetic to the Soviet view, who points out that it was used in both the USSR and the USA (Calloway, 1992: 106). Podrabinek (1980: 94-5) argues that it was used for punitive reasons. Whilst this may be true, it is quite possible that this treatment may be an example of the survival in the USSR of yet another archaic treatment.

The detention of dissidents in a Soviet psychiatric hospital had an arbitrary quality. That is, a person could be detained without warning and at the sole discretion of the psychiatrist. To protest at one's incarceration '...will be evaluated by the psychiatrist as evidence of mental illness. The situation is absolutely hopeless. This circular device is wearisome for all: you cannot defend yourself because you were pronounced insane; you cannot lodge a formal protest with the authorities because you were not arrested; you cannot appeal because you were not sentenced' (Podrabinek, 1980: 19). The role of the medical staff is important. Some doctors, at hospitals such as the Serbsky Institute, played an active, conscious role in the use of repressive psychiatry. Those who resisted being incorporated into these measures or who made common cause with dissidents found themselves subject to very serious sanctions. For now it will be sufficient to point out that in 1972 Dr. Semyon Glutzman, the doctor who examined General Grigorenko and publicly announced that he was not mentally ill, was sentenced to seven years in a labour camp and three in exile (Bloch and Reddaway, 1978: 235).<sup>3</sup>

One of the features of Soviet psychiatry, which made it easier to harass people, was the existence of supervision registers. Once a person had been diagnosed as mentally ill his name would be recorded on a register. Even if discharged as

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<sup>3</sup> See also Glutzman, 1989.

healthy, the former patient's name remained on it and this meant that one could be summoned for an outpatient examination at any time. If one were found to be ill then this could lead to hospitalisation. In practice, the millions of people who were on such registers were seen rarely, if at all. However, the registers meant that a permanent record of a nervous breakdown was kept. The ability to detain a person at any time was used to facilitate the extra-judicial harassment of dissidents by arresting them without the open use of the police or KGB and without the dissident having committed an offence. It could be argued that the use of some kind of supervision register for the mentally ill is not confined to the USSR. The British government responded to a number of high-profile incidents involving the policy of Care in the Community by suggesting that some form of supervision register is required in the United Kingdom. Calloway has suggested that there was little difference between the proposed supervision registers in Britain and the controversial Soviet counterpart.<sup>4</sup> However, there was an important qualitative difference. The British registers were proposed to supervise those thought to be at risk to themselves or others. In fact, such supervision in the community already exists. One can be discharged from hospital whilst formally supervised under a section of the 1983 Mental Health Act - even one which allows for compulsory detention and treatment. In some cases this requires the permission of the Home Secretary.

The Soviet supervision registers included all former patients and not just those thought to be at risk of relapse or a danger to themselves or others. Many had never been considered such a danger. The sole criterion for being on a register was that one had been treated for some form of mental disorder. Being on a register prevented former patients from taking some forms of employment or holding a driving licence. These included jobs which were traditionally well paid such as Metro train drivers. In practice, most former patients were left to their own devices. Occasionally, often years after their initial breakdown, they were required to attend the local polyclinic or psychiatric hospital for examination, a process that was tedious and embarrassing for those who had long since put their illness behind them (Kazanetz, 1979: 744). Continued listing on a Soviet mental health register was also not subject to appeal. In Britain, the Mental Health Act lays down strict guidelines

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<sup>4</sup> Calloway, P., Interview, 23/5/94, Fulborn Hospital, Cambridge.

for the detention and supervision of the mentally ill. An appeals procedure means that an independent second opinion can challenge the original detention order. Detention using the Soviet supervision registers was at the discretion of the psychiatrist and was not always subject to judicial control. Psychiatrists who were closely linked to the KGB were unlikely to be hindered by the judiciary, even if one assumes they were not acting on instructions from senior figures within the state.

One of the criticisms levelled against Soviet psychiatry concerns the length of stay in hospital. Assessment at the Serbsky Institute, which was an All-Union centre for forensic psychiatry, was around three to four months. Supposedly, only in exceptional cases could this period be extended. The Serbsky specialises in the pre-trial assessment of defendants. Therefore, the length of time spent at the Serbsky Institute is generally shorter than in a GPH. Discharge commissions responsible for forensic psychiatric patients were supposed to meet every six months but in practice the gap was often longer. The discharge commission reported to a court recommending either transfer to a GPH, discharge or continued confinement. Once confined in a GPH, the length of stay could be very long, possibly for years. One way in which inmates managed to effect a release was what may best be described as a recantation of heretical ideas. Preferably, this was accompanied by an acknowledgement by the patient that he felt better. Some SPH patients were released as a result of outside political pressure.

Unfortunately, it is difficult to find statistical information for average inpatient stays in the USSR. In Britain, in 1981, 88.5 per cent of patients were discharged in less than three months (DHSS, 1984: 22). The figures for admissions and discharges are figures for events rather than individual patients so this figure includes patients who were admitted repeatedly for short periods. Podrabinek (1980: 16) states that inpatient stays for dissidents in SPHs was often for a year or more. He also asserts that, whilst the internal regimen of the SPH is far stricter than the GPH, the more relaxed regimen of the GPH may have lent itself to more arbitrary treatment. In a SPH 'medical subordination was strongly supported by military subordination' and the 'limits of arbitrariness were precisely defined.' He goes on: '...political prisoners are more often than not sent to SPHs. Cases are known where, at a general psychiatric hospital, people were not drugged at all. Besides, GPHs are designed for treatment, not incarceration; they are not directly connected with the KGB. Like most hospitals, they have a shortage of available beds. For these reasons,

there are no long term stays in these hospitals. This route of punitive medicine is shorter and much less tragic than the SPH route' (Podrabinek 1980: 18). That most political detainees in psychiatric hospitals were confined to SPHs is supported by Koppers (1990) who has compiled a data base of political detainees from a wide variety of (mostly secondary) sources. Of the 339 cases listed by Koppers 54.6 per cent (n=185) were confined to a SPH. This rises to 55.4 per cent when those cases in which there was no information on the hospital type was included from the calculations.

The Serbsky Institute was frequently implicated in Soviet psychiatric abuse, but it was not alone. The Kashchenko Hospital in Moscow, an All-Union Scientific Centre for Mental Health, also features in many cases of the harassment and incarceration of dissidents. Like the Serbsky Institute, it was an All-Union research centre and a branch of the Academy of Medical Sciences of the USSR. The KGB had considerable influence at both hospitals. Podrabinek's division of hospitals into SPH and GPH is problematic. The Kashchenko Hospital in Moscow might properly be regarded as a GPH but this did not stop it playing a repressive role. It is likely that the real distinction is between academic and research establishments in principal Soviet cities and provincial or small city hospitals. The former are an important base for a section of the higher intelligentsia whereas the latter, such as Psychiatric Hospital Number One in Magnitogorsk, which I visited, have a purely clinical function and little obvious KGB influence. There is evidence for this if one examines the records of dissidents whose cases became well known in the West. The majority were confined in one of the major municipal centres such as Moscow, Leningrad or Kazan. Provincial hospitals are implicated in some cases but usually they held only one or two dissidents in the course of the 1960s and 70s.

This is born out by Koppers' data base, which shows that 34.7 per cent of those who had their place of confinement listed were in Moscow (n=101); 14.4 per cent in Leningrad (n=42); 11 per cent in Kazan (n=32) and 10 per cent in Dnipropetrovsk SPH (n=29), the rest (n=87) being fairly widely dispersed in over 68 hospitals. In 48 cases the hospital was not listed (Koppers, 1990).

### **SOME CASE STUDIES OF PSYCHIATRIC ABUSE**

It is beyond the scope of this thesis to provide a comprehensive account of all cases of Soviet psychiatric abuse. As details are obtainable from the voluminous

literature on this subject there is little point in reproducing them extensively. However, it is useful to discuss some case studies of those detained. Most accounts of Soviet psychiatric abuse are concerned with individual cases (Medvedev & Medvedev, 1971) or are a general discussion of the problem and feature numerous cases (Bloch and Reddaway, 1978). The aim of this thesis is to explain why Soviet psychiatry took the form it did and for this purpose an overview of some of the cases will suffice.

Some dissidents were referred to psychiatrists as part of the legal process. However, psychiatry was generally used to discredit the views of dissidents and harass them without having to resort to a public trial. Incarceration in a psychiatric hospital was used as an alternative to the labour camp, although there were cases when dissidents were sent to labour camps despite also being given psychiatric diagnoses. These were not merely exceptions to a general rule but were the result of a relationship between psychiatry and the judiciary, which was qualitatively different to that in the West. This is more fully discussed in Chapter One. The question is, why should the state send some dissidents to prison or the camps and others to a psychiatric hospital? It has been suggested that dissidents from the elite or higher intelligentsia were more likely to be confined to hospital along with those who were particularly vocal or had a high profile. It was more convenient to describe the activities of a former member of the CPSU as the result of mental illness than that of an ordinary worker or member of the lower intelligentsia. It also meant that such an activist could be tried in absentia and did not have the opportunity to make a speech from the dock. If the dissident in question had also suffered mental illness in the past this also facilitated hospitalisation (Bloch and Reddaway, 1978: 274-5).

Anna Gorbanevskaya worked as an engineer and translator for the State Institute of Experimental Design and Technical Research. After taking part in a demonstration on Red Square against the invasion of Czechoslovakia she was forced to resign her job and, with Victor Feinberg, was sent to a psychiatric hospital and diagnosed as mentally ill. She was declared to be suffering from 'deep psychopathy' and told that 'the possibility of sluggish [*vyalotekushaya*] schizophrenia' could not be excluded (Bloch and Reddaway, 1978: 132). The other participants in the Red Square demonstration were sent to prison. Gorbanevskaya's psychiatric commitment was facilitated by the fact that she had been a voluntary patient at the Kashchenko Hospital in 1959. Other well known cases were not related to a particular event but

were indicative of the political climate of the time. They subsequently became the focus of further dissent among the Soviet intelligentsia and in some cases became *causes celebres* in the West where their plight became used as a weapon in the Cold War. Usually, the support that the dissidents received from the West was welcome and occasionally it led to people being released. However, it also meant that the state would increase the pressure on dissidents who publicised their grievances in the Western media. In March 1968 ‘...ninety five leading mathematicians protested against the incarceration of Yesenin-Volpin in a mental institution for the role he had played in challenging the legality of the Sinyavsky-Daniel trial and for actively protesting the Galanskov-Ginzburg trial. In a letter to the Minister of Health, the Procurator General, and the Chief Psychiatrist of Moscow, the mathematicians denounced Volpin’s forcible confinement, but when the letter was published by the New York Times, fifteen of them withdrew their names from the protest’ (Rothberg, 1972: 236-48). The mathematicians withdrew their names following an intensified effort by the KGB to quell the dissent (Bloch and Reddaway, 1978: 73)<sup>5</sup>

Arrest and confinement to a psychiatric hospital could be for trivial offences. In December 1968, Olga Ioffe, a student of Moscow State University, was arrested and found to have samizdat materials. On August 20 1970 she was committed to a psychiatric hospital and diagnosed as a ‘chronic schizophrenic’. Valeria Novodvorskaya distributed a poem that criticised the CPSU and, as a result, was referred to the Serbsky Institute. She was eventually detained in the Kazan SPH as a ‘paranoid schizophrenic’. The fact that psychiatry was used as an alternative to the judicial system was not lost on dissidents who frequently demanded that their case be heard in open court. A Gorki University history teacher and three students were arrested in the summer of 1969 for distributing leaflets opposing the rehabilitation of Stalin. One of the students was sent for psychiatric examination but was later charged in a criminal court, along with the others, when his wife threatened self-immolation (Rothberg, 1972: 294-5).

Although many students were among the dissident activists during the period of the decline of the USSR, other members of the intelligentsia were also subject to detention in a psychiatric hospital. Revolt Pimenov was arrested in July 1970. He

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<sup>5</sup> According to Bloch & Reddaway, 99 mathematicians, not 95, signed the original protest.

was a mathematician born in 1931 and was interned in a psychiatric hospital after resigning from the *Komsomol*. He was later declared to be of sound mind but was only released on condition that he withdrew his resignation (Rothberg, 1972: 337-8).

On March 19, 1969 S.P. Pisarev, who had been a member of the CPSU for fifty-two years, a professional Party worker, a decorated war veteran and invalid, sent an open letter to the Presidium of the Soviet Academy of Medical Sciences. He protested against "mistakes" committed by the Serbsky Institute and explained the reasons for them. The Institute "provide[s] a pseudo-scientific sanction for the indeterminate isolation of psychologically healthy people in prison hospitals." He recalled that the Serbsky Institute had been involved in similar activities during the Stalin period. They had even been exposed in 1956 by a special Central Committee commission which had resulted in hundreds of perfectly sane people being released from psychiatric hospital wards." This report was however buried in the archives and the members of the commission were quietly removed from their posts (Rothberg, 1972: 295).

Although it has proved impossible to trace this report it seems that the 'exposure' in 1956 had far more to do with the decision after the death of Stalin to begin using psychiatric hospitals for political purposes. It is interesting to note that Georgii Morozov was appointed to the Directorship of the Serbsky Institute in 1957 (Buyanov, 1992: 19) As we shall see, those confined to psychiatric hospitals, including Yesanin-Volpin, under Stalin were likely to have been spared a worse fate. The 1956 clampdown tightened up procedures for certifying a patient as non-imputable and prevented psychiatrists from shielding patients from harsher treatment at the hands of the KGB.

In 1968, Zhores Medvedev was dismissed from his post as an academic researcher for his writings, which were critical of the conduct of science in the USSR. These were published in Britain as 'The Medvedev Papers' and contained his pamphlets; 'Fruitful Meetings Between Scientists of the World' and 'Secrecy of Correspondence is Guaranteed by Law'. Subsequently, on the pretext of being summoned to a clinic to discuss the behaviour of his son, Medvedev was subjected to harassment and eventual detention in a psychiatric hospital (Medvedev & Medvedev, 1971). Zhores Medvedev was further detained because of his book 'The Rise and Fall of T.D. Lysenko', which embarrassed the Soviet authorities as it went far beyond a discussion of genetics and discussed the political basis of the Lysenko

affair. It had first circulated in *samizdat* because it had been rejected by a number of Soviet publishers. Columbia University Press published it in 1969. The fact that it had been published outside the USSR and without *Glavlit* approval was seen as compounding the offence of criticising the state. Roy Medvedev publicly protested against the 'illegal' confinement of his brother. 'On June 4, [1969] a second team of psychiatrists was dispatched from Moscow to examine Zhores for schizophrenia. Among the seven physicians were the director of the Serbsky Institute, Dr. Grigorii Morozov, and his assistant, Professor D.R. Lunts. After this second examination, Zhores Medvedev was ordered detained for at least a month' (Rothberg, 1972: 295-98).

The poet, Josif Brodsky, underwent treatment at the Kashchenko psychiatric hospital from December 1963 to January 1964. He was charged under the Parasitism Laws, ostensibly for not having gainful employment. However, the real reason for his appearance before a court was because of his alleged 'anti-Soviet' views. These amounted to little more than being critical of the authoritarian and anti-democratic nature of the regime. His defence council tried to show that Brodsky was unfit for regular work because of a pre-existing nervous condition. The judge sent him for a psychiatric examination to determine 'whether this illness will prevent Brodsky from being sent to a distant locality for forced labour. The official psychiatric report declared that Brodsky had "psychopathic character traits" but is capable of working. Therefore, administrative measures can be taken.' He remained in a camp, in the Arctic, until 1967 (Rothberg, 1972:127-30).

The difference in the relationship between psychiatry and the judiciary in the USSR is illustrated by the fact that among the patients listed by Koppers (1990) for whom there is information 157 (46.3 per cent) were arrested and charged under a section of the Soviet Criminal Code. Although there was no information in 182 cases 21.2 per cent (n=72) of the total or 45.9 per cent of those for whom there was information were charged under section 70 (Anti-Soviet Agitation and Propaganda) of the Criminal Code. A further 18 per cent (n=61) were charged under section 190 (Failure to Report Crimes) or 38.9 per cent of those for whom there was information.<sup>6</sup> In the USSR, as in the West, the mentally ill were formally regarded as unfit to plead. A psychiatric diagnosis would normally preclude a prison sentence. In

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<sup>6</sup> For an English translation of the Criminal Code of the RSFSR see Berman, 1966.



Britain the question would be whether the person committing the offence was capable of realising that they were doing wrong. British courts, generally, attach great weight to the opinion of clinical experts. However, in the USSR the independence of clinical witnesses could not be relied on, particularly if they held high rank in the KGB. The psychiatrist could be pressurised into giving the diagnosis expected of him by the court. The judges' independence was no more reliable. If a prison sentence was required then it would be given, notwithstanding a psychiatric diagnosis. Dissidents who were diagnosed as mentally ill were usually sent to hospitals but sometimes sent to a camp or prison. Koppers (1990) lists 8 persons held in either camp hospitals or other prison hospitals; 2.4 per cent of those for whom there is information.

The diagnosis of mental illness did not prevent Victor Khaustov from being sent to a labour camp. He had been diagnosed as schizophrenic in 1964. 'Khaustov maintained throughout that he was sane, but he was judged to be guilty and sentenced to three years of hard labour in a camp with a "severe" regimen' (Rothberg, 1972:184-5). In the case of Khaustov and Josif Brodsky, psychiatry delivered the diagnosis which was required of it. They were fit to be sent to a camp. However, most dissidents were confined to psychiatric hospitals as an alternative to the camp, in order to prevent a public trial.

A trial could result in a referral to a psychiatric hospital for assessment and detention. Vladimir Bukovsky was convicted in 1962 of circulating anti-Soviet material including Milovan Djilas' 'The New Class', and as a consequence was confined to a psychiatric hospital until 1964. Bukovsky's mother reported: 'Of the past four years he's spent nearly three locked up: the Leningrad prison mental hospital, the Serbsky clinic, and now he's in Lefortovo. He comes out and they pick him up again. They don't give him a chance to start work or to study' (Rothberg, 1972:189). Similarly, in 1956, Nikolai Samsonov submitted a treatise entitled 'Thinking Aloud' to the Party's Central Committee. This dealt with the creation of a bureaucratic elite and the erosion of Leninist principles. Soon afterwards he was arrested and charged with counter revolutionary activities. During his interrogation he underwent a psychiatric examination. The examining commission under Professor Torubarov found him to be mentally ill and ordered Samsonov to be confined to the Leningrad SPH. Eventually Samsonov was able to effect a release in 1964 by means of a signed recantation of his earlier treatise following treatment with a tranquilliser,

Aminazine. Aminazine is the Russian name for Chlorpromazine (Krylov, 1993: 175), which is also known in Britain by its brand name, Largactil, and is probably the most common form of phenothiazine tranquilliser used for the treatment of acute schizophrenia.

All of these cases share a common pattern. They all feature the use of psychiatry to discredit and generally harass dissidents and their families. Quite often the harassment included other sanctions which were threatened before confinement to a psychiatric hospital. Occasionally, psychiatric detention included ill treatment of one sort or another. Usually, the psychiatrists involved were from large psychiatric hospitals or All-Union Centres and held KGB or MVD appointments. They were themselves part of the elite or a privileged part of the intelligentsia which had a reason to support the system. Even if they did not support it they still had a great deal to lose by not co-operating with the state.

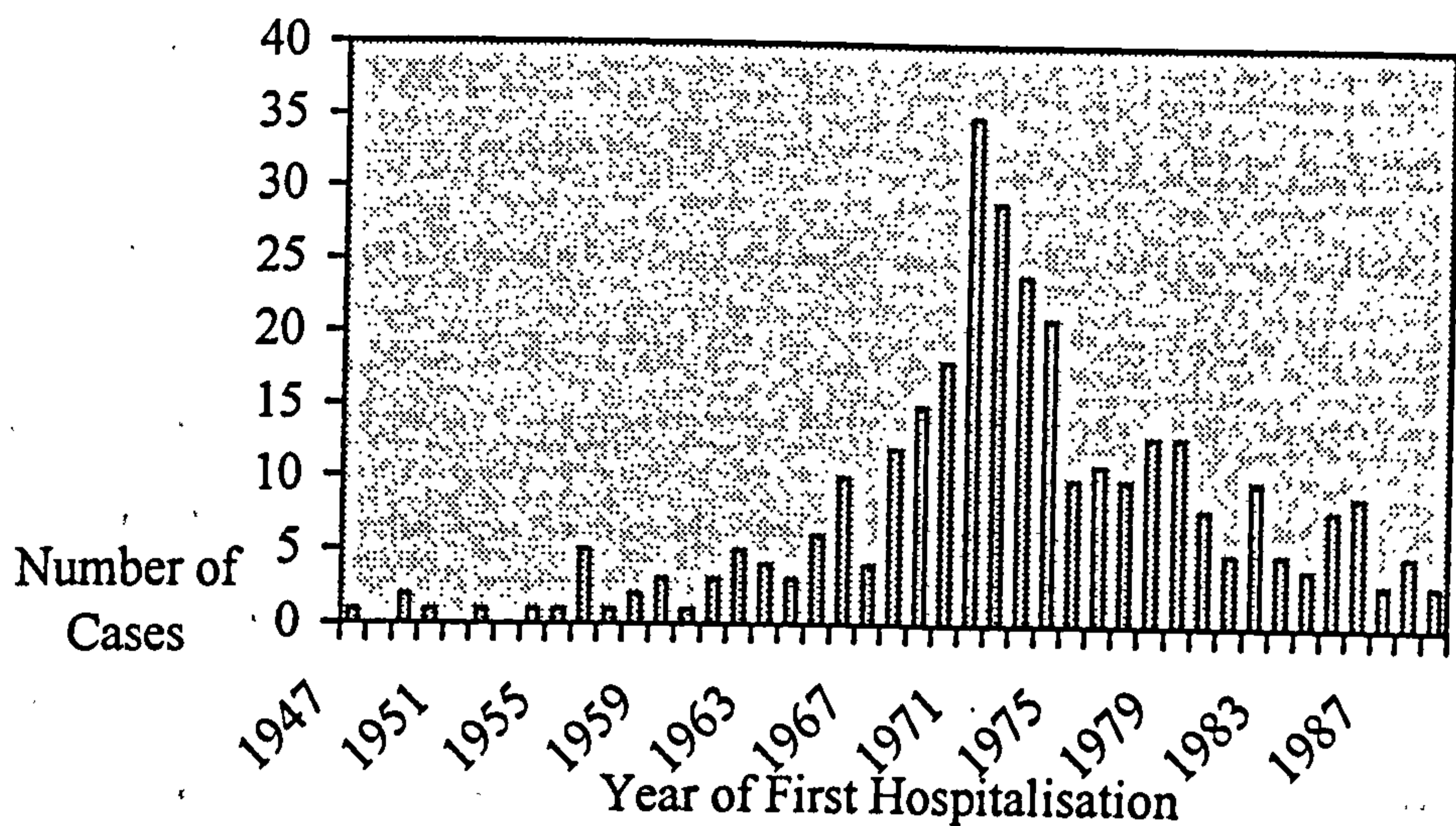
### **THE SCALE OF PSYCHIATRIC ABUSE**

Estimates of the number of political detainees in psychiatric hospitals vary greatly. One reason for this is that some writers may have overstated the numbers in order to discredit the USSR in the Cold War. However, more sober estimates, from well informed writers who were also opposed to the Soviet regime, tend to place the total number in the hundreds rather than thousands. While precise figures are not available, there are some consistent estimates. One of the most consistent estimates suggest that there were around 210 'confirmed' cases held between 1962 and 1976. There were a further 50 people for whom there was insufficient information. In other words, about 70 dissenter-patients were held each year. The numbers could vary depending on the time of year as potential protesters were often detained just before major Soviet holidays, such as May 1st and November 7th. The number of political detainees also varied considerably over the period with a significant intensification of abuse after 1968. These are made up of patients which were notified to Bloch and Reddaway and largely consist of those dissidents in the major metropolitan hospitals such as the Leningrad SPH, Kazan and Moscow (in particular the Serbsky Institute and the Kashchenko Hospital). They acknowledge that they have less information regarding more distant psychiatric hospitals and allowing for this they estimate the number of people who were subject to detention in psychiatric hospital because of dissident views as around 350 'at any one time' between 1962 and 1975. They

further state that this number of detainees may not be valid for the whole of that period. There was a sharp rise in dissent from 1968 and as a result a sharp rise in the number of political detainees from then (Bloch & Reddaway, 1978: 261). Andre Koppers lists 339 cases in his 'Biography of Soviet Psychiatric Abuse', which was compiled from a review of the secondary sources and cases notified to organisations such as Amnesty International. The most intensive period of psychiatric abuse among the cases recorded by Koppers was from 1966 to 1982. The peak year for confinements among those listed by Koppers was 1971 (n=35). We can see the distribution of the cases listed by Koppers in graph one.

Calloway has estimated that the number of dissidents subject to psychiatric abuse was quite small and argues that at least some were actually mentally ill. He asserts that; 'It is not easy to get estimates of the numbers in the different dissident groups. In the 1960s and 1970s, according to Bloch and Reddaway (1984), there was a massive increase in various kinds of dissent, mainly nationalist and religious. This is given as the reason for psychiatry being used to contain the situation. However, it can also be argued that as the group of dissenters gets bigger the more people with some form of mental illness there will be within that group. Figures for active religious believers and nationalists vary from the tens of thousands to millions. It is somewhat easier to make an estimate of refusenik population through the number of emigration visas applied for and sent. There would be a measure of agreement for a figure of about 400,000 refuseniks past and present. Taking 1% as a conservative estimate of the point [of] prevalence of serious psychiatric illness in a population would give a figure of 4,000 refuseniks with severe mental illness. The Soviet argument is that Bloch and Reddaway's 120 dissenter-patient refuseniks are from this group of 4,000 mentally ill dissidents. The critical question is why should the 120 dissenter-patients be taken from the 396,000 healthy refuseniks rather than the 4,000 that one would expect to be mentally ill. Even if this 4,000 were accounted for separately, the question is why should just 120 people be dealt with in this controversial way and the other 396,000 ignored' (Calloway, 1992: 232).

**Graph One: Distribution of First Admission to a Psychiatric Hospital**



It could be argued that the actual number that were affected by Soviet psychiatric abuse is not terribly important. No one is arguing that psychiatry was the sole means of dealing with dissent. It was only one of a number of strategies employed by the elite to control the population. Bloch and Reddaway's figures refer to refuseniks who, notwithstanding the fact that they were mentally well, were still dealt with in psychiatric clinics and hospitals. Obviously, people holding dissenting views can also become mentally ill but this is not the issue. The crucial question is not why should 120 dissenter-refuseniks be separated out from such a large group but why should so many well people be treated in psychiatric institutions? This remains important even if the numbers are in hundreds, rather than thousands. Furthermore, Calloway gives no indication of why it was that psychiatrists participated in such a repressive policy. From the interviews I conducted with Soviet psychiatrists no explanation can come from any generalisations about the character of the psychiatrists themselves. Calloway generally supports the Soviet position. Whilst he sees differences between Soviet and Western psychiatry he tends to see these as differences of detail rather than substance. In other words, he regards the differences between Soviet and Western psychiatry as no more significant than between the USA and Britain. Consequently, Calloway appears to be somewhat uncritical of Soviet psychiatry. In a conversation with me Calloway described himself as coming from a Stalinist political background and it is significant that Joseph Wortis wrote the preface to his book.<sup>7</sup> Wortis had a long history of support for the USSR and, in 1950, wrote the first book published in the West on the subject of Soviet psychiatry. It is

<sup>7</sup> Calloway, P., 23/5/94, Interview at Fulbourn Hospital, Cambridge.

entirely supportive of the Soviet system and confines itself to an uncritical description of psychiatry in the USSR.

A dissident who monitored Soviet psychiatry for a decade stated that by 1988 there were at least 30 confirmed cases of people who were still committed to mental institutions as a result of political activities, and 120 or so other suspected cases (Podrabinek, in *The New York Times*, 22/11/88: A9). In 1988 the USSR admitted for the first time that there had been the systematic abuse of psychiatry. These figures are consistent (probably not accidentally) with those of the American delegation, which visited the USSR in late February and late March 1989. The American delegation consisted of twenty-six people including psychiatrists, lawyers and others, as well as Peter Reddaway. Many of the people they wanted to visit were released prior to their arrival. Those that had been released were examined. The delegation concluded that few of those who had been confined to hospitals would have been detained in the West. Of the patients who were still in hospital not all were found to be suffering from serious mental disorders.

### **PSYCHIATRY AND A DISSIDENT INTELLIGENTSIA**

Although some manual workers were confined to psychiatric hospitals for opposing the regime, psychiatry was used mostly against the intelligentsia.<sup>8</sup> This is a reflection of the fact that the dissident movement itself was rooted in the intelligentsia. Reddaway supports this view when he says of the Democratic Movement, which expressed itself through the *Chronicle of Current Events*; 'The movement's class-structure becomes clearer if we analyse the identifiable mainstream members by occupation. We find that nearly a half (with scientists strongly represented) have academic jobs, nearly a quarter are writers, artists and actors, one in eight is an engineer or technician, one in ten is in publishing, teaching, medicine or the law, one in twenty is a worker, a similar proportion are students, and one in a hundred is in the military. Ideologically speaking, the Democratic Movement is [...] less diverse than its nineteenth-century forerunner. The main explanation for this lies in the movement's remarkable unanimity on one vital point:

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<sup>8</sup> V. A. Klebnikov and A. V. Nikitin were two workers confined to psychiatric hospitals for trying to organise politically in the Ukrainian Donbass region. They are discussed in Haynes and Semyonova, 1979.

the importance of law as a potential, even actual, instrument through which to promote democratisation and secure civil rights' (Reddaway, 1972: 23-4).

This is supported by Koppers (1990) who, among the 339 people whose cases he documents, lists the occupations of 227 dissidents who have been confined to psychiatric hospital against their will. Any quantitative analysis of the occupations cannot be precise. The occupational categories that Koppers employs, such as 'worker', are somewhat arbitrary. However, if one looks at the various occupations there is a clear pattern. Among those for whom there is information, the intelligentsia or those in administrative positions make up over 72 per cent (n.162). Skilled workers make up 10.1 per cent (n.23) and those just listed as 'workers' make up 15.9 per cent (n.36). I have grouped together those who are obviously in the intelligentsia such as academics (n=29 or 12.8 per cent) with those in administrative posts such as managers. In dividing up the various occupational groups those that I have included in the intelligentsia are; artists (including poets and writers) (n=19 or 8.4 per cent), priests or seminary students (n=8 or 3.5 per cent), students (20 or 8.8 per cent), doctors (n=8 (including one psychiatrist) or 3.5 per cent), lawyers (n=8 or 3.5 per cent) and engineers (n=16 or 7 per cent). I have also included in the intelligentsia military officers (n=7 or 3.1 per cent) but excluded other ranks (n=6 or 2.6 per cent). The main criteria for including an occupational group in the intelligentsia was whether the job required a higher education. Koppers' information is not always detailed or particularly reliable because it comes from many secondary sources for which there is not always verifiable evidence. Interpretation of the figures has to be undertaken cautiously but it does tend to support my assertion that psychiatry was used mostly against the intelligentsia.

The Soviet State responded to different forms of resistance in different ways. As those who tried to organise workers were potentially the most dangerous to the elite they were treated most harshly (Ticktin, no date: 6). Even if the killings abated somewhat after 1953, the judicial system was still employed against the working class. Another reason why the regime treated workers differently is that working class opposition to the regime took a different form to that of the intelligentsia. The nature of atomisation in the USSR meant that resistance often took an individualised form. The most widespread form of working class resistance was working badly. Workers often worked slowly, turned up for work late, or got drunk. Although the effect on the economy was devastating it would have been impossible to send all

workers who worked slowly to mental hospitals. Moreover, such individual action posed little immediate threat to the regime's stability in the way that collective, public statements and actions could. When there were strikes among workers, these were often dealt with, initially, by making concessions. Frequently, KGB intimidation and arrest of workers' leaders followed this. When it came to the working class this often led to familiar punishments such as prison, exile or worse. There have even been fairly recent cases of deaths under suspicious circumstances of political activists. These have included the Russian anarchist Pyotr Siuda and Martha Philips, a paid organiser for the Spartacist League (*Byulleten' Spartakovtsev* No.3, Spring 1992).

Among the complaints of dissidents there are many references to the 'difference between official constitutional guarantees and their actual implementation in Soviet life'. When Zhores Medvedev and other dissidents were confined to psychiatric institutions they repeatedly stressed that this was done in an unlawful way. However, as we have seen, there were no laws, properly speaking, regarding the confinement of the mentally ill until 1988. The only legal regulations were civil and criminal procedures for dealing with those unfit to plead. Beside this, there were established ministry and departmental procedures. It will be argued that these were not laws in the strict sense but bureaucratic regulations of a specifically Soviet type. The emphasis placed on law by the dissenting intelligentsia was a reflection of their desire that there should be guaranteed rights for the intelligentsia against the '...ubiquitous incursions of the state in classic liberal fashion. It would at the same time regularise social relations between the elite and intelligentsia, providing a guaranteed and stable social contract to replace the uncertainties of the Stalin period. But law would also guarantee against social disorder and instability. Law must also mean order; in other words, control over the working class. Not surprisingly, with such a demand, the intelligentsia were forced into a utopian strategy against the elite and away from any possible alliance with the working class' (Cox, 1975: 9-10). The dissident, Major-General Grigorenko, condemned the trials of dissidents as "political" and insisted that Bukovsky was sentenced only 'because he defended himself and because he refused to recognise the right of the organs of the KGB to engage in uncontrolled and illegal interference in the personal lives of citizens' (Rothberg, 1972: 198-208). This illustrates the point that in the USSR there cannot be said to have been any distinction between the state and civil society.

The fact that psychiatry was used in a seemingly unlawful way has to be explained. This is dealt with in Chapter One and reinforces my argument that law did not exist in the same way that it does in the West. It is not merely a case of there not being a 'proper' separation of powers but rather a feature of a society in which private property relations were entirely absent but which did not have the only other possible guarantee which would pertain to a socialist society: democracy. Under conditions where the working population is in control of all areas of society it is hard to imagine how the state as a repressive force could survive. The USSR had the worst of both worlds: a repressive state without the formal guarantees that private property brings with it and without the democracy that socialism would entail. Complaints regarding the unconstitutional nature of the abuse of power were a constant feature of dissident literature on Soviet psychiatry.

The demands of the intelligentsia differed from those of workers. Whereas the working class demanded control over the work process and an end to privilege many of the demands of the intelligentsia centred upon a recognition of the 'rule of law'. Many of the demands were for a relaxation of control over the intelligentsia without these additional freedoms being applicable to the working class. The social-democratic nature of the intelligentsia's demands is illustrated by the fact that Roy Medvedev, Valentin Turchin and Andrei Sakharov issued a public appeal arguing that 'freedom of ideas and information is essential for the growth and success of a modern economy.' Sakharov and others promulgated 'a fourteen point program which would make information about the state accessible to the public, permit foreign books and papers to be sold, create a public-opinion institute, reform the legal and educational systems, and eventually offer direct elections with a choice of candidates for both Party and government positions' (Rothberg, 1972: 289-295). The demands of the intelligentsia were typically those that one associates with liberal-democratic society, including freedom of speech and association, freedom from arbitrary imprisonment or confiscation of property, an end to interference in matters of art, science and literature, the freedom to travel and publish at home and abroad without censorship. Among dissidents from the intelligentsia one repeatedly sees a demand that the Soviet constitution be respected and the letter and spirit of written law obeyed. Although dissidents were often charged with anti-Soviet propaganda many argued that they were not anti-Soviet and insisted that it was the state which



was acting illegally. They claimed to be defending rights which were guaranteed by Soviet law (Medvedev & Medvedev, 1971(2): 295-7).

The demand for free speech was effectively a demand for free speech for the intelligentsia. This is not the same as demanding free speech for the working class, which called for an end to the privileges of the intelligentsia and the elite, not to mention for an end to the elite itself. Many in the intelligentsia supported some form of transition to capitalism or a mixed economy and this found its expression in the demands for freedoms which would guarantee private property rather than ending state property in favour of socialism. A proportion of the elite shared this view even if they couldn't make such views public. A section of the elite was aware that making concessions could mean releasing an opposition that was unstoppable and they could lose everything. The elite had to maintain a position of being opposed to the market even if they took full advantage of the benefits of whatever private sources there were, including purchases made on foreign trips, access to private tailors, or hard currency shops.

Repression and slaughter on the scale of Stalin's camps could not be maintained indefinitely. After Stalin's death, psychiatry was added to the state's repressive armamentarium in order to allow a degree of subtlety in comparison with previous methods, at least for the intelligentsia. The concessions made to the intelligentsia under Khrushchev meant that the upper stratum of the intelligentsia, like the elite, was more or less free of KGB harassment and arrest. Psychiatry allowed a discrete alternative to the labour camp and firing squad. From the point of view of the Soviet elite the advantage of psychiatry was that it negated any oppositional statements as the ramblings of a madman. Secondly, open court proceedings were easily circumvented in favour of the closed deliberations of medical expertise. Thirdly, confinement could be without a prior statement of the time limitation. Fourthly, the state could deal with a troublesome dissenter under the guise of the its solicitude for the welfare of the person in question. The psychiatric hospital was used as an 'ameliorated version of the labour camp' (Rothberg, 1971: 170).

The intelligentsia has been treated very differently in various periods of Soviet history. Under Lenin concessions had to be made to the intelligentsia owing to the isolated position of the USSR. The backward level of development of the Russian Empire meant that the liberal professions made up a smaller proportion of

the population relative to other countries. Moreover they enjoyed less autonomy than their Western counterparts. The disaster of the First World War and the flight of many intellectuals from the revolution put the USSR in an even weaker position. The defeat of socialist revolutions outside the USSR meant that it had little hope of assistance from friendly states. Under those circumstances, Lenin was forced to make concessions to specialists who were in short supply at the best of times and mostly hostile to the new regime.

During the Stalinist repression of the 1930s many specialists and intellectuals who supported the revolution, and many who did not, were killed. The corollary of this was a macabre form of social mobility, which saw people promoted from formerly lowly positions. They made up a stratum of Soviet society who were dependent for their new found status on the Stalinist regime. Among them was the leadership of Soviet psychology and psychiatry. In order to benefit from this form of social mobility loyalty was far more important than skill, qualifications or learning. Some have even suggested that a general lack of learning was almost a prerequisite for success (Buyanov, 1992: 19-20). Although Buyanov does not explain why this is the case he implies that a person in such a position will not be seen by the elite as a threat.

However, until World War Two, most clinical psychiatrists had trained under tsarism and were probably hostile to the Stalinist regime. Whilst the mass killings of the Stalin period may have had the effect of consolidating power for the elite it clearly had disastrous consequences for science and technology. Highly skilled specialists were killed or displaced in favour of inexperienced or poorly educated *vydvizhentsy* - those who had been 'pushed up' from the peasantry or working class but who had played little part in the Revolution. They owed their social position to the regime and retained their position solely by virtue of their loyalty to it. The most frequently cited example of this phenomenon is that of T.D. Lysenko in agronomy but Lysenkoism had its counterpart in psychology and psychiatry.

The fact that Soviet political economy increasingly relied on forced and semi-forced labour had a catastrophic effect on the product of the Soviet economy. To terrorise philosophy professors may not cause a great deal of disruption but to terrorise physicists and engineers will have a deleterious effect on production sooner or later. Fear could not control the population indefinitely. If the elite were to retain control, measures had to be taken to win over a section of the population. After

Stalin's death, the opportunity was taken to make concessions to the intelligentsia. The fact that the intelligentsia plays a crucial role in the development of technology made them a valuable ally. A measure of freedom was granted: not freedom to organise against the elite but freedom to help the system work better. Scientists were needed by the Khrushchev regime in a way that artists were not and to a certain extent the restrictions were removed from them. 'Without accepting the theories of relativity and quantum mechanics, there was no way to build atomic and hydrogen bombs; without accepting the principles of cybernetics, computer technology could not be developed for industrial and military uses; without accepting these concepts, Soviet space exploration was impossible.' (Rothberg, 1972: 319).

### **THE POLITICAL ECONOMY OF THE SOVIET INTELLIGENTSIA**

'The specific economic form, in which unpaid surplus-labour is pumped out of direct producers, determines the relationship of rulers and ruled, as it grows directly out of production itself and, in turn, reacts upon it as a determining element. Upon this, however, is founded the entire foundation of the economic community which grows up out of the production relations themselves, thereby simultaneously its specific political form. It is always the direct relationship of the owners of the conditions of production to the direct producers - a relation always naturally corresponding to a definite stage in the development of methods of labour and thereby its social productivity - which reveals the innermost secret, the hidden basis of the entire social structure, and with it the political form of the relation of sovereignty and dependence, in short, the corresponding specific form of the state. This does not prevent the same economic basis - the same from the standpoint of its main conditions - due to innumerable different empirical circumstances, natural environment, racial relations, external historical influences, etc., from showing infinite variations and gradations in appearance, which can be ascertained only by analysis of the empirically given circumstances' (Marx; 1959: 791-2).

Under capitalism the extraction of the surplus is through a labour contract which has all the appearances of being freely entered into. The fact that one has no choice but to sell one's labour power does not change the fact that under capitalism the appearance is of a free and fair contract. The worker is paid (more or less) the value of his or her labour power which is determined, like other commodities, by the cost of reproducing it. The wage must be equal not only to the value of the food,

clothing and other essentials consumed by the worker but also the cost of bringing up children, of education and so on. The level of development of a given society also determines this. Hence, it can include the cost of holidays or consumer durables insofar as they too become necessities in a developed industrial society. Under capitalism, the realisation of the social surplus appears to be a part of the work process as a whole. Land, labour and capital all appear to be equal contributors to the generation of surplus value, and profits seem to be the wages of entrepreneurship. The fact that the worker's surplus labour time is the source of value is not obvious and the value of a given commodity appears to be a natural property of the commodity like its colour or weight.

The USSR was different and no one was under any illusion that the social elite was in a privileged position. The fact that the worker did not sell his labour power in a free labour market meant that the exploitative nature of the labour process was completely transparent. If any confirmation was needed, the fact that it was illegal not to have a job, or not to be at work when one was supposed to be, reinforced the point that labour was (in the case of the camps) forced or semi-forced for the overwhelming majority of the population. The Soviet system of unfree labour resulted in a defective social product that contributed greatly to its decline. It led to the familiar feature of the Soviet economy where the repair sector of the economy was larger than the production sector. An unfree workforce also meant that political instability was a feature of the system. After World War Two there was an urgent need to increase production. For this there had to be a degree of co-operation from the working population. 'To elicit such co-operation meant giving people more freedom and security (what the regime called "strengthening socialist legality") and more and better wages and working conditions, consumer goods and housing (what the regime called "material incentives")' (Rothberg, 1972: 5). It was not intended to move to any kind of democracy that would be recognisable to the revolutionary movements that founded the USSR. In short, '...people were not to be given enough freedom to contest seriously the decisions and purposes of the "centre," only enough to fulfil the centre's purposes more effectively' (Rothberg, 1971:8).

The social surplus took a different form in the USSR. Instead of money which could either be spent freely on consumer goods or used for further accumulation as capital the elite enjoyed the surplus in the form of a complex system of privileges. Accommodation, health care, transport, food and access to a wide

range of goods and services was obviously different from and better than that enjoyed by workers. The elite also had more Roubles but this was less important than their privileges. The absence of commodity production also means that, strictly speaking, the Rouble was not money at all. However, the elite often had access to real money, *valuta*, which it could either spend or accumulate, preferably abroad.

The intelligentsia had an intermediate position. The intelligentsia is defined here as anyone with a higher education. The intelligentsia may not have had the degree of control over their workplace that the elite enjoyed but they, like workers, enjoyed a certain degree of control over the work process even if this control was negative in content. In other words, whether they worked well or badly they still got paid. In addition, they enjoyed access to higher education for their children, which ensured that their children too would be able to enter the intelligentsia. Like the elite, the intelligentsia suffered from the insecurity that was a feature of the specifically Soviet form taken by the social surplus. Without real money and a free labour market all their privileges could be lost as the result of administrative fiat. One of the disadvantages of the Soviet system for the elite was that because they were not a bourgeoisie, in the sense of being property owners, their situation was always precarious. The loss of office could mean the loss of everything and this was just as true for the intelligentsia (Dzhirkvelov, 1987: 126-7).

After the initial training period, a doctor in Britain enjoys a high salary and a certain amount of control over his or her labour time. In addition, senior doctors have a good deal of control over the disposal of a proportion of the social surplus. Senior hospital doctors or general practitioners control how money is spent within the National Health Service. They can leave the NHS and work privately or may have private patients in addition to their NHS practice. This tempers the nature of their NHS contracts and although many British doctors are, effectively, salaried employees they are not all obliged to sell their labour power in the same way as most other workers. They may own their practice or shares in the private hospital in which they work. From the beginning of the NHS, general practitioner contracts preserved the traditional position of the doctor as an independent practitioner who charges a fee for services. They are paid according to a capitation fee, a payment for the number of people 'on the books', and receive further payments when they treat someone. This illustrates the difference between a Soviet doctor and a British one. Soviet doctors enjoyed little of the independence of their British counterparts; they

were low-paid salaried employees. An infraction against the state by a Soviet doctor could mean the loss of their life, degree, home, car or anything else the state decided to withdraw. Only senior doctors enjoyed some form of control over their work place. Very senior doctors, such as the director of the Serbsky Institute, were effectively part of the elite.

There was a division between the higher and the ordinary intelligentsia. 'The higher intelligentsia includes academicians, professors, writers and artists of note, successful journalists, medical specialists, much of the factory management as well as many in the political, military and police hierarchy' (Ticktin, no date: 10). This higher intelligentsia was a highly privileged group and was closely integrated with the elite. They shared many interests even if there were conflicts based on the degree of control held by those in the intelligentsia and the elite, who had political control. On the one hand, that section of the higher intelligentsia which was not governing had its own demands; freedom of speech, foreign travel and currency, more secure and easier living standards for their families to which the elite could not easily accede. This is not because they disagreed with these demands. Indeed, there is evidence that they had support from individual members of the government machine. A good example of the overlap between the higher intelligentsia and the elite was Dr. Danil Lunts, a consultant psychiatrist at the Serbsky Institute and a colonel in the KGB. As a part of the higher intelligentsia he had an interest in maintaining the *status quo*. The dominant position of his particular clique was expressed through the importance of the Serbsky Institute as one of the leading forensic psychiatric hospitals in the USSR.

The higher intelligentsia suffered heavily under Stalin but by 1953 the intelligentsia was a sizeable section of the population. In 1967 it comprised an estimated 10,676,000 (Cox, 1975: 6). The concessions made to them under Khrushchev made them practically inviolable with the aim of forging an alliance with the elite. It was the failure of this project that led to a dissident movement within the intelligentsia. In attempting to incorporate the intelligentsia the elite had great difficulty in meeting their aspirations. Many found that it was increasingly difficult to guarantee that their children would enter higher education and enjoy the benefits they expected from their position (Cox, 1975: 29). The macabre social mobility of the Stalin period ended. A failing economy meant that many of the social aspirations of the intelligentsia could not be met. Many saw their incomes fall far

behind those of manual workers. The result was dissent among the intelligentsia and the repressive use of psychiatry to control the situation. The 'Thaw' led to an increase in overt resistance to the regime and Khrushchev's economic failures exacerbated an already faltering economy (Rothberg, 1972: 80-1). Control in many cases was along familiar lines such as the shooting of workers in Novocherkassk in 1962. However, as the elite could only use outright physical terror against the intelligentsia as a last resort other means had to be found. Psychiatry came to be seen as an alternative from about 1959 (Buyanov, 1992: 19) although prisons and camps were still used. The end of the 1960's saw an increase in the abuse of psychiatry that grew to its peak in the 1970s.

Khrushchev's dilemma was that he needed to make the intelligentsia and the elite inviolate but also needed to maintain control. Without the independence that private property gives this can only be achieved by bureaucratic fiat. It was an attempt at liberalisation without the market or private property and therefore bound to be a utopian project. 'Whereas under Stalin the question of the loyalty to the regime was of some importance, by the 1950's the new enlarged elite that had been formed in the post-1917 period and purges could only be economically counterproductive besides being politically and personally intolerable. By the time Stalin died the elite's increased size and relative stability meant that there was no longer any need to give the secret police free rein but, if the elite was at least united [...] on the need to have an elite (themselves), the same cannot be said of the rest of society. For the latter, therefore, there could be no change as regards overall secret police control, although the form this takes has clearly been changed. If previously people had been executed *en masse*, or gaoled for merely making jokes, this was ended. Repression now takes the more subtle forms of dismissals, deportations, blocking promotion and making it impossible to get a job or enter an educational institution' (Ticktin, no date: 7). One can add to this list incarceration in a psychiatric hospital.

Khrushchev needed the practical benefits that would accrue from an intelligentsia, which was able to work without daily interference, especially in matters of natural science. However, the state had difficulty granting such demands particularly when the USSR was so inherently unstable. The elite needed to be able to criticise Stalin, if for no other reason than to show that there would be no return to the terror. One graphic manifestation of this was Khrushchev's denunciation of

Stalin at the Twentieth Congress of the CPSU. However, this meant that the whole of the elite could be criticised. They were all implicated in the atrocities of the Stalin period, including Khrushchev (Medvedev, 1982). Following a resolution of the twenty-second congress of the CPSU, Khrushchev's partial repudiation of the Stalin personality cult was symbolised by the removal of Stalin's body from the Lenin mausoleum. It was buried in a plot behind it.

'There is a persistent myth, [...] that Khrushchev's fall in October 1964 was, notwithstanding his many undisputed failures in domestic and foreign affairs, a victory for a neo-Stalinist wing inside the party leadership. This erroneous view is inconsistent with the earlier actions and policies of the new leadership. Censorship, far from being extended, was partially loosened with the abolition of the Ideological Commission in 1965. The production of consumption goods received vigorous support in one of the first statements of the new leadership on economic policy' (Cox, 1975:30-1). Khrushchev's removal from office did not mean an immediate return to the Stalin cult but the failure of the programme of liberalisation did. After this, a new period of Stalinisation began and the repressive use of psychiatry intensified. The grey granite bust over Stalin's grave was erected on the 25th of June 1970.

The economy ceased to be partially based on camp labour but those who took part in real protest were still imprisoned even if not in the same numbers. Although the terror eased somewhat, the fear of it and the KGB remained. Fewer people were shot or imprisoned but they were still harassed and intimidated. The problem of governing such a society remained that of dealing with the society as a whole. The explosive situation had to be avoided where the demands of the upper reaches of society were met at the expense of the necessarily unarticulated demands of the working class. As a result, the intelligentsia's demands had to be contained. At the same time the intelligentsia's demand for a return to private property could only put them in an antagonistic position to the only social force which could change the situation: the working class (Ticktin, no date: 10-11).

## **DISSENT, ART AND PUBLISHING**

The objective of allowing criticism was to ensure the regime functioned more efficiently. It was never intended that criticism would be allowed to call for an end to the regime itself. There was a line over which one could not step without



punishment, despite the fact that much of the governing elite was in agreement with many of the dissidents. While Party officials publicly attacked certain writers they privately admitted the correctness of their views, just as they attacked private enterprise but bought their clothes from underground private tailors. The system appeared to continue only because the governing elite was afraid to change it (Ticktin, no date: 12).

One of the concessions made to the intelligentsia was freedom of expression and a level of artistic freedom unimaginable under Stalin. In the arts it became possible to depart from 'socialist realism' to a certain extent and even make Stalinist repression the subject of one's artistic work. This was done most graphically by Solzhenitsyn in 'A Day in the Life of Ivan Denisovich' and other important works. Heated debates took place around art and literature. Buying a book or attending a poetry reading became an expression of discontent. In the absence of an explicitly political forum discussion was projected into art and, as we have seen, debates around psychiatric diagnoses. As it was impossible to criticise the Soviet regime openly it became possible to attack it by staging a reading of the poems of Yevtushenko (Rothberg, 1972: 41-2). The problem for the elite was that once controls had been lifted, even slightly, it became very difficult to confine criticism to the supposed causes of inefficiency. The criticism extended naturally to the regime itself; arguably the real cause of inefficiency.

If one wished to publish in the USSR, the adoption of an Aesopian language was a way of discussing the nature of the regime and avoiding the censorship and punishment that followed open criticism. For example, criticism of Soviet psychiatry was possible in the form of a literary discussion of Chekhov's 'Ward Number Six'. Alternatively, allusions were made to Chekhov's story such as Valerii Tarsis' book 'Ward Number Seven'. Another example is in a report in *Komsomolskaya Pravda*, entitled, 'Ward Number Six; Not Everyone is Discharged' (24/9/91: 1). This was also the case in psychiatric journals where heated debates over the value of a quintessentially Soviet diagnostic category such as 'Slow Flow Schizophrenia' became a way of discussing the very nature of the USSR. To defend this diagnosis was a way of supporting the existing system and those in the higher intelligentsia who used this category. To argue for the adoption of diagnoses which were closer to the International Classification of Diseases was a coded way of arguing for

'reform'.<sup>9</sup> Many publications were first released abroad. Such foreign publication was seen as being an oppositional statement in its own right. Some attempted to publish abroad in order to escape the censorship rules. Others found their work published abroad as a result of *samizdat* copies finding their way to foreign publishing houses, which were eager to publish dissident Soviet writers. Writers such as Zhores Medvedev and Viktor Nekrasov were subsequently confined to psychiatric hospital.

In psychiatry, particular journals became associated with diagnostic categories. The Korsakov Journal became associated with the conservative 'Moscow School' and Snezhnevsky's nosological classification, which included 'slow flow schizophrenia'. The Korsakov Journal was also the most widely circulated psychiatric journal outside of the USSR and represented the 'official' position of Soviet psychiatry. It was also one of very few psychiatric journals. As it reflected the official line it often contained rebuttals of criticisms of Soviet psychiatry even if it did not refer to the criticisms directly. For example Babayan (1969), the USSR's specialist on mental health law, published an article criticising some aspects of US mental health law and stating the position of Soviet law. Throughout the article there was no indication of the growing criticisms of Soviet psychiatry but it presented the official line that Soviet law was as good as if not better than US law. As the abuse of Soviet psychiatry declined, along with the USSR itself, more journals, outside of the control of the Serbsky Institute, were published. Some were clearly designed to be commercially successful. There was also a section of the psychiatric profession that was entirely in favour of a move to the market and their views were expressed through other journals that were not associated with the Serbsky Institute. Examples include the Bekhterev Journal of Psychiatry from Leningrad and 'Sotsial'naya i Klinicheskaya Psikhia', which was published from the Moscow Scientific Research Institute of Psychiatry which is located at the Kashchenko Hospital. Another example, 'Sinaps', was published in Paris, in a glossy and popular format, from 1991 by the Association for the Promotion of Mental Health and Aid to the Mentally Ill and then imported into Russia.

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<sup>9</sup> See, for example, the article by A.B. Smulevich, '*Vyalotekushchaya shizofreniya-mif ili klinicheskaya real'nost'*' (1990) and the subsequent reply by N.A. Shataylo (1991).

*Sotial'naya i Klinicheskaya Psikhia*, which was published from 1991, was clearly designed to reflect mainstream perspectives in world psychiatry. For example, unlike the Korsakov Journal, it had foreign psychiatrists on its editorial board. One of its very first articles was a critique of the state of psychiatric care in the USSR and in support of attempts to introduce mental health law (Gurovich, I. Ya. et al, 1990: 6-15).

After the official All-Union Association of Neuropathologists and Psychiatrists resigned from The World Psychiatric Association (WPA) it was quickly replaced by the Russian Independent Psychiatric Association (NPA), which was instantly recognised by the WPA. Later, the NPA became the focal point for dissident psychiatrists and a section of the intelligentsia within psychiatry that distanced themselves most fully from psychiatric abuse. They also established their own journal, '*Nezavisimy Pshikhiatricheski Zhurnal*', that played a critical oppositional role. The NPA's journal was an explicitly oppositional one and carried more political articles than clinical ones. For example, the first issue was based on the proceedings of the fourth congress of the NPA and carried articles on slow flow schizophrenia, legal problems in forensic psychiatry and 'anti-psychiatry and anti-Semitism' (Savenko, 1992).

In Soviet psychological journals there had long been a type of conformity within the subject. Soviet psychology had to be seen to be 'materialist'. This in fact bore little relation to the materialism of Marx or Lenin but was far closer to a crude positivist materialism. There was a great deal of reference to psycho-neurology and Soviet psychology shared a striking similarity with behaviourism. However, by adopting an Aesopian language, similar to that adopted in the arts, psychological journals could also express an opposition to the regime. A good example comes from the pages of *Voprosy Psikhologii*. The Russian Psychoanalytic Society was closed down in 1933. After that it became very difficult to discuss psychoanalysis. However, it was still possible for some senior members of the intelligentsia to read otherwise forbidden books such as those of Freud, Fromm and Marcuse. It was possible to denounce such writers with the usual invective such as 'idealist', 'petty-bourgeois' and so on. (Roshchin, 1974, No.6: 36-49). In so doing it was possible to give a summary of the main arguments of such writers and thereby give those who had no access to such books at least a glimpse of otherwise forbidden work and thereby make a coded criticism of the regime. For example, Roshchin, in this article

attacks Freud, Fromm and Horney on the basis of their 'biological reductionism'. It could be argued that the real target of the accusation of such a reductionist approach was in fact Soviet psychology itself.

### THREE PERIODS OF PSYCHIATRY AND DISSENT

One can identify three distinct periods of the development of Soviet psychiatry. From 1917 to 1929 it played no role as a repressive state response to dissent. Moreover, there was so little psychiatric provision that it probably played only a marginal therapeutic role. In so far as it existed it was overwhelmingly part of the mainstream of world psychiatry. There was nothing distinctively 'Soviet' about it. If anything it was distinguished by being rather underdeveloped. That is, there was rather poor provision spread thinly over the country with the church still playing a role in the care of the mentally ill. All the currents of Western psychology and psychiatry were influential in Russia. From around 1925 the calls for a distinctively Marxist psychology began to exert some influence in academic departments of psychology but its influence on clinical psychology was hardly felt. It was still possible to publish work from a psychoanalytic perspective up until 1929.<sup>10</sup> The increasing bureaucratisation of the elite meant that calls for a distinctively Soviet psychology and psychiatry gradually began to be influential after 1929. From about 1935 a distinctive Soviet psychiatric nosology developed. From 1929 to 1953 Soviet psychology and psychiatry became isolated and acquired their distinctive character but still played little or no overtly repressive role.

There is an important distinction to be drawn between the macabre social mobility of the 1930s and the kind of competition between groups within the intelligentsia under Khrushchev and Brezhnev. In the 1930s people like Lysenko, Blonsky or Chelpanov were able to make their way into the higher intelligentsia largely on the basis of their loyalty to the regime. They were the upwardly mobile who would use Stalinism as the means of entry into the intelligentsia and the elite and their main victims were Marxists and the former bourgeois intelligentsia who were displaced from their jobs for ideological reasons and often killed. The competition between different groups within Soviet psychiatry in the declining years of the USSR was a debate about the move to the market. It centred on questions like

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<sup>10</sup> See, for example, Kannabykh, *Istoria Ochestvennoi Psikhiatrii*, Leningrad, 1929.

the diagnosis of slow flow schizophrenia because such coded debates were one of the few ways social issues could be discussed at all. These were also debates within a large and fairly stable group.

Only after 1953 did Soviet psychiatry take on the role of systematically being used by the state to control dissent. This view is supported by Gusarov when he says; 'It was better under Stalin only in one respect: with all the shooting left and right, the Stalin regime absolutely did not use psychiatric hospitals as a means of "defending society".' Indeed, from Gusarov's account it would seem that, compared to other forms of repression under Stalin the psychiatric hospital was an 'oasis of humanism'. Little mention of drugs is made. Perhaps this is not surprising, as psychotropic drugs did not come into widespread use in the West until the 1950's. Gusarov gives us this picture of life in a psychiatric hospital under Stalin: 'In the third department of Kazan hospital, Melnikov plucked away on a mandolin, Vakhromenyev tortured an innocent guitar, the cross-eyed right wing deviationist studied English, I and the Irkutsk gynaecologist battled for the title of chess champ, Inyakin, the "inventor of ether", was getting together a volleyball team whilst Yura Mikitchenko, the writer, conformist and undisguised informer, pored over Lenin. And one may add to this that, although their "crimes" were rather dubious (for example, while drunk, I used unprintable words about Stalin), ninety-five percent of these people were really sick. In view of this the overall picture doesn't appear quite so grim' (Guserov, in *Fireside* 1979: 156). As Gusarov implies, this does not mean that psychiatry was not abused at all, but that its systematic and widespread use did not begin until after Stalin's death. Moreover, insofar as Soviet psychiatrists played any political role at all it was as likely to have been benign. From the beginning of the terror in 1936 psychiatric hospitals became one way which a person could escape the camps and firing squads. The majority of psychiatrists had been trained under the old regime and were hostile or indifferent to it. Such 'abuse' as there was often took the form of diagnosing opponents of the regime as mentally ill in order to save their lives.

There are examples of dissidents confined in psychiatric hospital as early as 1949 such as Aleksandr Yesenin-Volpin who was arrested and imprisoned because of two of his poems. He was confined to a hospital and only later sentenced to five years in exile. He was released with the 1953 general amnesty. In this case, as with other early cases of psychiatric abuse, the use of psychiatry was not the primary strategy for dealing with dissent. Although it did not save Yesenin-Volpin from a

psychiatric hospital the declaration of non responsibility may have saved him from a worse fate. This is a view that Yesenin-Volpin himself took when he testified before a US Senate sub-committee established to investigate the allegations of Soviet psychiatric abuse. He said; 'I was arrested for the first time in 1949 on charges of having engaged in anti-Soviet agitation. For several weeks I was kept in jail. From there I was sent for a psychiatric examination to the Serbsky Institute of Forensic Psychiatry in Moscow. There I was declared "not responsible" for my actions and interned in a Leningrad prison hospital. I remained in this institution for about a year. In the conditions of Stalin's era, I was inclined to consider this confinement not so much a measure of repression, but rather as a chance of escaping a much harsher punishment' (Yesenin-Volpin, 1973: 15).

Prior to 1949 there were also accounts of patients held without treatment of any kind. They were permitted much more freedom of movement than one could possibly hope for in prison or a labour camp. The Kashchenko psychiatric hospital, in Moscow, is actually set in very pleasant grounds, although how much access to them was permitted in 1949 is not known. For those allowed into the grounds now it is also fairly easy to walk out of the hospital as there are a number of exits and it is only twenty minutes' walk to the nearest Metro station.

Even Bloch and Reddaway, who imply that psychiatric abuse has been a ubiquitous feature of Russian and Soviet history, acknowledge that not only was there less confinement of political detainees in psychiatric hospitals under Stalin but that it may well have saved them from a worse fate. The problem with their account of psychiatric abuse in the early Soviet period is that it contains some evident distortions. They cite the cases of Angelica Balabanova, a leading Bolshevik activist who they suggest was ordered to a 'sanatorium' because of disagreements with the Party. Their only source for this is her memoirs 'My Life as a Rebel' and they quote her out of context. If the full quote is included then it is clear that psychiatry was at no time even suggested. Similarly, the Socialist Revolutionary, Maria Spiridonova, is cited as an early victim. Once again the only source they cite contains no reference to psychiatry.

The only source Bloch and Reddaway cite for Soviet psychiatric abuse under Stalin is an anonymous émigré psychiatrist who published his experiences in the *American Journal of Psychiatry*. One of the accounts of this psychiatrist was of being pressurised to concur with the diagnosis of his colleagues regarding the case of a

young worker who, although sane, was diagnosed as schizophrenic. By arguing for the man's sanity he 'might well have rendered the "patient" vulnerable to what would probably have been a harsher form of punishment - imprisonment or detention in a labour camp, and the possibility of death there' (Bloch & Reddaway, 1978: 51-2).

The first accounts of abuse in the West emerged in 1970. The American Journal of Psychiatry carried a series of four letters from an unnamed Soviet Psychiatrist who had left for the USA shortly after World War Two (Bloch & Reddaway, 1978: 51).<sup>11</sup> He described his experiences at the Kazan psychiatric hospital where there were many political detainees. Up until 1949 even hospitals like the Serbsky were regarded as relatively humane given the possible alternatives (Bloch & Reddaway, 1978: 52-3). It is hard to escape the conclusion that staff in the psychiatric hospitals were aware that they could potentially save people from exile and death in the camps and tried to keep them in hospital.

After 1949 it seems that the elite became aware that psychiatric hospitals had become a means of evading the more violent forms of social control. A special commission was appointed to investigate the Serbsky Institute. It was headed by R. S. Zemlyachka and ruled that fewer defendants were to be found not responsible. It is also at about this time that Dr. Danil Lunts was appointed and it seems that his appointment was in large part an attempt to 'tighten things up' at the Serbsky Institute. This included finding fewer people as not responsible in law by virtue of mental illness (Bloch & Reddaway, 1978: 53-5).

A further commission to investigate psychiatric services was instituted in 1955 but its report has never been published. Some argue that it led to political detainees being released but it is not clear whether those detainees were in psychiatric hospitals because psychiatric staff were trying to keep them out of the camps or because the state was trying to punish or harass them. What is clear is that on 24th of May 1959 an article appeared in Pravda in which Khrushchev appeared to equate social deviance with insanity: "A crime is a deviation from the generally accepted standards of behaviour, frequently caused by mental disorder. Can there be

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<sup>11</sup> The issues of the American Journal of Psychiatry Bloch and Reddaway refer to are; Vol. 126: 1327-1328; Vol. 127: 842-843; Vol. 128: 1575-1576 and Vol. 131: 474.

diseases, nervous disorders among certain people in the Communist society [of the future]? Evidently there can be. If that is so, then there will also be offences which are characteristic of people with abnormal minds. To those who might start calling for opposition to Communism on this "basis", we can say that now, too, there are people who fight against Communism...but clearly the mental state of such people is not normal" (*Pravda*, 24/5/59 quoted in Bloch & Reddaway, 1978: 62). If one were to choose a particular point at which Soviet psychiatry took the form of an explicitly repressive tactic, it could be pinpointed to Khrushchev's statement.

## **THE DECLINE OF SOVIET PSYCHIATRIC ABUSE**

When Joseph Wortis wrote 'Soviet Psychiatry' in 1950 there was little to indicate the controversy that would erupt by the middle of the 1960's. Wortis confined himself to painting a very positive picture of his subject matter and there is none of the defensiveness which later became commonplace. Nowhere did he feel compelled to answer any criticisms of the state abuse of psychiatry. At that time there were no public references to Soviet psychiatric abuse in the USSR or the West. The work of Soviet psychologists and psychiatrists was published in translation and was taken up by some Western academics with enthusiasm. Those who popularised Soviet psychiatrists and psychologists were inclined to argue that their work was, in some way, a Marxist account of the subject. They fell into the trap of taking at face value the terminology which Soviet writers needed to employ in order to be published at all. Those who were engaged in bringing Soviet psychiatrists and psychologists to a wider Western audience often did so uncritically. Some, like Wortis, were explicit supporters of the USSR, others gave their support tacitly by an uncritical appraisal of Soviet psychology and psychiatry.

The first complaints about the political abuse of psychiatry began to appear in Britain in 1965 when the Observer published a serialisation of Valerii Tarsis' *Ward Number Seven*. There followed a flurry of exposes in the British quality press. In the early 1970s articles appeared in the American academic press detailing particular cases and urging psychiatric associations around the world to take action against their Soviet counterparts. From 1970 onwards a series of books were published giving detailed accounts of the treatment suffered by dissidents. Most concentrated on the abuse of psychiatry for political reasons which became a means of discrediting the USSR and a weapon in the Cold War. The focus was on how Soviet



psychiatry violated civil rights and few were concerned with the generally poor level of service for all Soviet citizens. In other words, little attention was given to the fact that Soviet psychiatry was defective, as were somatic medicine and all other Soviet products. Needless to say, the Soviet authorities and their allies strenuously denied all the allegations contained in the Western press. In criticising Soviet psychiatry the usual implication was that liberal democracy is the best guarantee of a science free of value judgements and ideological interference. The best guarantor in medicine is portrayed as a self-regulating medical profession. Holding the USSR up as an example of socialism in action was a useful means of discrediting socialism itself and there were repeated assertions that the seeds of psychiatric abuse lay in the works of Marx and Lenin themselves.

The Western medical establishment quickly took up the issue often in a way that was not dissimilar to the dissidents themselves. That is, they emphasised the illegal detention for political reasons. Sometimes discussion of the problem entailed an examination of the patient *in absentia* on the basis of his writings and accounts of witnesses. For example Andre Masters, writing in *The Lancet*, stated that 'My own study of the "Bukovsky Documents", assuming these are factually correct and are exact translations, leads to the following conclusions. In the cases of P.G. Grigorenko, I. Yakhimovich, V. Borisov, and V. Kuznetsov, the psychiatric reports contain no evidence to support the diagnoses but are based on purely political considerations. In the case of Z. Medvedyev, (sic) there appears to be a gross misapplication of psychiatric authority, the whole episode being full of illegalities. In the case of the other detainees, there is not sufficient evidence, but their writings suggest completely rational thinking and no hint of mental illness.' He goes on: 'Basically the Soviet mental-health legislation seems to have more safeguards for the patient than the British Mental Health Act or its derivatives here in Canada' (1972: 376-7). In other words, the problem was seen as a technical one and therefore amenable to reform. It was also seen as a problem that could be repeated in the West without the vigilance of an independent medical profession and an independent press.

The first article to appear in the American press appeared in the New York Times (13/12/69) which reported that Major General Grigorenko had been arrested in May 1969 on charges of anti-Soviet activity and that it was not uncommon to confine dissenters to psychiatric hospitals. This was followed by a series of

anonymous letters in the American Journal of Psychiatry (9/3/70: 1327) from a psychiatrist who has previously worked at the Kazan SPH, the first of which merely supported the accusations made regarding Grigorenko. The second letter (6/12/70: 842-3) contained a few interesting revelations. Of these the first was confirmation of the use of 'wet wraps' as a treatment. The second was that Jan Pilsudski, the brother of Joseph Pilsudski, was held in the Kazan SPH in 1941, but that the fact that he was in a psychiatric hospital may have made him 'one of the lucky ones since he happened not to be an inmate of the Katyn Camp near Smolensk, where high Polish dignitaries and Army officers were detained. All 10,000 of these prisoners were executed by the Soviet secret police in June and July 1941, after the Germans attacked the Soviet Union.' It seems that in the path of the advancing German Army it was Soviet policy to kill all political prisoners but to evacuate to safety all psychiatric patients. This second letter from the anonymous psychiatrist ended with a call to the American Psychiatric Association to take steps through various international bodies against the USSR.

Soviet psychiatry also had its defenders in the USA and the American Journal of Psychiatry published a letter from an American psychiatrist who had visited the Moscow Neuropsychiatric Institute and the Bekhterev Institute in Leningrad (Bengelsdorf, 1971: 1575). This was accompanied by a rejoinder by the same anonymous psychiatrist who pointed out that prestigious institutes in major Soviet cities were regarded as showcases and were usually the only places that foreign visitors were allowed to see. From the early 1970s to the withdrawal of the All-Union Society of Neuropathologists and Psychiatrists (VONP) from the World Psychiatric Association in 1983 most of the Western press coverage took the same form, the condemnation of the punitive treatment of dissidents.

## **WITHDRAWAL FROM THE WORLD PSYCHIATRIC ASSOCIATION**

After the first calls for sanctions against the official representatives of Soviet Psychiatry a campaign developed to pressurise the USSR to release dissidents and reform the practice of psychiatry in line with the West. This was focused on three main areas; the apparent lack of legal safeguards for the mentally ill against arbitrary and punitive treatment and the facts that treatment was not based on current scientific research and that diagnoses were inconsistent with the International Classification of Diseases.

The first professional psychiatric association to publicly condemn the abuse of psychiatry in the USSR was the Canadian Psychiatric Association in January 1971. However, it was the increasingly public condemnation in the World Psychiatric Association (WPA) which had the greatest impact. The WPA was founded in 1961 as an association of national professional psychiatric associations. The USSR was affiliated and represented by VONP; although the constitution of the WPA can recognise any professional psychiatric association for purposes of affiliation the USSR was represented by one official state-sponsored body. The leadership of this body was implicated in much of the abuse and connected to the KGB. Other affiliates of the WPA also included the professional psychiatric associations of other Warsaw Pact countries.

There was an attempt to get the WPA to discuss Soviet psychiatric abuse at its congress in Mexico in 1971. The WPA has a world congress every six years. In 1971 Vladimir Bukovsky, an active dissident, who had been deported from the USSR in exchange for the Chilean communist Luis Corvalan, led the campaign for over ten years. However, the issue was not discussed owing to the threat of the Soviet Psychiatric Society to withdraw from the WPA (Bloch & Reddaway, 1984: 43).

The General Assembly of the WPA condemned the political abuse of psychiatry at its Honolulu conference in August 1977 by a narrow majority of 90 to 88 with 8 votes declared invalid (Bloch & Reddaway, 1984: 57). The voting system allocated votes to societies on the basis of the dues paid per head of membership of the society up to a maximum of 30 votes. This meant that poorer associations were penalised. For example, the American Psychiatric Association had 30 votes whereas the VONP, which was entitled to 30 votes, had only 23 votes as it had not paid dues for all its members. If the voting had been on the basis of one vote per country the balance would have been 19 in favour of condemning the USSR and 33 opposed. The Soviet response was to issue a statement condemning the WPA action as a politically motivated slander and the vote as having been rigged.

The Honolulu congress also established a code of ethics for psychiatrists, The Declaration of Hawaii states that 'The psychiatrist must on no account utilise the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to co-operate' (Bloch & Reddaway,

1984: 235). This was taken to be a coded critique of the USSR. A further resolution, put forward by the American delegation, established a committee to investigate complaints of psychiatric abuse. Although the resolution formally condemned abuse wherever it occurs, it was interpreted as aimed at Soviet psychiatry and the Soviet delegation and their allies opposed it.

The period between the Honolulu congress and the congress scheduled for Vienna in 1983 saw a concerted campaign to persuade affiliates of the WPA to support a resolution that would expel, 'withdraw membership from' or suspend VNOP. As it became clear late in 1982 that some form of sanction would succeed VNOP pre-empted any action by resigning in January 1983. The letter of resignation was signed by, among others, Georgii Morozov, Director of the Serbsky Institute and head of VNOP.

There was no mass walk-out of other Warsaw Pact members of the WPA. Czechoslovakia and Bulgaria resigned although some Czech psychiatrists contacted the WPA to say they wished to attend in a personal capacity. However, the Czech government refused their exit visas. The Polish delegation suffered similarly but contacted the WPA to say that their absence should not be taken to imply that they wished to resign. The Romanian delegation attended but as non-voting members as they had not paid their dues. Only the Cuban delegation staged a walk-out, having attended early sessions (Bloch and Reddaway, 1985: 213-7). The Vienna General Assembly of the WPA in July 1983 passed a resolution saying that the WPA would welcome a return of the VONP but on condition that there was sincere co-operation and concrete evidence that political abuse had come to an end. This was to include a visit by a mostly American delegation.

Reforms were made in the USSR order to regain access to the WPA but mainly because profound political changes in the USSR had meant that psychiatric abuse had outlived its usefulness and by the time of the next General Assembly of the WPA in Athens in 1989 had become a liability. Dr. Anatoly Koryagin, who was imprisoned in 1981 for seven years in a labour camp and five years of exile, was released in 1987 and was allowed to emigrate. On the 1<sup>st</sup> of March Special Psychiatric Hospitals were transferred from the Ministry of Internal Affairs to the Ministry of Health (Halpern, 1989: 135). A resolution of the Supreme Soviet (No.8282-xi) was passed in 1987 and became the Soviet Union's first law regulating the detention of the mentally ill. The open confession that the USSR had abused

psychiatry was part of a concerted attempt to rejoin the WPA. However, by then, the dissidents were the political heirs of a disintegrating system. Behind Glasnost' and Perestroika was an acceptance of the need to move to the market. That section of the elite which was sympathetic to the demands of the dissidents won the day politically when Andropov became General Secretary of the CPSU. Despite the brief interregnum of Konstantin Chernenko, the momentum toward the market resumed with Gorbachev. Soviet psychiatric abuse became redundant.

## **THE REFORMS OF GLASNOST' AND PERESTROIKA**

In the spring of 1989 the Soviet Government allowed an official delegation of psychiatrists and forensic experts from the United States to interview patients, selected by the delegation, in whose cases hospitalisation was believed to have been politically motivated. The delegation inspected two forensic and two ordinary psychiatric hospitals and released a 100 page report in July 1989. The Soviet government released a response shortly thereafter.

Prior to the visit a number of patients were discharged. Only 13 of the original 37 hospitalised patients were still in hospital. A further 2 were added to the list of hospitalised patients. In addition to the 15 hospitalised patients a further 12 discharged patients were interviewed by the delegation. Nine of the 15 hospitalised patients were found to have severe psychotic symptoms. One had a severe personality disorder. Patients' records were often incomplete. Five of those who were still hospitalised 'were found to have no mental disorder according to international diagnostic criteria. Of particular concern was one patient who had been hospitalised in December 1988 (two months before the delegation's visit) with a diagnosis of schizophrenia, following an intense period of human rights activity. Because he was on the psychiatric register as a result of a prior hospitalisation, it had been possible to re-hospitalise him quickly. Among the 12 released patients interviewed by the delegation, the interviewers found no evidence of any past or current mental disorder in nine, and the remaining three had relatively mild symptoms that would not typically warrant involuntary hospitalisation in Western countries' (Bonnie, 1990:124) At that time the dissident, Aleksandr Podrabinek, said that there were at least 30 confirmed cases of people who are still committed to mental institutions as a result of political activities, and 120 or so other suspected cases. (The Washington Post, 12/2/88: A32).

The USSR began to detail psychiatric abuses in a newspaper expose on the 21st November 1988. The article said that arbitrary diagnosis, abuse of power and bribery were widespread in the psychiatric system. Interestingly, Dr. Mikhail Buyanov wrote the article in *'Uchitel'skaya Gazeta'* saying 'that during the 1970s Soviet psychiatrists gave law enforcement officers "the idea that anyone opposed to anything was hiddenly or openly a mental case". He added that members of a demoralised profession had been willingly deputised by "extra-medical organisations and officials"- an apparent reference to law enforcement officials and the KGB - and "acceded to any whim of the local authorities." Although articles in the Soviet press since the summer of 1987 have criticised some Soviet psychiatrists as corrupt, poorly trained and ineffectual, Mr. Buyanov goes well beyond anything published here in charging, as Western critics and Soviet dissidents have long maintained, that Soviet psychiatrists systematically abused their profession to suppress dissent. Mr. Buyanov said attempts were made to arrest people for "giving their opinion - opinions that were later heard from the rostrum of the 27th congress of the Communist Party and the 19th All-Union conference of the Communist Party." Dramatically, the author referred favourably to Anatoly Koryagin, a Kharkov psychiatrist who was imprisoned after he refused to issue a diagnosis saying a labour union activist and other dissidents were mad, and began reporting psychiatric abuses to the West. The article's content was muted to some extent by its authorship and its forum. Dr. Buyanov plays no role in the Soviet psychiatric hierarchy, and *'Uchitel'skaya Gazeta'*, although a national paper, has no governmental or Communist Party stamp. Earlier statements by officials in the Soviet psychiatric profession have admitted no more than occasional random errors by poorly trained or weak willed local doctors. Mr. Buyanov said he was expressing a personal opinion and "not speaking as an official." The defenders of the practices of the 1970s still hold prominent posts and other top officials in the profession have acknowledged no more than sporadic instances of abuse.

Citing the case of Zhores Medvedev, a biologist who was forcibly committed to a mental institution for more than a month in 1970 after writing articles debunking the pseudo-biological theories of Trofim D. Lysenko, Mr Buyanov said that the Medvedev case "opened a new chapter in the history of Soviet psychiatry. True, people were placed in mental hospitals for political rather than medical reasons

before but after 1970 this was done more often”, he said. “We erred. We erred consciously. It is necessary to recognise this” (The New York Times, 22/11/88: A9).

It is interesting that this was published in *‘Uchitel’skaya Gazeta’*, the newspaper of the teaching profession and not one of the medical journals. In addition to the reasons given in the New York Times article, this was probably due to the fact that the editorship of, for example, the Korsakov Journal was heavily implicated in the abuse and one would have expected a good deal of resistance to such a revelation. It also meant that the admission did not receive the widespread circulation of a newspaper like Pravda.

The 1988 law was explicitly drafted with the criticisms of Soviet psychiatry in mind. It made it an offence to detain someone for reasons other than mental illness and gave rights of appeal to patients and relatives, although the extent to which this was probably formal rather than substantial has already been discussed.

In 1988 it was announced by the Ministry of Health’s Chief Psychiatrist in Moscow that two million psychiatric patients were to be taken off the psychiatric registers. The patients would be removed from the lists as part of the government’s reforms. Dr. Kabanov acknowledged that in the past some doctors decided to ‘send people to institutions for instance, for reading Bulgakov’s works or for reading Pasternak’s verses and poems and said that “Of course, such mistakes will not be repeated”. The official news agency TASS described the event as a news conference to discuss “blank spots in psychiatry” (The Washington Post, 12/2/88)’.

By about 1989 the remaining dissidents, who were not mentally ill, were released from hospital. By 1990 the Supreme Soviet admitted that the 1988 decree on psychiatric care was insufficient to guarantee patients’ rights but this was never ratified. In 1991 the USSR ceased to exist. In 1992 the Russian Federation passed its own law protecting citizens from arbitrary confinement and the rights of the mentally ill. The use of psychiatry to persecute Soviet dissidents came decisively to an end. In all the number of dissidents was probably between 500 and 1,000. This was the aspect of Soviet psychiatry most widely discussed. The numbers of people kept in inadequate conditions receiving inferior treatment probably ran into millions. Since the end of the USSR the health of those living in the former USSR has declined dramatically except for those who always enjoyed better access to medicine. Now, instead of clinics reserved for Party members the new Russian capitalists can either go abroad for treatment or, like Yeltsin, bring in top American surgeons. So far there

is no evidence of any modern political abuse of psychiatry. But there is plenty of evidence of a disintegrating medical service and indicators that all aspects of health are declining including mental health. About this the Western press is almost silent.



## CONCLUSION

Throughout the 1960s and 70s Soviet psychiatry was exposed to a level of scrutiny that no other medical service in any other country has been. The descriptions of Soviet psychiatry were consistent, numerous and usually damaging. However, descriptions are not explanations and the fact that such revelations were made during the cold war meant that political objectives were often more important than trying to understand what lay at the root of Soviet psychiatric abuse. In concentrating on the state abuse of psychiatry other factors were ignored, such as the fact that Soviet medical services were uniformly poor and even non-dissidents were victims of a brutal, repressive regime which put medical care, at least for the working class, low down on its list of priorities.

The fact that what information there was came from those on the political right whose objective was to discredit not only the USSR but the entire socialist project meant that the political left either defended the USSR or remained silent. This is unfortunate as the fact that Soviet psychiatry was so different meant that an analysis of it provides a key to understanding psychiatry in capitalist countries. However, perhaps the left should not be reproached too severely. After all, the number of people who are genuinely on the left, as opposed to Stalinists and social democrats, is actually very small. Of those, few will have had the opportunity to undertake any serious theoretical education let alone learn Russian and undertake research into an apparently arcane subject.

However, the prerequisite for understanding Soviet psychiatry was not being able to spend time talking to Soviet psychiatrists but understanding the nature of the USSR itself. For this there has been ample evidence for many years that it was neither capitalist (state or otherwise) nor socialist (state or otherwise).

If I had to choose the two most important texts for understanding Soviet psychiatry they would be Ticktin's 'The Origin of the Crisis in the USSR' and Pashukanis' 'General Theory of Law and Marxism'. Their combined importance struck me on one day in the library of the Serbsky Institute in 1992 when it occurred to me that *there are no laws protecting the Soviet mental patient as there is no law in the USSR*. It is from this that the rest of my explanation for the nature of Soviet psychiatry follows. There are other explanations for important features of Soviet psychiatry but they too follow from the fundamental nature of Soviet political economy. Therefore, this thesis

has been something of an exploration and critique of other explanations of Soviet psychiatry.

Soviet political economy made the psychiatric patient vulnerable but it also made the psychiatrist so dependent upon the state that he could not resist the pressure to play a part in the repressive use of psychiatry. However, the period in which psychiatry was used for repressive purposes was a relatively short one. From 1917 until about 1950 it had no place alongside more direct forms of terror such as labour camps. During this period psychiatrist actually did resist the regime in the only way they could, by keeping people out of the camps. After 1953 psychiatry came to play a new, historically specific role of keeping the intelligentsia under control without the reversion to direct violence. By this time there were many more psychiatrists who had trained under the Stalinist regime and who knew that in order to advance one's career it was necessary to co-operate with the state.

Psychiatry in the Russian Empire was late in developing and when it did it was following the state taking an active role in promoting it just as the state had played an active role in the development of capitalist industry. The Russian medical profession was similarly less well developed than in, say, Britain. The weakness of the liberal professions in Russia was the result of an equally poorly developed bourgeoisie. During Russia's revolutions of 1905 and 1917 the weak and divided ruling classes could not prevent the proletariat taking power. Similarly, the liberal professions were powerless to exert any real influence. Their own demands at times also went beyond the narrow demands for higher pay, status and professional autonomy. However, the lack of a medical profession on the Western model is not the explanation for why it was possible for the Soviet elite to use psychiatry as a repressive force unprecedented in history.

Russian psychiatrists were educated in the traditions of Western medical science. Soviet medical science in general and psychiatry in particular only differentiated itself from the rest of the world in the 1930s. Even after Soviet psychiatry had formally become based on 'Marxist-Leninist' principles, the extent to which Soviet psychiatrists themselves adhered to such views is highly questionable. When a psychiatrist wrote an academic paper he put in references to Marx or Lenin in order to get the paper accepted but in fact all Soviet science, including psychiatry, used a distorted positivist methodology and not a Marxist one.

The heated debates around a Marxist psychology in the 1920s were only partly motivated by theoretical considerations. For the most part, the debates were really an

expression of the growing bureaucratisation of the USSR and a concomitant destruction of scientific scholarship, particularly from a Marxist perspective.

All Soviet products were defective and psychiatry was no different. Crude quantitative indicators were used to give the impression of progress in industry and the social services. This masked a situation where the USSR produced a vast amount of waste and goods which were inferior to anything produced outside such a system. However, a defective medical service is still a medical service of sorts. Treatment was free and did provide some useful treatments. The gross inequality of the Soviet system has now been compounded by a worse one under capitalism and this is reflected in the worsening health of the population of the FSU. As in the wealthy capitalist countries the poorer one is in the FSU the worse the state of one's health. However, in the FSU this has led to a dramatic decline in health as measured by standard indicators such as infant mortality and life expectancy. Many of these premature deaths are caused by diseases that are related to stress and poverty. Deaths from alcohol abuse have soared, as have deaths from heart disease.

The state has put into place a mixed private and public health care system but the system of social insurance is failing in the face of a population which is so impoverished that they cannot possibly pay for medicines even if they can receive a free consultation. In psychiatry, the increased stress has led to more suicides although reliable figures are hard to find. Of those who do receive treatment the majority will find that the hospital they are treated in is falling apart and they will have to rely on relatives and friends to feed them as the hospital probably won't. However, if one is of the Russian new rich the situation is totally different. Good quality private care is available in Russia and there is always the alternative of either going abroad or, as Boris Yeltsin has done, have a foreign specialist come to him. There will be no reconstruction of the FSU along the lines of the post-war Marshall plan. The market is not only not working for the majority of Russian people but has had some disastrous consequences.

Soviet psychiatry was abused for political reasons and with the end of the USSR it outlived its usefulness. It is unlikely to be used in a similar way in the near future. It is equally unlikely that as many books will be written about the thousands dying of poverty in the FSU as were written about Soviet dissidents, many of whom were demanding a transition to capitalism. Many of the prominent dissidents who publicised the abuse of psychiatry were able to leave the USSR. The intelligentsia, whom they represented, is now suffering badly under the new conditions. The rapidly changing social conditions in the FSU will require constant study in order to understand the

impact of the changes. One of the most important areas of such study must be health. One of the most worrying trends in the health of people in the FSU is the re-emergence of infectious diseases on an alarming scale. The increasing poverty in the FSU means that inevitably people will seek a better life in Western Europe. Even if that were not the case diseases like tuberculosis do not respect geo-political boundaries. Now that the Cold War is over there is a tendency to regard the FSU as being less important as an area of study. Arguably, the deepening crisis of peoples health is one reason why it has never been more important.

## APPENDIX ONE

### STATUTE: ON THE CONDITIONS AND PROCEDURES GOVERNING THE PROVISION OF PSYCHIATRIC ASSISTANCE.<sup>1</sup>

#### I. General Regulations

1. The present statute, in accordance with the fundamentals of health legislation in the USSR and the Union Republics and other legislative documents, defines the circumstances and procedures governing the specialised medical treatment in the case of persons with psychiatric disorders and for the protection of their rights and for the protection of their rights and legal interests; also what measures should be taken to protect society from the dangerous acts of mentally ill persons. Psychiatric treatment is administered according to the principles of democratism, socialist legality, humanism and compassion.
2. Persons suffering from mental disorders are guaranteed: Free medical treatment by qualified staff and based on modern research, techniques and medical practise; treatment using compassionate methods and medical preparations permitted by the USSR Ministry of Health in conditions which are only as restrictive as necessary for the success of the treatment; a respectful and humane approach, without any infringement of the patients human dignity; Social and legal assistance, judicial protection, supervision by the Procurator, the help of a lawyer to safeguard their rights and legal interests. The patient, his family or legal representatives may request the inclusion of any psychiatrist employed in an institution of the local health authority in the commission, which examines him. A person may not be deprived of his rights nor subjected to a restriction of his legal rights solely on the grounds that he is under psychiatric observation or in a psychiatric hospital (section). The internment in a psychiatric hospital (section) of a person known to be mentally healthy is a criminal offence, punishable in accordance with the law of the Union Republics.

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<sup>1</sup> Passed by a Decree of the Presidium of the Supreme Soviet, 5, January, 1988 (No. 8282-XI) and came into force on the 1<sup>st</sup> of March 1988. Published in English by Van Voren (Ed.), 1989. This is a copy of that translation. The only amendments that I have made are the correction of obvious typographical errors.

3. When there are adequate grounds to suppose that a person is mentally disturbed, he may only be subjected to a psychiatric examination, dynamic out-patient observation, or treatment in a psychiatric hospital (section) without his consent under the conditions and procedure established by the present statute.
4. In fulfilling his duties concerning the medical treatment of mentally ill persons and preventing the commission of socially dangerous acts, a psychiatrist must act independently and be guided solely by medical criteria and the law.
5. Persons, who in the course of their duties have access to information concerning mentally ill persons, are not entitled to reveal this. Such breaches of confidence will be penalised in accordance with current legislation.
6. The management of prophylactic-medical institutions providing the population with psychiatric treatment and the task of ensuring that legislation on the protection of people's mental health is complied with, are the responsibility of the Soviets of People's Deputies and their executive and managerial organs, in accordance with the legislation of the USSR and the Union Republics.
7. Executive committees of local Soviets of People's Deputies are obliged to undertake the care of the mentally ill, to defend their rights and legal interests and to try and include them in the life of society by: providing jobs in local enterprises, setting up special production units with easier working conditions for those with limited work ability; appointing guardians (legal representatives), in accordance with established legal procedure, for those mentally ill persons who need them; helping to provide improved living conditions for such persons; taking steps to provide other forms of social assistance.

## II. Initial Psychiatric Examination

8. The initial psychiatric examination can only be carried out by a psychiatrist, with the consent of the examinee, or, in the case of a person under 16 years of age with the consent of his parents, guardian, or warden. In cases where a person's mental condition cannot be assessed under out-patient conditions such an examination will be carried out in a psychiatric hospital (section). The psychiatrist carrying out the initial examination is obliged to introduce himself formally to the examinee.
9. A person whose actions give sufficient grounds to conclude that he is suffering from a mental disorder and which disrupts social order or infringes the rules of the socialist community and also constitutes a direct danger to himself or those

around him may be subjected to an initial psychiatric examination without his consent, or that of his family or legal representatives, on the orders of the chief psychiatrist or in an emergency, on the orders of a psychiatrist attached to a specialist first-aid brigade or territorial medical-prophylactic institution.

10. Should doubt arise as to the mental health of a person who engages in socially dangerous activities which come under the jurisdiction of the criminal law, he must be sent for a forensic psychiatric examination in accordance with the Code of Criminal Procedure.
11. Anyone who disagrees with the conclusions reached regarding his mental health is entitled, as are his family or legal representatives, to appeal to the chief psychiatrist of the health authority with jurisdiction over the prophylactic-medical institution where the diagnosis was carried out. The chief psychiatrist is obliged to establish a commission of psychiatrists to examine the person who has appealed and will reach his own conclusion on the basis of the commission's findings. Psychiatrists involved in the initial examination may not be included in the commission.

### III. Out-Patient Psychiatric Help

12. Out-patient psychiatric help, whether consultative, medical or rehabilitary, including dynamic observation by a dispensary, is carried out at the patient's request, or with his consent. If the patient is under 16 years of age, or his mental state prevents him making a decision of his own free will, such help is given with the consent of his family or legal representatives.
13. Persons suffering from chronic psychiatric illness which tends to take an unfavourable course and requiring compulsory treatment and dynamic dispensary observation, will be given out-patient psychiatric treatment without asking their consent, or that of their families or their legal representatives, in accordance with the procedure established by the USSR Ministry of Health.
14. The decision as to the need for compulsory dynamic dispensary observation and when to discontinue it is taken by a commission of psychiatrists. In complex and controversial cases the commission is led by a chief psychiatrist. The reasons for the need for compulsory observation must be explained to the patient's family or legal representatives and, if his condition permits, to the patient himself.

#### IV. In-Patient Psychiatric Treatment

15. A patient may be admitted to a psychiatric hospital (section) if his mental condition requires examination or treatment in hospital conditions. Admission to a psychiatric hospital (section) is carried out on the orders of a psychiatrist, with the patient's consent; if he is under 16 years of age, or his mental state renders him incapable of functioning properly, the consent of his family or legal representatives must be obtained; in their absence the psychiatrist must act in agreement with the chief psychiatrist.
16. Persons whose mental state represents a direct danger to themselves or those around them may be admitted to a psychiatric hospital (section) without their consent, or that of their family or legal representatives – in cases of emergency hospitalisation—at the decision of a psychiatrist, who must inform the family or legal representatives without delay. The higher health authority must also be informed and it will, if necessary, examine the reasons for and the legality of the reasons taken.
17. Organs of internal affairs must assist medical workers in carrying out hospitalisation in cases dealt with under Articles 15 and 16 of this statute.
18. Patients admitted to psychiatric hospitals (sections) as emergency cases must be examined by a commission of psychiatrists within 24 hours, excluding non-working days and holidays. If the commission concludes that it is necessary to keep the patient in psychiatric hospital (section) for compulsory treatment, the hospital (section) administration must send details of this conclusion and the reasons for it, within 24 hours, to the chief psychiatrist of the local health authority, for inspection and ratification and must also inform the patient's family or legal representatives. The patient, his family or legal representatives may appeal against the decision to the chief psychiatrist of the higher health authority.
19. If a commission of psychiatrists decides that there was no need to admit the patient to hospital and that he does not require in-patient psychiatric treatment, he should be discharged immediately. In order to keep a mentally disturbed person in hospital, his consent must be obtained; in cases where the patient is incapable of exercising his free will, the consent of his family or legal representatives must be obtained.
20. Patients who have been admitted to a psychiatric hospital (section) with their consent, or that of their family or legal representatives, will be discharged when they recover, or when their mental condition improves sufficiently for further



hospitalisation to become unnecessary, following an application for discharge by the patient, his family or legal representatives. Patients, who have been admitted to hospital with their consent, or that of their family or legal representatives, may be refused discharge if, at the time of their application, it is established that their mental state represents a direct danger to themselves and those around them. The question of the continuation of compulsory treatment is decided by a commission of psychiatrists. In complex or controversial cases the commission will be headed by the chief psychiatrist of the local health authority.

21. Patients admitted to a psychiatric hospital (section) under emergency procedures must be examined at least once a month by a commission of psychiatrists, who will decide whether to stop or continue compulsory treatment. In cases of prolonged hospital treatment, the chief psychiatrist of the hospital's (section's) health authority will authorise the continuation of treatment on the basis of the conclusions of a commission of psychiatrists that further compulsory treatment is necessary. The health authorities are also responsible for checking that patients are admitted for adequate reasons and control over the duration of hospitalisation and the discussions as to the continuation of compulsory treatment.
22. Compulsory treatment of mentally ill persons who have committed socially dangerous acts which come under the jurisdiction of the criminal law, is carried out according to the procedure established by legislation and takes place in psychiatric hospitals (sections) administered by the health authorities, with normal, reinforced or strict surveillance. Patients who are undergoing compulsory treatment on the order of a court must be examined by a commission at least once every six months.

#### V. Basic Duties and Rights of Chief Psychiatrists

23. Organisation and methods management and control over the work of prophylactic-medical institutions administering psychiatric help, which are subject to the health authorities, and the decision of complex and controversial cases involving dynamic dispensary observation and admission to psychiatric hospital (section) are the responsibility of chief psychiatrists at district, city, regional, territorial and republic levels, who are appointed by the appropriate health authorities.
24. Chief psychiatrists have within the framework of their competence the following duties: working out proposals for submission to health authorities concerning

public mental health care and the organisation of specialist medical help for persons with mental disorders; establishing control over the work of prophylactic-medical institutions administering psychiatric help, which are subject to the health authorities, organising their regular inspection with the participation of representatives from the local Soviet of People's Deputies and supervising the work of lower-ranking chief psychiatrists; ensuring that the rights and legal interests of those suffering from mental disorders are respected; taking the necessary steps to protect society from dangerous acts by the mentally ill; examining citizens' statements and complaints in accordance with the established procedure.

25. Chief psychiatrists have the following rights: to carry out personally, or to order the initial and subsequent examinations of persons displaying symptoms of mental disorder, in circumstances described in Articles 8, 9 and 11 of this statute. They do so on their own initiative, at the request of relatives, state authorities or public organisations; to decide when a mentally ill person needs dynamic dispensary observation (putting on a register) and when this is no longer necessary (removal from the register); to admit persons with psychiatric disorders to a psychiatric hospital (section) in cases stipulated in this statute, including those when the consent of the patient, his family or legal representative is not obtained; to take decisions on the basis of medical and social evidence contained in the conclusions of a commission of psychiatrists, regarding the continued internment, or discharge from a psychiatric hospital (section) of mentally ill persons; to make representation to a court, based on the conclusions of a commission of psychiatrists, regarding the curtailment or change of compulsory medical treatment of mentally ill patients who have committed socially dangerous acts.

## VI. Final Regulations

26. The rules governing the initial examination, out-patient and in-patient psychiatric help, including emergency hospitalisation of those mentally ill persons who represent a direct danger to themselves or those around them, the way in which patients are looked after as in-patients, their rights and duties during their stay in psychiatric hospitals (sections), are laid down by the USSR Ministry of Health in accordance with the present statute, are subject to publication and must be available for inspection.

27. The actions of a chief psychiatrist are subject to appeal by the person concerned and his representative, in accordance with the USSR law 'On the Procedure for Appeal in Court Against Unlawful Actions by Officials Which Infringe the Rights of Citizens'; appeals may be sent to the chief psychiatrist senior to the chief psychiatrist against whom the appeal is made and then to a court, or to a court directly.
28. In accordance with the USSR law 'On the USSR Procuracy', the USSR Procurator-General and his subordinate procurators are responsible for ensuring that the law is observed by prophylactic-medical institutions administering psychiatric help.

**T. Menteshashvili**

**Secretary of the Presidium of the USSR Supreme Soviet**

## APPENDIX TWO

# DRAFT LEGISLATION OF THE UNION OF SOVIET SOCIALIST REPUBLICS CONCERNING PSYCHIATRIC CARE IN THE USSR.<sup>1</sup>

### Preface

Today *Meditinskaya Gazeta* is publishing the draft legislation on psychiatric care in the USSR. This is the first law in the history of our state wholly dedicated to this extremely important and delicate question. The work on this draft has passed through various stages. It was initiated by a decree of the Presidium of the Supreme Soviet of the USSR, which came into force on the 1<sup>st</sup> of March 1988. This not only summed up and brought together various departmental instructions and circulars but placed the question of the delivery of psychiatric care itself before society in a wholly new way.

However, after the appearance of the decree it became clear that the present quasi-legal act would not be sufficient to address the whole complicated amalgam of problems in this area. The drafting was undertaken by a working party of made up of representatives of leading scientific clinicians from various institutes around the country as well as representatives of interested parties and official departments.

In publishing the current draft, the editorial staff awaits the comments, suggestions and amendments of the medical professions and other readers. It is very important that this project come before the Supreme Soviet for discussion as quickly as possible since its adoption will serve as a vital step in the further improvement of our health care.

### GENERAL STATUTES

#### Article One: The Tasks of the Law.

1. The present law aims to guarantee medical and social assistance to citizens suffering from nervous disorders, the enhancement of the conditions of their life

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<sup>1</sup> This is my translation of an article originally published in *Meditinskaya Gazeta*, 27/7/90: 1-2.

and work as well as the prevention of mental illness and the promotion of mental health of the nation.

2. The law also serves to protect the rights and legal interests of those persons suffering from nervous disorders; the establishment of a basis and procedure for the delivery of psychiatric care; the defence of the citizen and of society from the dangerous acts of the mentally ill and the protection of the rights of medical and other workers engaged in psychiatric care.

#### Article Two: Principles of the Delivery of Psychiatric Care.

1. Psychiatric care exists on the basis of the principles of compassion, humanism and social justice and stems from the right of every person to have control over ones own health. Furthermore, the primary duty of the doctor is to render assistance to the sick, defend his rights and legal interests. This follows from the fulfilment of his obligations as a doctor and his professional ethics.

#### Article Three: The Rights of Those Suffering From Psychiatric Disorders.

1. The person suffering from a psychiatric disorder enjoys all the rights of a citizen provided for in the constitution of the USSR and in the constitutions of the union and autonomous republics. The restriction of these rights is limited by the mental disorder as envisaged by parts one and two of article four of the current law.
2. All persons suffering from psychiatric disorders are guaranteed;
  - A respectful and humane approach, without any infringement of the patients human dignity.
  - Information concerning the nature of their psychiatric disorders and the application of methods of treatment providing that this is not to the detriment of their health.
  - The application of remedies and methods of treatment by the authorised agencies of health care shall be in accordance with established diagnoses of the character of psychiatric disorders and consistent with contemporary developments in medical science.
  - Where possible treatment shall be administered in the home of the patient or his close relatives making use of the least invasive methods.
  - The possibility to refuse treatment and observation if the person concerned is capable of understanding such a decision.

- Detention as an in-patient at a medical establishment shall only be for such time as is necessary for observation and treatment.
- Rendering of therapeutic and social assistance shall not be humiliating but carried out in conditions consistent with the sanitary-hygienic aspirations of human dignity.
- Sanatoria and convalescent treatment according to medical prescription.
- The right to invite any doctor-psychiatrist to participate in the work of the commission on questions regulating the provisions of the current law.
- The right to social assistance from the state.
- The right to lodge complaints and claims with state and social Offices, authorities and organisations.
- The assistance of a lawyer, legal representative and also another legally accredited person.

#### Article 4: Limitations to the Rights of Those Suffering from Mental Disorders.

1. The committal of a person incapacitated by a psychiatric disorder shall be implemented only by court decision and only in accordance with the due process of civil law.
2. The committal of a person temporarily incapacitated as a result of a psychiatric disorder shall only be effected by the independent professional opinion of members of a mental health commission. This shall be carried out in the event of acts deemed to be a source of increased danger and only according to the procedures provided for by the decision of the medical commission. The patient may appeal against the decision to the court procurator.
3. The categories of mental disorder which may be incompatible with various professional activities or those professional activities which may exacerbate dangerous mental illness shall be determined by the council of ministers of the USSR. The content of the categories shall be reviewed not less than once in five years taking account of specific research, collegiate experience and scientific expertise.
4. It is not permitted to deprive or restrict the legal rights of those suffering from mental disorders except on the basis of a psychiatric diagnosis for the purposes of psychiatric observation in a psychiatric clinic or similar place of safety.

#### **Article 5: The Right to Medical Information.**

- 1. Those suffering from psychiatric disorders have the right to receive information concerning the nature of their disorders (providing that this is not to the detriment of their health), regarding the possibility of their incapacity for work and also concerning the aims and duration of the recommended form of psychiatric care, planned procedures and methods of treatment; including the alternatives, possible side effects and likely outcome. The discussion not to place such information at the disposal of the patient on the grounds that this will be to the detriment of his health shall rest with the medical-psychiatric commission.**
- 2. In situations where the a person has not yet attained fourteen years of age or has been acknowledged as incapable the right to receive such information rests with his legal representative. Between the ages of fourteen and sixteen years of age the right to information regarding treatment shall rest with the minors themselves and also with their legal representatives.**

#### **Article 5: The Voluntary Administration of Psychiatric Care.**

- 1. Psychiatric care shall be rendered to persons suffering from nervous disorders on a voluntary basis at their own request and with their consent.**
- 2. Persons who have not attained fifteen years of age or who are acknowledged to be incapable may be treated at the request of and with the agreement of their legal representative.**
- 3. The consent to treatment of a person suffering a psychiatric disorder or his legal representative is not required only under circumstances laid out in the current legislation.**

#### **Article 7: Legal Liability for the Groundless Commitment to a Psychiatric (Psycho-Neurological) Institution or Department.**

**The wilful confinement in a psychiatric institution or department of a person known to be mentally healthy is a criminal offence, punishable in accordance with the law of the Union Republics.**

#### **Article 8: The Obligation to Protect Medical Confidentiality.**

**A person who in execution of their medical duties has access to a citizen's psychiatric case history is obliged to protect medical confidentiality. The disclosure of such information to the detriment of the patient shall render such a person liable to criminal prosecution.**

**Article 9: Provision of Social Assistance and Rehabilitation of Those Suffering from Psychiatric Disorders.**

1. Local soviets of peoples deputies and their agencies are obliged:
  - To provide care for those suffering from psychiatric disorders.
  - To protect their rights and legal interests.
  - To undertake measures to include such people into the life of the community.
  - To provide employment for those capable of work in enterprises, institutions and organisations close to their homes and in accordance with medical recommendations.
  - To organise such professional training as is required.
  - To arrange legal representation for those in need of it in accordance with the law.
  - To allocate accommodation in accordance with established law.
  - To undertake such measures required to create favourable living conditions.
2. With this aim in mind and within the limits of their competence local soviets should:
  - Establish a range of out patient and hospital psychiatric care located, wherever possible close to the local community.
  - Ensure that these correspond to accepted modern standards of psychiatric care.
  - Organise hostels, rest homes or other forms of establishment (unit) of an analogous type with sufficient places for those suffering from psychiatric disorders that have become isolated from their normal social circle.
  - Found special sheltered workshops for those who are still able to work.
  - Enable enterprises to establish special workshops for those suffering from a psychiatric disorder.
  - Provide fiscal incentives to encourage enterprises, institutions, and organisations which have provided employment for those suffering from mental disorders and to establish strict quotas for enterprises, institutions and organisations of the local economy which join the local provision for such persons.
3. The groundless refusal of work to those suffering from those suffering from a psychiatric disorder will be subject to judicial proceedings in accordance with current law.



**Article 10: The Independence of the Doctor in Administering Psychiatric Care.**

1. The psychiatrist in the discharge of his duties connected with the administration of medical care to those suffering from psychiatric disorders and the prevention of the possible perpetration of socially dangerous acts is independent in his own decisions and judgement on the basis only of medical evidence, ethical principles and the law. State and social organs institutions and organisations and official persons are obliged to render assistance to the doctor where the patient presents a danger.

**Article 11: Accountability for Obstructing the Administration of Psychiatric Care**

1. A person who wilfully obstructs or prevents a psychiatrist or other medical personnel from carrying out their lawful duty to administer psychiatric care to a person suffering from a mental disorder or prevent the committal of a socially dangerous act shall be subject to the legal process of the Union Republic.

**Article 12: The Representation of the Legal Interests of a Person in Receipt of Psychiatric Care**

1. Whilst in receipt of psychiatric care a person suffering from a psychiatric disorder has the right to appoint a lawyer or other person of their own choice to represent (in accordance with the established law) for the defence of their rights and legal interests.
2. The administration of an institution giving psychiatric care must guarantee that a lawyer will be summoned, except in the cases set out in part 3 of Articles 17 and 22 of the current law.
3. As stated in part one of this Article a legal representative has the right to undertake his duties at any time from his being summoned. He has the right to see the person whose legal interests he is representing. He may receive information in connection with medical and other measures relevant to his client. A lawyer has the right of access to the medical documentation.
4. The defence of the rights and legal interests of minors and persons declared not responsible should be undertaken by a designated legal representative.
5. The legal representative of a minor shall be the child's parents, adopted guardians. A person declared to be not responsible should be represented by their legal guardian or the institution's administration.

6. The execution of civil proceedings or other juridical acts which require the presentation of a patient's case shall be carried out in accordance with the established regulations pertaining to the civil legal procedures.

#### Article 13: Forensic Psychiatric Expertise and the Execution of Compulsory Medical Measures by a Court

1. Forensic psychiatric expertise in criminal and civil matters shall be sought in accordance with the regulations set out in the legislative criminal, criminal procedural, civil and civil procedural codes.
2. Compulsory treatment of a person with a psychiatric disorder, following the decision of a court where the person is known to present a social danger may be undertaken in accordance with the established regulations set out in the legislative criminal and criminal procedural codes. The may be carried out on and in-patient or on an out patient basis in a psychiatric treatment or prophylactic institution (or department) of the health service.

#### Article 14: Psychiatric Examination in Order to Decide the Question of Fitness for Military Service

The basis and rules for out-patient and in-patient psychiatric examination in order to decide the question of a persons fitness for military service and the condition of his mental health and suitability for military service is defined by the Law on General Military Service, other laws regulating enlistment for military service and the current law.

### **OUT-PATIENT PSYCHIATRIC CARE**

#### Article 15: The Tasks of Treatment-Prophyllactic Institutions Carrying Out Psychiatric Out-Patient Care

Treatment-prophylactic institutions rendering out-patient psychiatric care should carry out the following:

- The preliminary psychiatric examination.
- Consultative, diagnostic, therapeutic and psycho-prophylactic care.
- Day care.<sup>2</sup>
- Social security and welfare rights assistance.

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<sup>2</sup> *Dispansernoe nablyudenie.*

- Legal advice concerning the provisions of the current law.
- Temporary help with work invalidity.
- Psychiatric expertise (within the limits of the provisions of the institution and responsible to the psychiatric commission).
- Assistance in providing employment for persons suffering from psychiatric disorders along with organs of social security such as local Soviets of peoples deputies.
- Participation in deciding the question regarding the guardianship of those deemed to not be responsible.
- The most active involvement in questions regarding the in-patient treatment, discharge and subsequent examination and also the continuity of treatment, the social and work adaptation of persons suffering from psychiatric disorders.
- The most active co-operation with the militia for the prevention of socially dangerous acts.
- Other non-hospital psychiatric care.

#### Article 16: The Preliminary Psychiatric Examination

1. The preliminary psychiatric examination shall be conducted under the observation of the psychiatrist of a treatment-prophylactic institution carrying out psychiatric care which is independent of the psychiatric out patients or other clinic where the person has been referred for the treatment of their mental condition.
2. A preliminary psychiatric examination shall be carried out where there is evidence that the person is suffering some form of mental illness or requires observation.
3. A preliminary psychiatric examination that is carried out on an out-patient basis shall be at the request of the patient or where the person is a minor under 15 years of age at the request of his legal representative. In the event that the parents of a minor have differing views of the outcome of a psychiatric examination then, at their request or with their consent, the out come shall be decided following the decision of the procurator. In the absence of minor's parents or other legal representative the procurator shall have the power of attorney.
4. The psychiatrist who undertakes the preliminary psychiatric examination is obliged to present his specialist findings to the patient or his legal representative including the aim of the examination.

5. The preliminary psychiatric examination may be carried out upon the patient without his consent and (or) his legal representative only under circumstances where there is a reason to believe that to delay treatment of his psychiatric disorder would:
  - a) Lead to their being a danger to the patient or others.
  - b) Is inclined to lead to deterioration in the patients existing condition or bring about serious moral or material harm if the person is left without psychiatric treatment.
  - c) The decision regarding the preliminary psychiatric examination without the consent of the examinee shall be undertaken by a psychiatrist employed in a treatment- prophylactic institution (department, office<sup>3</sup>) undertaking psychiatric care. In circumstances set out in point 'a' of the current article the preliminary psychiatric examination should be carried out within 24 hours of being referred to the local procurator. In circumstances set out in point 'b' of the current article the preliminary psychiatric examination should be carried out with the agreement of the local procurator.
7. The information from a psychiatric examination regarding the mental health shall be recorded in the medical documentation. The patient's passport details should also be included as well as the reason for referral to a psychiatrist and any medical recommendations.

**Article 17: The Procedure for Making an Application and Obtaining a Decision Regarding Referral for a Psychiatric Examination of a Person Without His Consent**

1. The decision regarding the referral of a person for a psychiatric examination without his consent and (or) the consent of his legal representative shall be undertaken by a psychiatrist following an application for detention and the receipt of information that such an examination is required as set out in points 'a' and 'b' of part 5 of Article 16 of the current law.
2. An application may be made by the relatives of the person who requires the examination, his neighbours, general practitioner, other citizens or interested parties.
3. In extraordinary circumstances when, according to reported information a person presents a serious danger to himself or others the application may be in an oral form. The decision regarding his psychiatric examination or the refusal to

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<sup>3</sup> *Kabinet*. In this context this could be translated as 'Doctors Surgery'.

- undertake such an examination must be made by the psychiatrist as soon as possible.
4. Under circumstances where a person does not present a serious danger to himself or others the application for his psychiatric assessment must be in a written form and contain such information to provide convincing evidence for the need for such an assessment. Information regarding the refusal by the patient or his legal representative of a voluntary consultation with the psychiatrist. The psychiatrist has the right to request further information necessary to undertake his decision. Having established that the application contains sufficient data regarding circumstances witnessed as set out in point 'b' of part 5 of Article 16 of the current law, the psychiatrist must make a written report of his assessment. Any reason for refusal to do so must be explained.
  5. Having established that there are grounds for a petition, the psychiatrist must present his decision, in writing, to the procurator concerning the necessity for a psychiatric examination. This must contain his reasons and other relevant materials. Under such circumstances a psychiatric examination shall be carried out only with the permission of the procurator.

#### Article 18: Types of Out-Patient Psychiatric Care

1. The out-patient psychiatric care of a person suffering from a mental disorder shall, depending on the medical evidence, take the form of out-patient consultation and treatment or day care.
2. Out patient consultation and treatment shall take place solely on a voluntary basis following self-referral, request or the consent of the citizen. In the case of a minor under 15 years of age this shall be with the consent of his parents or his legal representative.
3. Day care may be provided for certain types of mental disorder (see part one, Article 19) independently of consent of the patient, his relatives or legal representative. It assumes that the active, dynamic observation of the persons mental state along with the periodic examination and treatment by a psychiatrist.

#### Article 19: Day Hospital Observation

1. Day hospital observation shall be provided for persons suffering from the following conditions:
  - Chronic and serious mental disorders which seem to be unchanging or result in frequent relapses.

- Chronic mental disorders which manifest themselves with a tendency to commit acts dangerous to the patient or others.
2. The early discharge of a person from day patient observation may be carried out if he experiences a marked and sustained improvement in his mental health. Following discharge from day-patient observation the patient may receive consultative treatment as an out-patient at his request. This may be administered without his consent only under the circumstances set out in part 5 of Article 16 and part 1 of the current Article of this law.
  3. Decisions regarding the admission and discharge from day hospital observation shall be undertaken by a commission of psychiatrists of an out-patient psycho-neurological institution or a commission assigned to the task by the chief psychiatrist of and organ of the health service no later than one month from the referral of the patient to the commission.
  4. The decision of the commission, stating its reasons, shall be written in the medical records of the out patient.

## **IN PATIENT PSYCHIATRIC CARE**

### **Article 20: The Tasks of Treatment-Prophylactic Institutions Providing Psychiatric In-Patient Care**

1. Treatment-prophylactic institutions providing psychiatric in-patient care shall provide:
  - Treatment and social and work rehabilitation for persons suffering from psychiatric disorders.
  - Clinical assessment of hospitalised persons to evaluate the state of their mental health and in order to establish a diagnosis.
  - Conditions for undertaking various forms of psychiatric examination.
  - Social security assistance.
  - Legal consultation regarding the provisions of this law.
2. In patient psychiatric care shall be carried out under conditions which guarantee the safety of hospitalised persons and those in the community. Patients shall be under the constant supervision of medical personnel in accordance with the established rules pertaining to those hospitalised for observation and the protection of their rights and legal interests.

## **Article 21: The Grounds for Hospitalisation as a Psychiatric In-Patient**

- 1. The basis for admission as an in-patient to a psychiatric hospital (department) is that the patient is suffering from a psychiatric disorder to such an extent that he requires observation or treatment which cannot be provided on an out-patient basis.**
- 2. Such persons may be cared for in a psychiatric hospital voluntarily at their own request or consent. In the case of those considered to be not responsible or minors less than 15 years of age hospitalisation requires the consent of their legal representative. Consent to hospitalisation should be recorded and signed by the person hospitalised or their legal representative along with the history of their illness.**
- 3. Consent to hospitalisation is not required in circumstances set out in articles 22 and 23 of the current law.**

## **Article 22: Urgent Hospitalisation as a Psychiatric In-Patient**

**A person who is manifestly suffering from a mental illness and who is incapable of taking the decision to seek psychiatric care and who, by virtue of his mental state, is a danger to himself or others may be admitted as an in-patient to a psychiatric hospital without his consent or that of his legal representative in accordance with the provisions for urgent hospitalisation following the decision of a psychiatrist. The procurator in the vicinity of the psychiatrist taking the decision must be informed of such an emergency admission within 24 hours in order that the in-patient stay may be legally extended should this prove necessary.**

## **Article 23: Admission as a Psychiatric In-Patient of Persons Deemed to not be Capable of Taking Decisions but not Requiring Urgent Hospitalisation**

- 1. A person who is manifestly suffering from a psychiatric disorder which prevents him from being responsible for taking decisions with the possible consequence of him being a danger to himself from the point of view of his health, serious moral or material harm if without psychiatric care his condition goes untreated he may be admitted as a psychiatric in-patient without the consent of the patient or that of his legal representative. This requires the decision of a psychiatrist and the consent of the procurator. The exception to this is where the procurator has already given his permission for the psychiatric examination of a patient**

- immediately following hospitalisation under the provisions of point 'b' of part 5 of article 16 of the current law.
2. The grounds for hospitalisation in such circumstances must be confirmed by a commission of psychiatrists in accordance with the provisions of Article 25 of the current law.

#### **Article 25: The Assessment by a Commission of a Person Hospitalised Without His Consent**

1. A person admitted to a psychiatric hospital in accordance with the provisions of Articles 22 and 23 of the current law must be examined within 48 hours excluding public holidays. A commission of psychiatrists must reach a decision regarding the grounds for hospitalisation or that there are insufficient basis for such a hospitalisation. If there are no grounds for hospitalisation and the patient has no wish to remain in hospital he must be discharged as soon as possible. If there are grounds for hospitalisation then further examining commissions should review the patients case on a monthly basis over the course of six months in order to decide whether it is necessary for the patient to continue treatment as an in-patient.
2. A copy of the decision of the psychiatric commission regarding the necessity to remain as an in-patient without his consent should be lodged with an Office of the health service and the procurator within 24 hours. This should be the health service Office responsible for involuntary admissions and the procurator in the hospital's locality.
3. If 6 months after the patient is admitted without his consent the psychiatric commission decides that he still needs to be detained for treatment then his case must be referred to a court by the hospital administration. Further extensions of the period of in-patient treatment must be referred to a court. Information regarding the patient must be circulated to the court responsible for his case, which will decide on further compulsory treatment.
4. If a person, hospitalised without his consent, during the course of treatment, expresses his consent to continued treatment as a psychiatric in-patient, then providing that his consent is given to the psychiatrist in a written form by the patient or his legal representative, he shall then be considered to be a voluntary patient.



## **Article 26: Information Regarding Admission as a Psychiatric In-Patient**

A person who has been hospitalised must be informed of the reasons for it providing that this will not harm their health. Within 24 hours measures must be taken to notify his relatives or legal representative regarding his hospitalisation. The patient, his relatives or legal representative must also be informed about appeals and complaints procedures concerning the decision to detain him in a psychiatric hospital.

## **Article 27: The Rights and Duties of a Person Admitted as a Psychiatric In-Patient**

1. All persons admitted as a psychiatric in-patient for treatment or assessment have the right:

- To request their discharge from hospital.
- To meet with a lawyer or priest.
- To put forward complaint and applications to health service Offices, the procurator or a court.
- To subscribe to newspapers and journals.
- To receive paid work of an appropriate amount and quality if the patient can participate in productive labour.
- To directly contact the senior doctor or administrator of the department regarding questions relating to his treatment or the observation of his rights as set out in the relevant articles of the current law.

2. These persons also have the following rights which shall be limited by the treating doctor or manager of the department only in exceptional circumstances in the interests of the health or safety of the patient himself or others:

- To undertake correspondence without censorship.
- To receive provisions and parcels.
- To receive visitors on visiting days.
- To have and acquire essential items.

3. A hospitalised person, who according to his mental state is capable of making his own decisions, may examine the rules and internal regulations in force for psychiatric in-patients.

## **Article 28: Discharge From Psychiatric In-Patient Treatment**

1. The basis for discharge as a psychiatric in-patient is:

- Recovery or improvement in the mental state that no longer requires further in-patient treatment.

- That, on examination, the reason for admission as an in-patient no longer exists.
  - The conclusion of a commission of psychiatrists of the treatment-prophylactic institution or a health service Office which is no longer satisfied that grounds for the continued compulsory hospitalisation and they believe that he should no longer be detained in a psychiatric hospital.
  - If the admission as an in-patient was voluntary then following a personal application to the procurator or a court for discharge by the hospitalised person or his legal representative.
2. A person admitted as a psychiatric in-patient may be refused a discharge if at the moment he applies for it a commission of psychiatrists is of the opinion that his mental state is such that he is not capable of making such a decision and if he presents a danger to himself or those around him. He may also be refused discharge if in the absence of treatment there will be deterioration in his condition, his health or he will suffer serious moral or material harm. In such circumstances he may be detained as an in-patient in accordance with the procedure set out in Article 25 of the current law.

## **PSYCHO-NEUROLOGICAL INSTITUTIONS OF THE OFFICE OF SOCIAL SECURITY**

### **Article 29: The Tasks of Psycho-Neurological Offices of Social Security**

Psycho-neurological institutions of the office of social security shall render medical and social care to the elderly and infirm suffering from psychiatric disorders who are in need of the social security or nursing care, medical care and supervision.

### **Article 30: Legislation Regulating the Activities of Psycho-Neurological Institutions of the Office of Social Security**

The activity of psycho-neurological institutions of the offices of social security shall be regulated by the current law and also legislation regarding Social Security.

### **Article 31: The Basis for Admitting a Person to a Psycho-Neurological Institution of the Office of Social Security**

1. The basis for admitting a person to psycho-neurological institution shall be undertaken when an elderly or infirm person is, in the opinion of a psychiatric commission, suffering from a psychiatric disorder which prevents them from being admitted to a general social security institution.

2. Such persons may be voluntarily admitted to a psycho-neurological institution following a written application or a decision of a court that a person is not able to care for himself.

#### Article 32: The Rights and Duties of Persons Admitted to a Psycho-Neurological Institution of the Office of Social Security

Such rights and duties are set out in Article 27 of the current law that includes persons admitted to psycho-neurological institutions of the offices of social security.

#### Article 33: Discharge and Transfer from a Psycho-Neurological Institution of the Office of Social Security

1. The basis for transferring a person from a psycho-neurological institution to a general institution shall be following the decision of a psychiatric commission. Such a transfer shall be made if there is insufficient medical evidence that the person requires specialist care provided by a psycho-neurological institution.
2. The basis for discharge from a psycho-neurological institution are:
  - A personal application for discharge by the patient who, in the opinion of a psychiatric commission, is capable of exercising such a decision.
  - Following an application by the members of the patient's family, guardian or trustee who are able to provide nursing care for the person to be discharged.
  - Following the decision of a court.

### **COMPLAINTS REGARDING THE ACTIONS OF MEDICAL WORKERS AND THE DUTY OF PERSONS PROVIDING PSYCHIATRIC CARE**

#### Article 34: The Complaints Procedure

1. The activities of medical and social security workers providing psychiatric care whom infringe upon the rights and interests of a citizen may be the subject of a complaint to their superiors, relevant office or responsible person. In the event that the outcome of such a complaint is unsatisfactory then the case may be referred to a court.
2. Complaints regarding the groundless preliminary psychiatric assessment or an infringement of the law or its enforcement, a groundless medical opinion or decision concerning referral for day care, admission as an in-patient for observation, assessment or any kind of treatment without the consent of the

patient may be referred to the relevant office, responsible person or the procurator.

3. Complaints regarding the groundless admission of a person who is temporarily not responsible as a result of a psychiatric disorder and complaints about individual aspects of professional activities and duties connected with the cause of dangerousness may be referred to a higher authority in accordance with the procedures of the relevant office or to a court.
4. Complaints regarding the groundless involuntary hospitalisation as a psychiatric in-patient or admission to a social security institution, the refusal to discharge a person from such institutions may be referred to a higher authority, relevant office, responsible person or a court.
5. The person may make a complaint whose rights and interests have been infringed in the process of carrying out psychiatric care or his legal representative.

#### **Article 35: Time Limits for Complaints**

1. In circumstances set out in parts 2 and 3 of Article 34 of the current law a complaint may be made no later than one month from the commission of the act about which the person wishes to complain. If the complaint is that set out in part four of Article 34 and during the course of the commission of an act about which the patient wishes to complain he has been detained as a psychiatric in-patient then he may complain up to one month following his discharge.
2. A person who has gone past the date up to which he may have complained but has a good reason may apply to the appropriate office that may review the case.

## **APPENDIX THREE**

### **LAW OF THE RUSSIAN FEDERATION<sup>1</sup>**

#### **CONCERNING PSYCHIATRIC CARE AND THE GUARANTEES OF THE RIGHTS OF CITIZENS UNDER ITS PROVISION**

In recognition that the highest aim for every person is good health in general and mental health in particular:

Taking into account that a psychiatric disorder can transform a person's attitude to life, to oneself and society and also the attitude of society to that person:

Taking cognisance that the lack of statutory legal regulation of psychiatric care may be one of the causes of its use for non-medical reasons, thereby inflicting damage on the health, human dignity and the rights of citizens as well as the international prestige of the state:

In acceptance of the necessity to bring to public attention the legal fulfilment in the Russian Federation of those rights and freedoms of man and citizen which are recognised in the international community and in the Russian Constitution:

The Supreme Soviet of the Russian Federation hereby enacts the current law.

### **SECTION ONE**

#### **General Regulations**

##### **Article 1: Psychiatric Care and the Principles of its Provision**

1. Psychiatric care includes attention to the mental health of citizens according to the procedures set forth in the current law and other laws of the Russian Federation relating to the diagnosis of psychiatric disorders, treatments, care and medico-social rehabilitation of persons suffering from psychiatric disorders.

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<sup>1</sup> This is my translation of the *Law of the Russian Federation Concerning Psychiatric Care and the Guarantees of the Rights of Citizens Receiving it*. It was reproduced from *Vedomosti c'ezda narodnykh deputatov Rossiiskoi Federatsii i Verkovnovo Soveta Rossiiskoi Federatsii*, No. 33, s. 1913-1914 and published in pamphlet form by the Russian Independent Psychiatric Association in 1993.

2. Psychiatric care of persons suffering from psychiatric disorders shall be guaranteed by the state to be administered according to the principles of legality, humanity and in observance of the rights of man and citizen.

#### **Article 2: Legislation of the Russian Federation Regarding Psychiatric Care**

1. The Legislation of the Russian Federation concerning psychiatric care consists of and other legislative acts of the Russian Federation and constituent republics of the Russian Federation and also judicial acts relating to psychiatric care of autonomous regions, autonomous districts, areas, zones and the cities of Moscow and St. Petersburg.
2. The government of the Russian Federation and the governments of the constituent republics of the Russian Federation as well as the Ministries and departments have the right to sanction legislative acts concerning psychiatric care within the limits of their competence.
3. Legislative and other judicial acts established in the Russian Federation and constituent republics of the Russian Federation, autonomous regions, autonomous districts, areas, zones and the cities of Moscow and St. Petersburg may not limit the rights and guarantees of the citizen and their observance in the provision of psychiatric care which falls under the jurisdiction of the current act.
4. In the event that an international treaty, to which the Russian Federation is a signatory, establishes regulations concerning psychiatric care other than those already enacted by the legislature of the Russian Federation then the international treaty shall take precedence.

#### **Article 3: The Application of the Current Law**

1. The current law shall apply to all citizens receiving psychiatric care and institutions of the Russian Federation administering psychiatric care on the territory of the Russian Federation who shall conform to its provisions.
2. Foreign citizens and stateless persons on the territory of the Russia Federation who are receiving psychiatric care shall be entitled to all the rights established in the current law equally with citizens of the Russian Federation.

#### **Article 4: Voluntary Psychiatric Treatment**

1. Psychiatric care shall be carried out under conditions of voluntary treatment with the consent of the patient except under circumstances set forth in the current law.

2. Minors under the age of 15 years and also those persons who, according to the rules set out in the current law, who are judged to be not responsible, may receive psychiatric care at the request of their guardian or legal representative in accordance with the provisions of the current law.

#### **Article 5: The Rights of Persons Suffering From Psychiatric Disorders**

1. Persons suffering from psychiatric disorders are entitled to all the rights and freedoms of the citizen as set out in the constitution of the Constitution of the Russian Federation, Constitutions of the constitutive republics of the Russian Federation, the legislature of the Russian Federation and constitutive republics of the Russian Federation. Limitations of the rights and freedoms of citizens suffering from psychiatric disorders are permitted only in circumstances set out in the laws of the Russian Federation.
2. All persons suffering from psychiatric disorders and receiving psychiatric care have the right to respectful and humane treatment that excludes that degrading to human dignity. They may receive information concerning ones rights, the nature of their condition and the forms of treatment to be undertaken in a form which takes into account the persons mental state. Psychiatric care, wherever possible shall be administered in the least restrictive circumstances, wherever possible in the home. Detention in a psychiatric hospital shall be for as long as is necessary for observation and treatment. All forms of treatment (including convalescence) shall be to meet medical objectives. The administration of psychiatric care shall be under hygienic, clinical conditions. Patients shall receive the following only with prior consent and have the right to refuse at any stage of treatment; any medical preparation or method, scientific research or teaching exercise including photography, video or cinematic filming. The patient may invite any specialist practising psychiatry, providing that the psychiatrist agrees, to work on the commission overseeing the implementation of the current law. Patients are also entitled to the assistance of a lawyer, legal representative or another person in accordance with the law.
3. Limitations of the rights and freedoms of persons suffering from psychiatric disorders shall only be on the basis of a psychiatric diagnosis the facts of which shall be ascertained under dispensary observation either in a psychiatric hospital or in a psycho-neurological institution for social security provision or non-teaching purposes. Responsible persons guilty of specific crimes shall be

answerable for their actions to the legislature of the Russian Federation and the constituent republics of the Russian Federation.

**Article 6: Limits to the Execution of Different Aspects of Professional Responsibility and Duties Concerned with the Commission of Dangerous acts**

1. A citizen may be temporarily (for a period not exceeding five years and with the right of subsequent re-examination) declared unfit as a result of a psychiatric disorder to carry out various aspects of his professional responsibilities and duties as a result of the increased danger involved.
2. A list of medical psychiatric contraindications for the existence of distinct aspects of professional responsibilities and duties associated with an increased risk of danger shall be recorded with the government of the Russian Federation and periodically (not less than once in five years) re-evaluated in the light of accumulated experience and scientific evidence.

**Article 7: The Representation of Citizens who are in Receipt of Psychiatric Care**

1. A citizen who is in receipt of psychiatric care has the right to invite a representative of his choice to defend his rights and legal interests. The assignment of a representative shall be in accordance with the established civil procedures of the civil legislative processes of the Russian Federation.
2. The defence of the rights and legal interests of minors under the age of 15 years shall be according to the established law dealing with those who are incapable. Whilst in receipt of psychiatric care a legal representative shall be appointed (parents, adoptive parents or guardian) and in the event of their absence the administration of either a psychiatric hospital or a psycho-neurological institution for social security or special training.
3. The defence of the rights and legal interests of a citizen in receipt of psychiatric care may be undertaken by a lawyer. The procedure for appointing a lawyer and the payment of his fees shall be the responsibility of the established jurisdiction of the Russian Federation. The administration of an institution providing psychiatric care shall ensure the provision of a lawyer. Exceptions in urgent circumstances are provided for under point 'a' in the fourth part of article 23 and point 'a' in article 29 of the current law.



## **Article 8: The Prohibition of Demands for Information Regarding the Condition of Mental Health**

- 1. The realisation of civil rights and freedoms requires the provision of information regarding the state of ones mental health as ascertained by psychiatric examination. This shall be permitted only under conditions established by the laws of the Russian Federation.**

## **Article 9: The Preservation of Medical Confidentiality Whilst Undergoing Psychiatric Care**

**Information regarding the condition of a citizen with a psychiatric disorder and the details of his treatment and care in a psychiatric institution and also any other information regarding the condition of his mental health is medically confidential and protected by law. In order that the rights and legal interests of a person with a psychiatric disorder may be protected, information regarding the patients mental health and his psychiatric treatment may, at the patients request, or at the request of his legal representative, be disclosed to whom so ever is granted access to such information.**

## **Article 10: The Diagnosis and Treatment of Persons Suffering From Psychiatric Disorders**

- 1. The diagnosis of a psychiatric disorder shall be established in accordance with generally accepted international standards. It may not be based solely on a disagreement of a citizen with the social, cultural, political or religious norms nor with any other cause unconnected with the patient's psychological health.**
- 2. For the diagnosis and treatment of a person suffering from a psychiatric disorder such medical preparations and methods as are approved by the established laws of the Russian Federation shall by employed.**
- 3. Medical preparations and methods shall by employed in accordance with diagnostic and treatment aims in accordance with the character of the disorder in question and may not be used for the punishment of a person who is suffering from a psychiatric disorder or in the interests of other persons.**

## **Article 11: Consent to Treatment**

- 1. The treatment of a person suffering from a psychiatric disorder shall be following his written consent except under circumstances laid out in the fourth part of the current article.**
- 2. A doctor is obliged to place before a person suffering from a psychiatric disorder such information regarding that disorder in a way, which takes account of the patient's mental state, the aims and methods of treatment and this shall include the alternatives, duration, recommended treatment and also the patients feelings, possible risk, likely effects and expected results. The information given shall be recorded in the patient's notes.**
- 3. Consent to the treatment of minors under fifteen years of age and also such persons who are regarded as not responsible shall be given by their legal representative having received such information as set out in part two of the current article.**
- 4. Treatment without consent may be administered to a person suffering from a mental disorder, or without the consent of his legal representative only under such exceptional circumstances of a medical nature and on the basis of the established criminal codes of the RSFSR. Involuntary hospitalisation shall be on the basis set out in article 29 of the current law. Under these circumstances, except in emergency cases, treatment shall be undertaken only following the decision of a commission of psychiatrists.**
- 5. With regard to those persons covered by the provisions of the fourth part of the current article, the application of surgical or other methods of treatment of an irreversible nature, for psychiatric disorders and also carrying out clinical trials of medicines and techniques is not permitted.**

## **Article 12: Refusal of Treatment**

- 1. A person suffering from a psychiatric disorder or his legal representative has the right to refuse proposed treatment or to discontinue it except under circumstances set out in the aforementioned part 4 of Article 11 of the current law.**
- 2. The consequences of discontinuation or refusal of treatment must be explained to the person who has refused such treatment or his legal representative. The refusal of treatment, following such information regarding the possible consequences, shall be written in the clinical notes and signed by the person in question or his legal representative and a psychiatrist.**

### **Article 13: Compulsory Medical Interventions**

1. Compulsory medical measures may be undertaken by the decision of a court with relation to a person who is suffering from a psychiatric disorder whose activities are known to be a danger to those around him. This shall be in accordance with the established criminal codes of the RSFSR.
2. Compulsory medical measures may be undertaken in a psychiatric institutions and bodies of health promotion. Persons detained in a psychiatric clinic by the decision of a court for the purposes of compulsory medical intervention is entitled to the rights set out in Article 37 of the current law. They shall be recognised as unfit for work for the whole period of their detention in a psychiatric clinic and they shall the right to state social insurance benefits or the basic pension.

### **Article 14: Forensic Psychiatric Expertise**

1. Forensic psychiatric expertise in criminal and civil matters shall be pronounced in accordance with the current criminal procedural codes of the RSFSR and civil procedural codes of the RSFSR.

### **Article 15: Psychiatric Examination to Decide the Question of the Fitness of Citizens for Military Service**

The grounds and procedures for out-patient and in-patient examination to determine a citizen's fitness, state of mental health and suitability for military service in the defence forces, armed forces, security forces, internal forces, railway corps and other military units, persons in leading or rank and file positions of the staff concerned with internal affairs shall be as set out in the current law and the legislation of the Russian Federation relating to military service.

## **SECTION TWO**

### **The Guarantee of Psychiatric Care and Social Protection of Persons Suffering From Psychiatric Disorders**

#### **Article 16: Aspects of Psychiatric Care and Social Protection Guaranteed by the State**

1. The state guarantees: Emergency psychiatric care; consultation, diagnosis, treatment, psycho-prophylactic and rehabilitative care on an out-patient and

clinic basis. All forms of psychiatric expertise for those unable to work for a definite period. Social security relief and assistance to find employment for persons suffering from psychiatric disorders. The settlement of questions of trusteeship. Consultation on questions of rights, and other aspects of legal assistance, in psychiatric and psycho-neurological institutions. A system of social relief for the disabled and the elderly suffering from psychiatric disorders and their care within it. Training for the disabled and minors suffering from psychiatric disorders. Psychiatric care in natural disasters and calamities.

2. For the security of persons suffering from psychiatric disorders their psychiatric care and social protection the state shall, where possible; provide all aspects of institutions providing out patient and clinic psychiatric care in the home locality of patients. Organise general and professional training for minors suffering from psychiatric disorders. Provide industrial-treatment institutions for work therapy, training for new occupations and also the arrangement in these institutions for persons suffering from psychiatric disorders, including the disabled, special enterprises, workshops or participation in suitable work for such persons. The institution of definite quotas of jobs in enterprises, institutions and organisations for the retraining of persons suffering from psychiatric disorders. The undertaking of methods of economic incentives for enterprises, institutions and organisations which set aside employment vacancies for persons suffering from psychiatric disorders. The provision from social expenditure of hostels for persons suffering from psychiatric disorders. The undertaking of other necessary measures to ensure the social support of persons suffering from mental disorders.
3. The guarantee of all aspects of psychiatric care and social protection of persons suffering from psychiatric disorders shall be the responsibility of the federal organs of state forces and administration of the constituent republics, autonomous regions, autonomous districts, areas, zones and the cities of Moscow and St. Petersburg as well as local independent organs of the Russian Federation in accordance with their competence as defined by the legislature of the Russian Federation.

#### **Article 17: The Financing of Psychiatric Care**

The financial provision of institutions and personnel providing psychiatric care shall be provided from the health promotion budget, the medical insurance fund

and other sources permitted by the legislature of the Russian Federation in proportion to the guaranteed level of provision of high quality psychiatric care.

## **SECTION THREE**

### **Institutions and Personnel Providing Psychiatric Care. The Rights and Duties of Medical Workers and Other Specialists**

#### **Article 18: Institutions and Personnel Providing Psychiatric Care**

1. The delivery of psychiatric care to those who need it shall be through state and non-state psychiatric and psycho-neurological institutions and through psychiatrists in private practise. The regulations regarding the issuing of licences to provide psychiatric care shall be as set out by the legislature of the Russian Federation.
2. The types of psychiatric care provided by psychiatric and psycho-neurological institutions or psychiatrists in private practise shall be recorded in the charter or licence documentation. Information regarding such documentation shall be supplied on request to visitors.

#### **Article 19: The Right to Participate in the Provision of Psychiatric Care**

1. The right of a doctor to render psychiatric care shall be confined to a psychiatrist who has received higher medical education and has additional qualifications in accordance with the established legislation of the Russian Federation.
2. Other specialists and medical personnel undertaking the provision of psychiatric care must, according to the established legislation of the Russian Federation, undergo specialist training and extend their qualifications before being permitted to work with persons suffering from psychiatric disorders.
3. The activity of a psychiatrist and other specialists and medical personnel who provide psychiatric care shall be founded on professional ethics and be carried out in accordance with the law.

#### **Article 20: The Rights and Duties of Medical Workers and Other Specialists Providing Psychiatric Care**

1. The professional rights and duties of a psychiatrist other specialists and medical personnel providing psychiatric care shall be set out in the legislation of the Russian Federation concerning health promotion and the current law.

2. The institution of a diagnosis of mental illness and taking the decision to administer psychiatric care on an involuntary basis or detention for observation pending such a decision shall be the exclusive right of a psychiatrist of a commission of psychiatrists.
3. The opinion of a doctor of another speciality concerning the state of a person's mental health has only a preliminary character. It shall not form the basis of a decision concerning the limitation of that person's rights or legal interests nor the granting of the status of a psychiatric patient to such a person.

#### **Article 21: The Psychiatrist's Independence in Providing Psychiatric Care**

1. In providing psychiatric care the psychiatrist is independent in his decisions and shall be guided only by clinical evidence, medical duty and the law.
2. The opinion of a psychiatrist, which is not in agreement with a medical commission, shall be entitled to record his particular view in the medical notes.

#### **Article 22: The Guarantees and Privileges of Psychiatrists, Other Specialists, Medical and Other Personnel Engaged in Providing Psychiatric Care**

Psychiatrists, other specialists, medical and other personnel practising in the field of psychiatric care have the rights and privileges established by the legislation of the Russian Federation for persons engaged in activities with special conditions of employment. In particular they are entitled to state insurance provision for those suffering death or harm to their health as a result of their employment duties.

A person who suffers ill health leading to temporary disability of whilst practising in the field of psychiatric care shall be entitled to receive a sum from the insurance up to his annual monetary salary. This shall be dependent upon the severity of the disability suffered. In the event of suffering permanent disability the sum from the insurance shall be his annual salary for up to five years. This shall be dependent upon the extent of the loss of his ability to work. In the event of his death the insurance sum paid to his heirs shall be ten times his annual monetary salary.

## **SECTION FOUR**

### **Aspects of Psychiatric Care and Procedures for its Delivery**

#### **Article 23: Psychiatric Examination**

1. Psychiatric examination shall be carried out the following purposes; to discover whether a person is suffering from a psychiatric disorder; to ascertain whether he requires psychiatric care and also to determine the type of care required.
2. Psychiatric examination and prophylactic observation shall be carried out at the request or with the permission of the examinee. In the case of a minor under 15 years of age this shall be at the request of the parents or legal representative. In the even that, in accordance with established law, the examinee is not responsible then the request or consent should come from his legal representative. In the event that one parent objects or in the absence of the parents or other legal representative the examination of a minor may be carried out following an appeal to a court to resolve the question of guardianship or organ of trusteeship.
3. A doctor carrying out a psychiatric examination is obliged to inform the examinee and his legal representative that he is a psychiatrist except under circumstances covered by point 'a' of part four of the current article.
4. The psychiatric examination of a person may be undertaken without his consent or without the consent of his legal representative in circumstances where, as a result of facts obtained from observation, there is a clear evidence for believing that the patient has a severe psychiatric disorder which entails:
  - a) Being a serious danger to himself or others.
  - b) Incapacity to such an extent that he is unable to independently satisfy the most basic requirements for living.
  - c) The existing impairment to his mental condition is such that serious deterioration will occur if the person is left without psychiatric care.
5. The psychiatric examination of a person may be undertaken without his consent and without the consent of his legal representative if observation is undertaken in a clinic on the basis of the aforementioned first part of Article 27 of the current law.
6. The information regarding the condition of a person's mental health obtained from a psychiatric examination shall be recorded in the medical notes along with the reasons for his referral to a psychiatrist and any medical recommendations.

**Article 24: The Psychiatric Examination of a Person Without His Consent or That of His Legal Representative**

1. In the events outlined in point 'a' of parts four and five of article 23 of the current law the decision regarding a psychiatric examination of a person without their consent or without the consent of his legal representative shall be taken by a psychiatrist independently.
2. In the events outlined in points (b) and (c) of part four of Article 23 of the current law the decision regarding psychiatric examination without his consent or that of his legal representative shall be undertaken by a psychiatrist with the sanction of a court.

**Article 25: Procedure for Serving an Application and Receiving Permission to Conduct a Psychiatric Examination of a Person Without His Consent or That of His Legal Representative**

1. A decision regarding the psychiatric examination of a person without their consent or that of their legal representative, with the exceptions set out in part five of Article 23 of the current law, shall be taken by a psychiatrist. This shall be after an application stating the information regarding the reasons for such an examination as enumerated in part four of Article 23 of the current law.
2. An application for a psychiatric examination may be made by the relatives of a person, a doctor of any speciality, a responsible person or another citizen.
3. In urgent circumstances when on receipt of information that a person presents a serious danger to himself or others an application may be made orally. The decision regarding the psychiatric examination shall be undertaken by a psychiatrist and recorded in the medical notes.
4. In the absence of any serious danger presented by a person to himself or others the application regarding his psychiatric examination shall be in writing and contain detailed information regarding the grounds why the examination is necessary. Any indication that the patient or his legal representative refuses treatment should be directed to the psychiatrist. The psychiatrist is entitled to such detailed information as necessary in order to make his decision. Having established that there is insufficient information to fully elucidate the circumstances as set out in points 'b' and 'c' of part four of Article 23 of the current law must explain in writing why he has not carried out an examination.



5. Having established that there are grounds for an application regarding the psychiatric examination of a person without his consent or that of his legal representative the psychiatrist may apply to the patient's local court. The application should contain the written conclusions and such other evidence in the doctor's possession. The court may then grant a four-day period from the moment the application is made for such an examination. An appeal against the actions of the court may be made in accordance with the civil code of the RSFSR.

#### Article 26: Form of Outpatient Psychiatric Care

1. Outpatient psychiatric care shall be available to a person suffering from a psychiatric disorder depending upon the medical indications in either consultative-treatment or dispensary form.
2. Consultative-treatment assistance shall be administered by a psychiatrist upon the self-referral of a person suffering from a mental disorder and with his consent. In the event of a minor under 15 years of age the request shall be that of his parents or other legal guardian.
3. Dispensary supervision may be established independently of the consent of a person suffering from a psychiatric disorder or his legal representative under conditions set out in the first part of article 27 of the current law and assuming that observation of the patients psychiatric condition shall be by regular psychiatric examinations and the administration of the necessary medical and social assistance.

#### Article 27 Dispensary Observation<sup>2</sup>

1. Dispensary observation may be established for a person suffering from a chronic, protracted and severe psychiatric illness or one with frequent acute manifestations.

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<sup>2</sup> This is a literal translation of the Russian *Dispansernoe Nabludenie*. There is a distinction to be drawn between this and *Ambulatornoe Nabludenie*. The latter is closer to British out patients department where patients attend for specific treatment and consultations with a doctor. The former is closer to a day-hospital where the patient attends during the day and returns home at night. I visited such a clinic at Psychiatric Hospital Number One in Magnitogorsk.

2. Decisions concerning the necessity to instigate or discontinue dispensary observation shall be undertaken by a commission of psychiatrists appointed by the administration of a psychiatric institution which undertakes out patient psychiatric care or a commission of psychiatrists appointed by a health promotion authority.
3. The considered opinion of a commission of psychiatrists shall be recorded in writing in the patient's notes. Decisions concerning the institution or discontinuation of dispensary observation may be queried in accordance with the provisions of Section Four of the current law.
4. Discharge from dispensary observation may be undertaken early to allow convalescence or following significant and sustained improvement in the psychiatric condition of the patient. Following discharge from dispensary observation out patient psychiatric care, in a consultative-treatment form, may be provided at the request and with the consent of the patient or his legal representative. In the event of a change in the mental state of a person suffering from a psychiatric disorder he may be examined without his consent or that of his legal representative under circumstances set out in the fourth part of Article 23, Articles 24 and 25 of the current law. Dispensary observation may be reviewed under such circumstances by a decision of a commission of psychiatrists.

#### **Article 28: The Basis for Hospitalisation as a Psychiatric In-Patient**

1. The basis for hospitalisation as a psychiatric in patient shall be following a psychiatric break down which in the opinion a psychiatrist the condition requires observation or treatment as an in patient or following referral by a court.
2. The basis for admission as an in patient may also for necessary deliberation by psychiatric expertise in accordance with the established laws of the Russian Federation.
3. The admission of a person as a psychiatric in-patient, with the exception of circumstances set out in Article 29 of the current law shall be undertaken voluntarily – following the patient's request or with his consent.
4. Minors under 15 years of age shall be admitted as in-patients at the request of or with the consent of the parents or other legal representative. A person declared incapable of giving consent, in accordance with established law, shall be admitted as an in-patient at the request or with the consent of his legal representative. In the event of the objection of one parent or in the parents'

absence or another legal representative, an organ of guardianship and trusteeship, which may appeal to a court, shall undertake admission of a minor as an in-patient.

5. The receipt of consent to in-patient treatment shall be recorded in writing in the patients notes signed by the patient or his legal representative and the psychiatrist.

#### **Article 29: The Basis for Involuntary Hospitalisation as an In-Patient**

1. A person suffering from a psychiatric disorder may be hospitalised as an in-patient without his consent or that of his legal representative following the decision of a court or his examination or treatment is possible only in an in-patient setting and the psychiatric breakdown is severe and gives reason to believe that;
  - a) He presents a significant danger to himself or others or
  - b) His incapacity, that is his inability independently satisfy the basic needs of his subsistence, or
  - c) The current harm to his health as a consequence of the deterioration of his mental state, will be exacerbated if left without psychiatric care.

#### **Article 30: Measures to Ensure Safety in the Administration of Psychiatric Care**

1. In patient psychiatric care shall be carried out in the least restricted environment consistent with the guarantee of safety for the hospitalised person, other persons under the observation of medical personnel, and the patients rights and legal interests.
2. Measures of physical restraint and isolation during involuntary hospitalisation as an in-patient shall be undertaken only in such circumstances and in such forms that in the opinion of the psychiatrist other methods could not prevent the actions of the hospitalised patient presenting a serious danger to himself or others. At all times such measures shall be under the constant control of medical personnel. The form and duration of physical restraint and isolation must be recorded in the patient's medical records.
3. Officers of the Militia are required to assist medical personnel under conditions of the involuntary hospitalisation of patients in order to guarantee the safe access to the patient in order to carry out the examination. Where it is necessary to prevent a threat to the life and health to members of the public by a hospitalised

person or where it is necessary to search or detain a person subject to a hospitalisation order, Militia officers shall act in accordance with the established law of the RSFSR "On the Militia".

**Article 31: The Examination of Minors and Other Persons Declared Not Responsible who are Treated as In-Patients at the Request or With the Consent of Their Legal Representative**

1. A minor under 15 years of age or a person who, in accordance with the law, has been declared to be not responsible may be admitted as an in-patient at the request or with the consent of their legal representative. Such a person must be examined by a commission of psychiatrists of a psychiatric institution in accordance with the provisions set out in the first part of Article 32 of the current law. In the course of the first six months such a person must be examined by a commission of psychiatrists no less than once per month in order to decide whether to extend the in-patient stay. If the stay should be extended longer than six months a commission of psychiatrists should carry out a reassessment no less than once every six months.
2. In the event that the psychiatric commission or the hospital administration should discover that a minor or a person who has been declared not responsible has been falsely committed as an in-patient by their legal representative then the administration must notify the appropriate organ of guardianship/trusteeship in the patients home district.

**Article 32: The Examination of Persons Admitted as In-Patients on an Involuntary Basis**

1. A person who has been admitted as an in-patient in accordance with the provisions set out in Article 29 of the current law must be examined by a commission of psychiatrists of the psychiatric institution within 48 hours in order to decide the grounds for hospitalisation. Where there are no clear grounds for hospitalisation and the patient does not wish to remain he must be discharged promptly.
2. Where there are clear grounds for hospitalisation then the conclusion of the psychiatric commission shall be referred to the court closest to the psychiatric institution in order to decide the question of the length of stay as an in-patient.

### **Article 33: The Role of the Court in Deciding the Question of the Involuntary Admission as an In-Patient**

- 1. The question of whether a person should be involuntarily hospitalised as an in-patient in accordance with the provisions set out in Article 29 of the current law shall be decided in court in the vicinity of the psychiatric institution.**
- 2. An application for the involuntary hospitalisation of a person shall be made in court by a representative of the psychiatric institution in which the person has been admitted. Such an application must include indications for admission as set out in the current law and should include the basis for admission as an involuntary in-patient. The psychiatric commission's reasons for reaching their conclusion regarding the necessity for in-patient treatment should be appended to the application.**
- 3. Having received the application, the court shall authorise the admission of the patient as an in-patient for the period pending the courts deliberation.**

### **Article 34: Consideration of the Application for Involuntary Hospitalisation**

- 1. A court shall examine the application for involuntary hospitalisation as an in-patient within five days of it being received by the court or psychiatric institution.**
- 2. The patient must be informed of their right to take part in the court proceedings concerning the question of his hospitalisation. If the representative of the psychiatric institution is of the opinion that the patient, because of his mental state cannot participate in the courts deliberations the application for hospitalisation shall be considered in the psychiatric institution**
- 3. The following must be included in the hearing to decide the question of a person's hospitalisation: the procurator, a representative of the psychiatric institution, which has applied for hospitalisation, and a representative of the person to be committed.**

### **Article 35: The Resolution of the Court Regarding the Application for the Involuntary Admission of a Person as an In-Patient**

- 1. Having examined the application the court must either enforce or reject it.**
- 2. The resolution of the court to enforce the application shall be on the basis of the continued hospitalisation and continued detention of the patient in a psychiatric hospital.**

3. The patient, his legal representative, the management of the psychiatric institution, the procurator and also organs charged with the protections of the rights of citizens may appeal against the decision of the court within ten days in accordance with the established civil codes of the RSFSR.

#### **Article 36: Extension of Involuntary Hospitalisation**

1. The stay of a person in as an involuntary in-patient shall continue only for such time as the condition occasioning his admission persists.
2. A person admitted as an involuntary psychiatric in-patient must, during the first six months, undergo an examination by a psychiatric commission no less frequently than once per month. The psychiatric commission shall be drawn from the institution and shall decide whether to continue the patient's hospitalisation. If hospitalisation is longer than six months then the examining commission shall reassess the patient no less than every six months.
3. At the expiry of six months from the moment of admission of a person as an involuntary psychiatric in-patient the conclusion of the psychiatric commission concerning the necessity for extension of such hospitalisation shall be notified to the psychiatric institution's administration and to the local court. The court, in accordance with Articles 33-35 of the current law may decide to prolong the hospitalisation. Further such decisions regarding the extension of the period of hospitalisation of a person as an involuntary in-patient shall be taken by the court on an annual basis.

#### **Article 37: The Rights of Psychiatric In-Patients**

1. The patient must be informed of the reasons and aims of his admission as a psychiatric in-patient, his rights and the rules of the institution and the reasons for any entry in the medical records in a language that he fully understands.
2. All patients admitted for treatment or observation as psychiatric in-patients have the right to approach the senior doctor or administrator of the department directly regarding his treatment, observation and discharge as an in-patient and also the observation of his rights as set out in the current law. Patients have the right to complain and put forward applications, without prior censorship, to representative and executive state organs, the procuracy, courts, and a lawyer. They have the right consult a lawyer or a priest in private. They have the right to fulfil religious rituals, examine religious canons and possess, with the

agreement of the administration, religious accoutrements and literature. Patients may receive newspapers and journals and receive a programme of education from either a general or specialist school for children in accordance with the level of their intellectual development if the patient has not yet attained 18 years of age. Patients have the right to receive remuneration on a par with other citizens for labour in accordance with the quality and quantity of such work if he is engaged in productive labour.

3. Patients also have the following rights which may be limited according to the recommendation of the doctor responsible for his ward or by the chief physician in the interests of the patients health or the safety of other persons: the right to correspondence without censorship, to receive and send parcels, publications and money; to use the telephone, to own and acquire personal effects and wear ones own clothes.
4. Patients have the right to purchase services (such as individual subscriptions to newspapers and journals and other communications) in so far as this has been permitted and is within the patients' means.

#### **Article 38: A Service to Defend the Rights of Psychiatric In-Patients**

1. The state shall ensure that there is a service to defend the rights of psychiatric in-patients, which is independent of the office of the health service.
2. Representatives of such a service shall defend the rights of psychiatric in-patients, present their complaints and applications, which the administration of the relevant psychiatric institution shall permit or may be undertaken independently before representative and executive state bodies, the procuracy or a court.

#### **Article 39: The Obligations of the Administration and Medical Personnel of a Psychiatric In-Patient Service**

The administration and medical personnel of a psychiatric in-patient establishment are obliged to create the conditions for the fulfilment of the rights of patients and their legal representatives as set out in the current legislation. This includes: ensuring that those who are admitted as in-patients receive the medical care they need; allowing the opportunity for patients to familiarise with the text of the current law and the hospitals internal rules and regulations and that they have access to the addresses and telephone numbers of state and social organs, institutions,

organisations and responsible persons to whom the patient may turn in the event of a breach in the rights of the patient.

The administration and medical personnel must ensure that the conditions exist for correspondence and the conveyance of the patients' complaints and grievances to representative and executive organs of the state, the procuracy, court and also a lawyer.

Within 24 hours of admission as an involuntary in-patient measures must be taken to ensure that relatives, legal representatives or another person nominated by the patient. The relatives or legal representatives of the patient or another person nominated by him must be informed of any change in the patient's condition or any untoward incidents.

The safety of the patients must be ensured while in hospital and during the receipt of parcels and other items. The administration and medical personnel must fulfil the functions of a legal representative towards patients who, in accordance with the law, are acknowledged to be not responsible and who have no other legal representative. They must also explain to those with a religious faith, and others, the rules relating to the rights of the observation of ones religion which apply to psychiatric in-patients and are concerned with fulfilling religious obligations as well as the procedure for inviting a priest and offer such help as necessary to fulfil the rights of religious believers and atheists. They must also carry out such other duties as set out in the current law.

#### Article 40: Discharge as a Psychiatric In-Patient

1. The discharge of a patient as a psychiatric in-patient shall follow the improvement in his health or mental state to an extent that it no longer requires further in-patient care. A patient shall also be discharged if, following observation, the consultant no longer considers that there is a basis for in-patient care.
2. The discharge of a voluntary in-patient shall be carried out at the patient's personal request, that of his legal representative or following the decision of the responsible doctor.
3. The discharge of a person who has been hospitalised as an involuntary psychiatric in-patient may be carried out following the decision of a psychiatric commission or following a court order to discontinue such a hospitalisation.



4. A patient who has been confined for compulsory treatment may only be discharged following a decision of a court.
5. A patient who has been voluntarily admitted as a psychiatric in-patient may be refused his discharge if a psychiatric commission of a psychiatric institution establish that there is a basis for the patient's involuntary hospitalisation as set out in Article 29 of the current law. Under such circumstances questions regarding his stay as an in-patient, the length of hospitalisation and discharge from hospital shall be decided in accordance with the provisions set out in Articles 32-36 and part four of Article 40 of the current law.

**Article 41: The Basis and Procedure for Admission of a Person to a Social Security Psycho-Neurological Institution<sup>3</sup>**

1. A person may be admitted to a social security psycho-neurological institution on the basis of an application by the person suffering from a psychiatric disorder. A person may also be admitted following the decision of a medical commission that includes a psychiatrist. In the case of a minor under 18 years of age or a person who has been declared not responsible the decision shall be taken an office of guardian and trusteeship which shall act on the basis of a clinical decision of a medical commission which includes a psychiatrist. The commission's conclusion must include information regarding the person's psychiatric disorder and how it prevents him from being admitted to a general social security institution. It should also state the patient's capabilities and also why there are insufficient grounds for referral to a court to decide the question of the patient's incapacity.
2. The office of guardianship and trusteeship is obliged to undertake measures to protect the property interests of a person who has been admitted to a social security psycho-neurological institution.

**Article 42: The Basis and Procedure for Admitting a Minor to a Psycho-Neurological Institution for Special Training**

The basis for admitting a minor under 18 years of age who is suffering from a psychiatric disorder to a psycho-neurological for special training shall be following

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<sup>3</sup> This is a literal translation of *psikhonevrologicheskoe uchrezhdenie*. It could have been translated as 'hospital for the mentally handicapped' or some form of words such as 'unit for learning disabilities' but I thought it best to preserve the meaning conveyed by a literal translation.

an application from his parents or other legal representative and the recommendation of a commission consisting of a psychologist, an educationalist,<sup>4</sup> and a psychiatrist. Their recommendation must contain information regarding the necessity for the training of a minor in the conditions of a special school for children with impaired intellectual development.

#### **Article 43: The Rights of Persons Admitted to a Psycho-Neurological Institution for Social Security or Special Training and the Duties of the Administration of Such Institutions**

1. A person admitted to a psycho-neurological for social security or special training is entitled to the rights set out in Article 37 of the current law.
2. The duties of the administration and personnel of a psycho-neurological institution for social security or special training are those conditions for the realisation of the rights of persons living in them as established by Article 39 of the current law as well as the legislation of the Russian Federation regarding social security and education.
3. The administration of a psycho-neurological institution for social security or special training must review each case of persons living in them no less than once per year. The review shall be conducted by a medical commission including a psychiatrist with the aim of reviewing the need for further residence and whether the patient remains incapacitated.

#### **Article 44: Transfer and Discharge From a Psycho-Neurological Institution for Social Security or Special Training**

1. The basis for transferring a person from a psycho-neurological institution for social security or special training to a general type of institution shall be following the recommendation of a medical commission including a psychiatrist who have shown that there are insufficient grounds for the continued residence or special training in a specialist psycho-neurological institution.
2. The discharge from a psycho-neurological institution for social security or special training shall be undertaken:
  - At the request of the person with the recommendation of a medical commission including a psychiatrist who believe that the person's state of health allows them to live independently.

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<sup>4</sup> *Pedagog*

- Following an application by the parents or other relatives or the legal representative who are able to undertake the nursing care of a minor under 18 years of age or a person who has been legally declared to be incapacitated.

## **SECTION FIVE**

### **The Control and Surveillance by the Procuracy of the Performance of Those Rendering Psychiatric Care**

#### **Article 45: The Control and Surveillance by the Procuracy of the Performance of Those Rendering Psychiatric Care**

1. Control over the activities of an institution and persons who provide psychiatric care shall rest with the local authorities.
2. Control over the activities of psychiatric and psycho-neurological institutions shall rest with the offices of the health service, social security and education of the federal, republican (the constituent republics of the Russian Federation), autonomous regions, districts and areas and the cities of Moscow and St. Petersburg. They shall also rest with the ministries and departments that have such institutions.
3. The surveillance over the observation of legislation regarding the provision of psychiatric care shall rest with the general procuracy of the Russian Federation, procurators of the constituent republics of the Russian Federation and subordinate procurators

#### **Article 46: Joint Social Control Over the Observation of Rights and Legal Interests of Citizens Who are Receiving Psychiatric Care**

1. The professional societies of psychiatrists and other social societies, in line with their own regulations (statutes) may exercise control over the observation of rights and legal interests of a citizen at his request or with his consent while he is receiving psychiatric care. The right to admit persons to psychiatric and psycho-neurological institutions must be reflected in the regulations (statutes) of such societies and with the agreement of the offices that have jurisdiction over psychiatric and psycho-neurological institutions.
2. Representatives of professional societies must agree the conditions for admission to a psychiatric or psycho-neurological institution with the institution's

administration. They must acquaint themselves with the rules in force within them, implement them and guarantee to protect medical confidence.

## **SECTION SIX**

### **Complaints Regarding the Delivery of Psychiatric Care**

#### **Article 47: The Procedure and Limits for Complaints**

1. The activities of medical workers, other specialists, workers in social security and education, and medical commissions which infringe the rights and legal interests of citizens receiving psychiatric care may be subject to a complaint at the discretion of the plaintiff directly to a court and also to higher authorities (a senior responsible person) or the procurator.
2. The complaint may be made by the person whose rights and legal interests have been infringed, his representative, and also organisations who in law and according to their regulations (statutes) have the right to defend the rights of the citizen. The complaint should be made within one month from the day it became clear to the patient that his rights and legal interests had been infringed.
3. A person who wishes to complain but for whom one month has lapse may still complain if he has good cause for the delay. The complaint should be referred to the responsible office or person who may review it.

#### **Article 48: The Procedure for Presenting a Complaint in Court**

1. Complaints concerning the conduct of medical workers, other specialists, workers in social security and education and also medical commissions who have infringed the rights and legal interests of citizens receiving psychiatric care shall be examined by a court in accordance with the regulations set out in Chapter 24 of the Civil Procedural Code of the RSFSR and the current articles.
2. The person whose rights and legal interests have been infringed must be allowed to participate in the examination of a complaint by the court providing that it is not detrimental to his health. The person about whom the complaint has been made or his legal representative and the procurator must also be present.
3. The costs associated with examining the complaint in courts shall be born by the state.

**Article 49: The Procedure for Examining a Complaint by a Higher Authority (Senior Responsible Person).**

1. A complaint, which has been referred to a higher authority (senior responsible person), shall be examined within a ten day period from the moment of referral.
2. The decision of the higher authority (senior responsible person) regarding the complaint must be informed by and on the basis of law.
3. A copy of the decision of the higher authority (senior responsible person) shall, within a three day period, be sent or delivered to the plaintiff and the defendant.
4. The decision of the higher authority (senior responsible person) may be subject to an appeal in a court in accordance with the provisions set out in Chapter 24 of the Civil Procedural Code of the RSFSR.

**Article 50: Responsibility for the Infringement Current Law**

Criminal responsibility for the infringement of the current law shall rest with the legislature of the Russian Federation. Administrative and other responsibility for the infringement of the current law shall rest with the legislature of the Russian Federation and the constituent republics of the Russian Federation.

**President of the Russian Federation: B. Yeltsin**

Moscow, House of Soviets of Russia,

2 July 1992

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