PSYCHIATRY AND SOCIETY: THE CASE OF SPAIN

Hillside Hospital, New York, Easter 1970

by
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1. Social organization:

Paternalistic structure <---> social organization,

Social change <——-> dialectic process

Social maturity<—-—->little change in Spain so far.

2. Socio-political organization and psychiatry

Establishment <———> equilibrium,

Equilibrium and Psychiatry <————> Mental illness; Cultural Threats
- a) Eliminate them
- b) Asylums (closed-in evil) — Insane, Delinquents, Russia
- c) Mental Illness - Degenerates, - Organicity
- d) PSAN challenges the equilibrium puts back blame on society

Requirements for a society to accept guilt
- Cultural maturity
- Conditions to be able to enter in and to elaborate the Paranoid schizoid and depressive positions
- Psychoanalysis and democracy - Cultural Evolution

- ***Actual state of affairs in Spain***

Introduction (cultural transplants)

0bservations:
- a) Socio-cultural background
- b) Family structure
- c) The patients: Nosologic
- d) Institutions
- e) The Psychiatrists- University Psychiatry

Public image of Psychiatry and Psychiatrists
The doctor-patient relationship: Cultural expectations.
Final Considerations
The future of Spanish Psychiatry

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As you probably know, Spain is a country that, since 1936 and after three years of civil war, has been under the rule of Generalissimo Franco.

Seen from the outside, and regardless of how many political changes have taken place, it looks like a dictatorship. The political regime, according to the necessities of the moment**,** has been labeled in, different ways: from the Movimiento Nacional Sindicalista, to vertical democracy, to the present when it is called a kingdom, with a prince-elect who is to succeed the ruler of Spain as head of state the day the latter is gone. Regardless of the name we give it, Spain's regime is determined by a paternalistic social structure, that reflects itself in its political organization.

In my opinion Spain, or any other country, has the kind of political organization that best fits with its social and psychological structure. Regardless of how strong the internal pressures are, a political change does not occur unless a previous social change has taken place. This change will always be the result of a dialectic process between the renewing or so called revolutionary forces and the conservative ones. All societies are continuously subject to this kind of processes and the way a given society is able to deal with this inner struggle and conflict shows its degree of social maturity. The greater the capacity a given society has to allow change, without losing the sense of social identity, the greater is its degree of maturity.

A classification of the different developmental stages through which societies, civilizations and cultures go would be very much in place here, in order to understand and situate the actual state of affairs in Spain, but this would be far beyond the scope of this paper and the time we have. I will limit myself to state that the socio-political organization of Spain today is of a vertically descendent nature, that power and responsibility runs from top to bottom (what others would define as a paternalistic state), and that even if there are forces within this system that oppose its organization, they are kept in check and have not been able so far to produce substantial changes within the whole system.

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How does the socio-political structure reflect itself in the ideological formulations of Psychiatry and its practice?

In my opinion, in a socio-political organization such as the one I have described so far, the Establishment will make use of all its resources in order to secure the continuity of the established equilibrium. Mental illness is an index of personal conflicts as well as of social ones. Psychiatry is one of the means by which any Establishment tries to keep at bay the forces that challenge the social system from within. Depending on the degree of development and maturity of a society, the means they use to keep under control mental illness will vary:

a) Mental illness is always a sign that disrupting uncontrolled forces are at work. Before the birth of Psychiatry, and in the Magical Thinking Era*,* the solution was very simple: individuals who challenged the established order were eliminated. They were considered bedevilled or heretics, and therefore were burned. The same tactics were applied to the carriers of foreign cultures; the strangers would be considered enemies and would be fought or killed.
b) In the process of time and under Christian influence and with the taboo against killing, people learned to distinguish the dangers from within from those from without. For the latter, the same old method was considered to be good, and wars continued to be an accepted way of defense up to our days. The hermetic closing of borders was a good method too, but it is difficult to maintain them leak-proof.
c) For the enemies from within, a very interesting method was invented: The Asylums. The ambivalent sadistic charity of some members of the society had the task of keeping "Evil" out of sight and under control. The invention of "Insanity" was one of the greatest achievements of humanity, and additionally, had the advantage of making a few responsible for the evilness of all, and to lock the disruptive forces into a safe place. Not all dissident members of society were fortunate enough to be called insane; some continued to be killed, put into jail or exiled under the heading of "Delinquents". Even nowadays similar criteria are being used. When we are shocked by the fact that political opponents in the USSR are treated as mental patients, we are losing sight of the fact that within the soviet system those people are as mentally ill as the ones we commit to our mental hospitals.
d) When Medicine entered the Asylums for the Insane, at first in order to take care of their corporal needs and later of their minds as well, another important break-through was being achieved. The concept of Mental Illness was being born. The medical thinking of those times, with the cause effect orientation, had to find a reason for that new kind of illness. The blame was to be put on something: Either they were "degenerates", who were paying with their illness for their own or their parents vices, (alcohol, sexual promiscuity, masturbation), or, as the anatomopathological and microbiological findings had shown, they were affected by an infectious or external factor. Also, there was something else whereupon to put the blame: Organogenicity. If no external cause was found, we always had a solution by calling them "endogenous diseases".

e) So far we have seen how societies use psychiatric concepts as cultural defenses, directed at isolating evilness and locating it in some of its members. With the birth of Psychoanalysis (with the idea of the unconscious, the theory of instincts, and of the development of personality), this type of defense was going to be challenged. Evil was a universal concept, and blame was going to be placed back onto society, first at the level of parents, later at the level of civilization. That is the equivalent, at the cultural levels of what M. Klein has described in human development as the passing from the schizoid paranoid position to the depressive position.

I have my doubts that the psychoanalytical challenge could be taken on board by any society which is not lead by truly democratic principles.

For a society to be able to take on board and accept the part of the blame that belongs to it, without being overwhelmed by it, the society needs a lot of internal maturity and a tremendous capacity to elaborate, to work through and to neutralize the destructive forces with constructive ones, to transform them and to put them at the service of the community. The new concepts challenge the whole cultural equilibrium and the more rigid the cultural system is, the more it will resist the forces that threaten it from within. We all know about the strength with which the new ideas of Freud were to be opposed in the Old World. He himself had predicted the resistances his new insights were going to be met with. He considered this to be due to personal intrapsychic conflicts. I doubt however to what extent, if at all, he was aware that there are intrinsic super-personal forces, which I would call cultural defenses, that were at work.

I have my doubts that psychoanalytical challenge could be taken on board by any society which is not lead by truly democratic principles and ideologies. Psychoanalytical tenets are the crystallization of a set of cultural values: Respect for the individual person, tolerance for ambivalence and contradictions, pursuit of personal freedom, capability for compromise and a burning desire for honesty, truth and purity, all of which are only given in democracies. Only a cultural system which is flexible and sufficiently developed to allow contradictory forces to be unleashed within itself, without being overwhelmed by the fear of losing its sense of identity, is ready to meet the challenge of Psychoanalysis. One only has to consider how different the outcome of psychoanalysis has been in the U.S.A. and in the Old World, in developed and in underdeveloped countries, in those with a totalitarian political structure and those with a democratic one.

Taking a challenge means running a risk. The future consequences are to be seen. I would not be surprised if such as social unrest, violence, changes in the value and believe systems, revolutions and counter revolutions, were a logical consequence of society not able to stop at time the revolutionary forces unleashed by Psychoanalysis, social and cultural evolution in a process that nothing can stop. It grows at an exponential rate. The way a given society deals with the problem will depend on its ideological system. The alternative dichotomies, good versus evil, mind versus body, individual man versus society, have to be overcome if the human race wants to survive. The ages have gone when Man expected the solution of his problems from God and blamed Fate for all of his adversities. If God exists, and for many of us He still does, we know He has left to Man the task of taking care of himself, and has provided Man with the potential evolutionary powers to do so and to do better than we have done so far. History is going to prove if we were right or wrong in our supposition.

All societies have a tendency to solve the immanent problems of living. Some will put the accent on the rights of the individuals, others on the rights of society. The solutions depend on the special set of circumstances and the level of cultural development and social structure. The controversy will be solved through a dialectical process from which an integrative synthesis is going to develop if Mankind is to survive.

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The actual state of affairs of Spanish Psychiatry
and how it relates to the Spanish social structures

When I first came back into contact with Spanish Psychiatry seven years ago, I had been away from my country for a decade. During those years I had been subject to three cultural transplants and in the process I had become a Psychiatrist and a Psychoanalyst. The country, as you can imagine, was not at a standstill, waiting for my return. It had itself experienced a series of transformations that projected themselves at the political as well as the social and cultural level. The rate of change for me and for the country has not been the same. So, I was confronted with the task of cultural re-implantation in my own country. I have some ideas and experiences about the processes and mechanisms involved in cultural transplants. If any of you are interested in the them, we could comment upon it in the discussion that follows, but extending myself here would run beyond the scope of this paper and the time available.

In order to practice Psychiatry in a given community, the first thing you have to do is to become familiar with the cultural background of your patients, what your patients and their families are going to ask from you, what you are ready to give to them and, finally, what resources the community has in order to support your task or to obstruct it.

So, the first task I had was to arrive at an assessment of these conditions. I have been working on it for seven years and all I can offer you is a summary of this work up to date. As the object of study is a dynamic process, I cannot assure you that my observations are reliable in all their dimensions, or that my predictions will be valid a few years from now.

There go my observations:

About the social background

I have already mentioned the political aspects of this society from the socio-economic viewpoint .I can add that it is a capitalistic system with great differences between social classes. It is a pyramidal system where the rich and the ones at the top, the high class, are very few; and they enjoy a multitude of advantages. The middle class, low middle class mainly, is limited, and the lower working class is the largest. The weight of taxes falls mainly on the second and third states. The high class holds all political power. Climbing up the scale is very difficult indeed. There is some social mobility between second and third states and practically none up to the first. Nepotism is wide spread in all strata. The best are always your friends, or your relatives, regardless of their real worth.

Family-Structure

This structure should be classified under the heading of "Paternalistic Extended Family Networks". with all its characteristics, like a very small capacity for change, a low degree of adaptability for their individual members, changing socio-economic conditions are met poorly, foreign cultural influence is faced either with pseudo-identifications by the young, who take in the letter but not the spirit, or sheer rejection by the older. In recent years, coinciding with some opening of the borders, there is a clash of generations. Unfortunately, the young and revolutionary now hold ideologies but use the totalitarian methods and attitudes of the elder and conservatives.

Such a family system is able to absorb a tremendous amount of pathology. Follies à deux, à trois, or of the whole family are a common finding. Who tries to practice Family Psychiatry as I do, meets resilient family resistances, many of them insurmountable. They determine who is the patient and he is offered to you without alternative. The family will go to any extend of trouble to keep the patient within the family. They will obstruct any measures you take in order to really help him or them *and* they willingly go along with any one who tends to crystallize the pathological family equilibrium.

The Patients

a) Neurological classification and public attitudes toward the different categories.

I. Character Disorders is the most frequent category. They are well tolerated by society and you see them rarely in your practice.

The Passive Aggressive Dependent Type is the most wide-spread. You can see them only indirectly through marital conflicts or as parents of child patients. Sadomasochistic relationships prevail in marital couples, usually accompanied by sex role reversal, with latent homosexuality. Since there is no divorce as a way out, the solution usually is some kind of emotional disturbance. Paranoid types reach high echelons in the societal system.

II. Psychosomatic conditions are respected within society. General practitioners do their best in order to "somatize" these prospective neurotic patients. "Being ill" or "having something" secures sympathy from families and doctors. A repeatedly organic negative diagnosis is dreadful to the patient, that means they do not suffer from anything, or they are just "maniáticos" equivalent of "lunatics" in English. They will go to any number of doctors until they find a charitable soul that grants them an honest diagnosis. Lately E.E.G. findings are making wonders in this direction.

III. Neurotic Patients. Nobody in their sound mind would accept to be suffering from such shameful condition. *Suffering from nerves* is more respectable, "surmenage" is even fancy. A leading psychiatrist stated in a National Conference that neurosis did not exists and that in his region, well known for the religiousness of its people, he had never seen such *a* condition. Another internationally known psychiatrist has discovered a new conc*ept, la "Ansiedad Vital*,* which is an endogenous condition and can be compared to the endogenous depression. Imagine how anxiety producing is the name of anxiety! This professor is the author of a book called "Ocaso del Psicoanálisis" or "The Fall of Psychoanalysis" edited in the 1930ies, and is still convinced about it today. I can assure you that he has done his best to make it come true.

IV. Perversions and Psychopathic Conditions. These are not psychiatric conditions but legal ones. The police and the Courts take care of them.

V. Addictions. There are not many so far, the few you see are barbiturate addictions. I have only seen one on amphetamine. Everybody takes tranquilizers. These are dispensed without

prescription. Until recently one could also buy hypnotics this way, some kids *are* starting nowadays with marihuana hashish (the Moorish type). But that is just a fad, with no social or psychiatric preoccupation. *Stronger stuff is ava1lable quite easily, but natives rarely use* it. The Balear Islands used to be the Paradise Islands for foreign addicts; dope is readily available and cheap. Tourism increased the market of drugs so much and started peddling business, so in the last two years the police has had to take some measures and practice some arrests and handle fines.

VI. Delinquency. We have one of the lowest delinquency rates according to official records. The truth is that we have an extremely efficient system of law enforcement and that anybody can walk safely through the streets day or night. The use of arms is strictly controlled.

VII. Psychosis. Let us not talk about it. This is a disgrace that can happen in the best of families. As a matter of fact the psychotic patients only grow up in the best families. The others are just plain "nuts", "furiosos". Families with psychotics are quite expert at hiding it. It can be denied for long periods of time, there is a home "closed door" system that works quite well; when the situation becomes impossible to maintain one can always send them to a far away town or country (depending on the financial resources and social status) for an expensive "cure of rest". If that happens, it is a shame on the family and becomes the "skeleton in the closet"; nobody ever mentions it any more.

b) From the socio-economic point of view.

I. Private Patients. Practically everybody, except the poorest, goes at one time or another to privately consult the psychiatrist. Prestige is a very important thing: 1he higher the fees, the longer the waiting list, the more people wait for their turn in waiting rooms, corridors and halls, the higher the titles held (e.g., University Professor), the more assistants and pretty nurses they have in the office, the less time they spend with their patients ... the better are the doctors for the general public. Good public relations that secure press and TV appearances help also with prestige. One does not really need to help or cure anybody in order to hold a flourishing practice.

II. Insurance Patients either from private companies or from the S.O.E. (obligatory insurance for all Spanish workers). Only ambulatory assistance is provided. A specialist in the S.O.E. sees anything between 15 and 20 patients in his daily hour, including neurological and psychiatric patients. If hospitalization is required, it is never included in the insurance policy, as far as psychiatric patients are concerned.

III. Welfare or Charity Patients. They are attended at University Clinics, City Emergency Rooms and Psychiatric Hospitals (City, State or Charity Hospitals). Ambulatory treatment is rarely provided for those patients.

The Institutions

There are two kinds: Private and public; the latter can be owned either by the State, the City or Religious Orders. Segregation of sexes is the usual practice; social discrimination is common in both kinds of institutions. Institutions are always understaffed. For a hospital with 1500 beds one M.D., who is not required to be a specialist, is enough to cover the night shift. During the day psychiatrists attend the hospital for a couple of hours daily, and take care of anything between 100 and 500 patients. The nursing staff is not specialized; it is rare to find even registered nurses in mental hospitals. Assistants and religious untrained personal are the ones who really take care of the patients. Doctors operate at a supervisory level; of course, they are badly paid.

The wages vary between $50 and $200 a month for a doctor and more or less the same for an assistant doctor. In private institutions every patient has his own private doctor who will visit the patient as frequently as the doctor wants to; but nursing staff is of such low quality that you can be pleased if they give the patient the medication you have prescribed and in the way you indicated. There is no such thing an O.T. really and to milieu or institutional therapy lip service is paid. There are exceptions, of course, but very rare indeed. The richest patients are sent abroad. Switzerland used to be one of the places of choice, not precisely because of the quality of treatment they offer, but because firstly it was more discreet and secondly more expensive, so the family's guilt feelings were more easily appeased. An alternative today is to send them to Madrid where clinic rates are also guilt relieving and where a well known professor is able to take care of hundreds of patients all by himself.

The Psychiatrists

Usually they are self-trained. Until 1950, Psychiatry was taught in the undergraduate programs under Legal Medicine. Then the first chairs of Psychiatry were created. Before the end of the 1950ies no specialty law existed and any M.D. was allowed to practice any specialty he pleased. People after qualifying as M.D. (no internship was required) would start an apprenticeship under a "Maestro". Some people started their specialization even before the first or second year of undergraduate program; the method of training was sheer practice with patients and rare

ward-rounds with the "maestro"; slaving for him in his private practice was a possible way of gaining his favors, or maybe for gaining a scholarship for a short study trip to Germany, or abroad. A psychiatrist who did not speak German could not be a good one.

Any M.D.'s who had been practicing as a specialist for more than three years was automatically granted the title of the specialty of his choice. Then Specialty Schools of Psychiatry were created in the realms of the University in 1964. Two years of attending theoretical classes (6 to 8 hours a week for more or less 120 weeks), no seminars, no practice, no supervision, was enough to grant them the title. Examinations, if any, were symbolic.

Nowadays with the new Law of Education, some very few teaching hospitals are starting three-year residency programs for Psychiatry. Usually they are understaffed with teachers. Not even today there is a Certifying board for Specialties.

University Psychiatry; to go for a tenure, one has to pass a competitive examination. The more important merits are the kind of relationships or connections one has with the Examining Board. Once professorship is reached, one becomes a State employee, and the professor becomes the master and god of his own chair until death or retirement at 70 will part them. All the hardship that goes into becoming a professor pays off in the prestige that it holds in the community and the secondary benefits (private practice and high fees). Not a single professor of Psychiatry in Spain is full time in teaching or research.

It is possible that the actual reform of the university will change this state of affairs a little bit.

Public image of Psychiatry and the Psychiatrist

People in general are very suspicious of both, prestige wise. Psychiatry rates as one of the lowest among medical specialties. People refer to them as "Loqueros", "charlatanes", "embaucadores", etc. Neither the rest of the medical profession thinks very highly of their psychiatrist colleagues. General practitioners make very few referrals, with the exception of major psychosis, Psychotropic drugs are prescribed at random by the G.P. with little knowledge of Psychiatry and drugs. Psychotherapy is practiced by everybody (Supportive Psychotherapy, of the type of "mano en el hombro", the "don't get nervous", or "you should not think that way" etc. etc.). Some self-trained dynamic psychiatrists practice psychotherapy; this can go from wild psychoanalysis to existential psychotherapy -quite respectable by the way- to endless rationalizations with the patient on the couch and everything. Child Psychiatrists -there is a good tradition in Barcelona- deal mainly with problems of deficiency. Psychoanalysts (very few, altogether no more than about10) are bitterly attacked by psychiatrists, on grounds of theoretical positions, the psychoanalysts themselves get at each other's throat.

The patient-doctor relationship: Cultural expectations

What people ask from psychiatry is mostly immediate symptomatic relieve. If you do not give them a prescription (the longest and the more complicated the better, they feel disappointed. They are biased against being helped through "talking"; they have done that before with their families, the priests and their friends and they know it does not help This cultural attitude increases the difficulties for starting an analysis. Besides, they have to hide it from friends and acquaintances; if word gets around it can really be quite detrimental, For example, in the house where I live the parents use my name to make their children behave.

If the patient is "unsound", people ask you to commit them against their will and consent; very few patients indeed are committed on a voluntary basis. Commitment procedures are simple: The signature of a G.P., a call to the police or to a city ambulance, made at the request of a relative or a simple citizen is enough for the patient to be put under observation. The decision and responsibility for a commitment, release, therapy, etc., lies in the hands of the director of the institution. The patients responsibility is delegated by the family entirely upon the physician whose authority then becomes omnipotent. Patients have practically no legal protection, nor rights. Malpractice suits are unknown. Some psychiatrists give E.C.T. to their patients without them or their families knowing about it. Once the family has transferred their responsibility, they renounce to their own. They usually make themselves responsible for the fees of private patients but it is quite difficult to make them take back responsibility for other aspects. The degree of cooperation of the family for treatment, discharge, rehabilitation, etc. is very limited, and the doctor has to use all the weight of his authority and all his manipulative capacity in order to secure some. People's attitude forces psychiatrists to play an authoritarian paternalistic role, which doctors are willing to assume. Another aspect of the same phenomena is the medical expectations that patients have from the psychiatrist. The patients expect miracles and the doctors are ready to promise them. People's gullibility is great and some doctors ride along in order to really perform miracles on the grounds of suggestibility and prestige. When the "miracles" does not come off, treatment ends in a disappointment on both parts, an attitude of cynism and skepticism toward the doctor. The doctor who lets himself be caught in what I call the "magical circle", will end up by losing his scientific attitude, regardless of how hard he tries to save it. Giving in to the pressures for magical acting is a great temptation. The thought that "nothing else can be done" is the first step towards accepting defeat. Emigration or absorption by

the system are obviously two possible answers to the question of the psychiatric conditions of this country. Not to give up requires a lot of stamina, psychological and professional resources and the possibility to secure a minimum of satisfactions that feed ones system and keep alive hope. The greatest risk is to consider oneself a pioneer, and to be ready to accept a martyr's role. One has to look around for other signs of change, detect the elements responsible for it and try to join forces with them. Any socio-cultural system will try to keep elements of this type separate and the feeling of isolation these elements experience is the proof that they are exerting pressure for change.

Final Considerations

In summing up, from the Psychiatric point of view, Spain is at the beginning of the transitional period that goes from the Magical Thinking Era into the Scientifically oriented Era. This is not an isolated phenomenon, but one more expression of the many socio-economic and cultural changes that are taking place within this society.

In this exposition I could be blamed for giving too static a view of the state of affairs in Spain today, but this is the risk and limitation of cross-sectional studies. Anyhow, the importance lies in giving you an assessment of the situation in reference to the reciprocity and interdependence of the relationship between society and the psychiatrist.

For anybody wanting to work in a setting that is not his own, or from which he has been separated for an extended period of time, it is recommendable to try to assess the actual state of affairs, to then try to see the historical determinants which have lead to the present situation, to attempt to weigh the dynamic forces at play, and to foresee which are the possible developments likely to take place and to clarify for himself the role he is to assume in order to secure that his contribution will foster development in the direction he thinks is desirable and realistically possible.

If one is committed to the idea that scientific thinking is more desirable than wishful thinking, one should be submitting oneself to a process of self-scrutiny in reference to one’s own personal incongruences and the cultural process one is part of. That gives a chance to continue to be scientific in one’s thinking and behaviour.

The Future of Spanish Psychiatry

The future of psychiatry is not going to be a result of the isolated growth and efforts of psychiatry itself, but it implies the joint influx of an operating network of forces that are pressing towards change. The more these forces are governed by scientifically oriented principle and the less by uncontrolled emotional ones based on the primary processes, the better for the future.

There are obvious signs that Spain is moving towards a more mature position. The new Law of Education shows that the Establishment is being unbalanced. Naturally, the existing system will try to use it for its own ends. But once the system gives way on a basic issue like this one, the whole changing process is unchained; economic, social, political and medical welfare policies will follow. The homeostatic balance and safety measures will fail and no conservative force will be able to stop it.

The future of Spanish Psychiatry will depend upon the general direction that the country takes. I am hopeful that it will be towards maturity and progress.