

'ONE of US?'

Could Existential Therapy have an explicit social role?

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Abstract - Community Care is often seen as an enlightened and compassionate response to the needs of the mentally distressed. However, a discussion of the development of community care policy and a look at attitudes of the community to those experiencing distress suggest that this is not so. Uncaring community attitudes seem to be a result of current policy. The tragedy at Dunblane highlights the urgent need for a return to the original philosophy of care in the community. This philosophy maintains that a policy of mental health care is inseparable from social policy on the whole. This paper is presented in the spirit of encouraging existential-phenomenological therapists to attend to the realm of social critique by describing the nature of our communities and their impact upon our clients and ourselves. By developing a phenomenological way of addressing *the context* of our interactions with others, could we develop a valuable social dimension to our work as therapists?

I am interested in the interaction between the 'community' and those members of the community who are experiencing mental distress. Increasingly since 1948, British mental health service provision has been devolving to the community level. This de-institutionalisation is promoted as an indication that we live in a caring society. The 'community care movement' is based upon the idea that institutions segregate people from the rest of society and that this is unacceptable (Bennett and Morris, 1983, cf. Goodwin, 1993, p.2). According to the Irish Psychiatrist Ivor Browne, the original pioneers of community care

... saw this movement as primarily the democratisation of human relationships and the breaking down of the contradictions within society which created total institutions such as mental hospitals ... They saw this movement as a struggle towards independence and self-esteem for those human beings we call patients ... (Browne, 1980, p.1).

I need to begin by looking at the development of community care policy to explore whether it really is an expression of these original intentions. I will then discuss community attitudes to the mentally distressed and take a speculative look at the newspaper reports of the tragic killings in Dunblane. I will suggest that unless *community attitudes* to 'care in the community' are taken seriously, continued implementation of the current policy may be dangerous. I will propose that a return to the original intentions of the movement is crucial to the success of community care. Models of care which emphasise equally the individual and the community are mentioned.

Explaining policy development

In *Community Care and the Future of Mental Health Service Provision*, Simon Goodwin describes the emergence of a community care policy for the mentally distressed (1993, pp.5-30). The conventional understanding is that the state adopted an enlightened and benevolent approach. New psychoactive drugs enabled psychiatrists to control behavioural symptoms so that patients could leave hospital sooner or be treated entirely as out-patients. Administrative changes in service provision from

hospital sites to out-patient or day centres allowed more flexible and socially-minded intervention. And the legislative response of the state was to encourage voluntary and informal treatment and an emphasis on community services (Goodwin,1993,pp.6-17).

This conventional understanding of 'community care' relies upon specific assumptions. It equates mental distress with a medical model of 'illness'. Provision is drug-centred rather than caring in a broader sense. Sufficient resources to develop community facilities were never forthcoming (Goodwin,1993,p.9) so custodial care is, in reality, born by families when possible, or by private sector Bed and Breakfast accommodation. It proposes that the development of new medications made community care possible, yet Goodwin points out that there is no evidence that the introduction of psychotropic drugs had any appreciable effect upon the organisation of mental health services (1993,p.11). The "propaganda" surrounding the change in mental health provision assumes a cohesive community which wants to support the mentally distressed. While the mentally distressed were cared for in institutions, there was a growing concern for democratising staff/patient relationships (for example the work of Basaglia) yet there was no corresponding work done in the community before de-institutionalisation began. There is no actual evidence that the move to a 'community care' policy grew out of the original benevolent intentions.

Goodwin offers an alternative explanation for the development of the community care policy based upon Habermas's 'Critical Theory'. He sees the policy evolving out of the state concerns of cost, control, and legitimation (Goodwin,1993,p.47). The antagonisms between these three state concerns accounts for the subsequent twists and turns in community care policy. As the economy contracts and unemployment increases, the number of people seeking mental health services increases (Dooley and Catalano,1984,c.f.Smith and Giggs,1988,pp.137-42). Just as the demand for services increases, the state must decrease its provision of services in order to meet the cost criteria set down by decreasing capital accumulation. We have designed a system that cannot respond when a response is most needed.

Goodwin argues that the policy of community care is not simply about 'care', but about fiscal and social control, while seeming to be compassionate (legitimation). The state is caught between the constraints of revenue from capitalist economics and its

own public propaganda. Therefore, we have a policy of 'care in the community' but a practice of closing institutions without providing new facilities.

Rather than the medical model, Goodwin sees mental distress as a socially constructed phenomenon derived from the struggle between an individual's interests/actions and their particular environment. In Goodwin's words;

"Mental distress", in many (though perhaps not all) of its manifestations, represents a socially constructed phenomenon that is intrinsically related to the nature and development of societies; in this case British capitalism. It is a category that allows for the setting of limits about what constitutes acceptable behaviour, and also allows for the legitimate management of people who "fail" to perform certain roles (1993, p.42).

Psychiatry's role is to manage this distress cost-effectively in order to maintain current social roles. It is cheaper to provide treatment to a distressed (unpaid) housewife, and maintain her at home and in that role, than to let her "breakdown" and have to provide expensive hospital accommodation while also introducing professionals to provide support for her family. It also appears to be the appropriate response of a humane society to care for a miserable woman (this appearance of care bolsters the legitimacy of the state while simultaneously masking the possibility that her misery is a product of these social relations). Contemporary community care and its medical model of mental illness seems a coverup for the underlying motives of the state in capitalism.

'The real dispute is ... between those who want to improve the social prospects of people with long-term mental illness, to reclaim them not for mental patienthood, but for citizenship, and those who settle for a highly restricted vision of the 'place' of people with mental illness in social life' (Barham,1992,c.f.Goodwin,1993,p.217). Goodwin thinks that community care should be supported on the basis that desegregation in the long run is possible, and that attitudes can change enabling the distressed to participate in mainstream society. In other words, the original motivation of the pioneers of this policy might be realised if we take a more holistic approach, looking at both care and community. Before we can do this, the community must be

willing to reflect upon its attitude to individuals experiencing distress, and the true nature of distress itself.

Community Attitudes are Crucial to Community Care

The medical view prevails in society. If someone is labelled as mentally ill, then they are victims of a disease. A criminal can be morally wrong, evil even, but a mad person is sick. This creates a problem for society;

The social disruption the mentally ill create indicates a punishment response, while at the same time, the appearance of inability to control the behaviour indicates that a more humane response would be appropriate. This ambiguity in the status of the mentally ill makes the societal reaction to them highly problematic (Horowitz,1982,p.28).

Rabkin (1985,c.f.Dear and Taylor,1982,p.54) found that characteristics of the patient influenced the response by the community. Unpredictable patients who were seen as unaccountable for their actions, especially males with low socio-economic status, exhibiting behavioural symptoms (rather than physical ones), and without social ties in the community, were the most likely to be rejected by the community. If the person's behaviour was incomprehensible, bizarre or disruptive (rather than withdrawn or depressed), and especially if there were manifestations of violent behaviour, the person would be rejected by the community.

Homogeneous and highly cohesive neighbourhoods tend to reject the mentally distressed. Neighbourhoods of well-educated, transient residents without children tend to be more supportive (Armstrong,1976;Trute and Segal,1976,c.f. Dear and Taylor,1982,pp.53-4). Two studies published in 1996 (Wolff et.al.) found that education is an important determinant of attitudes toward the mentally distressed, except when the respondent had children at home (1996a,p.192). This is not because parents of young children lack understanding of mental illness but due to an 'accentuated wariness' of their children's vulnerability (1996a,p.197). The nature of the tragedy in Dunblane, and many tragedies since then, will undoubtedly and understandably entrench the attitudes of parents.

But a community can also facilitate the re-socialization of an ex-psychiatric patient, and this can be associated with a decrease in symptoms. However, the ability of the community to fulfil this role is questionable not only because of its attitude to the ex-patient but also because of the increased atomisation of society as it adapts to later capitalism. Psychiatry can label and prescribe, but it cannot create the sense of community, the interpersonal ties, which are necessary for integration. The result of maintaining the mentally distressed in a setting where they cannot be received is that they are kept on the fringe, where they are subject to control rather than care. And as acceptance can facilitate recovery, so can rejection aggravate the already difficult position of the individual, adding greatly, perhaps unbearably, to their distress.

The Dunblane Tragedy

In the small village of Dunblane, Scotland, on the morning of March 13, Thomas Hamilton shot 16 young children and their teacher before turning a gun on himself. In order to try to get a sense of this man and the community in which he lived, I reviewed the newspaper articles for the week immediately following the tragedy. As much as possible I stayed with accounts of Hamilton's life and quotes by people in the community. I am anxious to avoid making a study of the actual reporting, or a pseudo-analysis of the murderer. My main intention is to inquire about the community attitude towards Hamilton and the impact this may have had upon his life.

Thomas Hamilton grew up with a false sense of who he was. He was raised to think that his grandparents were his mother and father and that his real mother was his sister. His natural father had left when Hamilton was eighteen months old. He only discovered the truth at the age of thirty-eight (Bogan and McKie,1996,p.1;Smith and Gordon,1996,p.4). According to neighbours of the time, the grandmother tried to convince people that Hamilton was her son by inventing stories of the pregnancy and labour (Ferguson et.al.,1996,p.17). Meanwhile the real mother was shut away. The grandmother was described as a ' ... sour, narrowly respectable woman ... [who] ... fancied herself a cut above the neighbours' (ibid.). Her husband was described as a shy and retiring man who spent most of his time away from home (ibid.).

In primary school, Hamilton was described as a loner, '... who didn't play with other children...' (Smith and Gordon, 1996, p.5). In secondary school he was still considered an 'outsider whom no one liked' (Ferguson et.al., 1996, p.5). In his early twenties, Hamilton became active as a volunteer with the Scouts, until in 1974 he was expelled due to 'irresponsibility' (and not sexual misconduct as is constantly alleged, Campbell et.al., 1996, p.3). As an adult Hamilton operated his own DIY shop and was viewed by local shopkeepers as 'ambitious'. His business collapsed in the early 1980s due to rumours that he abused boys. He never worked again (Ferguson et.al., 1996, p.17).

Dunblane is one of the communities in which Hamilton operated boy's clubs after his expulsion from The Scouts. Isabelle Murray, the Sun's City Editor, knows Dunblane and described it as a 'comfortable prosperous place' (Murray, 1996, p.17). It has very little unemployment, a population of 8000, made up of mostly 'conventional' two-parent families of owner-occupiers. There are remarkably few single parents. A quiet, traditional way of life was enjoyed by young parents and retired couples;

A Gothic cathedral towers over the tiny high street where shops have been in the same families for generations. Butchers, bakers, and florists still close for an old-fashioned half-day on Wednesdays ... There is no McDonalds or multi-plex cinema ... Many families have settled in Dunblane because it is considered a safe and clean place to bring up youngsters ... (Murray, 1996, p.17).

It is described as an idyllic community for the prosperous young families who live there. For someone in mental distress however, it could have been a very different place. A homogeneous tight-knit community of single family dwellings can be a most alienating and rejecting environment for anyone who is 'marginal'. Hamilton was kept very much on the fringe of his community.

The attitude toward Hamilton is obvious from a comment made by a neighbour who moved to the area four years ago; 'The first thing you heard from people here was that the guy was weird' (Clouston and Boseley, 1996, p.2). A local newspaper girl said, 'He made your flesh crawl, he was rubbing his hands and walking with a stoop' (Parker et.al., 1996, p.4). He was described as 'creepy', 'smarmy', and 'a very tactile person

who was forever putting his arm around the boys' (Parker et.al.,1996,p.4). A neighbour said, 'He was a real weirdo. His hair was cut strangely with a "V" at the back and bald on the top. He looked like something from outer space. I called him Spock because he was like an alien' (ibid.). There are many references to his appearance, and his gait; ' He just seemed to walk at the one pace, he sort of crept along by the side of the hedge' (ibid.). We get the impression of an extremely isolated man who was perceived as 'weird', 'devious', 'sick and perverted'.

The rumours about Hamilton seemed to start partly because of his unusual demeanour, his 'high-pitched effeminate voice', and his behaviour towards the boys in his clubs. He was thought to have 'interfered' with boys in his clubs and to have been kicked out of the army for being a homosexual. None of this could be verified. The boys called him ' ... "gay man" because he acted a bit poofy' (Parker et.al.,1996,p.5). A local woman saw his photos of boys playing games with their shirts off; 'I told all my friends and family and the word got around' (ibid.). Hamilton lived in a world of rumours. Police and education authorities investigated him but nothing could be proved, meanwhile boys stopped coming to his clubs and his business failed.

Hamilton protested his innocence to charges of child molesting. He wrote to council authorities, the Scouts, his MP, and the Queen. A city councillor recounts meeting him in the street;

As usual he brought up the subject and again said that he was being harassed by inference and innuendo. He said people still seemed to suspect him of this conduct but how grateful he was that nobody had been able to get any proof because there wasn't any. I was really listening to a man who had this burden and was trying to unload it a bit (Farrell et.al,1996,p.2).

This councillor, as well as a council ombudsman and some parents, felt Hamilton was being treated unjustly. The council had decided to ban Hamilton from using schools to run his clubs, based upon the 'gossip' of 'hysterical parents' according to the ombudsman (ibid.). There were years of innuendo and years of Hamilton trying to clear his name. Meanwhile, daily life was becoming increasingly alienating, as

Hamilton wrote in a letter to the Queen; 'I cannot even walk the streets for fear of embarrassing ridicule' (Victor,1996,p.2).

Since childhood Hamilton was isolated. It seems that being an isolated person became the community's excuse to isolate him even further, until he found himself unemployed and humiliated as he walked the streets of his neighbourhood. No one wanted to know him, he was banned from his local camera shop due to his photos, and unable to convince anyone of his innocence (Campbell et.al.,1996,p.3). Hamilton saw himself as trying to help bored children stay out of trouble. In return the police, teachers, neighbours, and young people spread the rumour on a 'nod and a wink basis' that he was a 'pervert' (quoted from Hamilton's letters,c.f. The Guardian,1996,p.5). In a final attempt to combat his mounting isolation Hamilton delivered a circular to parents; 'I have no criminal record nor have I ever been accused of sexual abuse by any child and I am not a pervert' (Eastman,1996,p.17).

After the murders, articles appeared from so-called experts, forensic psychiatrists mostly, who humbly offered different opinions as to the source of Hamilton's problems and whether he was 'ill' (see Johnson,1996,p.19; Cusick,1996,p.3; Bailes,1996,p.4). Questions of whether Hamilton was 'mad', 'evil', or both (Eastman,1996,p.17) seem to highlight our current confusion and inadequate understanding of so-called mental illness. These articles all focus on Hamilton as an individual, not upon the community in which he lived. There were a few articles and letters to the editor which suggested that Hamilton should not have been in the community at all. These letters focused on the inadequacies of community care and called for powers to force treatment on individuals because 'treatment does work' (Young,1996,p.17; Dallas,1996p.24).

There were a couple articles that did draw a link between Hamilton and the community;

... strong community ties can have only increased the pressure on loners like ... Hamilton, when despite the bonding of most of the population, they found themselves excluded. A successful community is one which is able to reach out to everyone living in it, no matter

how unattractive they may be (Thompson,1996,p.18).

Andrew O'Hagan wrote about Hamilton as a member of our society and 'there is something up with our way of life, and no amount of repression will quite rub it away' (1996,p.2). He continues, 'Dunblane has something behind it ... Something crazy, of course, but something real' (O'Hagan,1996,p.2). To make even a little sense of what happened in Dunblane, and to understand it as a general warning, we need to acknowledge and understand the role of the community. In other words we need to look at how '... the two worlds met, close-knit community and unravelling mind' (Ferguson et.al.,1996,p.19).

Community care is about 'community'

There is a dangerous contradiction between care in the community and the medical model which it is currently based upon. Current policy relies upon maintaining the mentally distressed in community settings where they are viewed as 'sick', different in kind from their neighbours. This thinking relieves both the state and community members from facing the anxiety of identifying with the mentally distressed or questioning the causes of their condition. It encouraged the community to view Thomas Hamilton as different from them, eliciting scorn rather than empathy. There is no lessening of the tragedy which Hamilton caused, but there is a warning of the situation which may arise when individual distress and community rejection collide. We need to develop models of community care which are based upon the nature of contemporary community, and which are willing to address its dehumanising aspects.

Radical Care

In *The Politics of Mental Health*, Ragnhild Banton et. al. (1985) present a psychoanalytic account of individual development within a Marxist perspective. This is a practical application of the model of Critical Theory. Whereas Goodwin emphasises the competing motives behind policy and the subsequent strains, Banton et.al. propose an alternative and highly political form of mental health service delivery, and emphasise its revolutionary potential to change society.

Their theory balances the social and the personal by regarding the psyche as

internalised social ideals, so individual meaning and desire originate from the social world. This counters the individualising of distress as simply personal illness. The social forces which contribute to suffering are reinforced within and without;

... whenever there is a battle for change there must be a change in awareness or ideas as well as practice; ... ideas are not just linked through discourse to power relations of diverse kinds, but also to unconscious and conscious feelings that need to be registered in order for change to come about ... The internal sources of resistance to change should not be ignored or underestimated (Banton et.al.,1985,pp.150-1).

The individual psyche will circumvent social change unless it is freed from its own internalisation of the prevailing ideology (Habermas stressed emancipation from self-deception through self-reflection). This equal emphasis on social structure and internalised oppression seems to be an attempt to develop a form of mental health provision that questions rather than reifies economic and social constraints. Psychological needs are real needs and 'everyone is entitled to have those needs met by psychotherapy if that should be appropriate' (Banton et.al.,1985,p.163).

In contemporary conventional psychiatry there is no interest in subjective experience because it is irrelevant in the treatment of illness. There is no need for social analysis because it's not about society. So the practice of psychiatry becomes an effective, indirect form of maintaining conformity without seeming to be in conflict with democratic values. This 'community care' is more clearly about social control than compassion.

Care and the Human Community

The unconventional Irish psychiatrist Ivor Browne¹ says we need to make 'Being' a priority and 'Doing' a by-product of our societies; ' To be is the primary task of a human being, any doing or function which deprives him of his consciousness as a Being is destroying him as surely as slow starvation' (Browne, 1972,p.1). He draws

upon the Systems Theory of Maturana and Varela who say a living system is autopoietic, self-producing ;

A living creature only functions satisfactorily when it has autonomy, that is when it takes responsibility for itself. When it is denied responsibility it becomes allopoietic or dependent, defined from without (1975,c.f. Browne,1972,p.5).

The hypothesis is that a human group operates as a living system. It has an internal organisation, an emotional life, a boundary, and functions as a self-regulating system in order to preserve its stability and continued existence.

Human communities are biological systems in which every individual is embedded within a social institution, itself embedded within a larger institution. All of these levels are autopoietic. This explains why change, at the individual or state level, is so difficult. Each self-contained autopoietic 'it' is simultaneously a component of another autopoietic system. So that the first is allopoietic with respect to the second, making the second a viable autopoietic system. But this means that the larger system will mistakenly perceive the smaller, embedded one, as diminished - and treat it as less than a living system (Browne, 1972,pp.6-20).

In this capitalist society we have created institutions which have taken on their own existence and control us as allopoietic components. So we find ourselves working for the structures we initially designed to work for us. We are not living in whole communities. Our ruthless and competitive communities are "sick" (metaphorically so), in order to function as independent individuals we need to create a barrier against them. The more we have to create a barrier the more difficult it is to develop intimate and loving relationships (Browne,1977,p.11). The more impossible it is for us to experience 'care'.

Browne pleads for a humane response to mental distress and a model of community care which emphasises independence. Rather than simply releasing patients or attempting care in community settings, we should enable individuals to be as

¹ Dr. Browne was a colleague of RD Laing and was also influenced by Timothy Leary and most

independent as possible. A thirty-year-old "schizophrenic" should not be released from institutional incarceration only to be incarcerated in his family and frozen into a parent/child relationship. Institutionalisation is a state of dependence and can happen anywhere; ' I can remember one girl I dealt with back in 1959 who was being washed, fed with a spoon and dressed by her mother, although a few years earlier she had held down a good job in New York ...' (Browne, date unknown,p.3).

Browne believes that delusions can be dishonesties, an escape from living (Browne, date unknown, pp.8-9). Removing symptoms alone (the medical model) does not result in a 'normal' person. Browne stresses that social supports, skills training, employment, and housing, will enable the independent development of the mentally distressed by addressing their deficits. Studies have suggested that schizophrenics do much better when discharged to neutral environments with less contact with their families, than when discharged back into the family home (c.f. Browne and Kiernan,1967,p.8). All of this is of course contrary to the current practice of keeping people in the community without providing facilities - relying on relatives to take care of them.

It would be interesting to examine the differences between the two models of alternative community care outlined above. However, for now it is more important to note their general similarities. They both bring the community into the analysis. They do not simply individualise distress or label it as illness. By not making distressed members of our communities different in kind, they increase our capacity to empathise. We are encouraged to realise that there is a social meaning to distress, a meaning we can understand because we are subject to the same forces. At the same time both models suggest why individual change is so difficult; either a system is trying to maintain you unchanged, or your own internalisation of social norms inhibits change.

When the community cannot recognise itself in the face of the mentally distressed, that is of crucial importance,

... the "return to the community" of mental health services and patients

recently by the transpersonal work of Stanislav Grof.

is a return in an alienated form: the community receives back a part of itself in a form not recognisable as having belonged, or as still belonging, to the community (Banton et.al.,1985,p.179).

There will be no welcome for a stranger who is not 'one of us'. Community attitudes to the mentally distressed expose the crucial need for a radical attitude to mental health; the necessity to accept as political and social what has been hidden as personal, silent pain. What are the ramifications of this for us, as existential therapists?

Concluding Summary

Looking at recent plans for community care in the London Boroughs of Camden and Islington suggests that the issues I am trying to present here are not being addressed. There are progressive policies highlighting the need to maximise independent living for people with 'mental health problems'. There is a recognition that 'community care is not a cheap option' (Islington Community Living Plan,1995,p.0.3) and a willingness to lobby the government for increased funding. But there is also an implicit individualising of distress.

These plans contain no mention of social factors in the incidence of the onset of mental distress and most worrying there is nothing about community attitudes. Although there have been improvements in recognising community needs in some areas, the policy response has been piecemeal and has not resulted in a re-evaluation of the underlying philosophy of care. Goodwin would explain this reluctance to re-evaluate care with reference to the state concerns of cost, control and legitimisation. Banton et.al. would emphasise a psychoanalytic theory regarding the power of internalised ideology. Browne would take a holistic look at the overall system trying to maintain itself at the expense of individual members. As existential-phenomenological therapists, what is our view?

I have argued for the need to return to the original intentions of care in the community. We cannot use the medical model to maintain the distinction between distressed individual and host community without impairing the therapeutic potential

of community care. A model of mental distress which acknowledges social and economic factors is necessary to alter the meaning of 'care' from custodial care and drug treatment to care as empathy for the welfare of another person as a whole human being. This is described by Heidegger as caring for other *dasiens*, constituting beings, and he terms it 'solicitude' (Yalom,1980,p.409). Community attitudes to its mentally distressed members could be addressed fundamentally in this way.

Perhaps it is obvious then, that the community health care system cannot be separated from the overall social system. The tragedy at Dunblane highlights the potential danger of pursing current policy². De-institutionalisation continues at such a pace that any initial understanding by the community has since turned to friction and 'exacerbation of public fears' (Taylor,1988). One cannot escape the thought that as the mentally distressed are maintained in an unprepared, unwilling, and under-serviced community, there will be a corresponding hardening of community attitudes towards them. How will this be presented to us in our consulting rooms, and what will be our response? To have 'care in the community', it seems that we need to develop a community that incorporates a willingness to reach out to the "otherness" in others, without the motive of control and without complete understanding. What could be more existential, and perhaps more impossible?

² The fact that Hamilton was not a patient or under a 'community care order' does not diminish the validity of using his situation to illustrate the present argument.

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