THOMAS SZASZ

THE THEOLOGY OF MEDICINE

The Political–Philosophical Foundations of Medical Ethics

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The Theology of Medicine

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The Theology of Medicine

THE POLITICAL-PHILOSOPHICAL FOUNDATIONS OF MEDICAL ETHICS

Thomas Szasz

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Had not the Roman government permitted free inquiry, Christianity could never have been introduced. Had not free inquiry been indulged at the era of the Reformation, the corruptions of Christianity could not have been purged away. If it be restrained now, the present corruptions will be protected, and new ones encouraged. Was the government to prescribe to us our medicine and diet, our bodies would be in such keeping as our souls are now.

Thomas Jefferson, "Notes on the State of Virginia" (1781)

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Preface

This book is a collection of essays most of which have appeared previously. Many of them, however, were first prepared for lectures and were subsequently published in a shorter version than the original text from which they were excerpted. I have retained the full-length versions of these essays and some of them—for example "The Ethics of Addiction" and "The Ethics of Suicide"—are published in this form here for the first time.

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sacrificing persons by saying that they are carrying out God's will; and, perhaps more important still, people often claim to be carrying out God's will when they sacrifice others, whether in a religious crusade or in a so-called psychotic episode. The important thing about this imagery is that it makes us witness to, and even participants in, a human drama in which the actors are seen as robots, their movements being directed by unseen, and indeed invisible, higher powers.

If stated so simply and starkly, many people nowadays might be inclined to dismiss this imagery as something only a religious fanatic would entertain. That would be a grave mistake, as it would blind us to the fact that it is precisely this imagery that animates much contemporary religious, political, medical, psychiatric, and scientific thought. How else are we to account for the systematic invocation of divinities by national leaders? Or the use of the Bible, the Talmud, the Koran, or other holy books as guides to the proper channeling of one's freedom to act in the world? One of the universal solvents for guilt, engendered by the undesirable consequences of one's actions, is God. That is why religion used to be, and still is, an important social institution.

But the belief in deities as puppeteers and in people as puppets has diminished during the past few centuries. There has, however, been no corresponding increase in the human acceptance of, and tolerance for, personal responsibility and individual guilt. People still try to convince themselves that they are not responsible, or are responsible only to a very limited extent, for the undesirable consequences of their behavior. How else are we to account for the systematic invocation of Marx and Mao by national leaders? Or the use of the writings of Freud, Spock, and other ostensibly scientific works as guides to the proper channeling of one's freedom to act in the world? Today, the universal solvent for guilt is science. That is why medicine is such an important social institution.

For millennia, men and women escaped from responsibility by theologizing morals. Now they escape from it by medicalizing morals. Then, if God approved a particular conduct, it was good; and if He disapproved it, it was bad. How did people know what God approved and disapproved? The Bible—that is to say, the biblical experts, called priests—told them so. Today, if Medicine approves

a particular conduct, it is good; and if it disapproves it, it is bad. And how do people know what Medicine approves or disapproves? Medicine—that is to say, the medical experts, called physicians—tells them so.

The extermination of heretics in Christian pyres was a theological matter. The extermination of Jews in Nazi gas chambers was a medical matter. The inquisitorial destruction of the traditional legal procedures of Continental courts was a theological matter. The psychiatric destruction of the rule of law in American courts is a medical matter. And so it goes.

Human life—that is, a life of consciousness and self-awareness—is unimaginable without suffering. Without pain and sorrow, there could be no pleasure and joy; just as without death, there could be no life; without illness, no health; without ugliness, no beauty; without poverty, no riches; and so on ad infinitum with the countless human experiences we categorize as undesirable and desirable.

All our exertions—moral and medical, political and personal—are directed toward minimizing undesirable experiences and maximizing desirable ones. However, if the calculus of personal conduct could be reduced to such a simple prudential principle, human life would be much less complicated than it is. What complicates it of course is the fact that many of the things we regard as desirable are opposed by, or can be secured only at the cost of, others that we regard as also desirable. There seems to be no limit to the internal conflicts and contradictions among the things we abstractly value and wish to maximize. For example, enjoyable eating or drinking often conflicts with good health, sexual pleasure often conflicts with dignity, liberty often conflicts with security, and so on. This is, quite simply, why the pursuit of relief from suffering, reasonable though it may seem, cannot be an unqualified personal or political goal. And if we make it such a goal, it is certain to result in more, not less, suffering. In the past, the greatest unhappiness for the greatest number was thus created by precisely those political programs whose goal was the most radical relief of suffering for the greatest number of human beings. While those campaigns against suffering were in progress, people viewed them with unqualified approval; now we look back at them as the most terrifying tyrannies.

In the absence of the perfect vision that comes only with hindsight, let us at least try to look at our own age critically. If we do so we shall glimpse—or even see clearly enough—the contours of two contemporary ideologies that have set themselves this same perennial goal—namely, the radical relief of suffering for the greatest numbers. One of these, holding the East in its grip, is the Marxist-Communist campaign against unhappiness: it promises total relief from suffering through victory over capitalism, the ultimate cause of all human misery. The other, holding the West in its grip, is the scientific-medical campaign against unhappiness: it promises total relief from suffering through victory over disease, the ultimate cause of all human misery.

In countries under Communist rule, where its efforts to relieve suffering are unchecked by any effective countervailing force, Communism has thus succeeded in being the greatest source of suffering; whereas in the so-called free West, where "therapeutism" has achieved a power unchecked by any effective countervailing force, Medicine has succeeded in becoming one of the greatest sources of suffering.

How medicine, the art of healing, has changed from man's ally into his adversary, and how it has done so during the very decades when its powers to heal have advanced the most momentously during its whole history—that is a story whose telling must await another occasion, perhaps even another narrator. It must suffice here to note that there is nothing new about the fact that in human affairs the power to do good is usually commensurate with, if not exceeded by, the power to do evil; that human ingenuity has created, especially in the institutions of Anglo-American law and politics, arrangements that have proved useful in dividing the power to do good into its two basic components—namely, *good* and *power*; and that these institutional arrangements, and the moral principles they embody, have sought to promote the good by depriving its producers and purveyors of power over those desiring to receive or reject their services. The most outstanding monument to that effort on the part of rulers to protect their subjects from those who would do them good, even if it meant doing them in, is the First Amendment clause guaranteeing that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise

to the blacks. Now we are doing it to each other, regardless of creed, color, or race.

How was slavery justified and made possible? By calling blacks *chattel* rather than *persons*. If blacks had been recognized as persons, there could have been no selling and buying of slaves, no fugitive slave laws—in short, there could have been no American slavery. And if plantations could be called *farms*, and forcing blacks to work on them could be called guaranteeing them their *right to work*, then slavery might still be regarded as compatible with the Constitution.[2] As it is, no term can now conceal that slavery is involuntary servitude. Nothing can. Whereas anything can now conceal the fact that institutional psychiatry is involuntary servitude.

How are involuntary psychiatric interventions—and the many other medical violations of individual freedom—justified and made possible? By calling people *patients*, imprisonment *hospitalization*, and torture *therapy*; and by calling uncomplaining individuals *sufferers*, medical and mental-health personnel who infringe on their liberty and dignity *therapists*, and the things the latter do to the former *treatments*. This is why such terms as *mental health* and the *right to treatment* now so effectively conceal that psychiatry is involuntary servitude.

It is at our own peril that we forget that language is our most important possession or tool; and that whereas in the language of science we explain events, in the language of morals we justify actions. We may thus explain abortion as a certain type of medical procedure but must justify permitting or prohibiting it by calling it *treatment* or the *murder of the unborn child*.

In everyday life, the distinction between explanation and justification is often blurred, and for a good reason. It is often difficult to know what one should do, what is a valid justification for engaging in a particular action. One of the best ways of resolving such uncertainty is to justify a particular course of action by claiming to explain it. We then say we have had no choice but to obey the Truth—as revealed by God or Science.

2. In this connection, see generally my *The Second Sin* (Garden City, N.Y.: Doubleday, Anchor Press, 1973) and *Heresies* (Garden City, N.Y.: Doubleday, Anchor Press, 1976).

Another reason for concealing justifications as explanations is that, rhetorically, a justification offered as such is often weak, whereas a justification put forth as an explanation is often very powerful. For example, formerly, if a man had justified his not eating by saying that he wanted to starve himself to death, he would have been considered mad; but if he had explained it by saying that he was doing so the better to serve God, he would have been regarded as devoutly religious. Similarly, today, if a slender woman justifies her not eating by saying she wants to lose weight, she is considered to be a madwoman suffering from anorexia nervosa; but if she explains it by saying that she is doing so to combat some political wrongdoing in the world, she is regarded as a noble protester against injustice.

To be sure, people do suffer. And that fact—according to doctors and patients, lawyers and laymen—is now enough to justify calling and considering them patients. As in an earlier age through the universality of sin, so now through the universality of suffering, men, women, and children become—whether they like it or not, whether they want to or not—the patient-penitents of their physician-priests. And over both patient and doctor now stands the Church of Medicine, its theology defining their roles and the rules of the games they must play, and its canon laws, now called *public health* and *mental health* laws, enforcing conformity to the dominant medical ethic.

My views on medical ethics depend heavily on the analogy between religion and medicine—between our freedom, or the lack of it, to accept or reject theological and therapeutic intervention. It seems obvious that in proportion as people value religion more highly than liberty, they will seek to ally religion with the state and support state-coerced theological practices; similarly, in proportion as they value medicine more highly than liberty, they will seek to ally medicine with the state and support state-coerced therapeutic practices. The point, simple but inexorable, is that when religion and liberty conflict, people must choose between theology and freedom; and that when medicine and liberty conflict, they must choose between therapy and freedom.

If Americans were confronted with this choice today, and if they regarded religion as highly as they regard medicine, they would no doubt try to reconcile what are irreconcilable—by calling incarceration in ecclesiastical institutions *the right to attend church* and torture on the rack *the right to practice the rituals of one's faith.* If the latter terms were accepted as the proper names of the former practices, coerced religious observance and religious persecution could be held to be constitutional. Those subjected to such practices could then be categorized as persons *guaranteed their right to religion*, and those who object to such violations of human rights could be dismissed as the subverters of a free society's commitment to the practice of *freedom of religion.* Americans could then look forward breathlessly to the next issues of *Time* and *Newsweek* celebrating the latest breakthrough in *religious research.*

And yet, perhaps it is still not too late to recall that it was respect for the cure of souls, embraced and practiced freely or not at all, that inspired the framers of the Constitution to deprive clerics of secular power. It was enough, I assume they reasoned, that theologians had spiritual power; they needed no other for the discharge of their duties. Similarly, it is respect for the cure of bodies (and "minds"), embraced and practiced freely or not at all, that inspires me to urge that we deprive clinicians of secular power. It is enough, I believe, that physicians have the power inherent in their scientific knowledge and technical skills; they need no other for the discharge of their duties.

Although the essays assembled in this volume have been written over the period of a decade, they are all animated by the aim to explore the ceremonial or religious aspects of various medical practices. Let me hasten to say that I am not denying the scientific or technical aspects of medicine. On the contrary, I believe—and it is rather obvious—that the genuine diagnostic and therapeutic powers of medicine are much greater today than they have ever been in the history of mankind. That, precisely, is why its religious or magical powers are also much greater. Anyone who interprets my efforts to explain, and sometimes to reduce, the magical, religious, and political dimensions of medicine as an effort to cast aspersions on,

1

The Moral Physician

What is the moral mandate of medicine? Whom should the physician serve? The answers to these simple questions are by no means clear. Since medicine has rather intimate connections with health and illness, life and death, it is not surprising that we are now as uncertain about the aim of medicine as we are about the aim of life itself. Indeed, we can be no more clear or confident about what medicine is for than we can be about what life is for.

The moral foundations of modern medicine have a dual ancestry: from the Greeks, medicine has inherited the idea that the physician's primary duty is to his patient; and from the Romans, that his primary duty is to do no harm. The first of these ideas, although quite unrealized, is often said to be the ideal of Western medicine; the second, although quite unrealizable, is often said to be its First Commandment.

Primum non nocere. (First, do no harm.) What a lofty prescription! But what an absurd one. For the questions immediately arise, To whom should the physician do no harm? and Who will define what constitutes harm?

Life is conflict. The physician often cannot help a person without at the same time harming someone else. He examines an applicant for life insurance, finds that he has diabetes or hypertension, and reports it to the insurance company. He treats a Hitler or Stalin and helps to prolong his life. He declares that a man who tortures

his wife with false accusations of infidelity is psychotic and brings about his psychiatric incarceration. In each of these cases, the physician harms someone—either the patient or those in conflict with him. These examples, of course, merely scratch the surface. We may add to them the physician's involvement with persons desiring abortions or narcotics, with suicidal patients, with military organizations, and with research in biological warfare—and we see how woefully inadequate, indeed how utterly useless, are the traditional moral guidelines of medicine for the actual work of the physician, whether as investigator or practitioner. Accordingly, if we wish to confront the moral dilemmas of medicine intelligently, we must start, if not from scratch, then from the basics of ethics and politics.

Everywhere, children, and even many adults, take it for granted not only that there is a god but that he can understand their prayers because he speaks their language. Likewise, children assume that their parents are good, and if their experiences are unbearably inconsistent with that image, they prefer to believe that they themselves are bad rather than that their parents are. The belief that doctors are their patients' agents—serving their patients' interests and needs above all others—seems to me to be of a piece with mankind's basic religious and familial myths. Nor are its roots particularly mysterious: when a person is young, old, or sick, he is handicapped compared with those who are mature and healthy; in the struggle for survival, he will thus inevitably come to depend on his fellows who are relatively unhandicapped.

Such a relationship of dependency is implicit in all situations where clients and experts interact. Because in the case of illness the client fears for his health and for his life, it is especially dramatic and troublesome in medicine. In general, the more dependent a person is on another, the greater will be his need to aggrandize his helper, and the more he aggrandizes his helper, the more dependent he will be on him. The result is that the weak person easily becomes doubly endangered: first, by his weakness and, second, by his dependence on a protector who may choose to harm him. These are the brutal but basic facts of human relationships of which we must never lose sight in considering the ethical problems of biology, medicine, and

the healing professions. As helplessness engenders belief in the goodness of the helper, and as utter helplessness engenders belief in his unlimited goodness, those thrust into the roles of helpers—whether as deities or doctors, as priests or politicians—have been only too willing to assent to these characterizations of themselves. This imagery of total virtue and impartial goodness serves not only to mitigate the helplessness of the weak, but also to obscure the conflicts of loyalty to which the protector is subject. Hence, the perennial appeal of the selfless, disinterested helper professing to be the impartial servant of all mankind's needs and interests.

Traditionally, it was, of course, the clergy that claimed to be the agent of all mankind—asserting that they were the servants of God, the creator and caretaker of all mankind. Although this absurd claim had its share of success, it was doomed to be rejected in time because the representatives of the most varied creeds all claimed to speak for the whole of mankind. Gullible as men are, they can stand just so much inconsistency. Thus, by the time our so-called modern age rolled around, the mythology of any particular religion speaking for all of mankind became exposed for what it is—the representation of certain values and interests as the values and interests of everyone. Nietzsche called this the death of God. But God did not die; He merely disappeared behind the stage of history to don other robes and reemerged as scientist and doctor.

Since the seventeenth century, it has been mainly the scientist, and especially the so-called medical scientist or physician, who has claimed to owe his allegiance, not to his profession or nation or religion, but to all of mankind. But if I am right in insisting that such a claim is always and of necessity a sham—that mankind is so large and heterogeneous a group, consisting of members with inherently conflicting values and interests, that it is meaningless to claim allegiance to it or to its interests—then it behooves us as independent thinkers to ask ourselves, "Whose agent is the expert?"

Plato is fond of using the physician as his model of the rational ruler, and in *The Republic* he explicitly considers the question of whose agent the physician is. Early in that dialogue, he offers us this exchange between Socrates and Thrasymachus:

> Now tell me about the physician in that strict sense you spoke of: is it his business to earn money or to treat his patients? Remember, I mean your physician who is worthy of the name?
>
> To treat his patients.[1]

It would seem that we have not advanced one step beyond this naïve, hortatory answer to the question of whose agent the physician is. In the conventional contemporary view too, the doctor's role is seen as consisting in the prevention and treatment of his patient's illness. But such an answer leaves out of account the crucial question of who defines health and illness, prevention and treatment.

Although Plato seemingly supports the idea that the physician's duty is to be his patient's agent, as we shall see that is not what he supports at all. By making the physician the definer not only of his own but also of his patient's best interests, Plato actually supports a coercive-collectivistic medical ethic rather than an autonomous-individualistic one.

Here is how Plato develops his defense of the physician as agent of the state:

> But now take the art of medicine itself. . . . [It] does not study its own interests, but the needs of the body, just as a groom shows his skill by caring for horses, not for the art of grooming. And so every art seeks, not its own advantage—for it has no deficiencies—but the interest of the subject on which it is exercised.[2]

Having established his claim for benevolent altruism, Plato proceeds to draw the ethical and political conclusions he was aiming at all along: the moral justification of the control of the subordinate by the superior—patient by doctor, subject by ruler:

> But surely, Thrasymachus, every art has authority and superior power over its subject. . . . So far as the arts are concerned, then, no art ever studies or enjoins the interest of the superior party, but always that of the weaker over which it has authority. . . . So the physician, as such, studies only the patient's interest, not his own. For as we agreed, the business of the physician, in the strict sense, is not to make money for himself, but to exercise his power over the patient's body. . . . And so

1. *The Republic of Plato*, trans. F. M. Cornford (New York: Oxford University Press, 1945), p. 22.

2. Ibid., p. 23.

> with government of any kind: no ruler, in so far as he is acting as ruler, will study or enjoin what is for his own interest. All that he says and does will be said and done with a view to what is good and proper for the subject for whom he practices his art.[3]

That this argument is contrary to the facts Thrasymachus himself points out. But such facts scarcely affect the force of Plato's rhetoric, which is based on the perpetually recurring passions of men and women to control and be controlled. Thus, Plato's rhetoric still has an astonishingly timely ring: it could serve, without any significant modification, as a contemporary exposition of what is now usually called medical ethics.

Indeed, so little have men's views changed in the past twenty-five hundred years on the dilemma of the physician's dual allegiance, to himself and to his patient, that it will be worth our while to follow to its end Plato's argument about the selflessness of the moral man of medicine:

> . . . any kind of authority, in the state or in private life, must, in its character of authority, consider solely what is best for those under its care. . . . each [skill] brings us some benefit that is peculiar to it: medicine gives health, for example; the art of navigation, safety at sea; and so on.
>
> Yes.
>
> And wage-earning brings us wages; that is its distinctive product. Now, speaking with that precision which you proposed, you would not say that the art of navigation is the same as the art of medicine, merely on the ground that a ship's captain regained his health on a voyage, because the sea air was good for him. No more would you identify the practice of medicine with wage-earning because a man may keep his health while earning wages, or a physician attending a case may receive a fee.
>
> No.
>
> . . . This benefit, then—the receipt of wages—does not come to a man from his special art. If we are to speak strictly, the physician, as such, produces health; the builder, a house; and then each, in his further capacity as wage-earner, gets his pay. . . . Well, then, Thrasymachus, it is now clear that no form of skill or authority provides for its own benefit.[4]

3. Ibid., pp. 23–24.
4. Ibid., pp. 27–28.

As these quotations show, Plato is a paternalist.[5] Quite simply, what Plato advocates is what many people seem to need or want, at least some of the time: namely, that the expert should be a leader who takes the burden of responsibility for personal choice off the shoulders of the ordinary man or woman who is his client. This ethical ideal and demand, characteristic of the closed society, must be contrasted with the ethical ideal and demand of the open society, in which the expert must speak the truth and the client must bear the responsibility of his own existence—including his choice of expert.

I shall have more to say later about the fundamental alternative between authority and autonomy, noble lies and painful truths. For now, I want to follow Plato a little further in *The Republic* to show how inextricably intertwined in his thought are the notions of authority and mendacity—indeed, how it is power that renders lying virtuous and powerlessness that renders it wicked:

> Is the spoken falsehood always a hateful thing? Is it not sometimes helpful—in war, for instance, or as a sort of medicine? . . . And in those legends we were discussing just now, we can turn fiction to account; not knowing the facts about the distant past, we can make our fiction as good an embodiment of truth as possible.[6]

In the Platonic program of fictionalizing history, we recognize, of course, another much-applauded modern scientific enterprise—in fact, a species of psychiatric prevarication that its practitioners pretentiously call *psychohistory*. As the modern psychiatric physician is entitled, by his limitless benevolence, to use mendacity as medicine, so, according to Plato, is the ruler:

> If we were right in saying that gods have no use for falsehood and it is useful to mankind only in the way of a medicine, obviously a medicine should be handled by no one but a physician. . . . If anyone, then, is to practice deception, either on the country's enemies or on its citizens, it must be the Rulers of the commonwealth, acting for its benefit; no one else may meddle with this privilege. For a private

5. See K. R. Popper, *The Open Society and Its Enemies* (Princeton, N.J.: Princeton University Press, 1950).
6. *The Republic*, p. 74.

> person to mislead such Rulers we shall declare to be a worse offense than for a patient to mislead his doctor. . . .[7]

Plato also uses the metaphor of mendacity as a medicine to justify his eugenic policies. All the mischief done ever since in the name of genetics as a means of improving the human race has been perpetrated by following the policy here proposed by Plato:

> Anything like unregulated unions would be a profanation in a state whose citizens lead the good life. The Rulers will not allow such a thing. . . . We shall need consummate skill in our Rulers . . . because they will have to administer a large dose of that medicine we spoke of earlier. . . . We said, if you remember, that such expedients would be useful as a sort of medicine. . . . It follows from what we have just said that, if we are to keep our flock at the highest pitch of excellence, there should be as many unions of the best of both sexes, and as few of the inferior, as possible, and that only the offspring of the better unions should be kept. And again, no one but the Rulers must know how all this is being effected; otherwise, our herd of Guardians may become rebellious.[8]

Clearly, the Platonic physician is an agent of the state—and, if need be, the adversary of his patient. In view of the immense influence of Platonic ideas on modern medicine, it is hardly surprising that we now face moral dilemmas attributable directly to the medical arrangement advocated by Plato and his countless loyal supporters, past and present.

Lest it seem that I have overemphasized the Platonic physician's allegiance to the state, even at the cost of his being the unconcealed adversary of the so-called patient, let us see what Plato says about physicians qua physicians, not as the models for rulers. What he says may seem shocking to some of us—because it sounds so modern and because it supports the most disreputable medical, eugenic, and psychiatric policies of twentieth-century governments, both totalitarian and free.

Revealingly Plato begins his discussion of the duties of doctors by reviling malingerers and persons now usually called mentally ill. Plato's objection to medicalizing ordinary miseries—problems in

7. Ibid., p. 78.
8. Ibid., pp. 157–159.

living—is, to be sure, a position I myself support, but for a reason and an aim that are the very opposite of his: he wants doctors to persecute such people, and persecuted by them they have been; whereas I want doctors to leave them alone if that is what the patients want.[9]

> Is it not [asks Plato rhetorically] also disgraceful to need doctoring, not merely for a wound or an attack of some seasonal disorder, but because, through living in idleness and luxury, our bodies are infested with winds and humours, like marsh gas in a stagnant pool, so that the sons of Asclepius are put to inventing for diseases such ingenious names as flatulence and catarrh?
>
> Yes; they are queer, these modern terms.
>
> And not in use, I fancy, in the days of Asclepius himself. . . . in the old days, until the time of Herodicus, the sons of Asclepius had no use for the modern coddling treatment of disease. But Herodicus, who was a gymnastic teacher who lost his health, combined training and doctoring in such a way as to become a plague to himself first and foremost and to many others after him.
>
> How?
>
> By lingering out his death. He had a mortal disease, and he spent all his life at its beck and call, with no hope of a cure and no time for anything but doctoring himself. . . . his skill only enabled him to reach old age in a prolonged death struggle.[10]

Plato clearly disapproves of such use of medicine and the art of the physician. And he minces no words in asserting that a physician ministering to a sufferer such as Herodicus is a bad man—a traitor to the community and the state.

> If Asclepius did not reveal these valetudinarian arts to his descendants, it was not from ignorance or lack of experience, but because he realized that in every well-ordered community each man has his ap-

9. See especially my *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper & Row, 1974), *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970), and *The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy* (New York: Basic Books, 1964).

10. *The Republic*, pp. 95–96.

pointed task which he must perform; no one has leisure to spend all his life in being ill and doctoring himself.[11]

What then should a chronically ill person do? He should die—"get rid of his troubles by dying"[12] is the way Plato puts it—for his own sake and the sake of the state. But what about people who feel sick, who are preoccupied by their own ill health and its care, but who are not sick enough to die? Physicians should turn their backs on such people. "They should not be treated,"[13] he says, thus unmistakably identifying the sufferer's own desire for medical care as a wholly irrelevant criterion for legitimizing such treatment.

It seems to me that never before—not just in totalitarian societies but in all societies—has Western medicine been so dangerously close to realizing this particular Platonic ideal as today. Here again are Plato's words on the subject:

> Surely, there could be no worse hindrance than this excessive care of the body. . . . Shall we say, then, that Asclepius recognized this and revealed the art of medicine for the benefit of people of sound constitution who normally led a healthy life, but had contracted some definite ailment? He would rid them of their disorders by means of drugs or the knife and tell them to go on living as usual, so as not to impair their usefulness as citizens. But where the body was diseased through and through, he would not try, by nicely calculated evacuations and doses, to prolong a miserable existence and let his patient beget children who were likely to be as sickly as himself. Treatment, he thought, would be wasted on a man who could not live in his ordinary round of duties and was consequently useless to himself and society.[14]

Implicit throughout this dialogue is the identity of the person making the judgment about who is useful and who is not, who should be treated and who should not be: it is the physician, not the patient.

Herein lie the main lessons for our present ethical predicaments in genetics; they are best framed as questions: Do we support or op-

11. Ibid., p. 96.
12. Ibid.
13. Ibid., p. 98.
14. Ibid., p. 97.

pose the view—and the policy—that the expert's role should be limited to providing truthful information to his client? Do we support or oppose the view—and the policy—that the expert's duty is to decide how the nonexperts should live and that he should therefore be provided with the power to impose his policies on those so unenlightened as to reject them?

If we are not skilled at analyzing Plato's arguments, if we do not realize that choices such as these confront us with the necessity of ranking our priorities, and if we blind ourselves to the conflicts in life between bodily health and personal freedom, then we may become geniuses at manipulating the gene but will remain morons about trying to manipulate our fellow man and letting him manipulate us. Plato had, of course, no hesitation in judging, and in letting physicians judge, whose life was worth something and whose was not, who should be treated and who should not:

> . . . if a man had a sickly constitution and intemperate habits, his life was worth nothing to himself or to anyone else; medicine was not meant for such people and they should not be treated, though they might be richer than Midas.[15]

It seems to me difficult to overemphasize that Plato's foregoing proposals are political remedies for perennial moral problems. How should society treat the sick and the weak, the old and the "socially useless"? How should the services of healers be employed—like those of soldiers, of priests, or of entrepreneurs? We should beware of flattering ourselves by believing that new biomedical capabilities necessarily generate genuinely new moral problems, especially since we haven't solved—haven't even faced—our old problems.

I shall not belabor here the idiocies and horrors proposed or perpetrated in the name of medicine, and specifically genetics, in recent decades. A single example should suffice to illustrate my point—that medical experts, like all human beings, may easily identify themselves with the holders of power, may eagerly become their obedient servants, and may in this way suggest and support the most heinous policies of mayhem and murder against suffering or stigmatized individuals.

15. Ibid., p. 98.

The following words, written in 1939, are not those of a Nazi physician, but of a distinguished scientist who must have been thoroughly familiar with Plato:

> Eugenics is indispensable for the perpetuation of the strong. A great race must propagate its best elements. . . . Women [however] voluntarily deteriorate through alcohol and tobacco. They subject themselves to dangerous dietary regimens in order to obtain a conventional slenderness of their figure. Besides, they refuse to bear children. Such a defection is due to their education, to the progress of feminism, to the growth of short-sighted selfishness. . . .
>
> Eugenics may exercise a great influence upon the destiny of the civilized races. . . . The propagation of the insane and the feebleminded . . . must be prevented. . . . No criminal causes so much misery in a human group as the tendency to insanity. . . . Obviously, those who are afflicted with a heavy ancestral burden of insanity, feeble-mindedness, or cancer should not marry. . . . Thus, eugenics asks for the sacrifice of many individuals. . . .
>
> . . . Women should receive a higher education, not in order to become doctors, lawyers, or professors, but to rear their offspring to be valuable human beings.
>
> There remains the unsolved problem of the immense number of defectives and criminals. . . . As already pointed out, gigantic sums are now required to maintain prisons and insane asylums and protect the public against gangsters and lunatics. Why do we preserve these useless and harmful beings? The abnormal prevent the development of the normal. . . . Why should society not dispose of the criminals and the insane in a more economical manner? . . . Criminality and insanity can be prevented only by a better knowledge of man, by eugenics, by changes in education and in social conditions. Meanwhile, criminals have to be dealt with effectively. . . . The conditioning of petty criminals with the whip, or some more scientific procedure, followed by a short stay in hospital, would probably suffice to insure order. Those who have murdered, robbed while armed with automatic pistol or machine gun, kidnapped children, despoiled the poor of their savings, misled the public in important matters, should be humanely and economically disposed of in small euthanasic institutions supplied with proper gases. A similar treatment could be advantageously applied to the insane, guilty of criminal acts.[16]

16. A. Carrel, *Man, the Unknown* (New York: Harper & Row, 1939), pp. 299–302, 318–319.

The man who wrote this was Alexis Carrel (1873–1944), surgeon and biologist, member of the Rockefeller Institute in New York, and the recipient in 1912 of the Nobel Prize in physiology and medicine for his work on suturing blood vessels.

Besides being his own agent, which of course the medical scientist or physician always is, and besides being an agent of his patient, which the physician is more and more rarely (hence the disenchantment with medical care among both physicians and patients despite the remarkable technical advances of medical science), the physician may be—and indeed often is—the agent of every conceivable social institution or group. It could hardly be otherwise. Social institutions are composed of, and cater to, the needs of human beings; and among human needs, the need for the health of those inside the group—and frequently for the sickness of those outside of it—is paramount. Hence, the physician is enlisted, and has always been enlisted, to help some persons and harm others—his injurious activities being defined, as we have already seen in Plato's *Republic*, as helping the state or some other institution.

Let me offer a very brief review of how physicians have through the ages not only helped some, usually those who supported the dominant social ethic, but also harmed others, usually those who opposed the dominant social ethic.

During the late Middle Ages, physicians were prominent in the Inquisition, helping the inquisitors to ferret out witches by appropriate "diagnostic" examinations and tests.[17]

The so-called discipline of public health, originating in what was first revealingly called "medical police" (*Medizinalpolizei*), came into being to serve the interests of the absolutist rulers of seventeenth- and eighteenth-century Europe. The term, according to George Rosen, was first employed in 1764 by Wolfgang Thomas Rau (1721–1772):

> This idea of medical police, that is, the creation of a medical policy by government and its implementation through administrative regulation, rapidly achieved popularity. Efforts were made to apply this

17. See *The Myth of Mental Illness*, pp. 32–34.

concept to the major health problems of the period, which reached a high point in the work of Johann Peter Frank (1748–1821) and Franz Anton Mai (1742–1814).[18]

The medical police were never intended to help the individual citizen or sick patient; instead, they were quite explicitly designed "to secure for the monarch and the state increased power and wealth."[19] Since increased power and wealth for the state could often be obtained only at the expense of decreased health and freedom for certain citizens, we witness here a collision between the Platonic and Hippocratic medical ethics—the former easily triumphing over the latter. Rosen's summary of Frank's work shows its undisguisedly Platonic character:

> Carrying out the idea that the health of the people is the responsibility of the state, Frank presented a system of public and private hygiene, worked out in minute detail. . . . A spirit of enlightenment and humanitarianism is clearly perceptible throughout the entire work, but as might be expected from a public medical official who spent his life in the service of various absolute rulers, great and small, the exposition serves not so much for the instruction of the people, or even of physicians, as for the guidance of officials who are supposed to regulate and supervise for the benefit of society all the spheres of human activity, even those most personal. Frank is a representative of enlightened despotism. The modern reader may, in many instances, be repelled by his excessive reliance on legal regulation, and by the minuteness of detail with which Frank worked out his proposals, especially in questions of individual, personal hygiene.[20]

Among Frank's more interesting proposals was a tax on bachelors—part of the medical police's effort to increase the population to provide more soldiers for the monarch—a proposal we have still not ceased implementing.

The French Revolution helped to cement further the alliance between medicine and the state. This alliance is symbolized by the healer's aspiring to perfect more humane methods of execution. In

18. G. Rosen, *A History of Public Health* (New York: MD Publications, 1958), pp. 161–162.

19. G. Rosen, "Cameralism and the Concept of Medical Police," *Bulletin of the History of Medicine* 27 (1953): 42.

20. Rosen, *A History of Public Health*, p. 162.

1792, the guillotine—developed and named after Dr. Joseph Ignace Guillotin, a physician and member of the Revolutionary Assembly and creator of its Health Committee (*Comité de salubrité*)—became the official instrument of execution in France. Again, it is revealing that the first guillotine was assembled at the Bicêtre, one of Paris's famous insane asylums, and that it was tried out on live sheep and then on three cadavers of patients from the asylum. After the first flush of enthusiasm for this medical advance wore off, Guillotin's contribution to human welfare was viewed, even in those days, ambivalently—leading him to remark in his last will, "It is difficult to do good to men without causing oneself some unpleasantness."[21]

In our own day, in the so-called free societies, virtually every group or agency, public and private, has enlisted the physician as an agent of its particular interests. The school and the factory, employers and labor unions, airlines and insurance companies, immigration authorities and drug-control agencies, prisons and mental hospitals, all employ physicians. The physician so employed has a choice only between being a loyal agent of his employer, serving his employer's interests as the latter defines them, or being a disloyal agent of his employer, serving interests other than his employer's as the physician himself defines them.

The principal moral decision for the physician who does not work in an ideal private-practice situation is choosing what organization or institution he shall work for; more than anything else, that will determine the sort of moral agent he can be to his patient and others. It follows from this that we should pay more attention than has been our habit to the ways institutions and organizations—whether the CIA or the United Nations or any other prestigious and powerful group—use medical knowledge and skills. Although these considerations may seem simple, their appreciation is not reflected by what seems to be the viewpoint that characterizes the recent burgeoning of literature on problems of medical ethics, especially as they relate to genetics. To illustrate this, let me quote two remarks from an international conference in 1971 on Ethical Issues in Human

21. Quoted in A. Soubiran, *The Good Doctor Guillotin and His Strange Device*, trans. M. McGraw (London: Souvenir Press, 1963), p. 214.

Genetics, devoted mainly to problems of genetic knowledge and counseling.

One participant, a professor of genetics in Paris, in a discussion about counseling parents who might give birth to a child with Tay-Sachs disease, had this to say:

> I think the question is whether I would like to suppress a child or not. My simple answer is definitely not, because we have to recognize one thing which is very frequently overlooked: medicine is essentially and by nature working against natural selection. That is the reason why medicine was invented. It was really to fight in the contrary sense of natural selection. . . . When medicine is used to reinforce natural selection, it is no longer medicine; it is eugenics. It doesn't matter if the work is palatable or not; that is what it is.[22]

There are two things seriously wrong here. First, this expert's remarks about the antagonism between medicine and natural selection are nonsense—and remarkable nonsense at that for a biologist to entertain and expound. Second, by speaking about "suppressing a child," this expert equates and confuses advising a parent not to have a child, performing an abortion, and killing an infant.

Another participant, a professor of sociology in Ithaca, New York, in a discussion of the "Implications of Parental Diagnosis for the Quality of, and Right to, Human Life," said:

> . . . the best way of expressing its [society's] interest is through the counselor-physician, who in effect has a dual responsibility to the individual whom he serves and to the society of which he and she are parts. . . . we will all certainly be diminished as human beings, if not in great moral peril, if we allow ourselves to accept abortion for what are essentially trivial reasons. On the other hand, we will, I fear, be in equal danger if we don't accept abortion as one means of ensuring that both the quantity and quality of the human race are kept within reasonable limits.[23]

22. J. Lejeune, "Discussion" of F. C. Fraser's "Survey of Counseling Practices," in B. Hilton et al., eds., *Ethical Issues in Human Genetics: Genetic Counseling and the Use of Genetic Knowledge* (New York: Plenum, 1973), p. 19.

23. R. S. Morison, "Implications of Prenatal Diagnosis for the Quality of, and Right to, Human Life: Society as a Standard," in ibid., pp. 210–211.

If that is how the experts reason about the ethical problems of genetics, we are in a bad way indeed. The priest, the accountant, and the defense lawyer do not try to serve antagonistic interests simultaneously; the politician, the psychiatrist, and the expert on genetic counseling do.[24]

My views on medical ethics in general and on the ethical implications of genetic knowledge and engineering in particular may be summarized as follows.

The biologist and the physician are, first and foremost, individuals; as individuals they have their own moral values that they are likely to try to realize in their professional work as well as their private lives.

In general, we should regard the medical man, whether as investigator or practitioner, as the agent of the party that pays him and thus controls him; whether he helps or harms the so-called patient thus depends not so much on whether he is a good or bad man as on whether the function of the institution whose agent he is, is to help or harm the so-called patient.

Insofar as the biologist or physician chooses to act as a scientist, he has an unqualified obligation to tell the truth; he cannot compromise that obligation without disqualifying himself as a scientist. In actual practice, only certain kinds of situations permit the medical man to fulfill such an unqualified obligation to truth telling.

Insofar as the biologist or physician chooses to act as a social engineer, he is an agent of the particular moral and political values he espouses and tries to realize or of those his employer espouses and tries to realize.

The biologist's or physician's claim that he represents disinterested abstract values—such as mankind, health, or treatment—should be disallowed; and his efforts to balance, and his claim to represent, multiple conflicting interests—such as those of the fetus against the mother or society or of the individual against the family or the state—should be exposed for what they conceal, perhaps his secret loyalty to one of the conflicting parties or his cynical re-

24. See my *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1973), esp. pp. 190–217.

jection of the interests of both parties in favor of his own self-aggrandizement.

If we value personal freedom and dignity, we should, in confronting the moral dilemmas of biology, genetics, and medicine, insist that the expert's allegiance to the agents and values he serves be made explicit and that the power inherent in his specialized knowledge and skill not be accepted as justification for his exercising specific controls over those lacking such knowledge and skill.

2

Illness and Indignity

All of us in the health professions share certain fundamental aspirations and goals, among which the most important are keeping the healthy person healthy, restoring the sick person to health, and most generally, safeguarding and prolonging life. That these ends are so overwhelmingly good and noble is what makes their pursuit so gratifying and those in the health professions so richly honored and rewarded.

But life would be simpler than it is if health and longevity were its only, or even its principal, purposes—that is, if there were no goals or values that often conflict with their pursuit. One of the values that we cherish, and that often conflicts with the pursuit of health at any cost, is dignity.

Dignity is of course that ineffable and yet obvious quality of human encounters that enriches the participants' self-esteem. The process of dignification is characteristically reciprocal; dignified conduct in one person or party generates dignified conduct in another and vice versa.

Conversely, indignity is that equally obvious but much more easily definable quality of human encounters that impoverishes the participants' self-esteem. There are many forms of it, one of the most common and most tragic being the indignity of disability, illness, and old age. Many sick people behave, simply because of their illness, in ways that make their conduct undignified. When a person loses control over his basic bodily functions, when he cannot work,

then—often against his most intense efforts—he is rendered undignified. Language, the oldest but still the most reliable guide to a people's true sentiments, starkly reveals the intimate connection between illness and indignity. In English, we use the same word to describe an expired passport, an indefensible argument, an illegitimate legal document, and a person disabled by disease. We call each of them *invalid*. To be an invalid, then, is to be an invalidated person, a human being stamped *not valid* by the invisible but invincible hand of popular opinion. While invalidism carries with it the heaviest burden of indignity, some of the stigma adheres to virtually all illness, to virtually any participation in the role of patient.

This fact generates two very important problems for people in the health professions: one is that the sick person's undignified behavior may stimulate the professional person's inclination to respond with undignified behavior of his own; the other is that patients disabled in ways that render them grossly undignified may prefer death with dignity to life without it. Let me offer a few observations on each of these problems.

The connections between illness and indignity are, in the main, quite obvious. Because the patient cannot work, cannot take care of himself, must disrobe and submit his body for examination by strangers, and for many other equally good reasons, the sick person perceives himself as suffering not only from an illness but also from a loss of dignity. Moreover, the patient's loss of dignity often generates a reciprocal loss of respect for him by those around him, especially by his family and physicians. This unfortunate process of degradation is often concealed, though in my opinion never very successfully, by the imagery and vocabulary of paternalism—family and physician treating the patient as if he were a child (or childlike) and the patient treating them as if they were his parents (or superiors).

This fundamental tendency—to infantilize the sick person and to parentalize the healer—manifests itself in countless ways in the everyday practice of medicine. For example, the patient is expected to trust his physician, but the physician need not trust his patient; the patient is expected to impart his intimate bodily and personal

experiences to the physician, but the physician may withhold vital information from the patient.

The patient's undignified position vis-à-vis the medical authorities is symbolized by the linguistic structure of the medical situation. The patient communicates in ordinary language, which he shares with his physician; the physician communicates partly in the same language, insofar as he speaks *to* his patient, and partly in another language, insofar as he speaks *about* him. The physician's second language used to be Latin and is now the technical jargon of medicine. The upshot is that patients often do not know or understand what is wrong with them, what is in their medical records, or what drugs they are taking. To be sure, like children or other fearful, humiliated, or oppressed persons, patients often do not want to know these things. Yet even if this were so—and it is not always so—it would not, in my opinion, justify withholding such information from them. After all, many people do not want to know what is under the hood of an automobile, but we would not accept that as justifying automobile manufacturers in maintaining a systematic policy of withholding this information from car buyers or releasing it to them only under special circumstances.

My point is that many people today accept it as right and proper that patients should not understand their prescriptions or that they should not know what is in their hospital records; at the same time, they object to the indignities that the medical situation often imposes on them. The result of this unarticulated conflict is that people often feel anxious and humiliated at the prospect of seeking medical care and frequently avoid or reject such care altogether.

We must keep in mind that people want and need not only health but also dignity, that often they can obtain health only at the cost of dignity, and that sometimes they prefer not to pay that price. It is obvious, for example, that patients participate most eagerly and most intelligently in medical situations that entail little or no humiliation on their part; thus, people seek help freely for refractive errors of their eyes or for athletic injuries. It is equally obvious that patients participate most reluctantly or not at all in those medical situations that entail a great deal of humiliation on their part; thus, people are often reluctant to seek medical help for syphilis or gonorrhea, even though these diseases can now be treated effectively and safely,

and they often do not seek medical help at all for "conditions" whose treatment is humiliating to the point of legally articulated stigmatization—such as drug addiction or the so-called psychoses.

There is a practical lesson here for all of us—namely, that it is not enough that we do a technically competent job of healing the patient's body; we must do an equally competent job of safeguarding his dignity and self-esteem. In proportion as we fail in this latter task, we destroy the practical value of our technical competence for the sick person.

Inexorably, efforts to combat disease or stave off death conflict with the need to maintain dignity. The currently popular phrase *death with dignity* is therefore quite misleading: it is not just that people want to die with dignity, but rather that they want to live with it. After all, dying is a part of life, not of death. It is precisely because many people live without dignity that they also die without it. Determined and dignified persons, whether soldiers or surgeons, have always wanted to die with their boots on. Military men have traditionally preferred death on the battlefield or even suicide to surrender and loss of face; medical men prefer a sudden death from a myocardial infarct to a lingering demise from generalized carcinomatosis. These examples illustrate my contention that there is often an irreconcilable antagonism between preserving and promoting dignity and preserving and promoting health.

There are of course many such antagonisms in life, which is what makes human existence tragic in the classical Greek and Christian conceptions of it. For example, in personal and political affairs, we desire both freedom and security but can often gain the one only at the expense of the other. The modern scientific and technical outlook, valuable through it is for realizing scientific and technical ends, misleads us badly insofar as it deals in isolation with the concepts of health and dignity and promises to maximize each at the cost of nothing more than scientific and technical effort and expertise. This perspective has led to a lopsided—and, indeed, erroneous—estimate of the bargain entailed in maintaining or securing good health. Many people now believe—and they are grievously mistaken—that they can retain or recover their health merely as a result of scientific advances in medicine (fashionably called *breakthroughs*) without

their having to make any sacrifices for it—that is, without their having to pay money for it, without their having to curb their appetites and passions for it, and without their having to suffer some loss of dignity for it.

The irreconcilable conflict that may arise between prolonging life and maintaining dignity was—as were all the fundamental conflicts characteristic of the human condition—well appreciated and articulated by the ancient Greeks. In the *Phaedo*, Plato illustrates this dilemma and Socrates' method of resolving it.

The death scene opens with Socrates and some of his closest friends gathered in anticipation of Socrates' drinking the hemlock. After some conversation between Socrates and his friends, Socrates says farewell and asks the executioner to bring the poisoned cup. But Crito urges Socrates to wait, to prolong his life for as long as he can: "But Socrates," he pleads, ". . . I know that other men take the poison quite late, and eat and drink heartily, and even enjoy the company of their chosen friends, after the announcement has been made. So do not hurry; there is still time."[1]

Socrates' reply articulates the distinction between life as a biological process that may and perhaps ought to be prolonged for as long as possible and as a spiritual pilgrimage that can and should be traversed and ended in a proper manner. This is what Socrates says:

> And those whom you speak of, Crito, naturally do so; for they think that they will be gainers by so doing. And I naturally shall not do so; for I think that I should gain nothing by drinking the poison a little later but my own contempt for so greedily saving up a life which is already spent.[2]

The distinction between the death of the body and the end of life, which is the difference between Crito's and Socrates' outlook on life and death, continues to baffle us in the health sciences. The main reason why it does is, remarkably, also explained by Socrates.

Crito asks his friend how he wants to be buried. Socrates replies:

1. Plato, *Euthyphro, Apology, Crito, with the Death Scene from Phaedo*, trans. F. J. Church, (Indianapolis, Ind.: Bobbs-Merrill, 1956), p. 69.
2. Ibid.

> He [Crito] thinks that I am the body which he will presently see as a corpse, and he asks me how he is to bury me. All the arguments which I have used to prove that I shall not remain with you after I have drunk the poison . . . have been thrown away on him. . . . For, dear Crito, you must know that to use words wrongly is not only a fault in itself, it also corrupts the soul. You must be of good cheer, and say that you are burying my body; and you may bury it as you please, and you think right.[3]

The distinction Socrates here makes between himself and his body is at once obvious and elusive; we all know how often modern people, scientifically informed and enlightened people, fail to make this distinction.

The richness of the death scene for our theme is by no means exhausted by my foregoing remarks on it. There is significance, too, in Socrates' parting words. "Crito," he says, "I owe a cock to Asclepius; do not forget it."[4] The ritual sacrifice Socrates here requests his friend to make on his behalf refers to the custom of offering, on recovering from sickness, a cock to Asclepius, the god of healing. In other words, Socrates views his death as a recovery from an illness, presaging the Christian view.

In short, the message I want to bring to you is simply this: Do your utmost to exercise your skills in healing, but do not do so by sacrificing dignity, either your patient's or your own—the two being tied together by bonds not unlike those of matrimony, except, especially in these days, stronger. For, if I may paraphrase the Scriptures, what does it profit a man if he gains his health but loses his dignity?

3. Ibid., p. 68.
4. Ibid., p. 70.

3

A Map for Medical Ethics: The Moral Justifications of Medical Interventions

After a lifetime of reflection on what it means to be a patient and to be sick, and what it means to be a doctor and to treat, it has finally dawned on me that much of our contemporary confusion concerning medical ethics rests on our failure to articulate the differences between certain fundamental facts and certain elementary justifications and to agree on which considerations justify certain medical interventions and which do not. In this brief essay, I shall try to offer a map that may help us to orient ourselves in the maze of medico-ethical problems that now face us. Like any map, it will not tell us where we ought to go. But it will tell us where the various roads lead.

Let us choose as our paradigm of illness breast cancer and as our paradigm of treatment removal of the cancerous breast. Cancer is an illness; that is a biological and medical fact. Mastectomy is a treatment; that is a surgical and legal fact. The medico-ethical and medico-legal question is, What justifies the medical (surgical) intervention of mastectomy?

1. According to some people, such a patient should have a mastectomy because she has cancer. That is the disease-oriented justification for the intervention.

2. According to others, she should have a mastectomy because it will cure her. That is the treatment-oriented justification for the intervention.

3. And according to still others, she may have a mastectomy because she seeks medical help, the physician offers surgical treatment, and the surgeon has recommended and the patient has agreed to a mastectomy. That is the consent-oriented justification for the intervention.

It is important to keep in mind that although in the ideal case the three justifications coincide and collapse, as it were, into a single affirmation by both patient and doctor about what ought to be done, the justifications are independent of one another and often in conflict. A few illustrations will exemplify and dramatize the potential disjunctions between the medical facts and the moral justifications considered thus far.

1. Disease may not justify medical intervention—for example, if the patient rejects treatment because she or he is a Christian Scientist (or for any other reason). And medical intervention may be justified in the absence of disease: abortion and vasectomy are medical interventions, but pregnancy and the capacity to impregnate are not diseases.

2. Cure (in the sense of therapeutic effectiveness) may not justify medical intervention—for example, as before, if the patient rejects the treatment. And medical intervention may be justified in the absence of therapeutic effectiveness: venesection was, and electroshock is, an accepted form of treatment—however, we now acknowledge that bloodletting only impaired the patient's circulatory system, and we may one day acknowledge that electrically induced convulsions only impair the patient's central nervous system.

3. Consent may not legally justify medical intervention—for example, if the patient is a morphine addict and the physician supplies him with morphine. And medical intervention may legally be justified in the absence of consent—for example, if electroshock is given to a so-called suicidally depressed commited mental patient.

Thus, our dilemmas of medical ethics have at least two sources: factual (or epistemological) and moral (or ethical). In the former class belong such questions as, What is disease? What is treatment? What is consent? In the latter belongs the question, What justifies certain particular contacts between sufferers and healers that we call medical (surgical, psychiatric, and so on) interventions?

There are vexing problems in both categories. How do we define, know, or agree on what is disease or treatment? Is pregnancy (wanted or unwanted) a disease? Is abortion a treatment? Is old age a disease? Is euthanasia a treatment? The problems are obvious, and there is no need to belabor them here. Suffice it to say that even if we agreed—which would not make us right—on what we shall count as falling into these classes and outside of them, many of our medico-ethical problems would remain unaffectedly vexing. For regardless of our agreement on matters of definition, naming, or "factualness," there would remain our problems concerning justification. Those problems require choosing and accepting responsibility for the inexorable consequences of our choices.

We have several choices with respect to justifying medical interventions. First, we might travel west (as it were)—that is, justify medical intervention by disease. That way lie the coercions and countercoercions of patients and doctors, physicians and politicians. For if disease justifies treatment, then individuals will tend to claim or conceal diseases depending on whether or not they want particular treatments. And medical professionals will tend to discover or deny diseases depending on whether they want to impose or withhold particular treatments. (People who claim to be in severe pain in order to obtain analgesics and physicians who impose methadone on those who desire heroin are signposts down that road.)

Second, we might travel east—that is, justify medical intervention by treatment. That way lie the similar coercions and countercoercions of patients and doctors, physicians and politicians. For if curative efficacy justifies medical intervention, physicians will tend to claim or conceal therapeutic powers depending on whether or not they want to dispense it, impose it, or withhold it. And individuals will tend, depending on their desires, to try to qualify for, or disqualify themselves from, various treatments. (Physicians who

avoid the use and falsify the pharmacological properties of opiates, psychiatrists who claim to be able to treat mental illness by imprisonment, and politicians who legislate about the imprisoned mental patient's rights to treatment are signposts down that road.)

Third, we might travel north—that is, justify medical intervention by consent. That way—where the air is clear but cool—lies medicine as a contractual service occupation. In such a system, only those patients who want treatment will receive it and only those physicians who want to dispense treatment will administer it. This system will make possible certain medical interventions that please patient and doctor but may displease others; and it will make impossible certain others desired by the patient, the patient's family, the doctor, the medical profession, or society generally, because one or another or both of the parties necessary for the medical contract refuse to enter into it. (Individuals with infectious diseases such as gonorrhea who refuse treatment or Catholic physicians who refuse to do abortions are signposts down that road.)

Finally, we might head south—that is, justify medical intervention by a capricious and confused combination of all three of the preceding justifications. That way—where the air is hazy and hot—paved with good medical intentions, lies hell. In such a system, the relations between sufferers and healers will be governed by the worst—the most despotic, capricious, and mendacious—elements of each of the three other systems. Patients, physicians, politicians, and people generally will then tend to fabricate increasingly arbitrary and self-serving definitions of illness and treatment and will try to impose them, by fraud and force, on anyone who resists. (The official acceptance of taking heroin as a disease and of being given methadone under medical auspices as a treatment is a signpost down that road; so is the official acceptance of personal disagreements as psychiatric diseases and of medically administered tortures as psychiatric treatments.)

I did not promise to offer, and did not offer, any solution to the problems exemplified by the situations cited. What I have offered, as I remarked at the beginning, is a map that I hope gives a reasonably accurate picture of the territory that all of us—whether as patients

or doctors or both—must traverse in life. And I am offering one more thing—a reflection about it.

I know, or believe, that life is inherently tragic. In the Greek and Christian sense and tradition, tragedy is our fate. That is a given. But there is another kind of tragedy, the kind that we, as patients and physicians, as lawmakers and laymen, fabricate by evading the tragic choices thrust upon us by life. The belief that we can have a medico-ethical and medico-legal system that combines the virtues, but not the wickedness, of justifying medical interventions by illness, treatment, and consent is, I submit, such a tragedy. It is, in other words, not a tragic fate we must bear, but a tragic folly we must avoid.

4

The Ethics of Addiction

Lest we take for granted that we know what drug addiction is, let us begin with some definitions.

According to the World Health Organization's Expert Committee on Drugs Liable to Produce Addiction,

> Drug addiction is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means, (2) a tendency to increase the dosage, and (3) a psychic (psychological) and sometimes physical dependence on the effects of the drug.[1]

Since this definition hinges on the harm done to the individual and to society by the consumption of the drug, it is clearly an ethical one. Moreover, by not specifying what is "detrimental" or who shall ascertain it and on what grounds, this definition immediately assimilates the problem of addiction with other psychiatric problems in which psychiatrists define the patient's dangerousness to himself and others. Actually, physicians regard as detrimental what people do to themselves but not what they do to people. For example, when college students smoke marijuana, that is detrimental; but when psychiatrists administer psychotropic drugs to involuntary mental patients, that is not detrimental.

1. Quoted in L. C. Kolb, *Noyes' Modern Clinical Psychiatry*, 7th ed. (Philadelphia: Saunders, 1968), p. 516.

The rest of the definition proposed by the World Health Organization is of even more dubious value. It speaks of an "overpowering desire" or "compulsion" to take the drug and of efforts to obtain it "by any means." Here again, we sink into the conceptual and semantic morass of psychiatric jargon. What is an "overpowering desire" if not simply a desire by which we choose to let ourselves be overpowered? And what is a "compulsion" if not simply an unresisted inclination to do something, and keep on doing it, even though someone thinks we should not be doing it?

Next, we come to the effort to obtain the addictive substance "by any means." That suggests that the substance is prohibited, or is very expensive for some other reason, and is hence difficult to obtain for the ordinary person rather than that the person who wants it has an inordinate craving for it. If there were an abundant and inexpensive supply of what the "addict" wants, there would be no reason for him to go to "any means" to obtain it. Does the World Health Organization's definition mean that one can be addicted only to a substance that is illegal or otherwise difficult to obtain? If so—and there is obviously some truth to the view that forbidden fruit tastes sweeter, although it cannot be denied that some things are sweet regardless of how the law treats them—then that surely removes the problem of addiction from the sphere of medicine and psychiatry and puts it squarely into that of morals and law.

The definition of addiction offered in *Webster's Third New International Dictionary of the English Language, Unabridged* exhibits the same difficulties. It defines addiction as "the compulsory uncontrolled use of habit-forming drugs beyond the period of medical need or under conditions harmful to society." This definition imputes lack of self-control to the addict over his taking or not taking a drug, a dubious proposition at best; at the same time, by qualifying an act as an addiction depending on whether or not it harms society, it offers a moral definition of an ostensibly medical condition.

Likewise, the currently popular term *drug abuse* places this behavior squarely in the category of ethics. For it is ethics that deals with the right and wrong uses of man's powers and possessions.

Clearly, drug addiction and drug abuse cannot be defined without specifying the proper and improper uses of certain pharmacologically active agents. The regular administration of morphine by a physician

to a patient dying of cancer is the paradigm of the proper use of a narcotic, whereas even its occasional self-administration by a physically healthy person for the purpose of pharmacological pleasure is the paradigm of drug abuse.

I submit that these judgments have nothing whatever to do with medicine, pharmacology, or psychiatry. They are moral judgments. Indeed, our present views on addiction are astonishingly similar to some of our former views on sex. Intercourse in marriage with the aim of procreation used to be the paradigm of the proper use of one's sexual organs, whereas intercourse outside of marriage with the aim of carnal pleasure used to be the paradigm of their improper use. Until recently, masturbation—or self-abuse, as it was called—was professionally declared and popularly accepted as both the cause and the symptom of a variety of illnesses.[2]

To be sure, it is now virtually impossible to cite a contemporary American (or foreign) medical authority to support the concept of self-abuse. Medical opinion now holds that there is simply no such thing, that whether a person masturbates or not is medically irrelevant, and that engaging in the practice or refraining from it is a matter of personal morals or life-style. On the other hand, it is now virtually impossible to cite a contemporary American (or foreign) medical authority to oppose the concept of drug abuse. Medical opinion now holds that drug abuse is a major medical, psychiatric, and public-health problem; that drug addiction is a disease similar to diabetes, requiring prolonged (or lifelong) and carefully supervised medical treatment; and that taking or not taking drugs is primarily, if not solely, a matter of medical concern and responsibility.

Like any social policy, our drug laws may be examined from two entirely different points of view—technical and moral. Our present inclination is either to ignore the moral perspective or to mistake the technical for the moral.

An example of our misplaced overreliance on a technical ap-

2. See my *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970), pp. 180–206.

proach to the so-called drug problem is the professionalized mendacity about the dangerousness of certain types of drugs. Since most of the propagandists against drug abuse seek to justify certain repressive policies by appeals to the alleged dangerousness of various drugs, they often falsify the facts about the true pharmacological properties of the drugs they seek to prohibit. They do so for two reasons: first, because many substances in daily use are just as harmful as the substances they want to prohibit; second, because they realize that dangerousness alone is never a sufficiently persuasive argument to justify the prohibition of any drug, substance, or artifact. Accordingly, the more the "addiction-mongers" ignore the moral dimensions of the problem, the more they must escalate their fraudulent claims about the dangers of drugs.

To be sure, some drugs are more dangerous than others. It is easier to kill oneself with heroin than with aspirin. But it is also easier to kill oneself by jumping off a high building than a low one. In the case of drugs, we regard their potentiality for self-injury as justification for their prohibition; in the case of buildings, we do not.

Furthermore, we systematically blur and confuse the two quite different ways in which narcotics may cause death—by a deliberate act of suicide and by accidental overdosage.

As I have suggested elsewhere, we ought to consider suicide a basic human right.[3] If so, it is absurd to deprive an adult of a drug (or of anything else) because he might use it to kill himself. To do so is to treat everyone the way institutional psychiatrists treat the so-called suicidal mental patient: they not only imprison such a person but take everything away from him—shoelaces, belts, razor blades, eating utensils, and so forth—until the "patient" lies naked on a mattress in a padded cell, lest he kill himself. The result is the most degrading tyrannization in the annals of human history.

Death by accidental overdose is an altogether different matter. But can anyone doubt that this danger now looms so large precisely because the sale of narcotics and many other drugs is illegal? People who buy illicit drugs cannot be sure what drug they are getting or how much of it. Free trade in drugs, with governmental action limited to safeguarding the purity of the product and the veracity

3. See Chapter 6, "The Ethics of Suicide."

of the labeling, would reduce the risk of accidental overdose with "dangerous drugs" to the same levels that prevail, and that we find acceptable, with respect to other chemical agents and physical artifacts that abound in our complex technological society.

Although this essay is not intended as an exposition on the pharmacological properties of narcotics and other mind-affecting drugs, it might be well to say something more about the medical and social dangers they pose. Before proceeding to that task, I want to make clear, however, that in my view, regardless of their dangerousness, all drugs should be legalized (a misleading term I employ reluctantly as a concession to common usage). Although I recognize that some drugs—notably heroin, the amphetamines, and LSD among those now in vogue—may have undesirable personal or social consequences, I favor free trade in drugs for the same reason the Founding Fathers favored free trade in ideas: in an open society, it is none of the government's business what idea a man puts into his mind; likewise, it should be none of the government's business what drug he puts into his body.

It is a fundamental characteristic of human beings that they get used to things: one becomes habituated, or addicted, not only to narcotics, but to cigarettes, cocktails before dinner, orange juice for breakfast, comic strips, sex, and so forth. It is similarly a fundamental characteristic of living organisms that they acquire increasing tolerance to various chemical agents and physical stimuli: the first cigarette may cause nothing but nausea and headache; a year later, smoking three packs a day may be pure joy. Both alcohol and opiates are addictive, then, in the sense that the more regularly they are used, the more the user craves them and the greater his tolerance for them becomes. However, there is no mysterious process of "getting hooked" involved in any of this. It is simply an aspect of the universal biological propensity for learning, which is especially well-developed in man. The opiate habit, like the cigarette habit or the food habit, can be broken—usually without any medical assistance—provided the person wants to break it. Often he doesn't. And why indeed should he if he has nothing better to do with his life? Or as happens to be the case with morphine, if he can live an essentially normal life while under its influence? That, of course, sounds com-

pletely unbelievable, or worse—testimony to our "addiction" to half a century of systematic official mendacity about opiates, which we can break only by suffering the intellectual withdrawal symptoms that go with giving up treasured falsehoods.

Actually, opium is much less toxic than alcohol. Moreover, just as it is possible to be an alcoholic and work and be productive, so it is (or rather, it used to be) possible to be an opium addict and work and be productive. Thomas De Quincey and Samuel Taylor Coleridge were both opium takers, and "Kubla Khan," considered one of the most beautiful poems in the English language, was written while Coleridge was under the influence of opium.[4] According to a definitive study by Light and others published by the American Medical Association in 1929, "morphine addiction is not characterized by physical deterioration or impairment of physical fitness. . . . There is no evidence of change in the circulatory, hepatic, renal, or endocrine functions. When it is considered that these subjects had been addicted for at least five years, some of them as long as twenty years, these negative observations are highly significant."[5] In a 1928 study, Lawrence Kolb, an assistant surgeon general of the United States Public Health Service, found that of 119 persons addicted to opiates through medical practice, 90 had good industrial records and only 29 had poor ones:

> Judged by the output of labor and their own statements, none of the normal persons had their efficiency reduced by opium. Twenty-two of them worked regularly while taking opium for twenty-five years or more; one of them, a woman aged 81 and still alert mentally, had taken 3 grains of morphine daily for 65 years. [The usual therapeutic dose is ¼ grain, 3 to 4 grains being fatal for the nonaddict.] She gave birth to and raised six children, and managed her household affairs with more than average efficiency. A widow, aged 66, had taken 17 grains of morphine daily for most of 37 years. She is alert mentally . . . does physical labor every day, and makes her own living.[6]

4. A. Montagu, "The Long Search for Euphoria," *Reflections* 1 (May–June 1966): 65.

5. A. B. Light et al., *Opium Addiction* (Chicago: American Medical Association, 1929), p. 115; quoted in Alfred R. Lindesmith, *Addiction and Opiates* (Chicago: Aldine, 1968). p. 40.

6. L. Kolb, "Drug Addiction: A Study of Some Medical Cases," *Archives of Neurology and Psychiatry* 20 (1928): 178; quoted in Lindesmith, *Addiction and Opiates*, pp. 41–42.

I am not citing this evidence to recommend the opium habit. The point is that we must, in plain honesty, distinguish between pharmacological effects and personal inclinations. Some people take drugs to cope—to help them function and conform to social expectations. Others take them to cop out—to ritualize their refusal to function and conform to social expectations. Much of the drug abuse we now witness—perhaps nearly all of it—is of the second type. But instead of acknowledging that addicts are unable or unfit or unwilling to work and be normal, we prefer to believe that they act as they do because certain drugs—especially heroin, LSD, and the amphetamines—make them sick. If only we could get them well, so runs this comfortable and comforting view, they would become productive and useful citizens. To believe that is like believing that if an illiterate cigarette smoker would only stop smoking, he would become an Einstein. With a falsehood like that, one can go far. No wonder that politicians and psychiatrists love it.

The idea of free trade in drugs runs counter to another cherished notion of ours—namely, that everyone must work and that idleness is acceptable only under special conditions. In general, the obligation to work is greatest for healthy adult white males. We tolerate idleness on the part of children, women, blacks, the aged, and the sick, and we even accept the responsibility of supporting them. But the new wave of drug abuse affects mainly young adults, often white males who are, in principle at least, capable of working and supporting themselves. But they refuse: they drop out, adopting a life-style in which *not* working, *not* supporting oneself, *not* being useful to others, are positive values. These people challenge some of the most basic values of our society. It is hardly surprising, then, that society wants to retaliate, to strike back. Even though it would be cheaper to support addicts on welfare than to "treat" them, doing so would be legitimizing their life-style. That, "normal" society refuses to do. Instead, the majority acts as if it felt that, so long as it is going to spend its money on addicts, it is going to get something out of it. What society gets out of its war on addiction is what every persecutory movement provides for the persecutors: by defining a minority as evil (or sick), the majority confirms itself as good (or healthy). (If that can be done for the victim's own good, so much the better.) In short, the war on addiction is a part of that vast

modern enterprise which I have named the "manufacture of madness." It is indeed a therapeutic enterprise, but with this grotesque twist: its beneficiaries are the therapists, and its victims are the patients.

Most of all perhaps, the idea of free trade in narcotics frightens people because they believe that vast masses of our population would spend their days and nights smoking opium or mainlining heroin instead of working and shouldering their responsibilities as citizens. But that is a bugaboo that does not deserve to be taken seriously. Habits of work and idleness are deep-seated cultural patterns; I doubt that free trade in drugs would convert industrious people from hustlers into hippies at the stroke of a legislative pen.

The other side of the economic coin regarding drugs and drug controls is actually far more important. The government is now spending millions of dollars—the hard-earned wages of hard-working Americans—to support a vast and astronomically expensive bureaucracy whose efforts not only drain our economic resources and damage our civil liberties but create ever more addicts and, indirectly, the crime associated with the traffic in illicit drugs. Although my argument about drug taking is moral and political and does not depend upon showing that free trade in drugs would also have fiscal advantages over our present policies, let me indicate briefly some of the economic aspects of the drug-control problem.

On April 1, 1967, New York State's narcotics addiction-control program, hailed as "the most massive ever tried in the nation," went into effect. "The program, which may cost up to $400 million in three years," reported *The New York Times,* "was hailed by Governor Rockefeller as 'the start of an unending war.' "[7] Three years later, it was conservatively estimated that the number of addicts in the state had tripled or quadrupled. New York State Senator John Hughes reported that the cost of caring for each addict during that time was $12,000 per year (as against $4,000 per year for patients in state mental hospitals).[8] It was a great time, though, for some of the ex-addicts themselves. In New York City's Addiction Services Agency, one ex-addict started at $6,500 a year

7. *The New York Times,* April 1, 1967.
8. Editorial, "About Narcotics," *Syracuse Herald-Journal,* March 6, 1969.

on November 27, 1967, and was making $16,000 seven months later. Another started at $6,500 on September 12, 1967, and went up to $18,100 by July 1, 1969.[9] The salaries of the medical bureaucrats in charge of the programs are similarly attractive. In short, the detection and rehabilitation of addicts is good business; and so was, in former days, the detection and rehabilitation of witches. We now know that the spread of witchcraft in the late Middle Ages was due more to the work of witchmongers than to the lure of witchcraft. Is it not possible that, similarly, the spread of addiction in our day is due more to the work of addictmongers than to the lure of narcotics?

Let us see how far some of the money spent on the war on addiction could go in supporting people who prefer to drop out of society and drug themselves. Their habit itself would, of course, cost next to nothing, for free trade would bring the price of narcotics down to a negligible amount. During the 1969–1970 fiscal year, the New York State Narcotics Addiction Control Commission had a budget of nearly $50 million, not including the budget for capital construction. Using that figure as a tentative base for calculation, here is what we come to: $100 million will support thirty thousand people at $3,300 per year; since the population of New York State is roughly one-tenth that of the nation, we arrive at a figure of $500 million to support one hundred and fifty thousand addicts nationally.

I am not advocating that we spend our hard-earned money in this way. I am only trying to show that free trade in narcotics would be more economical for those of us who work, even if we had to support legions of addicts, than is our present program of trying to "cure" them. Moveover, I have not even made use, in my economic estimates, of the incalculable sums we would thus save by reducing crimes now engendered by the illegal traffic in drugs.

Clearly, the argument that marijuana—or heroin, or methadone, or morphine—is prohibited because it is addictive or dangerous cannot be supported by facts. For one thing, there are many drugs —from insulin to penicillin—that are neither addictive nor danger-

9. *The New York Times,* June 29, 1970.

ous but are nevertheless also prohibited—they can be obtained only through a physician's prescription. For another, there are many things—from dynamite to guns—that are much more dangerous than narcotics (especially to others) but are not prohibited. As everyone knows, it is still possible in the United States to walk into a store and walk out with a shotgun. We enjoy that right not because we do not believe that guns are dangerous, but because we believe even more strongly that civil liberties are precious. At the same time, it is not possible in the United States to walk into a store and walk out with a bottle of barbiturates, codeine, or other drugs. We are now deprived of that right because we have come to value medical paternalism more highly than the right to obtain and use drugs without recourse to medical intermediaries.

I submit, therefore, that our so-called drug-abuse problem is an integral part of our present social ethic, which accepts "protections" and repressions justified by appeals to health similar to those that medieval societies accepted when they were justified by appeals to faith.[10] Drug abuse (as we now know it) is one of the inevitable consequences of the medical monopoly over drugs—a monopoly whose value is daily acclaimed by science and law, state and church, the professions and the laity. As the Church formerly regulated man's relations to God, so Medicine now regulates his relations to his body. Deviation from the rules set forth by the Church was then considered to be heresy and was punished by appropriate theological sanctions, called *penance*; deviation from the rules set forth by Medicine is now considered to be drug abuse (or some sort of mental illness) and is punished by appropriate medical sanctions, called *treatment*.

The problem of drug abuse will thus be with us so long as we live under medical tutelage. This is not to say that if all access to drugs were free, some people would not medicate themselves in ways that might upset us or harm them. That of course is precisely what happened when religious practices became free.

What I am suggesting is that although addiction is ostensibly a medical and pharmacological problem, actually it is a moral and

10. See my *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970).

political problem. We talk as if we were trying to ascertain which drugs *are* toxic, but we act as if we were trying to decide which drugs *ought to be* prohibited.

We ought to know, however, that there is no necessary connection between facts and values, between what is and what ought to be. Thus, objectively quite harmful acts, objects, or persons may be accepted and tolerated—by minimizing their dangerousness. Conversely, objectively quite harmless acts, objects, or persons may be prohibited and persecuted—by exaggerating their dangerousness. It is always necessary to distinguish—and especially so when dealing with social policy—between description and prescription, fact and rhetoric, truth and falsehood.

To command adherence, social policy must be respected; and to be respected, it must be considered legitimate. In our society, there are two principal methods of legitimizing policy—social tradition and scientific judgment. More than anything else, time is the supreme ethical arbiter. Whatever a social practice might be, if people engage in it generation after generation, then that practice becomes acceptable.

Many opponents of illegal drugs admit that nicotine may be more harmful to health than marijuana; nevertheless, they argue that smoking cigarettes should be legal but smoking marijuana should not be, because the former habit is socially accepted while the latter is not. That is a perfectly reasonable argument. But let us understand it for what it is—a plea for legitimizing old and accepted practices and illegitimizing novel and unaccepted ones. It is a justification that rests on precedence, not on evidence.

The other method of legitimizing policy, increasingly more important in the modern world, is through the authority of science. In matters of health, a vast and increasingly elastic category, physicians thus play important roles as legitimizers and illegitimizers. One result is that, regardless of the pharmacological effects of a drug on the person who takes it, if he obtains it through a physician and uses it under medical supervision, that use is, ipso facto, legitimate and proper; but if he obtains it through nonmedical channels and uses it without medical supervision (and especially if the drug is illegal and the individual uses it solely for the purpose of altering his mental state), then that use is, ipso facto, illegitimate and im-

proper. In short, being medicated by a doctor is drug use, while self-medication (especially with certain classes of drugs) is drug abuse.

That too is a perfectly reasonable arrangement. But let us understand it for what it is—a plea for legitimizing what doctors do, because they do it with good, therapeutic intent; and for illegitimizing what laymen do, because they do it with bad, self-abusive (masturbatory) intent. It is a justification that rests on the principles of professionalism, not of pharmacology. That is why we applaud the systematic medical use of methadone and call it "treatment for heroin addiction," but decry the occasional nonmedical use of marijuana and call it "dangerous drug abuse."

Our present concept of drug abuse thus articulates and symbolizes a fundamental policy of scientific medicine—namely, that a layman should not medicate his own body but should place its medical care under the supervision of a duly accredited physician. Before the Reformation, the practice of true Christianity rested on a similar policy—namely, that a layman should not himself commune with God but should place his spiritual care under the supervision of a duly accredited priest. The self-interests of the Church and of Medicine in such policies are obvious enough. What might be less obvious is the interest of the laity in them: by delegating responsibility for the spiritual and medical welfare of the people to a class of authoritatively accredited specialists, those policies—and the practices they ensure—relieve individuals from assuming the burdens of those responsibilities for themselves. As I see it, our present problems with drug use and drug abuse are just one of the consequences of our pervasive ambivalence about personal autonomy and responsibility.

Luther's chief heresy was to remove the priest as intermediary between man and God, giving the former direct access to the latter. He also demystified the language in which man could henceforth address God, approving for that purpose what until then had significantly been called the *vulgar tongue*. Perhaps it is true that familiarity breeds contempt: Protestantism was not just a new form of Christianity, but the beginning of its end, at least as it had been known until then.

I propose a medical reformation analogous to the Protestant Reformation—specifically, a "protest" against the systematic mystification of man's relationship to his body and his professionalized separation from it. The immediate aim of the reform would be to remove the physician as intermediary between man and his body and to give the layman direct access to the language and contents of the pharmacopoeia. It is significant that until recently physicians wrote prescriptions in Latin and that medical diagnoses and treatments are still couched in a jargon whose chief aim is to awe and mystify the laity. If man had unencumbered access to his own body and the means of chemically altering it, it would spell the end of Medicine, at least as we now know it. That is why, with faith in Medicine so strong, there is little interest in this kind of medical reform: physicians fear the loss of their privileges; laymen, the loss of their protections.

Our present policies with respect to drug use and drug abuse thus constitute a covert plea for legitimizing certain privileges on the part of physicians and illegitimizing certain practices on the part of everyone else. The upshot is that we act as if we believed that only doctors should be allowed to dispense narcotics, just as we used to believe that only priests should be allowed to dispense holy water.

Finally, since luckily we still do not live in the utopian perfection of one world, our technical approach to the drug problem has led, and will undoubtedly continue to lead, to some curious attempts to combat it.

In one such attempt, the American government succeeded in pressuring Turkey to restrict its farmers from growing poppy (the source of opium, morphine, and heroin).[11] If turnabout is fair play, perhaps we should expect the Turkish government to pressure the United States to restrict its farmers from growing barley. Or should we assume that Muslims have enough self-control to leave alcohol alone but Christians need all the controls politicians, policemen, and physicians, both native and foreign, can bring to bear on them to enable them to leave opiates alone?

11. "Pursuit of the Poppy," *Time*, September 14, 1970, p. 28.

In another such attempt, the California Civil Liberties Union sued to enforce a paroled heroin addict's "right to methadone maintenance treatment."[12] In this view, the addict has more rights than the nonaddict: for the former, methadone, supplied at the taxpayer's expense, is a right; for the latter, methadone, supplied at his own expense, is evidence of addiction to it.

I believe that just as we regard freedom of speech and religion as fundamental rights, so we should also regard freedom of self-medication as a fundamental right; and that instead of mendaciously opposing or mindlessly promoting illicit drugs, we should, paraphrasing Voltaire, make this maxim our rule: I disapprove of what you take, but I will defend to the death your right to take it!

To be sure, like most rights, the right of self-medication should apply only to adults; and it should not be an unqualified right. Since these are important qualifications, it is necessary to specify their precise range.

John Stuart Mill said (approximately) that a person's right to swing his arm ends where his neighbor's nose begins. Similarly, the limiting condition with respect to self-medication should be the inflicting of actual (as against symbolic) harm on others.

Our present practices with respect to alcohol embody and reflect this individualistic ethic. We have the right to buy, possess, and consume alcoholic beverages. Regardless of how offensive drunkenness might be to a person, he cannot interfere with another person's right to become inebriated so long as that person drinks in the privacy of his own home or at some other appropriate location and so long as he conducts himself in an otherwise law-abiding manner. In short, we have a right to be intoxicated—in private. Public intoxication is considered to be an offense against others and is therefore a violation of the criminal law.

The same principle applies to sexual conduct. Sexual intercourse, especially between husband and wife, is surely a right. But it is a right that must be exercised at home or at some other appropriate location; it is not a right in a public park or on a downtown street.

12. "CLU Says Addict Has Right to Use Methadone," *Civil Liberties*, July 1970, p. 5.

It makes sense that what is a right in one place may become, by virtue of its disruptive or disturbing effect on others, an offense somewhere else.

The right to self-medication should be hedged in by similar limits. Public intoxication, not only with alcohol but with any drug, should be an offense punishable by the criminal law. Furthermore, acts that may injure others—such as driving a car—should, when carried out in a drug-intoxicated state, be punished especially strictly and severely. The habitual use of certain drugs, such as alcohol and opiates, may also harm others indirectly by rendering the subject unmotivated for working and thus unemployed. In a society that supports the unemployed, such a person would, as a consequence of his own conduct, place a burden on the shoulders of his working neighbors. How society might best guard itself against that sort of hazard I cannot discuss here. However, it is obvious that prohibiting the use of habit-forming drugs offers no protection against that risk, but only adds to the tax burdens laid upon the productive members of society.

The right to self-medication must thus entail unqualified responsibility for the effects of one's drug-intoxicated behavior on others. For unless we are willing to hold ourselves responsible for our own behavior and hold others responsible for theirs, the liberty to ingest or inject drugs degenerates into a license to injure others. But here is the catch: we are exceedingly reluctant to hold people responsible for their misbehavior. That is why we prefer diminishing rights to increasing responsibilities. The former requires only the passing of laws, which can then be more or less freely violated or circumvented; whereas the latter requires prosecuting and punishing offenders, which can be accomplished only by just laws justly enforced. The upshot is that we increasingly substitute tender-hearted tyranny for tough-spirited liberty.

Such then would be the situation of adults were we to regard the freedom to take drugs as a fundamental right similar to the freedom to read and to worship. What would be the situation of children? Since many people who are now said to be drug addicts or drug abusers are minors, it is especially important that we think clearly about this aspect of the problem.

I do not believe, and I do not advocate, that children should have a right to ingest, inject, or otherwise use any drug or substance they want. Children do not have the right to drive, drink, vote, marry, or make binding contracts. They acquire those rights at various ages, coming into their full possession at maturity, usually between the ages of eighteen and twenty-one. The right to self-medication should similarly be withheld until maturity.

In this connection, it is well to remember that children lack even such basic freedoms as the opportunity to read what they wish or worship God as they choose, freedoms we consider elementary rights for adult Americans. In those as well as other important respects, children are wholly under the jurisdiction of their parents or guardians. The disastrous fact that many parents fail to exercise proper authority over the conduct of their children does not, in my opinion, justify depriving adults of the right to engage in conduct we deem undesirable for children. That remedy only further aggravates the situation. For if we consider it proper to prohibit the use of narcotics by adults to prevent their abuse by children, then we would have to consider it proper also to prohibit sexual intercourse, driving automobiles, piloting airplanes—indeed virtually everything!—because those activities too are likely to be abused by children.

In short, I suggest that "dangerous" drugs be treated more or less as alcohol and tobacco are treated now. (That does not mean that I believe the state should make their use a source of tax revenue.) Neither the use of narcotics nor their possession should be prohibited, but only their sale to minors. Of course, that would result in the ready availability of all kinds of drugs among minors—though perhaps their availability would be no greater than it is now but only more visible and hence more easily subject to proper controls. That arrangement would place responsibility for the use of all drugs by children where it belongs: on parents and their children. That is where the major responsibility rests for the use of alcohol and tobacco. It is a tragic symptom of our refusal to take personal liberty and responsibility seriously that there appears to be no public desire to assume a similar stance toward other dangerous drugs.

Consider what would happen should a child bring a bottle of gin to school and get drunk there. Would the school authorities blame

the local liquor stores as pushers? Or would they blame the parents and the child himself? There is liquor in practically every home in America and yet children rarely bring liquor to school, whereas marijuana, LSD, and heroin—substances that children do not find in the home and whose very possession is a criminal offense—frequently find their way into the school.

Our attitude toward sexual activity provides another model for our attitude toward drugs. Although we generally discourage children below a certain age from engaging in sexual activities with others (we no longer "guard" them against masturbation), we do not prohibit such activities by law. What we do prohibit by law is the sexual seduction of children by adults. The pharmacological seduction of children by adults should be similarly punishable. In other words, adults who give or sell drugs to children should be regarded as offenders. Such a specific and limited prohibition—contrasted with the kind of generalized prohibitions that we had under the Volstead Act or have now against countless drugs—would be relatively easy to enforce. Moreover, it would probably be rarely violated, for there would be little psychological interest and no economic profit in doing so. On the other hand, the use of drugs by and among children (without the direct participation of adults) should be a matter entirely outside the scope of the criminal law, just as is their engaging in sexual activities under like circumstances.

There is of course a fatal flaw in my proposal. Its adoption would remove minors from the ranks of our most cherished victims: we could no longer spy on them and persecute them in the name of protecting them from committing drug abuse on themselves—a practice we have substituted for our spying on them and persecuting them in order to protect them from committing self-abuse on themselves (that is, masturbating).[13] Hence, we cannot, and indeed we shall not, abandon such therapeutic tyrannization and treat children as young persons entitled to dignity from us and owing responsibility to us until we are ready to cease psychiatrically oppressing children—"in their own best interests."

13. See *The Manufacture of Madness,* chap. 11.

Sooner or later, we shall have to confront the basic moral dilemma underlying our drug problem: does a person have the right to take a drug—any drug—not because he needs it to cure an illness, but because he wants to take it?

The Declaration of Independence speaks of our inalienable right to "life, liberty, and the pursuit of happiness." How are we to interpret that phrase? By asserting that we ought to be free to pursue happiness by playing golf or watching television but not by drinking alcohol, or smoking marijuana, or ingesting amphetamines?

The Constitution and the Bill of Rights are silent on the subject of drugs. Their silence would seem to imply that the adult citizen has, or ought to have, the right to medicate his own body as he sees fit. Were that not the case, why should there have been a need for a constitutional amendment to outlaw drinking? But if ingesting alcohol was, and is now again, a constitutional right, is ingesting opium, or heroin, or barbiturates, or anything else not also such a right? If it is, then the Harrison Narcotic Act is not only a bad law but unconstitutional as well, because it prescribes in a legislative act what ought to be promulgated in a constitutional amendment.

The nagging questions remain. As American citizens, do we and should we have the right to take narcotics or other drugs? Further, if we take drugs and conduct ourselves as responsible and law-abiding citizens, do we and should we have a right to remain unmolested by the government? Lastly, if we take drugs and break the law, do we and should we have a right to be treated as persons accused of a crime rather than as patients accused of being mentally ill?

These are fundamental questions that are conspicuous by their absence from all contemporary discussions of problems of drug addiction and drug abuse. In this area as in so many others, we have allowed a moral problem to be disguised as a medical question and have then engaged in shadowboxing with metaphorical diseases and medical attempts, ranging from the absurd to the appalling, to combat them.

The result is that instead of debating the use of drugs in moral and political terms, we define our task as the ostensibly narrow technical problem of protecting people from poisoning themselves

with substances for whose use they cannot possibly assume responsibility. That, I think, best explains the frightening national consensus against personal responsibility for taking drugs and for one's conduct while under their influence. In 1965, for example, when President Johnson sought a bill imposing tight federal controls over "pep pills" and "goof balls," the bill cleared the House by a unanimous vote, 402 to 0.

The failure of such measures to curb the "drug menace" has served only to inflame our legislators' enthusiasm for them. In October 1970, the Senate passed, again by a unanimous vote (54 to 0), "a major narcotics crackdown bill hailed as a keystone in President Nixon's anticrime program. Added to the bill were strong new measures for the treatment and rehabilitation of drug abusers."[14] In December 1971, the Senate approved—this time by a unanimous vote of 92 to 0—a "$1 billion-plus bill to mount the nation's first all-out, coordinated attack on the insidious menace of drug abuse";[15] in February 1972, the House voted 380 to 0 for a $411 million, three-year program to combat drug abuse; and in March, the House voted 366 to 0, to authorize a $1 billion three-year federal attack on drug abuse.

To me, such unremitting unanimity on this issue can mean one thing only: an evasion of the actual problem and an attempt to master it by attacking and overpowering a scapegoat—"dangerous drugs" and "drug abusers." There is an ominous resemblance between the unanimity with which all "reasonable" men—especially politicians, physicians, and priests—formerly supported the protective measures of society against witches and Jews and now support them against drug addicts and drug abusers.

Finally, those repeated unanimous votes on far-reaching measures to combat drug abuse are bitter reminders that when the chips are really down, that is, when democratic lawmakers can preserve their intellectual and moral integrity only by going against certain popular myths, they prove to be either mindless or spineless. They prefer running with the herd to courting unpopularity and risking reelection.

14. *Syracuse Post-Standard*, October 8, 1970.
15. *The International Herald Tribune*, December 4–5, 1971.

After all is said and done—after millions of words are written, thousands of laws are enacted, and countless numbers of people are "treated" for "drug abuse"—it all comes down to whether we accept or reject the ethical principle John Stuart Mill so clearly enunciated in 1859:

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. . . . In the part [of his conduct] which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[16]

The basic issue underlying the problem of addiction—and many other problems, such as sexual activity between consenting adults, pornography, contraception, gambling, and suicide—is simple but vexing: in a conflict between the individual and the state, where should the former's autonomy end and the latter's right to intervene begin?

One way out of the dilemma lies through concealment: by disguising the moral and political question as a medical and therapeutic problem, we can, to protect the physical and mental health of patients, exalt the state, oppress the individual, and claim benefits for both.

The other way out of it lies through confrontation: by recognizing the problem for what it is, we can choose to maximize the sphere of action of the state at the expense of the individual or of the individual at the expense of the state. In other words, we can commit ourselves to the view that the state, the representative of many, is more important than the individual and that it therefore has the right, indeed the duty, to regulate the life of the individual in the best interests of the group. Or we can commit ourselves to the view that individual dignity and liberty are the supreme values of life and that the foremost duty of the state is to protect and promote those values.

In short, we must choose between the ethic of collectivism and the ethic of individualism and pay the price of either—or of both.

16. J. S. Mill, *On Liberty* (Chicago: Regnery, 1955), p. 13.

5

The Ethics of Behavior Therapy

My aim in this essay is to offer an exposition of the moral dimensions of behavior therapy; to identify the actual activities of behavior therapists; and to indicate my acceptance of some of their interventions, my rejection of others, and the justifications for my judgments.

Let me begin by registering my agreement with the contention of behavior therapists that, like all therapists, they influence behavior. My unqualified agreement with behavior therapists ends right here. Although there are qualified agreements between us on some other points—such as the significance of actual behavior rather than its verbal rationalization or the importance of classifying the patient's and professional's goals in therapy—my position is divided from theirs (as it is from that of most other psychiatrists and psychotherapists): I insist on distinguishing sharply between voluntary and involuntary psychotherapeutic interventions, between choice leading to contract and coercion leading to capitulation—in short, between doing something *for* a person and doing something *to* him.

I can sense that at this point many behavior therapists will want to interrupt and declare their own allegiance—no doubt sincere—to the principle of informed consent to treatment and their opposition —no doubt well meant—to the use of psychiatric or psychological technology for punishment. Such protests, I am afraid, leave me as unconvinced and unmoved as do the similar protests of the training analysts and institutional psychiatrists that they labor always and

only for the benefit of their analysands or patients. It is an old saying that words are cheap, a maxim with which behavior therapists can hardly quarrel. It is therefore not very important or interesting what behavior therapists *say* about what they do or why they do it; what is important and interesting is what they *do* and how they describe it. So examined, much of what they do appears to be plainly coercive, imposed on the client or patient by force or fraud.

Before illustrating this contention, let me anticipate and try to rebut an objection that may be raised here. "There are many behavior therapists who do many things," so the objection might run. "While it may be true that among all these interventions there are some that are coerced or involuntary, they represent a small fraction of the total, and hence they are not representative of what behavior therapy *really* is."

That sort of argument is, in my opinion, disingenuous. Although I do not know, and I dare say no one does, what the exact proportion of voluntary to involuntary behavior-therapeutic interventions is—whether it is 99 to 1, or 1 to 1, or 1 to 99—one thing is clear from a perusal of the published literature in the field: behavior therapy is used routinely on patients who do not or cannot give informed consent to it.

Modern behavior therapy is tainted, it seems to me, with a hereditary defect that it has acquired from the mother out of whose womb it emerged. I refer to the social context in which behavior therapy was first carried out: the state mental hospital.

The experiments in question are those performed by Ogden Lindsley and B. F. Skinner at the Metropolitan State Hospital in Waltham, Massachusetts, under the auspices of the Department of Psychiatry at Harvard Medical School, supported by grants from the Office of Naval Research and the Rockefeller Foundation, and reported in 1954. Lindsley and Skinner studied fifteen male patients who had been hospitalized for an average of seventeen years. Their conclusions are best stated in their own words:

> The similarity between the performance of psychotic patients and the performance of "normal" rats, pigeons, and dogs on two schedules of intermittent reinforcement suggests that psychotic behavior is controlled to some extent by the reinforcing properties of the immediate

physical environment, and that the effects of different schedules of reinforcement upon the behavior of psychotics should be investigated further.[1]

There is no need to encumber this presentation with my objections to Skinner's ideas and ethics, as I have set them forth elsewhere;[2] suffice it to note that in the above passage Lindsley and Skinner put the word *normal*, with which they qualify rats, in quotation marks but do not put the word *psychotic*, with which they qualify persons, in quotation marks. In other words, they accept as obvious that just as some individuals are diabetic or leukemic, so others are psychotic. I consider that a fatal flaw to everything that follows in Skinner's work having to do with "mental patients," as well as in the work of behavior therapists who accept that psychiatric premise.[3] Finally, that Lindsley and Skinner here also accept—and that all those who have subsequently referred to this work approvingly also accept—the moral legitimacy of incarcerating "psychotics" and then "treating" them against their will is obvious. That this carries with it an ethical burden that invalidates all subsequent work based on this model may be less obvious but is, I think, the case.

During the past several decades, a great deal of behavior therapy has been conducted in closed institutions—that is, in mental hospitals and prisons. As I mentioned earlier, I do not know, and I doubt if anyone does, whether more behavior therapy is conducted coercively than contractually. The fact remains that many of the recipients of the "benefits" of behavior therapy have been, and continue to be, persons whose status as clients or patients was, *pro forma* or de facto, involuntary. I shall comment first on behavior therapy in mental hospitals and then on behavior therapy in prisons.

Lindsley's detailed report on the experiments to which I referred

1. O. R. Lindsley and B. F. Skinner, "A Method for the Experimental Analysis of the Behavior of Psychotic Patients," *American Psychologist* 9 (August 1954): 419.

2. See my review of *About Behavior* by B. F. Skinner, *Libertarian Review* 3 (December 1974): 6–7.

3. See my *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper & Row, 1974).

already seems to set the tone for much of this sort of work. "The free operant method," he writes in 1956, "can be used, with very little modification, to measure the behavior of any animal from a turtle to a normal genius." It is odd that Lindsley here qualifies genius as "normal" because in the very next sentence he proposes to apply this method to "psychotics": "Since neither instructions nor rapport with the experimenter are demanded, the method is particularly appropriate in analyzing the behavior of non-verbal, lowly motivated, chronic psychotic patients."[4]

The patients reported on in the study had been incarcerated for an average of twelve years. Here briefly is what Lindsley says about them and what he did with them:

> We selected patients who were preferably not on parole, not working in hospital industries, not receiving active therapy, not receiving visitors, and not going on home visits. We did this in order to minimize extraneous variables and to facilitate patient handling. . . . Our standard procedure is to go up to a patient, for the first time, on the ward and ask him if he wants to come with us and get some candy or cigarettes. Those who do not answer are led, if they do not follow us, to the laboratory. If at any time a patient balks or refuses, he is left on the ward.[5]

Evidently, Lindsley believes that dealing with the patients in that way is enough to establish that they are not coerced. He completely ignores the fact that he is functioning as a member of the authority structure of the hospital. I consider such work to be only slightly less odious than experimenting on the inmates of concentration camps. I say that because I believe it is the moral duty of psychologists and psychiatrists to safeguard the dignity and liberty of people generally, and, in particular, of those with whom they work. If instead they take professional advantage of the imprisoned status of incarcerated individuals or populations, they are, in my opinion, criminals.

Much of the literature on the use of behavior therapy in mental institutions exudes a similarly offensive moral odor. A few illustrations must suffice.

4. O. R. Lindsley, "Operant Conditioning Methods Applied to Research in Chronic Schizophrenia," *Psychiatric Research Reports* 5 (1956): 118–119.
5. Ibid., p. 128.

A paper by Isaacs, Thomas, and Goldiamond entitled "Application of Operant Conditioning to Reinstate Verbal Behavior in Psychotics" is typical. The title itself is deceptive, as it is a scientistic way of describing an effort to make nontalkative people talk. This is the authors' description of their first patient:

> Patient A—The S [subject] was brought to a group therapy session with other chronic schizophrenics (who were verbal), but he sat in the position in which he was placed and continued the withdrawal behaviors which characterized him. He remained impassive and stared ahead even when cigarettes, which other members accepted, were offered to him and were waved before his face.[6]

There is no evidence that the investigators made any effort to discover what the patient wanted and to satisfy his desires. The idea that this man, who preferred not to talk, should talk was clearly the investigators', which they then imposed on him by trying to bribe him with cigarettes. This subject, as well as the other one mentioned in this paper, was, moreover, an involuntary mental patient: "Patient A, classified as a catatonic schizophrenic, 40, became completely mute almost immediately upon commitment 19 years ago."[7] Perhaps he did not like the company he was condemned to keep.

Although the authors relate with evident professional pride how they tried to make the man talk by offering him cigarettes (whose "abuse" is now about to be declared a newly discovered form of mental illness by the American Psychiatric Association), there is no evidence that they tried to achieve the same result by freeing him from psychiatric imprisonment.

The *use*—and I am setting this term in italics to call attention to it—of helpless, incarcerated, so-called schizophrenic patients as subjects for behavior therapy is, of course, a routine matter. I could fill hundreds of pages with excerpts from papers reporting on such treatments. Here is a typical report by Teodoro Ayllon, a prominent behavior therapist: "The subjects were two female patients in a mental hospital. Both patients had been classified as

6. W. Isaacs, J. Thomas, and I. Goldiamond, "Application of Operant Conditioning to Reinstate Verbal Behavior in Psychotics," in L. P. Ullmann and L. Krasner, eds., *Case Studies in Behavior Modification* (New York: Holt, Rinehart & Winston, 1965), p. 69.

7. Ibid.

schizophrenic. . . . Anne was 54 years old and had been in the hospital for 20 years. Emelda was 60 years old and had been in the hospital for 18 years."[8]

Anne and Emelda would not eat unless fed, and the purpose of Ayllon's treatment was to make them feed themselves. The beneficiaries of this sort of treatment are clear enough. Whether a therapist should be proud or ashamed to do this sort of thing is just the kind of question evaded by single-minded attention to the technical aspects of behavior (or other) therapy.

In another paper Ayllon makes it even clearer that, regardless of his professed aim, what he actually does is to make "difficult" patients easier to manage:

> The patient was a 47-year-old female diagnosed as a chronic schizophrenic . . . hospitalized for 9 years. Upon studying the patient's behavior on the ward, it became apparent that the nursing staff spent considerable time caring for her. In particular, there were three aspects of her behavior which seemed to defy solution. The first was stealing food. The second was the hoarding of the ward's towels in her room. The third undesirable aspect of her behavior consisted in her wearing excessive clothing, e.g., half-dozen dresses, several pairs of stockings, sweaters, and so on.[9]

Ayllon devised a complicated social ritual to deal with the food stealing that, in his own words, "resulted in the patient missing a meal whenever she attempted to steal food."[10] In plain English, for stealing food the patient was punished by starvation.

In view of the support that behavior therapy and behavior therapists lend to the principles and practices of institutional psychiatry, it is not surprising that the American Psychiatric Association's Task Force on Behavior Therapy has issued a glowing report on it. The following excerpts from the report reveal the close ties between coercive psychiatry and the conditioning therapies:

8. T. Ayllon, "Some Behavioral Problems Associated with Eating in Chronic Schizophrenic Patients," in Ullmann and Krasner, eds., *Case Studies,* pp. 73–74.

9. T. Ayllon, "Intensive Treatment of Psychotic Behavior by Stimulus Satiation and Food Reinforcement," in Ullmann and Krasner, eds., *Case Studies,* p. 78.

10. Ibid., p. 79.

> The early development of the token economy system took place almost exclusively within the context of the closed ward psychiatric treatment center and was found quite useful in preventing or overcoming the habit deterioration or social breakdown syndrome that accompanies prolonged custodial hospitalization, whatever the initial diagnosis.[11]

Assuming its typical posture—foot in mouth—the American Psychiatric Association here spills the beans: behavior therapy is useful because it enables psychiatric wardens to impose "prolonged custodial hospitalization" on their victims, while sparing them the unpleasantness of having to put up with the victims' "habit deterioration."

The task force's remarks on the abuses of behavior therapy incriminate this form of intervention still further. Here too the American Psychiatric Association persists in its habitual rhetoric in trying to justify the psychiatric oppression of patients:

> Therapists must be on guard against requests for treatment that take the form "Make him 'behave,' " in which the intention of the request is to make the person conform. . . . One safeguard against this is to obtain the patient's informed agreement about the goals and methods of the therapy program whenever possible.[12]

Whenever possible! And when not possible, then of course it is permissible to impose behavior therapy without consent.

The American Psychiatric Association's hypocrisy concerning coercion is further amplified in the task force's remarks about aversive therapies:

> First, aversive methods should be carried out under the surveillance of the therapist's clinical peers and colleagues; second, aversive methods especially should be used only with the patient's informed consent. . . . If the therapist is aware of precisely what reinforces his own behavior, he can avoid exploitation in his work with patients.[13]

This declaration about limiting the use of aversive therapies to consenting clients is hypocritical. If that is what the writers of this

11. American Psychiatric Association, Task Force on Behavior Therapy, *Behavior Therapy in Psychiatry* (New York: Aronson, 1974), p. 25.
12. Ibid., p. 100.
13. Ibid., p. 102.

report and the American Psychiatric Association itself believe, why have they not demanded the criminal prosecution of those who use aversive therapy on involuntary clients or patients—for example, the psychiatrists and psychologists at the California Medical Facility in Vacaville, where succinylcholine was used as an "aversive tool" and where this "therapy" was imposed on at least five inmates whose consent was solicited but not obtained?[14] Since these inmates were asked for consent, the "therapists" must have considered them capable of giving consent. The fact that the professionals treated them without it—in the face of the inmates' explicit refusal to give consent—establishes, in my mind at least, that the therapists acted criminally. The silence of behavior modifiers about such uses of their ideas and interventions renders their pious pronouncements about consent and contract less than persuasive.

In this connection, I should like to call attention to an important paper by Dougal Mackay in which he demonstrates the utter incompatibility between the basic principles of behavior therapy and the imagery and ideology of psychiatry, which behavior therapists nevertheless enthusiastically support.[15] Why they do so is, of course, clear enough. Deprived of the professional support of medicine and the social justification of treatment, behavior therapists would have to sell their services in the open market; there they could not coerce involuntary clients to do things they did not want to do, and they could not con the public and the state into supporting them at the taxpayers' expense. That would put them back where the psychoanalysts were in Vienna in 1900—which is exactly where they belong.

The use of behavior therapy in prisons, especially when its results influence the judgments of the prison personnel and parole boards,

14. T. S. Szasz, ed., *The Age of Madness: The History of Involuntary Mental Hospitalization Presented in Selected Texts* (Garden City, N.Y.: Doubleday, Anchor Press, 1973), pp. 356–359.

15. D. Mackay, "Behavior Modification and Its Psychiatric Straitjacket," *New Behaviour*, May 15, 1975, pp. 153–157. In this connection, see also D. A. Begelman, "Ethical and Legal Issues in Behavior Modification," in M. Hersen, R. Eisler, and P. Miller, eds., *Progress in Behavior Modification* (New York: Academic Press, 1975), vol. 1, pp. 159–189; and G. C. Davison and R. B. Stuart, "Behavior Therapy and Civil Liberties," *American Psychologist* 30 (July 1975): 755–763.

raises fundamental questions, not only about infringements on the prisoners' rights, but also about the nature and limits of the penal system. In the United States, it would be clearly unconstitutional to demand as a condition of release from prison that a prisoner convert from religion A to religion B. Evidently, it is not unconstitutional to demand that he convert from behavior A to behavior B, especially when the conversion is called behavior therapy.

Jonathan Cole, a prominent apologist for institutional psychiatry, offers this view about the use of behavior therapy in prisons:

> Assuming a prisoner is clearly informed about the nature of a behavior modification program and has the option to withdraw from it if he finds it unpleasant or undesirable, there seems to be no conceivable objection to offering a prisoner or a group of prisoners a chance to change behaviors which they agree need changing.[16]

Cole finds it inconceivable that anyone should object to such an arrangement because of the possibilities of abuse inherent in it, and he offers no remedy for prison authorities' or parole-board members' punishing prisoners for refusing such "offers"—in fact, he does not even consider that possibility. Yet it seems real enough, as the following example shows:

> Three convicted child molesters have sued to end a state program which uses electric shock and social conditioning to change their sex behavior. The three inmates say the program is unconstitutional because they are allegedly forced to participate to gain parole. As part of the program's therapy, shock is administered to the groin during a slide show of nude children. The shock stops when slides of nude women are shown.[17]

Showing slides of nude women to male prisoners and calling it therapy is imaginative indeed. But why not display live models? Better still, why not supply the prisoners with prostitutes? Perhaps I should make it clear that I advance these suggestions tongue in cheek. Such a caveat is necessary, as pimps and procurers with

16. J. O. Cole, "What's in a Word? Or Guilt by Definition, Part II," *Medical Tribune*, June 18, 1975, p. 9.
17. *New York Post*, January 30, 1975.

medical credentials now claim to be, and are widely accepted as, therapists.

Behavior therapy has long been an integral part of the program at the Patuxent Institution, a hybrid between a prison and a mental hospital and, in fact, one of the most infamous psychiatric concentration camps in the United States. Its operation rests on the fact that all its inmates are sentenced to an indeterminate sentence, enhancing the captives' "cooperation" with the captors. The principles animating this institution and the practices carried out in it have received the enthusiastic support of some of the biggest names in American psychiatry—among them, of course, Karl Menninger.[18]

In a class-action suit in 1971, the court, responding to a group of prisoners alleging that they had been subjected to "inhuman treatment," ruled that the use of segregation units at the institution constitutes cruel and unusual punishment. The ruling has led to increased controversy about the methods used at Patuxent. An article in the *APA Monitor* states:

> Psychologist Arthur Kandel, one of Patuxent's three associate directors, testified that the segregation cells (referred to by the inmates as "the hole") were really negative reinforcers . . . used as positive treatment conditions. The court, however, ruled that the physical conditions in the segregation units constituted cruel and unusual punishment. . . . Sigmund Manne, Patuxent's chief psychologist, explains that the indeterminate sentence is "an essential part of the therapeutic program. . . . People respond affectively to the indeterminate sentence," he says. "They don't understand that it's a necessary part of treatment." [19]

In language and law, cure and control are like two banks of a river clearly separated by a body of water—that is, they are clearly separated by a willingness to distinguish between the interests of two parties in conflict with each other. The word *therapy*—as in psychiatric therapy or behavior therapy—is a bridge over the water: it

18. See my *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963) and Chapter 9, "Justice in the Therapeutic State," below.

19. S. Trotter, "Patuxent: 'Therapeutic' Prison Faces Test," *APA Monitor* 6 (May 1975): 1.

unites the two parties in a fake cooperation and enables one or the other or both of them to declare the nonexistence of any difference between cure and control, contract and coercion, freedom and slavery.

I have written elsewhere about the debauchment of language in psychiatry and, more particularly, about the use of debauched language by psychiatrists to describe and justify their penological and punitive practices.[20] Psychiatry is now so chock-full of a kind of mental-health newspeak that it is often difficult to know what facts, if any, authors assert. Usually the only thing that is clear is that they insist that what they do is therapeutically effective and morally good. The following quotation from an article entitled "Custody Cases: How Coercive Treatment Works in Kansas City" is typical:

> "Frequently the more disturbed the child, the more severe the psychopathology in the parents and the less able they are to enter voluntarily into a therapeutic alliance," say Paul C. Laybourne, Jr., M.D., director of the [University of Kansas Medical] Center's Division of Child Psychiatry, and associate Janet M. Krueger, A.C.S.W. There may be no such thing as a completely voluntary psychiatric patient under any circumstances, they suggest, supporting their view with a quotation from . . . Richard R. Parlour, M.D.: "Patients are coerced into treatment by pain, fear, and despair as well as by spouses, employers, and judges. Voluntary treatment is a myth."[21]

Here are prominent psychiatrists asserting that two and two makes five and receiving respectable attention for their revelations. Why should that be so? Because they are defending the nobility of the medical faith and the infallibility of the therapeutic papacy, sentiments dear to the hearts of the psychiatric priesthood. But if there is no difference between voluntary and involuntary patienthood, then there is also no difference between voluntary and involuntary servitude. It is only that some people are coerced into working by

20. *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970) and *The Second Sin* (Garden City, N.Y.: Doubleday, Anchor Press, 1973).

21. "Custody Cases: How Coercive Treatment Works in Kansas City," *Roche Report: Frontiers of Hospital Psychiatry*, March 15, 1975, p. 1.

the whip and others by their desire for fame and fortune. That, of course, makes it something of a mystery why slavery should have been opposed and abolished.

The writings of Joseph Wolpe and Arnold Lazarus exhibit a heavy growth of this same semantic fungus. While, on the one hand, they remain discreetly silent about the differences between voluntary and involuntary patients and treatments, on the other, they implicitly endorse the traditional coercions of institutional psychiatry by putting down on paper such sentences as these:

> Some other kinds of corrective statements that commonly need to be made [in behavior therapy] are typified by the following:
>
> 1. You are not mentally ill and there is no chance of your going insane. . . . It is often sufficient to express reassurance in an authoritatively dogmatic way. . . . It must be explained that however bad a neurosis becomes it is still not a psychosis; that psychoses show a clear inherited pattern not manifested in neurosis; that there is evidence of biochemical abnormality in the serum of some psychotics, while neurotics are indistinguishable from normals.[22]

Some people believe that the Jews are the Chosen People; others, that Jesus is the Son of God and is Himself a God; and if Wolpe and Lazarus want to believe what I have quoted in the preceding paragraph, I see no reason to object. After all, it is precisely because they believe and preach those statements that they have been the high priests of behavior therapy.

Wolpe and Lazarus set these "authoritatively dogmatic"—the term is theirs—teachings in their ethical context when they address themselves directly to the moral issues of behavior therapy, where their conclusions are:

> Our discussion of the moral aspects of psychotherapy cannot be concluded without reference to an objection to behavior therapy that is frequently brought up at lectures and seminars, though we do not recall seeing it in print. The complaint is that the behavior therapist assumes a kind of omnipotence in that his methods demand the patient's complete acquiescence, and this, it is felt, denudes the patient of human dignity. The truth is that the grade of acquiescence required

22. J. Wolpe and A. A. Lazarus, *Behavior Therapy Techniques: A Guide to the Treatment of the Neuroses* (New York: Pergamon Press, 1966), p. 19.

> is the same as in any other branch of medicine or education. Patients with pneumonia are ready to do what the medical man prescribes, because he is the expert. The same is the case when psychotherapy is the treatment required.[23]

In short, Wolpe and Lazarus admit—indeed proudly proclaim—that their model for their own therapeutic behavior is the medical man who prescribes treatment for pneumonia.

Leonard Ullmann and Leonard Krasner, both prominent workers in the behavior-therapy movement, have considered specifically the ways in which their views differ from mine. Repeating and remarking on their comments should help to further clarify the issues set before us.

Ullmann briefly summarizes my views on autonomous psychotherapy,[24] cites my statement that "it is the autonomous psychotherapist's responsibility to keep an impenetrable wall between the therapeutic situation and the patient's real life,"and then comments: "The first difference in point of view is that behavior therapy deals with real-life behavior. Work in the home, classroom, ward, and the like facilitates generalization and fosters the changes in behavior which are the target of behavior therapy."[25]

There is a misunderstanding or misrepresentation here between what I mean by "real life" and what Ullmann says I mean by it. I mean quite simply that the therapist must not exert any power outside the consulting room for or against the patient. For example, the therapist may discuss the draft with his patient but may not give him a letter to take to his draft board, or he may discuss suicide with the patient but may not commit him to a hospital to prevent it. In other words, in autonomous psychotherapy the relationship between the therapist and the patient is like that between an architect and the workmen who actually build a house. In each case, the former, no less than the latter, deals with very real things, but he

23. Ibid., p. 23.

24. See my *The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy* (New York: Basic Books, 1964).

25. L. P. Ullmann, "Behavior Therapy as Social Movement," in C. M. Franks, ed., *Behavior Therapy: Appraisal and Status* (New York: McGraw-Hill, 1969), p. 513.

deals with them on a verbal or symbolic level—the architect designs a building but does not himself pour concrete. Similarly, the therapist talks about marriage and divorce, conformity and deviance, but does not—and must not—himself make the patient do anything.

In Ullmann's hands my distinctions between the symbolic and the behavioral levels, and between the power of language and law, are transformed into a dichotomy between real and unreal behaviors. Unlike me, behavior therapists, says Ullmann, deal with real-life behavior. By that Ullmann means the actual involvement of behavior therapists in the day-to-day life of the patient. He never uses the word *power*, so it remains unarticulated—though by no means unclear—who will control whom.

The second difference that Ullmann finds between my views and those of behavior therapists is even more astonishing. Let me quote it before commenting on it:

> A second point of difference is the matter of ability to make choices. Because there is only heredity and environment, one must accept the position that any given act, if all antecedents were known, would be determined and completely predictable. . . . In this regard, the individual has no "choice." . . . The concept of choice also poses a logical problem, that of an endless regress. If a person makes a "free choice," what chooses the choice, and what chose that which chooses? Behavior is not completely predictable or determined from the viewpoint of the observer whether that observer is the psychologist or the person himself. The degree of determinism, then, is a function of the theoretical level, and to a lesser extent, of the observer's knowledge. It is paradoxical that the very unpredictability of his behavior may lead the patient to presume that it is determined. . . . There may be real comfort in being powerless and not responsible.[26]

Surely, this is not the place to rehash the controversy over freedom and determinism. I shall therefore try to limit myself to offering a few simple observations.

In the first place, Ullmann is inconsistent even in just this passage (as well as in the whole essay). At the beginning, he asserts that behavior is determined—that people do not make choices. At the end, however, he castigates people who claim that they are

26. Ibid., p. 528.

powerless and not responsible. Although Ullmann qualifies his assertion by saying "in this regard, the individual has no 'choice,' " the individual does have a choice, since "in this regard" refers to conditions that can never be realized. Indeed, Ullmann then explains that "the skill of the therapist is directed toward having the patient make the 'right' choice." Yet only a few pages later he writes: "If the therapist believed in freedom of choice, he could solve this problem. The point of the previous section is that he cannot believe in freedom of choice."[27]

Does Ullmann mean that the therapist *cannot* believe in freedom of choice or that he *must not* believe in it? Obviously, he can believe in it. I do, and I can hardly imagine that I am the only one in the whole world who does. I must confess that I find Ullmann's reasoning and use of language dismaying.

Krasner too considers my position on the ethics of psychotherapeutic influencing, and he, even more sharply than Ullmann, contrasts it with that of the behavior therapists. He joins the issue that I long ago suggested was one of the basic moral premises of psychotherapy—namely, whose agent is the therapist? My view is that the so-called therapist may in fact be the agent of countless individuals and institutions, and that when there are conflicts between them, he must choose whom he proposes to serve. Furthermore, I insist that insofar as the therapist proposes to be a healer, he must be the agent of his patient or client; and that insofar as he proposes to be the agent of society (or of any other individual or group in conflict with the ostensible patient), he ought to recognize, and make explicit, that he functions as the patient's adversary and not as his ally.[28] Here is the way Krasner deals with these issues:

> If it is true that the therapist or modifier of behavior can bring about specified changes in behavior in an individual, on whose behalf is he acting? For whom is the new behavior "good," or desirable, or valuable—for the client, for the therapist, or for society? . . . I could weasel out of this dilemma by some kind of compromise; I could say that I have drawn the issue too sharply, that life is rarely clear-cut,

27. Ibid., pp. 514, 519.
28. See *The Myth of Mental Illness.*

and that the decision is up to the patient. Yet I will not try to avoid this issue and will take a stand that *the therapist is always society's agent.* Szasz takes an apparently opposite point of view in arguing that an individual should have absolute choice over his own behavior, including self-destruction if he so desires. [Italics added[29].]

It would seem from this passage that Krasner is willing to commit the behavior therapist to be an enforcer of social norms and values. However, he declares that that is not what he intends:

Does this mean that I am developing a picture of a behavior modifier defending the social status quo. . . ? Not at all; in fact, I refer to the view of the therapist himself as an instrument of social change, a modifier of social institutions. In effect the therapist, society's agent, helps change individual behavior and also social institutions themselves.[30]

Sensing the inconsistencies in the views he is propounding, Krasner tries—not very successfully—to resolve them:

It may look as if behavior modifiers are inconsistent in their view of the relation between society and the individual; in one instance they are agents of society, in the other they denounce society for its rejection of the individual. But these views complement each other. . . . The therapist represents society, but it is a society which is not punitive but rather seeks ways to supply maximum positive social reinforcement to the individual. . . . The good society is one in which all people are positive social reinforcers. The important value is to behave so as to please others and to contribute (as assessed by others) to the general welfare of all men—society. . . . Individuality as unusual, creative, exciting, even unpredictable behaviors elicits positive reinforcement in others, if the behaviors have a social utility, if they are "good" behaviors.[31]

Krasner's whole argument is so weak that I will let most of it speak for itself. His last sentence, however, is so obscenely false that it requires comment. The unusual, creative individual, Krasner declares, "elicits positive reinforcement in others." Socrates and Jesus,

29. L. Krasner, "Behavior Modification—Values and Training: The Perspective of a Psychologist," in Franks, ed., *Behavior Therapy*, pp. 541–542.
30. Ibid., p. 542.
31. Ibid., pp. 543–544.

Spinoza and Semmelweis, would have been interested in this social psychological law. What is one to say when in our day—when perhaps the single most powerful human motive is envy—one of the most prominent American psychologists and behavior therapists asserts that "good" (the quotes are his) behavior elicits positive reinforcement in others? Is this a fatuous tautology or a horrifying assent to Maoism? Either way, I think Krasner here damages the cause of behavior therapy far more than even I would want to.

In the end, it seems to me that behavior therapists cannot easily escape from their own pragmatic strictures, in particular from their own contention that what counts is not what clients or patients say, but what they do: *mutatis mutandis*, what counts is not what behavior modifiers or therapists say, but what they do. Judged by this criterion, behavior therapists are condemned, in my eyes at least, by their uncritical acceptance of the semantic and social consequences of the medicalization of human problems and by their self-serving imposition of behavioral interventions on captive clients. I say this not because I am against behavior therapy, but because I am against therapeutic coercion.

There is, in my mind, an important distinction between not liking something and being opposed to it. I do not like behavior therapy, but I am not opposed to it. I might explain that further by restating what I think behavior modifiers actually do.

Politically speaking, if the behavior therapist has actual—legally legitimized and enforceable—power over the client, then he relieves him of his symptoms in much the same way that the tax collector relieves the citizen of his money. If, on the other hand, he has no such power and his authority over the client derives from the client's own desire for dependency and protection, then the behavior therapist relieves him of his symptoms in much the same way that a church relieves its members of their money.

Psychologically speaking, insofar as in behavior therapy a person is *made* to do something he is afraid to do and hence does not want to do, one of two things must apply—coercion or mock coercion. If the therapist has real power over the patient—for example, if he is a committed mental patient and the therapist has legal authority to "treat" him—then behavior therapy is simply one of the count-

less ways in which a person who possesses power controls the conduct of another who does not. If, on the other hand, the therapist has no real power over the patient—for example, if the patient is a fee-paying client in a psychologist's private office—then behavior therapy is one of the countless ways in which two persons enact scenes of mock coercion, one of the participants pretending to control, the other pretending to be controlled, and both pretending to believe the other's pretending.

Whether we regard either or both or neither of these uses of behavior therapy as virtuous or wicked will depend, in general, on our ethics and politics and, in particular, on our loyalty, hostility, or indifference to behavior therapy as a psychiatric-psychological method and mystique.

I believe that in the mental-health field, no less than in medicine, our actions should be informed and governed by an ancient Latin maxim and by a fresh amplification of it. The old maxim is *Caveat emptor* ("Let the buyer beware"). The extension of it that I suggest is *Optet emptor* ("Let the buyer choose").

My emphasis is thus on letting the client or patient choose—and benefit or suffer from the consequences of his choice. That is an ethical, not a technical, standard. Hence, my views differ from those of the psychiatric and psychological technicians, whose standard Cole articulates when he declares, "The issue is not whether behavior modification is bad but whether it works."[32] In my view, the issue is not whether behavior modification works but whether the client wants it.

As a rule, a direct confrontation between the technical and the ethical approaches to human affairs is quite unproductive. Each party is interested in something else. The result is an impasse, but perhaps it is an impasse worth restating clearly. The technicist wants to know whether a certain method of intervention in human affairs works or not. It is of course his intervention, and he decides whether it works or not. If it does, he considers it morally good, and it makes no difference what the recipient of his intervention thinks about it.

32. J. O. Cole, "What's in a Word? Or Guilt by Definition, Part I," *Medical Tribune*, June 11, 1975, p. 22.

From that posture, involuntary medical or psychiatric interventions appear good and justifiable, since they are for the benefit of the patient or client. The ethicist wants to know whether a certain method of intervention in human affairs is contracted or coerced. If it is contracted, he concludes that it benefits both parties, although it is likely to be more desirable or necessary for the party that seeks the contract than for the one that accedes to it. If it is coerced, he concludes that it helps the coercer and harms the coerced. From that posture, involuntary medical or psychiatric interventions appear bad and unjustifiable, since they subvert the moral mandate of the helping professions.

Although there may, in actual practice, be a bit more to the moral subtleties of actual psychiatric encounters than is entailed in the foregoing dichotomy, the positions I have pictured point to two important and easily identifiable social roles and personal styles. And the twain shall never meet.

6

The Ethics of Suicide

In 1967, an editorial in the *Journal of the American Medical Association* declared that "the contemporary physician sees suicide as a manifestation of emotional illness. Rarely does he view it in a context other than that of psychiatry."[1] It was implied, the emphasis being the stronger for not being articulated, that to view suicide in this way is at once scientifically accurate and morally uplifting. I shall try to show that it is neither and that, instead, this perspective on suicide is both erroneous and evil—erroneous because it treats an act as if it were a happening and evil because it serves to legitimize psychiatric force and fraud by justifying it as medical care and treatment.

It is difficult to find a "responsible" medical or psychiatric authority today that does not regard suicide as a medical, and specifically as a mental-health, problem.

For example, Ilza Veith, the noted medical historian, declares that "the act [of suicide] clearly represents an illness and is, in fact, the least curable of all diseases." Of course, it was not always thus. Veith herself remarks that "it was only in the nineteenth century that suicide came to be considered a psychiatric illness."[2]

1. Editorial, "Changing Concepts of Suicide," *Journal of the American Medical Association* 199 (March 1967): 162.
2. I. Veith, "Reflections on the Medical History of Suicide," *Modern Medicine*, August 11, 1969, p. 116.

If so, we might ask, What was discovered in the nineteenth century that required removing suicide from the category of sin or crime and putting it into that of illness? The answer is, nothing. Suicide was not *discovered* to be a disease; it was *declared* to be one. The renaming and reclassifying as sick of a whole host of behaviors formerly considered sinful or criminal is the very foundation upon which modern psychiatry rests. I have discussed and documented the process of reclassification elsewhere.[3] Here it should suffice to show how it affects our views on suicide. I shall do so by citing some illustrative opinions.

Bernard R. Shochet, a psychiatrist at the University of Maryland, asserts that "depression is a serious systemic disease, with both physiological and psychological concomitants, and suicide is a part of this syndrome." This claim, as we shall see again and again, serves mainly to justify subjecting the so-called patient to involuntary psychiatric interventions, especially involuntary mental hospitalization: "If the patient's safety is in doubt, psychiatric hospitalization should be insisted on."[4]

Harvey M. Schein and Alan A. Stone, psychiatrists at Harvard University express the same views. "Once the patient's suicidal thoughts are shared," they write, "the therapist must take pains to make clear to the patient that he, the therapist, considers suicide to be a maladaptive action, irreversibly counter to the patient's sane interests and goals; that he, the therapist, will do everything he can to prevent it; and that the potential for such an action arises from the patient's illness. It is equally essential that the therapist believe in the professional stance; if he does not he should not be treating the patient within the delicate human framework of psychotherapy."[5]

It seems to me that if a psychiatrist considers suicide a "maladaptive action," he himself should refrain from engaging in such

3. See my *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper & Row, 1974) and *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970).

4. B. R. Shochet, "Recognizing the Suicidal Patient," *Modern Medicine*, May 18, 1970, pp. 117, 123.

5. H. M. Schein and A. A. Stone, "Psychotherapy Designed to Detect and Treat Suicidal Potential," *American Journal of Psychiatry* 125 (March 1969): 1248–1249.

action. It is not clear why the patient's placing confidence in his therapist to the extent of confiding his suicidal thoughts to him should ipso facto deprive the patient from being the arbiter of his own best interests. Yet this is exactly what Schein and Stone insist on. And again the thrust of the argument is to legitimize depriving the patient of a basic human freedom—the freedom to change therapists when patient and doctor disagree on therapy: "The therapist must insist that patient and physician—*together*—communicate the suicidal potential to important figures in the environment, both professional and family. . . . Suicidal intent must not be part of therapeutic confidentiality." And later, they add: "Obviously this kind of patient must be hospitalized. . . . The therapist must be prepared to step in with hospitalization, with security measures, and with medication. . . .[6] Many other psychiatric authorities could be cited to illustrate the current unanimity on this view of suicide.

Lawyers and jurists have eagerly accepted the psychiatric perspective on suicide, as they have on nearly everything else. An article in the *American Bar Association Journal* by R. E. Schulman, who is both a lawyer and a psychologist, is illustrative. Schulman begins with the premise that no one could claim that suicide is a human right: "No one in contemporary Western society," he writes, "would suggest that people be allowed to commit suicide as they please without some attempt to intervene or prevent such suicides. Even if a person does not value his own life, Western society does value everyone's life."[7]

I should like to suggest, as others have suggested before me, precisely what Schulman claims no one would suggest. Furthermore, if Schulman chooses to believe that Western society—which includes the United States with its history of slavery, Germany with its history of National Socialism, and Russia with its history of Communism—really "does value everyone's life," so be it. But to accept that assertion as true is to fly in the face of the most obvious and brutal facts of history.

Moreover, it is mischievous to put the matter as Schulman phrases it. For it is not necessarily that the would-be suicide "does not value

6. Ibid., pp. 1249, 1250.

7. R. E. Schulman, "Suicide and Suicide Prevention: A Legal Analysis," *American Bar Association Journal* 54 (September 1968): 862.

his own life" but rather that he may no longer want to live it as he must and may value ending it more highly than continuing it.

Schulman, however, has abandoned English for newspeak. That is illustrated by his concluding recommendation regarding treatment. "For those," he writes, "who complete the suicide, that should be the finis as the person clearly intended. For those unsuccessful suicides, the law should uniformly ensure that these people be brought to the attention of the appropriate helping agency. This is not to say that help should be forced upon these people but only that it should be made available. . . ."[8] It is sobering to see such writing in the pages of the *American Bar Association Journal*; it calls to mind what has been dubbed the Eleventh Commandment—"Don't get caught!"

The amazing success of the psychiatric ideology in converting acts into happenings, moral decisions into medical diseases, is thus illustrated by the virtually unanimous acceptance in both medical and legal circles of suicide as an "illness" for which the "patient" is not responsible. If, then, the patient is not responsible for it, someone or something else must be. Psychiatrists and mental hospitals are thus often sued for negligence when a depressed patient commits suicide, and they are often held liable.

How deeply the psychiatric perspective on suicide has penetrated into our culture is shown by the following two cases: in the first, a woman attributed her own suicide attempt to her physician; in the second, a woman attributed her husband's suicide to his employer.

A waitress was given diet pills by a physician to help her lose weight. She then attempted suicide, failed, and sued the physician for giving her a drug that "caused" her to be emotionally upset and attempt suicide. The court held for the physician. But the fact remains that both parties, and the court as well, accepted the underlying thesis—which is what I reject—that attempted suicide is *caused* rather than *willed*. The physician was held not liable, not because the court believed that suicide was a voluntary act, but because the plaintiff failed to show that the defendant was negligent in the "treatment" he prescribed.[9]

8. Ibid.

9. *Fontenot* v. *Tracy*, Super. Ct., San Diego Co., Docket No. 309672 (Cal., 1970); cited in *The Citation* 21 (May 1970): 17–18.

In a similar case, the widow of a ship captain sued the shipping line for the suicide of her husband. She claimed that the captain leaped into the sea because "he was in the grip of an uncontrollable impulse at the time" and that the employer was responsible for that "impulse." Before the case could come to trial, the ship's doctor tried to assert the physician-patient privilege and declined to testify. The court ruled that in a case of this type there was no such privilege under admiralty law. I don't know whether or not the plaintiff has ultimately succeeded in her suit. But again, whatever the outcome, the proposition that suicide is an event brought about by certain antecedent *causes* rather than that it is an act motivated by certain *desires* (in this case, perhaps the ship captain's wish not to be reunited with his wife) is here enshrined in the economics, law, and semantics of a civil suit for damages.[10]

When a person decides to take his life and when a physician decides to frustrate him in this action, the question arises, Why should the physician do so?

Conventional psychiatric wisdom answers, Because the suicidal person suffers from a mental illness whose symptom is his desire to kill himself; it is the physician's duty to diagnose and treat illness; ergo, he must prevent the patient from killing himself and at the same time must treat the underlying disease that causes the patient to wish to do away with himself. That looks like an ordinary medical diagnosis and intervention. But it is not. What is missing? Everything. The hypothetical suicidal patient is not ill: he has no demonstrable bodily disorder (or if he does, it does not cause his suicide); he does not assume the sick role—he does not seek medical help. In short, the physician uses the rhetoric of illness and treatment to justify his forcible intervention in the life of a fellow human being—often in the face of explicit opposition from his so-called patient.

I object to that as I do to all involuntary psychiatric interventions, and especially involuntary mental hospitalization. I have de-

10. *Reid* v. *Moore-McCormack Lines, Inc.*, Dist. Ct., N.Y., Docket No. 69 Civ. 1259 (D.C., N.Y., January 15, 1970); cited in *The Citation* 21 (May 1970): 31.

tailed my reasons why elsewhere and need not repeat them here.[11] For the sake of emphasis, however, let me state that I consider counseling, persuasion, psychotherapy, or any other voluntary measure, especially for persons troubled by their own suicidal inclinations and seeking such help, unobjectionable, and indeed generally desirable. However, physicians and psychiatrists are usually not satisfied with limiting their help to such measures—and with good reason: from such assistance the individual may gain not only the desire to live, but also the strength to die.

However, we still have not answered the question posed above, Why should a physician frustrate an individual from killing himself? Some might answer, Because the physician values the patient's life, at least when the patient is suicidal, more highly than does the patient himself. Let us examine that claim. Why should the physician, often a complete stranger to the suicidal patient, value the patient's life more highly than does the patient himself? He does not do so in medical practice. Why then should he do so in psychiatric practice, which he himself insists is a form of medical practice? Let us assume that a physician is confronted with an individual suffering from diabetes or heart failure who fails to take the drugs prescribed for his illness. We know that that can happen, and we know what happens in such cases—the patient does not do as well as he might, and he may die prematurely. Yet it would be absurd for a physician to consider, much less to attempt, taking over the conduct of such a patient's life, confining him in a hospital against his will in order to treat his disease. Indeed, an attempt to do so would bring the physician into conflict with both the civil and the criminal law. For, significantly, the law recognizes the medical patient's autonomy despite the fact that, unlike the suicidal individual, he suffers from a real disease and despite the fact that, unlike the nonexistent disease of the suicidal individual, his illness is often easily controlled by simple and safe therapeutic procedures.

Nevertheless, the threat of alleged or real suicide, or so-called dangerousness to oneself, is everywhere considered a proper ground

11. See my *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963) and *Ideology and Insanity*, esp. chaps. 9 and 12.

and justification for involuntary mental hospitalization and treatment. Why should that be so?

Surely, the answer cannot be that the physician values the suicidal individual's life more highly than does that individual himself. If he really did, he could prove it—and indeed would have to prove it—by the means we usually employ to judge such matters. Here are some examples.

Because of famine, a family is starving: the parents go without food and may perish so that their children might survive. A boat is shipwrecked and is sinking: the captain goes down with the ship so that his passengers might survive.

Were the physician sincere in his claim that he values the would-be suicide's life so highly, should we not expect him to prove it by some similar act of self-sacrifice? A person may be suicidal because he has lost his money. Does the psychiatrist give him his money? Certainly not. Another may be suicidal because he is alone in the world. Does the psychiatrist give him his friendship? Certainly not.

Actually, the suicide-preventing psychiatrist does not give anything of his own to his patient. Instead, he uses the claim that he values the suicidal individual's life more highly than that individual does himself to justify his self-serving strategies; the psychiatrist aggrandizes himself as a *suicidologist*—as if new words were enough to create new wisdoms—and he enlists the economic and police powers of the state on his own behalf, using tax monies to line his own pockets and to hire underlings to take care of his patient, and psychiatric violence to guarantee himself a patient upon whom to work his medical miracles.

Let me suggest what I believe is likely to be the most important reason for the profound antisuicidal bias of the medical profession. Physicians are committed to saving lives. How then should they react to people who are committed to throwing away their lives? It is natural for people to dislike, indeed to hate, those who challenge their basic values. The physician thus reacts, perhaps "unconsciously" (in the sense that he does not articulate the problem in these terms) to the suicidal patient as if the patient had affronted, insulted, or attacked him. The physician strives valiantly, often at the cost of his own well-being, to save lives; and here comes a person who not only does not let the physician save him but, *horribile*

dictu, makes the physician an unwilling witness to that person's deliberate self-destruction. That is more than most physicians can take. Feeling assaulted in the very center of their spiritual identity, some take to flight, while others counterattack.

Some physicians will thus avoid dealing with suicidal patients. That explains why many people who end up killing themselves have a record of having consulted a physician, often on the very day of their suicide. I surmise that those people go in search of help only to discover that the physician wants nothing to do with them. And in a sense it is right that it should be so. I do not blame the doctors. Nor do I advocate teaching them suicide prevention—whatever that might be. I contend that because physicians have a relatively blind faith in their lifesaving ideology—which, moreover, they often need to carry them through their daily work—they are the wrong people for listening and talking to individuals intelligently and calmly about suicide. So much for those physicians who, in the face of the existential attack that they feel the suicidal patient launches on them, run for their lives. Let us now look at those who stand and fight back.

Some physicians (and other mental-health professionals) declare themselves ready and willing to help not only suicidal patients who seek assistance, but all persons who are, or are alleged to be, suicidal. Since they too seem to perceive suicide as a threat, not just to the suicidal person's physical survival but to their own value system, they strike back and strike back hard. That explains why psychiatrists and suicidologists resort, apparently with a perfectly clear conscience, to the vilest means: they must believe that their lofty ends justify the basest means. Hence, we have the prevalent use of force and fraud in suicide prevention. The upshot of that kind of interaction between physician and patient is a struggle for power. The patient is at least honest about what he wants: to gain control over his life and death—by being the agent of his own demise. But the psychiatrist is completely dishonest about what he wants: he claims that he only wants to help his patient, but actually he wants to gain control over the patient's life in order to save himself from having to confront his doubts about the value of his own life. Suicide is medical heresy. Commitment and electroshock are the appropriate psychiatric-inquisitorial remedies for it.

Like politicians, psychiatrists must often choose between being popular and being honest; though they may strive valiantly to be both, they are not likely to succeed. There are good reasons why that should be so. Men need rules to live by. They need authority they can respect and that is capable of compelling conformity to rules. Hence, institutions, even institutions ostensibly devoted to the study of human affairs, are much better at articulating rules than at analyzing them. I shall illustrate the relevance of these remarks to our attitude toward suicide by citing the recent history of our attitudes toward contraception and abortion. For birth control and abortion, like suicide, are matters that touch on religion and law as well as on medicine and psychiatry.

Although it was widely practiced, birth control was regarded as vaguely reprehensible until well past the Second World War. Only in 1965 did the Supreme Court strike down as unconstitutional a Connecticut statute against the dissemination of birth-control information and devices.[12]

In 1959, I polled the opinion of members of the American Psychoanalytic Association on several topics, some pertaining to the moral aspects of psychoanalytic practices. Among the questions I asked was, "Do you believe that birth-control information should be unrestrictedly available to all persons eighteen years of age and over?" The questionnaire, which was to be returned unsigned, was sent to 752 psychoanalysts; 430, or 56 percent, replied. Thirty-four analysts, or 9 percent of those responding, asserted that they did *not* believe that adult Americans should have free access to birth-control information.[13]

In this connection, it is significant that only in 1964 did the House of Delegates of the American Medical Association approve a resolution endorsing the general availability of contraceptive information and measures. Until that time, the American Medical Association *opposed* free access by American adults to birth control information!

The story about abortion is similar. In my poll, I also asked, "Do you regard the legally restricted availability of abortion as socially

12. *Griswold* v. *Connecticut,* 381 U.S. 479 (1965).

13. T. S. Szasz and R. A. Nemiroff, "A Questionnaire Study of Psychoanalytic Practices and Opinions," *Journal of Nervous and Mental Diseases* 137 (September 1963): 209–221.

desirable?" Two hundred and two, or nearly 50 percent of the analysts who responded, opposed the repeal of legal restrictions on abortion. (Only seven analysts identified themselves as Roman Catholics.)[14]

In 1965, the year after the Committee on Human Reproduction of the American Medical Association recommended the resolution on contraception just mentioned, it introduced a proposal for more "liberal" abortion laws—that is, for laws expanding the medical and psychiatric grounds for therapeutic abortions. The House of Delegates refused to approve that recommendation. Without discussion or dissent, the delegates agreed that "it is not appropriate at this time for the American Medical Association to recommend the enactment of legislation in this matter."[15]

In 1970, after New York State removed abortion from the purview of the criminal law, the American Psychoanalytic Association issued its "Position Statement on Abortion" affirming that "We view a therapeutic abortion as a medical procedure to be agreed upon between a patient and her physician; and one which should be removed entirely from the domain of the criminal law."[16]

The point I am making here, and have been making for some time, is simply that contraception and abortion, and suicide too, are not medical but moral problems. To be sure, the procedure of aborting a pregnancy is surgical; but that makes abortion no more a medical problem than the use of the electric chair makes capital punishment a problem of electrical engineering. The question is, What is abortion—the killing of a fetus or the removal of a piece of tissue from a woman's body?

Likewise, it is undeniable that suicide, if successful, results in death. But if the suicidal act is regarded as a disease because it is the proximate cause of death, then all other acts or events—from highway traffic to avalanches, from poverty to war—that may also be the proximate causes of death would also have to be regarded as diseases. Just so, say the modern manufacturers of madness, the

14. Ibid., p. 214.

15. Quoted in my "The Ethics of Abortion," *The Humanist* 26 (September–October): 147.

16. American Psychoanalytic Association, "Position Statement on Abortion," May 7, 1970.

community psychiatrists and the epidemiologists of mental illness, who push tirelessly for a 100 percent incidence of mental illness.[17] I say all that is malicious nonsense.

In the non-Communist West, opposition to suicide, like opposition to contraception and abortion, rests on religious grounds. According to both the Jewish and Christian religions, God created man, and man can use himself only in the ways permitted by God. Preventing conception, aborting a pregnancy, or killing oneself are, in this imagery, all sins: each is a violation of the laws laid down by God or by theological authorities claiming to speak in his name.

But modern man is a revolutionary. Like all revolutionaries, he likes to take away from those who have and to give to those who have not, especially himself. He has thus taken man from God and given him to the state (with which he often identifies more than he knows). That is why the state gives and takes away so many of our rights and why we consider the arrangement whereby the state stands *in loco parentis* to the citizen-child so natural. (Hence, the linguistic abomination of referring to the abolition of prohibittions, say, against abortion or off-track betting, as the *legalizing* of these acts.)

But this arrangement leaves suicide in a peculiar moral and philosophical limbo. For if a man's life belongs to the state (as it formerly belonged to God), then surely suicide is the taking of a life that belongs not to the taker but to the state.

The dilemma this simplistic transfer of body ownership from God to state raises derives from the fundamental difference between a religious and a secular world view, especially when the former entails a vivid conception of a life after death and the latter does not (or even emphatically repudiates it). More particularly, the dilemma derives from the problem of how to punish successful suicide. Traditionally, the Roman Catholic Church punished it by depriving the suicide of burial in consecrated ground. As far as I know, that practice is now so rare in the United States as to be prac-

17. See my *The Myth of Mental Illness*, esp. pp. 38–39.

tically nonexistent. Suicides are now given a Catholic burial, as they are routinely considered to have taken their lives while insane.

The modern state, with psychiatry as its secular-religious ally, has no comparable sanction to offer. Could that be one of the reasons why it punishes so severely—so very much more severely than did the church—the unsuccessful suicide? For I consider the psychiatric stigmatization of people as "suicidal risks" and their incarceration in psychiatric institutions a form of punishment, and a very severe one at that. Indeed, although I cannot support the claim with statistics, I believe that accepted psychiatric methods of suicide prevention often aggravate rather than ameliorate the suicidal person's problems. As one reads of the tragic encounters with psychiatry of such people as James Forrestal, Marilyn Monroe, or Ernest Hemingway, one gains the impression that they felt demeaned and deeply hurt by the psychiatric indignities inflicted on them and that as a result of those experiences they were even more desperately driven to suicide. In short, I am suggesting that coerced psychiatric interventions may increase, rather than diminish, the suicidal person's desire for self-destruction.

But there is another aspect of the moral and philosophical dimensions of suicide that must be mentioned here. I refer to the growing influence of the modern idea of individualism, especially the conviction that human beings have certain inalienable rights. Some people have thus come to believe (or perhaps only to believe that they believe) that they have a right to life, liberty, and property. That makes for some interesting complications for the modern legal and psychiatric stand on suicide.

The individualistic position on suicide might be put thus: A person's life belongs to himself. Hence, he has a right to take his own life, that is, to commit suicide. To be sure, this view recognizes that a person may also have a moral responsibility to his family and others and that, by killing himself, he reneges on these responsibilities. But those are moral wrongs that society, in its corporate capacity as the state, cannot properly punish. Hence, the state must eschew attempts to regulate such behavior by means of formal sanctions, such as criminal or mental-hygiene laws.

The analogy between life and property lends further support to

this line of argument. Having a right to property means that a person can dispose of it even if in so doing he injures himself and his family. A man may give, or gamble, away his money. But, significantly, he cannot be said to steal from himself. The concept of theft requires at least two parties—one who steals and another from whom something is stolen. There is no such thing as *self-theft*. The term *suicide* blurs that very distinction. The history of the term indicates that suicide was long considered a type of homicide. Indeed, when a person wants to condemn suicide, he calls it *self-murder*. Schulman, for example, writes, "Surely, self-murder falls within the province of the law."[18]

Some of the results of my poll are of interest in this connection. In it, I asked two questions about suicide. One was, "In your opinion, how often is a *successful* suicide (in contemporary Western democracies) a rational act motivated by the wish to die?" The other was the same question about *unsuccessful* suicide. Of the 430 analysts responding, only 2, or 0.5 percent, thought that successful suicide was always a rational act, and only a single analyst, or 0.25 percent, thought that unsuccessful suicide was. There were only 2 more respondents who thought that successful suicide was a rational act in over 75 percent of the cases and 2 who thought that unsuccessful suicide was a rational act in over 75 percent of the cases. The overwhelming number of respondents, approximately 80 percent for both questions, expressed the view that both successful and unsuccessful suicide is either never a rational act or is such in less than 5 percent of all cases.[19] In short, psychoanalysts came down squarely for viewing suicidal behavior, attempted or completed, as something irrational—that is, a symptom of mental illness. It is upon such confused and confusing images of suicide that our contemporary psychiatric practices of suicide prevention are based.

The suicidologist has a literally schizophrenic view of the suicidal person: he sees him as two persons in one, each at war with the other. One half of the patient wants to die; the other half wants to live. The former, says the suicidologist, is wrong; the latter is right. And he proceeds to protect the latter by restraining the former. How-

18. Schulman, "Suicide and Suicide Prevention," p. 857.
19. Szasz and Nemiroff, "Questionnaire," p. 214.

ever, since these two people are, like Siamese twins, one, he can restrain the suicidal half only by restraining the whole person.

The absurdity of the medical-psychiatric position on suicide does not end here. It ends in extolling mental health and physical survival over every other value, particularly individual liberty. In regarding the desire to live, but not the desire to die, as a legitimate human aspiration, the suicidologist stands Patrick Henry's famous exclamation, "Give me liberty, or give me death!" on its head. In effect, he says, "*Give him* commitment, *give him* electroshock, *give him* lobotomy, *give him* lifelong slavery, but *do not let him choose* death!" By so radically illegitimizing another person's (but not his own) wish to die, the suicide-preventer redefines the aspiration of the Other as not an aspiration at all: the wish to die becomes something an irrational, mentally diseased being *displays* or something that *happens* to a lower form of life. The result is a far-reaching infantilization and dehumanization of the suicidal person.

For example, Phillip Solomon writes that physicians "must protect the patient from his own [suicidal] wishes"; while to Edwin Schneidman, "Suicide prevention is like fire prevention."[20] Solomon thus reduces the would-be suicide to the level of an unruly child, while Schneidman reduces him to the level of a tree! In short, the suicidologist uses his professional stance to illegitimize and punish the wish to die.

There is of course nothing new about any of this. Do-gooders have always opposed personal autonomy or self-determination. In "Amok," written in 1931, Stefan Zweig puts these words into the mouth of his protagonist:

> Ah, yes, "It's one's duty to help." That's your favorite maxim, isn't it? . . . Thank you for your good intentions, but I'd rather be left to myself. . . . So I won't trouble you to call, if you don't mind. Among the "rights of man" there is a right which no one can take away, the right to croak when and where and how one pleases, without a "helping hand."[21]

20. P. Solomon, "The Burden of Responsibility in Suicide," *Journal of the American Medical Association* 199 (January 1967): 324; E. Schneidman, "Preventing Suicide," *Bulletin of Suicidology* (1968): 20.

21. S. Zweig, "Amok," in his *The Royal Game* (New York: Viking, 1944), p. 137.

But that is not the way the scientific psychiatrist or suicidologist sees the problem. He might agree (I suppose) that in the abstract man has the right Zweig claimed for him. But in practice suicide (so he says) is the result of insanity, madness, mental illness. Furthermore, it makes no sense to say that one has a right to be mentally ill, especially if the illness is one that, like typhoid fever, threatens the health of other people as well. In short, the suicidologist's job is to try to convince people that wanting to die is a disease.

Here is how Ari Kiev, director of the Cornell Program in Social Psychiatry and its suicide prevention clinic, does it:

> We say [to the patient], look, you have a disease, just like the Hong Kong flu. Maybe you've got the Hong Kong depression. First, you've got to realize you are emotionally ill. . . . Most of the patients have never admitted to themselves that they are sick.[22]

This pseudomedical perspective is then used to justify psychiatric deceptions and coercions of the crudest sort. For example, here is the way, according to the *Wall Street Journal*, the Los Angeles Suicide Prevention Center operates. A man calls and says he is about to shoot himself. The worker asks for his address. The man refuses to give it.

> "If I pull it [the trigger] now I'll be dead," he [the caller] said in a muffled voice. "And that's what I want." Silently but urgently, Mrs. Whitbook [the worker] had signalled a co-worker to begin tracing the call. And now she worked to keep the man talking. . . . An agonizing 40 minutes passed. Then she heard the voice of a policeman come on the phone to say the man was safe.[23]

But surely, if this man was able to call the Suicide Prevention Center, he could have, had he wanted to, called for a policeman himself; but he did not. He was deceived by the center in the "service" he got. Evidently, those who practice in this way—and such medical deception is of course time honored—believe that the ends, at least in their case, justify the means.

I understand that this kind of deception is standard practice in suicide prevention centers, though it is often denied that it is. A

22. *The New York Times*, February 9, 1969.
23. *The Wall Street Journal*, March 6, 1969.

report about the Nassau County Suicide Prevention Service corroborates the impression that when the would-be suicide does not cooperate with the suicide-prevention authorities, he is confined involuntarily. "When a caller is obviously suicidal," we are told, "a Meadowbrook ambulance is sent out immediately to pick him up."[24]

One more example of the sort of thing that goes on in the name of suicide prevention should suffice. It is a routine story from a Syracuse newspaper about a potential suicide. The gist of it is all in one sentence: "A 28-year-old Minoa [a Syracuse suburb] man was arrested last night on a charge of violation of the Mental Health Law after police authorities said they spent two hours looking for him in a Minoa woods."[25] But why should the police look for such a man? Why not wait until he returns? Those are rhetorical questions. Our answers to them depend on, and reflect, our concepts of what it means to be a human being: That is the crux of the matter.

The crucial contradiction about suicide viewed as an illness whose treatment is a medical responsibility is that suicide is an action but is treated as if it were a happening. As I showed elsewhere, that contradiction lies at the heart of all so-called mental illnesses or psychiatric problems.[26] However, it poses a particularly acute dilemma for suicide, because suicide is the only fatal "mental illness."

Before concluding, I should like to restate briefly my views on the differences between diseases and desires and show that, by persisting in treating desires as diseases, we only end up treating man as a slave.

Let us take as our paradigm case of illness a skier who takes a bad spill and fractures an ankle. The fracture is something that has happened to him; he has not intended it to happen. (To be sure, he may have intended it, but that is another case.) Once it has happened, he will seek medical help and will cooperate with medical efforts to mend his broken bones. In short, the person and his fractured ankle are, as it were, two separate entities, the former acting on the latter.

24. See "Clinic Moves to Prevent Suicides in Suburbia," *Medical World News*, July 28, 1967, p. 17.
25. *Syracuse Post-Standard*, September 29, 1969.
26. *The Myth of Mental Illness.*

Let us now consider the case of the suicidal person. Such a person may also look upon his own suicidal inclination as an undesired, almost alien, impulse and seek help to combat it. If so, the ensuing arrangement between him and his psychiatrist is readily assimilated to the standard medical model of treatment: the patient actively seeks and cooperates with professional efforts to remedy his "condition." As I already noted, I have neither moral nor psychiatric objection to that arrangement. On the contrary, I wholly approve of it.

But as we have seen, that is not the only way, nor perhaps the most important way, that the game of suicide prevention is played. It is accepted medical and psychiatric practice to treat people for their suicidal desires against their will. And what exactly does that mean? It means something quite different from the involuntary (or nonvoluntary) treatment of a bodily illness that is often given as an analogy. For a fractured ankle can be set whether or not a patient consents to its being set. It can be done because setting a fracture is a *mechanical act on the body*. But preventing suicide—suicide being the result of human desire and action—requires a *political act on the person*. In other words, since suicide is an exercise and expression of human freedom, it can be prevented only by curtailing human freedom. That is why deprivation of liberty becomes, in institutional psychiatry, a form of treatment.

In the final analysis, the would-be suicide is like the would-be emigrant: both want to leave where they are and move elsewhere. The suicide wants to leave life and move on to death. The emigrant wants to leave his homeland and move on to another country.

Let us take the analogy seriously; after all, it is much more faithful to the facts than is the analogy between suicide and illness. A crucial characteristic that distinguishes open from closed societies is that people are free to leave the former but not the latter. The medical profession's stance on suicide is thus like the Communists' on emigration: the doctors insist that the would-be suicide survive, just as the Russians insist that the would-be emigrant stay home.

The true believer in Communism is convinced that in the Soviet Union everything belongs to the people and everything done is done for their benefit: anyone who would want to leave such a country must be mad—or bad. In either case, he must be prevented from

doing so. Similarly, the true believer in Medicine is convinced that, with modern science guarding their well-being, people have opportunities for a happy and healthy life such as they never had before: anyone who would want to leave such a life prematurely must be mad—or bad. In either case, he must be prevented from doing so.

In short, I submit that preventing people from killing themselves is like preventing people from leaving their homeland. Whether those who so curtail other people's liberties act with complete sincerity or with utter cynicism hardly matters. What matters is what happens—the abridgement of individual liberty, justified, in the case of suicide prevention, by psychiatric rhetoric; and, in the case of emigration prevention, by political rhetoric.

In language and logic, we are the prisoners of our premises, just as in politics and law we are the prisoners of our rulers. Hence, we had better pick them well. For if suicide is an illness because it terminates in death, and if the prevention of death by any means necessary is the physician's therapeutic mandate, then the proper remedy for suicide is indeed liberticide.

7

Language and Lunacy

I must confess that I am not sure any more what the term *humanism* means. I know, of course, that all of us here are humanists and that it is good to be a humanist. But frankly I am troubled by that sort of use of the term *humanism*—that is, by the fact that humanism implies an idea or ideal that no one—in his right mind, if I may put it that way—can be against. I think we should try to transcend humanism as a mere rhetoric of self-approbation and give it a stricter meaning.

Although you may accept the necessity of this task without further discussion, let me cite in support of my foregoing assertion the principal definitions of humanism offered by *Webster's Third New International Dictionary*: ". . . (2) devotion to human welfare: interest in or concern for man (3) a doctrine, set of attitudes, or way of life centered upon human interests and values: as (*a*) a philosophy that rejects supernaturalism, regards man as a natural object, and asserts the essential dignity and worth of man and his capacity to achieve self-realization through the use of reason and scientific method—called also *naturalistic humanism, scientific humanism* . . . (*c*) a philosophy advocating the self-fulfillment of man within the framework of Christian principles—called also *Christian humanism*. . . ."

The first three characterizations of humanism are so framed as to command nearly universal assent; why should anyone be opposed to a "concern for man"? The fourth definition narrows the field to

those who reject fundamentalistic religions; and the fifth, to those who embrace Christianity. None of them are of much help. Moreover, there are those who speak of *socialist humanism, existentialist humanism,* and so forth—each of those terms referring to views of the world, and of man in it, from the particular normative perspective of the speaker and his ethical system. The term *humanism* in most of those contexts and phrases is simply a tautology. That contention is supported by the fact that no one, to my knowledge, has ever advocated an ethic of inhumanism or has ever called himself an *inhumanist.*

All this points to the importance of language in coming to grips with what is humanism, or at least with what we want to say about it in such a way as to render both assent to it and dissent from it intelligible and, at least in principle, respectable.

Although the contemporary concept of humanism is shrouded in considerable confusion and controversy, the humanists of the past—particularly those of Athens and Rome, and of the Renaissance and the Enlightenment—are like stars in the firmament with whose aid we can steer our course through the troubled seas of modern ideologies. Moreover, although books—and, indeed, whole lives—have been devoted to the exploration and exposition of those bygone humanisms and humanists, it is fair to say that those great epochs and their representative thinkers shared one characteristic—namely, an abiding concern for language and, more specifically, a concern for individual freedom as expressed by clear and forthright speech and for self-restraint as expressed by the disciplined and aesthetic use of language. A few illustrations, to convey the spirit rather than the substance of this outlook on life, will have to suffice here.

"A slave," said Euripides, "is he who cannot speak his thought." The right of a citizen to say what he pleased was fundamental in Athens. The Greeks, Edith Hamilton tells us, "had no authoritative Sacred Book, no creed, no ten commandments, no dogmas. The very idea of orthodoxy was unknown to them."[1] This pervasive sense of

1. E. Hamilton, *The Greek Way to Western Civilization* (New York: New American Library, Mentor, 1958), p. 208.

spiritual freedom and responsibility enabled the Greeks to see the world clearly: hence their unsurpassed power as artists, whether in fashioning stones or words. In Rome, Cicero, Seneca, and Plutarch continued the Greek tradition of humanism, laying the foundations for the ground on which, fifteen centuries later, the Enlightenment humanists made their stand and from which they drew their initial sustenance. *"Homo res sacra homini"* ("Man is a sacred thing to man"), said Seneca, who, in his own life, labored to oppose the fraudulent rhetoric of demagogy with clear and simple speech.

The modern age and, with it, modern humanism were ushered in with the rediscovery of the ancient classics, with the struggles that accompanied the translations of the Bible into the "vulgar" European tongues, and with the reemphasis by the *philosophes* of the intimate connection between clear thought and clear speech.

Both classical and Renaissance humanists thus displayed deep concern not only for human freedom and dignity but also for the disciplined and honest use of language. The essential, perhaps even organic, unity between man and his language has been severed in the modern age, with many contemporary humanists displaying unconcern for language and many contemporary students of language displaying unconcern for humanism.

In proportion, then, as a person uses language poorly or well, he thinks poorly or well; and, accordingly, we tend to attribute a diminished or enhanced human stature to him. Children, uneducated people, foreigners, and madmen thus tend to be seen as possessing a diminished human stature; whereas novelists, playwrights, composers, philosophers, and scientists tend to be seen as possessing an enhanced human stature. I am not asserting that the proper or accomplished use of language is sufficient for qualifying a person as a humanist, but I am suggesting that it may be necessary for it.

In short, I believe there is a pressing need among contemporary humanists for a fresh emphasis on language; for although rationality, reasoning, and thinking occupy important positions in the modern humanist credo, language, writing, and speaking are conspicuous by their absence from it. But it is idle, or worse, to persist in characterizing people according to how they reason when all that we can observe is how they use language.

To illustrate and support my suggestion that there is a grave danger in connecting humanism with reason rather than with language, I have chosen the example of Eugen Bleuler's perception of certain of the inhabitants of insane asylums, whom he called *schizophrenics.* That perception is, as I shall try to show, gravely mistaken.

It might be best, before turning to Bleuler's views on schizophrenia, to state briefly the current, generally accepted definition. Schizophrenia is said to be a "mental disease whose principal manifestation or symptom is a disturbance of thinking."[2] And what is thinking? Here is how the author of one of the standard American textbooks of psychiatry defines it: "The joining of ideas one to another by imagining, conceiving, inferring, and other processes, and the formation of new ideas by these processes, constitute the function we know as thinking. . . . Thought is the most highly organized of psychobiological integrations."[3]

That sort of pretentious psychiatric jargon seeks to conceal the observable facts of speech behind the abstract concept of thought. Modern psychiatry has accepted the notion of thought as if it were like liver or kidney and has erected a complex system of psychopathology upon it. In that way, psychiatrists have generated a whole catalogue of "disorders of thinking," among which they list such things as incoherence, delusions, hypochondria, obsessions, and phobias. But the communications to which these terms refer (if they refer to anything at all and are not used simply to stigmatize people whose language-behavior does not differ noticeably from that of others) are disorders only in the sense that they offend the patient's relatives, "normal" people, or psychiatrists. My point—a point that has been made by others, especially since Freud and Jung—is that so-called mental patients do not talk gibberish. To be sure, sometimes they talk differently than others do. Sometimes they say things that offend others. In short, they speak—just as do you and I—though perhaps in accents and metaphors that we do not understand or, if we understand them, that we do not like.

2. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 2d ed. (Washington, D.C.: American Psychiatric Association, 1968), p. 33.

3. L. C. Kolb, *Noyes' Modern Clinical Psychiatry,* 7th ed. (Philadelphia: Saunders, 1968), p. 95.

I have tried to suggest some connections among the notions of thinking, reasoning, speaking, language, and being human. Since I am a psychiatrist (of sorts); since so-called schizophrenic persons have, because of the disease from which they allegedly suffer, been regarded as not fully human; and since that disease is said to be a disorder, above all else, of thinking, I think you will agree that it is appropriate if I attend more closely to that mysterious disease. However, since I consider the disease to be mythical or nonexistent, I cannot attend to it as if it existed in nature; [4] instead, I will consider the account given of it by its inventor, Eugen Bleuler.

In 1911, Bleuler published the monograph *Dementia Praecox, or the Group of Schizophrenias*, which made him famous. In it, he proposes the name *schizophrenia* for a "group of diseases" characterized by certain patterns of behavior and speech on the part of the patient whom Bleuler considered pathological. "I call dementia praecox 'schizophrenia,' " he wrote, "because . . . the 'splitting' of the different psychic functions is one of its most important characteristics."[5] Since no one has seen or will ever see a psychic function, split or unsplit, Bleuler here speaks metaphorically. Yet, as I shall show in a moment, when the alleged patient speaks metaphorically, Bleuler calls him schizophrenic.

But here, first, is Bleuler's own definition of schizophrenia:

> By the term "dementia praecox" or "schizophrenia" we designate a group of psychoses whose course is at times chronic, at times marked by intermittent attacks, and which can stop or retrograde at any state, but does not permit a full *restitutio ad integrum*. The disease is characterized by a specific type of alteration of thinking.[6]

That is how, in 1911, the earlier notion that lunatics are irrational is rehabilitated and given fresh scientific legitimacy: madness becomes schizophrenia, a disease characterized by disordered thinking.

One does not need to know any psychiatry but only to have some

4. See my "The Problem of Psychiatric Nosology," *American Journal of Psychiatry* 114 (November 1957): 405–413, and *Schizophrenia: The Sacred Symbol of Psychiatry* (New York: Basic Books, 1976).

5. E. Bleuler, *Dementia Praecox, or the Group of Schizophrenias*, trans. Joseph Zinkin (New York: International Uuniversities Press, 1950), p. 8.

6. Ibid., p. 9.

respect for the proper use of language to appreciate that the psychiatrist's *thinking* is like the physicist's *ether*; it is an abstraction created to talk about observable things, such as speaking and writing. Indeed Bleuler's book is full of illustrations of the utterances, pleas, letters, and other linguistic productions of so-called schizophrenic patients. And he himself offers numerous remarks about language, such as the following: "Blocking, poverty of ideas, incoherence, clouding, delusions, and emotional anomalies are expressed in the language of the patients. However, the abnormality does not lie in the language itself, but rather in its content." [7]

Bleuler goes to great effort to protect himself against creating the impression that in describing a schizophrenic patient he is merely describing someone who speaks oddly, or differently than he does, and with whom he, Bleuler, disagrees. He never ceases to emphasize that such is not the case—that the patient is sick and his linguistic behavior is only a symptom of his illness. Here is one of Bleuler's statements epitomizing this line of argument:

> The form of linguistic expression may show every imaginable abnormality, or be absolutely correct. We often find very convincing ways of speaking in intelligent individuals. At times, I was unable to convince all of my audience attending clinical demonstrations of the pathology of such severely schizophrenic logic.[8]

Bleuler's premise here precludes—and seems intended to preclude—questioning *whether* the person in question is sick. We are allowed to question only *how* he is sick—what sort of illness he has, what sort of pathology his thinking exhibits. To assent to that is, of course, to give away the game before beginning to play it.

Frequently, the only thing wrong (as it were) with the so-called schizophrenic is that he speaks in metaphors unacceptable to his audience, in particular to his psychiatrist. Sometimes Bleuler comes close to acknowledging that. For example, he writes that

> a patient says that he is being "subjected to rape," although his confinement in a mental hospital constitutes a different kind of violation of his person. To a large extent, *inappropriate figures of speech* are

7. Ibid., p. 147.
8. Ibid., p. 148.

> employed, particularly the word "murder" which recurs constantly for all forms of torment and in the most varied combinations. [Italics added.] [9]

Here we have a rare opportunity to see how language displays what is quintessentially human and at the same time to see how language may be used to deprive individuals of their humanity. When persons imprisoned in mental hospitals speak of *rape* and *murder*, they use inappropriate figures of speech that signify that they suffer from thought disorders; when psychiatrists call their prisons *hospitals*, their prisoners *patients*, and their patients' desire for liberty *disease*, the psychiatrists are not using figures of speech but are stating facts.

The remarkable thing about all of this is that Bleuler understood perfectly well, probably much better than do many psychiatrists today, that much of what appears strange or objectionable in schizophrenic language is the way such persons use metaphor. Nevertheless, he felt justified, on the ground of that fact and that alone, in regarding such persons as suffering from a disease—in the literal rather than metaphorical sense. "When one patient declares," writes Bleuler,

> that she is Switzerland, or when another wants to take a bunch of flowers to bed with her so that she will not awaken any more—these utterances seem to be quite incomprehensible at first glance. But we obtain a key to the explanation by virtue of the knowledge that these patients readily substitute similarities for identities and think in symbols infinitely more frequently than the healthy: that is, they employ symbols without any regard for their appropriateness in the given situation.[10]

Bleuler's explanation of these symptoms creates fresh problems for the psychiatrist, logician, humanist, and civil libertarian. For this now-classic psychiatric perspective presses these questions upon us: If what makes schizophrenic utterances symptoms is that they are incomprehensible, do they still remain symptoms after they are no longer incomprehensible? If the utterances are comprehensible, why confine those who utter them in madhouses? Indeed, why confine

9. Ibid., p. 151.
10. Ibid., p. 428.

persons even if their utterances are incomprehensible? These are the questions Bleuler never asks. Moreover, they are the questions that cannot be raised in psychiatry even today, for such queries expose the empires of psychiatry as being as devoid of visible diseases as a well-known emperor was of visible clothes.

Consider in this connection the woman patient who, Bleuler writes, " 'possesses' Switzerland; and in the same sense she says, 'I am Switzerland.' She may also say, 'I am freedom,' since for her Switzerland meant nothing less than freedom." According to Bleuler,

> The difference between the use of such phrases in the healthy and in the schizophrenics rests in the fact that in the former it is a mere metaphor, whereas for the patients the dividing line between direct and indirect representation has been obscured. The result is that they frequently think of these metaphors in a literal sense.[11]

The source of Bleuler's egocentric and ethnocentric fallacy is dramatically evident here. Would a Catholic psychiatrist writing in a Catholic country have expressed himself so cavalierly about the literalization of metaphor constituting the cardinal symptom of schizophrenia, the most malignant form of madness known to medical science? For what, from a Protestant point of view, is the Catholic doctrine of transubstantiation if not the literalization of a metaphor? *Mutatis mutandis*, I have argued that the psychiatric conception of mental illness is also a literalized metaphor.[12] The main difference in my view between these cardinal Catholic and psychiatric metaphors and the metaphors of so-called schizophrenic patients lies not in any linguistic or logical peculiarity of the respective symbols, but in their social legitimacy.

The main purpose of my foregoing remarks was to show that our intuitive judgment about other people's humanity made on the basis of whether they express themselves as we do is untrustworthy. Hence, this criterion of humanness must be repudiated by humanists. The change could, I think, be salutary: it might lead to a perspective on people at least as humane as is our perspective on animals and

11. Ibid., p. 429.

12. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper & Row, 1974), and "Mental Illness as a Metaphor," *Nature* 242 (March 1973): 305–307.

things. We do not demand that bees explain to us the language of insects or that Egyptian tablets explain to us the meaning of hieroglyphics, and we do not conclude that unless they can explain their languages to our satisfaction, they are incomprehensible or meaningless. Yet that is exactly what psychiatrists—and to a large extent everyone else—have done with respect to so-called mental patients: they insist that the patient give them an account of himself satisfactory to them—and if the patient fails to do so, they declare him to be ill and imprison him as insane.

Why do we not expect the same intellectual responsibility from ourselves when we face the riddle that the behavior of other people poses for us as we do when we face the riddle that the behavior of animals and things poses for us? Formerly, persons whose behavior was regarded as incomprehensibly wicked were called heretics and witches; now they are called mental patients. Who knows what they will be called tomorrow? Obviously, these behaviors are wicked only because they violate the core values of those in power, and they are incomprehensible only because those who ostensibly try to understand them in fact try not to and define them as incomprehensible and hence irrational.

In this connection, I would like to mention a paradox that has long struck me as bitterly ironic. In the field of animal behavior—now a large and growing discipline—workers often compare the communicative behavior of porpoises to those of people and call their signaling behavior language. In the earlier days of psychiatry—when the keepers of madmen were more correctly called mad-doctors and alienists—the keepers compared madmen to wild beasts and viewed the pleas of the insane as the squeals of caged animals. Today—when the keepers are medical scientists—psychiatrists compare the schizophrenic to the syphilitic and view his thought disorder as a manifestation of his brain disorder. The ethologist may thus be said to have a burning passion for humanizing animals and the psychiatrist for dehumanizing persons.

My foregoing remarks are pertinent to the concerns of humanists not only because they throw fresh light on the relations between how people use language and how other people judge them, as more or less sane, or more or less human, but also because they throw

fresh light on the dual function of language, especially in human relations—that is, for understanding people and for controlling them. This dual function of language in human relations stands in sharp contrast to the singular function of language in relation to animals and things: in our relations with the nonhuman world, we use language only for understanding and employ some sort of direct—nonverbal, nonsymbolic—action for control.[13] The upshot is that we often claim that we want to understand another person when in fact we want to control him. Indeed, it is when we most want to control others that we usually make two contradictory claims about them—namely, that their behavior is incomprehensible and that we understand their behavior better than they understand it themselves. We should be skeptical of such claims whether they are offered by psychiatrists or psychologists, psychoanalysts or psychohistorians—our newest breed of psychoassassins, who, of course, consider themselves to be our humanists *par excellence.* Faced with such explanations and explainers, we should ask, *Cui bono?* Who benefits from such explanations? What is the relationship between subject and explainer? Are they friends or foes? Does the subject want to be an object of explanation at all? For it is obvious that explaining a person's behavior against his will, and explaining it when one holds him in contempt, is, albeit ostensibly an explanation, actually a metaphorical confinement: such an explanation confines by means of a contemptuous and degrading imagery, just as banishment, prison, and the gallows confine by means of degrading and destructive action.

The struggle for human liberty and dignity is now being waged on many fronts and in many different ways. As humanists—as linguistic humanists, if I may suggest a tentative self-description some of us might find fitting—we could, and should, be in the vanguard of those whose weapons are pens, not swords; typewriters and books, not demonstrations and bombs. That means that we must defend human rights because the victims are human beings. If you find that assertion contrived or opaque, may I remind you that it is currently popular for humanists and civil libertarians to champion

13. See my *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970), pp. 190–217.

the "rights of the mentally ill" and the rights of other victimized groups such as homosexuals, drug addicts, blacks, women, and so forth. From the point of view I am trying to articulate, all that is a grave mistake. We should reject slogans such as "protecting the rights of the mentally ill" (and of other victimized groups); instead, we should protect the rights of people to reject being called or categorized as mentally ill (or anything else) against their will (except as part of the process of the administration of the criminal law). In other words, we should stand steadfast for the right of men and women to reject those involuntary identifications or diagnoses that have traditionally justified and made possible, and often continue to justify and make possible, their inferior or subhuman treatment at the hands of those who ostensibly care for them but who actually scapegoat them.

Specifically, we should insist that the members of certain victimized groups have no right to treatment, to abortion or day-care centers, to methadone, or to any other service or special consideration; what they do have a right to, however, is to be considered and called persons or human beings. Moreover, as there are no rights without corresponding duties, this position—in contrast to the currently popular paternalistic-therapeutic position toward the insane, the poor, women, and so forth—implies, first, that, however different certain members of these groups might be from us, we should refuse to regard them as a priori better or worse, more or less deserving, than anyone else in society; and, second, that these victims should accept the same obligation of regarding themselves as neither inherently better than or superior to, nor worse than or inferior to, others. We cannot have our cake and eat it too; we cannot preach humanism and practice male or female chauvinism, paternalism, or therapeutism.

In concluding, I should like to return to my original proposition that high among the humanist's concerns should be language and, in particular, his own disciplined use of it. That this is not a novel idea I not only acknowledge but emphasize. I respect intellectual tradition too highly to believe that a humanist should even aspire to novelty. I believe that, instead, he should try to reaffirm and rearticulate the wisdom of the humanists who have gone before him and

should build on the solid, albeit familiar, foundation that they have laid down for us.

Accordingly, I should like to end by citing some observations on language that best express those timeless principles and practices to which, as humanists, we must perpetually recommit ourselves.

"A Chinese sage of the distant past," as Erich Heller tells it,

> was once asked by his disciples what he would do first if he were given power to set right the affairs of the country. He answered: "I should certainly see to it that language is used correctly." The disciples looked perplexed. "Surely," they said, "this is a trivial matter. Why should you deem it so important?" And the Master replied: "If language is not used correctly, then what is said is not what is meant; if what is said is not what is meant, then what ought to be done remains undone; if this remains undone, morals and art will be corrupted; if morals and art are corrupted, justice will go astray; if justice goes astray, the people will stand about in helpless confusion."[14]

In our own day, George Orwell was obsessed—in the loftiest sense of this word—by the idea that language was the very soul of man. "Newspeak" is not a warning about an imaginary, future threat to human dignity; it is the imaginative rendering of an ancient, perhaps perennial, human proclivity to corrupt and control man by corrupting and controlling his language. Orwell's short essay "Politics and the English Language" may well serve as a manifesto for linguistic humanists. In it, he writes:

> The inflated style is itself a kind of euphemism. A mass of Latin words falls upon facts like soft snow, blurring the outlines and covering up all the details. The great enemy of clear language is insincerity. When there is a gap between one's real and one's declared aims, one turns as it were instinctively to long words and exhausted idioms, like a cuttlefish squirting out ink. In our age there is no such thing as "keeping out of politics." All issues are political issues, and politics itself is a mass of lies, evasions, folly, hatred, and schizophrenia. When the general atmosphere is bad, language must suffer. I should expect to find—this is a guess which I have not sufficient knowledge to verify—

14. E. Heller, "A Symposium: Assessment of the Man and the Philospher," in K. T. Fann, ed., *Ludwig Wittgenstein: The Man and His Philosophy* (New York: Dell, Delta Books, 1967), p. 64.

that the German, Russian, Italian languages have all deteriorated in the last ten or fifteen years, as a result of dictatorship.[15]

Orwell concludes with a recommendation we might well adopt as our credo:

> . . . one ought to recognize that the present political chaos is connected with the decay of language, and that one can probably bring about some improvement by starting at the verbal end. If you simplify your English, you are freed from the worst follies of orthodoxy. You cannot speak any of the necessary dialects, and when you make a stupid remark its stupidity will be obvious, even to yourself. Political language . . . is designed to make lies sound truthful and murder respectable, and to give an appearance of solidity to pure wind. One cannot change this all in a moment, but one can at least change one's own habits.[16]

Everything Orwell says here about political language applies also, perhaps with even greater force, to the languages of the so-called behavioral sciences and, among them, especially to that of psychiatry. Yet it is to behavioral scientists, and especially to psychiatrists—who call and consider themselves humanists and are generally so considered by others—that the modern humanist movement has often looked for inspiration and guidance. That is a grievous error: among the enemies of humanism, psychiatry—that is to say, the ideology of mental health and mental illness and the psychiatric deceptions and coercions justified in its name—is one of the most dangerous and most powerful. Terence, we might here recall, said, "I am a man, nothing human is alien to me." The psychiatrist has inverted that. He declares, "I am a psychiatrist, nothing alien is human to me," thus reasserting the old, barbaric view of the human.

Recognizing an adversary concealed as an ally, unmasking a foe masquerading as a friend, is, however, half the battle. As for the rest of it—the battle against one of the most vicious contemporary sociopolitical creeds that wages war against human freedom and

15. G. Orwell, "Politics and the English Language," in *The Orwell Reader: Fiction, Essays, and Reportage* (New York: Harcourt Brace Jovanovich, 1956), pp. 363–364.
16. Ibid., p. 366.

dignity by corrupting language—everything, or very nearly everything, remains to be done. I am confident, however, that if we succeed in this struggle—or, better, in proportion as we succeed in it—it will be not because we are reasonable or well-meaning, rational or liberal, religious or secular, but rather because we protect and perfect our souls by protecting and perfecting our language.

8

The Right to Health

In every society—whether it be tribal or industrial, theological or secular, capitalist or Communist—goods and services are distributed unequally. That is, in fact, what the words *rich* and *poor* really mean; it is their "operational definition": the rich have, and the poor have not. The "haves" eat more nutritious foods, dwell in more comfortable and spacious homes, and travel by means of more luxurious transportation than do the "have nots." Similar differences exist between the same persons and groups with respect to medical care. When the rich man falls ill, he occupies a hospital bed in a single room or private suite and receives treatment from the best—or at least the most expensive—physicians in town. When the poor man falls ill, he occupies a bed in the charity ward—though it may no longer be called that—and receives treatment from young men who, though called *doctor*, are only medical students. In short, though it is not a disgrace to be poor, it is not a great honor either.

Although it is self-evident that the poor will always have more needs than the rich and the rich more satisfactions than the poor, that fact is now repeatedly discovered and denounced by psychiatric epidemiologists. For example, Ernest Gruenberg declares that there is in our society "a pattern in which the prevalence of illness is an inverse function of family income, while the volume of medical care received is a direct function of family income."[1] In plain English,

1. E. Gruenberg, "Counting Sick People," *Science* 161 (July 1968): 347.

that means that poverty begets sickness and affluence begets medical attention. The same statement, of course, could be made about every other important human need and satisfaction. For example, to earn a living, a poor man has a greater need for transportation than does a rich man, who could stay at home and live off his investments; yet the former must do with the inferior public transportation system provided by the community whereas the latter enjoys a fleet of private cars, boats, and airplanes. Such considerations do not deter Gruenberg, and many other physicians addressing themselves to the subject, from observing—plaintively and, I think, rather naïvely—that "one may doubt . . . [that] efforts to redistribute medical care have eliminated the paradox."[2] But there is no paradox—except, that is, in the eyes of the utopian social reformer who views all social differences as contagious diseases waiting to be wiped out by his therapeutic efforts.

The concept that medical treatment is a right rather than a privilege has gained increasing support during the past decade.[3] The advocates of the concept are no doubt motivated by good intentions: they wish to correct certain inequalities in the distribution of health services in American society. That such inequalities exist is not in dispute. What is in dispute, however, is how to distinguish between inequalities and inequities and how to determine which governmental policies are best suited to the securing of good medical care for the maximum number of persons.[4]

The desire to improve the lot of less fortunate people is laudable; indeed, I share that desire. Still, unless all inequalities are considered to be inequities—a view clearly incompatible with social

2. Ibid.

3. See, for example, B. S. Brown, "Psychiatric Practice and Public Policy," *American Journal of Psychiatry* 125 (August 1968): 141–146.

4. Ever since the French Revolution, and increasingly during the past century, virtually all Western governments have fostered the belief that not only great inequalities of wealth but inequalities of all kinds—for example, of ambition, of talent, and of course of health—are inequities. The result has been described with unmatched irony by C. S. Lewis: "Men are not angered by mere misfortune, but by misfortune conceived as injury. And the sense of injury depends on the feeling that a legitimate claim has been denied. The more claims on life, therefore, that your patient can be induced to make, the more often he will feel injured" (*The Screwtape Letters and Screwtape Proposes a Toast* [New York: Macmillan, 1971], pp. 95–96).

organization and human life as we know it—two important questions remain: First, which inequalities should be considered inequities? Second, what are the most appropriate means for minimizing or abolishing the inequalities we deem unjust? Appeals to good intentions are of no help in answering those questions.

There are two groups of people whose situation with respect to medical care the advocates of the concept of a right to treatment regard as especially unfair or unjust and whose condition they seek to ameliorate. One group is composed of poor people who need ordinary medical care. The other group is composed of the inmates of the public mental hospitals who supposedly need psychiatric care. However, the propositions that poor people ought to have access to more, better, or less expensive medical care than they do now and that people in public mental hospitals ought to receive better psychiatric care than they do now pose two quite different problems. I shall therefore deal with each separately.

The availability of medical services for a particular person, or group of persons, in a particular society depends principally on the supply of the desired services and the prospective user's powers to command those services. No government or organization—whether it be the United States government, the American Medical Association, or the Communist Party of the Soviet Union—can provide medical care except insofar as it has the power to control the education of physicians, their right to practice medicine, and the manner in which they dispose of their time and energies. In other words, only individuals can provide medical treatment for sick people; institutions, such as the church and the state, can promote, permit, or prohibit certain therapeutic activities but cannot by themselves provide medical services.

Social groups wielding power are notoriously prone to prohibit the free exercise of certain human skills and the availability of certain drugs and devices. For example, during the declining Middle Ages and the early Renaissance period, the Church repeatedly prohibited Jewish physicians from practicing medicine and non-Jewish patients from seeking their services. The same prohibition was imposed by the state in Nazi Germany. In the modern democracies of the free West, the state continues to exercise its prerogative to prohibit certain kinds of therapeutic activities. To be sure, the prohibition is no

longer based on the ground that the healers have the wrong religion; instead, it is now based on the ground that they are untrained or inadequately trained as physicians. This situation is an inevitable consequence of the fact that the state's licensing powers fulfill two unrelated and mutually incompatible functions: to protect the public —that is, the actual or potential patients—from incompetent medical practitioners by insuring an adequate level of training and competence on the part of all physicians, and to protect the members of a special vested-interest group—that is, the physicians—from competition from an excessive number of similarly trained practitioners and from healers of different persuasions and skills who might prove more useful to their would-be clients than those officially approved. The result is a complex and powerful alliance, first, between the church and medicine and, subsequently, between the state and medicine—with physicians playing double roles as medical healers and as agents of social control. The restrictive function of the state with respect to medical practice has been, and continues to be, especially significant in the United States.

Without delving further into the intricacies of this large and complex subject, it should suffice to note that our present system of medical training and practice is far removed from that of laissez faire capitalism for which many, and especially its opponents, mistake it. In actuality, the American Medical Association is not only an immensely powerful lobby of medical vested interests, but a force that the reformers ardently support.[5] The consequence of the alliance between organized medicine and the American government has been the creation of a system of education and licensure with tight controls over the production and distribution of health care in a context of an artificially created chronic shortage of medical personnel. That result has been achieved by limiting the number of practitioners through the regulation of medical licensure.

The laws of economics being what they are, when the supply of a given service is smaller than the demand for it we have a seller's market; that is good for the sellers, in this case the medical profession. Conversely, when the supply is greater than the demand, we

5. See, for example, J. S. Clark, Jr., "Can the Liberals Rally?" *Atlantic Monthly*, July 1953, pp. 27–31.

have a buyer's market; that is good for the buyers, in this case the potential patients. One way—and according to the supporters of a free-market economy, the best way—to help buyers get more of what they want at the lowest possible price is to increase the supply of the needed product or service. That would suggest that instead of government grants for special neighborhood health centers and community mental-health centers, the medical needs of the less affluent members of American society could be better served simply by repealing laws governing medical licensure.[6] As logical as that may seem, in medical and liberal circles, this suggestion is regarded as hare-brained or worse.

Since medical care in the United States is in short supply, its availability to the poor may be improved by redistributing the existing supply, by increasing the supply, or by both. Many individuals and groups clamoring for an improvement in our medical-care system fail to scrutinize the artificially created shortage of medical personnel and refuse to look to the free market for a restoration of the balance between demand and supply. Instead, they seek to remedy the imbalance by redistributing the existing supply —in effect, robbing Peter to pay Paul. That proposal is in the tradition of other modern liberal social reforms, such as the redistribution of wealth by progressive taxation and a system of compulsory social security. No doubt, a political and economic system more

6. The deleterious effects on the public of professional licensure in general, and of medical licensure in particular, have been well analyzed and articulated by Milton Friedman. He notes that the justification for enacting special licensure provisons, especially for regulating medical practice, "is always said to be the necessity of protecting the public interest. However, the pressure on the legislature to license an occupation rarely comes from the members of the public. . . . On the contrary, the pressure invariably comes from members of the occupation itself" (*Capitalism and Freedom* [Chicago: University of Chicago Press, 1962], p. 140).

Unless one believes in the special altruism of physicians (for which there is no evidence), the conclusion is inescapable that the actual aim of restrictive licensure laws—as contrasted with the certification of the special competence of such people as mathematicians or physicists, which carries no implication of legal restraints on others not so certified—is the very opposite of their ostensible or professed aim. Under the pretense of protecting the public from incompetent practitioners, they protect the profession from the competition of other vendors of desired services and from the scrutiny of an enlightened public.

socialistic in character than the one we now have could promote an equalization in the quality of the medical care received by the rich and the poor. Whether that would result in the quality of the medical care of the poor approximating that of the rich or vice versa would remain to be seen. Experience surely suggests the latter. For over a century, we have had our version of state-supported psychiatric care for all who need it—namely, the state mental-hospital system. The results of that effort are available for all to see.

Ironically, it is precisely the inadequacy of care in public mental institutions that has inspired the concept of a right to treatment. In two landmark decisions handed down by the U.S. Court of Appeals for the District of Columbia Circuit, the court affirmed the concept of a right to treatment for persons confined in public mental hospitals. In *Rouse* v. *Cameron*, Judge Bazelon, speaking for the majority, declared that "the purpose of involuntary hospitalization is treatment, not punishment"; noted that "Congress established a *statutory* 'right to treatment' in the 1964 Hospitalization of the Mentally Ill Act"; and concluded that "the patient's right to treatment is clear."[7]

It might be noted that Rouse had been involuntarily committed to Saint Elizabeth's Hospital in November 1962 after a finding of not guilty by reason of insanity of carrying a dangerous weapon. Had Rouse been found guilty of that offense, the maximum sentence would have been one year in prison. However, having been "acquitted," he had at the time of his appeal already spent four years in Saint Elizabeth's Hospital. Moreover, Rouse contended that he had never been mentally ill, that he was not mentally ill, and that he never needed psychiatric treatment—opinions that Bazelon not only ignored but inverted into their very opposites.

On the day the Rouse decision was handed down, the same court reiterated and extended its views on the right to treatment in *Millard* v. *Cameron*. Millard had been charged with indecent exposure in June 1962, pleaded guilty to the charge, and was subsequently committed to Saint Elizabeth's Hospital as a "sexual psychopath." His appeal was based on the contention that he was

7. *Rouse* v. *Cameron*, 125 U.S. App. D.C. 366, 373 F. 2d 451 (1966), pp. 452, 453, 456.

receiving no treatment. Judge Bazelon, again speaking for the court, declared: "In *Rouse* v. *Cameron* . . . [we] held that the petitioner was entitled to relief upon showing that he was not receiving reasonably suited and adequate treatment. Lack of such treatment, we said, could not be justified by lack of staff or facilities. We think the same principles apply to a person involuntarily committed to a public hospital as a sexual psychopath."[8]

However, in neither *Rouse* nor *Millard* did Judge Bazelon define what "adequate treatment" was or say what, in the court's opinion, would constitute clearly inadequate treatment. Let us therefore examine what the concept of a right to medical or psychiatric treatment entails and implies.[9]

Most people in public mental hospitals do not receive what one would ordinarily consider treatment. With that as his starting point, Morton Birnbaum has advocated "the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness."[10] Although it defined neither "mental illness" nor "adequate medical treatment," the proposal was received with enthusiasm in both legal and medical circles.[11] Why? Because it supported the myth that mental illness is a medical problem that can be solved by medical means.

The idea of a *right* to mental treatment is both naïve and dangerous. It is naïve because it considers the problem of the publicly hospitalized mental patient as medical, rather than educational, economic, religious, and social. It is dangerous because the proposed remedy creates another problem—compulsory mental treatment—for, in the context of involuntary confinement, the treatment too must be compulsory.

8. *Millard* v. *Cameron*, 125 U.S. App. D.C. 383, 373 F. 2d 468 (1966), p. 472.

9. In this connection, see my *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963), pp. 214–216.

10. M. Birnbaum, "The Right to Treatment," *American Bar Association Journal* 46 (1960): 499.

11. See, for example, T. Gregory, "A New Right" (editorial), *American Bar Association Journal* (1960): 516; and *The New York Times*, December 15, 1967.

Hailing the right to treatment as a "new right," the editor of the *American Bar Association Journal* compared psychiatric treatment for patients in public mental hospitals with monetary compensation for the unemployed. In both cases, we are told, the principle is to help the "victims of unfortunate circumstances."[12]

But things are not so simple. We know what unemployment is; but we are not so clear about what mental illness is. Moreover, a person without a job does not usually object to receiving money, and if he does, no one compels him to take it. The situation of the involuntarily hospitalized mental patient is quite different; he does not want psychiatric treatment, and the more he objects to it, the more firmly society insists that he must have it.

Of course, if we define psychiatric treatment as *help for the victims of unfortunate circumstances*, how can anyone object to it? But the real question is twofold: What is meant by psychiatric help? and What should the helpers do if the victim refuses to be helped?

From a legal and sociological point of view, the only way to define mental illness is to enumerate the types of behavior psychiatrists consider indicative of such illness. Similarly, we may define psychiatric treatment by listing the procedures that psychiatrists regard as instances of such therapy. A brief illustration should suffice.

Maurice Levine lists forty methods of psychotherapy. Among them, he includes physical treatment, medicinal treatment, reassurance, authoritative firmness, hospitalization, ignoring of certain symptoms and attitudes, satisfaction of neurotic needs, and bibliotherapy. In addition, there are physical methods of psychiatric therapy, such as the prescription of sedatives and tranquilizers, the induction of convulsions by drugs or electricity, and brain surgery.[13] Obviously, the term *psychiatric treatment* covers everything that may be done to a person under medical auspices—and more.

If psychiatric treatment is all the things Levine and others tell us it is, how are we to determine whether or not patients in mental hospitals receive adequate amounts of it? Surely, many of them are already being treated with large doses of authoritative firmness, with ignoring of symptoms, and certainly with satisfaction of neurotic

12. Gregory, "A New Right ," p. 516.
13. M. Levine, *Psychotherapy in Medical Practice* (New York: Macmillan, 1942), pp. 17–18.

needs. This last therapeutic agent has particularly sinister possibilities for offenders. Psychoanalysts have long maintained that many criminals commit antisocial acts out of a sense of guilt. What they neurotically crave is punishment. By that logic, indefinite incarceration itself might be regarded as psychiatric treatment.

At present, our publicly operated psychiatric institutions perform their services on the premise that it is morally legitimate to treat so-called mentally sick persons against their will. Illustrative is a document prepared by the Committee on the Recodification of the New York State Mental Hygiene Law. It begins with the declaration that "it is axiomatic that the entire Mental Hygiene Law is concerned with patients' rights, especially rights to adequate care and treatment."[14]

That assertion is a brazen falsehood. The primary concern of any mental-hygiene law is to empower physicians to imprison innocent citizens under the rubric of "civil commitment" and to justify torturing them by means of a variety of violent acts called *psychiatric treatments*. As one would expect, among the members of the above-mentioned committee were the commissioner and two assistant commissioners of the New York State Department of Mental Hygiene. Conspicuous by their absence from the committee were inmates of public mental hospitals, or former inmates, or experts selected by these "patients" to represent them.

In relation to psychiatric treatment, then, the most fundamental and vexing problem is this: how can a treatment that is compulsory also be a right? As I have shown elsewhere, the problem posed by the mistreatment of the publicly hospitalized mentally ill derives not from any insufficiency in the treatment they receive, but rather from the basic conceptual fallacy inherent in the notion of mental illness and from the moral evil inherent in the practice of involuntary mental hospitalization.[15] Preserving the concept of mental illness and the social practices it has justified and papering over its glaring cognitive and ethical defects by means of a superimposed right to mental treatment only aggravates an already intolerably oppressive situation.

14. Institute of Public Administration, "A Mental Hygiene Law for New York State," Art. 37, February 1968 draft.

15. *Law, Liberty, and Psychiatry*.

The problem posed by the "warehousing" of vast numbers of unwanted, helpless, and stigmatized people in huge state mental hospitals could be better resolved—better, that is, for the victimized patients, though not necessarily for the society that is victimizing them or for the professionals who profit from this arrangement—by asking, What do involuntarily hospitalized mental patients need more—a right to receive treatments they do not want or a right to refuse such interventions?

As my foregoing remarks indicate, I see two fundamental defects in the concept of a right to treatment. One is scientific and medical, stemming from unclarified issues concerning what constitutes an illness or a treatment and who qualifies as a patient or physician. The other is political and moral, stemming from unclarified issues concerning the differences between rights and claims.

In the present state of medical practice and popular opinion, the definitions of the terms *illness*, *treatment*, *physician*, and *patient* are so imprecise that the concept of a right to treatment can only serve to muddy further an already extremely confused situation. For example, one can treat, in the medical sense of the term, only a disease or, more precisely, only a person, now called a patient, suffering from a disease. But what is a disease? Certainly, cancer, stroke, and heart disease are. But is obesity a disease? How about smoking cigarettes? Using heroin or marijuana? Malingering to avoid the draft or collect insurance compensation? Homosexuality? Kleptomania? Grief? Each of those conditions has been declared a disease by medical and psychiatric authorities who hold impeccable institutional credentials. And so have innumerable other conditions from bachelorhood, divorce, and unwanted pregnancy to political and religious prejudice.

Similarly, what is treatment? Certainly, the surgical removal of a cancerous breast is. But is an organ transplant treatment? If it is and if such a treatment is a right, how can those charged with guaranteeing people the protection of their right to treatment discharge their duties without having acess to the requisite number of transplantable organs? On a simpler level, if ordinary obesity, due to eating too much, is a disease, how can a doctor treat it when its treatment depends on the patient eating less? What does it mean

then that a patient has a right to be treated for obesity? I have already alluded to how easily that kind of right becomes equated with a societal and medical obligation to deprive the patient of his freedom—to eat, to drink, to take drugs, and so forth.

Furthermore, who is a patient? Is he someone who has a demonstrable bodily illness or injury—such as cancer or a fracture? A person who complains of bodily symptoms but has no demonstrable illness, like the so-called hypochondriac? The person who feels perfectly well but is said to be ill by others, like the so-called paranoid schizophrenic? Or is he a person who professes political views differing from those of the psychiatrists who brand him insane, like Senator Barry Goldwater?

Finally, who is a physician? Is he a person licensed to practice medicine? One certified to have completed a specified educational curriculum? One possessing certain medical skills as demonstrated by public performance? Or is he one claiming to possess such skills?

It seems to me that improvements in the medical care of poor people and in the care of people now said to be mentally ill depend less on declarations about their rights to treatment than on certain reforms in the speech and conduct of those professing a desire to help them. In particular, such reforms would have to entail refinements in the use of such medical concepts as illness and treatment and a recognition of the basic differences between medical intervention as a service, which the individual is free to seek or reject, and medical intervention as a method of social control, which is imposed on him by force or fraud.

I can perhaps best illustrate the unsolved dilemmas of what constitute diseases and treatment by citing some actual cases. As recently as 1965, a Connecticut statute made it a crime for any person to artificially prevent conception.[16] Accordingly, a mother

16. In *Griswold* v. *Connecticut*, the Connecticut anticontraceptive statute was declared unconstitutional by the Supreme Court on the ground that it violated the right of marital privacy, a right the court considered within the penumbra of the specific guarantees of the Bill of Rights. The significance of this case lies in its offering an instance in which a state's duly appointed legislators denied a certain kind of medical assistance to their constituents, while a majority of the Supreme Court deemed such assistance a right. Connecticut General Statutes Revised, § 53–32 (Supp. 1965), ruled invalid in *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

of ten requesting contraceptive help from a physician in a public hospital in Connecticut would have been refused such assistance. Did what she seek constitute treatment? Not according to the legislators who defined the prescription of birth-control devices as immoral and illegal acts rather than as interventions aimed at preserving health.

Today, a similar situation obtains with respect to a woman's unwanted pregnancy and her wish for an abortion. Is being pregnant when one does not want to be an illness? Is abortion a treatment, or is it the murder of a fetus? If it is murder, why is no abortionist ever prosecuted for *murder*? How can the preservation of a pregnant woman's mental health justify such killing, now called *therapeutic abortion*?[17]

On the other hand, should a wholly secular, utilitarian point of view prevail and the use of birth-control devices and abortion be considered treatments, what would it mean for a woman to have a right to such interventions? Clearly, it would have to mean that she has a right to unhampered access to physicians willing to prescribe birth-control devices and perform abortions. Where would such a medico-legal posture leave a Roman Catholic obstetrician? By refusing to abort a woman wishing a termination of her pregnancy, he would be interfering with her right to treatment in a way that might be analogized to a white barber's refusal to cut the hair of a black customer, or vice versa, thus interfering with his customer's civil rights.

As still another example, consider the situation of an unhappily married couple. Are they sick? If they define themselves as neurotic and consult a psychiatrist, they are considered sick and their insurance coverage may even pay for their treatment. But if they seek the solution of their problem in divorce and consult an attorney, they are not considered sick. Thus, although unhappily married people are often considered ill, divorce is never considered to be a treatment. If it were, it too would have to be a right. Where would that leave our present divorce laws?

One could go on and on. I shall cite, however, only one more

17. In this connection, see my "The Ethics of Birth Control," *The Humanist* 20 (November–December 1960): 332–336, and "The Ethics of Abortion," ibid., 26 (September–October 1966): 147–148.

instance—the practice of involuntary mental hospitalization—to show how deeply confused and confusing is our present situation with respect to the concept of treatment and hence how very mischievous any extension of the concept of a right to treatment, as a right secured by the government, is bound to be.

In most jurisdictions, persons said to be mentally ill and dangerous to themselves or others may be committed to a mental hospital. Such incarceration in a building called a hospital is considered a form of psychiatric, and hence medical, treatment. But who in fact is the patient? Who is being treated? Ostensibly, the person treated is the one who is incarcerated. But since he does not seek medical help, whereas those who secure his confinement do, one might argue that involuntary mental hospitalization is treatment for those who seek commitment rather than for those who are committed. That would be analogous to arguing that a therapeutic abortion is treatment for the pregnant woman, not for the aborted fetus—an assertion few would deny. If that argument is accepted, in any conflict injuring one party could be defined as a treatment of his opponent. The following recent statement on the psychiatric treatment of "acting-out adolescents" is illustrative: "The move toward 'freedom, love, peace,' has encouraged anti-social acting out, including the increasing use of marijuana and psychedelic drugs. Consequently, emotionally disturbed young men who are acting in a way that directly conflicts with their parents' standards are being hospitalized in increasing numbers."[18] In that sort of situation, whose right to treatment do the advocates of such hospitalization wish to guarantee —that of the parent to commit his rebellious child as mentally ill or that of the child to defy his parents without being subjected to quasi-medical penalties?

The second difficulty posed by the concept of a right to treatment is of a political and moral nature. It stems from confusing rights with claims and protection from injuries with provision of goods or services.

18. L. W. Krinsky and R. M. Jennings, "The Management and Treatment of Acting-Out Adolescents in a Separate Unit," *Hospital and Community Psychiatry* 19 (March 1968): 72.

For a definition of *right,* I can do no better than to quote John Stuart Mill. In *Utilitarianism,* he writes:

> I have treated the idea of a right as *residing in the injured person and violated by the injury.* . . . When we call anything a person's right we mean that he has a valid claim on society to protect him in the possession of it, either by the force of law, or by that of education and opinion. . . . To have a right, then, is, I conceive, to have something which *society ought to defend me in the possession of.* [Italics added.][19]

Mill's distinction helps us to distinguish rights from claims. Rights, Mill says, are "possessions"; they are things people have by nature, like liberty; acquire by dint of hard work, like property; create by inventiveness, like a new machine; or inherit, like money. Characteristically, possessions are what a person *has,* and of which others, including the state, can therefore deprive him. Mill's point is the classic libertarian one—the state ought to protect the individual in his rights. That is what the Declaration of Independence means when it refers to the inalienable rights to life, liberty, and the pursuit of happiness. It is important to note that, in political theory no less than in everyday practice, that requires that the state be strong and resolute enough to protect the rights of the individual from infringement by others and that it be decentralized and restrained enough, typically through federalism and a constitution, to insure that it will not itself violate the rights of the people.

In the sense specified above, then, there can be no such thing as a right to treatment. Conceiving of a person's body as his possession—like his automobile or watch (though no doubt more valuable)—it is just as nonsensical to speak of his right to have his body repaired as it would be to speak of his right to have his automobile or watch repaired.

It is thus evident that in its current usage, and especially in the phrase *right to treatment,* the term *right* actually means *claim.* More specifically, *right* here means the recognition of the claims of one party, considered to be *in the right,* and the repudiation of the claims of another, opposing party, considered to be *in the wrong*

19. J. S. Mill, *Utilitarianism,* in M. Lerner, ed., *Essential Works of John Stuart Mill* (New York: Bantam Books, 1961), p. 238.

—the rightful party having allied himself with the interests of the community and enlisted the coercive powers of the state on his own behalf. Let us analyze that situation in the case of medical treatment for ordinary bodily disease—for example, diabetes. The patient, having lost some of his health, tries to regain it by means of medical attention and drugs. The medical attention he needs is, however, the property of the physician, and the drug he needs is the property of the manufacturer who produced it. The patient's right to treatment thus conflicts, first, with the physician's right to liberty—that is, to sell his services freely—and, second, with the pharmaceutical manufacturer's right to property—that is, to sell his products as he chooses. The advocates of a right to treatment for the patient are less than candid regarding their proposals for reconciling that alleged right with the actual rights of the physician to liberty and of the pharmaceutical manufacturer to property.

Nor is it clear how the concept of a right to treatment can be reconciled with the traditional Western concept of the patient's right to choose his physician. If the patient has a right to choose the doctor by whom he wishes to be treated and if he also has a right to treatment, then in effect the doctor is the patient's slave. Obviously, the patient's right to choose his physician cannot be wrenched from its context and survive: its corollary is the physician's right to accept or reject a patient (except for rare cases of emergency treatment). No one of course envisions the absurdity of physicians being at the personal beck and call of individual patients, becoming literally their medical slaves as some had been in ancient Greece and Rome.

The concept of a right to treatment has a different, much less absurd but far more ominous, implication. For just as the corollary of the individual's freedom to choose his physician is the physician's freedom to refuse treating any particular patient, so the corollary of the individual's right to treatment is the denial of the physician's right to reject as a patient anyone officially so designated. The transformation of the medical relationship, from individualistic and contractural to bureaucratic and coercive, in one fell swoop removes the individual's right to define himself as sick and to seek medical care as he sees fit and the physician's right to define whom he considers to be sick and wishes to treat; it places those decisions instead

in the hands of the state's medical bureaucracy. To see how that works in the United States and on a less-than-total scale, coexisting with a flourishing system of private medical practice, one need only look at our state mental hospitals. Every patient admitted to such a hospital has a right to treatment, and every physician serving in such a hospital system has an obligation to treat any patient assigned to him by his superiors or committed to his care by the courts. Missing from the system, and similar systems, are the patient's traditional economic and legal controls over the medical relationship and the physician's traditional economic dependence on, and legal obligations to, the individual he has accepted as a patient.

As a result, bureaucratic, as contrasted with entrepreneurial, medical care ceases to be a system of curing disease and becomes instead a system of controlling deviance. Although that outcome seems to me inevitable in the case of psychiatry (in view of the fact that ascription of the label *mental illness* usually functions as quasi-medical rhetoric concealing social conflicts), it need not be inevitable for nonpsychiatric medical services. However, in every situation where medical care is provided bureaucratically (as in Communist societies), the physician's role as agent of the sick patient is necessarily alloyed with, and often seriously compromised by, his role as agent of the state. Thus, the doctor becomes a kind of medical policeman, sometimes helping the individual and sometimes harming him.

Returning to Mill's definition of a right, one could say further that just as a man has a right to life and liberty, so too has he a right to health and hence a claim on the state to protect his health. It is important to note here that the right to health differs from the right to treatment in the same way as the right to property differs from the right to theft. Recognition of a right to health would obligate the state to prevent individuals from depriving each other of their health, just as recognition of the two other rights now prevents them from depriving others of their liberty and property. It would also obligate the state to respect the health of the individual and to deprive him of this asset only in accordance with due process of law, just as it now respects the individual's liberty and property and deprives him of them only in accordance with due process of law.

As matters now stand, the state not only fails to protect the in-

dividual's health, but it actually hinders him in his efforts to safeguard his own health; for example, it permits both industries and individuals to befoul the air we breathe. Furthermore, the state also prohibits individuals from obtaining medical care from certain officially unqualified experts and from buying and ingesting certain officially dangerous drugs. Sometimes, the state deliberately deprives the individual of treatment under the very guise of providing treatment.[20]

To be sure, there are good reasons, in an age in which the powerful centralized state is idolized as the source of all benefits, why the concept of a right to treatment is regarded as progressive and is popular and why the concept of a right to health has, so far as I know, never even been articulated, much less recognized by legislators and courts. On the one hand, recognition of a right to health rather than to treatment would impose greater obligations on the state to insure domestic peace, especially the protection from theft of an individual's health as a type of private property; on the other hand, it would impose greater restraints on its own powers vis-à-vis the citizen, especially on its jurisdiction over the licensure of physicians and the dispensing of drugs. Such a government would have to shoulder greater responsibilities for its duties as policeman, while it would have to limit its alleged responsibilities for dispensing services—in short, the very antithesis of the type of state that modern liberal social reformers consider desirable and necessary for the attainment of their goals. Instead of fostering the independent judgment of the individual, such reformers encourage his submission to an ostensibly competent and benevolent authority; hence, they project the image of medical therapist onto the state, while casting the citizen in the complementary role of sick patient. That of course places the individual in precisely that inferior and submissive role vis-à-vis the government from which the founding fathers sought, by means of the Constitution, to rescue him. Politically, the right to treatment is thus simply the right to submit to authority—a right that has always been dear both to those in power and those incapable of managing their own lives.

20. See, for example, "Testing Synanon," *Time*, July 12, 1968, p. 74.

The state can protect and promote the interests of its sick, or potentially sick, citizens in one of two ways: either by coercing physicians, and other medical and paramedical personnel, to serve patients—as state-owned slaves, in the last analysis; or by creating economic, moral, and political circumstances favorable to a plentiful suply of competent physicians and effective drugs—letting individuals care for their bodies as they care for their other possessions.

The former solution corresponds to and reflects efforts to solve human problems by recourse to the all-powerful state. The rights promised by such a state—exemplified by the right to treatment—are not opportunities for uncoerced choices by individuals, but powers vested in the state for the subjection of the interests of one group to those of another.[21]

The latter solution corresponds to and reflects efforts to solve human problems by recourse to individual initiative and voluntary association without interference by the state. The rights exacted from such a state—exemplified by the right to life, liberty, and health—are limitations on its own powers and sphere of action and provide the conditions necessary for, but of course do not insure the proper exercise of, free and responsible individual choices.

In these two solutions, we recognize the fundamental polarities of the great ideological conflict of our age, perhaps of all ages, and of the human condition itself—individualism and capitalism on the one side, collectivism and communism on the other. *Tertium non datur.* There is no other choice.

21. The position of the physician in Czechoslovakia is illustrative. "The constitution [of Czechoslovakia] declares that health care is a right of the people and that it is the duty of the state to satisfy that right." In practice, that right is assured through "the assignment [by the state] of a low economic (productive) status to the health services. . . . A skilled factory worker may earn much more than a doctor through premium pay. Even a taxi driver may earn more than a doctor. . . . Almost universal was the comment: 'We are not attracting the best people into medicine' " (J. D. Cooper, "Czechoslovakia Reflects Regional Plan Problems," *Hospital Tribune*, September 9, 1968, pp. 1, 16).

9

Justice in the Therapeutic State

The concept of justice and the concept of treatment belong to two different frames of references or realms of discourse—the former to law and morals, the latter to medicine and health. Both justice and treatment articulate ideas basic to human life; both have dual uses—one popular, the other technical. Although justice is closely linked with, and receives its most precise meaning from, the workings of the legal system, the concept is not the private property of lawyers but belongs to everyone. Similarly, although treatment is closely linked with, and receives its most precise meaning from, the workings of the medical profession, the concept is not the private property of physicians but belongs to everyone. I shall be concerned here with examining the relations between these two concepts in an effort to clarify currently popular and prevalent attempts to assimilate jurisprudence to science, law to medicine, the judge to the physician, and justice to treatment.

Law and medicine are among the oldest and most revered professions. That is because each articulates and promotes a basic human need and value—social cooperation in the case of law, health in that of medicine. Simply put, the law opposes some types of social processes: it calls them *crimes* and imposes punishment on those who commit them. Likewise, medicine combats some types of bodily processes: it calls them *diseases* and offers treatment to those who suffer from them.

To exist as a person is synonymous with existing as a social being. The regulation of social relations is an indispensable feature of every society and indeed of every coming together of two or more individuals. The concept of justice is thus necessary both for the regulation of human relations and for judging the moral quality of the resulting situation. That is what is meant by the statement that without law there can be no justice but that the law itself may be unjust.

What constitutes justice varies from place to place and from time to time. The variance does not prove that the concept is devoid of meaning or is unscientific—as some contemporary social scientists claim. Instead, it shows that to the question, What is a good or proper social order? mankind has given, and continues to give, not one but many answers. For example, in principle at least, capitalists believe that those who work harder or produce more, or whose services are more valuable to the community, should receive more for their work than those whose efforts are less productive; whereas Communists believe that the products of all individuals should be pooled and distributed on the basis of the Marxist formula "From each according to his abilities, to each according to his needs."

Framed as general rules of the game of life, contrasting concepts of justice such as those listed above would seem to have nothing in common. That is a fallacy. For what underlies all concepts of justice is a notion so basic to social intercourse that without it life would promptly degenerate into a Hobbesian war of all against all. The notion common to all diverse concepts of justice is *reciprocity*—that is, the expectation that we shall keep our promises to others and they shall keep theirs to us. "It is confessedly unjust," wrote John Stuart Mill, "to *break faith* with any one: to violate an engagement, either express or implied, or to disappoint expectations raised by our own conduct."[1] More recently, Paul Freund has similarly sought to locate the core of justice in the concept of contract. He writes that "the concept of contract is a paradigm case of justice viewed as the satisfaction of reasonable expectations."[2]

1. J. S. Mill, *Utilitarianism*, in *Essential Works of John Stuart Mill*, ed. M. Lerner (New York: Bantam Books, 1961), p. 230.
2. P. A. Freund, "Social Justice and the Law," in R. B. Brandt, ed., *Social Justice* (Englewood Cliffs, N.J.: Prentice-Hall, 1962), p. 95.

Why is contract so all-important to human life? Because it is the foremost rational, nonviolent instrument for the equalization of social power. Contract is the social device *par excellence* that liberates the relatively powerless individual (or group) from domination by his more powerful superiors, thus freeing him to plan for the future. Conversely, lack of contract, or systematic contract violation, is an essential characteristic of oppression: deprived of the power to plan for the future, the inferior individual (or group) becomes subjected to the status derogation of dependency by his superiors. Thus, when the future arrives, the oppressed individual will be unable to care for himself and will be dependent on his protectors (for example, parents, politicians, psychiatrists).

To be sure, like all social arrangements, contract favors some members of the group and frustrates others. Specifically, it favors the weak (that is, those who lack the power to coerce or, if they possess such power, the will to use it), and it frustrates the strong (that is, those who have such power or, if they lack it, strive to possess it). Generally, then, contract favors the child as against the parent, the employee as against the employer, and the individual as against the state. In each of those relationships (and in other similar situations), the superior member of the pair does not require contract to plan for his future: he can control his partner, by brute force if necessary. In short, contract expands the self-determination of the weak by constricting the powers of the strong to coerce him; at the same time, by placing the value of abiding by the terms of a contract above that of naked power and by universalizing that value, contract tames not only the power of the strong to coerce but also that of the weak to countercoerce.

In political life, the paradigm of contract is the rule of law, the principle that limits interferences by the state in the conduct of the individual to circumstances that are clearly defined and known in advance to the individual. By avoiding law breaking, the citizen can thus feel secure from unexpected interference by state power. That arrangement may be contrasted with despotic or tyrannical government, whose principal characteristic in its dealings with the individual is not harshness but rather arbitrariness. Indeed, the

brutality and terror of that kind of political arrangement lie precisely in the utter unpredictability with which the police power of the state may be deployed against the individual.

One more example of the fundamental role of contract in the concept of justice should suffice. It is an ancient legal maxim that there should be no punishment without law (*Nulla poena sine lege*). The principle that a person should not be punished for an act that was not prohibited by law at the time when he engaged in it shows dramatically that the concept of justice is rooted in ideas and sentiments that have more to do with the need to make behavior predictable than with the need to protect society from harm. For, clearly, a person may harm his neighbor without his behavior's qualifying as an act prohibited by law. Arguing from the allegedly scientific point of view, the modern psychiatrist or behavioral scientist would hold that what is—or ought to be—important here is the proper restraint and remotivation of the malefactor, not the abstract idea of justice. Hence, he needs no preexisting law to justify invoking the social sanction he calls psychiatric treatment. Indeed, it is precisely at this point that the behavioral scientist falls back on the analogy between misbehavior and illness by arguing that just as a person may fall ill without his condition being officially recognized by medical science in the form of a diagnosis, so too he may engage in "dangerous" conduct without his behavior being officially recognized by the law as a criminal act. In that view, what determines the existence of the undesired condition, whether it be disease or deviance, illness or crime—and what justifies social intervention against it, whether it be treatment or punishment, medical hospitalization or mental hospitalization—is the judgment of the expert, not a rule written down by lawmakers and legitimized by the judicial and political processes of government.

These two fundamental principles of regulating human relations—the contractual and the discretionary—serve different aims. Each acquires its value from its function—to foster the individual's capacity for independence by enabling him to plan for the future in the case of contract, and to enable the expert to act with optimal effectiveness by freeing him from the limitations of restricting rules

in the case of discretion. Since those are two radically different ends, it is hardly surprising that each requires different means for its attainment.

Man is not only a person, a social being; he is also an animal, a biological organism. Hence, his biological equipment—that is, his body—which is a necessary but not a sufficient condition for his role as a person, will also be of paramount importance to him. For if a person's body is injured or becomes diseased, his ability to perform his social and personal functions will be altered, impaired, or even destroyed; and if his body ceases to function altogether, then he ceases to exist as a member of the group or as a person. Thus, just as the law has come into being to regulate and safeguard man's relations to his fellow man, so medicine has come into being to regulate and safeguard his relation to his own body.

Inasmuch as these two basic human needs are closely related—man's relations to his body always occurring in a context of preexisting social regulations—it is not surprising that law and medicine (their concepts, interventions, and sometimes their personnel) are often intertwined and that during various historical periods each of these disciplines has made deep inroads into the territory of the other. In the Middle Ages, for example, when the religious ideology ruled undisputed over the minds of men, the scope and function of the medical healer was strictly circumscribed by the authority of the Church. Not only the dissection of bodies, but also the use of drugs was thus forbidden as contrary to the will of God. Hence it was that medicine, independent of the teachings and powers of the Church, was in the hands of Arab and Jewish physicians or was practiced illegally by white witches. Similarly, in our day, when a medical-psychiatric ideology rules undisputed over the minds of men, legal concepts and methods of social control are confused with, and corrupted by, medical concepts and methods of social control. The upshot is the transformation of the state from a legal and political entity into a medical and therapeutic one.[3]

3. In this connection, see my *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970) and *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Garden City, N.Y.: Doubleday, Anchor Press, 1970).

The impetus that drives men to depoliticize and therapeuticize human relations and social conflicts appears to be the same as that which drives them to comprehend and control the physical world. The history of this process—that is, of the birth of modern science in the seventeenth century and its rise to ideological hegemony in the twentieth—has been adequately set forth by others.[4] I shall confine myself here to illustrating the incipient and developed forms of this ideology through quotations from the works of two of its most illustrious American protagonists—Benjamin Rush and Karl Menninger.

Benjamin Rush (1745–1813) signed the Declaration of Independence, was physician general of the Continental Army, and served as professor of physic and dean of the medical school at the University of Pennsylvania. He is the undisputed father of American psychiatry: his portrait adorns the official seal of the American Psychiatric Association. I shall list without comment passages from Rush's writings that show how he transformed moral questions into medical problems and political judgments into therapeutic decisions.

> Perhaps hereafter it may be as much the business of a physician as it is now of a divine to reclaim mankind from vice.[5]

> Mankind considered as creatures made for immortality are worthy of all our cares. Let us view them as patients in a hospital. The more they resist our efforts to serve them, the more they have need of our services.[6]

> Miss H. L. . . . was confined in our hospital in the year 1800. For several weeks she discovered [displayed] every mark of a sound mind, except one. She hated her father. On a certain day, she acknowledged,

4. For example, see F. A. Hayek, *The Counter-Revolution of Science: Studies on the Abuse of Reason* (New York: Free Press, 1964), and F. Matson, *The Broken Image: Man, Science, and Society* (New York: Braziller, 1964).

5. Benjamin Rush to Granville Sharp, July 9, 1774, in J. A. Woods, ed., "The Correspondence of Benjamin Rush and Granville Sharp, 1773–1809," *Journal of American Studies* 1 (April 1967): 8.

6. Rush to Granville Sharp, November 28, 1783, ibid., p. 20.

with pleasure, a return of her filial attachment and affection for him; soon after she was discharged cured.[7]

> Physicians [are the] best judges of sanity. . . .
> Suicide is madness. . . .
> Chagrin, shame, fear, terror, anger, unfit[ness] for legal acts, are transient madness.[8]

> Lying is a corporeal disease. . . . Persons thus diseased cannot speak the truth upon any subject.[9]

> Terror acts powerfully upon the body, through the medium of the mind, and should be employed in the cure of madness.[10]

> There was a time when these things [criticism of Rush's opinions and actions] irritated and distressed me, but I now hear and see them with the same indifference and pity that I hear the ravings and witness the antic gestures of my deranged patients in our Hospital. We often hear of "prisoners at large." The majority of mankind are *madmen at large*.[11]

> Were we to live our lives over again and engage in the same benevolent enterprise [political reform], our means should not be reasoning but bleeding, purging, low diet, and the tranquilizing chair.[12]

Rush's foregoing views provide an early nineteenth-century example of the medical-therapeutic perspective on political and social conduct. His statements amply support my contention that although ostensibly he was a founder of American constitutional government, actually he was an architect of the therapeutic state.[13] The leaders of the American Enlightenment never tired of emphasizing the

7. Rush, *Medical Inquiries and Observations upon the Diseases of the Mind* (1812; New York: Macmillan, Hafner Press, 1962), pp. 255–256.
8. Rush, "Lecture on the Medical Jurisprudence of the Mind" (1810), in *The Autobiography of Benjamin Rush: His "Travels through Life" Together with His "Commonplace Book for 1789–1812"*, ed. G. W. Corner (Princeton, N.J.: Princeton University Press, 1948), p. 350.
9. Rush, *Medical Inquiries*, p. 265.
10. Ibid., p. 175.
11. Rush, *Letters of Benjamin Rush*, ed. L. H. Butterfield (Princeton, N.J.: Princeton University Press, 1951), vol 2, p. 1090.
12. Ibid., p. 1092.
13. See my *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963), esp. pp. 212–222.

necessity for restraining the powers of the rulers—that is, for checks and balances in the structure of government. Rush, on the other hand, consistently advocated rule by benevolent despotism—that is, political absolutism justified as medical necessity.

In short, as the Constitution articulates the principles of the legal state, in which both ruler and ruled are governed by the rule of law; so Rush's writings articulate the principles of the therapeutic state, in which the citizen-patient's conduct is governed by the clinical judgment of the medical despot. The former constitutes a basis for expanding the personal liberty of the citizen; the latter, for expanding the political power of the government.

To bring into focus the ideology and rhetoric on which our present-day therapeutic society rests, I shall next present in capsule form the pertinent opinions of one of its foremost contemporary spokesmen, Karl Menninger.

Karl Menninger (b. 1893) is a founder of the famed Menninger Clinic and Foundation, a former president of the American Psychoanalytic Association, the recipient of numerous psychiatric honors, and the author of several influential books in the mental-health field. Like Rush before him, Menninger is one of the most prominent psychiatrists in America. His views illustrate the contemporary psychiatric mode of viewing all manner of human problems as mental illnesses—indeed, all of life as a disease requiring psychiatric care. The following quotations point up that view.

> . . . the declamation continues about travesties upon *justice* that result from the introduction of psychiatric methods into courts. But what science or scientist is interested in *justice?* Is pneumonia just? Or cancer? . . . The scientist is seeking the amelioration of an unhappy situation. This can be secured only if the scientific laws controlling the situation can be discovered and complied with, and not by talking of "justice." . . .[14]

> Prostitution and homosexuality rank high in the kingdom of evils.[15] From the standpoint of the psychiatrist, both homosexuality and

14. K. Menninger, *The Human Mind*, 3rd ed. (New York: Knopf, 1966), p. 449.

15. Menninger, Introduction to *The Wolfenden Report: Report of the Committee on Homosexual Offenses and Prostitution* (New York: Stein & Day, 1964), p. 5.

prostitution—and add to this the use of prostitutes—constitute evidence of immature sexuality and either arrested psychological development or regression. Whatever it may be called by the public, there is no question in the minds of psychiatrists regarding the abnormality of such behavior.[16]

. . . in the unconscious mind, it [masturbation] always represents an aggression against someone.[17]

Eliminating one offender who happens to get caught *weakens* public security by creating a false sense of diminished danger through a definite remedial measure. Actually, it does not remedy anything, and it bypasses completely the real and unsolved problem of how to identify, detect, and detain potentially dangerous citizens.[18]

The principle of *no* punishment cannot allow of any exception; it must apply in every case, even the worst case, the most horrible case, the most dreadful case—not merely in the accidental, sympathy-arousing case.[19]

When the community begins to look upon the expression of aggressive violence as the symptom of an illness or as indicative of illness, it will be because it believes doctors can do something to correct such a condition. At present, some better-informed individuals do believe and expect this.[20]

Do I believe there is effective treatment for offenders . . . ? Most certainly and definitely I do. Not all cases, to be sure. . . . Some provision has to be made for incurables—pending new knowledge—and these will include some offenders. But I believe the majority of them would prove to be curable. The willfulness and the viciousness of offenders are part of the thing for which they have to be treated. They must not thwart our therapeutic attitude. It is simply not true that most of them are "fully aware" of what they are doing, nor is it true that they want no help from anyone, although some of them say so.[21]

16. Ibid., p. 6.
17. Menninger, *Man against Himself* (New York: Harcourt Brace Jovanovich, 1938), p. 61.
18. Menninger, *The Crime of Punishment* (New York: Viking Press, 1968), p. 108.
19. Ibid., p. 207.
20. Ibid., p. 257.
21. Ibid., pp. 260–261.

> Some mental patients must be detained for a time even against their wishes, and the same is true of offenders.[22]

As the foregoing quotations show, Menninger focuses systematically on the offender, or alleged offender, who, in his view, is either punished with hostile intention or treated with therapeutic intention. Accordingly, he urges that we abandon the legal and penological system with its limited and prescribed penalties and substitute for it a medical and therapeutic system with unlimited and discretionary sanctions defined as treatments.

In short, the enlightened behavioral technologist has for centuries sought the destruction of law and justice and their replacement by science and therapy.

Those who see the main domestic business of the state as the maintenance of internal peace through a system of just laws justly administered and those who see it as the provision of behavioral reform scientifically administered by a scientific elite have, in fact, two radically different visions of society and of man. Since each of these groups strives after a different goal, it is not surprising that each condemns the other's methods; constitutional government, the rule of law, and due process are indeed inefficient means for inspiring the personality change of criminals, especially if their crime is not shoplifting (which is Menninger's favorite example), but violating laws regulating contraception, abortion, drug abuse, or homosexuality. Similarly, unlimited psychiatric discretion over the identification and diagnosis of alleged offenders, coercive therapeutic interventions, and lifelong incarceration in an insane asylum are neither effective nor ethical means for protecting individual liberties or insuring restraints on the powers of the government, especially when the individual's "illness" is despair over his inconsequential life and the wish to put an end to it.

The legal and the medical approaches to social control represent two radically different ideologies, each with its own justificatory rhetoric and restraining actions. It behooves us to understand clearly the differences between them.

In the legal concept of the state, justice is both an end and a means; when such a state is just, it may be said to have fulfilled its

22. Ibid., p. 265.

domestic function. It has then no further claims on its citizens (save for defense against external aggression). What people do—whether they are virtuous or wicked, healthy or sick, rich or poor, educated or stupid—is none of the state's business. This, then, is a concept of the state as an institution of limited scope and powers. (In such a state, the people are, of course, not restrained from fulfilling their needs not met by the state through voluntary associations.)

In the scientific-technological concept of the state, therapy is only a means, not an end: the goal of the therapeutic state is universal health, or at least unfailing relief from suffering. The untroubled condition of man and society is a quintessential feature of the medical-therapeutic perspective on politics: conflict among individuals, and especially between the individual and the state, is invariably seen as a symptom of illness or psychopathology; and the primary function of the state is accordingly the removal of such conflict through appropriate therapy—imposed by force if necessary. It is not difficult to recognize in the imagery of the therapeutic state the old inquisitional, or the more recent totalitarian, concept of the state, now clothed in the garb of psychiatric treatment.

Whether we want a society in which man has a chance, however small, to develop his powers and to become an individual or one in which such individualism is considered to be evil and man (if we may call him that) is fashioned into a plastic, compliant robot by his scientific masters is, in the last analysis, a basic ethical question to which we cannot, and need not, address ourselves here. Of course, all who feel deeply about either of these alternatives believe that they are championing man's dearest and most authentic aspirations. According to the libertarians, more than anything else man needs protection from the dangers of unlimited government; according to the therapeutists, he needs protection from the dangers of unlimited illness. Moreover, as so often happens when people become separated by an ideological gulf, the advocates of these two points of view are no longer on speaking terms. In particular, the behavioral engineers and psychiatric therapists, who have succeeded in defining their position as the progressive and scientific one, have ceased even to acknowledge the existence of a large body of fact and thought critical of what I call the "theory and practice of psy-

chiatric violence." That was true of Rush nearly two hundred years ago, who in his writings never engaged those who opposed tyranny, whether priestly or medical; and it is true now of Menninger, who never confronts those who fear and distrust the violence of psychiatrists no less than of politicians.

Among contemporary scholars and thinkers who have opposed the behavioristic-scientistic forces tending toward the "abolition of man," C. S. Lewis stands very high indeed. Until his death in 1963, Lewis was professor of medieval and Renaissance English at Cambridge University. He is probably best known for his book *The Screwtape Letters*, which first established him as an influential spokesman for Christianity in the English-speaking world and a brilliant critic of modern science and technology as dehumanizing social institutions.[23] I list below passages illustrative of Lewis's views pertinent to the relations between psychiatry and law.

> I am not supposing them [the Conditioners] to be bad men. They are, rather, not men (in the old sense) at all. They are, if you like, men who have sacrificed their own share in traditional humanity in order to devote themselves to the task of deciding what "Humanity" shall henceforth mean. . . . Nor are their subjects necessarily unhappy men. They are not men at all: they are artefacts. Man's final conquest has proved to be the abolition of Man.[24]

> . . . when we cease to consider what the criminal deserves and consider only what will cure him or deter others, we have tacitly removed him from the sphere of justice altogether; instead of a person, a subject of rights, we now have a mere object, a patient, a "case."[25]

> The first result of the Humanitarian theory is, therefore, to substitute for a definite sentence (reflecting to some extent the community's moral judgment on the degree of ill-desert involved) an indefinite sentence terminable only by the word of those experts . . . who inflict it. Which of us, if he stood in the dock, would not prefer to be tried by the old system?[26]

23. C. S. Lewis, *The Screwtape Letters and Screwtape Proposes a Toast* (New York: Macmillan, 1967).
24. Lewis, *The Abolition of Man* (New York: Macmillan, 1965), pp. 76–77.
25. Lewis, "The Humanitarian Theory of Punishment," *Res Judicatae* (Melbourne University, Melbourne, Australia), vol. 6 (1953): 225.
26. Ibid., p. 226

> Of all tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. . . . To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles, and domestic animals. But to be punished, however severely, because we have deserved it, because we "ought to have known better," is to be treated as a human person made in God's image.[27]

> For if crime and disease are to be regarded as the same thing, it follows that any state of mind which our masters choose to call "disease" can be treated as a crime; and compulsorily cured. . . . but under the Humanitarian theory it will not be called by the shocking name of Persecution. . . . The new Nero will approach us with the silky manners of a doctor. . . . Even if the treatment is painful, even if it is life-long, even if it is fatal, that will be only a regretable accident; the intention was purely therapeutic.[28]

But the Humanitarians remain undaunted. Fifteen years after Lewis wrote the passages just quoted, Menninger declares: "The secret of success in all [penological] programs, however, is the replacement of the punitive attitude with the therapeutic attitude. A therapeutic attitude is essential regardless of the particular form of treatment or help."[29]

The decision whether to treat others justly (fairly) or therapeutically (benevolently) is not a choice facing only jurists and psychiatrists; on the contrary, it is a choice everyone must make. The way an individual responds to that challenge, the choice he makes, largely shapes and defines his moral character. Some choose justice; they are regarded as competent and reliable by their friends and as unyielding by their enemies. Others choose benevolence; they are regarded as kindly and loving by their friends and as despotic by their enemies. That is not to say that individuals cannot, in principle, be both just and benevolent. As persons they may be

27. Ibid., p. 228.
28. Ibid., p. 229.
29. Menninger, *The Crime of Punishment*, p. 262.

both; but when faced with concrete situations, they must often choose between those two values and types of conduct.

The same considerations hold for societies. William Frankena puts it well when he asserts that "societies can be loving, efficient, prosperous, or good, as well as just, but they may well be just without being notably benevolent, efficient, prosperous, or good."[30] He also notes, correctly, that there is an internal contradiction between a state being both loving and just: the more loving it is, the more unjust it must become, and vice versa (unless justice is itself considered a form of love). A "just society," Frankena continues, restating the traditional definition, "is, strictly speaking, not simply a loving one. It must in its actions and institutions fulfill certain formal requirements dictated by reason rather than love: it must be rule-governed."[31] That puts the case of the just state versus the therapeutic state squarely before us. And it helps us see what I consider the fatal flaw—both empirically and ethically—in the argument for love over justice.

As we saw earlier, justice may, in its most basic sense, be readily defined as the fulfillment of contracts or expectations. Contracts, moreover, consist of performances and counterperformances—that is, of overt acts. They thus differ from intentions, sentiments, or states of mind—which are private experiences. Accordingly, justice is open to public inspection, scrutiny, and judgment, whereas love is closed to such examination and evaluation. Hence, the claim that one is acting justly is a plea for the support of the good opinion of others, whereas the claim that one is acting lovingly leaves no room for the judgment of others and in its zeal brooks no opposition. In short, although love appeals to the ideal of consideration for the *needs of others* and justice appeals to the ideal of consideration for *agreed-upon rules*, in actual practice just actions afford more protection for the self-defined interests of others than do loving actions.

I have tried to show that justice and freedom are closely related

30. W. F. Frankena, "The Concept of Social Justice," in Brandt, ed., *Social Justice*, p. 3.
31. Ibid., p. 23.

concepts and that the value of the former is contingent on that of the latter. Thus, if freedom is debased, so is justice.

I use the term *freedom* to signify man's ability to make uncoerced choices. In that sense of the term, freedom is endangered from two different directions, by two different kinds of threats. One threat emanates from within the individual, from the limitations of his body, his mind, and his personality; for example, illness and stupidity diminish or impair freedom by diminishing or impairing man's capacity to formulate or execute uncoerced choices. Another threat emanates from outside the individual, from the limitations of his worldly, and especially his social, circumstances; for example, other men, acting either as individuals or through the coercive apparatus of the church or the state, diminish or impair freedom by diminishing or impairing man's capacity to formulate or execute uncoerced choices.

To confuse these two sources of danger to individual liberties is fatal to their cause. Yet that is precisely what the modern liberal and scientific social critic and reformer often does: by stressing the similarities rather than the differences between man's vulnerability at the hands of nature and of the state, between the injury inflicted on a person by an illness and by an individual, the behavioral scientist technicizes human problems and thus transforms man into a thing. Having done that at the outset, what is there left for him to protect? Nothing but an image, a shadow—which he then casts into the role of the alleged beneficiary of his spiritual munificence. In that way, the behavioral technologist authenticates himself as a great healer and a great scientist. But his performance is a tragic farce, a playact not unlike that of the child or so-called madman: in each of these cases, the performer impersonates an important or noble actor—whether it be fireman, Savior, or physician—and plays his part without regard to the participation of other actors or audience. It is this lack of confirmation by their respective beneficiaries—of child as fireman, of madman as Jesus, and of humanitarian institutional psychiatrist as healer—that defines each of these roles as counterfeit. But there is this difference for the psychiatrist: whereas child and madman lack the power to impose their role playing on unconsenting others (thus usually having to confine their

performances to their families), psychiatrists, invested with the coercive powers of the state, often impose their definitions of reality on others.[32] Hence, in the therapeutic state, care, help, and treatment are not what the involuntary patients request, but what the humanitarian psychiatrists impose.

What, then, of justice in the therapeutic state? Its fate may be varied, but of this we can be certain: it will cease to exist as we have come to know it. Justice may thus be consigned to the history books as the relic of a barbarous age that valued individual freedom more highly than collective security, or it may be redefined in the newspeak of our times as treatment.

32. See generally my *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper & Row, 1974), esp. pp. 241–249.

10

The Illogic and Immorality of Involuntary Psychiatric Interventions: A Personal Restatement

Involuntary mental hospitalization—or compulsory admission to hospital, as it is called in England—is the paradigmatic policy of psychiatry. Whenever and wherever psychiatry has been recognized and practiced as the medical specialty dealing with the treatment of insanity, madness, or mental disease, then and there persons have been incarcerated in insane asylums, madhouses, or mental hospitals.[1]

In recent years, this deprivation of liberty has been justified on two different grounds, one more popular in America, the other in England. In the United States, the defenders of involuntary psychiatry claim that mental health is more important than personal freedom and that the well-being of the individual and the nation justify certain psychiatric infringements on individual liberty. In England, its defenders, sidestepping the dilemma of such a rank-ordering of values, claim that the civil-liberties problem inherent in compulsory mental hospitalization is now so small as to be insignificant.[2]

In the American view, then, compulsory psychiatric confinement

1. See my (ed.) *The Age of Madness: The History of Involuntary Mental Hospitalization Presented in Selected Texts* (Garden City, N.Y.: Doubleday, Anchor Press, 1973).

2. See my "The ACLU's 'Mental Illness' Cop-Out," *Reason* 5 (January 1974): 4–9, and Preface to the British Edition, *The Age of Madness* (London: Routledge & Kegan Paul, 1975), pp. xv–xviii.

is a sort of limited martial law; while in the British view, it is a sort of dead-letter law. But mental patients do not menace society so gravely as to justify suppressing them by extralegal measures, nor are they suppressed so rarely as to justify our regarding the measures used against them as moribund.

Because involuntary mental hospitalization continues to be the paradigmatic practice of coercive or institutional psychiatry, it seems to me worthwhile to recapitulate briefly the justifications for its legitimacy advanced by its supporters and the justifications for its illegitimacy that I have advanced.

The coercion and restraint of the mental patient by the psychiatrist—or, better, of the madman by the alienist, as these protagonists were first called—is coeval with the origin and development of psychiatry. As a discrete discipline, psychiatry began in the seventeenth century with the building of insane asylums, first in France, then throughout the civilized world. These institutions were of course prisons in which were confined not only so-called madmen but all of society's undesirables—abandoned children, prostitutes, incurably sick persons, the aged and indigent.[3]

How did people in general, and those directly responsible for these confinements—the legislators and jurists, the physicians and the victims' relatives—in particular justify such incarceration of persons not guilty of criminal offenses? The answer is: by means of the imagery and rhetoric of madness, insanity, psychosis, schizophrenia, mental illness—call it what you will—which transformed the inmate into a patient, his prison into a hospital, and his warden into a doctor. Characteristically, the first official proposition of the Association of Medical Superintendents of American Institutions for the Insane, the organization that became in 1921 the American Psychiatric Association, was, "Resolved, that it is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane."[4]

3. See my *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper & Row, 1970), pp. 13–16.

4. Quoted in N. Ridenour, *Mental Health in the United States: A Fifty-Year History* (Cambridge, Mass.: Harvard University Press, 1961), p. 76.

Ever since then, this paternalistic justification of psychiatric coercion has been a prominent theme in psychiatry, not only in America but throughout the world. Thus, in 1967—123 years after the drafting of its first resolution—the American Psychiatric Association reaffirmed its support of psychiatric coercion and restraint. In its "Position Statement on the Question of the Adequacy of Treatment," the association declared that "restraints may be imposed [on the patient] from within by pharmacologic means or by locking the door of a ward. Either imposition may be a legitimate component of a treatment program."[5]

The British Mental Health Act of 1959 provides medico-legal measures for both civil and criminal commitment virtually identical to those of the various American states. Part IV of the act, entitled "Compulsory Admission to Hospital and Guardianship," articulates the criteria for civil commitment as follows: "An application for admission for observation may be made in respect of a patient on the grounds (*a*) that he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital under observation . . . (*b*) that he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."[6]

Justifications for involuntary psychiatric interventions of all kinds—and especially for involuntary mental hospitalization—similar to those accepted in the United States and the United Kingdom are, of course, advanced in other countries. In short, just as involuntary servitude had been accepted for millennia as a proper economic and social arrangement, so involuntary psychiatry has been accepted for centuries as a proper medical and therapeutic arrangement.

It is this entire system of interlocking psychiatric ideas and insituations, justifications and practices, that for some twenty years I have analyzed and attacked. I have described and documented the precise legal status of the mental-hospital patient—as an innocent

5. Council of the American Psychiatric Association, "Position Statement on the Question of the Adequacy of Treatment," *American Journal of Psychiatry* 123 (May 1967): 1459.

6. *Mental Health Act, 1959,* 7 and 8 Eliz. 2, Ch. 72 (London: Her Majesty's Stationery Office, 1959), p. 15.

person incarcerated in a psychiatric prison; articulated my objections to institutional psychiatry—as an extralegal system of penology and punishments; and demonstrated what seems to me, in a free society, our only morally proper option with respect to the problem of so-called psychiatric abuses—namely, the complete abolition of all involuntary psychiatric interventions.

My objections to the principles and practices upon which involuntary psychiatric interventions rest may be summarized as follows:

The term *mental illness* is a metaphor. More particularly, as this term is used in mental-hygiene legislation, *mental illness* is not the name of a medical disease or disorder but is a quasi-medical label whose purpose is to conceal conflict as illness and to justify coercion as treatment.

If mental illness is a bona fide illness—"like any other," as official medical, psychiatric, and mental-health organizations such as the World Health Organization, the American and British medical associations, and the American Psychiatric Association maintain—then it follows, logically and linguistically, that it must be treated like any other illness. Hence, mental-hygiene laws must be repealed. There are no special laws for patients with peptic ulcer or pneumonia; why then should there be special laws for patients with depression or schizophrenia?

If, on the other hand, mental illness is, as I contend, a metaphor and a myth, then it also follows that mental-hygiene laws should be repealed.

Further, if there were no mental-hygiene laws—which create a category of individuals who, though officially labeled as mentally ill, would prefer not to be subjected to involuntary psychiatric interventions—then the misdeeds now committed by those who care for mental patients could not arise or endure.

In short, all those who draft and administer laws pertaining to involuntary psychiatric interventions should be regarded as the adversaries, not the allies, of the so-called mental patient. Civil libertarians, and indeed all men and women who believe that no one may be justly deprived of liberty except upon conviction for a crime, should oppose all forms of involuntary psychiatric interventions.

What, then, are some of the most important objections to my contention that mental disorders are not bona fide diseases and to my claim that imprisonment for insanity, as opposed to lawbreaking, is incompatible with the moral principles of a free society?

First, some of my critics say that I am wrong because what we now call mental diseases may yet be shown to be caused, at least in some cases, by subtle pathophysiological processes in the body—in particular, by disorders in the molecular chemistry of the brain—that we do not yet know how to measure or record. Nevertheless, such processes, like those responsible for the psychoses associated with paresis or pellagra, exist (so runs this argument), and it is only because of the present state of our knowledge, or rather ignorance, that we cannot yet properly diagnose them. But such an advance in the science and technology of medical diagnosis would only add to the list of literal diseases and would not in the slightest impair the validity of my argument that when we call certain kinds of disapproved behaviors mental diseases, we create a category of metaphorical diseases. This type of objection to my views, which actually represents just another instance of biological reductionism, misses the point I try to make; to uphold it would be like upholding the view that because certain canvases thought to be forged Renoirs or Cézannes prove to be, on closer study, genuine, all forged masterpieces are genuine. If there are real or literal diseases, there must also be others that are fake or metaphorical.

Second, other critics say that I am wrong, not because I say that mental illnesses are unlike bodily illnesses (an assertion with which they claim to agree), nor because I say that involuntary hospitalization or treatment is no more justified for so-called mental illness than it is for bodily illness (a moral principle with which they also claim to be in sympathy), but because the term *mental illness* often designates a phenomenologically identifiable and hence valid category of conduct. But I do not deny that. I have never maintained that the conduct of a depressed or elated person is the same as that of a person who is contented and even-tempered or that the conduct of a person who claims to be Jesus or Napoleon is the same as that of one who makes no such false claims. I object to psychiatric diagnostic terms not because they are meaningless, but be-

cause they are used to stigmatize, dehumanize, imprison, and torture those to whom they are applied. To put it somewhat differently, I oppose involuntary psychiatry, or the rape of the patient by the psychiatrist; but I do not oppose voluntary psychiatry, or psychiatric activities between consenting adults.

The idea that a person accused of crime is innocent until proven guilty is not shared by people everywhere but is, as I need hardly belabor, characteristically English in its historical origin and singularly Anglo-American in its consistent social application. And so is its corollary—that an individual has an inalienable right to personal liberty unless he has been duly convicted in court of an offense punishable by imprisonment. Because this magnificent edifice of dignity and liberty is undermined by psychiatry, I consider the abolition of involuntary psychiatric interventions to be an especially important link in the chain I have tried to forge for restraining this mortal enemy of individualism and self-determination. I hope that my work will help people to discriminate between two types of physicians: those who heal, not so much because they are saints but because *that is their job*; and those who harm, not so much because they are sinners but because *that is their job*. And if some doctors harm—torture rather than treat, murder the soul rather than minister to the body—that is, in part, because society, through the state, asks them, and pays them, to do so.

We saw it happen in Nazi Germany, and we hanged many of the doctors. We see it happen in the Soviet Union, and we denounce the doctors with righteous indignation. But when will we see that the same things are happening in the so-called free societies? When will we recognize—and publicly identify—the medical criminals among us? Or is the very possibility of perceiving many of our leading psychiatrists and psychiatric institutions in that way precluded by the fact that they represent the officially correct views and practices; by the fact that they have the ears of our lawyers and legislators, journalists and judges; and by the fact that they control the vast funds, collected by the state through taxing citizens, that finance an enterprise whose basic moral legitimacy I have called into question?

11

The Metaphors of Faith and Folly

In the Middle Ages, the lives and languages of people were suffused with the imagery of God and permeated by the ideology of Christianity; today, they are suffused with the imagery of science and permeated by the ideology of medicine. That is why the metaphors of the family formerly played an extremely important role in the practical affairs of men and women and why the metaphors of illness play a similar role in them now.

It seems to me reasonable to assume that a medieval person need not have been a theologian to understand—had he wanted to and had he had the courage to—that the vocabulary of the family was used on him and by him in two quite different senses. It was one thing for him to call his parents *father* and *mother* and his siblings *brother* and *sister*. It was quite another for him to call God his *Father in Heaven* and his parish priest simply *Father*.

Had our hypothetical medieval demetaphorizer wanted to pursue a purely linguistic analysis of religion and religious institutions, he could have quickly discovered that although the Church was said to be God's family, it was not exactly like his own family or any other family that he actually knew. For example, in the families he knew, there were, besides the parents and children, also uncles and aunts, cousins and second cousins, and so forth. But there were no cousins and nephews in the Family. Similarly, God was said to have a Son. Did He also have a liver or kidney? There is no need to go on. That way lay blasphemy then and lies humor now, unless one goes too far and offends.

All I am trying to do in these preliminary remarks is to show that it might have been possible for an ordinary person in a theocratic society to understand the metaphors of faith—that is, to grasp the real character of words borrowed and metaphorized from the family, and to use that supposition as my basis for suggesting that it may be similarly possible for an ordinary person in our therapeutic society to understand the metaphors of folly—that is, to grasp the real character of words borrowed and metaphorized from medicine.

Let us start by considering some aspects of the language of medicine.

The terms *ill* and *sick* are often used interchangeably. For example, we can say, "Jones has pneumonia, he is quite ill." And we can say just as well, "Jones has pneumonia, he is quite sick."

Ill, however, has a history and a scope that have nothing to do with medicine or disease. It then means, roughly, *bad*, *unfortunate*, *tragic*, or something of that sort. For example, we can speak of *ill will* or *ill fate*, but we cannot speak of *sick will* or *sick fate*. Moreover, we can speak of *ill health* but cannot substitute *sick* as an adjective for *health*.

On the other hand, *ill* has often a much more restricted implication than *sick*, so that there are many instances in which we can use the latter but not the former term. For example, we don't say, "The tiger is ill," or "The tree is ill," but we do say, "The tiger is sick," or "The tree is sick." Revealingly, the strict use of *ill* is restricted to persons; not even body parts or organs may be ill, although they may be sick. We don't say, "His hand is ill," or "He has an ill hand," but we say, "His hand is sick," or "He has a sick hand."

If we want to convey the idea of *ill* about an animal, a part of the human body, or even an abstract noun, then we use *sick*. Thus, we can say about a person that "his liver is sick," and we can also say that a cat or a car, a television set or a joke, or even a whole society is sick. None of them can be ill, however.

It seems that the only nouns to which we cannot attribute the characteristic or condition of being sick are those which refer to concrete nonliving things that do not affect us. For example, we do not usually say that "the mountain is sick," but we might say that

if we were Alpinists threatened by avalanches or rock slides. The sky affects us more often, and hence it is less unusual to say that "the sky looks sick." And if we play table tennis, the equipment always affects us, and it is therefore quite natural to say that "this ping-pong ball is sick." In none of these uses, however, can *ill* replace *sick*.

Qualifying *ill* and *sick* with *mentally* introduces new wrinkles into how those terms can be used and what they mean. Clearly, from a purely linguistic viewpoint, if *mentally ill* meant exactly the same thing as *ill* (as some psychiatric propagandists would have us believe), then the term would not have come into being and could not have retained currency. But that alone need not detain us. What should interest us instead is that *mentally ill* and *mentally sick* tend to function linguistically very much as the metaphorically *sick* functions and not at all as does the literally *sick* or *ill.* (By *metaphorically sick*, I mean that the person uses it to express disapproval or dislike of the referent or attributes some sort of malfunctioning or wrongness to it, whereas by *literally sick* or *ill*, I mean that the person uses it to express the specific idea of some sort of bodily disorder or medical disease.)

The literally or medically *sick* occurs in all tenses and moods and with all sorts of time modifiers; the metaphorically or mentally *sick* does not. For example, we can say all of the following: "Jones is sick; he cannot work." "Jones was sick; he could not work." "Jones has been sick; he has not been working." "Jones had been sick; he missed a lot of work." "Jones will be sick; he will not be at work." "Jones is sick today; he is not working." "Don't get sick, Jones; you don't want to miss work."

When metaphorically *sick* is used explicitly, it has a much more restricted range of tenses. We can say, "The joke is sick," or "The joke was sick." But it would be weird to say, "The joke has been sick," or "The joke will be sick." And it would be absurd to say, "The joke is sick today," or "The joke is often sick."

The psychiatrically or mentally *sick*, which I have long contended is covertly metaphorical, has the same restricted range of use as does the overtly metaphorical *sick*. Thus, we can say, "Jones is mentally sick (or ill); he shot the president," or "Jones was mentally sick; he shot the president." But it would be awkward to

say, "Jones has been mentally sick; he shot the president," or "Jones had been mentally sick; he shot the president." And it would be quite wrong, as well as most odd, to say, "When Jones will be mentally sick, he will shoot the president." (If we thought this about Jones, we would say he is mentally sick.) And it would be odder still to say, "Don't get mentally sick, Jones, you don't want to shoot the president." Humorous as that sounds, the psychiatric and witty dimensions of *mentally sick* would become undistinguishable were we to say, "Jones is mentally sick today; he shoots the president," or "Jones is often mentally sick; he shoots a lot of presidents."

Some of these differences between *sick* and *mentally sick* stem from the fact that we tend to use *sick* to describe states and *mentally sick* to describe characteristics, and that we attribute more permanence to the latter than to the former. Thus, Jones may have pneumonia and may recover from it. Hence, we say, "Jones is sick," and "Jones was sick." But if Jones is an American, so long as Jones is alive, we cannot in the same way say, "Jones is an American," and "Jones was an American" (for the latter means not that he is no longer an American but that he is no longer alive).

The literally or physically *sick*, denoting conditions rather than characteristics, implies no permanency; whereas the metaphorically or mentally *sick*, denoting characteristics rather than conditions, does. It is worth recalling in this connection that permanence has always been the very essence of true madness: when madness was insanity or lunacy, it was incurable; when it became dementia praecox or schizophrenia, it became genetically fixed and had a chronic, downhill course. Even today, *psychotics* can have *remissions* but cannot have *recoveries*.

In the Age of Faith, men and women had to, and wanted to, call their spiritual problems sins and their spiritual authorities fathers, who, in turn, called them children. In the Age of Medicine, men and women have to, and want to, call their spiritual problems sicknesses and their spiritual authorities doctors, who, in turn, call them patients.

The metaphorical character of this sort of language is half-concealed and half-revealed. The words and deeds of men and

women reveal that they both know and don't know, want to know and don't want to know, the differences between earth and heaven, man's law and God's law, father and priest, body and mind, medicine and psychiatry, physician and philosopher.

What, it may be asked, is the proper task of science in the face of this sort of situation? Surely, it cannot be to impose its images on those who do not want to see them. But just as surely, it must be to insist that those who want to see them be allowed to do so.

12

Medicine and the State: A *Humanist* Interview

PAUL KURTZ: Dr. Szasz, you have led some vigorous battles on many fronts. What would you say is the key value that you have attempted to defend?

THOMAS SZASZ: If I had to name a single value, it would be individual self-determination or freedom, in a political sense. After all, freedom is an issue only when it is threatened by a person, a group, an organization, or some force. I have tried to identify what the principal forces are that now threaten individual freedom.

KURTZ: And what are they?

SZASZ: In Communist countries, it is the Communist party, the Communist state. In so-called free societies, especially in the United States and England, it is the bureaucratic state, the paternalistic state—or, as I have called it, the therapeutic state. One of the most important aspects or parts of such a state—and hence one of the major threats to individual freedom—is the alliance between medicine and the state, and one particular facet of that alliance, which has concerned me the most, is the acceptance and use of psychiatry as a genuine medical discipline. The alliance is dangerous because it means that the social control of what is really self-determining behavior is called treatment for mental illness and is accepted as something medical rather than moral, as something therapeutic rather than punitive.

KURTZ: How do you think medicine operates in conjunction with the state? Exactly how does it deny freedom?

SZASZ: Let me give you my conclusions about that first, and then we'll fill in the details as we move along. As I see it, medicine does not merely operate in conjunction with the state; in modern industrial societies, medicine is actually a part of the state—it is a sort of *state religion*. I mean that in the sense that most people on both sides of the Iron Curtain now believe in health rather than salvation, in pills rather than prayer, in physicians rather than priests, in medicine and science rather than theology and God. In short, medicine now functions as a state religion much as, for example, Roman Catholicism did in medieval Spain.

KURTZ: You mean that the state and the church are overlapping institutions, not really separate and distinct entities?

SZASZ: Exactly. In Spain, and in other theocratic societies, the state legitimized the church and vice versa. They were intertwined ideologically, economically, politically—in every way. It was an alliance that was very difficult—to say the least—to oppose. That same sort of thing has been happening with medicine and the state in all the civilized countries for the past hundred years or so, especially since the end of the Second World War. The state supports and legitimizes medicine, and medicine in turn supports and legitimizes the state. It's an unholy alliance, if I may put it that way.

KURTZ: Could you illustrate that with an example?

SZASZ: Yes. Medical education is completely controlled by the state—that is, by the state and federal governments. The control is partly economic—much of the money comes from the government; partly educational—the schools have to be approved by state education departments and similar agencies; and partly legal—physicians have to be licensed to practice medicine. And physicians in turn serve the state in both subtle and obvious ways—by reporting births and deaths, controlling deviant behavior, assisting law-enforcement agencies. It goes much further than that, of course. What is health? disease? treatment? The very definition of these things is something that in the last analysis the state determines and medicine accepts and implements. Some examples will show what I mean. Today in New York State, doing an abortion is treatment. Only a year or so ago it was a crime. Locking someone up in a prison called a

mental hospital is also considered to be a form of treatment. Why? Because the state says so; the law says so.

KURTZ: Yes, mental hospitalization is a good example.

SZASZ: I have been interested in involuntary mental hospitalization not only because it is such a blatant violation of human rights, but also because it reveals so clearly how we have medicalized certain moral and political problems. If someone wants to do something we really don't like—such as killing himself—then we say he is depressed and lock him up in a mental hospital. How is that possible? Because psychiatry says that depression is a disease; obviously, if you are an American, you should want to live. Look how similar that is to people's being locked up in mental hospitals in the Soviet Union because they criticize the system. Obviously, to the Soviet state and its psychiatrists, anyone who publicly expresses political dissent must be crazy; if he weren't crazy, he would be an obedient Communist.

KURTZ: But in the Soviet Union, that has a political basis—to support the state. Is there the same motive for locking up persons in mental institutions here?

SZASZ: Professor Kurtz, I think we have to come to some agreement about what we mean by political and what we mean by psychiatric. Otherwise, there is a risk that what the Russians do psychiatrically will appear to us as political and what we do will appear to us as psychiatric—and probably vice versa. I would insist that in a fundamental sense all involuntary psychiatry is political. It's the use of the police power of the state against the dissenting citizen. It is as simple as that. What constitutes dissent varies, of course, from country to country. It must. In each case, naturally, dissent is directed against what the citizens don't like, and that differs from country to country.

KURTZ: And people—some people—who deviate from ideological conformity, who dissent in certain socially prohibited ways, may be locked up in psychiatric institutions?

SZASZ: Yes.

KURTZ: What other examples of state control through medicine would support your point? For example, what about drug abuse?

SZASZ: That is a very striking case in point today. Here, again, the state defines—quite arbitrarily from a pharmacological point of

view—what is illness and what is treatment, what is permitted and what is prohibited. Taking heroin is addiction. Receiving methadone is treatment. But what's the difference between heroin and methadone? I'll tell you what: it's the same as the difference between Protestantism and Catholicism!

KURTZ: But the public has been told that on heroin you can't function, while on methadone you can; you need methadone to hold down a job, so the methadone-maintenance people argue.

SZASZ: Naturally. How well could you function in post-Reformation Europe if you were a Catholic in a Protestant country, or vice versa? Not very well. So, if you were a Protestant in Paris, it was a good idea to become a Catholic. And if you were a Catholic in London, it was a good idea to become a Protestant. Just so with drugs: it is easier to live in America on methadone than on heroin; the government likes it better that way.

KURTZ: But methadone is a drug. It is administered by the state under certain programs.

SZASZ: Precisely. Methadone is defined as a therapeutic agent and heroin as a dangerous and illegal drug. But heroin itself was developed and first used as a therapeutic agent—as a treatment for morphine addiction. It's sad. But Santayana was so right when he warned that those who cannot remember the past are condemned to repeat it.

KURTZ: So you think in both cases the state merely imposes certain values on the citizens?

SZASZ: Exactly. In the case of religion, certain theological values —for example, you must be a Catholic and not be a Protestant. In the case of medicine, certain therapeutic values—for example, you must take methadone and not heroin.

KURTZ: Is there no difference between these drugs?

SZASZ: Is there no difference between Catholicism and Protestantism?

KURTZ: Yes, but they are also similar.

SZASZ: So are heroin and methadone. They are not identical, but they are similar. And of course it is possible—should the person be otherwise so motivated—to function on both of these drugs, just as it is possible to function as either a Catholic or a Protestant—

provided one is not persecuted for one's religious habit or drug habit! It's the persecution that's disabling, not the drug.

KURTZ: Can you suggest another example to illustrate how the alliance between medicine and the state operates? How it curtails freedom?

SZASZ: Yes, abortion.

KURTZ: The law used to prohibit abortion, but it no longer does, at least in New York State.

SZASZ: Yes, but there are actually two different points to be made here: first, it is the state that determines whether abortion is a crime or a cure; and, second, the state remains intimately involved in abortion even now that it's legal. The state does not simply allow a woman to have an abortion as it allows her to take aspirin. It forces the taxpayer to pay for it. Since abortion is now defined as treatment, if a poor woman has an abortion, the taxpayer pays for it. I think that is a grave moral wrong. After all, an abortion is necessary only because a man and a woman have engaged in sexual intercourse—which may be very nice. It is what's called sumptuary behavior, in fancy language. And so are drinking and smoking. Hence, in my mind, forcing taxpayers to buy abortions for poor women is like forcing taxpayers to buy alcohol or cigarettes for poor men. What mischievous nonsense.

KURTZ: Having the taxpayer pay for abortions, some argue, protects society from unwanted children.

SZASZ: That is a rationalization. It is possible to explain or justify any social policy if one is willing to accept such vague notions as "protection from unwanted children." Lots of children are wanted while they are *in utero* and become unwanted only *in vivo*—after they are born. How about them? Should we kill them to protect society from unwanted children? Actually, the matter of tax-supported abortions raises another interesting issue, one I have never seen mentioned or discussed. I refer to the fact that such abortions actually infringe on the religious liberties of those who, because of their religious convictions, disapprove of abortion—who consider abortion a morally wrongful act. In other words, using the tax monies, say, of devout Catholics to pay for abortions puts the government, however unwittingly, into the business of actively

supporting certain kinds of antireligious activities. Now, it may be all right for the ACLU to do that or for any other private group to do that. But if the government does it, it does something that gets uncomfortably close to the sorts of antireligious activities that have characterized Communist societies. The state itself becomes a church; political dogma becomes, in effect, religious dogma, though of course it's never called religion; and we fall into the very trap the First Amendment is supposed to protect us from.

KURTZ: How does your argument affect education and, specifically, medical education?

SZASZ: Let me first make clear that I believe, more or less, in traditional medicine—in so-called Western, scientific medicine. But I do not believe—and this is the cutting edge of my argument—that the state should support only that sort of medical education and should, in effect, outlaw every other kind. It should not, in my opinion, support any kind of medical education. Scientific medicine should compete in the free marketplace of ideas—and in the free economic marketplace—with osteopathy, and homeopathy, and Christian Science, and Zen Buddhism, and what have you.

KURTZ: Would you then have private professional organizations, like the AMA, set standards?

SZASZ: No. I believe the organizations best suited for setting standards are the schools. So there could, and should, be standards in medicine—just as there are in mathematics or religion, but those standards are neither set nor enforced by the state. I have come to believe that if we value personal freedom and dignity, we must be satisfied with nothing less than a complete separation between medicine and the state—a separation analogous to that between church and state guaranteed in the First Amendment.

KURTZ: But health and welfare are basic points in the Constitution.

SZASZ: But how could health be more important to the general welfare than religion? Not to mention the vexing questions of what is health, and what is religion, and again, who has the final authority to define them. The classic American answer to this dilemma was that the way to promote true religion (not *the* true religion) was by promoting religious freedom and by opposing the establishment of a state religion—of religious monopoly, as it were. The basic

concept of American political liberty is thus rooted in the idea that since the established churches used to threaten pluralism, diversity, and personal freedom, the state should guarantee the impossibility of any church's using the power of the state to impose its views on anybody who does not want them imposed on him. That is the essential problem we now face with respect to medicine. So my view does not imply that every form of medical practice is as good as any other, any more than defending religious tolerance implies that one thinks any system of religious beliefs and practices is as good as any other.

KURTZ: Then you think that medicine is a kind of religion and ought to be pluralistic without the state's determining one point of view against another.

SZASZ: Determining and *imposing* that point of view!

KURTZ: Would there then be professional bodies? Would there be any norms or standards of correct practice and therapy?

SZASZ: Of course, there could be and would be, just as there are in other professions today, such as mathematics. If IBM wants to hire a mathematician, it can't look to the state to tell it who is qualified. But it can find out if the man has a Ph.D. from Harvard or MIT. Or the company can set its own standards, can make its own assessment of the applicant's capabilities.

KURTZ: Your point, then, is that the state should not license doctors.

SZASZ: Certainly not. The licensing of doctors is the *symbol* of what I am talking about. It's as if the state would license Catholic priests for the ministry—and would prohibit all other clergymen to practice religion because they are quacks.

KURTZ: But then who should do the licensing?

SZASZ: There should be *no* licensing.

KURTZ: No licensing? Anyone could practice medicine?

SZASZ: Of course.

KURTZ: But how would you protect the public? What about the quacks?

SZASZ: Professor Kurtz, the idea that licensing doctors protects the public is one of the most uncritically accepted falsehoods of our day.

KURTZ: What do you mean?

SZASZ: Well, suppose a professor of medicine or surgery at the University of London were to come to New York; could he practice medicine? Or suppose a professor of medicine or surgery at Harvard—or the State University of New York—were to move to Miami because it's warmer there; could he practice there?

KURTZ: No, not without first passing the state medical-board examinations.

SZASZ: Exactly. And that is to protect the public? Hardly. I grant, of course, that licensure examinations may, *inter alia,* also protect the public. But I insist that their first and foremost function is to protect physicians, the medical profession, from too much competition. In short, medical licensure is a method for preserving a closed union shop for physicians—for maintaining an artificial shortage of doctors. And the whole thing has been successfully palmed off on the American public as something done for its protection.

KURTZ: So how should the public be protected? Doesn't it need protection from incompetent medical practitioners?

SZASZ: Oh, I agree that people need protection—but not only from bad, stupid, inept, greedy, evil doctors; they need protection also from bad parents and children, husbands and wives, mothers-in-law, bureaucrats, teachers, politicians—the list is endless. And then of course, they'll need protection from the protectors! So the question of how people should be protected from incompetent medical practitioners is really a part of the larger question of how they should be protected from the countless hazards of life. That is a vastly complicated problem for which there are no simple solutions. The first line of protection for the public lies, I would say, in self-protection. People must grow up and learn to protect themselves—or suffer the consequences. There can be no freedom without risk and responsibility. More specifically, the public could look to what school the doctor graduated from and could set up all sorts of unofficial testing mechanisms—sort of consumers' bureaus. The possibilities of nongovernmental checks on competence are immense. The trouble is no one is interested in even thinking along those lines nowadays.

KURTZ: Many people know very little about medicine. They may go to a man who claims to know what he is doing but doesn't.

SZASZ: That's true. But what I am talking about now is a long-range view. It's a view that couldn't be implemented overnight. To

make it meaningful, practical, we would have to envision corresponding changes in education, in people's interest in, and knowledge about, their own bodies, about drugs, and so forth.

KURTZ: Why do you think that people don't know more about medicine?

SZASZ: There are many reasons. One is because they aren't taught anything about it. You know, most professions thrive on mystification, on keeping the public in the dark—despite all the protestations about popularizing medical knowledge. I have always thought that twelve-year-olds and thirteen-year-olds could be taught a great deal about how the body works—really works; it's no more difficult either to teach or to learn that than is algebra or French grammar.

KURTZ: You would teach medicine in high school?

SZASZ: Certainly. Not how to take out an appendix, but how the body works, what doctors do—the basic principles and facts of phsysiology, pharmacology, the major diseases that affect man and the treatments for them. Real information—what's in medical textbooks—not the lies children are now taught in the name of sex education, drug education, health education. None of that is possible, however, so long as education is a state monopoly.

KURTZ: Why not?

SZASZ: Because the doctor is a priest who teaches only his religion, and only to a select few. As a priest protected by the state, the doctor becomes the keeper of all kinds of secrets. Remember the Latin prescriptions and the diagnostic mumbo jumbo to keep from patients the knowledge of what ails them. Even today, physicians seriously contemplate when patients should and should not be told they have cancer. The whole thing is really quite absurd once one stands back and looks at it as an anthropologist might at another culture. Magic used to be used as medicine. Now medicine is used as magic.

KURTZ: But that is not all the doctors' fault?

SZASZ: Certainly not. I wouldn't want to give the impression that I think it is. It takes two to tango. Freud was quite right in emphasizing that one of the greatest passions men have is the passion *not* to know—to repress, to mystify—the obvious. Thus, there is a sort of conspiracy between people who do not want to

know, who want to remain stupid, and experts who will lie to them, who will make a profession out of stupefying them. The priests used to do a good job of that. Now the physicians do it. And, above all, the politicians are in there pitching to make sure people hear all the lies they want to hear.

KURTZ: I think much of it comes from our religious prohibitions.

SZASZ: Only in a historical sense, not otherwise. It's easy to blame religion where I think we should blame, if blame we must, human nature. Religion—formal religion—is not very important in those areas anymore. How could it be when Blue Cross now pays for abortions? And yet, in New York State, a woman cannot buy a diaphragm in a drugstore even if she knows her size. She must have a prescription for it from a physician. I mention that again to note its symbolic significance: it reveals the ceremonial, magical role and power of the doctor.

KURTZ: Can we go back to heroin and methadone to focus and highlight your position? What is your position on so-called dangerous drugs? Should there be no controls?

SZASZ: None for adults. I don't see how anyone can take seriously the idea of personal self-determination and responsibility and not insist on his right to take anything he wants to take. The American government simply does not have the right to tell him what he may or may not take—any more than it has the right to tell him what he may or may not think. That doesn't mean, obviously, that it's a good thing to take certain drugs. It most assuredly can be a very bad thing. But a person must, if he is to be free, have the right to poison and kill himself. As, indeed, he now does with tobacco, but not with marijuana; with alcohol, but not with heroin.

KURTZ: You agree, obviously, with John Stuart Mill's *On Liberty*, which argues the same way.

SZASZ: Yes. Mill taught us all this. We really have no choice in the matter—that is, of drugs and self-injury and suicide; we must either agree with him or commit ourselves to a sort of unlimited inconsistency and hypocrisy.

KURTZ: Why can't we have a balance between personal freedom and state protection?

SZASZ: We can in some areas but not in others. For example, we can have state protection with respect to genuine public-health

issues, such as sewage disposal or water purification. But we can't if we try to go beyond that and expect the state to provide us with a sort of metaphorical public health—for example, by putting things into water or bread that are supposedly good for us. There are things the state can't do and shouldn't try to do. I refer to the libertarian principle that the state shouldn't do what the people can do for themselves. The state can't protect people beyond a certain, very minimal, point without denying them their freedom of choice. When it tries, the result is a disaster—or, to be precise, two kinds of disasters. In the free world, the state's ostensible efforts to protect the people from medical harm have gone hand in hand with the most blatant state-supported programs of "poisoning" people—for example, the opium wars in the nineteenth century (which were waged to spread the use of opium, not to curtail it) or the agricultural supports to tobacco growers today and the use of federal funds to encourage cigarette smoking abroad. In the totalitarian countries, the cost of trying to achieve a balance between personal freedom and state protection has been even higher: there it has required the liquidation of the most elementary human rights, such as the right to property, to a free press—even the right to leave one's country.

KURTZ: Well, are you against laws for prescriptions?

SZASZ: Of course.

KURTZ: There should be no laws . . .

SZASZ: There should be no *prescriptions!*

KURTZ: But suppose my wife had a cold. She likes to take antibiotics, and I worry about it—about whether they are necessary, whether she may develop a sensitivity to them, that sort of thing. How would you protect the public against that?

SZASZ: I am looking to protection through self-control. Today, without prescriptions, people can buy lye and all sorts of very dangerous cleaning fluids, and they know quite well how to protect themselves from those things. Really, amazingly well. Where there is a will, there is a way. But where there is no will—well, then, I would let the individual suffer the consequences rather than punish the whole society by prohibiting the "abused" substance.

KURTZ: You feel it's really impossible to protect people from themselves?

SZASZ: Impossible as well as immoral, in a sense. The problem

we touch on here is really as old as mankind. It goes to the very roots of freedom and responsibility—and humanism—to the roots of the question of what is man. It's all contained in the parable of the Fall. Who was the first pusher? The serpent. And who were the first addicts? Eve and Adam. And what was the consequence of that "original addiction"? Freedom! It's all there, in the first few pages of the Old Testament. But who reads that nowadays? And who reads it with open eyes or with an open mind?

KURTZ: Many people agree with some of that, or with much of it, but then they say, "What about children?" Would you let children buy any drug they want?

SZASZ: No, I would not. In a practical sense, for the present, I think the method we have developed with respect to alcohol is quite sensible: children can't buy it, but if they use it, say, at home, it's none of the law's business. So a twelve-year-old can't go into a liquor store and buy a bottle of gin. And that law is well enforced, as far as I know. The point is that the control of children—what children do with respect to drugs—is, and should be, a problem for the child's parents and, as the child grows older, for the child himself. We have forgotten the simple fact that childhood is the period of life when one should learn self-control—and if one doesn't, then one will be an adult lacking self-control.

KURTZ: But how do you deal with those cases where you have a breakdown of the family, where there is increasing lack of responsibility among parents?

SZASZ: I don't know how to deal with such cases. I only know how *not* to deal with them. I know that the breakdown of the family cannot and should not be dealt with by treating the whole society as a child. But that is just what we do now: because some children are not controlled by their parents and misbehave as a result, we treat all adults as if they were misbehaving children. The result is the paternalistic state—the therapeutic state, as I have called it—that we now have.

KURTZ: Dr. Szasz, you emphasize that the alliance between medicine and the state, between psychiatry and the state, is similar to the alliance between religion and the state. Do you find that in other fields as well—for example, in the law?

SZASZ: Certainly, the problem is not limited to medicine or psy-

chiatry. In totalitarian countries, where the whole legal profession is an arm of the state, really a servant of the state, we have something quite similar to what is developing in Western countries with respect to the medical profession. However, in American law, the situation is not quite so bad. We have a strong, viable tradition that articulates and legitimizes a dual role for the criminal law: on the one hand, the law serves the state to protect it from the citizen; on the other hand, it serves the citizen to protect him from the state. And in civil law, of course, the law serves to protect the citizens from one another. Thus, there is a general understanding—a popular appreciation—that lawyers and courts deal with conflicts and that in conflicts both parties are entitled to representation. We have nothing like that in medicine, and that is just the problem.

KURTZ: You think we need a bill of rights for patients?

SZASZ: No, I don't think that would do it. I think that would be just a piece of paper. There has to be a popular understanding first—a common-sense appreciation of the difference between illness as a biological and medical concept and conflict as a personal and political concept.

KURTZ: Why is there this confusion, this misunderstanding?

SZASZ: There are good reasons for it. In medicine, the traditional image of the problem is that of a patient fighting against his disease; in that situation, the disease—the infection, cancer, what not—is the adversary and the doctor the ally. This then is the basis of the misunderstanding for all the medical situations in which this imagery, this explanation, doesn't apply—in which the physician is the patient's adversary, not his ally. For example, in what we now call drug addiction, the drug is the ally and the doctor is the adversary; also, in what we now call serious mental illness, I would say the psychosis—the delusion—is the ally and again the doctor is the adversary. But medicine and the law do not recognize that, and people do not recognize it either—except when they are the victims, and then it's usually too late.

KURTZ: So what is the answer? What would help if not a bill of rights for patients?

SZASZ: I think a conceptual and economic separation between medicine and the state must come first, and of course civil libertarians and others—philosophers, writers, sociologists—could help

to separate those medical situations where the physician is the patient's ally from those where he is his adversary.

KURTZ: Now, are there other institutions in society that also undermine freedom—since to you freedom is apparently the most important value? We talked about medicine and the law; what about education?

SZASZ: Well, many of the things I have said about medicine others have said about education, and I quite agree with them—Paul Goodman, for example, and Bertrand Russell before him. To the extent that education is financed and legitimized by the state, education becomes propaganda. That problem is even larger and older than that of medicine. How is the independence and integrity of the educator maintained? What is taught and to whom? One has to think only of Socrates to realize how ancient the problem is.

KURTZ: In modern society, still another problem is the development of large institutions and organizations independent of the state. Many people now consider that large corporations, industrial firms, function like states and that they too can jeopardize freedom, can encroach on individual liberty. What would be your view on that?

SZASZ: My view is—and it is certainly not a very original view—that any organization, any institution, public or private—the state, the church, a profession, a business—tends to become repressive as it grows beyond a certain size. Of course, it may even start out to be repressive; repression may be its very *raison d'être.* But even if it is not that at the outset, repression soon becomes one of its goals, one of its interests. That is because as soon as any organization or institution becomes established, it will come in conflict with other organizations or institutions with competing interests. The larger and more successful group will try not only to promote its interests, products, markets, and so forth, but also to suppress and to annihilate its competitors. In that sense, any group, any organization, is by its very nature repressive. That is an idea that goes back, of course, to Montesquieu and the Founding Fathers. It is the reason why libertarians have always insisted that anyone who values the individual and his freedom must oppose the accumulation of monolithic power regardless of who accumulates it and for what purpose. Power accumulated for good reasons—for doing good—is the most dangerous of all. Who can be against good health today?

Who could be against good religion in the past? Who can be against good education? After all, we know that two and two makes four. Why should anyone be allowed to say they make five? Because if we prevent people from teaching that, we unleash a complex process that leads inevitably to the accumulation of monopolistic educational power with all its dreadful consequences.

KURTZ: Many people look, however, to the state as a countervailing power. They regard private corporations and organizations as systems of power that impose their will on the individual, and they believe that the state functions as the protector of the individual. For example, the state sets standards in medicine, in education. And we have antitrust laws, the Federal Trade Commission, the Federal Communications Commission. Are you unsympathetic to all that?

SZASZ: The American state has become an exceedingly complicated social instrument. Parts of it do protect the individual, and other parts of it injure the individual. Now, of course, the state does have other functions than the protection of individual freedom, and I accept that. For that very reason, however, I think it's foolish to trust the state very far for what it does for the individual. It usually does more *to* him than *for* him.

KURTZ: Now, as a libertarian, would you be opposed to socialism? I mean could one combine libertarianism and socialism?

SZASZ: Well, before I answer that, could you say just what you mean by socialism?

KURTZ: Socialism is being redefined today. I mean simply the idea that the state owns some of the basic means of production; perhaps also that the state would enter more and more into producing goods and providing services that are not produced in the private sector, and that it would be concerned with social welfare. That is true, for example, of British socialism.

SZASZ: If that is what you mean, then I would say not only that socialism is incompatible with libertarianism but that it is one of its most dangerous and powerful enemies. I am not an anarchist, though, as you know, that ideology exercises a certain charm for many libertarians. I consider anarchism unrealistic, impractical. Man is a social being. We can live only in groups; we must live in groups; we must have certain kinds of social cooperation. We now

secure such cooperation in part through what we call the state. But I believe with traditional libertarians that the state should do as little as possible in competition with individual initiative. The state should provide for national defense and exercise the police function and some types of regulatory functions. But the more the state does beyond those things, the more it becomes an enemy of the people. The best examples of that at present are state-supplied education and state-supplied medicine. Look at our *public* schools. Look at our *state* hospitals. Who wants them? Not the consumers "committed" to them! Those are the two roads to totalitarianism. In Communism, all that is done overtly, of course. There the state controls everything. In the so-called free societies, we move toward similar controls by letting the state control education and medicine.

KURTZ: There are differences though.

SZASZ: Of course there are. But the trend, the direction, is toward state control. And the end result tends to be the same—the reduction of individual choice.

KURTZ: Dr. Szasz, you noted the collectivist-totalitarian trends in Western societies, trends emanating from the state control of education and medicine. What about the difference between the Communist societies and the free ones?

SZASZ: Do you know where I think one of the most important practical social differences lies between the Communist and non-Communist societies? In the fourth estate.

KURTZ: The newspapers?

SZASZ: Yes, the free press. I think it's astonishing—and wonderfully revealing—how people defend the freedom of the press while they do not defend nearly so much, or not at all, freedom of education or freedom of medicine. We think it's absolutely essential that the press be free—that the newspapers be able to print what they want—and that Americans should have the right to read what they want. But we do not think they should have the right to buy penicillin without a doctor's prescription. Why can't you buy penicillin? Because it can hurt you? Can't lies hurt you? The newspapers are full of lies. The magazines are full of lies. Why doesn't the government protect people from lies? Because that would be a violation of the First Amendment. And that's fine. But there is a chink in the First Amendment, and that chink is called health and medicine and

treatment. Anything that can be brought under that umbrella—that can be so classified—can be manipulated and regulated and prohibited by the government. Just one quick example: tobacco, which is a plant, is classified as an agricultural product and is promoted by the government; marijuana, which is another plant, is classified as a dangerous drug and is prohibited by the government.

KURTZ: Is it a matter of degree, as to personal freedom, between the totalitarian countries and the Western democracies?

SZASZ: That's complicated. In part, it's a matter of degree; in part, it's a matter of law; in part, it's a matter of economic arrangements. And perhaps most of all, it's a matter of tradition. After all, I believe—and again I draw on a long list of other opinions here—that in the West there is a significant tradition concerning the value of the individual—a strong feeling for individual liberty; there is no comparable tradition or feeling in the East.

KURTZ: In your view, then, humanism draws deeply from the well of freedom—freedom of the individual—and considers it to be its central value.

SZASZ: Yes. That would be my view of humanism. But obviously there are other views, other definitions. I need hardly tell you that. I might mention here, in conclusion, that there seem to me really two entirely different ways of approaching what humanism is—of identifying it. One is by trying to define the good life, the good person—tolerance, openness, love, reason, whatever the definer values. The articulation and realization of that kind of life—that life-style, to use a current cliché—then becomes humanism. The other approach is not to give it such a psychological or moral definition at all. It is to say instead—and this is the view I prefer—that humanism is the result, the consequence, of an optimal or maximal kind of pluralism and diversity in society. In that sense, humanism is not this or that way of living, but the diversity that results from the economic, political, and psychological circumstances that permit one person to live one way and another, another way.

KURTZ: So humanism would maximize the autonomy of the individual to choose as he sees fit.

SZASZ: Exactly. And such autonomy has no meaning outside of a political and socioeconomic context that provides and protects the range of choices available.

KURTZ: So it's not only freedom for the individual but a free society. They go hand in hand.

SZASZ: Yes. But I would prefer to reassert the political dimension of everything that we have been talking about. Humanism is usually thought of primarily in ethical and psychological terms. I want to emphasize the political criteria and ideas. And among those, there is one notion I want to single out, and that is *dissent*. After all, authorities never object to people agreeing with them. But they get unhappy and often quite nasty when people disagree with them. So it's disagreement that must be nurtured and protected. In short, instead of thinking of humanism as this or that kind of life-style or ideology, I think we should think of it more as the right to disagree and reject authority—religious authority, educational authority, medical authority—and of course the right to take one's chances with one's own judgment and decision. That would be a definition of humanism in terms of dissent rather than in terms of affirmation. Of course, we could view that as the affirmation of the individual against the group, of the layman against the expert. It's a simple idea, but still full of unexplored promises and possibilities. The idea is this: the Fall was really not a fall but a rise—a rise from infantilism to humanism.

It is error alone which needs the support of government. Truth can stand by itself. . . . The way to silence religious disputes, is to take no notice of them. Let us too give this experiment fair play, and get rid, while we may, of those tyrannical laws. It is true, we are yet secured against them by the spirit of the times. I doubt whether the people of this country would suffer an execution of heresy, or three years' imprisonment for not comprehending the mysteries of the Trinity. But is that spirit of the people an infallible, a permanent reliance? Is it government? Besides, the spirit of the times may alter, will alter. Our rulers will become corrupt, our people careless. . . . From the conclusion of this war we shall be going down hill. It will not then be necessary to resort every moment to the people for support. They will be forgotten, therefore, and their rights disregarded. They will forget themselves, but in the sole faculty of making money, and will never think of uniting to effect a due respect for their rights.

Thomas Jefferson, "Notes on the State of Virginia" (1781)

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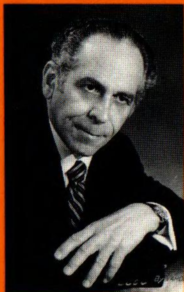
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Thomas Szasz is the author of more than six hundred articles and twenty-four books. He was a practicing psychiatrist and is a professor emeritus of psychiatry at the Health Science Center, State University of New York, in Syracuse.

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Psychiatric Slavery

Thomas Szasz

With a New Preface by the Author

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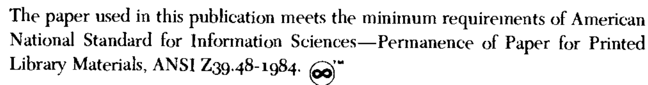

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For

Ursula and George

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Preface

To commit violent and unjust acts, it is not enough for a government to have the will or even the power; the habits, ideas, and passions of the time must lend themselves to their committal.

—Alexis de Tocqueville[1]

I

When Tocqueville spoke of "unjust acts," he was speaking as a detached observer, viewing state-sanctioned violence as an outsider. From the insider's point of view, state-sanctioned violence is, by definition, just. Prior to the passage of the Thirteenth Amendment, the Constitution of the United States condoned chattel slavery as just and humane. Today, people throughout the civilized world condone psychiatric slavery as just and humane.

Why do I use the phrase *psychiatric slavery* as the title? I admit that its shock value was an attraction. However, my main reason for choosing this title was that I consid-

ered the comparison between involuntary servitude and involuntary psychiatry enlightening and valid.*

What is slavery? *Webster's Third Unabridged* defines it as "control by imposed authority" and illustrates its use by citing Jonathan Swift's statement: "All government without the consent of the governed is slavery." As times change, the meanings of words change. Today, the connotations of the term "slavery" are altogether negative. This was not true in ancient societies. There is no condemnation of slavery in the Old or New Testaments or in the Koran. Jews, Christians, and Mohammedans alike owned and traded slaves. And so did Blacks as well as Whites.[2]

These are familiar facts. I mention them to underscore that, throughout most of history, people viewed slavery as a socially indispensable institution and that this perception was shared by masters and slaves alike. In *Psychiatric Slavery* I show how the premise that psychiatric slavery is a socially indispensable institution undergirds all efforts at so-called psychiatric reform and that (with few exceptions) this perception is shared by mental health professionals and mental patients alike.

Since liberty implies responsibility, it is easy to see the source of slavery's appeal: it promises relief from responsibility. Conservatives and libertarians know this well, yet rarely apply it to psychiatry. In 1950, Dean Russell, a respected conservative commentator, wrote:

> Many present-day Americans are trying to avoid this personal responsibility that *is* freedom. They are voting for men who promise to install a system of compulsory, government-guaranteed "security"—a partial return to the slave laws of Georgia that guaranteed all slaves "the right to food and raiment, to kind attention when sick, to maintenance in old age . . ." Just as the law once guaranteed "adequate" medical care for American slaves, so a law to guarantee medical care for all Americans is being demanded today. And who will determine what is adequate medical care for a person?[3]

* This comparison resembles the comparison between the Inquisition and involuntary psychiatry in *The Manufacture of Madness*, subtitled: "A Comparative Study of the Inquisition and the Mental Health Movement."

In a few short years, the sort of health care system Russell warned against has become a part of the "American Way of Life." How could Russell have so underestimated the American people's susceptibility to the siren song of security from life-as-illness? In part, by ignoring psychiatric slavery. Commenting on the government's efforts to protect people from themselves, he declared: "Since they [the Founders] recognized the absurdity of passing laws to protect a person from himself, they left all citizens free to make their own decisions concerning their own personal welfare."[4] Russell could not have been unaware that "mental patients"—cast in that role by others or themselves—were deprived of the right and freed of the duty to "make their own decisions concerning their own personal welfare."

II

Psychiatric slavery—that is, confining individuals in madhouses—began in the seventeenth century, grew in the eighteenth, and became an accepted social custom in the nineteenth century. Because the practice entails

depriving individuals innocent of lawbreaking of liberty, it requires appropriate moral and legal justification. The history of psychiatry—especially in its relation to law—is largely the story of changing justifications for psychiatric incarceration. The metamorphosis of one criterion for commitment into another is typically called "psychiatric reform." It is nothing of the kind. The bottom line of the psychiatric balance sheet is fixed: Individuals deemed insane are incarcerated because they are "mentally ill and dangerous to themselves and/or others."* For more than forty years, I have maintained that psychiatric reforms are exercises in prettifying plantations. Slavery cannot be reformed, it can only be abolished. So long as the idea of mental illness imparts legitimacy to the exercise of psychiatric power, psychiatric slavery cannot be abolished.

Power is the ability to compel obedience. Its sources are force from above, and dependency from below. By force I mean the legal and/or physical ability to deprive another person of life, liberty, or property. By dependency I mean the desire or need for others as protectors or providers.** "Nature," observed Samuel Johnson, "has given women so much power that the law has very wisely given them little."[5] The sexual power (domination) women wield (over men who desire them) is here cleverly contrasted with their legal powerlessness (a subservience imposed on them by men).

To distinguish between coercive and non-coercive

* In this essay, I limit myself to a critique of the civil commitment of persons not charged with crimes. I consider the insanity defense and other (ab)uses of coercive psychiatry in several of my other books, especially *Law, Liberty, and Psychiatry; Psychiatric Justice;* and *Insanity: The Idea and Its Consequences.*

** The spheres of legitimacy for power and dependency, respectively, are defined by law, custom, and tradition.

means of securing obedience, we must distinguish between force and persuasion, violence and authority. Alfred North Whitehead put it thus: "[T]he intercourse between individuals and between social groups takes one of these two forms, force and persuasion. Commerce is the great example of intercourse by way of persuasion. War, slavery, and governmental compulsion exemplify the reign of force."[6] When Voltaire exclaimed, *"Ecrazez l'infame!"* he was using the word *l'infame* to refer to the power of the Church to torture and kill, not to its power to misinform or mislead.

The potency of power as force, symbolized by the gun, rests on the ability to injure or kill the Other; whereas the potency of power as influence rests on the ability to gratify the Other's desires. The individual who depends on another person for the satisfaction of his needs—or whose needs/desires can be aroused by another—experiences the Other as having power over him. Such is the power of the mother over her infant, of the doctor over his patient, of Circe over Ulysses. In proportion as we master or surmount our desires, we liberate ourselves from this source of domination.

The main source of psychiatric power is coercive domination, exemplified by the imposition of an ostensibly diagnostic or therapeutic intervention on a subject against his will. Its other source is dependency, exemplified by individuals defining themselves as unable to control their own behavior and seeking psychiatric controls. Involuntary psychiatric interventions rest on force, voluntary psychiatric relations on dependency. Equating them is as absurd as equating rape with consensual sex.*[7]

* Some psychiatric critics—opposing the use of psychiatric drugs, electric shock treatment, or psychotherapy—advocate the legal prohibition of one or another method or relationship, on the ground that people need the protection of the state from the "exploitation" intrinsic

When a person suffers—from disease, oppression, or want—he naturally seeks the assistance of persons who have the knowledge, skill, or power to help him or on whom he projects such attributes. In ancient times, priests—believed to possess the ability to intercede with gods—were the premier holders of power. For a long time, curing souls, healing bodies, and relieving social-economic difficulties were all regarded as priestly roles, utilizing both coercive and cooperative interventions. Only in the last few centuries have the roles of priest, physician, and politician become differentiated, as Religion, Medicine, and Politics—each institution allotted its "proper" sphere of influence, each struggling to enlarge its scope and power over the others. Moreover, only in the West has the power of the priest been reduced to the same level as the power of the people, that is, to the opportunity to persuade willing listeners.

The separation of Church and State—that is, withdrawing from religious authorities and organizations the legal authority to use force and denying them funds extracted by force (taxes)*—represents a sharp break in the history of mankind. Although paying lip service to an Almighty, the American Constitution is, in effect, a declaration of the principle that only agents of the state can exercise power legitimately, and that the sole source of the government's legitimacy is the "happiness of the people," insured by securing "the consent of the governed." Gradually, other western states have adopted this outlook. The Argentinean poet and novelist Adolfo Bioy Casares satirized the resulting "happiness" thus:

> Well then, maybe it would be worth mentioning the three periods of history. When man believed that happiness was dependent upon God, he killed for religious reasons. When man believed that happiness was dependent upon the form of government, he killed for political reasons. After dreams that were too long, true nightmares . . . we arrived at the present period of history. Man woke up, discovered that which he always knew, that happiness is dependent upon health, and began to kill for therapeutic reasons.[8]

Among these therapeutic reasons, the treatment of mental illness occupies a unique place.

III

Who was Kenneth Donaldson and how did he become entangled with the psychiatric system? Briefly, he was an unemployed and unwanted guest in his father's house. When Donaldson refused to remove himself, his father turned to the psychiatric system to remove him. Thus did Kenneth Donaldson become a "guest" of the psychiatric hospital system, officially called a "patient." Ensconced in his new home, Donaldson refused "treatment": He insisted that he was not mentally ill and claimed he was a Christian Scientist. Notwithstanding the internally contra-

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to the practices of psychiatrists and psychotherapists. However, coercive protection from psychiatric treatment is just as patronizing and inimical to dignity-and-liberty as coercive protection from psychiatric illness.

* Many Americans erroneously believe that this condition obtains in all modern democracies. In Britain, there is no formal separation of church and state. In Germany and Switzerland, religious bodies receive moneys collected by the state.

dictory character of Donaldson's subsequent complaint—that his psychiatrists failed to treat his illness—the Supreme Court accepted the case, presumably as an opportunity to reinforce the legitimacy of psychiatric slavery. To be sure, the "complaint" was not really Donaldson's: The real protagonists were his handlers, self-anointed reformers of mental health policy, who fabricated an absurdly hypocritical strategy to advance their own misguided agenda. Donaldson was merely their foil.

Why did the Donaldson case arouse so much professional and popular interest? Partly because it reopened—in the context of the new psychopharmacological treatment of mental illness—the question of what constitutes proper ground for civil commitment; and partly because Donaldson's malpractice suit reached the Supreme Court. Today, the case is an arcanum in the history of psychiatric reform. The issues it raised are, however, of continuing interest and importance.

Although the long-term confinement of mental patients in buildings called "mental hospitals"—as Donaldson had been confined—is no longer fashionable, this does not mean that the uses of coercive psychiatry have diminished. On the contrary. While most mental patients are now housed in buildings *not* called "hospitals," they are still deprived of liberty, typically by court-ordered "outpatient commitment" and "drug treatment," euphemisms that disguise their true status more effectively than ever.[9] Since the Donaldson ruling, psychiatrists routinely invoke claims such as that patients' "rejection of treatment is itself a symptom of their illness";[10] that the "cause [of the 'revolving door syndrome'] may be the result of efforts to protect patients' civil rights—sometimes at the cost of their 'treatment rights'";[11] and that a "180-day outpatient commitment" policy should be widely adopted because a person who "is suffering from a severe mental disorder . . . lacks the capacity to make an informed decision concerning his need for treatment."[12]

IV

In the modern West, slavery qua slavery is of course as dead as the proverbial dodo. Reviewing a book about Jefferson, Brent Staples declares: "Slavery and the Declaration of Independence can in no way be reconciled. . . . The natural rights section of the Declaration—the most famous words in American history—reflected the belief that personal freedom was guaranteed by God Himself."[13]

Alas, if only it were that simple. The words "freedom-slavery," like the words "right-wrong," are by definition antithetical. Hence, asserting that they cannot be reconciled is a pleonasm. But it is a pleonasm only in principle. In practice it is a temptation—a challenge to people's ingenuity to reconcile irreconcilables—to which many yearn to yield. All that is needed to accomplish the task is hypocrisy and demagoguery: Would-be dominators can then "discover" that the persons they seek to enslave are child-like, the victims of one or another calamity from which they need to be protected. This formula explains why chattel slavery and the Declaration of Independence could coexist for nearly a century; why racial and gender slavery and the Declaration of Independence could coexist well into the twentieth century; and why psychiatric slavery and the Declaration of Independence can now coexist in perfect harmony.

Although modern governments repudiate slavery as the grossest violation of "universal human rights," they con-

tinue to exert far-reaching controls over personal conduct, typically justifying coercive paternalism as the *protection of victims from themselves*. Today, the mental patient does not lose his liberty because the state deprives him of it; he loses it because the state declares him to be the beneficiary of a new "constitutional right." In the Donaldson case, the justices of the Supreme Court discovered such a new right, heretofore hidden in the Constitution. They declared: "[A] State cannot constitutionally confine [in a mental hospital] *without more* a nondangerous individual . . ."[14] Psychiatrists lost no time dubbing this "[something] more" the "mental patient's right to treatment." It is important to emphasize that the "treatment" the court had in mind was, by definition, involuntary: It applied *only* to *involuntary mental patients*.

The importance of the Donaldson ruling lay in the fact that it ratified psychiatry's latest medical and therapeutic pretensions. By recognizing the administration of psychoactive drugs to mental patients as bona fide medical treatment, the Supreme Court once again lent the weight of its authority to literalizing the metaphors of mental illness and mental treatment. In addition, by defining involuntary psychiatric interventions—epitomized by involuntary drugging—as bona fide medical treatments, the court redefined involuntary psychiatric interventions from serving the needs of the public to serving the needs of the denominated patient.

The catastrophic implications of these ideas have not yet begun to dawn on American lawmakers, much less on the American people. The "new Nero," C. S. Lewis warned, "will approach us with the silky manners of a doctor."[15] Today, almost a quarter of a century after the Donaldson decision, the Supreme Court is considering

whether a terminally ill patient has a constitutional right to physician-assisted suicide. Never mind that the term "terminally ill" is dangerously elastic; that suicide is illegal, prohibited by the *mental health law* of every one of the fifty states; or that because suicide is illegal, it cannot be "assisted," it can only be "accompliced." These are but minor roadblocks retarding our triumphant march toward the full realization of the Therapeutic State. "Even if the treatment is painful, even if it is life-long, even if it is fatal, that"—mocked Lewis—"will be only a regrettable accident; the intention was purely therapeutic."[16]

V

Psychiatric slavery rests on civil commitment and the insanity defense. Each intervention is a paradigm of the perversion of power. If the person called "patient" breaks no law, he has a right to liberty. And if he breaks the law, he ought to be adjudicated and punished in the criminal justice system. It is as simple as that. Nevertheless, so long as conventional wisdom decrees that the mental patient must be protected from himself, that society must be protected from the mental patient, and that both tasks rightfully belong to a psychiatry wielding powers appropriate to the performance of these duties, psychiatric power will remain unreformable.

Some people do threaten society: they commit crimes—that is, acts that deprive others of life, liberty, or property. Society needs protection from such aggressors. What does psychiatry contribute to their management? Civil commitment, inculpating the innocent, and the insanity defense, exculpating the guilty. Both interventions authenticate as "real" the socially useful fictions of mental illness

and psychiatric expertise. Both create and confirm the illusion that we are coping wisely and well with vexing social problems, when in fact we are obfuscating and aggravating them. Psychiatric power thus corrupts not only the psychiatrists who wield it and the patients who are subjected to it, but the community that supports it as well.

As Orwell's nightmarish vision of *Nineteen Eighty-Four* nears its climax, O'Brien explains the functional anatomy of power to Winston thus:

> [N]o one seizes power with the intention of relinquishing it. Power is not a means; it is an end. One does not establish a dictatorship in order to safeguard a revolution; one makes the revolution in order to establish the dictatorship. The object of persecution is persecution. The object of torture is torture. The object of power is power. Now do you begin to understand me?[17]

The empire of psychiatric slavery is more than three hundred years old and grows daily more all-encompassing. But we have not yet begun to acknowledge its existence, much less to understand its role in our society.

Notes

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13. Staples, Brent, "The Master of Monticello," *New York Times Book Review*, March 23, 1997, p. 7.
14. This volume, p. 79, emphasis added.
15. Lewis, C. S., "The Humanitarian Theory of Punishment," *Res Judicatae* (Melbourne University, Melbourne, Australia), 6: 229, 1953; quoted in, Szasz, T. S., *The Theology of Medicine: The Political-Philosophical Foundations of Medical Ethics* (Syracuse: Syracuse University Press, 1988), p. 130.
16. *Ibid.*
17. Orwell, G., *Nineteen Eighty-Four* (New York: Harcourt Brace, 1949), p. 266.

Preface to the Original Edition

There is, as Richard Weaver has so well put it, no life without prejudice; hence, there is also no person without prejudice.[1] I therefore hasten to acknowledge that the observations and remarks I plan to present are animated and informed by one of my prejudices: namely, that to be a fully human person one must be free and responsible, and must treat others—so far as it is at all possible to do so—as free and responsible persons. This prejudice is diametrically opposed to, and is hence incompatible with, the prejudice that animates and informs institutional psychiatry and those who defend or support its principles and practices.

The judicial branch of the American government, with the Supreme Court at its head, has so far defended and supported involuntary psychiatry. With respect to psychiatry, I therefore find myself squarely in opposition to these authorities. Nevertheless, I have learned from them; and, in my more optimistic moments, I like to believe that they have learned from me and may yet learn more. That, indeed, is one of the good things about "enemies," especially non-violent, respectful, and intelligent enemies. They tell you what you do wrong—which your friends rarely do.

It seems to me that the United States Supreme Court, especially in relation to its struggles with the problem of involuntary psychiatry, has had too many friends and too few enemies. In nearly every case concerning matters of psychiatry that has come before this Court in recent years, virtually every group representing care and compassion, power and prestige, wealth and wisdom, has petitioned the Court as *amicus curiae*.* Since many of the friends of the Court are actually promoting their own self-interests concealed as some individual's or group's constitutional rights, I want to nominate myself, at least for the present occasion, as an enemy, in the sense of opponent, of the Court; and I want to offer my remarks as

* The following are some of the groups and organizations that have submitted *amicus curiae* briefs to the Supreme Court in support of the "right to treatment" for involuntary mental patients: American Association of Mental Deficiency; American Federation of State, County, and Municipal Employees A.F.L.–C.I.O.; American Orthopsychiatric Association; American Psychological Association; American Psychiatric Association; Joseph P. Kennedy Foundation; National Association for Mental Health; National Association for Retarded Citizens; National Center for Law and the Handicapped; National Association for Autistic Children; State of Texas; State of Ohio; State of New Jersey; the federal government.[2]

an *inimicus curiae* brief to that august body. If a clear view of the problems of involuntary psychiatry requires, as I believe it does, emancipation from customary forms of legal and psychiatric thinking about them, then perhaps such a view might be facilitated by a fresh format which departs from the customary friend-of-the-court courtesies, and calls a spade not an agricultural instrument for soil penetration, but a spade.

Acknowledgments

On February 18, 19, and 20, 1976, I enjoyed the privilege of delivering the annual Robert S. Marx Lectures at the University of Cincinnati College of Law. This book is based on, and is a considerably expanded version of, the lectures I presented on that occasion. I should like to take this opportunity to thank, once more, the Robert S. Marx Trustees and the faculty of the University of Cincinnati College of Law for inviting me to be the Marx Lecturer for the academic year 1975–1976.

I wish to thank also Professor Travis Lewin of the Syracuse University College of Law for his generous help

in the preparation of this book; Mr. Bruce Ennis for providing me with copies of the briefs for Donaldson and O'Connor; and my daughter, Susan Marie Szasz, for her careful reading of the manuscript and her suggestions for improving it.

To question the ethical basis of slavery, even when the institution was disappearing from view, would be to question fundamental conceptions of God's purpose and man's history and destiny. If slavery were an evil and performed no divinely appointed function, then why had God authorized it in Scripture and permitted it to exist in nearly every nation.[1]

—D. B. Davis, *The Problems of Slavery in Western Culture*

If it was a crime, as many writers asserted, to deprive Americans of their natural liberty, it was actually an act of liberation to remove Negroes from their harsh world of sin and dark superstition. . . . "Though the odious Appellation of Slaves *is annexed to this Trade," wrote a leading economist, ". . . they are certainly treated with great Lenity and Humanity: . . . I cannot but think their condition is much bettered to what it was in their own Country."*[2]

—D. B. Davis, *The Problems of Slavery in Western Culture*

One must remember that slavery was a system, not an individual relationship. No matter how Christian, benevolent, or kind a slaveholder might be, he himself was a captive of the system.[3]

—D. L. Dumond, *Antislavery: The Crusade for Freedom*

I

Justifying the Unjustifiable

I

Before addressing myself to my specific subject—that is, to an analysis of the *Donaldson* case and its implications—I want to offer some brief remarks about two issues whose clarification is crucial to a sensible discussion of any problem of psychiatry and law. They are: first, the distinction between an explanation and a justification; and second, the sorts of justifications human beings have traditionally used to legitimize certain kinds of con-

duct on the parts of some persons toward certain others.

Typically, an explanation refers to an event, whereas a justification refers to an act. The difference between these terms is much the same as that between things and persons.

For example, we might ask, "How did lightning kill Jones?" We might then be told that it did so by causing him to have ventricular fibrillation and cerebral anoxia.

We might also ask, "Why did lightning kill Jones?" We might then be told that it was because he continued to play golf during a thunderstorm instead of going back to the clubhouse for a drink, as did his friend Smith. It is important to keep in mind that this sort of statement is an assertion about Jones, the victim, not about lightning or some other aspect of the "cause" of his death.

Our question about why lightning killed Jones may, however, elicit another type of reply, and it is essential that we consider it also. If our interlocutor is a devoutly religious person, or a very mystical one, he might tell us that lightning killed Jones because it was "God's will" (or something of that sort).What is important about this answer is that is purports to explain an event by assimilating it to the model we use for justifying an action. By imagining God as some sort of superman, we picture death caused by lightning as God taking a life. This sort of account pleases and satisfies many people because it fulfills the deeply felt human need for legitimizing, or illegitimizing, not only those things that people do to one another but also those that happen to them.

Suppose, however, that Jones was killed not by lightning but by Smith. We might then reasonably ask both how and why Smith acted as he did. The "how" question seeks to elicit an explanation of Smith's method for causing Jones' death—for example, did he shoot him, poi-

son him, or stab him? What, then, does the "why" question seek? The usual answer is that it seeks an account of Smith's motives or reasons for killing Jones. But this, as I shall now show, is only partly true. Actually, in asking this sort of question about Smith, people usually want to know several things, among which the most obvious and important are: first, Smith's avowed aim or reason for his act; second, his real reason; third, the authorities' official account of the reason; fourth, the psychiatrist's expert opinion about the reason; fifth, the defense attorney's claim about the reason; and sixth, the jury's judgment about the reason.

Each of the above reasons is, strictly speaking, a claim or a conjecture; none is an explanation or a cause, in the sense in which these latter terms are understood and used in natural science. Nevertheless, when confronted with this sort of situation, most people feel, as if it were instinctively, that one or another of the reasons listed is true, and that the others are false. In fact, they may all be true, in the sense that each represents the sincere conviction of the speaker; or they may all be false, in the sense that Smith acted for reasons, perhaps known only to himself, other than any of those articulated in the several conjectures. Let me illustrate this with a simple example.

Suppose that a person, observing patrons ordering food in a restaurant, is asked why one of the customers, named Smith, ordered hamburger rather than lobster. The observer would, of course, first ask Smith, who might explain that he did so because he prefers hamburger to lobster. The observer himself might conjecture that it was because hamburger is cheaper. Who really knows why Smith chose as he did? In the sense in which we can know the chemical composition of hamburger or lobster, no one can know why anyone orders one or the other. The only

honest answer to this sort of "why" question is to give an account of the reason for the act *as* claim or conjecture, and to acknowledge frankly the *identity of the claimant or conjecturer.*

Much of the tradition and practice of Anglo-American law is premised on precisely this understanding of human acts and the problems posed by efforts to resolve conflicting claims between persons sensibly and fairly. In both civil and criminal suits, the arbiters assume that plaintiff and defendant, prosecuting attorney and defense attorney, each presents different claims and conjectures about why the protagonists in the judicial drama acted as they did. It is then up to the jury to develop its own conjecture, whose practical implication the court then imposes on the litigants. The jury, or court, does so not because it is necessarily more intelligent or more honest than the participants in the litigation, but because it is more neutral and has the authority and the power to do so.

Psychiatric testimony distorts this model of contesting claimants seeking to convince a presumably impartial jury or court, because insofar as the psychiatrist testifies about why a person acted as he did, he offers a conjecture that he defines and that is widely accepted as a cause. This is epitomized by the belief—now authoritatively accepted as scientifically correct—that some people kill because they hate their victims, others because they want their money, and still others because they have schizophrenia. Mental illness as a cause, and murder as a product of it, must thus be seen for what it is: not simply a mistaken idea, but the manifestation of the judicial acceptance of psychiatrists as scientists of the mind.[2] It is precisely this premise that I have attacked in my past analyses of legal psychiatry, and that I want to single out

here as a preliminary test of our critical spirit. Either we accept this psychiatric idolatry—in which case we regard the principles and practices of modern forensic psychiatry as progressive and scientific, or we reject it—in which case we regard psychiatric pronouncements on the human mind, especially when offered in courts of law, as agnostics regard theological pronouncements on God.

II

Let us now consider how we justify human actions. My initial proposition in this connection is that the most powerful justification for an act, and especially for a socially established practice, is no justification at all. The most completely justified forms of conduct are those for which no justification is offered because none is expected.

A dramatic example of this is the absence of any reference to slavery in the Constitution of the United States of America.* Another is the absence, until recently, of any reference in psychiatric texts to the fact that many so-called psychiatric patients are, in fact, patients against their will. Not mentioning the involuntary servitude of Negroes or the involuntary patienthood of madmen is thus the most powerful justification possible of their enslavement and imprisonment. All other justifications of these policies are feeble in comparison. In fact, once the systematic oppression of one group by another becomes fully

* The first time the Constitution mentions slavery by name—that is, as "involuntary servitude"—is when, in 1865, the Thirteenth Amendment abolishing slavery is added to it. I can think of no better example to illustrate the point that no oppressive institution can be named correctly and survive; or, perhaps, no oppressive institution can be named correctly until after it has been overthrown.

articulated and is maintained by offering some sort of justification for it, its days are numbered. In the circular logic that appears to govern human affairs of this sort, if a practice is truly justifiable, no justification for it is offered; and if a justification is offered for it, it seems only to prove its fundamentally unjustifiable character. Perhaps this is something the French always knew, for their proverb warns that "Qui s'excuse, s'accuse" (He who excuses himself, accuses himself).

This primal justification by silence—by the tacit acceptance of act or practice, belief or ritual, as "obviously right"—seems to have its roots in language. Consider, in this connection, the Jewish injunction against naming God or forming any kind of image or representation of Him. This prohibition betrays a profound recognition of the role of language in enabling human beings to master their material and personal environment; a recognition, in other words, of the fact that to keep men and women in subjection to authority, it is necessary to obstruct their use of language.[3] Thus, an authority that justifies itself is no longer an absolute authority. Indeed, this is the way we distinguish between religious and scientific authorities.

Once the justification of no justification is relinquished, people resort to a few simple and quite consistent claims to legitimize what they do, especially when what they do is to harm another person or group. There are three main categories of such justifications. One is that "we" are human, but "they" are not. Both victimizer and victim may be nearly anyone or any group, but in Western history, as we know, the typical "they's" have been Jews, Negroes, witches, heretics, and madmen. After no justification at all, this is the next most powerful justification,

since by transforming the victim from person to thing—the Jew to vermin, the Negro to chattel, the so-called mental patient to sick organism—he is immediately removed from the realm to which moral discourse normally applies.* Killing sick or aged cats or dogs is not something that legislators and jurists worry about. Thus, if we can metaphorize certain individuals or groups as animals—or as forms even lower on the evolutionary scale!—then we can practice treatment or euthanasia on them. If we want to feel really proud of ourselves, we can declare that our objects of solicitude have a right to treatment or to euthanasia. Our self-appointed right to treat and kill thus becomes their right to treatment and merciful death.

Another standard justification for victimization is for the victimizer to claim that "he" himself is a victim. Jew, Negro, witch, madman—each and every member of these groups has been said to constitute a threat to the ordinary, peace-loving citizen, whose duty it thus becomes to defend himself and his group against these enemies. This is a plausible justification for harmful acts, but it is much weaker than the two others we have considered, as it leaves the critical observer free to weigh the claims and counterclaims of the conflicting parties.

* In a recent criticism of my views, Moore makes just this point to support the psychiatric coercion of mental patients:

> Since mental illness negates our assumptions of rationality, we do not hold the mentally ill responsible. It is not so much that we excuse them from a prima facie case of responsibility; rather, by being unable to regard them as fully rational beings, we cannot affirm the essential condition to viewing them as moral agents to begin with. In this the mentally ill join (to a decreasing degree) infants, wild beasts, plants, and stones—none of which are responsible because of the absence of any assumption of rationality.[4]

The fourth standard justification for victimization—now perhaps the most fashionable—is a peculiar refinement of the previous claim: "They" are a threat, not to "us," but to "themselves!" As the formula for self-defense grows out of the proposition that "they" are a threat to "us" because "they" are Jews or heretics, witches or madmen—so the formula for coerced treatment grows out of the proposition that "they" are a threat to "themselves," because they are inept or insane, poor or psychotic. This then justifies "our" ostensibly helping "them," while "we" remain securely in possession of the power to define and deploy our therapy. This tactic, originally theological but in recent centuries mainly therapeutic, is perhaps the most desperate, deceptive, and despicable of all the justifications for human victimization.[5] It is ironic that in its psychiatric application, it should now have the support of many of the most liberal elements of American society, including that of the American Civil Liberties Union.[6]

Although the principal justifications for human victimization lend themselves readily to division along the lines I have indicated, the categories so generated and named are not as discrete as they might seem. In fact, each of the tactics implies, and borrows from, those of the others. Thus, the dehumanization tactic implies threat, defense, and sometimes therapy; self-defense often merges into dehumanization; and therapy usually conceals both dehumanization and self-defense.

In the history of psychiatry, which is coeval with the history of involuntary mental hospitalization, the coercion of the madman by the mad-doctor has been justified in all of the ways listed above: that is, by silence, and by claims that the madman is subhuman, dangerous, and needs treatment. I have written extensively on these matters,

subjecting the justificatory rhetoric of psychiatry to special scrutiny. There is no need here to review the evidence which such an inquiry into the history and language of psychiatry produces. Suffice it to say that the attempt to justify involuntary mental hospitalization on the grounds of treatment is neither novel, as its present proponents pretend, nor, in my opinion, is it morally acceptable.[8]

Two wrongs do not make a right. It is wrong to deprive innocent people of liberty. But it is also wrong to try to set them free by acceding to the definition of the victims as patients, of the victimizers as psychiatrists, and of the control of former by the latter as diagnosis, hospitalization, and treatment.

In this book I shall use the Donaldson case to amplify and exemplify the view I have always held about commitment: namely, that in a society such as ours is and aspires to be, involuntary mental hospitalization is an unjustifiable moral and legal wrong. Hence, attempts to illegitimize it on the grounds that psychiatrists fail to treat involuntary mental patients is as faulty logically and as unworthy morally as are attempts to legitimize it on the grounds that psychiatrists protect society from madmen or madmen from themselves. Because each of these justifications is premised on the legitimacy of depriving innocent persons of their liberty under psychiatric auspices, supporting such justifications validate, implicitly but therefore all the more powerfully, the legitimacy of psychiatric coercion.

As the founders of our Republic rejected theological coercion, not in this or that particular application of it, but in principle—so, I submit, we ought to reject psychiatric coercion, not in this or that particular application of it, but in principle.

III

If we wish to raise our understanding of problems of psychiatry and law to an intellectually more satisfying level than that on which discussions of such problems are usually conducted, it is essential that we keep in mind the differences between explanations and justifications, and the principal rhetorical forms of justifying injury to others.

It is essential, also, that we recognize that the disjunction between avowed claims and actual conduct is crucial to the behavior of both madmen and mad-doctors—or, to use the contemporary vernacular, both mental patients and psychiatrists. For example, a person likely to be diagnosed as schizophrenic may declare: "I am the Messiah, God commands me to save the world, and to do so I must kill so-and-so." The patient's putative aim is to save the world, to do good. However, his actual conduct, as judged by the recipients of his benevolence, is deemed to be dangerous and harmful, with consequences all too familiar.

The situation with respect to the mad-doctor or institutional psychiatrist is much the same, with the roles reversed. He declares: "I am a doctor, my medical training and ethic command me that I help sick people, and to do so I must electroshock so-and-so." The doctor's putative aim is to help the patient, to treat him for his disease. However, his actual conduct, as judged by the recipients of his benevolence, is deemed to be not treatment but torture, with consequences again all too familiar.

Such disjunctions between putative aims and actual performances cannot long stand unresolved. In the modern world they are resolved, at least in the areas I am here considering, by the simple expedient of substituting

authority for evidence. Thus, when the majority—when official science in alliance with the state—declare, as they do in the case of mad-doctoring, that the psychiatrist's actual performances are treatments consistent with his putative objectives of curing mental illness, the disjunction between the doctor's self-serving aims and his other-damaging acts is better than resolved: It is defined out of existence.

Similarly, when the majority declare, as they do in the case of madness, that the mental patient's putative objectives and his actual performances are the symptoms and signs of a medical disorder, the disturbing disjunction between his self-serving aims and his other-damaging acts is again better than resolved: It is defined out of existence. Henceforth, both of these disjunctions can be recognized and addressed only at the risk of insulting established professional beliefs and practices, and incurring the risks customarily accompanying such behavior.

Obviously, where the state is a party to this sort of psychiatric misrepresentation—where it is itself the agent or agency of fraud or force—it cannot also be the safeguard against its own action. This, then, is the fundamental political, ideological, and economic source of the difficulty that faces the contemporary critic of psychiatry. Countless psychiatric principles today are based on baldfaced lies—such as calling buildings in which innocent people are imprisoned hospitals. And countless psychiatric practices today consist of nothing but crass coercions—such as the incarceration of persons under psychiatric auspices called mental hospitalization. These dramatic disjunctions between putative objectives and actual performances, pervasive in institutional psychiatry, are now supported by church, state, and science. Accordingly, the psychiatric

scholar's first task must be to reassert the evidence of his naked eyes and ears. For it is of little use to explain, justify, or modify policies that linguistically imply that certain propositions are true when they are actually false, and that socially authenticate aims as medical and technical when they are actually moral and political.

2
The Case of Kenneth Donaldson

I

Kenneth Donaldson was incarcerated in the Florida State Hospital at Chattahoochee in January 1957 and was released in July 1971. His commitment was initiated by his father, who petitioned for it, and it was granted by a county judge sitting in Pinellas County, Florida.

If we want to come to grips with the actual human problems of commitment and mental hospitalization, it is necessary that we form an accurate picture of what happened in the Donaldson case (which is typical of count-

less such cases), and that we confront the human dilemmas it poses.

When Kenneth Donaldson arrived in Florida, in August 1956, he was forty-eight years old, divorced, and unemployed. For several months he lived with his parents, who resided at a trailer court, apparently uneventfully. In November of 1956, according to Bruce Ennis,* Donaldson "mentioned to his father that someone, perhaps one of the neighbors, might be putting something in his food."[1] Although Ennis says that Donaldson mentioned this idea to his parents, it might be more accurate to say that he complained to them, or that he accused the neighbors of poisoning him. These distinctions are important, as we cannot understand the interplay between so-called mental patients and others unless we recognize the paramount role of inflated self-importance and covert or overt coercion in the claims and conduct of the former, and of inflated self-importance and deceptive therapeutic counter-coercion in the claims and conduct of the latter.

Let us assume that the older Donaldson heard his son's idea about poisoning as an accusation or complaint. What could he do about it? This sort of complaint makes a person's loved ones wonderfully confused and helpless, which is, in my opinion, just what it is intended to do. There is also a hint, or more, in such a communication that Donaldson may have thought that *his parents* were poisoning him. After all, he was eating *their* food. The metaphoric meaning of madness is all too apparent in such communi-

* Bruce Ennis was chief counsel for Donaldson in his suit against O'Connor and argued his case before the Supreme Court. He is the Director of the New York Civil Liberties Union's Civil Liberties and Mental Illness Litigation Project, and Staff Counsel for the Mental Health Law Project.

cation, but this is a subject we cannot consider in detail here.[2] Suffice it to say, speculatively to be sure, that Donaldson was upsetting his parents by telling them, in effect, that he was not entirely happy to be in their home and was not exactly grateful for their support. Had the elder Donaldson been able to hear his son's message in this way and had he been able to free himself of the psychiatric prejudices of the day, he might have replied: "If you don't like it here, why don't you leave?" Had he done so, the *Donaldson* case as legal history would have ended before it began.

This is not the only thing that might have happened differently. For just as Donaldson's father had the option of separating himself from his son rather than committing him, so Donaldson himself had certain options which we cannot ignore.

If people live in a society where there are automobiles and traffic lights, or electricity and high tension lines, they will have some familiarity with the uses and dangers of these artifacts and the rules for using them. Similarly, if people live in a society where there are psychiatrists, commitment laws, and persons locked up in mental hospitals, then they will know something—some more, some less—about these things. In fact, Kenneth Donaldson knew quite a lot about psychiatry. Although Ennis does not mention it, Donaldson had been in a mental hospital once before: in 1943, he had spent three months in the Marcy State Hospital in Utica, New York. These facts are essential for our understanding of Donaldson's complicity in his own commitment and protracted confinement.*

* Indeed, the supposition that Kenneth Donaldson possessed more than the average amount of information on this subject is supported by Ennis himself: "Intelligent and articulate, Donaldson rapidly be-

It seems likely that when Donaldson told his father that someone was putting poison in his food, he knew that a possible—if not probable—outcome of such a communication was involuntary mental hospitalization. But regardless of whether or not Donaldson thought or knew what I am here imputing to him when he made his first complaints about poisoning to his father, he must surely have had some inkling about the reaction his communication was likely to provoke. There must have been some sort of verbal or nonverbal communication between the two Donaldsons after the son dropped the verbal bomb about poisoning in his father's lap. It seems inconceivable that during this period Donaldson had no inkling that his father was planning to commit him. Perhaps his father even threatened to do so. We simply do not know. All the records are silent about these events.

In short, there was a period before his commitment during which Donaldson had some options about whether to allow himself to be committed or not. According to Ennis, Donaldson first mentioned being poisoned to his father in late November. It was not until December 10 that the father filed a petition for a sanity hearing. During those weeks, had Donaldson wanted to avoid hospitalization, he could have stopped complaining about being poisoned, could have pleaded with his father not to commit him, or could have left his father's home and Florida, thus relieving his parents of the immediate emotional and practical pressure to commit him. Again, we do not know what happened then, but we may infer that Donaldson

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came the 'scribe' and spokesman for his section [in the hospital]. In 1961, largely because of his documented complaints to public officials, the Florida legislature established a committee to investigate the hospital."[3]

made no serious attempt to avoid commitment. In view of his previous mental hospitalization, his non-resistance to commitment is significant; and so is his subsequent noncooperation with the hospital authorities. To ignore that, in these ways, Donaldson asked to be treated as a psychiatric slave, is as absurd as to insist that because he did, it was justifiable to treat him as one.

II

Donaldson's own account of his hospitalization in Florida and of the events preceding it is consistent with the conjectures I have offered and will offer subsequently. To a *Washington Star* reporter, he gave the following explanation of what happened to him:

> Donaldson says his troubles began in 1943, when he was living in Syracuse. "I blacked out going home from work one night. I didn't know what the reason was. My father and my wife found me walking in the street in the morning. They asked me to go before the county judge, and he said there was no way he could commit me. But because I felt that I couldn't go back to work that night, he said I should sign myself in at the state observation center for 10 days, and I did."[4]

Donaldson here claims, first, that he "blacked out," using a symptom that is just as much an evasion as is the psychiatric diagnosis of schizophrenia; second, that he was hospitalized because of the actions of his father, wife, and the county judge, and not because of his own actions; and third, that he was sent to the hospital because

he could not go to work. What is Donaldson's blacking out hiding here? In his book about his psychiatric experiences, Donaldson gives this account about how his difficulties began:

> On a dreary winter morning in 1943, I stood before an Onondaga County judge in the stately courthouse of Syracuse, New York, before the regular session came to order. I was not a criminal. I was there to ask the judge's advice on a matter that had come up on my job at a defense plant. I had had some trouble and felt that I could not go back to work again. But the law said that I could not quit a defense job. The judge said it was a matter for the doctors. He advised me to sign myself in at a psychiatric observation center for ten days. On my decision voluntarily to place my fate in the hands of doctors lies the wreckage of my life, traumatizing everyone else in my family as well.[5]

Ironically, Donaldson's book is full of the most damaging evidence against many of his own claims and the claims of the Mental Health Law Project (MHLP) advanced on his behalf. For example, he reproduces an "Abstract of Commitment Paper," which gives his full name as "W. Kenneth," and states that he was admitted to the Marcy State Hospital on March 12, 1943 as a transfer from the Syracuse Psychopathic Hospital.[6] The petitioner for this commitment was Olive J. Donaldson, Kenneth Donaldson's wife, who stated that:

> Patient has had a previous episode for which he was not hospitalized. In January 1943 he stated that he was being followed and that people were after him. Patient believes that he has committed a serious crime and that the FBI is after him. He later said that the Government has provided Army and Navy men to look after him. Patient has run away from home on two occasions and has frequently talked about this.[7]

On March 11, 1943, just prior to his transfer to Marcy State Hospital, the examining physicians at the Syracuse Psychopathic Hospital made this note about Donaldson's mental condition: "Restless, overactive, shallow emotionally, affect at times inappropriate. . . . thought men were following him to kill him and that he was being protected by many men. . . . makes rather grandiose plans. . . ."[8]

What all this means is, to a large extent, a matter of conjecture, but surely it suggests that Donaldson was not happy at home and wanted to get away from it, and that at least partly as a result of his domestic and personal difficulties he ended up as a mental hospital patient.

In his interview with the *Washington Star*, Donaldson gave the following account of his hospitalization in Florida:

> Donaldson was again locked up when he visited Florida. He thought it was because of a manuscript he had written criticizing mental institutions. He did not learn until 3½ years later that his parents had asked that he be examined. "It said in my papers that I had been examined physically and mentally by two doctors and the deputy sheriff," Donaldson recalled. "But they came nowhere near

me. And for 15 years, doctors kept telling me I was crazy because I said I wasn't examined."[9]

It is worth noting that in his efforts to explain what happened to him, both here and elsewhere, Donaldson dwells on his previous hospitalization, which Ennis omits. And he omits his complaints about being poisoned, which Ennis cites as the reason for his commitment.

Donaldson's account of his life after his discharge from Marcy State Hospital is also inconsistent with Ennis's account of it. Ennis says that at the time of his commitment in Florida, Donaldson was unemployed. Donaldson says: "I drove my car home from [Marcy], went to work the next week, and never lost a day's work until I was put in Florida State Hospital in 1957."[10]

After his stay at Marcy, according to Donaldson, his life was ruined by the stigma of being an ex-mental patient. He attributes his divorce and also his frequent changes of jobs to it. But this cloud had a silver lining: As a result of his psychiatric experiences, Donaldson found his calling. Henceforth he would devote his life to crusading for the rights of mental patients. He started to write a book "as my only means of exposing the harassment and thus hopefully putting an end to it. Before the book was completed, I went to Florida for a visit with my parents. From there I mailed the manuscript to the *Saturday Evening Post*. . . . Three days later I landed in the 'hole' of the Pinellas County Jail in Clearwater on a writ of Inquisition of Incompetency."[11]

Before his commitment to the Florida State Hospital, Donaldson was in no position to get very far in his chosen career as a psychiatric reformer. His confinement, release, and litigation changed all that. Propped up by the Mental Health Law Project as one of its favorite "victims," and he in turn propping up the MHLP as one of its star claimants, in 1975 both Donaldson and the MHLP emerged on the scene as the leading mental health reformers in the United States.

III

The county judge who committed Donaldson told him "that he was being sent to the hospital for a 'few weeks' to take some of this new medication, after which the judge said that he was certain that Donaldson would be 'all right' and would 'come back here.' "[12]

Clearly, the person most responsible for Donaldson's commitment was Donaldson's own father, who petitioned for it; and the second most responsible person was the county judge, who not only committed Donaldson but also misled him, to put it mildly. It is, in fact, unnecessary for a person to be in a hospital—full-time, and under lock and key—just to take pills. Indeed, one might go further and say that a hospital, especially a mental hospital, is precisely the one place in American society where a person cannot take pills; pills are there given to him.

The committing judge's remark about "new medication" is a classic example of the justificatory rhetoric of institutional psychiatry. What the judge said to Donaldson sounds good, and it probably made both the judge and Donaldson's father feel better about what they were doing. In reality, Donaldson was committed because he acted "crazy" and was officially adjudged to be "crazy." What justified his commitment, from the point of view of traditional psychiatry, was his mental illness—which had to be serious enough to warrant involuntary hospi-

talization. According to the psychiatrists, it was indeed serious enough: "Soon thereafter [admission, Donaldson] was diagnosed as a 'paranoid schizophrenic.'"[13]

The cardinal characteristics of paranoid schizophrenia are, first, that the patient makes claims about himself or the world with which psychiatrists and the society they represent disagree; and second, that the patient insists that he is normal or sane, whereas the psychiatrists and the society they represent insist that he is crazy or insane.[14] Kenneth Donaldson displayed both of these symptoms of paranoid schizophrenia in their most flagrant forms: He claimed that he was being poisoned, while the psychiatrists knew that he was not; and he claimed that he was mentally healthy, while the psychiatrists knew that he was mentally sick. It is important to keep these claims and counter-claims in mind, for they form the frame into which considerations of Donaldson's non-treatment must be placed before they can be properly understood or judged.

Since Donaldson's suit was brought on the ground that he was denied treatment for his mental illness, a treatment to which he had a supposed constitutional right, the facts surrounding his illness and non-treatment are of the greatest importance. Although Donaldson had ostensibly been committed for treatment, Judge Wisdom of the Court of Appeals emphasized that: "Donaldson received no commonly accepted psychiatric treatment. Shortly after his first mental examination, Donaldson, a Christian Scientist, refused to take any medication or to submit to electroshock treatments, and he consistently refused to submit to either of these forms of therapy. No other therapy was offered."[15]

Did Donaldson refuse to submit to these treatments because he was a Christian Scientist or because he did not consider himself to be mentally sick? As I shall show in a moment, Donaldson had, throughout his hospitalization, advanced both of these grounds for his objection to psychiatric treatments.

Donaldson's claimed adherence to the religion of Christian Science has been consistently underplayed or ignored in considerations of this case. As a Christian Scientist, Donaldson was entitled, under the First Amendment, to the practice of his religion. One of the things that the doctrine of Christian Science teaches is the rejection of doctors and medical treatment. Thus, as a Christian Scientist, Donaldson's most basic right in the state hospital lay not in any fictitious right to treatment, but in the very real right to reject treatment.*

Once in the hospital, Donaldson chose to exercise his right as a Christian Scientist.** And the psychiatrists chose to respect his right. For this Judge Wisdom punished them: "At trial, Gumanis mentioned 'recreational' and 'religious' therapy as forms of therapy given Donaldson; but this amounted to allowing Donaldson to attend

* In 1971, a U.S. Court of Appeals ruled in favor of a woman, a Christian Scientist, who sued Bellevue Hospital in New York City on the ground that while involuntarily hospitalized, she was given medication against her will. Her claim was upheld on the ground that she had a "constitutional right to refuse medical treatment because of religious beliefs."[16]

** In his claim against O'Connor, Donaldson actually advanced two alternative arguments, namely, that he should have been treated or released, and that he was not a person properly subject to involuntary mental hospitalization and treatment. The courts holding for Donaldson seemed to give some weight to both of these claims, making a logically incisive analysis of the case virtually impossible.

Church and to engage in recreational activities, privileges he probably would have been allowed in a prison."[17]

The court's stance here is remarkable: It puts the words "recreational" and "religious" modifying therapy between quotation marks, although it never puts the term "electroshock" qualifying therapy between quotation marks. This means either that it considers religion and recreation as totally non-therapeutic, but considers electroshock to be therapeutic—which is moronic; or that it downgrades these common-sense procedures as insignificant or useless——which is malevolent. The court's branding prayer and play as non-therapeutic because they might be allowed in prison is also peculiar. By this reasoning, if a myopic is allowed glasses in prison, or a diabetic insulin, then corrective lenses and injections of insulin also are not therapeutic.

Furthermore, the evidence is clear that Donaldson rejected treatment on two separate grounds—because he was a Christian Scientist and because he was not ill. Nowhere in the presentation or litigation of this case are these two grounds clearly identified, and nowhere is it emphasized that they strongly support one another and Donaldson's fundamental rejection of himself as a patient and of his captors as his doctors.

In his anonymous contribution to the Georgetown Symposium on the Right to Treatment, Donaldson emphasizes his rejection of the patient role on the ground that he was not ill: "I came to this state from the North as a visitor in August 1956. There was nothing wrong with me mentally, morally, physically, financially, or legally. . . . Yet, without any examination by anybody, I was declared sick."[18]

Nevertheless, in his suit against O'Connor and Gumanis,

the psychiatrists in charge of him at the Florida State Hospital, the crux of Donaldson's claim was that he was deprived of his "constitutional right to treatment," a claim the trial judge accepted and incorporated into his instructions to the jury.[19] The judge underscored his acceptance of this "right" by also telling the jury that "the purpose of involuntary hospitalization is treatment. . . . Without such treatment there is no justification from a constitutional standpoint for continued confinement."[20] Although defining involuntary treatment as a constitutional right is patent nonsense, it is especially absurd in a case where the patient is a Christian Scientist who steadfastly denies that he is ill and needs treatment.*

It is ironic that Donaldson successfully maintained his integrity against his psychiatric "enemies," to whom he never acknowledged his need for psychiatric treatment, only to lose it to his legal "friends," to whom he eagerly conceded his need for it.** No sooner was he released, after having resisted confessing mental illness to psychiatrists O'Connor and Gumanis, than he turned around and, in effect, confessed it to attorneys Birnbaum and Ennis:

* As a Christian Scientist, Donaldson consistently refused the treatment offered him at the Florida State Hospital. His legal posture is thus like that of a Catholic woman who refuses an abortion, and then sues the doctors for not having aborted her. I cannot judge the MHLP's intentions or motives in doing what it did with Donaldson. But I insist that, especially in the morally murky waters of legal psychiatry, those who strive for freedom from psychiatric coercion cannot afford to use their adversaries' immoral methods for achieving their own aims.

** According to Donaldson himself, "The principal treatment [in the hospital] is brainwashing, consisting of lies . . . intended to bring the inmate to his knees, i.e., to a confession of 'mental illness.' After the confession, the inmate is in line for consideration for release. No confession, no release. . . ."[21]

He allowed his lawyers to litigate on the basis that he was deprived of treatment that he needed for his mental illness! The moral of this distasteful lesson is that institutional psychiatrists, in order to justify their diagnosis and confinement of the patients, refuse to release mental patients unless they confess to having been mentally ill; and that right-to-treatment lawyers—in order to justify their claims for the patients' therapeutic deprivations—refuse to champion mental patients unless they confess to having needed treatment for mental illness.

IV

How did Donaldson gain his release from the hospital? The circumstances surrounding his discharge are revealing. During his 14½ years of confinement, Donaldson petitioned for his freedom, unsuccessfully, through numerous writs of habeas corpus. According to Morton Birnbaum:*

> [O]n 18 separate occasions, [Donaldson's] claims were presented to various Florida and federal courts, including the U.S. Supreme Court on four separate occasions. Through the last adverse decision by the Supreme Court in 1970, no court granted his petition for a writ of habeas corpus in spite of the fact that from 1969 on, he had had town privileges so that he could go back and forth into Chattahoochee at will.[22]

During the last two years of his hospitalization, Donaldson could thus have easily escaped, or "eloped," as psy-

* Morton Birnbaum, a general practitioner and lawyer, represented Donaldson while he was a patient at the Florida State Hospital. Birnbaum is the Executive Director of the Center for Law and Health Care Policy, New York City.

chiatrists put it. But he didn't. Nor was he discharged, although it seems that the hospital authorities were ready to let him go, provided he left on their terms. Moreover, although Donaldson claimed that he wanted to be free, evidently he wanted to be free only on his own terms. For many years, the relationship between O'Connor and Donaldson thus closely resembled that of a married couple seeking a divorce but unable to agree on the terms for it, each insisting on his or her complete innocence and demanding that a judge settle their dispute.[23] In an unhappy marriage, husband and wife often make demands on each other that each refuses to fulfill; in particular, each often asks the other to leave instead of himself or herself leaving. Similarly, during many years of Donaldson's "incarceration," keeper and kept were making demands on each other that each refused to fulfill. "Why do you want to stay and fight, when you could be free?" Donaldson quotes "Miss F.," a hospital social worker, asking him. His reply: "I didn't ask for this. I didn't choose the nuthouse for a career."[24] Actually, he did just that.*

* During the better part of his long period of "hospitalization," Donaldson could easily have gained his liberty if he had compromised on his principles. O'Connor and Gumanis evidently felt that they had met Donaldson half way by acceding to his requests to abstain from giving him treatments he did not want. In turn, they demanded that, like other patients, Donaldson be discharged by being signed out and by going to staff, conditions which, like the "treatments," Donaldson refused to accept.

For example, in 1966 Donaldson's daughter came to the hospital and wanted to sign him out. Donaldson refused to see her. "I explained to my children," he writes, "that I'm not going to be subjected to indignities ladled out by a bunch of goddammed mammy-jamming honey-dippers. . . . If I gave one inch and let my daughter sign me out, I would lose the whole case against institutional psychiatry, for then the doctors could say they had cured me and let me go."[25] Similarly, when a friend came to the hospital to take

Why was Donaldson released when he was? The illness and treatment rhetoric would lead one to believe either that he received some effective therapy shortly before release or that he made some spontaneous progress toward recovery. There is not a shred of evidence that either occurred. Nor did anyone associated with the case make such a claim. Actually, Donaldson's release had no direct relationship to either Donaldson or his captors. It was brought about by changes in the psychiatric-political climate and fresh legal support for his cause.[27]

In the years preceding Donaldson's release, federal appellate courts had handed down several decisions limiting the grounds for psychiatric incarceration, and touting the notion of a right to treatment as a newly discovered constitutional right for involuntary mental patients. In the meantime, Donaldson had gained the support of the American Civil Liberties Union, which had long crusaded for better commitment laws, and which now embraced Donaldson as a promising test case.

The change in the power positions of the *dramatis personae* governing Donaldson's fate is revealed by the fact that while still a hospital inmate, he collaborated with his lawyers in bringing a class action suit on behalf of all patients in the hospital's ward where he himself was confined.[28] No patient who has been diagnosed as schizophrenic and locked up for fourteen years can do such a thing unless he has powerful friends, indeed, in the legal profession. Donaldson had made such friends, and they

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him with him, he insisted that the psychiatrists let him go without going to staff, and when they refused to do so, he stayed in the hospital.[26] The result was five more years of jousting between patient and doctor, each trying to bring the other to his knees—and five more years of hospitalization or incarceration.

were "springing" him from the madhouse—albeit not without using him for their own purposes.

V

In his class action suit, Donaldson asked for damages and for habeas corpus relief for all members of the class. In July 1971 just two weeks before this suit was scheduled for argument before a federal court, Kenneth Donaldson received an unconditional discharge from the Florida State Hospital. "*Res ipsa loquitur*": The thing speaks for itself. Obviously, Donaldson was released from psychiatric confinement, not because he had suddenly become mentally healthy, nor because he had suddenly become non-dangerous, but because subjecting the legitimacy of his continued psychiatric incarceration to such a test was, under the new circumstances, deemed too risky by the legal-psychiatric authorities in charge of his case. Thus, the two most suggestive sets of facts about the Donaldson case—namely, those surrounding his commitment and his discharge—have been the two things most conspicuously ignored in all the briefs filed in this case and in all the judicial decisions rendered about it.

What happened after Donaldson was released? His petition for release suddenly became moot. The District Court accordingly dismissed the class action suit.[29] Donaldson's legal champions thereupon filed an amended complaint, alleging that the psychiatrists in charge of Donaldson "acted in bad faith toward plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights."[30] The complaint sought $100,000 in damages on behalf of Donaldson.

The trial began on November 21, 1972 and lasted four

days. Donaldson's attorneys set out to prove, among other things, that "the defendants confined plaintiff against his will, knowing that he was not mentally ill or dangerous, and knowing that if mentally ill he was not receiving treatment for his mental illness."[31] They succeeded in proving this. Two of the defendant psychiatrists, O'Connor and Gumanis, were found personally guilty of depriving Donaldson of his liberty—thanks to the instructions the trial judge gave to the jury.* Two of his key instructions were:

> You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his mental condition.
>
> The purpose of involuntary mental hospitalization is treatment. . . . Without such treatment there is no justification, from a constitutional standpoint, for continued confinement.[32]

Donaldson was committed unjustly. Everyone who is committed is, in my opinion, committed unjustly. I submit, however, that Donaldson's psychiatrists were tried unjustly. The judge who presided over the trial ordered the jury to bring in what was in effect a directed verdict against the defendants. It did so, awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis.[33]

* This judgment was not upheld by the Supreme Court and was remanded to the lower courts for reconsideration (see pages 79–80).

The view that Donaldson's so-called constitutional right to treatment was the crux of the issue in trial court is supported by the initial summary statement of the case by the Fifth Circuit Court of Appeals: "This case," wrote Judge Wisdom, "requires us to decide for the first time the far-reaching question whether the Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals. . . . Donaldson contends that he had a constitutional right to receive treatment or be released from the state hospital."[34]

After a review of the facts of the case, the Court of Appeals held "that the Fourteenth Amendment guarantees involuntarily civilly committed mental patients a right to treatment, and that the evidence was sufficient to support the verdict. . . . Accordingly, we affirm the judgment in Donaldson's favor."[35]

Besides emphasizing and re-emphasizing how Donaldson "received no commonly accepted psychiatric treatment," the Court cited, with unqualified approval, many authorities who support the doctrine of a right to treatment."[36] The first case cited was *Rouse* v. *Cameron*,[37] one of Judge David Bazelon's signal contributions to the advancement of the Therapeutic State.*

* There is a remarkable similarity between the *Rouse* and the *Donaldson* decisions that is worth noting here—namely, that in both cases judges intoxicated with the religion of psychiatry claimed not only that involuntarily hospitalized mental patients had a right to treatment but also insisted that, specifically, an individual who claimed to be well and who rejected treatment had such a right. Dissenting from Chief Judge Bazelon's opinion in the *Rouse* case, Judge Danaher sagely observed that the majority "are deciding a case which is not before us. In the first place, this appellant . . . was contending on his pleadings and at the trial that he was not insane and that he needed no treatment. His own expert, Dr. Marland, testified that Rouse was not mentally ill. . . ."[38] In short,

VI

I have long maintained that commitment is a response to a problem of housing rather than to a problem of illness.[39] At the time of his commitment, Donaldson was a homeless man—forty-eight years old, unemployed, living with his aged parents. It requires no great leap of the imagination to see that this living arrangement might have been something less than ideal for Donaldson and his parents. But none of them faced this dilemma directly. All agreed to disguise it as a problem of mental illness. The father filed a petition to have his son declared incompetent and to commit him to the state hospital; mother and son went along unprotestingly. Once arraigned, Donaldson did ask for a lawyer, and he pretended in other ways to protest his commitment. But these were mere dramatic gestures. In fact, he went along: He cooperated fully in the transfer of his residence from his father's home to the state hospital.

I submit that whatever its purported aims, justifications, or rationalizations might have been, Donaldson's original commitment was a solution to his problem of homelessness. Once we see this, we can formulate the moral problem it poses: Is compulsory housing a proper remedy for such a problem? I say that in a free society it is not. Housing qua housing may, and perhaps should, be offered

Bazelon's "landmark" decision in the *Rouse* case rested on the paradoxical premise that the government psychiatrists at St. Elizabeth's Hospital who were denying patients such as Rouse their right to treatment were, nevertheless, well qualified to determine whether or not the inmates in their captivity were mentally ill and hence in need of treatment.

to persons so disabled; but they should be left free to reject such offers and to suffer the consequences.

What about the needs of those who want to remove members of their household (or others) from their homes (or society) by rehousing them in mental hospitals? In a free society, they should not have such an option. Were the option of commitment removed from society, persons disturbed by so-called mental patients would have to choose frankly between living with them or "divorcing" them. The problem of justifying civil commitment would then never arise.

If there was one thing on which all the participants in the Donaldson case agreed, it was to avoid dealing with, or even mentioning, the basic issues underlying Donaldson's incarceration. The efficacy of this method of dealing with problems depends, as does the efficacy of so much else in human affairs, on whether or not others cooperate with it. If they do—if many or all concerned with an embarrassing or painful problem are happy to solve it by changing the subject—then denial works. The Donaldson case embodies and exemplifies the desire of psychiatrists, judges, and the public in general to look away from the embarrassing and painful problems of involuntary psychiatry—and gaze instead at the heart-warming sight of the right to treatment.

3

The Brief for Donaldson

I

After the Court of Appeals for the Fifth Circuit upheld Donaldson's damage award, O'Connor appealed to the Supreme Court. How did Donaldson, a penniless ex-mental patient, support his court battles? In the way that is typical of litigation of this sort in modern American law: by being adopted as a test case by a powerful group waging its own crusade for social reform through court action. In Donaldson's case, the supporting organization was the Mental Health Law Project. Since the litigation of such test cases reveals as much about the interests and

intentions of the individuals and groups that sponsor and support it as it does about the merits of the victim's case, it is necessary that we extend our scrutiny of the *Donaldson* case to the Mental Health Law Project itself, with special emphasis on its position on involuntary mental hospitalization; on the brief its lawyers filed, ostensibly for Donaldson; and on the implications—legal, logical and moral—of the arguments set forth in the brief.

According to its own definition, the Mental Health Law Project is "an interdisciplinary public-interest organization devoted to protecting the legal rights of the mentally handicapped (and those so labeled) and improving conditions for their care, treatment, education, and community life."[1]

Because of my interest in language and because I believe that words are as important to psychiatry as numbers are to arithmetic, I first want to offer a brief remark about the MHLP's name.[2] Names are, after all, symbols that persons bestow on themselves, others, and what they do; hence, names often reveal a great deal about who people are and what they do. If we assume that the originators of the MHLP named their organization truthfully, we would have to conclude that it is a law project *for* mental health *not against* involuntary psychiatry. By combining "mental health" and "law" in the name of this project, its founders and directors imply that they consider mental health as real or as substantial as law. Furthermore, by using the term mental health, they imply that it is something distinguishable from mental illness, a term that, in turn, leads them to support, however tacitly, the idea that mental illness is an illness that may be treated and cured by means of medical treatments. In my opinion, every one of these beliefs and premises hinders rather than helps the

cause of diminishing and abolishing the present-day, legally legitimized victimization of people in the name of mental health. In fact, these beliefs and premises may, whether wittingly or otherwise, lead the members and supporters of the MHLP to promote the very evils they ostensibly oppose.

The Mental Health Law Project was established in 1972 by three sponsors—the American Civil Liberties Union Foundation (ACLU), the American Orthopsychiatric Association (AOA), and the Center for Law and Social Policy (an organization supported by the Ford Foundation). Headquartered in Washington, D.C., the project employs ten attorneys, headed by Paul R. Friedman, and four legal assistants. Its board of trustees covers a broad spectrum of personalities, from ex-mental patients active in patient liberation work to prominent institutional psychiatrists responsible for directing programs for involuntarily hospitalizing and treating mental patients. One of the psychiatrists on the MHLP's board of trustees is June Jackson Christmas, M.D., the Commissioner of the New York City Department of Mental Health and Mental Retardation Services. In that capacity, Christmas probably is responsible for more involuntary psychiatric confinements per year than any other psychiatrist in the world. Another psychiatrist on the board is Harold Visotsky, M.D., now the chairman of the Department of Psychiatry at Northwestern University School of Medicine in Chicago and formerly (from 1959 to 1969) the Director of the Illinois Department of Mental Health. Like Christmas, Visotsky is an institutional psychiatrist, in the strictest sense of that term: His ideological and economic loyalties always have been, and continue to be, to psychiatric in-

stitutions, not to individuals incarcerated in those institutions.

Indeed, the views expressed in the MHLP's official newsletter make it clear that this organization is self-consciously devoted to improving psychiatric slavery and to opposing efforts to abolish it. For example, in an editorial on the "Principle of the Least Restrictive Alternative," Paul Friedman, the managing attorney of the MHLP, comes down squarely in favor of both involuntary mental hospitalization and involuntary psychiatric treatment. Noting that competent mental patients "may" have a right to refuse treatment they do not want, he raises the question, "But what about incompetent residents?" and answers it as follows:

> When a mentally handicapped person is incompetent to give truly informed consent, there must be some form of substitute decision-making. But because hazardous or intrusive procedures may infringe on fundamental . . . rights, additional protections—such as review by an independent "human rights committee"—are needed to insure that such substituted decisions are in the "best interests" of the person. . . . For example, . . . [for] a severely disturbed mental patient, verbal psychotherapy should be tried before ECT is contemplated.[3]

This, of course, is only a slightly retouched form of a position long held by institutional psychiatry. Behind the high-sounding phrases, there remains the unequivocal approval of electroshock treatment for individuals without their consent but for their "best interests," as that interest

is determined by the individual's judicial and psychiatric adversaries.

A statement written by Joel Klein, one of the MHLP's staff attorneys, makes the project's position on involuntary mental hospitalization crystal clear. "My concern," writes Klein, addressing himself specifically to those who would outlaw psychiatric slavery "is that one result of abolishing involuntary commitment will be to ignore the legitimate treatment needs of some people who require care."[4] Speaking for the MHLP in its official newsletter, Klein thus identifies himself as another true believer in the religion of psychiatry: Mental illness is an illness that requires treatment, especially when the patient has no insight into his own need for it. "First," explains Klein, as if he had just discovered this idea himself, "there are people who, precisely because of severe mental illness, will not accept treatment voluntarily. For example, some depressed people believe they are unworthy of help."[5] From this Klein concludes that, "If effective treatment can be provided within a reasonably short period, I believe that sound social policy should allow for a limited curtailment of civil liberties to permit it."[6] Actually, the position here advocated is even more repressive than that of traditional institutional psychiatry—inasmuch as it supports involuntary mental hospitalization not because the patient is dangerous but because it affords his captors an opportunity to give him the treatment:

> [P]ragmatic reasons lead me to conclude that involuntary commitment should be accepted in limited circumstances. Involuntary patients arguably have a constitutional right to treatment, as several courts

> already have held. Thus, once a patient is committed, his lawyer can use the courts to insure that treatment is provided.[7]

Klein's logic and the MHLP's true aims could hardly be more clearly stated: Because involuntary mental patients have a right to treatment but voluntary mental patients do not, the road to psychiatric reform lies through involuntary hospitalization and the involuntary treatment it makes possible. Here it is, right from the pages of the MHLP's "Summary of Activities":

> [I]t seems extremely unlikely that voluntary patients will soon be found to have a constitutional right to treatment. Rather, when indigent, they must accept whatever services a state provides—usually significantly less than needed. In short, the irony is that people who want mental treatment frequently cannot get it, while those who do not want it sometimes can. I cannot overemphasize that in the absence of involuntary commitment it will be extremely difficult to force the state to provide decent mental health care.[8]

Such, then, are the psychiatric positions of the organization that used Donaldson as its celebrated test case. In Klein's own words, the central aim of the MHLP is to *force* the state to provide involuntary psychiatric treatment for involuntary patients. This aim is not merely different from that of *forcing* the state to free its involuntary mental patients but is antithetical to it: For if there are no involuntary patients, there are no persons with a right

to mental treatment, an outcome that would place the MHLP's goal of providing more and better involuntary mental treatment utterly beyond reach.

II

The character of the organizations that have brought the MHLP into being and support it, and their record on psychiatry, raise equally serious questions about the true aims of this group. As an organization sponsored by the ACLU, the AOA, and the Ford Foundation, the MHLP is an odd alliance, indeed. The American Orthopsychiatric Association is, in fact, one of the several American unions for the protection and promotion of institutional psychiatry. Founded in 1924 by Karl Menninger, its explicit aim was to bring together the "representatives of the neuropsychiatric or medical view of crime." [9] The name of the organization itself betokens a lack of interest in, and respect for, civil liberties or human rights—as the very term "orthopsychiatry" implies the belief that crime is a medical problem, and that physicians are a morally, politically, and scientifically chosen elite whose duty it is to straighten out the crooked behavior of their fellow men and women.[10]

Before World War I, the American Orthopsychiatric Association celebrated the glories of involuntary mental hospitalization by singing its praises in choirs conducted by such pioneer therapeutic totalitarians as Gregory Zilboorg. "The law," declared Zilboorg, "has never been neglectful of the so-called insane. In civil law, it is extremely lenient; it commits an individual to the mental institution with the greatest reasonableness and with the minimum of difficulties. . . ."[11]

Since then, the American Orthopsychiatric Association has more than lived up to its original mandate. For example, among its recent presidents was Judge David Bazelon, a prominent proponent of civil commitment and the right to treatment.[12]

The American Civil Liberties Union's psychiatric record also leaves much to be desired. During the first few decades of its existence, the ACLU took no notice of psychiatry and involuntary mental hospitalization. Once it did, however, it immediately embraced it as an answer to the problems of social deviance and social control. In his adulatory history of the ACLU, Charles Markmann relates how, toward the end of World War II, the Union "began to draft model statutes for the commitment of the insane. . . . Twenty years after the first Union draft of a model bill for commitments to mental hospitals, Congress enacted for the District of Columbia a law closely following the Union's proposals."[13]

The Union thus has a long history of uncritically accepting the concept of mental illness, whose treatment by imprisonment is casually delegated to the psychiatric profession. Although in recent years the ACLU has made some ambivalent attempts to confront the realities of involuntary psychiatry, its position on the issue of commitment has remained pro-psychiatry and anti-civil liberties.[14] This may be owing partly to the influence of its two most prominent psychiatric-judicial experts, Karl Menninger and Ramsey Clark. Clark's views on commitment can be conveyed by means of a single quotation:

> Where commitment is necessary, civil commitment of a contractual nature offers the opportunity for physical control over the addict without the stigma of a

> conviction for crime. Voluntary participation, which is the basis for civil commitment,[*] creates an attitude helpful in achieving a cure.[16]

This pro-commitment view is not limited to a few psychiatrically biased individuals in the ACLU. As recently as 1972,

> The ACLU Board of Directors [was] still polishing its policy on mental commitments. However, most of the Union's leaders appear to agree on certain minimal standards: Involuntary commitment should be the last resort to which society turns in dealing with the mentally impaired. Before commitment there must be clear demonstration that the individual is a danger to himself or herself or to others. . . . And there must be assurance that the individual who is committed will, in fact, be treated adequately.[17]

Perhaps the most telling evidence for the view that the ACLU is still inimical to the civil rights of mental patients is, ironically, furnished by Donaldson himself in his autobiographical account of his psychiatric calvary. Recalling a conversation he had with Birnbaum at the Florida State Hospital shortly before his release, Donaldson writes that Birnbaum told him: "I delayed filing because the American Civil Liberties blew hot and cold. They keep asking

* Clark's view of civil commitment as voluntary is similar to the Soviet view of it.[15] It is fitting that this Orwellian touch should be added to the history of mad-doctoring by Communist psychiatry and by the chairman of the ACLU's National Advisory Council.

what your politics are. I'm a member myself and I keep telling them what's the difference, he's incarcerated unconstitutionally. Finally, I told them I would proceed without them. But they definitely are in now."[18]

Thus, judging from the loyalties of the individuals and groups composing the MHLP, we would have to conclude that, at best, it is an organization for promoting mental health reform in the tradition of Dorothea Dix; or that, at worst, it is an organization for opposing the thrust of the abolitionist sentiment now growing in the United States with respect to mental health legislation. The latter inference is suggested by the fact that the MHLP's work deflects attention from the actual wrongs of involuntary mental hospitalization to the alleged wrongs of inadequate or insufficient psychiatric treatment for involuntary mental patients.

It is essential that we keep these facts about the AOA, the ACLU, and the MHLP in mind when we try to understand the historical background and the legal-political context of the *Donaldson* case. Donaldson's was truly a test case, with Kenneth Donaldson himself as the guinea pig. The claims and counterclaims in the case and the judicial rulings about it were the trials and errors of the experimenters. The results of these experiments have nothing to do with Donaldson or, for that matter, any other person. They show us only the forces of the psychiatric imperialists, in effect demanding explicit judicial sanctions for psychiatric slavery through the articulation of a constitutional right to treatment, and the forces of the defenders of the psychiatric status quo, concealing their coercions behind traditional judicial authorizations for the smooth management of the psychiatric plantations.

III

After setting forth the facts of the case and the fate of the litigation to date, the MHLP brief continues as follows:

> Respondent . . . was confined expressly for the purpose of receiving treatment for his alleged mental illness. Petitioner knew that respondent was not receiving *any* treatment, and that he was receiving only the custodial care he would have received in a prison. . . . Petitioner had the authority to release respondent from the hospital, but instead allowed his confinement to continue for nearly fifteen years.[19]

Except for the statement that O'Connor "had the authority to release" Donaldson, the foregoing assertions are simply not true. Donaldson was not confined expressly for the purpose of receiving treatment. He was confined because he was officially diagnosed as a paranoid schizophrenic who was adjudged to be dangerous to himself and others. Nevertheless, the MHLP's brief also claims that "petitioner knew that respondent was not dangerous to himself or to others, and that respondent was capable of providing for his basic needs in the community."[20]

It is not clear how the attorneys who wrote this could in good conscience assert that O'Connor *knew* all these things. It is an integral part of psychiatry as the "science" of the human mind that paranoid schizophrenics are dangerous. Just as true believers in Judaism believe that Jews are the Chosen People, and true believers in Christianity believe that Jesus is God, so true believers in psychiatry believe that paranoid schizophrenia is an identifiable

mental disease and that those who suffer from it are dangerous. The MHLP's brief does not challenge psychiatry as a fake science. Nor does it claim that O'Connor was anything but a true believer in psychiatry. Thus, by imputing beliefs to O'Connor that O'Connor presumably does not hold, probably never held, and, in principle, could not possibly have held, the attorneys for the MHLP do him the same injustice that institutional psychiatrists do their victims: they accuse him and condemn him by claiming that certain unsupported derogatory conjectures are "facts."

Actually, the MHLP's brief for Donaldson is so repugnant—in its claim for a right to treatment for a patient who consistently maintained that he was not sick and did not want any treatment, and who, to boot, was a Christian Scientist; in its tendentious citation of supporting evidence; and in singling out O'Connor as the devil in the drama while wholly neglecting the role of the courts in consistently authorizing and reauthorizing Donaldson's detention—that it can only compound a fair-minded observer's distaste for institutional psychiatry and its diagnoses with an equally intense distaste for the MHLP and its advocacy of a right to treatment.

In their argument, the MHLP attorneys cite the Court's statement in *Jackson* v. *Indiana*, that "the States have traditionally exercised broad power to commit persons found to be mentally ill."[21] This statement raises an obvious question: If the state has such power, how can O'Connor be faulted for keeping someone in his hospital who, the courts have repeatedly told him, is insane and should be confined? Ignoring this question, the MHLP brief jumps, without hesitation or evidence, from the broad power of the states to commit to the narrow but important ques-

tion which it claims the *Donaldson* case poses: namely, the right to treatment or release. In reality, this question is posed not by the merits of this case but by the MHLP.

IV

The *Donaldson* case is very troubling for several reasons, of which the MHLP's posture toward it is only one. Another reason is that, at least according to one legal commentator, Donaldson's original commitment was illegal. In an article written shortly before the Supreme Court handed down its decision, Brian Schwartz noted that Donaldson's confinement "violated Florida law, which limited involuntary commitment to persons resident in Florida for at least one year, whereas Donaldson had been in Florida for only four months. The examining physicians had erroneously reported that Donaldson had been in Florida for four years."[22]

The attorneys for the MHLP must have known this. Why, then, did they concentrate their legal firepower on a suit claiming a right to treatment instead of on one asserting false imprisonment? This rhetorical question suggests, too, that the MHLP does not want to abolish slavery but wants to improve the plantations.

One wonders, too, if Donaldson knew that his original confinement was illegal, not just for the reasons he had advanced, but simply because he was not a Florida resident. And if he knew it, why did he permit his lawyers to base their litigation on the premise that his commitment was legal?

Sidestepping the issues of why Donaldson was committed and whether his commitment was legal, the MHLP comes down squarely for a plea for a right to treatment:

"The most critical of the post-confinement rights—the right to be restored to liberty either by treatment or else by release—has been recognized and endorsed by medical experts, by legal commentators, and by the United States."[23] One of the groups cited under the heading of such medical experts is the American Psychiatric Association (APA). In fact, the APA was opposing, not supporting, Donaldson.[24] By making common cause with precisely those psychiatric and legal authorities most responsible for involuntary psychiatric interventions, Donaldson and his champions vitiate both their arguments and their credibility. A few facts about the APA and its position on commitment must suffice here.

In 1844, thirteen superintendents of mental hospitals joined to form the Association of Medical Superintendents of American Institutions for the Insane, the organization that became, in 1921, the APA. The original name of this first American psychiatric organization is revealing, and so is its first official resolution. The group's name articulated its character: it was an organization of "medical superintendents," that is, of physicians who were in charge of incarcerated individuals considered and called insane. The organization's first official proposition was: "Resolved, that it is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane."[25]

This paternalistic justification of psychiatric coercion has remained a prominent theme in psychiatry, not only in America but throughout the civilized world. In 1967—123 years after the drafting of its first resolution—the American Psychiatric Association reaffirmed its support of psychiatric coercion and restraint. In a "Position Statement on

the Question of the Adequacy of Treatment," the association declared that "restraints may be imposed [on the patient] from within by pharmacologic means or by locking the door of a ward. Either imposition may be a legitimate component of a treatment program." [26] In the same document, the APA declared that, "It would be manifestly 'poor treatment' to release a patient to commit an unlawful act." [27] Since "unlawful" is in no way qualified, this recommendation endorses involuntary mental hospitalization as a legitimate means of restraining a person from, say, running a red light or cheating on his income tax.

Not only does the MHLP cite approvingly the APA, which endorses psychiatric coercion, but it rests its entire legal strategy on Donaldson's behalf squarely on wrenching the nature and propriety of Donaldson's treatment out of the context in which it actually occurred. In my judgment, such a strategy, especially in the hands of persons ostensibly concerned with civil liberties, is unexcusable. Why? Because in a legal system such as ours, the legitimacy of treatment cannot depend on its efficacy; instead, it must depend on its being undertaken with the informed consent of the patient. This is the principle governing regular medical and surgical treatment. The entire tradition of medical tort litigation supports this principle—that is, the patient's right to request or reject treatment. With the exception of certain life-saving measures imposed on unconscious patients, a medical intervention imposed on a person without his consent is not treatment but assault and battery. The excellent quality of the treatment is no defense. By analogy, it does not matter whether involuntarily committed mental patients receive good, bad, or indifferent treatment or no treatment at all. The very context in which psychiatric

interventions are imposed on them renders it impermissible to call such measures treatments. The commission of such an intervention constitutes assault and battery, whereas its omission is simply the absence or omission of assault and battery.*

Finally—in a display of hypocrisy that would be difficult to top—the United States itself appeared as *amicus curiae* on behalf of the committed mental patient! Are we expected to forget—or, better still, to be ignorant of the fact—that the United States had incarcerated Ezra Pound, one of its most famous poets, in the madhouse and kept him there for fourteen years? [28] That a much-admired liberal attorney general of the United States engineered the psychiatric commitment of General Edwin Walker? [30] And that the United States locks up, in its own mental hospital in Washington, D. C., visitors to the White House deemed to be behaving strangely? [31] ** Truly,

* Because the Fifth Circuit's right to treatment ruling is likely to result in an increase in psychiatric assaults and batteries, it is ironic that it is precisely such psychiatric coercions that Donaldson, through the MHLP, is now implicitly endorsing. As Schwartz noted, "By holding Donaldson's attending physicians liable for failure to treat him, it [is] likely that mental hospitals, in order not to be liable for not providing treatment, will in the future force such modes of treatment as tranquilizers and ECT upon patients who, as Donaldson did, refuse them."[28]

** To appreciate the role of the United States in the controversy over the right to treatment, we must ponder the following two positions it has recently taken. In January 1975 in a submission to the Supreme Court Solicitor General Robert H. Bork asserted that the government supported the legal position that a patient such as Donaldson enjoyed a "constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition."[32]

In the summer of 1975, in a brief opposing a suit by the American Association of Physicians and Surgeons (AAPS) asking the Supreme Court to declare the Professional Standards Review Or-

with *amici curiae* like these, the Supreme Court needs some *inimici curiae.*

As the pleading on behalf of Donaldson is developed, it becomes, in effect, an ever more powerful defense of civil commitment. Addressing the court directly, the MHLP urges that "in order to affirm the holding of the Court of Appeals, this Court need not decide":

> 1. Whether an involuntarily confined mental patient who is dangerous, either to self or to others, has a right to be treated or be released;
> 2. Whether civil commitment of the mentally ill for any purpose other than treatment is constitutionally permissible.[35]

Why is the MHLP worried that the Supreme Court might rule that civil commitment "for any purpose other than treatment is constitutionally permissible"? I think it would be a good thing if it did so rule: Like any opponent who stands for the wrong thing, it could then more easily be knocked down. As I pointed out earlier, the best justification is no justification.[36] So long as the Supreme Court does not justify commitment at all, it is difficult, legally, to attack its stand on it. (It is, of course, easy enough to attack it intellectually and morally.)

Ironically, the evidence the MHLP cites in connection with the lack of treatment given to Donaldson supports

ganizations (PSROs) unconstitutional, the same solicitor general, representing the same United States, declared that "patients whose medical care is provided by public funds have no constitutional right to . . . obtain that care from a physician of their choice."[33]

It is clear that if the United States supports anything, it is the right to treat, not the right to treatment.[34]

not the claim to a right to treatment but its antithesis—namely, that involuntary mental treatment usually harms rather than helps the subject. After remarking on the "deterioration of patients' intellectual, social, and physical functioning as a result of custodial confinement in large understaffed and overcrowded mental hospitals," the authors of the MHLP observe:

> One of respondent's expert witnesses, Dr. Walter Fox, testified that respondent's lack of deterioration showed that respondent was uniquely independent: ". . . Mr. Donaldson had . . . more . . . internal strength than most of the people that would find themselves in that sort of total institution for that period of time."[37]

What inference may one draw from Donaldson's ability to maintain his mental functions despite long confinement? One is that he had "more internal strength than most people," a glamorization of Donaldson inconsistent with what we know about him. An inference more consistent with the facts would be that although being locked up in a mental hospital is bad, it is even worse to be locked up in one *and* to receive psychiatric treatment. In my opinion, the doctors at the Florida State Hospital helped Donaldson by not treating him. That Donaldson was not given electroshock or drugs, two treatments he specifically rejected and yet specifically mentioned as being withheld; and that he was allowed to exercise his skills as a defender of his own rights and of the rights of other patients by writing legal briefs—these circumstances suggest that he was treated rather better and more hu-

manely than most patients in most hospitals under similar circumstances.*

What is perhaps most unfortunate about the MHLP's plea for Donaldson is that in its effort to win the case for the right to treatment, the MHLP stoops so low as to falsify the historical record of psychiatry. In promoting the idea of the right to treatment, its advocates must confront the fact that historically mental confinement has had nothing to do with treatment. This fact was adduced in defense of O'Connor. The authors of the MHLP brief brazenly call this claim incorrect: "Petitioner incorrectly asserts that 'the historical basis for the existence of state

* In his autobiography, Donaldson himself furnishes evidence to support this view and especially the impression that, at least initially, the doctors at the Florida State Hospital were quite conscientious in caring for him. By "caring" I here mean, of course, that they tried to treat him as good psychiatrists were then supposed to treat their psychotic patients. On February 12, 1957—that is, a month after admission—Dr. J. T. Benbow, the clinical director of the hospital, wrote to Mrs. William Donaldson, explaining that "Mr. Kenneth Donaldson . . . is adjusting quite well to our hospital routine. . . . We do feel that he is quite ill from a mental point of view, however, and we have received some reports of his previous hospitalization suggesting that his illness is of quite long standing."[38] Dr. Benbow concluded the letter by stating that Kenneth Donaldson needed "electroconvulsive treatments," and he enclosed a permission form for Donaldson's parents' signature. Donaldson reproduces this permission form, dated February 19, 1957, signed by William T. Donaldson and witnessed by Marjorie K. Donaldson.[39] Surely, the fact that despite this permission, physicians at the Florida State Hospital refrained from giving Donaldson electroshock treatment must be counted as quite exceptional compassion and decency on their part. Randle McMurphy, in Ken Kesey's fine novel, *One Flew Over the Cuckoo's Nest*,[40] was treated with considerably less compassion but in a manner that presumably fully satisfies the MHLP's claims for a right to treatment.

mental institutions was to safeguard the individual and society, and to relieve the family of the financial and physical burden of caring for the mentally ill.'"[41] The historical record of institutional psychiatry speaks for itself. It is a moving tale of medical crimes, and as such it is one of the most important weapons in the flight for freedom from psychiatric coercion.[42] In defending Donaldson, his legal champions threw away this weapon. It is enough to make one wonder whose side they were on.

In the last analysis, then, I consider the MHLP's claims—ostensibly on behalf of Donaldson but actually on behalf of its own ideas for mental health reform—repugnant because they purvey paternalism in the guise of professionalism, and substitute condescension for respect. The public-interest psychiatrists assume the role of "doctor knows best"; the public-interest lawyers, that of "attorney knows best." The psychiatrists confine and treat their patients as they, the doctors, deem fit, claiming that if the patients only knew psychiatry, the help they are getting is exactly what they would be seeking. Similarly, the lawyers litigate by claiming that their clients are psychotic and in need of involuntary treatment, claiming that if they, the clients, only understood the law, the legal help they are getting is just what they would be seeking. The fact that in some particular cases commitment might help the patient, and the contrived legal strategy of a right to treatment might help the client, only further complicates this matter. Surely, a person who claims that he is well and therefore wants no medical treatment is not treated with respect if psychiatrists act as if he were mentally ill and lawyers as if he had a right to treatment. In the morally murky waters of legal psychiatry, those who strive for freedom

from psychiatric coercion cannot afford to use immoral methods for achieving their aims.

V

It may be objected that in view of the practical exigencies of institutional psychiatry, efforts to improve the system are important and legitimate. I do not deny this. But the question is: Do such activities properly fall into the sphere of the ACLU or of any group or individual claiming to be protecting civil liberties? After all, there has never been a shortage of individuals and groups that have tried to improve institutional psychiatry. The ACLU is simply not needed for this task. In my opinion, the real task of civil libertarians concerned with involuntary psychiatry is not how to diminish its abuses, but how to destroy its professional pretensions and its political support. In short, our aim should be not to prettify plantations but to abolish slavery.

Of course, if we cannot eliminate injustice—which is often the case—it is desirable and proper that we help its victims as best we can. However, it is one thing for people to do so as individuals and quite another for them to do so as members of an organization. The appropriate institutions for extending help to needy persons regardless of the circumstances are organizations such as the Red Cross, the Salvation Army, the Rescue Mission, and other charitable agencies. The catch is that it is often difficult for groups—especially for prestigious groups with a high degree of public visibility—to try to improve situation *X* without thereby authenticating and strengthening the intellectual and moral basis for the existence of situation *X*. This was the case with slavery and with

Japanese-American relocation camps in the past; and it is the case now with involuntary psychiatry. Perhaps it is sometimes possible to reform these institutionalized injustices without legitimizing them, but this surely requires that those who pursue such a course make their unshakable determination to destroy the system as a moral wrong crystal clear. Since the ACLU has done nothing of the sort with respect to involuntary mental hospitalization, and since, on the contrary, it has always supported, and still supports, commitment laws, the logic of its own behavior drives one inexorably to the conclusion that the ACLU approves of psychiatric slavery and opposes all genuine efforts to abolish it.

The same considerations apply to the MHLP. The evidence I have cited compels one to conclude that the real aim of this organization is not to combat psychiatric coercion but to regulate it. This conclusion is supported by its own bylaws, which state:

> In furtherance of its objects and purposes, the Corporation [the MHLP] . . . shall:
>
> 1. Identify and implement the rights of the mentally impaired through test case litigation;
> 2. Work with other organizations in the field of mental health;
> 3. Conduct a program of clinical education and assist in the training of lawyers and others concerned with mental health law.[43]

Each of these goals is inconsistent with the aim of restoring persons accused of mental illness to full citizenship.

The first goal implies that the mentally impaired have, and ought to have, different rights from those of the rest of the population. Otherwise, there would be nothing to identify or implement. The second goal places the MHLP squarely in opposition to the involuntary mental patient. It is precisely because of other organizations in the mental health field that mental patients are deprived of essential dignities and liberties. If the MHLP wanted to restore the rights of mental patients, it would have to work not *with* but *against* organizations in the mental health field, every one of which supports involuntary psychiatric interventions. The third goal indicates that the MHLP subscribes to the deceptive medical jargon of institutional psychiatry and to the pseudo-therapeutic imagery it fosters. There is nothing clinical about psychiatric prisons and imprisonment. To view loss of liberty under psychiatric auspices from a clinical perspective is to authenticate it.

Although in some of their private comments some of the leaders of the MHLP claim that they oppose involuntary psychiatry, this opposition is in no way reflected in the MHLP's position statements and publications. Specifically, on the issue of involuntary mental hospitalization, the MHLP is on record as implicitly supporting such incarceration by proclaiming that one of the "important rights of the mentally handicapped," is "due process procedures in civil commitment." [44]

Furthermore, the MHLP claims that voluntary mental patients have a right to "adequate treatment"—whatever that is.[45] Worse, still, the project concurs with, and thus legitimizes, the traditional psychiatric policy of treating voluntary patients who want to terminate their psychiatric contacts as involuntary patients—long enough, at least,

to allow relatives, psychiatrists, and the courts to change such patients' status from voluntary to involuntary:

> Finally, all voluntary mental health services clients would have the right to withdraw from care or treatment at any time. The only condition placed on this right of immediate termination of care and treatment is that, for purposes of orderly administration, the right of clients in inpatient care and supervised residences is couched in terms of the right to discharge "within the four ordinary business hours following" an oral or written request for release.[46]

Since the MHLP's draft on "Procedures for Voluntary Treatment" is silent about the institutional psychiatrists' right to commit voluntary mental hospital patients who seek release, one is compelled to conclude that the project is not opposed to such a crass betrayal of the patient's trust in his supposedly voluntary status.

VI

I submit that through its brief to the Supreme Court and, more specifically, through its claim that Donaldson had a right to psychiatric treatment while confined in the Florida State Hospital, the MHLP has harmed rather than helped its client. I say this because there are, basically, only three things a lawyer can do for a client victimized by institutional psychiatry. First, he can secure his freedom. Since Donaldson was released before he filed his suit against O'Connor and Gumanis, he already had his

freedom. Second, he can sue and try to win money damages for his client. Donaldson's lawyers tried to do this but, perhaps largely because of their tactic, probably will fail. Third, he can dramatize his client's plight as the suffering of the noble soul, a martyr to a cause, the victim of a social evil. It is here, in my opinion, that the MHLP failed, and indeed betrayed, Donaldson.

By claiming that Donaldson had a constitutional right to treatment while in the Florida State Hospital, the attorneys for the MHLP harmed their client by depriving him of his good name, his credibility, his sincerity, his religion, and his sanity. For if Donaldson's own lawyers believe that he had a right to psychiatric treatment while in the hospital, it follows that they themselves must believe that Donaldson was mentally ill while he was incarcerated. If they believe that he had a right to treatment despite his own refusal of treatment, then it follows that they themselves must believe that Donaldson was so mentally incompetent while in the hospital as not to know his own best interests. Finally, if they believe that he had a right to treatment despite his avowed adherence to the faith of Christian Science, then it follows that they themselves must believe that Donaldson's religious affiliation is a sham. With friends like these, Donaldson needs no enemies.

4 The Brief for O'Connor

I

During much of the time that Kenneth Donaldson was confined at the Florida State Hospital, the superintendent of that institution was Dr. J. B. O'Connor. It was O'Connor and John Gumanis, the so-called "treating physician" whom Donaldson sued, who were ordered to pay $38,500 to Donaldson in damages. O'Connor, represented by the attorney general of the State of Florida and two assistant attorneys general, appealed the decision to the Supreme Court. Let us see how O'Connor and his legal champions saw and presented their case.

The brief for O'Connor begins with a résumé of the facts surrounding Donaldson's commitment: "The commitment order states his [Donaldson's] incompetency was due to paranoid schizophrenia with auditory and visual hallucinations and delusions. The order further stated that Donaldson . . . required restraint to prevent self-injury or violence to others. Two physicians served as the investigating commitee for the proceedings."[1]

It is important to note that these judgments about Donaldson's dangerousness were not O'Connor's but those of the court that committed him. Donaldson's dangerousness is thus very much in the record. Nevertheless, Donaldson's legal champions have consistently maintained that there was no evidence of his dangerousness, and the courts have concurred with this judgment.[2] Obviously, I am not asserting that Donaldson was, in fact, dangerous. I am asserting only that there was bureaucratic, legal, and psychiatric evidence that he was dangerous, and that, in view of this evidence it is unreasonable to charge O'Connor, as the brief for Donaldson does, with knowing that Donaldson was not dangerous.[3]

Furthermore, the brief for O'Connor notes something which the brief for Donaldson conveniently omits, namely that Donaldson had been in a mental hospital once before. It also cites another item pertinent to the question of Donaldson's dangerousness: "In January 1957, at the time of his admission to the Florida State Hospital, Donaldson was examined by a Dr. Clark Adair. The examination revealed that Donaldson expressed delusions of persecution for which he blamed 'rich Republicans' and believed that the 'Foreign Policy Association' had attempted to poison him by placing chemicals in his food."[5]

If one accepts the basic medical and moral premises of

traditional psychiatry—which Donaldson's legal champions themselves accept—then it is impossible to maintain that Donaldson was never dangerous. I need not belabor here that I reject this whole psychiatric rhetoric as so much humbug. In my opinion, Donaldson had no constitutional right to treatment, but he most certainly had a constitutional right to his delusions. By insisting that Donaldson had a right to treatment, his legal champions agree to playing in their adversaries' ballpark. They thus commit themselves to the view that institutional psychiatrists are bona fide doctors who diagnose and treat their patients; that they have a right to call persons "patients" even though they do not want to be patients; and that they have a right to diagnose such involuntary patients as dangerous. The upshot is that all the parties to this dispute accept the legitimacy of O'Connor and his staff diagnosing Donaldson as schizophrenic, and even of the claim that they owed him an obligation to treat his schizophrenia; but some of them—that is, the attorneys for the MHLP—reject the accuracy of a part of this diagnosis—namely, that Donaldson was dangerous. This argument for Donaldson simply makes no sense, as it arbitrarily accepts O'Connor's medical authority insofar as it authenticates the basis for Donaldson's claim to a right to treatment—that is, his mental illness; and rejects it insofar as it supports O'Connor's claim to confine Donaldson—that is, his dangerousness.

However, inasmuch as none of these claims and contentions can be empirically verified, it is imperative that we ask not whether Donaldson was mentally ill or dangerous, but rather who has the moral right to make such judgments, and who has the legal authority to impose them on others?

II

According to "scientific" psychiatry and the modern societies that support it, institutional psychiatrists have the above-mentioned rights and powers vis-à-vis their involuntary patients. Donaldson's legal champions have never challenged these psychiatric privileges and powers. Instead, they have tried to sidestep the problems they pose, with the result that the "facts" presented in the briefs for O'Connor and for Donaldson read as if they described two different cases. The MHLP's brief, as I have shown, extolls Donaldson's peacefulness and nondangerousness, whereas the brief for O'Connor sets forth, in the best tradition of institutional psychiatry, the "proofs" of Donaldson's dangerousness. A typical item states: "During January 1964, a meeting of nine members of the staff recommended continued hospitalization. The written opinion of the staff, issued following the meeting with Donaldson, found him dangerous to others and recommended further hospitalization." [6]

Donaldson did not take this lying down. He complained to the state legislature, which led to a further authentication of his dangerousness.* At the instigation of a member of the Florida state legislature, Dr. Franklin J. Calhoun, an independent psychiatrist, examined Donaldson and rendered this opinion: "The results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. . . . I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized."[7]

Between 1964 and 1968 Donaldson's repeated requests

* All these "facts" are omitted from the MHLP's brief for Donaldson.

for release were denied "due to the opinion of the staff that Donaldson was dangerous to himself and others. . . ."[8] To be sure, mental hospital superintendents hide their personal decisions behind such staff decisions, but that is the game of institutional psychiatry. So long as the courts recognize that game as medicine and the implementation of professional standards, it is difficult to understand how they can hold an individual psychiatrist responsible for failing to discharge a non-dangerous patient when that psychiatrist's whole staff has declared that the patient in question was dangerous! Indeed, if a hospital superintendent discharged such a patient, and if that patient committed suicide or a crime, the physician could then be charged with not exercising proper professional care in discharging a dangerous patient—indeed, in discharging him in the face of such an adverse opinion by his own staff. Given these legal realities, how could O'Connor possibly have discharged Donaldson? The two were united by the invisible, but virtually unbreakable, bonds of psychiatric matrimony.[9]

The brief for O'Connor seeks to exonerate him by placing the blame for Donaldson's confinement on the courts. In this case, this classic psychiatric evasion of responsibility is supported by unusually good evidence. Donaldson was diagnosed as a dangerous paranoid schizophrenic; he refused treatment; and the propriety of his confinement in the hospital was legitimized by the courts at least fifteen times.[10]

III

The brief for O'Connor concludes with an appeal to the Supreme Court to reverse the lower courts' decision be-

cause, first, the doctrine of a right to treatment cannot be defined or implemented; second, Donaldson refused the treatments he had been offered; and third, even if a constitutional right to treatment were now promulgated, none existed when Donaldson was hospitalized, and it would be unjust to apply it to O'Connor retroactively.

The roles are now completely reversed. Donaldson, the institutionalized psychotic, says he has a right to treatment. O'Connor, the institutional psychiatrist, counters, citing my argument, that there can be no such right:

> Dr. Szasz believes that what is termed a "right" to treatment should be labeled a "claim" for treatment and points out that a "right" to treatment for patients would seriously impair a physician's prerogatives of choosing his patients and methods of treatment. This conflict is heightened in a state mental hospital where a physician cannot choose his patients.[11]

O'Connor's claims are clearly more consistent with the facts than Donaldson's. O'Connor never wanted Donaldson as a patient. He accepted him because the courts said he must. Had the courts also ordered O'Connor to give Donaldson this or that specific treatment, no doubt O'Connor would have carried out that order too. He was evidently a loyal state hospital physician, working for those who hired him, paid him, and had the legal authority to define his rights and duties. Not so Donaldson, who claimed he did not want to be a mental hospital patient but managed to get himself hospitalized twice; and who claimed he did not want any psychiatric treatment but sued for a deprivation of his "right to treatment."

Responding to this glaring inconsistency in Donaldson's position, the brief for O'Connor argues that "even assuming the existence of a right to treatment, Donaldson could not present a valid claim. He failed to uphold his corresponding duty to be treated. His actions should have been construed as an effective waiver or repudiation of any right to treatment."[12]

O'Connor's brief tries to remind the court of the real nature and function of state mental hospitals. Here again one faces the boundless irony of this case—Donaldson pleading, implicitly, that we reaffirm and strengthen all that is coercive and corrupt in institutional psychiatry; and O'Connor pleading, explicitly, that we face the facts about it and confront their moral and practical implications. "State mental hospitals," observes the O'Connor brief, "are a creature and occasional victim of legislative fiat. . . . The administrator and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order."[13]

The inexorable consequences of a collectivized, state-operated psychiatry are here, at least, frankly acknowledged. In such a system, both patient and psychiatrist are constrained: the former is much like a prisoner and the latter much like his jailer, the two locked into a mutual embrace by the legislatures and the courts. All this has been concealed by the rhetoric of traditional psychiatry, pontificating about diagnoses, hospitals, and doctors. It is now concealed still further by the rhetoric of the promoters of the doctrine of the right to treatment, pontificating about the Constitution, mental illness, and treatment.

5

The Brief for the American Psychiatric Association

I

After the *Donaldson* case was appealed to the Supreme Court, the American Psychiatric Association (APA) filed an *amicus curiae* brief with the consent of both parties. The brief reveals, first of all, that like virtually everything in institutional psychiatry, this document is misleadingly titled. The APA here speaks not as a friend of the court but as a friend of itself. Introducing the brief in the *American Journal of Psychiatry*, Alan A. Stone, Chairman of the APA Commission on Judicial Action, writes:

> The amicus curiae brief of the American Psychiatric Association is published here both to emphasize a momentous historical event in psychiatry and to share with the membership the substantive thinking that went into APA participation. . . . The Supreme Court has agreed to accept the case; this marks the first time in the history of the United States that its highest tribunal has considered the rights of the non-criminally mentally ill. It will also be the first instance that the court will be considering the rights and duties of the psychiatrists who attend those patients. The APA brief asks the court to do justice to both patients and physicians.[1]

This statement illustrates many of the points I have made concerning the language of institutional psychiatry and the justification of involuntary psychiatric interventions. Nowhere in this paragraph is there any reference to the fact that the *Donaldson* case concerns a man who was an involuntary patient. And the institutional psychiatrists are called simply "physicians." If they were really just physicians, like dermatologists or gynecologists, there would be no need for a special judicial determination of their rights and duties. In fact, institutional psychiatrists are, in the court's own words, "agent[s] of the State."[2] That is why their rights and duties vis-à-vis patients are so problematic.

Moreover, Stone's and the APA's claim that the "brief asks the court to do justice to both patients and physicians" is flatly contradicted by the language of the association's own biweekly newspaper. On October 16, 1974 *Psychiatric News* reported the APA's intention to file an *amicus curiae* brief in the Donaldson case. The front-page

story was headlined: "APA Enters Florida Case to Defend Psychiatrists."[3] According to this story, the APA was squarely against Donaldson and the courts that awarded him damages from O'Connor and Gumanis, mainly on the grounds that the courts had validated Donaldson's confinement fifteen separate times.[4]

Stone's introduction to the APA's *amicus curiae* brief requires one more comment. The *Donaldson* case, he writes, concerns "the rights of the noncriminally mentally ill."[5] I maintain that the very act of speaking of the rights of the non-criminally mentally ill precludes one from raising the really important questions concerning the *Donaldson* case, such as: How is a person transformed from a normal American citizen into a non-criminal mentally ill individual? How can that person object to or resist this transformation, and who has the right to initiate it and carry it through to completion? The language of the APA effectively eludes these crucial questions. Its plea for justice is nothing less than a request for permission to transform people from persons to patients unhindered by legislative or judicial restraints. American psychiatrists have, after all, always favored "simple, medical criteria for commitment."[6]

II

The APA's brief is, more than anything else, a massive linguistic concealment and justification of psychiatric wardens as doctors, psychiatric prisons as hospitals, psychiatric stigmatizations as diagnoses, and involuntary psychiatric interventions as medical treatments. To appreciate this point, the brief must be read carefully in its entirety. In its very first sentence, the brief implies that institu-

tional psychiatrists function vis-à-vis their captive clients as doctors of medicine.[7] This is an untruth, not because these psychiatrists are necessarily bad men and women, but because they function vis-à-vis their patients as agents of the state.* The hospitals they work in are called, in the main, "state hospitals." Wherever they might work, they are authorized by the state to detain and treat persons against their will. It is for the rights of these doctors, who are the executors of the will of the people through their lawmakers—as against the rights of doctors who are the executors of the will of their patients through the patients' consent to treatment—that the APA is pleading in its brief of *amicus curiae:*

> Amicus believes this case to be of historic importance to the future of mental health care in the nation's public mental institutions. . . . The opinion below decides two questions that are fundamental to the future course of mental health care in this country. First, does the involuntarily committed patient at a state mental institution have a constitutional right to a level of treatment reasonably calculated to improve his or her mental condition? . . . The court below answered the first question by holding that there *is* a constitutional right to an adequate level of treatment, and that Respondent Kenneth Donaldson did not receive this level of care. Amicus APA whole-

* The unanimous opinion of the Court in the *Donaldson* case acknowledges this.[8] This, in turn, raises the question of whether O'Connor was supposed to be an agent-doctor or agent-warden? Since he had the power to confine and to release from confinement, he was clearly an agent-warden. This makes Donaldson a prisoner, an inference the justices seemed unwilling to draw from their own premises.

heartedly supports the Court of Appeals decision on this issue.[9]

Evidently the APA likes the idea that psychiatrists should have *not only* a right to imprison innocent individuals in insane asylums *but also* a right to impose any kind of intervention on them accredited as "treatment" by themselves and the courts. Whether we think this is good or bad, let us at least be honest enough to call it by its proper name: It is not a right to treatment but a right to treat.[10] In general, involuntary mental patients do not want the treatment they get from institutional psychiatrists. If they did, they would not have to be incarcerated and coerced, legally and personally, into submitting to the interventions which the psychiatrists call treatment, but the patients consider torture.

Ironically, institutional psychiatrists already have a right to treat, especially if their patients are declared incompetent. If so, why do they clamor for some sort of legal articulation of this right? The demand for the right to treatment is actually a cover for the demand for more funds to expand psychiatric facilities, personnel, and power. The APA itself acknowledges this: "Indeed, such actions [for damages against the responsible state agency] may be the most effective method to loosen the legislature's pursestrings, so that sufficient resources do become available."[11]

III

In effect, the APA position is that psychiatrists are doctors, doctors treat patients, and hence what psychiatrists

do is a good thing. If something bad happens, it must be someone else's fault. Whose? The responsible state agency's. The culprits are those who are too niggardly with the public funds and do not provide enough psychiatrists and good hospitals to properly implement the right to treatment. The APA articulates the problem, and its proper solution, as follows:

> [The second question is], assuming there is such a right [to treatment], who should be responsible for providing the remedy when an institution has inadequate resources to provide that level of treatment? . . . Regarding [this] second major question—the proper remedy for violation of this new right—Amicus believes the court below committed a serious error.[12]

In other words, the APA maintains that the psychiatrist, as doctor, has an obligation to satisfy the patient's right to treatment. However, if the patient is denied this right, the doctor, as state official, should not be held responsible for such a denial. The Court of Appeals ruling "conflicts with numerous decisions from other courts holding that state officials are not liable personally for damages when in good faith they have been unable to comply with a newly declared constitutional right."[13] The APA's war of words against its opponents could not be clearer. When it promotes treatment for involuntary patients, it calls wardens "doctors"; when it promotes individual nonresponsibility for malpractice, it calls doctors "state officials."

It is, of course, impossible here to review and analyze sentence by sentence and word by word, the APA's brief,

although doing so would reveal that what organized psychiatry now wants is what it has always wanted: more power, more public funds, and less legal accountability. To support this contention, I shall cite a few more passages from the APA's *amicus sui brief*. Pleading with the court to "affirm the constitutional right to treatment," the association acknowledges that: "The present case starkly reveals the overwhelming shame and challenge of the nation's mental health care system. The deplorable conditions shown to exist at Florida State Hospital at Chattahoochee are all too common in many jurisdictions throughout the country."[14]

There is no mental health care system in this or any other nation. There are only psychiatric prisons. Furthermore, this case has not revealed anything that has not been perfectly obvious for the past three hundred years. The APA's seeming admission of deplorable conditions in mental hospitals is patently insincere and self-serving. "Meaningful psychiatric care was not, and cannot be, provided under such circumstances," the brief proclaims in a statement with which I wholeheartedly agree.[15] But what would follow from such a state of affairs, were it taken seriously? In a hospital without adequate facilities for open heart surgery, the doctors do not accept patients requiring such surgery. *Mutatis mutandis*, in a hospital without adequate facilities for meaningful psychiatric care, the doctors should not accept patients who require such care. Hence, the first thing the APA ought to do is to lobby for the suspension of all admissions to hospitals that lack adequate facilities. Instead, it is lobbying for the right to treat patients who do not even want treatment, while loudly bewailing that the system prevents doctors from providing it.

IV

The Donaldson affair is, from beginning to end, a morally repugnant tragi-comedy. Donaldson claims never to have been ill and yet sues for damages on the grounds that he was deprived of his constitutional right to treatment. The APA claims that no one can be treated in institutions like the Florida State Hospital but that the psychiatrists who admitted, confined, and non-treated Donaldson are nevertheless totally blameless for this "unspeakable tragedy":

> It is an unspeakable tragedy when a mentally ill person is crowded into a facility like Chattahoochee, given little or no medical treatment, and allowed to remain there for years on end. Amicus believes strongly that such conditions violate the patient's constitutional right to treatment. The responsibility for a remedy, however, must lie with those who have the power to correct these conditions.[16]

This is a pitiful argument. If a patient were to offer it, psychiatrists would call him a psychopath. If the system is as bad as it is here stated to be—and it actually is much worse—then psychiatrists could easily remedy it by concerted action. They could quit working with committed patients. If psychiatrists would simply not commit or admit patients to hospitals that, according to the APA itself, are non-therapeutic or anti-therapeutic, then these tragic conditions soon would disappear. No one is compelled to be a psychiatrist; and even if he is a psychiatrist, he need not be a psychiatric slave master.

A comparison of involuntary servitude and involuntary

psychiatry makes one realize that in at least one respect the practical situation of those who wanted to abolish chattel slavery was more favorable than is the practical situation of those who want to abolish psychiatric slavery. Slavery was recognized as a condition inflicted by one person on another. The slaveholders could therefore never evade the responsibility for having slaves and for the condition of slavery. They could not credibly claim that blackness was some sort of mysterious disease for which slavery was the cure—although Benjamin Rush insisted that Negritude was a form of congenital leprosy,[17] and Samuel Cartwright maintained that Negro slaves escaped to the free states not because they preferred liberty to servitude but because they suffered from "drapetomania," a mental illness that made them run away.[18]

Unlike the slaveholders, institutional psychiatrists can, and do, avoid responsibility for the condition of psychiatric slavery by attributing it to, and confusing it with, the condition of mental illness. According to this official psychiatric view, the mental patient is indeed a victim—but he is a victim not of institutional psychiatry but of mental illness. This evasion of moral responsibility for psychiatric slavery, which pervades the psychiatric literature on involuntary psychiatric interventions, surfaces in this typical phrase in the APA's brief: "Amicus believes that such [mental hospital] conditions violate the patient's constitutional right to treatment."[19] However, conditions, in the abstract, cannot violate anyone's rights. Only persons can—even if they do so through institutions that formally legitimize such victimizations rather than through individual initiative. Involuntary mental patients are clearly victimized. It is past time that we clearly identified their victimizers.

I submit that the plight of the so-called mental patient will not be clearly seen, and hence will not be effectively remedied, until the APA is recognized as not only an organization of doctors, but also a lobby for psychiatric slavery. Psychiatrists and jurists have created this tragedy together and, like thieves falling out among themselves, each is now trying to pin the blame for it on the other. This is a good omen in that it heralds the disintegration of psychiatric slavery.

This disintegration could perhaps be hastened if we acknowledged the full horror of psychiatric slavery and recognized it for the historical, rather than personal, wrong that it is. For historical wrongs there can be no personal reckoning, no personal punishments. What there can be—and must be, if the wrong is to be righted—is a decisive moral recognition of the wrong and an abolition of the economic, legal, and political authentications and supports for its perpetuation. In collective life, as in personal life, the best way to repent for a wrong is by not repeating it.

6

The Supreme Court's Decision in *O'Connor* v. *Donaldson*

I

When the Fifth Circuit Court of Appeals upheld the award of money damages to Donaldson, the psychiatrists appealed to the United States Supreme Court. Donaldson claimed that by confinement without treatment, O'Connor had unconstitutionally deprived him of his liberty.[1] O'Connor argued in defense that he had acted in good faith, since "state law, which he believed valid, had authorized indefinite custodial confinement of the 'sick,' even if they were not treated."[2]

How did the Supreme Court resolve this conflict? Tech-

nically, by upholding Donaldson. Actually, by upholding O'Connor. The court vacated the money damages awarded Donaldson which, after all, was the only recompense that he had received for all his troubles. The court's formally unanimous opinion thus betrays a bottomless ambivalence toward the issues this case presents, and large areas of unresolved—perhaps even unarticulated—differences among the justices. My own conjecture is that the court had agreed to hear this case believing that it offered a good platform for articulating some sort of "right to treatment" for mental patients. It discovered, perhaps too late for comfort, that there was more to this problem than met the eye, and then the court sidestepped the basic issues by deciding the case so narrowly that its ruling amounted essentially to no decision at all. A careful reading of the court's opinion is consistent with these interpretations. Summarizing the case, the Supreme Court noted that the Court of Appeals declared that,

> [R]egardless of the grounds for involuntary civil commitment, a person confined against his will at a state mental institution has a "constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition." Conversely, the court's opinion implied that it is constitutionally permissible for a State to confine a mentally ill person against his will in order to treat his illness, regardless of whether his illness renders him dangerous to himself or others.[3]

These are absurd contentions, for reasons I have indicated earlier and elsewhere.[4] Evidently the justices of the Supreme Court thought so also. In any case, they felt it

was better not to deal with them, and accordingly redefined the case, as follows:

> We have concluded that the difficult issues of constitutional law dealt with by the Court of Appeals are not presented by this case in its present posture. Specifically, there is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment. As we view it, this case raises a single, relatively simple, but nonetheless important question concerning every man's constitutional right to liberty.[5]

If one stopped right here, one might think the court was about to address itself to the issue of civil commitment. But that, too, was deemed irrelevant to the case:

> We need not decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which, under contemporary statutes, are generally advanced to justify involuntary confinement of such a person—to prevent injury to the public, to ensure his own survival or safety, or to alleviate or cure his illness.[6]

II

What was there left to consider? What have become known in legal-psychiatric jargon as the mental patient's "post-confinement rights." The contention that the Su-

preme Court fastened on was that O'Connor did not release Donaldson sooner than he did. This was Donaldson's post-confinement right that O'Connor had violated:

> In short, a State cannot constitutionally confine without more [*sic*] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. Since the jury found, upon ample evidence, that O'Connor, as an agent of the State, knowingly did so confine Donaldson, it properly concluded that O'Connor violated Donaldson's constitutional right to freedom.[7]

Actually, O'Connor did not violate Donaldson's constitutional right to freedom: He took Donaldson in custody in conformity with the regulations of the Florida commitment laws; he held him in custody in conformity with those laws; and he allowed him to file periodic appeals with the courts for release, all of which upheld the legality of his confinement. I would hazard the guess that, on remand, the judgment against O'Connor will be reversed.

There is indeed evidence that the justices were leaning toward the view that O'Connor should not be held liable. They sent the case back to the district court for redetermination of O'Connor's liability, in the light of a standard of immunity specifying that "an official has, of course, no duty to anticipate unforeseeable constitutional developments."[8] It seems to me that the court is here saying two things: First, that O'Connor is legally innocent of any wrongdoing and the judgment against him should be reversed; and second, that in the future institutional psychiatrists ought to be nicer to their institutionalized in-

mates. As with slavery before, the justices' hearts went out to the victim, but their minds supported the victimizer.[9] It is difficult to see, given the strictures of the Donaldson case, what else they could have done that would have been much better.

In vacating the judgment of the Court of Appeals and remanding the case, the justices instructed the lower court to consider "whether the District Judge's failure to instruct with regard to the effect of O'Connor's claimed reliance on state law rendered inadequate the instructions as to O'Connor's liability for compensatory and punitive damages."[10] And, in a significant footnote to this statement, they added:

> Upon remand, the Court of Appeals is to consider only the question whether O'Connor is to be held liable for monetary damages for violating Donaldson's constitutional right to liberty. . . . Of necessity our decision vacating the judgment of the Court of Appeals deprives that court's opinion of precedential effect, leaving this Court's opinion and judgment as the sole law of the case.[11]

III

One of the most important aspects of this case is the issue of Donaldson's alleged dangerousness. The lower courts ruled that Donaldson was not dangerous, and the Supreme Court based its own decision on an uncritical acceptance of this ruling. But these judicial pronouncements about the psychiatrists' duties toward non-dangerous mental patients "capable of surviving safely in free-

dom" are utterly meaningless; and the decisions based on them are necessarily toothless.

Indeed, by using the term "dangerousness" casually and uncritically, all the courts ruling on the *Donaldson* case are guilty of authenticating a term crucial in the debate about forensic psychiatry that may be even more misleading than "mental illness" or "treatment." I say this partly because psychiatric dangerousness is undefined and undefinable, and partly because it is premised on a judgment rendered in retrospect. Mental patients released from hospitals as non-dangerous sometimes proceed to injure or kill themselves or others. It is then concluded that they were dangerous all along, and the hospital authorities may be held liable for their release. To the extent that the Donaldson judgment rests on his non-dangerousness, it could be, or could have been, vitiated at any time by Donaldson's committing suicide or engaging in some criminal act—possibilities open to any human being by virtue of his very freedom.

Moreover, by couching their judgments in terms of an unspecified non-dangerousness, the justices of the Supreme Court have effectively bypassed the crucial question that underlies all the controversies of institutional psychiatry, namely: Whose definition of dangerousness will the courts support? A longstanding tacit agreement exists between law and psychiatry which permits the institutional psychiatrist to call people "mentally ill" and "dangerous," and the courts to support or reject these diagnoses. Actually, such psychiatric judgments are usually rubber-stamped by the courts. In any case, it is clear that for judicial purposes the patient's judgment of his own dangerousness is utterly irrelevant. "This ruling," comments Louis Kopolow, Staff Psychiatrist for the Pa-

tients' Rights and Advocacy Programs of the National Institute of Mental Health, "does not directly apply to those who *might be* considered dangerous by *a* psychiatrist [or] to those who *might be* dangerous to themselves . . ." (emphasis added).[12] Unfortunately and perhaps unwittingly the justices of the Supreme Court are thus perpetuating the worst intellectual and moral abuses of institutional psychiatry. Where is the institutional psychiatrist who would agree that he is confining non-dangerous persons who could survive safely in freedom? O'Connor never agreed that Donaldson fell into that class; nor could any self-respecting institutional psychiatrist admit that any of his commited patients fall into it. In effect the Supreme Court identified a class of mental patients without any members.

Worse still, the problem of Donaldson's dangerousness is treated as if it were a question of fact rather than a judgment rendered by fallible and corruptible human beings and social institutions—in particular, by psychiatrists, judges, and courts. For fifteen years, courts ruled that Donaldson was dangerous. After he was released, several courts ruled that he is not, and never was, dangerous. This can mean only that the courts imprisoned a "psychiatrically innocent"—that is, non-dangerous—person. It defies all logic to claim that because Donaldson was so imprisoned, he was entitled to treatment while in "prison," or to damages from the "warden" in charge of his prison.

IV

Several aspects of *O'Connor* v. *Donaldson* make it exceptionally troublesome from a legal point of view.

Donaldson was a Christian Scientist. He requested that he be given no shock treatment or drugs, a request his psychiatrists respected. Yet his suit was for money damages from his psychiatrists for confining him without treatment. By refusing to hear the case, the court could have withheld its imprimatur from the lower courts' decision without giving any reasons. To be sure, it would have then, by default, given the Fifth Circuit's right-to-treatment ruling precedential effect which, by hearing the case, the court denied. However, the court would have been more evenhanded if it had refused to grant *certiorari* to both *Donaldson* v. *O'Connor* and *O'Connor* v. *Donaldson.*

Judicially, the abolitionist cause would be best served if the Supreme Court heard the case of a committed mental patient and ruled that his incarceration was unconstitutional, a decision that may well constitute an encroachment on the prerogatives of the legislature. In *Donaldson*, however, the court heard a case premised on the legitimacy of psychiatric slavery. It was thus compelled to reach a decision that was, more or less, pro-slavery. The point is that while the court could have reached a decision that was even more pro-slavery than the one it reached, it could not, given the context of *O'Connor* v. *Donaldson*, reach a decision that was decisively anti-slavery. As one legal commentator has put it: "*Donaldson* is but a first step in the Supreme Court's recognition of the post-commitment constitutional rights of institutionalized persons who have been involuntarily incarcerated *after a constitutionally sound civil commitment proceeding* (emphasis added).[13]

Ironically, many commentators on the *Donaldson* case never tire of emphasizing, with evident satisfaction, that

it marks the first time in the history of the United States that the Supreme Court has considered the rights of the noncriminally mentally ill. They fail to see this as dramatic proof of how stubbornly the Supreme Court has refused to face the brutal facts of psychiatric slavery. In its 199-year history, the court has tacitly approved of psychiatric imprisonment as medical hospitalization and of psychiatric torture as medical treatment. The complexities and confusions of the *Donaldson* case are the consequences of this, perhaps the most massive, denial of the very spirit of our national identity since the issue of slavery itself.[14]

V

Let us now consider Chief Justice Burger's separate opinion which, although it received scanty mention in the popular press, seems more important than the unanimous opinion with which it formally concurs but from which it philosophically dissents. Justice Burger emphasizes that Donaldson consistently refused treatment, and that this has greater bearing on O'Connor's alleged liability for nontreatment than it has been given:

> The Court appropriately takes notice of the uncertainties of psychiatric diagnosis and therapy, and the reported cases are replete with evidence of the divergence of medical opinion in this vexing area. . . . Nonetheless, one of the few areas of agreement among behavioral specialists is that an uncooperative patient cannot benefit from therapy and that the first step in effective treatment is acknowledgement by the patient that he is suffering from an abnormal condition. . . . Donaldson's adamant refusal to do so

> should be taken into account in considering petitioner's good-faith defense.[15]

Burger also notes that O'Connor's decision to detain Donaldson could not be considered arbitrary or unreasonable, as it was repeatedly authorized by the courts. One of his writs of habeas corpus had been appealed to the Supreme Court, which denied hearing it only one year before Donaldson was released:

> Whatever the reasons for the state courts' repeated denials of relief, and regardless of whether they correctly resolved the issue tendered to them, petitioner and the other members of the medical staff at Florida State Hospital would surely have been justified in considering each such judicial decision as an approval of continued confinement and an independent intervening reason for continuing Donaldson's custody.[16]

Burger then lectures the Court of Appeals, and perhaps his own brethren, on the true history of psychiatry:

> In short, the idea that States may not confine the mentally ill except for the purpose of providing them with treatment is of very recent origin, and there is no historical basis for imposing such a limitation on state power. . . . There can be little doubt that in the exercise of its police power a State may confine individuals solely to protect society from the dangers of significant antisocial acts or communicable disease. . . . Additionally, the states are vested with the historic *parens patriae* power. . . . The classic exam-

ple of this role is when a State undertakes to act as "the general guardian of all infants, idiots, and lunatics."[17]

Given the thus unchallenged constitutional legitimacy of applying traditional principles of *parens patriae* to the mentally ill, it does not follow, asserts Burger, that there need be any limitations on its requiring treatment:

> [T]he existence of some due process limitations on the *parens patriae* power does not justify the further conclusion that it may be exercised to confine a mentally ill person only if the purpose of the confinement is treatment. Despite many recent advances in medical knowledge, it remains a stubborn fact that there are many forms of mental illness which are not understood, some which are untreatable in the sense that no effective therapy has yet been discovered for them, and that rates of "cure" are generally low. . . . Similarly, as previously observed, it is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment; yet the failure of a large proportion of mentally ill persons to do so is a common phenomenon.[18]

In the course of his "concurring dissent," Burger remarks on the inadequacy of O'Connor's legal defense, especially in not pressing the point that only a year before his release the Supreme Court itself refused to hear one of Donaldson's appeals.[19] It is important to note that in the *Donaldson* case the arguments for the psychiatrist-defendants were every bit as inept as the arguments for

the patient were crafty. It is as if, while in the hospital, O'Connor had all the power and Donaldson all the true words about what was happening, whereas once out of the hospital Donaldson had all the power and O'Connor all the true words.*

Justice Burger, it would seem, is the only one among all of the participants in this tragi-comedy who is willing to address himself to psychiatric facts rather than to psychiatric fictions. His analysis of the case is cogent, and his conclusion is compelling:

> In sum, I cannot accept the reasoning of the Court of Appeals and can discern no other basis for equating an involuntarily committed mental patient's unquestioned constitutional right not to be confined without due process of law with a constitutional right to *treatment*. Given the present state of medical knowledge regarding abnormal human behavior and its treatment, few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of "such treatment as will give [them] a realistic opportunity to be cured." Nor can I accept the theory that a State may lawfully confine an individual thought to need treatment and justify that deprivation of liberty

* In 1971, Dr. J. B. O'Connor retired as Superintendent of the Florida State Hospital. On November 21, 1975, at the age of sixty-seven, he died. Attorneys for the MHLP thereupon filed a motion to substitute the executor of O'Connor's estate as defendant in Donaldson's action against O'Connor and petitioned the court for summary judgment for their client. Attorneys for O'Connor's estate filed a brief opposing summary judgment. This is how the matter of *O'Connor* v. *Donaldson* stood in June, 1976, when this manuscript went into production.

> solely by providing some treatment. Our concepts of due process would not tolerate such a "trade-off." Because the Court of Appeals' analysis could be read as authorizing those results, it should not be followed.[20]

According to the entire court, then, involuntarily hospitalized mental patients do *not* have a constitutional right to treatment.

7 Interpretations of the Supreme Court's *Donaldson* Decision

I

Judging by the interpretations of the *Donaldson* decision in both the popular and professional press, the justices could scarcely have been more successful in being misunderstood. They declared that they need not decide whether a committed mental patient has a right to treatment, nor on what grounds a person may be committed to a mental hospital. Nevertheless, the press uniformly reported that the Supreme Court had ruled that involuntary mental patients have a constitutional right to treatment and that such patients must be either treated or re-

leased. A brief review of the extensive press coverage of the *Donaldson* decision will illustrate this astonishing misreading and misreporting of the case.

In a long news story entitled "Historic Mental Health Ruling," the *Washington Post* gave a reasonably accurate account of the issues in the case and the court's resolution of them.[1] But it then interpreted the ruling as a victory for mental patients. One part of the report was subtitled "After nearly 20 years, an ex-mental patient is vindicated."[2] This ignored the facts that Donaldson had been released before he filed his suit against his psychiatrists; that the award itself was contingent on further proceedings; and that the Supreme Court had paid no attention to Donaldson's claim that he had never been ill.

As for the experts canvassed, the *Post* found them all very happy with the decision. Bertram Brown, director of the National Institute of Mental Health, acclaimed the *Donaldson* decision as giving "strong impetus to the movement away from treatment in large institutions which too often become custodial confinement."[3] If so, this would merely transfer involuntary mental patients from psychiatric imprisonment in hospitals to psychiatric parole in clinics. The players and the game remain the same: Psychiatrists retain the power to control people by means of involuntary treatment, and the patients retain the stigma and role of madmen who must submit to their medical masters. Only the location of the compulsory association between institutional psychiatrist and involuntary mental patient changes.

The report of the case in *The New York Times* was inaccurate and misleading. The headline of the story, "High Court Curbs Power to Confine the Mentally Ill," suggested that the court had ruled on commitment, which it

had not.[4] For the *Times*, Bruce Ennis had this to say about the meaning of the court's decision "[M]ental hospitals as we have known them can no longer exist in this country as dumping grounds for the old, the poor, and the friendless. [Such institutions] will have to re-evaluate the status of each patient."[5]

Claiming to have triumphed over the evils of institutional psychiatry, the victor here speaks, apparently unaware of what he is saying, in the language of the vanquished. Ennis does not say, as it seems to me he ought to, that being old, poor, or friendless are not diseases, and that such persons are not patients unless they choose to be. Instead, he says that institutional psychiatrists "will have to re-evaluate the status of each patient." But such re-evaluation will only mean that, should institutional psychiatrists choose to retain their victims, they will define them as mentally ill, dangerous, and receiving treatment. And should they choose to reject them and decide to throw them out of the hospital, even if they, the chronic mental patients, want to stay, then they will define them as no longer ill, not dangerous, and fit to be discharged.

Among the authorities interviewed, the *Times* quotes an unnamed spokesman for the New York Civil Liberties Union who called the ruling "a landmark legal victory in the effort to oppose involuntary commitment of mental patients."[6] It is no such thing. The Supreme Court's decision relates only to the "post-commitment rights" of already committed patients. To misunderstand this is to fail to see that what is here being claimed as a victory for mental patients is, instead, another victory for institutional psychiatrists.*

* This view is supported by a "Memo from the Director" of the National Institute of Mental Health distributed to psychiatric ad-

II

The reports on the *Donaldson* case in *Time* and *Newsweek* were no better. *Time* headlined its account "Opening the Asylums,"[8] which is not exactly what the court had done. The sensational headline was contradicted in the body of the story, where the reader could learn that, "For all the importance of the *Donaldson* decision, the court conceded that it was merely starting its work on the rigths of mental patients."[9] Although the court conceded no such thing, it is interesting to note that *Time* interprets the court's decision as a reaffirmation of the constitutionality of civil commitment, requiring, perhaps, only more precise criteria for it: "Left to future cases were such matters as . . . what are fair standards for commitment."[10]

The headline in *Newsweek*, "Freeing Mental Patients," was equally inaccurate.[11] The *Newsweek* story also implied that the monetary damage awarded to Donaldson by the lower courts was upheld by the Supreme Court. In addition to these mistakes of fact, *Newsweek* quoted Bruce Ennis, who told the *Washington Post* that "thousands, perhaps even hundreds of thousands of harmless mental patients will eventually be released from confinement because of the [Donaldson] decision,"[12] as stating

ministrators throughout the country in December 1975. Concluding his introduction to this memo—consisting of a reprinting of the Supreme Court's *Donaldson* decision and an analysis of its implications—Bertram S. Brown, the Director of NIMH, writes: "Finally, I would like to express my personal conviction that the *Donaldson* decision is an important victory for everyone who believes that the mentally ill should receive treatment and not merely custodial confinement."[7] In short, Brown clearly believes that the ruling strengthens rather than weakens psychiatric slavery.

to its own reporter that "No one is talking about the precipitous, wholesale release of thousands of mental patients tomorrow. There must be adequate planning for such discharges."[13] This statement betrays the official civil libertarian's deeply ingrained ambivalence toward so-called mental patients. For if Donaldson was falsely imprisoned in a mental hospital, as Ennis claimed, then he and others in his position deserve that they be restored to liberty immediately—not after adequate planning for it by those who are illegally imprisoning them.

One of the more interesting reactions to the Donaldson decision is a front-page report in the September 1975 issue of *Civil Liberties*, the official organ of the American Civil Liberties Union. Its interpretation of this ruling is remarkable, to say the least. First, the report was entitled "High Court Upholds Donaldson," a headline from which the unwary reader would infer that the Supreme Court upheld the money damages awarded to Donaldson by the lower courts.[14] Second, the ACLU claimed sole proprietary rights in the case, identifying it as "brought by the American Civil Liberties Union," thus slighting both Donaldson's and Birnbaum's efforts.[15] Third, the ACLU laid claims also to the concept of the right to treatment, calling the *Donaldson* ruling, supposedly prohibiting confinement without treatment, "the Union's most important victory since 1973."[16]*

* These claims are an outrageous attempt to falsify the historical record and make the ACLU appear as a long-time champion of the rights of the mentally ill. As I have noted earlier,[17] the ACLU has, in fact, been one of the "public-spirited" organizations responsible for the deprivations of the rights of the mentally ill. Moreover, the ACLU's self-aggrandizing claims about the *Donaldson* case are flatly contradicted by Donaldson in his autobiographical account of his hospitalization.[18] Even Birnbaum, a loyal mem-

This brazen attempt to redefine and recast the ultimate outcome of the *Donaldson* case, from ambiguous victory for O'Connor to absolute victory for Donaldson, is carried through systematically by various spokesmen for the MHLP. In an article arrogantly mistitled "The Supreme Court Unlocks Doors," Paul Friedman, the managing attorney for the MHLP, hails the decision as one whose "significance is great indeed and [whose] ramifications are only beginning to be felt."[20] According to Friedman, "At its most basic level, the opinion says that the members of our highest court care about the plight of the mentally handicapped and recognize that the United States Constitution protects this under-represented minority just as it protects other citizens."[21]

This simply is not true. If the Supreme Court had really cared about Donaldson's plight, it would have heard his appeal for freedom rather than O'Connor's appeal for reversal of the money damages against him. Moreover, Friedman's phrase reveals his profoundly condescending attitude toward so-called mental patients and his tacit assumption that the Supreme Court's attitude toward them is similar. "Caring" is not a part of the court's business. The court need not care about Blacks, Jews, women, or mental patients. Instead, what the Supreme Court must do is to ensure that the lower courts,

ber of the ACLU and co-counsel with Ennis in the *Donaldson* case, cannot refrain from pointing out that "the American Civil Liberties Union, while handling numerous cases to improve conditions in prisons for common convicted criminals who have murdered, raped, and plundered, had never handled any aspect of even one case involving a civilly committed patient who had committed no crime, until 1970 when it filed an *amicus curiae* brief in the *Donaldson case*."[19]

the police, the professions, and American society as a whole accord these individuals the same rights as are accorded anyone else under the equal protections clause of the Fourteenth Amendment. This the Supreme Court has never done for mental patients and has failed to do for Donaldson.

Having lost the case in the courts, the MHLP has tried to re-win it in the press. For instance, Friedman inaccurately proclaimed that state mental hospitals will now have to "re-evaluate all of their involuntarily hospitalized patients to identify non-dangerous individuals who are being held against their will in custodial confinement."[22]

In a later interview with *American Medical News*, Friedman went even further and claimed that the Supreme Court decision in the *Donaldson* case should not be interpreted as a rejection of the concept of the right to treatment:

> [S]ome reports intimate that the decision is a signal to lower courts not to enforce the right to treatment. . . . While it did not specifically endorse the right to treatment, the unanimous opinion did not express any disapproval of the right to treatment.[23]

This attempt to redefine defeat as victory—premised on completely ignoring Chief Justice Burger's separate opinion—seems to me preposterous.

III

A similar misreading and misreporting characterized the handling of the *Donaldson* case in the medical and psychiatric press. For example, on October 1, 1975, *Fron-*

tiers of Psychiatry printed a beaming photograph of Donaldson on its front page, with the caption: "Hailing it as 'a victory for common sense,' former mental patient Kenneth Donaldson holds up a copy of the Supreme Court opinion upholding lower court award to him of damages totaling $38,500."[24]

This is a remarkable piece of reporting, as it states exactly the opposite of what in fact happened. Had the Supreme Court denied O'Connor's petition protesting the damages he was ordered to pay, as it had previously denied Donaldson's repeated petitions protesting the hospitalization he was ordered to undergo, then Donaldson would have received $38,500 and the opinion of the Court of Appeals about the constitutionality of a right to treatment for involuntary mental patients would have stood as judicial precedent. The Supreme Court took all this away from Donaldson and his legal champions, and gave them instead a few high-sounding but empty phrases about the post-commitment rights of hypothetical patients.

The story in the July 1975 issue of *Clinical Psychiatry News* was more accurate. After summarizing the facts and the Supreme Court's decision, the anonymous writer went on to note that, "the right to treatment issue was avoided so zealously by the Court that the opinion by Justice Potter Stewart even contained a paragraph saying it was not deciding that issue. There were reports that this was partially to obtain the votes for a unanimous ruling."[25]

Among the experts quoted in this article was Alan Stone, chairman of the American Psychiatric Association's Judiciary Commission. who was said to be "delighted at the portion of the decision that vacated damages against

Dr. O'Connor. This is a real victory for us. The Commission is thrilled."[26]

Judd Marmor, the 1975 president of the APA, acclaimed the ruling as a measure that would put "greater pressure on legislatures to provide more funds that will be necessary to improve the situation," and hence put more of the taxpayers' money into the psychiatrists' pockets.[27]

Bertram Brown, director of the National Institute of Mental Health, took a psycho-political tack of a different sort. Instead of demanding more money for coercive psychiatry, he denied that it constituted a significant problem because, "The number of patients confined involuntarily to whom the decision applies is becoming smaller and smaller in response to the continuing trend toward voluntary admission."[28]

However, in the context of contemporary commitment policies, the actual situation of a so-called voluntary mental hospital patient is more like than unlike that of an involuntary mental hospital patient. In the words of the Utah Supreme Court, "a voluntary patient at the [mental] hospital is as much 'confined' and has as little freedom as a mentally alert trustee in a jail or prison."[29] In short, there really is no such thing as voluntary mental hospitalization, nor can there be so long as there is involuntary mental hospitalization.[30] Brown conveniently ignores this.

Clinical Psychiatry News also contacted O'Connor, who "called the decision 'nothing new' and said that the care offered to Mr. Donaldson was 'so far as we knew adequate at the time.' "[31]

O'Connor was right. The *Donaldson* decision is nothing new and neither are the reactions of psychiatrists to it

who have always maintained that they never committed anyone who did not need it.*

In August 1975 *Clinical Psychiatry News* published a follow-up on the *Donaldson* case, which revealed that in the opinion of most hospital psychiatrists, the Supreme Court rendered no decision at all: "Most medical directors and superintendents of mental hospitals in various states of the nation are convinced that the recent decision of the Supreme Court in the Donaldson case will have no effect or only a very slight effect on the operations of their institutions in the future."[33] Typical assessments of the case's impact ranged from "minimal" to "none whatsoever."[34]

One of the better reports on the Donaldson case appeared in *Medical Tribune.* It began by noting that "there were almost as many different opinions expressed on what the high court said and what the consequences will be, as there were experts interviewed."[35]

The report included an interview with Morton Birnbaum, who expressed disappointment at the court's sidestepping of the right to treatment issue, but was pleased over the court's recognition "for the first time [of] mental patients'

* In 1961, at a hearing before the Senate Subcommittee on the Constitutional Rights of the Mentally Ill, Winfred Overholser, the then superintendent of St. Elizabeth's Hospital, declared:

> In a discussion of the rights of the mentally ill, unfounded fears have been created regarding possible unlawful deprivation of liberty of the patient. Actually, the public mental hospitals, as instrumentalities of the State, may reasonably be expected to send patients back to the community as soon as their condition warrants, and always *habeas corpus* is available. After 45 years in mental hospitals and their administration, I am convinced that the basis for the belief that persons are improperly sent to mental hospitals is, for pracical purposes, entirely without foundation.[32]

rights to *habeas corpus.*"[36] However, the rights of mental patients to habeas corpus was not even an issue in the case. The fact that one of Donaldson's supposed defenders and one of the chief architects of the right-to-treatment doctrine draws this conclusion from the decision tells us something about the mentality of these false friends of the victims of psychiatric slavery: Namely, that instead of trying to abolish slavery, they want to "improve" it. This is borne out by Birnbaum's comment on the *Donaldson* case in *Psychiatric News:*

> Morton Birnbaum, M.D., the father of the right-to-treatment concept, said he is disappointed in the Supreme Court's decision. He anticipated that the Court would attack the right-to-treatment issue; instead it attacked hospitalization, an issue he feels is "relatively unimportant at this time."[37]

Birnbaum is not only consistently wrong-headed but also consistently wrong. The court did not attack hospitalization, and the issue of involuntary mental hospitalization is not unimportant at this time. Birnbaum cuts the pitiful figure of a person pretending to protect the human rights of a victimized group, and yet his every word and deed belie that claim.

IV

As time passed and as journalists studied the *Donaldson* decision more closely, their reports on its implications became more discerning and critical. For example, on August 17, 1975 in a front-page article in *The New York Times,* Boyce Rensberger offered a thoughtful analysis

of the practical consequences of the *Donaldson* decision, concluding that the ruling "produced little more than controversies about its narrow and sometimes vague language. . . ."[38] He summarized the decision as mandating that, "a mentally ill person could not be held against his will if the following criteria were met: The hospital was not offering treatment. The person was not dangerous to himself or others. The person was capable of living in the community with the help of friends or relatives."[39]

This summary highlights the hollowness of the opinion. The justices of the Supreme Court devised a ruling that presents as facts or phenomena what, in the real world, are invariably the claims or counterclaims of psychiatrists and patients. There are countless patients who contend that these criteria apply to them and to many other committed patients. But I dare say that there is not a single institutional psychiatrist who would ever admit that any of his patients meet these criteria. In short, the Supreme Court has devised a category of patients who ought to be released from mental hospitals, but the only persons who clearly meet the criteria they have specified are invisible men and women.

After reviewing and remarking on the ambiguities of the key words and concepts identifying each of the three categories listed above—such as therapy, dangerousness, and the capacity to live outside the mental hospital—Rensberger reported the actual, predictable responses of mental health administrators to the ruling: "At present many states have, at least as an initial reaction, said that the decision does not apply to them for one reason or another. One of the more common reasons is that all of their involuntary mental patients are considered dangerous."[40] Rensberger quotes one anonymous psychiatrist observing,

cynically but realistically: "You know what that means. . . . You're dangerous if they say you are, and if they want to put you away they say you're dangerous."[41]

There is, certainly, nothing new about this. All this makes it all the more dismaying that the supposed advocates of the rights of mental patients still are so eager to fight their psychiatrist-adversaries on the latter's grounds and by their rules. It seems that once again the friends of the mental patient have dug an even deeper hole for him.

V

One of the most immediate and interesting legal responses to the *Donaldson* decision was an article by Reginald Stanton in the *New Jersey Law Journal.* Stanton, a judge of the Morris County (N.J.) Court, evidently has had much experience with commitments and has studied the Donaldson decision closely. It is significant, therefore, that he interprets this decision as upholding, above all else, the constitutionality of committing individuals to mental hospitals who are too inept, as judged by psychiatrists and judges, to survive on the outside. According to Judge Stanton:

> This is a very important point because I have become increasingly convinced as I deal with patients committed to our mental institutions that most of them are not dangerous in the restricted sense of being a suicide risk or a threat to others. However, they are dangerous to themselves in the broad sense that, if left to themselves, they would not be able to cope and would not survive safely in freedom.[42]

He develops his argument as follows:

> I believe that the opinion in *O'Connor* v. *Donaldson* lends some support for my view on the state's right to confine the fundamentally inept mental patient. . . . Note that the Court was not satisfied to treat the patient as being "nondangerous." It carefully spoke of him as a nondangerous person who is "capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." I think the fair implication of the language is that a patient need not be released merely because he is "nondangerous" in the sense [that] he is not a suicide risk or a threat to others.[43]

The more closely Stanton analyzes the *Donaldson* decision, and the more vigorously he pushes his justifications for commitment, the more inexorably does he arrive at the conclusion that, instead of constricting the criteria for commitment, the *Donaldson* decision actually expands them! Noting the difficulties that psychiatrists and judges often have in making accurate diagnoses of patients whose commitment is sought, or of predicting their future behavior or dangerousness, Stanton sees the *Donaldson* ruling as offering relief from these uncertainties, resolving doubts about the patient in favor of his commitment and retention. Indeed, he sees the decision as relaxing the justifications for commitment:

> I do not believe that it is necessary to settle upon a specific diagnostic label for a patient in order to be satisfied that he is mentally ill. . . . [I]f one treats the concept of dangerousness to self as being broad enough to include the fundamentally inept mental patients, then a very much larger group of persons is subject to involuntary commitment.[44]

If Stanton is right, and I think he may be, then his interpretation lends strong support to my contention that the *Donaldson* decision is hardly the victory for the rights of mental patients which Donaldson and his champions claim it is. Instead, it is still another exercise in psychiatric renaming—that is, calling things that are harmful to patients helpful to them. To the list that has so far included such things as calling prisons "hospitals," wardens "doctors," and prisoners "patients," we may now add calling judicial decisions expanding the criteria for incarcerating persons as madmen a "victory for the civil rights of mental patients." *

VI

In its ruling on the *Donaldson* case, the Supreme Court considered, as we saw, only the so-called post-commitment rights of the involuntarily hospitalized mental patient. It did not consider the rights of the individual to resist being transformed into a committed patient, a status in which he could begin to enjoy the post-commitment rights so generously granted him by the court. The irony

* Shortly after the *Donaldson* decision was handed down, another legal commentator observed that "*Donaldson* is but the first step in the Supreme Court's recognition of the post-commitment constitutional rights of institutionalized persons who have been involuntarily incarcerated after constitutionally sound civil commitment proceedings,"[45] an interpretation that confirms the impression that the court strengthened, rather than weakened, psychiatric slavery.

of this legal posture is displayed dramatically by the case of a committed patient whose plight made the pages of the daily papers only a few weeks after the *Donaldson* decision was handed down.

In April 1975 Robert Friedman, aged forty-three, was arrested in a Chicago bus station for panhandling. In a briefcase he carried with him the police found $24,087 in small bills. Instead of being charged with a crime or released, Friedman was "ordered committed to a mental institution by a judge who said he was protecting Friedman from possible harm by thugs who might be after the cash he carried."[46] On August 4, 1975 when Friedman's predicament was reported in the press, he was still confined in a psychiatric institution, his predicament unaffected—perhaps even aggravated—by the benefits supposedly bestowed on people like him by the Supreme Court.

Why was Friedman committed? In this case, we need not make conjectures about it. Explained Judge Lawrence L. Genesen at a hearing after Friedman was committed: "I wonder what my decision would have been if he wasn't carrying $24,000 around. On the evidence, I decided that the man lacked good judgment. If he only had a quarter instead of $24,000, my interpretation of his judgment might have been somewhat different."[47]

Judge Genesen was here applying the doctrine of *parens patriae*. Friedman was the helpless child, and he, the judge, the parent who was protecting him. But why by commitment? Did commitment really protect Friedman's life, liberty, and property? Actually, in seeking to protect Friedman's liberty, the judge deprived him of it. In protecting Friedman's property, he confiscated it from him. According to a newspaper report of the case, "Friedman, 43, has seen half his life savings eaten away by hospital

fees and doctor's bills for treatment ordered by the court and by an $800-a-month drain the state says it costs to keep him at the mental facility he fought to stay out of. He was even ordered to pay the fees for a lawyer who argued that he be committed."[48]

There is, again, nothing new about any of this. It is why the doctrine of *parens patriae* could never be applied properly to the psychiatric area, and why it cannot now be applied properly to it. Friedman, it should be noted, is getting just the treatment that David Bazelon, Morton Birnbaum, the ACLU, the APA, the MHLP, and all the other enlightened supporters of the right-to-treatment doctrine have demanded: He is getting treated at a cost of $800 per month, whether he likes it or not. When Friedman sues, he will not be able to say, as Donaldson did, that he got no treatment. He got the best treatment the great city of Chicago has to offer its madmen.

I warned some time ago that the only thing worse than commitment is commitment safeguarded by the right to treatment.[49] The parody of psychiatric care that has surfaced in the case of Lawrence Friedman supports this rather obvious concern and easy prediction. However, the Friedman case is important not only as heart-rending evidence contradicting the claims of the right-to-treatment advocates, but also as a mirror in which we might see, ever so clearly, the boundless hypocrisy of psychiatric paternalism and the horrible brutality of psychiatric justice. Consider the following paradoxes.

Friedman is committed on the grounds that he is a danger to himself. How is he a danger to himself? By carrying a large sum of money on his person, which is his right. But this endangers him because the "normal" people of Chicago might steal his money, and in the process

of robbing him these "normal" people might injure or kill him.

Assuming that Judge Genesen wanted to protect Friedman from these hazards, he actually had several options: First, he might have warned Friedman of the unwisdom of his conduct, and let him go; second, he might have suggested that Friedman deposit most of his money in a bank and pocket only so much of it as he needed from day to day or week to week; third, he might have ordered Friedman to bank his money or face commitment; and finally, he might have provided Friedman with police guards to protect him from the illegal acts of the "normal" citizens of Chicago. No doubt one could think of other possible responses, individual and societal, to the problem Friedman posed for Judge Genesen and the city of Chicago. None, however, would be as pleasing and profitable to the practitioners of psychiatric justice as is civil commitment—especially when the committed mental patient is guaranteed the benefits of his constitutional right to treatment.

VII

This review of popular, psychiatric, and legal reactions to the Supreme Court's ruling in the *Donaldson* case amply supports my contention that the case was widely misread and misreported. Although this phenomenon is itself a subject worth exploring further, I will limit myself here to the conjecture that it is a result of the Supreme Court's own ambivalence toward the case. The court's opinion supported neither petitioner nor respondent and was, in fact, a non-decision.

In view of the actual relations between institutional

psychiatrists and institutionalized mental patients—which resembles closely the relations between unhappily married couples—the court's hesitancy about assigning blame to either party is understandable. In the bad marriage between psychiatrist and psychotic, to which the public is inevitably witness, each party has its legitimate grievances. Psychiatrists revile psychotics, psychotics revile psychiatrists, and the public—composed partly of psychiatrists and psychotics and partly of others whose behavior is not much better—would like to rid itself of the nuisance these querulants create as easily and cheaply as possible (which usually means maintaining the status quo). It is tempting, indeed, to conclude that each party has brought its misery on itself.[50] Historically and psychologically there is much merit in that conclusion, but morally we must reject it. Why? Because that is the essence of becoming civilized: eschewing interpersonal coercion through force and fraud and replacing it with cooperation through contract and self-control.

In everyday life we do not let people use the state's police power for settling any or all disagreements. People annoy and insult each other all the time, but as a rule they must live with each other as best they can, or separate. In the last analysis, psychiatric incarceration, although it is usually in a public hospital through a publicly administered procedure, is nevertheless a sort of private imprisonment sanctioned by the state. It is a relic of confinement in the private madhouse, an arrangement at which the law had long gazed with unseeing eyes. When at last, in the nineteenth century, the law began to look, it refused to believe the evidence of its senses, proclaiming that the fault with private psychiatric confinement was not that it was confinement but that it was private.[50]

The upshot was the erection of elaborate legal safeguards against the abuse of involuntary mental hospitalization, bestowing a far-reaching legal and medical legitimization on the practice of depriving innocent people of their liberty. This explains why combating this practice without opposing the legitimizations that support it has been so fruitless, and why it is bound to remain so.

8
A Right to Treatment or a Right to Treat?

I

The subject of the mental patient's so-called right to treatment has received much attention in recent years. It is impossible to assign an exact date to the origin of this idea, as the notion is clearly coeval with the practice of mad-doctoring.[1] Ever since the seventeenth century, when psychiatry in its modern sense began, madness was conceived of as some sort of malady, and the madman was viewed as someone who does not know his own best interests. It was an integral part of this image that the madman ought to be cared for by others. Although this care con-

sisted of brutal confinement, this seemingly altruistic idea became increasingly attractive to its purveyors and to the public. From the start, then, the madman's right to care was, in fact, the mad-doctor's right to confine him; and now the plea for the mental patient's right to treatment is, in effect, a plea for the psychiatrist's right to treat him.

Although it is difficult to discuss the right to treatment without considering what constitutes treatment and what the disease is for which it is supposed to be a remedy, I shall resist the temptation to take up this subject here. Suffice it to say that a great deal of so-called psychiatric treatment has as its aim a change in the patient's beliefs and behavior. Regardless of their particular psychiatric persuasion, most psychiatrists—and most non-psychiatrists—agree with this view. If such change of belief occurs voluntarily—with the subject's consent and, indeed, with his active cooperation—then it presents no special moral, legal, or constitutional issue. This sort of personality change falls readily into the general category of learning.[2] However, what if such change in belief is imposed on a person against his will? It then presents a very obvious moral, legal, and constitutional problem.* If coerced per-

* More than a half-century ago, Karl Jaspers, the great German psychiatrist-turned-philosopher, emphasized that the concept of treatment is not applicable to so-called psychotics:

> Rational treatment is not really an attainable goal as regards the large majority of mental patients in the strict sense. . . . Admission to hospital often takes place against the will of the patient and therefore the psychiatrist finds himself in a different relation to his patient than other doctors. He tries to make this difference as negligible as possible by deliberately emphasizing his purely medical approach to the patient, but the latter in many cases is quite convinced that he is well and resists these medical efforts.[3]

Nevertheless, contemporary psychiatrists and jurists prattle not

sonality change affects religious belief or conduct, then it clearly conflicts with the First Amendment guarantee of freedom of religion. How, then, should coerced psychiatric personality change be viewed?

I do not see how it is possible to deny that coerced psychiatric personality change—even (or especially) if it entails "helping" a person to give up his "psychotic delusions"—closely resembles coerced religious conversion. If so, it is obvious not only that there can be no such thing as a "right" to involuntary psychiatric treatment, such as Bazelon, Birnbaum, Ennis, and others are advocating, but that such an involuntary intervention is itself a clear constitutional "wrong."[4] The Supreme Court actually gave a ringing affirmation of this view in a suit concerning whether the state can require Jehovah's Witnesses to salute the flag. The court reasoned that such a salute "require(s) the affirmation of a belief and an attitude of mind" which it is constitutionally impermissible to create by coercion.[5] In phrases that I submit are applicable equally to coerced psychiatric treatment, the court declared that,

> (I)f there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion, or force citizens to confess by word or action their faith therein. If there are any circumstances which permit an exception, they do not now occur to us.[6]

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merely about the treatment of just such individuals but also about their right to it.

As befits an *inimicus curiae,* I would like to remind the justices of the Supreme Court of what evidently never occurred to them: namely, that they have always made an exception to this rule in the case of psychiatry. In fact, what never even occurred to the justices is that involuntary psychiatric treatment constitutes an instance of "forcing citizens to confess by word or act their faith" in a social reality interpreted by institutional psychiatry. Therein, precisely, lies the tragedy of psychiatric slavery.

II

Although the idea of depriving persons of liberty on the grounds of insanity is not of American origin, it fell on fertile soil in the United States. We are thus confronted with an astonishing, seemingly paradoxical, spectacle: Namely, that although American political reformers have done more to enlarge and secure individual liberty than has any such group anywhere in the world, American psychiatric reformers have done more to constrict and endanger it than has any such group anywhere in the world. From Benjamin Rush and Isaac Ray, through Dorothea Dix and the crooks of the "cult of curability," to Alexander, Menninger, Bazelon, and the other terrorists of the Therapeutic State—American psychiatric reform has been characterized by an implacable hostility to individual dignity, liberty, and responsibility, and by a corresponding zeal to replace personal self-control with the controls of pseudo-medical despots.[7] A few citations from the writings of some psychiatric "greats" will illustrate how well they loved, not liberty, but psychiatry.

In 1783 Benjamin Rush, the undisputed father of American psychiatry, whose portrait adorns the official seal of

the American Psychiatric Association, wrote to a friend: "Mankind considered as creatures made for immortality are worthy of all our cares. Let us view them as patients in a hospital. The more they resist our efforts, the more they have need of our services."[8]

Rush's life and writings reveal him to be a zealous therapeutic inquisitor who would have made many a theological inquisitor seem tame by comparison. He declared his own son insane and locked him up in his own hospital, where the son languished, except for one brief "remission," for twenty-seven years.[9] On January 2, 1811 Rush wrote to Jefferson: "He [John] is now in a cell in the Pennsylvania Hospital, where there is too much reason to believe he will end his days."[10]

As for Rush's criteria for commitment, he articulated them in his classical *Medical Inquiries and Observations upon the Diseases of the Mind,* hailed by psychiatrists as the first American textbook of psychiatry, as follows:

> Miss H. L. . . . was confined in our hospital in the year 1800. For several weeks she [displayed] every mark of a sound mind, except one. She hated her father. On a certain day, she acknowledged, with pleasure, a return of her filial attachment and affection for him; soon after she was discharged cured.[11]

The next "giant" in American psychiatry, Isaac Ray, offered this opinion in 1838 about the constitutional limits that ought to be placed on the deprivation of personal freedom under psychiatric auspices:

> When the restoration of the patient is the object sought for, as it always is or should be, in recent

> cases, no unnecessary restrictions should be imposed on this measure. The simple fact of the recency of the case should be sufficient, when properly attested, to warrant his seclusion, if it be deemed necessary for his care.[12]

These phrases recur with remarkably little change throughout the rest of psychiatric history and are advanced today as if they constituted a novel and revolutionary scientific program. At the core of Ray's recommendation for involuntary mental hospitalization lay a clear reordering of moral and political priorities—the promise of mental restoration in the asylum displacing the problems of personal liberty in society. As classic liberals and modern libertarians want a minimum of "unnecessary restrictions" on individual freedom, so institutional psychiatrists and psychiatrically enlightened jurists want a minimum of such restrictions on therapeutic coercions.

In 1929 Franz Alexander actually committed this horror to paper:

> The neurotic criminal obviously has a limited sense of responsibility. Primarily he is a sick person. . . . If he is curable, he should be incarcerated for the duration of psychiatric treatment so long as he still represents a menace to society. If he is incurable, he belongs in a hospital for incurables for life.[3]

For three decades following the publication of the foregoing sentences, Alexander was one of the most respected and influential psychiatrists and psychoanalysts in the United States.

Karl Menninger, himself one of Alexander's students—who went on to become the acknowledged dean of American psychiatry in the 1950s and 1960s—has continued to spread the gospel of social security through institutional psychiatry. Menninger is an enthusiastic advocate of preventive psychiatric detention. He advocates replacing penal sanctions with psychiatric sanctions—claiming even that although punishment is a crime, crime is a disease:

> Eliminating one offender who happens to get caught *weakens* public scrutiny by creating a false sense of diminished danger through a definite remedial measure. Actually, it does not remedy anything, and it bypasses completely the real and unsolved problem of *how to identify, detect, and detain potentially dangerous citizens* (emphasis in the original).[14]

Karl Menninger, president of the American Psychiatric Association, uncompromising advocate of psychiatric coercion, and the proprietor-leader of a famous private insane asylum named after his family, has occupied and continues to occupy a prominent position in the American Civil Liberties Union.

III

David Bazelon is one of the most prominent advocates of psychiatric coercion concealed as care and cure. He has succeeded in deforming liberty by ostensibly reforming criminology and psychiatry—an enterprise whose worth he has gravely misjudged, partly by thinking that it is good when it is evil, and partly by believing that it rests on new discoveries when in fact it rests on old de-

ceptions.* Thus in 1960 Bazelon offered this plea for psychiatric-legal reform:

> When the sentence has been served, the warden of the penitentiary signs a certificate to that effect, and the prisoner rejoins society—even though it may be obvious that the punishment has worked no cure. . . . On the other hand, the inmate of a mental hospital is released only when certified by the staff as cured, or at least not dangerous to himself or others. . . . Is it not evident that treatment rather than punitive incarceration offers society better protection? [16]

O'Connor and Gumanis acted on just these principles in treating Donaldson, and many of Bazelon's fellow jurists reared up in righteous indignation against them.

By 1967 Judge Bazelon had managed to get rid of personal choice and will altogether. In this process he also disposed of the individual, as we know this concept and use this term when we speak of individual freedom and responsibility:

> Scientists now generally agree [and Bazelon is obviously agreeing with them] that human behavior is caused rather than willed. . . . What is usually required of the [psychiatric] expert is a statement in simple terms of why the accused acted as he did—the psychodynamics of his behavior. . . . Where it occurs, under the Durham rule [handed down by

* In *Make Mad the Guilty,* Richard Arens documented how, in his quest for psychiatric salvation, Judge David Bazelon's judicial decisions have sacrificed both common sense and civil liberties.[15]

> Bazelon], the accused may be seen as a sick person and confined to a hospital for treatment, not to prison for punishment.[17]

Here it is in its naked horror: one of the most widely known and respected American judges advocating that persons accused of offenses be deprived of their constitutional right to trial by defining them as mad and locking them up in the madhouse. Indeed, as a judge, Bazelon has not only advocated this course of action but has also practiced it. It is not surprising that he is a much-decorated hero in the struggle for psychiatric justice, having received both a Certificate of Commendation and the Isaac Ray Award from the American Psychiatric Association. In 1970 Bazelon served as the President of the American Orthopsychiatric Association, one of the constituent bodies of the Mental Health Law Project—the "psychiatric liberties" group that shepherded the *Donaldson* case through the courts. In 1967 Bazelon was a leading member of an official United States Mission on Mental Health to Russia. In the Soviet Union, Bazelon saw nothing of the much-heralded Communist abuse of psychiatry but saw much to admire and praise. The following passage from his report on that trip conveys both his judgment of Soviet psychiatry and his position on involuntary mental hospitalization:

> [I]nstitutionalization is a significant part of the Russian approach. Even if a patient opposes hospital commitment, it is deemed voluntary if it is sought by the patient's family, his trade union, business organization, or polyclinic doctor. The Russian attitude seems to be that under these circumstances the pa-

tient himself would want hospitalization if he could make rational decisions. As a result, only three or four percent of all commitments are termed involuntary. I must hasten to add that many of our own psychiatrists share the same underlying attitude. . . . They justify this on the ground that they are acting for the patient's benefit. . . . And, of course, these psychiatrists may be right. Perhaps people who need treatment should be involuntarily hospitalized for their own benefit, even if they are not dangerous. But clearly this is a decision which must be made by society as a whole—not by the psychiatric profession alone or by individual psychiatrists.[18]

Nothing could show more clearly how devout a believer Bazelon is in mental illness and the psychiatric cures for it. He accepts as a given, as something too obvious to challenge, that every civilized society must have involuntary mental hospitalization. Indeed it is so important that just as war must not be left to the generals alone, so commitment must not be left to the psychiatrist alone: The decision must be made by society as a whole.

To be sure, Bazelon's views on psychiatric incarceration are not original: They are simply the faithful reflections, undistorted by doubt, of the prevailing psychiatric imbecility in the mirror of judicial inhumanity. To illustrate the extent to which psychiatric incarceration forms the backbone of official psychiatry, I want to cite a typical passage from *Noyes' Modern Clinical Psychiatry* (Seventh Edition), whose author, Lawrence C. Kolb, was for many years professor of psychiatry at Columbia University and is now the Commissioner of Mental Hygiene in New York State. In a chapter on "Personality Disorders," under the

section "Sexual Deviation," Kolb offers these revealing remarks:

> If the offender has not been guilty of violence, it is usually desirable that he be confined in a hospital atmosphere. . . . Through therapy and subsequent parole, some such offenders, if their desire for improvement is strong, may be enabled to channel their impulses into constructive activities.[19]

Exactly what sort of non-violent sex criminals is Kolb referring to here? In the three pages immediately preceding the passage quoted, he presents the pathology and treatment of the following sexual deviations: homosexuality, pedophilia, fetishism, transvestism, and exhibitionism. It is the non-violent practitioners of any or all of these perversions, then, that Kolb believes are best treated by coerced psychiatry and parole. His opinion, as befits so sage an expert, is of course not his alone. In support of it, he cites the recommendations of the most liberal and enlightened division of all the branches of the psychiatric establishment, a clique that has aptly called itself the Group for the Advancement of Psychiatry (GAP). Here is what Kolb cites from a 1949 GAP pamphlet, *Psychiatrically Deviated Sex Offenders:* "If the offender is curable he can be eventually released to society; if not, he should never be released. . . . The Committee is unreserved in its opinion that the committed sex offender should be actively treated in a non-penal institution."[20]

If this sounds like Franz Alexander's classic totalitarian line about neurotic criminals, it is because the members of GAP who wrote it probably derived their ideas from Alexander. It is important to note that the GAP is unre-

served in its endorsement of coerced psychiatric treatment; that Kolb is unreserved in his endorsement of this position; and that Kolb's book is the most authoritative and widely used text in American medical schools and psychiatric residency programs. Such, then, is the "official" American psychiatric position on psychiatric justice and psychiatric slavery.

IV

At the present time the chief interpreter of and spokesman for the official American psychiatric position on matters concerning law and psychiatry is Alan Stone, Professor of Law and Psychiatry at Harvard University, and the chairman of the American Psychiatric Association's Commission on Judicial Action. When Christianity was an established faith in the West, leading theologians distinguished themselves by writing Christian apologetics. Today, when psychiatry is an established faith, leading psychiatrists distinguish themselves by writing psychiatric apologetics.

After the Supreme Court handed down its ruling on the *Donaldson* case, Stone wrote a review of the history and present status of the concept of the right to treatment, unequivocally supporting it.[21] Why does he like it? Because it supports the medical legitimacy of psychiatry, is a useful vehicle for seeking more public funding for psychiatry, and offers a justification for urging the liquidation of the private practice of medicine and its replacement by national health insurance.

Stone cogently observes that in the history of the early right-to-treatment cases, "not one of them arose in the

context of the more numerous and familiar cases of civil commitment of the mentally ill. All of the cases involved men who, although diverted from the prison system into hospitals, had been originally charged with crimes."[22]

From this Stone infers that because they were charged with crimes, all these men "had extensive access to legal counsel"; which, in turn, "is illustrative of the lawyer's contention that without the right to counsel all other rights are bootless."[23]

I submit a different inference, namely that these cases illustrate the propensity in forensic psychiatry to remedy one injustice by adding another one to it. The problem in these cases lay not in the lack of treatment but in the diversion from the criminal process. If lawyers, psychiatrists, and civil libertarians had insisted that persons charged with crimes ought to be tried, sentenced if guilty, and discharged by the courts if innocent, the very problem of people languishing in mental hospitals as quasi-criminals would never have arisen.

When these problems did arise, they inexorably brought with them their own solution: the newly discovered constitutional right to treatment. Thus, according to Stone, in the celebrated case of *Rouse* v. *Cameron*, "Judge Bazelon found the right to treatment in his interpretation of the statute of the District of Columbia, [and] indicated there might be a constitutional right as well; he alluded to the question of cruel and unusual punishment and of due process and equal protection of the laws."[24]

Judge Bazelon did not, however, allude to the possibility that diversion from the criminal to the psychiatric route of social control was itself unconstitutional! In other words, he preferred to fashion a *new* constitutional

right for these persons incarcerated in insane asylums rather than to find the established constitutional right to trial applicable to their cases.[25]

I want to recall at this point the Fifth Circuit's decision in *Donaldson*, as it was premised on the concept of the right to treatment; and to note some of the problems, so far not considered, which such a quasi-medical approach to involuntary mental patients raises. The central claim that *Donaldson* placed before the Court of Appeals—and which that court upheld, but the Supreme Court rejected—was that "Where nondangerous patient is involuntarily committed under civil commitment procedures to state mental hospital, only constitutionally permissible purpose of confinement is to provide treatment and patient has due process right to such treatment as will help him to be cured or to improve his mental condition."[26]

This claim is a tissue of nonsense, and a dense one at that. I say this because it seeks to justify depriving an innocent person of liberty on the grounds that he is mentally ill and will receive treatment for it, a reasoning that implies—as essentially unchallengeable—that the subject has, in fact, an illness; that it is treatable; that the treatment will be forthcoming; and that it will be effective. Actually, each of these premises may be false. The "patient" may not have an illness at all, for example, because "mental illness" is not an illness; or he may not have the illness imputed to him, although such an illness exists, because he was falsely diagnosed; or, once confined, he may not be treated; or the treatment may be ineffective or even harmful.

What procedural protection is there, in a ruling such as was advanced in behalf of Donaldson, to protect healthy persons against false diagnoses of illness? Doctors are

fallible human beings. Mistaken diagnoses are an ever-present medical possibility. Who shall bear the risk of such error in cases where the very act of making a diagnosis is imposed involuntarily on the so-called patient?

The risks of diagnosing and treating disease are generally well appreciated. They are borne by patients, or would-be patients, in the hope that future medical benefits will accrue to them. Where such hope is absent—for example, in the fatally ill person—permission for further diagnostic explorations is often withheld, and wisely so. Once the diagnostic intervention is wrenched out of its traditional voluntary context, the very word "diagnosis" loses its meaning. For if the consequence of a positive finding of mental illness is psychiatric confinement, and if such confinement is undesired, the persons subjected to diagnostic studies of mental illness would inevitably regard the intervention not as diagnosis but as self-incrimination. If a person accused of a crime for which the penalty is only a fine has, nevertheless, a right against self-incrimination, how could that right be denied a person accused of a mental illness for which the treatment is incarceration? If, however, the right against self-incrimination is extended from the penal context to the psychiatric, then in all cases of involuntary psychiatric interventions, there will be a fresh conflict between two constitutional rights—the right against self-incrimination and the right to treatment. Which of these rights ought then to prevail? The right-to-treatment advocates stubbornly evade such questions. Instead, they extoll the obvious nobility of their cause, as does Stone when he writes:

> The constitutional right to treatment has now become an accepted part of our legal order, but it lacks

the imprimatur of the Supreme Court. . . . The Supreme Court actually dealt with the [*Donaldson*] case in a manner that leaves all the important right to treatment questions unanswered.[27]

Thus, neither the fact that *Donaldson* left all the important right to treatment questions unanswered, nor Chief Justice Burger's opposition to the concept of the right to treatment dampens Stone's enthusiasm for the idea. "There is," he remarks approvingly, "already an avalanche of decisions [affirming a right to treatment] in every area of noncriminal confinement."[28] The practical implications of the doctrine, as Stone sees them, are painfully familiar —that is, a demand and a justification for more tax monies for institutional psychiatry:

> In the end the real solution to the problems addressed by the right to treatment cannot come from complicated judicial discourse about civil rights and civil liberties. It must come in the form of a system of national health insurance that includes adequate mental health coverage for inpatient as well as outpatient treatment and for chronic as well as acute mental illness. To some, this will seem unrealistic or too expensive or too much like socialized medicine. But is there a humane alternative that psychiatrists can endorse?[29]

Yes. Leaving people alone. Offering them help but eschewing coercion.

V

It seems fitting to conclude this critique of the concept of the right to treatment with a careful consideration of

the views of Morton Birnbaum, the man often said to be the proud father of this anencephalic monster.* Birnbaum began his campaign for the right to treatment in 1960, from an observation that is both valid and important—namely, that people in public mental hospitals generally do not receive what one ordinarily would regard as medical treatment. There are at least two immediate and obvious conclusions that might be drawn from this observation. One is that such hospitals are medical institutions in name only. The other is that they are *bona fide* medical institutions in which more medical treatment ought to be dispensed. I drew, and continue to draw, the first conclusion. Birnbaum drew, and continues to draw, the second.

In 1960 in an article in the *American Bar Association Journal* Birnbaum advocated "the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment of his mental illness."[31]

In 1963 in *Law, Liberty, and Psychiatry* I rejected this proposal because, "it supported the myth that mental illness is a medical problem that can be solved by medical

* In view of the historical record of psychiatry, current claims for a right to treatment for the institutionalized mentally ill, especially as advanced by Bazelon and Birnbaum and their followers, are simply absurd and obscene. These psychiatric reformers write and talk as if their proposal for a right to treatment were a new scientific and humanitarian idea. Actually, more than one hundred years ago, the national association of American madhouse keepers agitated for what were, in effect, right-to-treatment laws. In 1868, in a unanimous resolution, the members of the Association of Medical Superintendents of American Institutions for the Insane, declared that "believing that certain relations of the insane should be regulated by statutory enactments calculated to secure their rights . . . [we] recommend that the following legal provisions be adopted by every state whose existing laws do not, already, satisfactorily provide for these great ends."[30]

means."[32] Furthermore, I view the care provided by compulsory mental treatment as potentially much more harmful than the metaphorical disease it is supposed to cure.

Despite the millions of words that have since been said and written for and against the right to treatment, the argument has advanced very little. I continue to insist that, because it is an evil like slavery, involuntary psychiatry should be abolished. Birnbaum continues to insist that, because it is a good like curing the disease of an unconscious patient, the involuntary treatment of the involuntary mental patient should be a right guaranteed and enforced by the courts.

As fresh evidence that mental illness is unlike bodily illness keeps cropping up, Birnbaum and I continue to interpret it in diametrically opposite ways. Obsessed with the idea of the right to treatment, Birnbaum declares—as if saying it made it so—that "Medicaid and Medicare statutes are in reality federal right-to-treatment statutes."[33] In fact, Medicaid and Medicare are methods of third-party payment for various medical interventions many of which may not be therapeutic, such as diagnostic procedures or hospitalization of the dying patient. But never mind; to Birnbaum everything that doctors do is treatment.

Having offered his personal definition of Medicare and Medicaid, Birnbaum indignantly declares: "I was quite surprised that in 1965 the initial Medicaid legislation . . . totally excluded only one group among the nation's poor and infirm: state mental hospital patients under 65."[34] That is a fact. Again, the question is: What shall we make of it? What Birnbaum makes of it is that "This is simply another example of how a sanist Congress elected by a sanist society handles this most complex problem in planning to deliver adequate health care to our nation."[35] What I make of it is that this is another example supporting the view that the status of state mental hospital inmates is more like that of children than of adult medical patients. Since such state mental hospital patients are, ostensibly, already cared for by the state, as *parens patriae,* Congress has concluded that there is no need for additional support for them.

Birnbaum, however, is incensed at this exclusion, perhaps the more so because he keeps telling himself it is all due to what he labels "sanism": "As I believe that the decision was incorrect and was sanist, I am now [1974] considering further petitioning of Congress to end this exclusion, filing a formal complaint with the United Nations Human Rights Council concerning Congressional sanism."[36] This threat is at once ridiculous and repellent. Birnbaum actually proposes to denounce his own country, still the freest in the world, to that bastion of super-morality, the United Nations! Are the Russians and their allies, who after all are quite influential in the U.N., not also "sanist"? Are they so nice to mental patients? Birnbaum's belief that the U.N. is more compassionate or moral than the U.S. Congress is, I submit, deeply revealing of his fundamental hostility to traditional American values of individual freedom and dignity.

On September 25, 1975 *The New York Times* reported on a new case filed by Birnbaum that seems to support the worst charges of psychiatric totalitarianism that could be brought against him. According to this story, Birnbaum has filed suit against federal and New York State officials

in a case designated as *Woe* v. *Weinberger* (Woe being the pseudonym of the patient and Weinberger being Caspar Weinberger, the former Secretary of Health, Education, and Welfare), contending that the plaintiff had been committed against his will to the Brooklyn State Hospital where he is receiving care that costs $25 a day. "Dr. Birnbaum argues that the court that committed Mr. Woe could have sent him to the psychiatric ward of Downstate Medical Center across the street, where psychiatric care costs $250 a day. . . But because Downstate . . . will not accept involuntary patients, Mr. Woe went to the state hospital."[37]

Birnbaum's posture is naively self-incriminating. A self-declared champion of the rights of the mentally ill, he is here championing the rights of involuntarily hospitalized mental patients to affirm their identities through their illnesses, and by means of a kind of psychiatric affirmative action program, their right to demand the most expensive treatment available for their diseases.

VI

Urging a right to treatment for involuntarily hospitalized mental patients commits one, linguistically and logically, to accept, first, that there is such a thing as mental illness; second, that persons afflicted with such an illness may be legitimately incarcerated in mental hospitals; and third, that such involuntary patients can be effectively treated by means of psychiatric treatments. Each of these propositions is highly questionable, to say the least. I articulate them here to re-emphasize that Birnbaum embraces all of them with the greatest enthusiasm.

Significantly, Birnbaum's suit is based on the claim that his client was harmed not *by being committed* to the Brooklyn State Hospital, but *by not being committed* to the Downstate Medical Center!

The Downstate Medical Center is the name of the medical school and affiliated hospitals of the State University of New York in Brooklyn. Because of its university affiliation, this hospital is a prestigious institution. The fact that such an institution refuses to accept involuntary mental patients—a practice unheard of a few decades ago—betokens a changing view of commitment among some leading psychiatrists. If one wanted to be optimistic, one might even speculate that today's refusal by some university and private hospitals to admit involuntary mental patients may be a harbinger of tomorrow's general rejection of this practice. Whether such a change is in the air or not, Birnbaum comes down squarely for the preservation, and indeed extension, of the practice of involuntary mental hospitalization.

Birnbaum charges that his client, Mr. Woe, requires involuntary confinement in a mental hospital; and he charges, further, that he should rightly be confined at the Downstate Medical Center. The real object of Birnbaum's argument can therefore be one thing and one thing only: a demand for state intervention to correct such psychiatric discrimination by ordering the Downstate Medical Center (and similar institutions) to admit involuntary mental patients.

This proposition is exquisitely ironic. In all my years in psychiatry, I have never heard even the most ardent institutional psychiatrist complain about hospitals that refuse to admit involuntary patients. Now, Birnbaum, stal-

wart defender of the mental patient, complains about precisely this breach in the psychiatric front. His demand, in *Woe* v. *Weinberger*, is:

> That a declaratory judgment be entered that the involuntarily civilly committed must constitutionally be integrated with the voluntarily hospitalized in the separate, unequal, and superior general hospital psychiatric facilities where they can receive the adequate and active care they need, and which is constitutionally required.[38]

In short, Birnbaum now demands, first, that the courts compel mental hospitals—both public and private—to admit involuntary mental patients; second, that voluntary and involuntary mental patients be compulsorily integrated; and third, by implication, that psychiatrists practicing in mental hospitals (and perhaps even those not so practicing) be compelled to accept involuntary subjects as their patients. These fresh demands in the name of the right to treatment are, indeed, the inexorable consequences of the paternalistic-psychiatric imagery inherent in this doctrine. That they are advanced just at this moment in the history of the struggle between the psychiatric totalitarians and the psychiatric libertarians is of the greatest symbolic significance.

Like many people, Birnbaum believes that some people are so seriously mentally ill that they must be confined in mental hospitals against their will. This belief, as I suggested, is like the belief that some people are so subhuman or childlike that they must be enslaved. The ideology behind slavery requires that, ideally, all blacks be slaves and that all whites who can afford it be slave own-

ers. If some blacks are free and survive in freedom, the ideology is threatened. And if some whites reject slave holding, the ideology is threatened even more. All this was clear enough during the days of Negro slavery in America. Hence, for example, the fugitive slave laws.

To uphold the dignity of the glorious institution of psychiatric slavery, Birnbaum is now suing the United States government, claiming that his client was deprived of his constitutional rights because some psychiatrists refused to accept him as a committed patient. The logic behind this is sound: If every psychiatrist treated involuntary mental patients, whether voluntarily or under state compulsion, then the hands of all psychiatrists would be equally bloody. It would be less likely that any would then object to the practice. At present a few psychiatrists reject psychiatric slavery as immoral, refuse to participate in the psychiatric slave trade, and either try to help psychiatric slaves escape to freedom, or, if the slaves prefer a secure bondage to an uncertain liberty, leave them alone. These psychiatric abolitionists represent an intolerable threat, at once practical and symbolic, to the psychiatric slave holders. Birnbaum endeavors to rid psychiatry of this threat: His aim is not to liberate the involuntary mental patient but to enslave the voluntary psychiatric patient (by compulsorily integrating him with the involuntary mental patient) and the free-market psychiatrist as well (by compulsorily transforming him into a court-dominated slave-master of his psychiatric slave-patient).

All this is in the best tradition of paternalistic social reformers who cannot tolerate human differences, which they first call inequalities, then inequities, and finally deprivations of constitutional rights. The upshot is that if they cannot raise the black man to the level of the white,

or the poor to that of the rich, or the sick to that of the healthy, they can at least reduce the latter to where, in each case, he is indistinguishable from the former. So it is now with the differences between the sane and the insane. Mental health reformers like Birnbaum and the MHLP are not satisfied with setting the insane free by abolishing psychiatric slavery. Why not? Because it would leave many mentally ill individuals palpably still less well off than some other persons not so categorized. What these therapeutic totalitarians want is not freedom but equality. This is why what they advocate is not the abolition of psychiatric coercion but the abolition of the psychiatric inequities between the sane and the insane and between various classes of the insane. By claiming that we ought to protect involuntarily committed mental patients from "deprivations of their constitutional rights to treatment," they are leading us further down the road toward the Therapeutic State.

9
Chattel Slavery and Psychiatric Slavery

I

In its decision in *O'Connor* v. *Donaldson*, the United States Supreme Court held for the respondent on the ground that he was compulsorily confined in a mental hospital even though he was not dangerous.[1] What should we make of this decision? How should we judge the judges and their judgments?

Suppose that in 1855 there had come before the Supreme Court the case of a slave named Donaldson who, having escaped from the South to one of the free states, was suing his former master, O'Connor, for damages for

illegal imprisonment. Suppose, further, that the court had decided the case narrowly—that is, without addressing itself to the issue of slavery—saying something like this: Since Donaldson was not chattel, and since as a slave he was deprived of work and kept in idleness, there was no justification for holding him in bondage. Would this have been a good decision? The answer depends on one's point of view.

If one believed that Negroes should be enslaved only because they are chattels and only in order to make them work, then one would have wholeheartedly endorsed the decision. If one believed that Negroes should be enslaved because they are black, and because slavery is a glorious institution indispensable for the integrity of our nation, then one would have opposed the decision. Finally, if one believed that Negroes should not be enslaved at all—indeed that no one should be—because there can be no slavery in a free society, then one would have regarded the decision ambivalently: good, because it diminishes, albeit ever so slightly, the power of the institution of slavery; and bad, because it implicitly legitimizes the practices of this institution, which are incompatible with the moral principles on which our society rests.

The same reasoning and conclusions apply to the *Donaldson* case. Replace involuntary servitude with involuntary psychiatry, blackness with schizophrenia, being chattel with being dangerous, work with treatment—and you have the same situation.

By deciding the case as it did, the court simultaneously weakened psychiatric slavery and strengthened it.

It weakened it by holding, explicitly, that if the patient/slave is non-dangerous/non-chattel, and is not receiving treatment/is not working, then he may not be confined/

enslaved. It strengthened it by holding, implicitly, that if the patient/slave is dangerous/chattel, and is receiving treatment/is working, then he may be confined/enslaved.

Perhaps some will object to this analogy on the ground that being a chattel and being dangerous are not analogous. But from the point of view of whether a person should or should not be deprived of liberty, they are. Both are strategic ascriptions justifying such deprivations. People do not come into the world labeled "chattel" and "not chattel," "schizophrenic," and "not schizophrenic," "dangerous" and "not dangerous." We—slave traders and plantation owners, psychiatrists and judges—so label them.

To be sure, some people *are* dangerous. Americans need hardly be reminded of this painful fact. But in American law, dangerousness is not supposed to be an abstract psychological condition attributed to a person; it is supposed to be an inference drawn from the fact that a person has committed a violent act that is illegal, has been charged with it, tried for it, and found guilty of it. In such a case, he should be punished, not treated—in jail, not in a hospital.

II

Admittedly, chattel slavery and psychiatric slavery are not identical, and 1855 is not 1975. Nevertheless, the ideological, economic, political, linguistic, and legal similarities between involuntary servitude and involuntary psychiatry are so commanding that we ignore them at our own peril.

When involuntary servitude flourished, that institution marshaled, and was supported by, the combined forces of popular opinion, science, economic interest (for the domi-

nant classes of society), and, last but not least, legal sanction. Now that involuntary psychiatry flourishes, it commands the support of the same forces. Between the birth of this nation in 1776 and the end of the Civil War in 1865, the courts, including the Supreme Court, repeatedly upheld and strengthened slavery. Psychiatric slavery has been similarly upheld and strengthened by the courts from colonial times to today. Remarking on the legal history of slavery, Leon Higginbotham notes that "[the majority] of the justices of the U.S. Supreme Court from 1789 to 1865 . . . had been slave owners. . . . During the time of slavery, when there were options, the majority of the U.S. Supreme Court chose positions most restrictive to blacks."[2]

The fact that mental patients have fared little better supports the cynical observation that the Supreme Court follows the elections. In the long run and for the sake of the integrity and stability of our form of government, this may be a good rather than a bad thing. In any case, these historical considerations—about both involuntary servitude and involuntary psychiatry—suggest that the remedy for such evils lies not in reforms through the courts but in a change in popular passions, or in legislative leadership, or perhaps in a combination of both.

III

In the meanwhile, psychiatric slavery, although under attack, continues to flourish. In their unanimous opinion in *Donaldson*, the justices declared: "We need not decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which, under contemporary statutes, are generally ad-

vanced to justify involuntary confinement of such a person."[3]

The crucial question thus remains unanswered: On what grounds, if any, may an individual be deprived of liberty by being incarcerated in a mental hospital? To appreciate the absurdity and the enormity of the Supreme Court's determination to evade this question but nevertheless rule on the *Donaldson* case, let us pursue further our scrutiny of the parallels between involuntary servitude and involuntary psychiatry.

Suppose that, in a society that accepted and authorized slavery, an ex-slave sued his former master for mistreatment while he was enslaved. How could such a claim be litigated without coming to grips with the issue of slavery? The attempt to do so would be sophistry. Yet, if we substitute involuntary psychiatry for involuntary servitude, that is precisely what all the protagonists in the *Donaldson* case have done.

Donaldson, speaking through his champions, pleads: "Never mind about why I was committed, and by all means never mind what commitment is all about. Just say that I was entitled to a 'treatment' of which I was 'deprived,' and punish the psychiatrists who, as agents of the state, obeyed its courts and implemented its laws." Donaldson thus avoids touching on the sensitive issue of psychiatric slavery, as if he feared that doing so would turn the judges against him.

O'Connor, perhaps realizing that to put up an effective defense he would have to incriminate the whole psychiatric profession as a guild of slave-holders and plantation operators, puts up virtually no defense at all. He could have said: "Let us stop all this nonsense about hospitals and treatment. I never asked for or wanted Donaldson. He

was sent to us by his father and the courts. I gave his father and the courts every opportunity to take him back. They never did. What, then, do you want of me?" But to say that would have required that O'Connor admit that his real job was not to cure disease but to control deviance.

The courts, for their part, entered eagerly into this game of deception and self-deception by agreeing to the fundamental rule of psychiatry—namely, that one must never speak in plain English about obvious acts but must always speak in the professional jargon of mad-doctoring about pretended purposes.

Extending the parallels between involuntary servitude and involuntary psychiatry further still, let us assume that, in the hypothetical society which accepts slavery, rules exist for freeing slaves. When, in the master's professional opinion, together perhaps with the opinion of other slaveholders, the slave is idle and can live as a free man, then, under these rules, a master must manumit his slave. Let us assume, further, that a slave, freed under this rule after a bondage of fourteen years, sued his former master for postponing his release unconstitutionally. Absurd as they may seem, these were the contentions the Supreme Court was asked to hear when it was petitioned to hear the *Donaldson* case. Upon them, briefs were written, arguments were heard, and judgment was granted—although the issue of slavery was never raised!

Since the rules governing release from psychiatric slavery clearly specify that the institutional psychiatrist must free those patients who, in his own professional judgment, merit release, legislatures and courts cannot give psychiatrists discretionary powers to release or to retain mental patients, and then try to regulate what is explicitly intended to be a discretionary power. To correct the

abuses of the psychiatrist's arbitrary power to confine and release mental hospital patients, the legislatures and the courts have only two alternatives. Either they must limit the psychiatrist's powers to confine and release by assuming more of these powers themselves. This would make it more obvious that the institutional psychiatrist functions as a jailer, that the inmates of his institution are prisoners, and that their relation to each other is governed by the legislatures and the courts. Or they must abolish psychiatric imprisonment, psychiatric prisons, and the whole system of involuntary psychiatry.

This presents the *dramatis personae* of psychiatric slavery with a wonderfully ironic dilemma. At long last, the administrators of psychiatric justice are beginning to realize that they are sitting astride a furious tiger, which they are rightly afraid to dismount. They should never have tried to ride the beast in the first place.

Notes

Preface to the Original Edition (pp. xxiii–xxvi)

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3. Dumond, D. L., *Antislavery: The Crusade for Freedom* (Ann Arbor, Michigan: University of Michigan Press, 1961), p. 95.

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2. See, for example, *Durham* v. *United States,* 214 F 2d, 862 (D.C. Circ., 1954).
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13. *Ibid.*
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23. In this connection, see Szasz, T. S., *Schizophrenia: The Sacred Symbol of Psychiatry* (New York: Basic Books, 1976), especially Chapter 4.
24. Donaldson, K., *Insanity Inside Out*, *op. cit.*, p. 283.
25. *Ibid.*, p. 231.
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28. Ennis, B., *Prisoners of Psychiatry*, *op. cit.*, pp. 90–92.
29. *Ibid.*, p. 92.
30. *Donaldson* v. *O'Connor*, *op. cit.*, p. 523.
31. *Ibid.*, p. 518.
32. *Ibid.*
33. Donaldson, K., *Insanity Inside Out*, *op. cit.*, p. 318.
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37. *Rouse* v. *Cameron*, 373 F.2d, 451 (1966).
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MIND TAPPING

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Dr. Robert Morris, former chief counsel for the *Senate Internal Security Subcommittee,* and former President of the *University of Dallas,* is now President of the *Defenders of American Liberties.* This group has been organized to protect the full legal rights of patriotic Americans, in situations where there appear to be pressures or procedures designed to deny, modify, or circumvent those rights.

His present article, *Pre-trial Mental Examination: A Dread Weapon,* first appeared as a guest editorial in *The Wanderer,* a Catholic weekly which consistently maintains very high standards and a solidly Americanistic point of view in both its news columns and its editorials. (Published at 128 East Tenth Street, St. Paul 1, Minnesota. Subscription, $4.00 per year.) The article deals with the use of the "dread weapon" in the case of General Walker. Dr. Morris, acting as President of the Defenders, served as counsel for General Walker in connection with these "mental health" charges, and consequently writes from first-hand experience. His article is reprinted by permission.

Dr. Thomas S. Szasz, Professor of Psychiatry, State University of New York, is at the Upstate Medical Center, Syracuse, New York. His article, *Mind Tapping: Psychiatric Subversion of Constitutional Rights,* was written and published before the invasion of Mississippi took place. It deals entirely, therefore, and in both brilliant and scholarly fashion, with the basic legal and medical principles involved, without any specific reference to the Walker case. But the misuse of these principles, which he fears and describes, was so exact and so flagrant in the persecution of General Walker as to make both the timeliness and clairvoyance of the article amaze the reader.

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By Robert Morris

COMPULSORY pre-trial psychiatric examination is becoming more widespread every day. The current Walker case puts it into the spotlight and well that it does for it literally could involve every person in our Land.

The sequence of events in the Walker case is almost incredible. After General Walker was apprehended by U. S. marshals, he was rushed to a mental prison. He was put in solitary confinement and ordered to undergo pre-trial psychiatric examination for a ninety-day period.

The justification for this extraordinary punishment was the Federal statute that was originally intended to aid defendants who were not competent to stand trial. It was not intended as a weapon for the prosecution to avoid the embarrassment of a trial that would either fail for lack of evidence or cause political repercussions. Everyone has the unconditioned right under the Sixth Amendment to a "speedy and public trial."

General Walker, the victim of this cruel treatment, at the time of his confinement had no lawyer, no notice of what was going on and had not set foot in court. The action was triggered by a telegram from the Director of the Federal Bureau of Prisons who said he possessed a "memorandum" of Dr. Charles E. Smith, Medical Director and Chief Psychiatrist of the Federal Prison Bureau, saying that he had examined "news reports" of General Walker's behavior and on the basis of these, at least in part, concluded: "I believe his recent behavior has been out of keeping with that of a person of his station, background and training, and that as suggested it may be indicative of an underlying mental disturbance."

That did it! A Government psychiatrist, almost a thousand

miles away, who has never seen Walker or the record of the case, on the basis of news reports, issued a memorandum that would ordinarily have destroyed a man's reputation forever and caused his involuntary imprisonment for an unforeseeable time.

I have looked at the press reports. They are contradictory. One dispatch said that General Walker "begged the students to cease their violence," another dispatch said he excited the crowds. For a professional man to use these contradictory reports to destroy the reputation of a fellow man is certainly grounds for removal, at least.

The "memorandum" also suggested that "indications" in General Walker's medical history aided Dr. Smith in his conclusion. Just before General Walker resigned from service and, therefore, when his full medical report was available, he had been offered one of the Army's top commands, in charge of training all troops in the Pacific, including such trouble spots as Laos and Vietnam. For Dr. Smith to suggest that the Army medical history contained "indications" that General Walker could not even defend himself in a law suit, when this assignment was offered, is certainly to impute a serious dereliction to the Department of Defense.

This weapon of pre-trial psychiatric examination was instituted as an aid to the defendant. The Federal statute under which the Government moved is clearly narrowed only to cases where the defendant cannot comprehend the elements of a trial. If, on the other hand, he knows there is a judge, a jury, a prosecutor and their functions and has the capacity to recollect events surrounding the alleged commission of crime, he must stand trial. It is as simple as that.

Overzealous psychiatrists — not the reputable ones — use this opening to usher into our Land a practice that may be very dangerous — involuntary psychiatric diagnosis and confinement.

The reason this is dangerous is that there are no generally accepted standards of psychiatric behavior or of "mental health." The religious, political and moral views of the individual psychiatrist play a determining role in the outcome.

These psychiatrists, who commit, say they are helping the defendant. Actually they may be imposing a punishment far more serious than a prison sentence because, as Dr. Thomas Szasz, professor of psychiatry at the State University of New York in Syracuse, and the author of the well received book, *The Myth Of Mental Illness,* has pointed out, while in both instances the defendant is forcibly confined, at least his mind is his own in prison.

If the committed person is "sick," as the committing psychiatrists may conclude, why cannot he be treated by a doctor of his choice, or of his family's choice? This is the United States. Why must he be imprisoned and subject to "mind tapping" by a psychiatrist of the Government who has almost complete control over his destiny thereafter, without a trial, without due process?

What particularly makes this already dangerous practice even more serious is the fact that Communists are moving into this field to seize some of this power over human beings. One wonders how many people the late Dr. Robert Soblen, a psychiatrist, and convicted Soviet agent who jumped bail, caused to be committed and what were his norms? I have seen not only among practicing psychiatrists but, even more serious, on the councils of some psychiatric groups that are trying to set up norms of behavior, the names of psychiatrists who could not deny the evidence of their participation in the Communist conspiracy before the Senate committee I served and instead invoked the Fifth Amendment, lest they incriminate themselves.

We can recall that Alger Hiss tried to destroy Whittaker Chambers as a witness by a psychiatric diagnosis. I was counsel to Paul Bang-Jensen, the Danish International civil servant who was sought out in November, 1956, by Soviet officials who wanted to defect and who told him how the Soviets "controlled" the 38th floor of the United Nations. The UN officials undertook a massive campaign, not to honestly examine or refute the evidence, but to declare Bang-Jensen "insane." A WHO psychiatrist was even sent to his office against his will. When a group of respected Americans formed a committee

for Katanga victims and presented evidence that the UN troops under Conor Cruise O'Brien, wantonly used force on Katanga and eclipsed the civil liberties of the Katanganese, UN officials replied, in defense, that the members of the committee were mad. The easily verifiable facts were not considered.

Let us have a look at this compulsory pre-trial psychiatric examination practice before it becomes more rampant. Let us see who is establishing the standards of correct psychiatric behavior before it is too late. Let us see why due process is being denied U. S. citizens in this important area. This is of vital concern to the Defenders of American Liberties.

Mind Tapping: Psychiatric Subversion Of Constitutional Rights

By Thomas S. Szasz, M.D.[1]

The right to a public trial and to decent limits on methods permitted the prosecution for incriminating the accused are among the most important features of a free society. The more these liberties are compromised, the more tyrannical is the government's hold over the people.

The expanding use of psychiatric interventions in the enforcement of the criminal law has, in my opinion, steadily diminished our constitutional liberties. The recent practice of pre-trial psychiatric examination of defendants, on the order of the court and against the wishes of the accused, promises to effectively nullify some of our most important constitutional rights—namely, the right to a speedy trial and the right, in the words of Louis D. Brandeis, "to be let alone."

II

The Sixth Amendment to the Constitution guarantees that:

> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defence.

The Sixth Amendment does not say that this right is contingent on the ability of the accused to prove his sanity to the satisfaction of government psychiatrists.

---

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The right to be let alone (more specifically, the privilege against self-incrimination) has received extensive judicial consideration—for example, in connection with wire tapping as a method of securing evidence for use in criminal trials. The majority of the Supreme Court judges—wrote Justice Douglas —have found "that wire tapping violated the command of the Fourth Amendment against unreasonable searches and seizures, and infringed on the guaranty of the Fifth Amendment that no one person shall be compelled to be a witness against himself." Chief Justice Oliver Wendell Holmes called wire tapping a "dirty business." Associate Justice Louis D. Brandeis held that the Fourth and Fifth Amendments conferred upon the citizen, as against the government, "the right to be let alone—the most comprehensive of rights and the right most valued by civilized men. Wire tapping was the most oppressive intrusion into the right of privacy that man had yet invented." Evidently, Brandeis did not anticipate involuntary pre-trial psychiatric examination. This, I submit, is an even more insidious invasion of privacy, and an even greater violation of the privilege against self-incrimination, than wire tapping.

It may be objected that mind tapping, as against wire tapping, is intended for the defendant's benefit, and hence, in the final analysis, is not injurious to his "best interests." Let us see if this is so.

III

Mental illness or incompetency, of sufficient severity, has, for a long time, constituted an excusing condition in the Anglo-American criminal law. Since mental illness is considered to be an excusing (or sometimes a mitigating) condition, it logically falls upon the shoulders of the accused, or his counsel, to introduce this issue into the criminal proceeding. In other words, just as the defendant has the right to plead either innocent or guilty, so he has the further right to plead insanity. He also has the right to plead that, because of the state of his physical or mental health, he can not effectively assist in his own defense, and hence ought not to be tried. This plea implies that the accused will submit to treatment so that, as soon as he is restored to health, he can be tried.

Progressive psychiatrization of the American criminal law in recent decades has introduced a new wrinkle into this traditional scheme. In the first place, mental illness is no longer considered to be merely a "defense." Instead, it is considered to be a disease like any other disease—a scientific "fact" which is alleged to be "objectively verifiable" by psychiatric experts. Second, psychiatrists have shown great alacrity at meting out life sentences in psychiatric institutions to people whom they consider deserving of this fate.

These two developments have made the issue of the defendant's possible insanity of considerable interest and attractiveness not only to his defense counsel, but also to the prosecution and the judge. For the prosecution, establishing the defendant's insanity, instead of his guilt, may become an easy method of securing "conviction" and "imprisonment"; the defendant will be incarcerated in a psychiatric institution for an indefinite period—a sentence at least as severe and probably more so than would result from conviction and sentencing to a penitentiary. To the judge, too, establishing the defendant's incapacity to stand trial may be tempting; it will save him the effort of conducting a trial that may be filled with distressing emotional and moral conflicts and dilemmas. Both he and the jury will be spared a taxing existential encounter, if only the defendant could be shown to be crazy. These are only a few of the more obvious incentives and seductions that may motivate men to subvert the rights guaranteed by the Constitution and the Bill of Rights. There are others.

IV

There is an important difference, however, between wire tapping and mind tapping. Wire tapping can be carried out without the suspect's awareness, and hence also without his consent and cooperation. In contrast, mind tapping—for that is what involuntary psychiatric examination really is—requires a measure of cooperation on the part of the subject. The question arises, what happens if the defendant refuses to submit to pre-trial psychiatric examination?

As a rule, pre-trial psychiatric examination is a consequence

of a plea of insanity on the part of the defendant. In some of these cases, the defendant submits willingly to examination by his own psychiatrist, that is, by the psychiatrist retained by the defense counsel, but refuses to be examined by the psychiatrist retained by the prosecution. In the face of this dilemma, the courts and legal scholars have held, first, that a person's unwillingness to participate in a psychiatric interview is itself *prima facie* evidence of mental illness. The defendant may thus be committed to a mental hospital, where he will stay until he cooperates with the psychiatrists, and perhaps longer. Second, they have suggested that when a defendant pleads insanity, and yet refuses to submit to a pre-trial examination at the hands of psychiatrists appointed by the court or by the prosecution, his refusal ought to be interpreted to mean that he is competent to stand trial.

Suppose, however, that the issue of insanity is raised not by the defendant (or his counsel), but by the court (or the prosecution). Suppose, further, that the defendant refuses to submit to pre-trial psychiatric examination, and demands to be tried. What would happen in such an instance? How would the criminal action against the defendant proceed?

This is an exquisitely significant dilemma. If a defendant had the good sense to refuse to submit to a court-ordered psychiatric examination—for, obviously, today he has nothing to gain, and everything to lose, by submitting to it—he would force the hands of the judge and the prosecutor. Indeed, we might look on such refusal as similar to a well-designed experiment in physics. From its outcome, we could draw far-reaching inferences about the particular social processes that we are observing, just as a good experiment in physics allows us to draw inferences about the physical processes that are being investigated.

V

Like all crucial experiments, this one too seems to be carried out only very rarely. In most cases, the defendant is an indigent person, who, unassisted, is probably unable to understand the complexities of the situation; and he is usually poorly represented by court-appointed defense counsel. There may be other

reasons as well why this dilemma has thus far been not more sharply etched.

Recently, however, two clear-cut answers, each from a different source, have been supplied. The first comes from Stephen S. Chandler, Chief Judge of the United States District Court for the District of Oklahoma. Judge Chandler presented his views on law and psychiatry before the Hearing of the Senate Subcommittee on the *Constitutional Rights of the Mentally Ill*, in Washington, D. C., on March 30, 1961. In reply to a question about what he would do if he suspected that a defendant was mentally ill, Judge Chandler stated that he would send the defendant to the medical center for federal prisoners, at Springfield, Mo., for psychiatric examination. He enlarged on this:

> I have sent defendants to Mr. Bennett's [James V. Bennett, Director, U.S. Bureau of Prisons] Springfield institution, and I find that I do not know where the money comes from to pay these psychiatrists but surely it is provided in 4244, is it—I have not read it in many years—but I just appoint them. The Department of Justice pays the psychiatrist, and they have never raised any question to me and I appoint good ones, and then see to it that the psychiatrist does not get any information—*that the Government does not try to influence him.* I ask him to take the case and study it and give me a report that I can depend on.
>
> I do not appoint a psychiatrist in whom I do not have the utmost confidence as to his ability and integrity.
>
> If there are any others, I do not know. I think it is important that the judge have confidence in any doctor whom he appoints.
>
> I might say this: In this work we have lots of problems. Sometimes Government officials do not cooperate fully. But I want to say this about the witness just before me, Mr. Bennett, if a judge cares enough to go to the trouble to take matters up with Mr. Bennett, he will help you work matters out to the extent of his facilities. He does not have enough doctors, he does not have enough facilities, it is pitiful, and I would say to this committee that he is a great and good man. I have learned that in 18 years of contact with him as an official, and I would consider very seriously any of Mr. Bennett's recommendations, because I think he knows better than anyone.
>
> I think he has no ax to grind with anybody except to do a fine job and he looks at it as some Government officials do not, from the standpoint of the defendant as, of course, the judge should. [Italics added; p. 248.]

It should be noted that Judge Chandler tried to define this procedure as being for the welfare of the defendant.

Miss Elyce H. Zenoff, Counsel for the Subcommittee, then asked the question that constitutes the "crucial experiment":

Miss Zenoff: "What do you do, Judge Chandler, if the defendant himself insists that he is not mentally ill and you think he is?"

Judge Chandler: "If there is a question about it, of course, I appoint a psychiatrist, and then if the doctor says there is a question about it, I send him to Springfield to get a report from there, and the only trouble with that is it is as good an institution as Mr. Bennett can make it with the help he has, but he should have a great many more psychologists and psychiatrists there to help him, because at the present time I am informed, that *they can only consult with the man you send there about once a month;* and as to the therapy that he gets and what they know about him, they do not have the staff to make the report that they would like to make, and we would like to have.

"What they do, they do very conscientiously."

Miss Zenoff: "What I mean, Judge Chandler, is if they report back to you that the man is mentally ill, and he says, I want to be tried; in other words, I am not mentally ill, what do you do then?"

Judge Chandler: "Yes. If they find that he is not able to stand trial because of his mental illness, why, I look into it and have a hearing, and if that is right, *he is left there until such time as they report that he is able to stand trial.* But at any moment that it came to me that *someone* thought he was able to stand trial, why I would see to it that an immediate hearing was had to determine that question." [Italics added; p. 248.]

The defendant's own plea to be allowed to stand trial would thus be overruled solely on the basis of the opinion of government psychiatrists. Note, further, that Judge Chandler went so far as to add that should it come to his attention that "someone thought he [the defendant] was able to stand trial," he would hold a hearing "to determine that question." Evidently, the defendant is not included among the people grouped under the heading "someone" for his protestations of sanity have already been ruled out of court by Judge Chandler.

But it is precisely to the accused—not to his wife or father or friend or attorney—that the Sixth Amendment guarantees the right to be tried!

Recently, in the prosecution of Mr. Bernard Brous, our crucial experiment was carried out with a somewhat different result. As will be recalled, Mr. Brous is one of the men charged with blowing up two telephone microwave relay towers in the Nevada-Utah desert, in May 1961. At the time of his arrest, he was quoted as saying that he committed these acts in protest

against certain government policies. Thus, the unusual criminal acts presumably were intended to call attention to himself and his views.

According to an Associated Press news dispatch, dated August 14, 1961, printed in *The New York Times,* August 16, 1961, this is what happened to Mr. Brous:

> The Government asked Federal Judge John Ross Monday to find Bernard Brous in contempt for refusing to undergo court-ordered mental examinations . . .
>
> Judge Ross ordered psychiatric examinations Aug. 3.
>
> United States Attorney Howard Babcock presented an affidavit by a psychiatrist, Dr. Otto Gericke, Superintendent of the Patton, Calif., State Hospital, who said Brous twice had refused to submit to tests.

The cat is now out of the bag. If the pre-trial psychiatric examination is really for the defendant's benefit, why should he be punished for refusing to submit to it? If, on the other hand, it is not for his benefit, then it must be for the benefit of either the judge or the prosecution. In this case, mind tapping would be a clear violation of constitutional rights. Lastly, the prosecution's demand for finding Brous in contempt of court betrays bad faith and unfairness on the part of either the prosecutor or the judge, or both, for it shows readiness to "try" the defendant for his behavior in the court room at the very moment when the court shows itself reluctant to try him for his behavior in the Nevada desert.

Every reader, of course, is free to draw his own conclusions from Judge Chandler's views and from the action of the government in the Brous case. I should like to re-emphasize two points.

In the procedure advocated by Judge Chandler, the mere suspicion of mental illness results in the defendant's loss of the right to be tried. In the Brous case, refusal to submit to court-ordered psychiatric examination is not considered an intelligent defense of one's constitutional rights, but instead is regarded as a fresh offense. Thus, the defendant who protests against involuntary mind tapping, like the "Fifth Amendment Communist" of the McCarthy era, is not supported by the court in his efforts to avail himself of his constitutional rights. Instead, he is attacked for his very self-defense!

VI

Reflecting on this problem, we should not forget the values inherent in the right to be tried, in *public* and by one's *peers,* and also the values inherent in the right to go to jail, instead of being subjected to unwanted psychiatric "treatments." In a jail, a person is "let alone"; in a mental hospital he may not be. A prisoner will be released after he completes his sentence, and possibly before. A mental patient may be required to undergo a change in his "inner personality"—a change that may be induced by measures far more brutal and intrusive than anything permitted in a jail — before the psychiatric authorities let him go. And they may never let him go. Commitment, unlike a sentence, is for an indefinite period.

How different the world might be today if only a handful of people had been sent away for psychiatric "treatments," instead of being tried and sent to jail. Gandhi, Nehru, Sukarno, Castro, Hitler—and of course many others, for example, the "freedom riders" in the South—have been sentenced to terms in prison. Surely, the social *status quo* could have been better preserved by finding each one of these men mentally ill and by subjecting them to enough electric shock treatments to quell their aspirations.

If this it not the sort of tyranny against which the Constitution was intended to protect us, what is?

VII

My argument rests. Some may object. After all—they may reply—psychiatrists are honest men. They would not claim that a person was mentally ill if they did not believe it was true. I have no intention of impugning anyone's honesty. But honesty is not the issue. The issues are mental illness and the right to be tried.

What constitutes mental illness is conveniently undefined. Its presence is ascertained by reference to the judgment of experts, in this case, psychiatrists. In this respect, mental illness is like witchcraft, which was also never clearly defined, but which experts had little difficulty diagnosing.

Given these circumstances, I submit that government psy-

chiatrists (or so-called forensic psychiatrists, generally)—like ecclesiastic witchhunters—will easily find large numbers of mentally sick people. This will be especially true whenever the "right" sorts of persons prefer the "charge" of insanity. If this is doubted, we should only ask ourselves how long the witch-hunter who never found witches would have lasted in his job? Similarly, how long would a court retain a psychiatrist who found most defendants fit to stand trial, and who would never interfere on psychiatric grounds with the trial of a defendant who wanted to be tried. Finally, would such a psychiatrist be as popular as those of his colleagues who find the defendant incompetent to stand trial in virtually every case in which this issue is raised by an important personage, whether judge, defense counsel, or prosecutor?

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by Thomas S. Szasz, M.D.

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Preface to the Second Edition

Every book is, inevitably, part autobiography. I started to work on this book in 1954, when, having been called to active duty in the Navy, I was relieved of the burdens of a full-time psychoanalytic practice and could turn my energies to putting on paper something of what had long been on my mind. The first publisher to whom I submitted the manuscript, in 1957 or 1958 I think, deliberated about it at length and then rejected it. I next sent it to Mr. Paul Hoeber, then the director of the medical division of Harper & Brothers (now Harper & Row, Publishers), to whom I am grateful for publishing a work which, especially then, must have seemed to fly in the face of nearly everything that was known about psychiatry and psychoanalysis.

Within a year of its publication, the Commissioner of the New York State Department of Mental Hygiene demanded, in a letter citing specifically *The Myth of Mental Illness,* that I be dismissed from my university position because I did not "believe" in mental illness. Neither the details of that affair nor the other consequences of my publishing this book belong in this Preface. Suffice it to say that much has happened to me since. And much, in part perhaps because of this book, has happened to psychiatry also.

Obviously, then, were I to write this book today, I would write it differently. But I am, on the whole, still quite satisfied with the original work. However, the original version of *The Myth of Mental Illness* now appears to me too detailed in the development of its thesis, overdocumented in its citations, and often couched in unnecessarily technical language. I have decided, therefore, that for this second edition I would eliminate everything that does not bear directly on its main themes, reduce the documentation, and rewrite the text, where necessary, in more straightforward English prose. At the same time, I have rejected the temptation to bring the arguments up to date or to add any significant new material—except for this Preface and a brief Summary—partly because, once begun, such rewriting would have been difficult to control, and partly because, in several of my books published since 1961, I have elaborated on the ideas first presented here.[1]

The problems to which I address myself in this book are easy to state but, because of the powerful cultural and economic pressures that define the "correct" answers to them, are difficult to clarify. They have to do with such questions as: What is disease? What are the ostensible and actual tasks of the physician? What is mental illness? Who defines what constitutes illness, diagnosis, treatment? Who controls the vocabulary of medicine and psychiatry, and the powers of the physician-psychiatrist and citizen-patient? Has a person the right to call himself sick? Has a physician the right to call a person mentally sick? What is the difference between a person complaining of pain and calling himself sick? Or between a physician complaining of a person's misbehavior and calling him a mentally sick patient? Without attempting to answer these questions or trying to anticipate the contents of this book, let me show briefly the sort of reasoning I bring to it.

It is impossible to undertake an analysis of the concept of mental illness without first coming to grips with the concept of ordinary or bodily illness. What do we mean when we say that

a person is ill? We usually mean two quite different things: first, that he believes, or that his physician believes, or that they both believe, that he suffers from an abnormality or malfunctioning of his body; and second, that he wants, or is at least willing to accept, medical help for his suffering. The term "illness" thus refers, first, to an abnormal biological condition whose existence may be claimed, truly or falsely, by patient, physician, or others; and second, to the social role of patient, which may be assumed or assigned.

If a person does not suffer from an abnormal biological condition, we do not usually consider him to be ill. (We certainly do not consider him to be physically ill.) And if he does not voluntarily assume the sick role, we do not usually consider him to be a medical patient. This is because the practice of modern Western medicine rests on two tacit premises—namely, that the physician's task is to diagnose and treat disorders of the human body, and that he can carry out these services only with the consent of his patient. In other words, physicians are trained to treat bodily ills—not economic, moral, racial, religious, or political "ills." And they themselves (except psychiatrists) expect, and in turn are expected by their patients, to treat bodily diseases, not envy and rage, fear and folly, poverty and stupidity, and all the other miseries that beset man. Strictly speaking, then, disease or illness can affect only the body. Hence, there can be no such thing as mental illness. The term "mental illness" is a metaphor.

To understand current psychiatric practices, it is necessary to understand how and why the idea of mental illness arose and the way it now functions. In part, the concept of mental illness arose from the fact that it is possible for a person to act and to appear as if he were sick without actually having a bodily disease. How should we react to such a person? Should we treat him as if he were not ill, or as if he were ill?

Until the second half of the nineteenth century, persons who imitated illness—that is, who claimed to be sick without

being able to convince their physicians that they suffered from bona fide illnesses—were regarded as faking illness and were called malingerers; and those who imitated medical practitioners—that is, who claimed to heal the sick without being able to convince medical authorities that they were bona fide physicians—were regarded as impostors, and were called quacks.

As a result of the influence of Charcot, Janet, and especially Freud, this perspective, both medical and lay, on imitations of illness and healing was radically transformed. Henceforth, persons who imitated illness—for example, who had "spells"—were regarded as genuinely ill, and were called hysterics; and those who imitated physicians—for example, who "hypnotized"—were regarded as genuine healers, and were called psychotherapists. This profound conceptual transformation was both supported and reflected by an equally profound semantic transformation—one in which "spells," for example, became "seizures," and quacks became "psychoanalysts."

The upshot of this psychiatric-psychoanalytic "revolution" is that, today, it is considered shamefully uncivilized and naïvely unscientific to treat a person who acts or appears sick as if he were not sick. We now "know" and "realize" that such a person is sick; that he is obviously sick; that he is mentally sick.

But this view rests on a serious, albeit simple, error: it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals. In other words, I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program. Of course, the word "sick" is often used metaphorically. We call jokes "sick," economies "sick," sometimes even the whole world "sick"; but only when we call minds "sick" do we systematically mistake and strategically

misinterpret metaphor for fact—and send for the doctor to "cure" the "illness." It is as if a television viewer were to send for a television repairman because he dislikes the program he sees on the screen.[2]

Furthermore, just as it is possible for a person to define himself as sick without having a bodily illness, so it is also possible for a physician to define as "sick" a person who feels perfectly well and wants no medical help, and then act as if he were a therapist trying to cure his "patient's" disease. How should we react to such a physician? Should we treat him as if he were a malevolent meddler or a benevolent healer? Today, it is considered quite unscientific and uncivilized to adopt the former posture, everyone—except the victim, and sometimes even he, himself—regarding such a physician as obviously a therapist, that is, a psychiatric therapist. I believe this is a serious error. I hold that psychiatric interventions are directed at moral, not medical, problems; in other words, that psychiatric help sought by the client stands in the same relation to psychiatric intervention imposed on him as religious beliefs voluntarily professed stand to such beliefs imposed by force.

It is widely believed that mental illness is a type of disease, and that psychiatry is a branch of medicine; and yet, whereas people readily think of and call themselves "sick," they rarely think of and call themselves "mentally sick." The reason for this, as I shall try to show, is really quite simple: a person might feel sad or elated, insignificant or grandiose, suicidal or homicidal, and so forth; he is, however, not likely to categorize himself as mentally ill or insane; that he is, is more likely to be suggested by someone else. This, then, is why bodily diseases are characteristically treated with the consent of the patient, while mental diseases are characteristically treated without his consent. (Individuals who nowadays seek private psychoanalytic or psychotherapeutic help do not, as a rule, consider themselves either "sick" or "mentally sick," but rather view their difficulties as problems in living and the help

they receive as a type of counseling.[3]) In short, while medical diagnoses are the names of genuine diseases, psychiatric diagnoses are stigmatizing labels.

Such considerations lead to two diametrically opposed points of view about mental illness and psychiatry. According to the traditional and at present generally accepted view, mental illness is like any other illness; psychiatric treatment is like any other treatment; and psychiatry is like any other medical specialty. According to the view I have endeavored to develop and clarify, however, there is, and can be, no such thing as mental illness or psychiatric treatment; the interventions now designated as "psychiatric treatment" must be clearly identified as voluntary or involuntary: voluntary interventions are things a person does for himself in an effort to change, whereas involuntary interventions are things done to him in an effort to change him against his will; and psychiatry is not a medical, but a moral and political, enterprise. This book is an attempt to demonstrate the fallacy of the former view and the validity of the latter.

I wish to thank my brother, Dr. George Szasz, for his help with the revisions; and my publisher, Harper & Row, and especially Mr. Hugh Van Dusen and Mrs. Ann Harris, for their decision to bring out a new edition of *The Myth of Mental Illness*, and for their help in preparing it.

THOMAS S. SZASZ, M.D.

Syracuse, New York
July 1, 1973

Preface to the First Edition

I became interested in writing this book approximately ten years ago when, having become established as a psychiatrist, I became increasingly impressed by the vague, capricious, and generally unsatisfactory character of the widely used concept of mental illness and its corollaries, diagnosis, prognosis, and treatment. It seemed to me that although the notion of mental illness made good *historical* sense—stemming as it does from the historical identity of medicine and psychiatry—it made no *rational* sense. Although mental illness might have been a useful concept in the nineteenth century, today it is scientifically worthless and socially harmful.

Although dissatisfaction with the medical basis and conceptual framework of psychiatry is not of recent origin, little has been done to make the problem explicit, and even less to remedy it. In psychiatric circles it is almost indelicate to ask: What is mental illness? In nonpsychiatric circles mental illness all too often is considered to be whatever psychiatrists say it is. The answer to the question, Who is mentally ill? thus becomes: Those who are confined in mental hospitals or who consult psychiatrists in their private offices.

Perhaps these answers sound silly. If they do, it is because they are silly. However, it is not easy to give better answers

without going to a good deal of trouble, first, by asking other questions, such as, Is mental illness an illness? and second, by resetting one's goals from understanding mental diseases to understanding human beings.

The need to re-examine the problem of mental illness is both timely and pressing. There is confusion, dissatisfaction, and tension in our society concerning psychiatric, psychological, and social issues. Mental illness is said to be the nation's number one health problem. The statistics marshaled to prove this contention are impressive: more than a half-million hospital beds for mental patients, and 17 million persons allegedly suffering from some degree of mental illness.

The concept of mental illness is freely used in all the major news media—the newspapers, radio, and television. Sometimes famous persons are said to be mentally ill—for example, Adolf Hitler, Ezra Pound, Earl Long. At other times the label is attached to the most lowly and unfortunate members of society, especially if they are accused of a crime.

The popularity of psychotherapy, and people's alleged need for it, is rapidly increasing. At the same time it is impossible to answer the question, What is psychotherapy? The term "psychotherapy" encompasses nearly everything that people do in the company of one another. Psychoanalysis, group psychotherapy, religious counseling, rehabilitation of prisoners, and many other activities, are all called "psychotherapy."

This book was written in an effort to dispel the perplexities mentioned, and thereby to clear the psychiatric air. Parts I and II are devoted to laying bare the socio-historical and epistemological roots of the modern concept of mental illness. The question, What *is* mental illness? is shown to be inextricably tied to the question, What do psychiatrists *do?* My first task, accordingly, is to present an essentially "destructive" analysis of the concept of mental illness and of psychiatry as a pseudomedical enterprise. I believe that such "destruction,"

like tearing down old buildings, is necessary if we are to construct a new, more habitable edifice for the science of man.

Since it is difficult to scrap one conceptual model without having another with which to replace it, I had to search for a new point of view. My second aim, then, is to offer a "constructive" synthesis of the knowledge which I have found useful for filling the gap left by the myth of mental illness. Parts III, IV, and V are devoted to presenting a systematic theory of personal conduct, based partly on materials culled from psychiatry, psychoanalysis, and other disciplines, and partly on my own observations and ideas. The omission from psychiatric theories of moral issues and normative standards, as explicitly stated goals and rules of conduct, has divorced psychiatry from precisely that reality which it has tried to describe and explain. I have endeavored to correct this defect by means of a game theory of human living, which enables us to combine ethical, political, religious, and social considerations with the more traditional concerns of medicine and psychiatry.

Although my thesis is that mental illness is a myth, this book is not an attempt to "debunk psychiatry." There are altogether too many books today that attempt either to sell psychiatry and psychotherapy or to unsell them. The former usually set out to show why and how this or that form of behavior *is* "mental illness," and how psychiatrists *can* help a person so afflicted. The latter often employ a two-pronged attack suggesting that psychiatrists themselves are "mentally ill," and that psychotherapy is a poor method for "treating" a sickness that manifests itself in symptoms as serious as those of mental illness.

I should like to make clear, therefore, that although I consider the concept of mental illness to be unserviceable, I believe that psychiatry could be a science. I also believe that psychotherapy is an effective method of helping people—not

to recover from an "illness," but rather to learn about themselves, others, and life.

In sum, then, this is not a book on psychiatry, nor is it a book on the nature of man. It is a book *about* psychiatry—inquiring, as it does, into what people, but particularly psychiatrists and patients, have done with and to one another. It is also a book about human conduct—since in it observations and hypotheses are offered concerning how people live.

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Syracuse, New York
June 30, 1960

The Myth of Mental Illness

Science must begin with myths and with the criticism of myths.

—Karl R. Popper

Introduction

Psychiatry is conventionally defined as a medical specialty concerned with the diagnosis and treatment of mental diseases. I submit that this definition, which is still widely accepted, places psychiatry in the company of alchemy and astrology and commits it to the category of pseudoscience. The reason for this is that there is no such thing as "mental illness." Psychiatrists must now choose between continuing to define their discipline in terms of nonexistent entities or substantives, or redefining it in terms of the actual interventions or processes in which they engage.

In the history of science, thinking in terms of entities has always tended to precede thinking in terms of processes. Alchemists and astrologers thus spoke of mysterious substances and concealed their methods from public scrutiny. Psychiatrists have similarly persisted in speaking of mysterious mental maladies and have continued to refrain from disclosing fully and frankly what they do. Indeed, whether as theorists or therapists, they may do virtually anything and still claim to be, and be accepted as, psychiatrists. The actual behavior of a particular psychiatrist may thus be that of a physician, psychologist, psychoanalyst, policeman, clergyman, historian, literary critic, friend, counselor, or teacher—or sundry

combinations of these roles. A physician is usually accepted as a psychiatrist so long as he insists that what concerns him is the problem of mental health and mental illness.

But let us suppose that there is no such thing as mental health or mental illness, that these terms refer to nothing more substantial or real than did the astrological notions of the influence of planetary positions on personal conduct. What then?

Methods of Observation and Action in Psychiatry

Psychiatry stands at the crossroads. Until now, thinking in terms of entities or substantives—such as illness, neurosis, psychosis, treatment—has been the rule. The question now is: Shall we continue along the same road or branch off in the direction of thinking in terms of interventions or processes? Viewed in this light, my efforts in this study are directed, first, at demolishing the major false substantives of contemporary psychiatric thought, and second, at laying the foundations for a process theory of personal conduct.

Discrepancies between what people say they do and what they actually do are encountered in all walks of life—science, medicine, and psychiatry among them. It was precisely against such discrepancies that Einstein warned his fellow physicists when he declared:

> If you want to find out anything from the theoretical physicists about the methods they use, I advise you to stick closely to one principle: Don't listen to their words, fix your attention on their deeds.[1]

Actions do speak louder than words. Clearly, there is no reason to assume that this proverb, or the principle proposed by Einstein, are not equally valid for understanding the methods, and hence the very nature, of psychiatry.

The foregoing principle now also forms the basis of a

systematic philosophy of science known as operationalism.[2] Simply stated, an operational definition of a concept is one that refers to actual interventions or operations. This sort of definition may be contrasted with an idealistic one, which refers to the basic or "essential" qualities of the object or idea. Modern physical concepts are defined in terms of physical operations, such as measurements of time, temperature, distance, and so forth. Earlier physical definitions made use of such ideal notions as phlogiston or ether. In the same way, psychiatric, psychological, or social concepts, defined operationally, would have to relate to actual interventions and observations. Actually, many contemporary psychosocial concepts are defined in terms of the expert's self-proclaimed intentions, interests, and values. Virtually all current psychiatric concepts are of this sort.

Hence, if we try to answer the question, What do psychiatrists do? our reply will necessarily depend on the kind of psychiatrist we have in mind. Actually, psychiatrists engage in all of the following activities (and the list is by no means complete): they physically examine patients, prescribe and administer drugs and electric convulsions, sign commitment papers, examine criminals at the request of judicial authorities, testify in legal proceedings, listen and talk to persons, offer speculations about ancient and modern historical events and personages, engage in research in biochemistry and neurophysiology, study monkeys and other animals, and so forth almost *ad infinitum.*

In this book I shall be concerned mainly with psychiatry as a discipline whose special method is, derisively but quite correctly, often said to be "only talking." If we disregard the "only" as gratuitous condemnation before the facts, and if under the term "talking" we encompass communications of all sorts, we arrive at a formulation of a basic method of psychiatry to which, although it is accurate, surprisingly few psychiatrists really subscribe. There is, as I noted before, a serious

discrepancy between what psychotherapists and psychoanalysts *do* and what they *say they do.* What they do, quite simply, is to communicate with other persons (often called "patients") by means of language, nonverbal signs, and rules; they analyze—that is, discuss, explain, and speculate about—the communicative interactions which they observe and in which they themselves engage; and they often recommend engaging in some types of conduct and avoiding others. I believe that these phrases correctly describe the actual operations of psychoanalysts and psychosocially oriented psychiatrists. But what do these experts tell themselves and others concerning their work? They talk as if they were physicians, physiologists, biologists, or even physicists. We hear about "sick patients" and "treatments," "diagnoses" and "hospitals," "instincts" and "endocrine functions," and, of course, "libido" and "psychic energies," both "free" and "bound." All this is fakery and pretense whose purpose is to "medicalize" certain aspects of the study and control of human behavior.

A psychiatry based on and using the methods of communication analysis has actually much in common with the disciplines concerned with the study of languages and communicative behavior, such as symbolic logic, semiotic,* semantics, and philosophy. Nevertheless, so-called psychiatric problems continue to be cast in the traditional framework of medicine. The conceptual scaffolding of medicine, however, rests on the principles of physics and chemistry, as indeed it should, for it has been, and continues to be, the task of medicine to study, and if necessary to alter, the physicochemical structure and function of the human body. Yet the fact remains that human sign-using behavior does not lend itself to exploration and understanding in these terms. We thus remain shackled to the wrong conceptual framework and terminology. No science, however, can be better than its linguistic apparatus allows it to be. And the language of psychiatry (and psychoanalysis) is

* The term "semiotic" designates the science of signs.[3]

fundamentally unfaithful to its own subject: in it, imitating medicine comes before telling the truth. We shall not, however, be able to hold on to the morally judgmental and socially manipulative character of our traditional psychiatric and psychoanalytic vocabulary without paying a price for it. Indeed, we are well along the road of having purchased superiority and power over patients at the cost of scientific self-sterilization and imminent professional self-destruction.

Causality and Historicism in Modern Psychiatry

Psychoanalytic theory was fashioned after the pattern of the causal-deterministic model of classical physics. The erroneousness of this transfer has been amply documented in recent years.[4] I wish to call attention here to that particular application of the principle of physical determinism to human affairs which Karl Popper called "historicism."[5] Briefly stated, historicism is a doctrine according to which historical events are as fully determined by their antecedents as are physical events by theirs. Hence, historical prediction is not essentially different from physical prediction. In principle, at least, the prediction of future events is possible, and is indeed the task of the human sciences. Popper's models of important historicist thinkers are Plato, Marx, and the modern totalitarian dictators and their apologists.

While Popper himself alludes to Freud as a historicist thinker, he does not fully develop a critique of psychoanalysis as a historicist doctrine. It is obvious, however, that not only psychoanalysis but also much of traditional and modern psychiatric theory assumes that personal conduct is determined by prior personal-historical events. All these theories downgrade and even negate explanations of human behavior in terms such as freedom, choice, and responsibility. "Every version of historicism," writes Popper, "expresses the feeling of being swept into the future by irresistible forces."[6] No more

perfect description of the Freudian imagery of human conduct—"swept into the future" by the Unconscious—could be wished for. Moreover, in psychoanalysis, not only are "unconscious forces" regarded as the causes of behavior, but these forces themselves are considered to be the results of instinctual drives and early life experiences. Here, then, lie the crucial similarities between Marxism and Freudianism: each is a historicist doctrine attributing all-pervasive causal influences on conduct to a single type of "cause" or human circumstance. Marx singled out the economic arrangements prevailing in society as the overwhelming causes and explanations of countless subsequent human events; Freud assigned the same powers to family-historical, or so-called genetic-psychological circumstances. Both of these unsupported—and, as Popper shows, unsupportable and palpably false—doctrines have nevertheless become widely accepted in our day. The sanction of legal recognition has, of course, long supported the psychiatric view that certain kinds of "abnormal" behaviors were "caused" by antecedently acting "mental diseases." This view was simply extended to behaviors of all kinds by Freud and his supporters, and has been embraced even by many of his opponents, especially the behaviorists.

My opposition to deterministic explanations of human behavior does not imply any wish to minimize the effects, which are indeed significant, of past personal experiences. I wish only to maximize the scope of voluntaristic explanations—in other words, to reintroduce freedom, choice, and responsibility into the conceptual framework and vocabulary of psychiatry.

In human affairs, and hence in the social sciences that try to explain these affairs, we are faced with a full and complicated interplay between observer and observed. This alone should suffice to demonstrate what Popper has aptly called the "poverty of historicism." In particular, the prediction of a social event itself may cause it to occur or may serve to prevent it

from occurring. The self-fulfilling prophecy stands as a stark symbol of the hazards of prediction in social affairs.

In view of the glaring inadequacies of historicist theories, the question arises as to why people subscribe to them. The answer seems to be that historicist doctrines function as religions masquerading as science. Popper puts it this way:

> It really looks as if historicists were trying to compensate themselves for the loss of an unchanging world by clinging to the belief that change can be foreseen because it is ruled by an unchanging law.[7]

Curiously, Freud—himself a devout determinist and historicist—proposed a similar explanation for why men cling to religion: he attributed religious belief to man's inability to tolerate the loss of the familiar world of childhood, symbolized by the protective father.[8] Man thus creates a heavenly father and an imaginary replica of the protective childhood situation to replace the real or longed-for father and family. The differences between traditional religious doctrine, modern political historicism, and psychoanalytic orthodoxy thus lie mainly in the character of the "protectors": they are, respectively, God and the priests, the totalitarian leader and his apologists, and Freud and the psychoanalysts.

While Freud criticized revealed religion for the patent infantilism that it is, he ignored the social characteristics of closed societies and the psychological characteristics of their loyal supporters.[9] He thus failed to see the religious character of the movement he himself was creating. It is in this way that the paradox that is psychoanalysis—a system composed of a historicist theory and an antihistoricist therapy—came into being. Perhaps we should assume that historicism fulfilled the same needs for Freud, and for those who joined him in the precarious early development of psychoanalysis, as it had for others: it provided him with a hidden source of comfort and security against the threat of unforeseen and unpredictable change. This view is consistent with the contemporary use of

psychoanalysis and dynamic psychiatry as means for obscuring and disguising moral and political conflicts as mere personal problems.

What, then, can we say about the relationship between psychosocial laws and physical laws? We can assert that the two are dissimilar. Psychosocial antecedents do not cause human sign-using behavior in the same way as physical antecedents cause their effects. Indeed, the use of terms such as "cause" and "law" in connection with human affairs ought to be recognized as metaphorical rather than literal. Finally, just as physical laws are relativistic with respect to mass, so psychological laws are relativistic with respect to social conditions. In short, the laws of psychology cannot be formulated independently of the laws of sociology.

Psychiatry and Ethics

In this book I shall view psychiatry, as a theoretical science, as consisting of the study of personal conduct. Its concerns are therefore to describe, clarify, and explain the kinds of games people play with each other and with themselves; how they learned these games; why they like to play them; what circumstances favor their continuing to play old games or learning new ones; and so forth.* Actual behavior is of course the datum from which the nature and rules of the game are inferred. Among the numerous types of behavior that persons engage in, the verbal form—that is, communications by means of conventional language—constitutes one of the central areas of interest for psychiatry. Hence, it is in the playing of language games that the interests of linguistics, philosophy, semiotic, and psychiatry meet. Each of these disciplines ad-

* A systematic analysis of personal conduct in terms of game-playing behavior will be presented in Part V. The model of games, however, is used throughout the book. Although it is difficult to give a concise definition of the concept of game, game situations are characterized by a system of set roles and rules binding for all of the players.

dresses itself to a different aspect of the language game: linguistics to its formal structure, philosophy and semiotic to its cognitive structure, and psychiatry to its personal significance and social usage.

I hope that this approach will effect a much-needed and long-overdue rapprochement between psychiatry on the one hand, and ethics and philosophy on the other. Questions such as, How does man live? and, How ought man to live? traditionally have been assigned to the domains of ethics, religion, and philosophy. Until the latter part of the nineteenth century, psychology and psychiatry were much more closely allied with ethics and philosophy than they are now. For example, much of what was formerly called "moral philosophy" is now called "social psychology" or simply "psychology." For the past century or so, psychologists have considered themselves, and have been accepted by others, as empirical scientists whose methods and theories are ostensibly the same as those of the biologist or physicist. Yet the fact remains that insofar as psychologists address themselves to the questions posed above, their work differs significantly from that of the natural scientist. Psychologists and psychiatrists deal with moral problems which, I believe, they cannot solve by medical methods.

In sum, then, inasmuch as psychiatric theories seek to explain, and systems of psychotherapy seek to change, human behavior, statements concerning goals and values must remain indispensable for all theories of personal conduct and psychotherapy.

Hysteria as a Paradigm of Mental Illness

If dated from Charcot's work on hysteria and hypnosis, modern psychiatry is approximately one hundred years old. How did the study of so-called mental illnesses begin and develop? What economic, moral, political, and social forces helped to mold it into its present form? And, perhaps most important,

what effect has medicine, and especially the concept of bodily illness, had on the development of the concept of mental illness?

My strategy in this inquiry will be to answer these questions using conversion hysteria as the historical paradigm of the sorts of phenomena to which the term "mental illness" refers. I chose hysteria for the following reasons:

Historically, it is the problem that captured the attention of the pioneer neuropsychiatrists Charcot, Janet, and Freud, and paved the way to the differentiation between neurology and psychiatry.

Logically, hysteria brings into focus the need to distinguish bodily illness from the imitations of such illness. It confronts the physician—and others as well—with the task of distinguishing "real" or genuine illness from "imaginary" or faked illness. This distinction—between fact and facsimile, object and sign, physics and psychology, medicine and morals—remains the core problem of contemporary psychiatric epistemology.

Psychologically and socially, hysteria offers a good example of how a so-called mental illness may now be most adequately conceptualized in terms of sign-using, rule-following, and game-playing. In other words, hysteria is (1) a form of nonverbal communication, making use of a special set of signs; (2) a system of rule-following behavior, making use of the rules of illness, helplessness, and coercion; and (3) an interpersonal game characterized by, among other things, strategies of deceit to achieve the goal of domination and control.

Furthermore, I believe that the interpretation of hysteria which I shall present pertains fully—with appropriate modifications—to all so-called mental illnesses, and indeed to personal conduct generally. The manifest diversity among mental illnesses—for example, the differences between hysteria, depression, paranoia, schizophrenia, and so forth—may be re-

garded as analogous to the manifest diversity among languages. In each case, behind the apparent phenomenological differences there are certain basic similarities. Within a particular family of languages, for example the Indo-European, there are important similarities of both structure and function. Thus, English, French, German, and Dutch have much in common with one another, whereas each differs from Hungarian. In the same way, hysteria and dreaming—that is to say, the picture languages of hysterical conversions and dreams—closely resemble each other: both are composed of iconic signs. And both differ from, say, the language of paranoia—which makes use of ordinary language, and which owes its characteristic form and impact not to the peculiarity of its symbols, but to the peculiar uses which ordinary linguistic signs serve in it.

But if hysteria is not a mental illness—if, indeed, there are no mental illnesses at all—why do we call the things we now call "mental illnesses" by that name?

The Invention of Mental Illness

Until the middle of the nineteenth century, and beyond, illness meant a bodily disorder whose typical manifestation was an alteration of bodily structure: that is, a visible deformity, disease, or lesion, such as a misshapen extremity, ulcerated skin, or a fracture or wound. Since in this original meaning of it, illness was identified by altered bodily structure, physicians distinguished diseases from nondiseases according to whether or not they could detect an abnormal change in the structure of a person's body. This is why, after dissection of the body was permitted, anatomy became the basis of medical science: by this means, physicians were able to identify numerous alterations in the structure of the body which were not otherwise apparent. As more specialized methods of examining bodily tissues and fluids were developed, the pathologist's

skills in detecting hitherto unknown bodily diseases grew explosively. Anatomical and pathological methods and criteria continue to play a constantly increasing role in enabling physicians to identify alterations in the physicochemical integrity of the body and to distinguish between persons who display such identifiable signs of illness and those who do not.

It is important to understand clearly that modern psychiatry—and the identification of new psychiatric diseases—began not by identifying such diseases by means of the established methods of pathology, but by creating a new criterion of what constitutes disease: to the established criterion of detectable alteration of *bodily structure* was now added the fresh criterion of alteration of *bodily function;* and, as the former was detected by observing the patient's body, so the latter was detected by observing his behavior. This is how and why conversion hysteria became the prototype of this new class of diseases—appropriately named "mental" to distinguish them from those that are "organic," and appropriately called also "functional" in contrast to those that are "structural." Thus, whereas in modern medicine new diseases were *discovered,* in modern psychiatry they were *invented.* Paresis was *proved* to be a disease; hysteria was *declared* to be one.

It would be difficult to overemphasize the importance of this shift in the criteria of what constitutes illness. Under its impact, persons who complained of pains and paralyses but were apparently physically intact in their bodies—that is, were healthy, by the old standards—were now declared to be suffering from a "functional illness." Thus was hysteria invented. And thus were all the other mental illnesses invented—each identified by the various complaints or functional-behavioral alterations of the persons affected by them. And thus was a compelling parallel constructed between bodily and mental illness: for example, as paresis was considered to be a structural disease of the brain, so hysteria and other mental illnesses were considered to be functional diseases of the same

organ. So-called functional illnesses were thus placed in the same category as structural illnesses and were distinguished from imitated or faked illnesses by means of the criterion of voluntary falsification. Accordingly, hysteria, neurasthenia, depression, paranoia, and so forth were regarded as diseases that *happened* to people. Mentally sick persons did not "will" their pathological behavior and were therefore considered "not responsible" for it. These mental diseases were then contrasted with malingering, which was the voluntary imitation of illness. Finally, psychiatrists have asserted that malingering, too, is a form of mental illness. This presents us with the logical absurdity of a disease which, even when it is deliberately counterfeited, is still a disease.

But, clearly, this is the inescapable consequence of confusing discovering diseases with inventing them: the enterprise of trying to discover bodily diseases, constrained by fixed criteria and the requirements of empirical evidence, *cannot* eventuate in the conclusion that every phenomenon observed by the investigator is a disease; but the enterprise of inventing mental diseases, unconstrained by fixed criteria or the requirements of empirical evidence, *must* eventuate in the conclusion that any phenomenon studied by the observer may be defined as a disease.

Part One

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The Myth of Mental Illness

I
GROWTH AND STRUCTURE OF THE MYTH

1 Charcot and the Problem of Hysteria

Since the modern concept of hysteria was cut from the cloth of malingering, and since the physician most responsible for establishing "hysteria" as a medically legitimate illness was Charcot, I shall start with an examination of his work; and I shall then trace the development of the concept of hysteria to the present time.

Charcot and Hysteria

Jean-Martin Charcot (1825–1893) was a neurologist and neuropathologist. In other words, he was a physician who specialized in diseases of the nervous system. Exactly what did this mean at that time? It is important that we understand what a physician like Charcot did, how he practiced, and how his work differed from that of his counterparts today.

One hundred years ago, physicians possessed practically no effective therapeutic methods with which to help their patients. This was especially true for the neurologist, who dealt almost entirely with what were then incurable diseases. Charcot, moreover, was not just a physician in private practice. He was also a professor of pathological anatomy at the Sorbonne, and, as such, his duties were educational and scientific; in addition

he was a physician in charge of the care of patients at the Salpêtrière. In short, there was nothing therapeutic, in the contemporary medical sense of this word, about much of his work. Most of Charcot's hospitalized patients, whether those with or without organic neurological diseases—and, as we shall see, it was often extremely difficult to make this distinction at that time—were hospitalized not so much because they were sick as because they were poor, unwanted, or disturbing to others. From an economic, social, and political point of view, these patients were similar to those who today are committed to mental hospitals with psychiatric diagnoses of "major" mental disorders.[1] The families of these patients either could not care for their disabled relative because they were too poor to do so and it was cheaper to have the patient hospitalized, or, if they could, they did not want to do so because the patient was too offensive or troublesome. Overwhelmingly, then, Charcot's hospital patients came from the lower classes and thus stood socially far beneath their physician. What was Charcot's personal attitude toward his patients? We can infer the answer to this question from Freud's obituary of his great teacher:

Having at his disposal a considerable number of patients afflicted with chronic nervous disease he was enabled to take full advantage of his peculiar talent. He was not much given to cogitation, was not of the reflective type, but he had an artistically gifted temperament —as he said himself, he was a *visuel*, a seer. He himself told us the following about his method of working. He was accustomed to look again and again at things that were incomprehensible to him, to deepen his impression of them day by day until suddenly understanding of them dawned on him. Before his mind's eye, order then came into the chaos apparently presented by the constant repetition of the same symptoms; the new clinical pictures which were characterized by the constant combination of certain syndromes took shape; the complete and extreme cases, the "types," were then distinguishable with the aid of a specific kind of schematic arrangement, and with these as a starting point the eye could follow down

the long line of the less significant cases, the *formes frustes,* showing some one or other peculiar feature of the type and fading into the indefinite. He called this kind of mental work, in which he had no equal, "practising nosography" and he was proud of it.[2]

Charcot's own term for this work—"practising nosography"—is indeed an apt expression to describe his charting of human misery and cataloguing it in the language of medicine. It is obvious that what Charcot here describes was of no more help to his unknown patients than is a biologist's description of unknown bacteria to the microbes; indeed, depending on the subsequent uses to which such information is put, the objects catalogued may be as easily harmed as helped.

Freud then continues:

But to his pupils, who made the rounds with him through the wards of the Salpêtrière—the museum of clinical facts for the greater part named and defined by him—he seemed a very Cuvier, as we see him in the statue in front of the Jardin des Plantes, surrounded by the various types of animal life which he had understood and described; or else he reminded them of the myth of Adam, who must have experienced in its most perfect form that intellectual delight so highly praised by Charcot, when the Lord led before him the creatures of Paradise to be named and grouped.[3]

To Charcot and Freud, these patients are mere objects or things to be classified and manipulated. It is an utterly dehumanized view of the sick person. But then, we might recall that even today physicians often speak of "cases" and "clinical material" rather than of persons, thus betraying the same bias.

Charcot's sole clinical interest was thus to identify, describe, and classify neurological diseases—diseases of the nervous system. He therefore had to establish which phenomena constituted such diseases, and which did not. As the geologist must differentiate gold from copper, and both from other metals which glitter, so the neurologist-nosographer must differentiate multiple sclerosis, tabes, and hysteria. How does he do this?

In Charcot's days the most important tool, besides the clinical examination, was the post-mortem study of the brain. Freud provided us with an interesting glimpse of how Charcot carried out his taxonomic work:

During his student days chance brought him into contact with a charwoman who suffered from a peculiar form of tremor and could not get work because of her awkwardness. Charcot recognized her condition to be "choreiform paralysis," already described by Duchenne, of the origin of which, however, nothing was known. In spite of her costing him a small fortune in broken plates and platters, Charcot kept her for years in his service and, when at last she died, could prove in the autopsy that "choreiform paralysis" was the clinical expression of multiple cerebro-spinal sclerosis.[4]

Guillain's biography of Charcot furnishes considerable additional information consistent with the picture sketched so far.[5] For example, we learn that Charcot moved in the highest social circles. He was a friend of Premier Gambetta and also of the Grand Duke Nicholas of Russia. He is said to have paved the way for the Franco-Russian Alliance. By all accounts, he aspired to the role of aristocratic autocrat. It requires no great feat of the imagination to infer what sort of personal relationship must have prevailed between him and his destitute and near-illiterate patients.

A firsthand account, although perhaps somewhat embellished, of the human side of Charcot's work may be obtained from Axel Munthe's beautiful autobiography, *The Story of San Michele*.[6] Of particular interest is Munthe's story of a young peasant girl who took refuge in hysterical symptoms to escape the drudgery of her home life. Munthe felt the "treatment" she was receiving at the Saltpêtrière was making her a lifelong invalid, and that Charcot was, in a way, keeping her imprisoned. He tried to "rescue" the girl, took her to his apartment, and hoped to convince her to return home. It appears from Munthe's story, however, that the young woman preferred the social role of hysterical patient at the Salpêtrière to that of

peasant girl in her village. Evidently, life in the hospital was more exciting and rewarding than her "normal" existence—a contingency Munthe seriously underestimated. What emerges from this account, too, is that the Salpêtrière, under Charcot, was a special type of social institution. In addition to its similarities to present-day state mental hospitals, its function could also be compared to armies and religious organizations. In other words, the Salpêtrière provided its inmates with certain comforts and gratifications lacking in their ordinary social environment. Charcot and the other physicians who worked there functioned as rulers vis-à-vis their subjects. Instead of intimacy and trust, their relationship to each other was based on fear, awe, and deception.

As Charcot's knowledge of neuropathology increased and as his prestige grew, his interest shifted from neurological disorders to disorders which simulated such conditions. Such patients were then classified either hysterics or malingerers, depending on the observer's point of view. Those labeled "hysterics" were declared relatively more respectable and fit objects for serious study. They were regarded as suffering from an illness, rather than as trying to fool the physician or exhibiting willful misbehavior. This is the most fundamental connection, although by no means the only one, between the notions of hysteria and malingering. Freud's account of Charcot's work is again illuminating:

> He explained that the theory of organic nervous diseases was for the present fairly complete, and he began to turn his attention almost exclusively to hysteria, thus suddenly focusing general attention to this subject. This most enigmatic of all nervous diseases—no workable point of view having yet been found from which physicians could regard it—had just at this time come very much into discredit, and this ill-repute related not only to the patients but was extended to the physicians who treated this neurosis. The general opinion was that anything may happen in hysteria; hysterics found no credit whatsoever. First of all Charcot's work restored

dignity to the subject; gradually the sneering attitude, which the hysteric could reckon on meeting when she told her story, was given up; she was no longer a malingerer, since Charcot had thrown the whole weight of his authority on the side of the reality and objectivity of hysterical phenomena.[7]

This passage reveals how the study of hysteria was prejudged by the importance of its investigator, Charcot. Certain crucial issues were, therefore, obscured and must now be reexamined. Even the simple statement that Charcot turned his attention to "hysteria" rests on the tacit assumption that *this* was the patient's trouble. It was decided by fiat that, in contrast to organic neurological disease, these people had "functional nervous illnesses." And most of these "illnesses" were then named "hysteria." Freud's interesting comment should now be recalled: hysterics were no longer diagnosed as malingerers because of Charcot's authority. Freud offered no evidence or reason for preferring the category of hysteria to that of malingering. Instead, he appealed to ethical considerations, although without explicitly saying so:

Charcot had repeated on a small scale the act of liberation commemorated in the picture of Pinel which adorned the lecture hall of the Salpêtrière. Now that the blind fear of being fooled by the poor patient which had stood in the way of a serious study of the neurosis was overcome, the question arose which mode of procedure would most speedily lead to the solution of the problem.[8]

This situation is historically significant on two counts: first, because it marks the beginning of the modern study of so-called mental illnesses; second, because it contains what I regard as the major logical and procedural error in the evolution of modern psychiatry.

Is Every Form of Suffering Illness?

Freud compared Charcot's work to Pinel's. But, as I see it, Pinel's liberation of the mental patient from the dungeon was

not a psychiatric achievement at all. It was a moral achievement. He claimed that the sufferers who had been placed in his charge were human beings, and as such entitled to the rights and dignities which, in principle at least, motivated the French Revolution. Pinel did not advocate that the patient should be better treated because he was sick. Indeed, the social role of the sick person was not an enviable one at that time. Hence, an appeal for better treatment on this ground would not have been effective.

Pinel's liberation of the mental patient should thus be viewed as social reform rather than as innovation in medical treatment. This is an important distinction. For instance, during the Second World War the removal of venereal infection from the classification of disciplinary offenses among military personnel was an act of social reform. The discovery of penicillin, while bearing on the same problem—namely, the control of venereal disease—was a scientific discovery.

What were the effects of Charcot's insistence that hysterics were ill and not malingering? Although this diagnosis did not alter the hysteric's disability, it did make it easier for him to be "ill." Like a little knowledge, this type of assistance can be dangerous. It makes it easier for both sufferer and helper to stabilize the situation and rest content with what is still a very unsatisfactory state of affairs. A comparison of Charcot with another famous French physician, Guillotin, may be illuminating in this connection.

Guillotin's highly questionable contribution to human welfare consisted of the reinvention and advocacy of the guillotine. This resulted in a relatively painless and, therefore, less cruel form of execution than those previously in vogue. In our day, the guillotine and the rope have been succeeded in America by the gas chamber and electric chair. Clearly, Guillotin's work is humane or inhuman, depending on which side of the issue we examine. From the point of view of making execution less painful for the executed, it was humane.

Since it also made things easier for the executioner and his employers, it was inhuman. What Charcot did was similar. To put it succinctly, Guillotin made it easier for the condemned to die, and Charcot made it easier for the sufferer, then commonly called a malingerer, to be sick. It may be argued that when dealing with the hopeless and the helpless, these are real accomplishments. Still, I would maintain that Guillotin's and Charcot's interventions were not acts of liberation, but were rather processes of narcotization or tranquilization.

In short, Charcot and Guillotin made it easier for people—particularly for the socially downtrodden—to be ill and to die. Neither made it easier for people to be well and to live. They used their medical knowledge and prestige to help society shape itself into an image it found pleasing. Efficient and painless execution fitted well into the self-image of Guillotin's society. Similarly, late-nineteenth-century European society was ready to view almost any disability—and particularly one, such as hysteria, that looked so much like a disorder of the body—as illness. Charcot, Kraepelin, Breuer, Freud, and many others lent their authority to the propagation of this socially self-enhancing image of what was then "hysteria," and what in our day has become the problem of "mental illness." The weight of authority of contemporary medical and psychiatric opinion continues, of course, to support and to expand this image.

The foregoing events have had far-reaching consequences in shaping contemporary consciousness and practices with respect to the so-called mentally ill. It might seem, at first glance, that to advocate, and indeed to insist, that an unhappy or troubled person is sick—and that he is sick in exactly the same sense and way in which a person suffering from cancer is sick—is humane and well-intentioned, as it aims to bestow upon such a person the dignity of suffering from a genuine illness over which he has no control. However, there is a hidden weight attached to this tactic which pulls the suffering

person back into the same sort of disrepute from which this semantic and social reclassification was intended to rescue him. Indeed, labeling individuals displaying or disabled by problems in living as "mentally ill" has only impeded and retarded the recognition of the essentially moral and political nature of the phenomena to which psychiatrists address themselves.

Another error in decreeing that some malingerers be called hysterics was that it led to obscuring the similarities and differences between organic neurological disease and phenomena that only resembled them. In analyzing hysteria, we have a choice between emphasizing the similarities or the differences between it and neurological illness. Actually, both are readily apparent. The similarities between hysteria and bodily illness lie chiefly in the patient's complaints, his clinical appearance, and the fact that he is disabled. The differences between them lie in the empirical findings on physical, laboratory, and post-mortem examination. Moreover, these similarities and differences do not really stand in opposition to one another: there is no reason to believe that every person who complains of being ill or who looks ill or who is disabled —or who manifests all three of these features—must also have a physicochemical disorder of his body! This does not deny the possibility that there may be a connection between such complaints and bodily diseases. The nature of this connection, however, is empirical, not logical. Once this is clear, it becomes a matter of scientific and social choice whether we prefer to emphasize the similarities—and place hysteria in the category of illness; or whether we prefer to emphasize the differences—and place it in the category of nonillness.

The Double Standard in Psychiatry

The aim of my analysis of the problem of hysteria up to here has been to make explicit the values which influenced mem-

bers of the psychiatric profession in the late nineteenth century. I dwelled on Charcot's attitude toward patients to show, first, that he never considered himself to be the patient's agent, and second, that his principal goal was to identify accurately specific diseases. As a result, Charcot tended to define all of the phenomena he studied as neurological disorders. If this accomplished nothing else, it at least justified the attention he paid to these phenomena and the pronouncements he made about them. In this respect, Charcot and his group stood in the same sort of relationship to hysteria as the contemporary physicist stands to nuclear war. The fact that atomic energy is used in warfare does not make international conflicts problems in physics; likewise, the fact that the brain is used in human behavior does not make moral and personal conflicts problems in medicine.

The point is that the prestige of the scientist—whether of a Charcot or of an Einstein—can be used to lend power to its possessor. He then may be able to achieve social goals that he could not otherwise attain. Once a scientist becomes so engaged, however, he has a powerful incentive to claim that his opinions and recommendations rest on the same grounds as his reputation! In Charcot's case, this meant that he had to base his case about hysteria on the premise that it was an organic neurological illness. Otherwise, if hysteria and hypnosis were problems in human relations and psychology, why should anyone have taken Charcot's opinions as authoritative? He had no special qualifications or competence in these areas. Hence, had he openly acknowledged that he was speaking about such nonmedical matters, he might have encountered serious opposition.

These historical developments lie at the root of a double standard in psychiatry that still persists. I refer to the dual orientation of physicians and psychiatrists to certain occurrences which they encounter in their practices. Charcot's

informal, off-the-record comment about hysteria illustrates this phenomenon:

Some years later, at one of Charcot's evening receptions, I happened to be standing near the great teacher at a moment when he appeared to be telling Brouardel a very interesting story about something that had happened during his day's work. I hardly heard the beginning, but gradually my attention was seized by what he was talking of: a young married couple from a distant country in the East—the woman a severe sufferer, the man either impotent or exceedingly awkward. *"Tachez donc,"* I heard Charcot repeating, *"je vous assure, vous y arriverez."* Brouardel, who spoke less loudly, must have expressed his astonishment that symptoms like the wife's could have been produced by such circumstances. For Charcot suddenly broke out with great animation, *"Mais, dans des cas pareils c'est toujours la chose genitale, toujours . . . toujours";* and he crossed his arms over his stomach, hugging himself and jumping up and down on his toes several times in his own characteristically lively way. I know that for a moment I was almost paralyzed with amazement and said to myself: "Well, but if he knows that, why does he never say so?" But the impression was soon forgotten; brain anatomy and the experimental induction of hysterical paralyses absorbed all available interest.[9]

Why was Charcot so insistent? With whom was he arguing? With himself! Charcot must have known that he was deceiving himself when he believed that hysteria was a disease of the nervous system. Herein lies the double standard. The organic viewpoint is dictated by social expediency insofar as the rules of the game of medicine are defined so that adherence to this position will be rewarded. Adherence to the psychological viewpoint is required by the physician's loyalty to the truth and his identification or empathy with the patient. This dichotomy is reflected in the two basic contemporary psychiatric methods, namely, the physicochemical and the psychosocial. In the days of Charcot and Freud, however, only the former was recognized as belonging to science and medicine. Interest

in the latter was synonymous with charlatanry and quackery.

Adherence to the organic or physicochemical viewpoint was, and continues to be, dictated also by the difficulty in many cases of differentiating hysteria from, say, multiple sclerosis or brain tumor (especially in their early stages). Conversely, patients with neurological illnesses may also exhibit so-called hysterical behavior or may show signs of other types of mental illness. This problem of the so-called differential diagnosis between "organic" and "psychological" illness has constituted one of the major stumbling blocks in the way of a systematic theory of personal conduct free of brain-mythological components.

Although the problem of malingering will be examined in detail in the next chapter, it is necessary here to say a few words concerning Charcot's view of the relationship between hysteria and malingering. In one of his lectures he said:

> This brings me to say a few words about malingering. It is found in every phase of hysteria and one is surprised at times to admire the ruse, the sagacity, and the unyielding tenacity that especially the women, who are under the influence of a severe neurosis, display in order to deceive . . . especially when the victim of the deceit happens to be a physician.[10]

Already, during Charcot's lifetime and at the height of his fame, it was suggested, particularly by Bernheim, that the phenomena of hysteria were due to suggestion. It was also intimated that Charcot's demonstrations of hysteria were faked, a charge that has since been fully substantiated. Clearly, Charcot's cheating, or his willingness to be duped—whichever it was seems impossible to ascertain now—is a delicate subject. It was called "the slight failing of Charcot" by Pierre Marie. Guillain, more interested in the neurological than in the psychiatric contributions of his hero, minimized Charcot's involvement in and responsibility for faking experi-

ments and demonstrations on hypnotism and hysteria. But he was forced to concede that "Charcot obviously made a mistake in not checking his experiments. . . . Charcot personally never hypnotized a single patient, never checked his experiments and, as a result, was not aware of their inadequacies or of the reasons of their eventual errors."[11]

To speak of "inadequacies" and "errors" here is to indulge in euphemisms. What Guillain described, and what others have previously intimated, was that Charcot's assistants had coached the patients on how to act the role of the hypnotized or hysterical person. Guillain himself tested this hypothesis with the following results:

In 1899, about six years after Charcot's death, I saw as a young intern at the Salpêtrière the old patients of Charcot who were still hospitalized. Many of the women, who were excellent comedians, when they were offered a slight pecuniary remuneration imitated perfectly the major hysteric crises of former times.[12]

Troubled by these facts, Guillain asked himself how this chicanery could come about and how it could have been perpetuated? All of the physicians, Guillain hastened to assure us, "possessed high moral integrity."[13] He then suggested the following explanation:

It seems to me impossible that some of them did not question the unlikelihood of certain contingencies. Why did they not put Charcot on his guard? The only explanation that I can think of, with all the reservation that it carries, is that they did not dare alert Charcot, fearing the violent reactions of the master, who was called the "Caesar of the Salpêtrière."[14]

We must conclude that Charcot's orientation to the problem of hysteria was neither organic nor psychological. He recognized and clearly stated that problems in human relationships may be expressed in hysterical symptoms. The point is that he maintained the medical view in public, for official

purposes, as it were, and espoused the psychological view only in private, where such opinions were safe.

The Definition of Hysteria as Illness: A Strategy

My criticism of Charcot rests not so much on his adherence to a conventional medical model of illness for his interpretation of hysteria as on his covert use of scientific prestige to gain certain social ends. What were these ends? They were the acceptance of the phenomena of hypnotism and hysteria by the medical profession in general, and particularly by the French Academy of Sciences. But at what cost was this acceptance won? This question is rarely raised. As a rule, only the conquest over the resistance of the medical profession is celebrated. Zilboorg describes Charcot's victory over the French Academy as follows:

> These were the ideas which Charcot presented to Académie des Sciences on February 13, 1882, in a paper on the diverse nervous states determined by the hypnotization of hysterics. One must not forget that the Académie had already condemned all research on animal magnetism three times and that it was a veritable *tour de force* to make the Académie accept a long description of absolutely analogous phenomena. They believed, and Charcot himself believed, that this study was far removed from animal magnetism and was a definite condemnation of it. That is why the Académie did not revolt and why they accepted with interest a study which brought to a conclusion the interminable controversy over magnetism, about which the members of the Académie could not fail to have some remorse. And remorse they well might have, for, from the standpoint of the actual facts observed, Charcot did nothing more than what Georget had asked the Académie to do fifty-six years previously. Whether one called the phenomenon animal magnetism, mesmerism, or hypnotism, it stood the test of time. The scientific integrity of the Académie did not. Like a government reluctant, indecisive, and uncertain of itself, it did nothing whenever it was safe to do nothing and yielded only when the pressure

of events forced it to act and the change of formulatory cloak secured its face-saving complacency.[15]

I believe that this "change of formulatory cloak," which secured the admittance of hysteria into the French Academy, constitutes a historical paradigm. Like the influence of an early but significant parental attitude on the life of the individual, it continues to exert a malignant effect on the life of psychiatry.

Such "pathogenic" historical events may be counteracted in one of two ways. The first is by reaction-formation—that is, by an overcompensation against the original influence. Thus, to correct the early organic bias the significance of psychogenic factors in so-called mental illness is exaggerated. Enormous efforts have been expended in modern psychiatry, psychoanalysis, and psychosomatic medicine to create the impression that "mental illness is like any other illness."

The second way to remedy such a "trauma" is exemplified by the psychoanalytic method itself. By helping the person become explicitly aware of the events that have influenced his life in the past, the persistent effects of these events on his future can be mitigated and indeed radically modified. In my epistemological analysis of the problem of mental illness, I have relied in part on the same method and premise—namely, that by becoming explicitly aware of the historical origins and philosophical foundations of current psychiatric ideas and practices, we may be in a better position to modify them than we would be without such self-scrutiny.

2 Illness and Counterfeit Illness

The Logic of Classification

Persons said to be *schizophrenic* often exhibit a certain unconventional manner of using language. For example, such an individual may say that a stag is an Indian, or that he is Jesus. In traditional psychiatry, this sort of behavior is called "schizophrenic thought disorder," and is attributed to the patient's following "primitive" or non-Aristotelian logic.[1] Since both stags and Indians move swiftly, he equates the two and says that stags are Indians; since he wants to be admired and loved like Jesus, he says he is Jesus. In short, such a person uses any kind of likeness or similarity—in appearance or intention—as the basis for classifying objects or ideas as belonging in the same group or as establishing a common identity between them.

In contrast, Aristotelian logic—which psychiatrists often call "normal" or "mature" logic[2]—consists of deductive reasoning of the following sort. From the major premise that "All men are mortals" and the minor premise that "Socrates is a man," we conclude that "Socrates is mortal." This sort of reasoning presupposes an understanding that a class called "man" consists of specific individuals, bearing proper names.

I will show later[3] that the former type of logical operation is intimately connected with a simple type of symbolization,

namely, that resting on a similarity between the object and the sign used to represent it. Such signs are called *iconic*, because they stand for the object represented much as a photograph stands for the person photographed. Languages composed of iconic signs lend themselves to, and are best suited for, codification on the basis of manifest or structural similarities. On the other hand, logically more complex languages, for example those using conventional signs, permit the classification of objects and phenomena on the basis of hidden or functional similarities.

On the Notions of Real and False

Identification and classification are fundamental to the need to order the world about us. The activity of ordering, while of special importance to science, is ubiquitous. For example, we classify some substances as solid, and others as liquid; we call certain objects "money," others "masterpieces of art," and still others "precious stones." Expressed logically, we declare that some things belong in class A, and others in class non-A. In some instances it may be difficult or impossible to establish in what class a particular item belongs. There are two general reasons for this: first, the classifier may lack the knowledge, skill, or tools necessary for distinguishing A from non-A; second, he may deliberately be deceived by other persons into believing that non-A is A. An unsophisticated person may thus misidentify copper as gold. Or a sophisticated art dealer may mistake a forgery for a masterpiece.

Ordinary language recognizes and reveals the importance of the human proclivity to imitate things, making one thing look like another. Many words denote a particular kind of relationship between two items, A and B, so that A signifies a designated object or event, and B signifies what may be called "counterfeit-A." The latter is characterized by looking, more or less, like A, this similarity in appearance being deliberately

created by a human operator for some purpose. For example, money may be "real" or "counterfeit"; a painting or sculpture may be an "original" or a "forgery"; a person may be telling the "truth" or "lying"; an individual complaining of bodily symptoms may be a "sick patient" or a "healthy malingerer."

What is the relevance of this discussion of the logic of classification to hysteria and the problem of mental illness? The answer is that we cannot have a clear and meaningful concept of illness as a class of phenomena (say, class A) without recognizing, first, that there are occurrences which look like illnesses but are not (class B); and second, that there are occurrences which are counterfeit illnesses (class B′). All this is logically inherent in classifying certain phenomena that persons exhibit as illnesses (or as the symptoms of illnesses). If blindness or the paralysis of a leg are diseases—to take the simplest cases—then we must be prepared to deal, epistemologically, medically, and politically, with imitations of blindness and paralysis and with the persons who perform these imitations. Throughout this book I regard bodily diseases as "real" or literal, and consider mental diseases as "counterfeit" or metaphorical illnesses. In the final analysis, whether we classify behaviors that, in some way, however obscure or remote, resemble bodily diseases but are in fact not such diseases as "illnesses" or as "nonillnesses" has, of course, the most profound implications not only for the individuals directly affected, but for the whole social and political system which authenticates the classification.

Illness, Counterfeit Illness, and the Physician's Role

Confronted with a counterfeit, the observer may be deceived because the imitation is very good, because he is relatively unskilled in differentiating A from non-A, or because he wants to believe that non-A is A. Translating this into the

language of bodily versus mental illness, we may assert that the physician may be deceived because certain hysterical or hypochondriacal bodily symptoms might be exceedingly difficult to distinguish from physicochemical disorders; or he may be unskilled in recognizing the manifestations of problems in living and might mistake bodily symptoms for physical illness; or, lastly, committed to the role of expert engineer of the body as a physicochemical machine, the physician may believe that all the human suffering he encounters is illness.

The differentiation of A from non-A rests on empirical *observations* and ends in the rendering of a *judgment.* The observer's role is similar to that of arbiter, umpire, or judge. For example, a painting may be brought to an art expert so that he can decide if it is a Renaissance masterpiece or a forgery. He may correctly identify the painting as falling into one or the other category. Or he may err either way. Or he may decide that he cannot determine whether the painting is an original or a forgery. In medical terms, this corresponds to the well-known "differential diagnosis" between organic and mental disease. In making a differential diagnosis, the physician functions as expert arbiter. If he limits himself to this role, he will simply classify the item brought to him as either A or non-A (including counterfeit-A); in other words, the physician will limit himself to telling the patient that the allegedly or apparently diseased body which he has brought for examination is sick or not sick.[4]

If the observer distinguishes two classes of items, so that he can identify some as members of class A and others as their imitations, he usually has certain reactions to his own judgment. His judgment may then be implemented by appropriate actions toward the items or persons concerned. For example, if money is identified as counterfeit, the police will attempt to arrest the counterfeiters. What will the physician do when confronted with counterfeit bodily illness? The physician's behavior in this situation has varied through the ages. Today,

too, his reaction depends heavily on the personalities and social circumstances of both doctor and patient. I shall comment only on those reactions to this challenge which are pertinent to our present concerns.

1. The physician may react as a policeman confronted by a counterfeiter. This was the usual response before Charcot, when hysteria was regarded as the patient's attempt to deceive the doctor. It was as if the patient had been a counterfeiter who wanted to pass his worthless bills to the physician. Accordingly, the doctor's reaction was anger and a desire to retaliate. For real money—that is, real illness—physicians rewarded people. For fake money—that is, fake illness—they punished them. Many physicians still conduct themselves according to these unwritten rules of the Original Medical Game.

2. The physician may react as a pawnbroker who, trying to avoid loaning money on paste jewelry, behaves as if all his clients wanted to cheat him. The pawnbroker refuses to lend money on imitation jewelry. Similarly, the physician may refuse to treat the so-called hysterical patient. He sends him away, declaring, as it were: "I treat only genuine—bodily—illness; I do not treat fake—hysterical—illness."

3. The physician may react by redefining illness and treatment, that is, by changing the rules of the Original Medical Game. This is what Charcot began and Freud perfected. The change of game-rules thus introduced may be summarized as follows. Under the old rules, illness was defined as a physicochemical disorder of the body which eventually manifested itself in the form of a disability. When disabled, the patient was to be protected and, if possible, treated for his illness; and he was usually excused from working and from other social obligations. On the other hand, when a person imitated being ill and disabled, he was considered and called a malingerer and was to be punished by physicians and social authorities alike. Under the new rules, the attitude toward this latter

group—or at least toward many members of it—was redefined. Henceforth, persons disabled by phenomena that resembled bodily diseases but were in fact not such diseases—in particular so-called hysterics—were also classified as ill—that is, "mentally ill"; and they were to be treated by the same rules that applied to persons who were bodily ill.

I maintain, therefore, that Freud did not *discover* that hysteria was a mental illness. He merely asserted and advocated that so-called hysterics be *declared* ill. The adjectives "mental," "emotional," and "neurotic" are semantic strategies to codify—and, at the same time, to conceal—the differences between two classes of disabilities or "problems" in meeting life: one consists of bodily diseases which, by impairing the functioning of the human body as a machine, create difficulties in social adaptation; the other consists of difficulties in social adaptation not attributable to a malfunctioning machinery but, on the contrary, inherent in the purposes the machine was made to serve by those who "built" it (parents, society) or by those who "use" it (individuals).

Changes in the Rules of Conduct and the Reclassification of Behavior

To illustrate the far-reaching implications of the foregoing process of reclassification, let us return to our analogy between the art expert and the doctor as diagnostician.

The expert may be commissioned to determine whether, for example, a beautiful French painting of uncertain origin was painted by Cézanne, as claimed by the art dealer, or whether it is a forgery, as feared by the prospective buyer. If the expert plays the game properly, he can reach only one of two answers: he concludes either that the painting is a genuine Cézanne or that it is a fake Cézanne.

But suppose that in the process of examining the painting, studying its origin, and so on, the art expert becomes increas-

ingly impressed by the craftsmanship of the artist and by the beauty of his work. Might he then not conclude that, although the painting is not a genuine Cézanne, it is nevertheless a "real masterpiece"? In fact, if the painting is truly excellent, he might even declare that it is a greater masterpiece than a real Cézanne. The artist—let us call him Zeno, hitherto an unknown painter of Greek descent—may then be "discovered" as a "great impressionist painter." But did the expert "discover" Zeno and his masterpiece? Or did he "make" him a famous artist, and his painting a valuable canvas, by the weight of his expert opinion, seconded of course by the weight of many other art experts?

This analogy is intended to show that, strictly speaking, no one discovers or makes a masterpiece. And no one "falls ill with hysteria." Artists paint pictures, and people become, or act, disabled. But the *names,* and hence the *values,* we give to paintings—and to disabilities—depend on the rules of the system of classification that we use. Such rules, however, are not God-given, nor do they occur "naturally." Since all systems of classification are made by people, it is necessary to be aware of who has made the rules and for what purpose. If we fail to take this precaution, we run the risk of remaining unaware of the precise rules we follow, or worse, of mistaking the product of a strategic classification for a "naturally occurring" event. I believe this is exactly what has happened in psychiatry during the past sixty or seventy years, during which time a vast number of occurrences were reclassified as "illnesses." We have thus come to regard addiction, delinquency, divorce, homosexuality, homicide, suicide, and so on almost without limit, as psychiatric illnesses. This is a colossal and costly mistake.

But immediately someone might object that this is not a mistake, for does it not benefit addicts, homosexuals, or so-called criminals to be regarded as "sick"? To be sure, such labeling might benefit some people, sometimes. But this is

so largely because people tolerate uncertainty poorly and insist that misbehavior be classified either as sin or as sickness. This dichotomy must be rejected. Socially deviant or obnoxious behavior may be classified in numerous ways, or may be left unclassified. Placing some physically healthy persons in the class of sick people may indeed be justified by appeals to ethics or politics; but it cannot be justified by appeals to logic or science.

For greater precision, we should ask: for whom, or from what point of view, is it a mistake to classify nonillnesses as illnesses? It is a mistake from the point of view of intellectual integrity and scientific progress. It is also a mistake if we believe that good ends—say, the social rehabilitation of criminals—do *not* justify the use of morally dubious means; in this case, deliberate or quasi-deliberate misrepresentation and mendacity.

This reclassification of nonillnesses as illnesses has, of course, been of special value to physicians and to psychiatry as a profession and social institution. The prestige and power of psychiatrists have been inflated by defining ever more phenomena as falling within the purview of their discipline. Mortimer Adler had noted long ago that psychoanalysts "are trying to swallow everything in psychoanalysis."[5] It is difficult to see why we should permit, much less encourage, such expansionism in a profession and so-called science. In international relations, we no longer treasure the Napoleonic ideal of national expansion at the expense of the integrity of neighboring peoples. Why, then, do we not consider psychiatric expansionism—even though it might be aided and abetted from many sides, that is, by patients, medical organizations, lawyers, and so forth—equally undesirable?

The role of the psychiatrist as expert arbiter charged with deciding who is or is not ill has not ceased with the renaming of malingering as hysteria and with calling the latter an illness. It has merely made his job more arbitrary and nonsensical.[6]

Let us now take a closer look at the logic of reclassifying some nonillnesses as illnesses. On the basis of certain criteria, we may decide to place all A's in one class and all non-A's in another. Subsequently, we may choose to adopt new criteria, revise our classification, and transfer some members of the latter class into the former. It is clear, however, that if we transferred all non-A's into the class of A's, class A would encompass all of the things we want to classify and would therefore be utterly useless. The usefulness of any class and of its name depends on the fact that it includes some things and excludes others. For example, there are many colors, but only a few are called "green." If we called more colors "green" than we now do, we could do so only at the expense of the names of other colors. Emphasizing that it is possible to see not only by green light but also by white, blue, yellow, and so forth, we might indeed insist on calling all colors "green."

It is just this sort of thing that has taken place in medicine and psychiatry during the past century. Beginning with such clear-cut bodily diseases as syphilis, tuberculosis, typhoid fever, cancer, heart failure, and fractures and other injuries, we have created the class called "disease" or "illness." This class had only a limited number of members, all of which shared the common characteristic of reference to a physicochemical state of bodily disorder. This, then, is the *literal meaning* of disease or illness. As time went on, new items were added to this class. Some, like brucellosis or tularemia, were added because new medical methods made the identification of new bodily diseases possible. Others, like hysteria and depression, were added, not because it was discovered that they were bodily diseases, but because the criteria of what constitutes disease have been changed—from the physicochemical derangement of the body to the disability and suffering of the person. This is the *metaphorical meaning* of disease or illness. In this way, at first slowly and soon at an increasingly rapid rate, many new members were added to the

class called disease. Hysteria, hypochondriasis, obsessions, compulsions, depression, schizophrenia, psychopathy, homosexuality—all these and many others thus became diseases. Soon, physicians and psychiatrists were joined by philosophers and journalists, lawyers and laymen, in labeling as "mental illness" any and every kind of human experience or behavior in which they could detect, or to which they could ascribe, "malfunctioning" or suffering. Divorce became an illness because it signaled the failure of marriage; bachelorhood, because it signaled the failure to marry; childlessness, because it signaled the failure to assume the parental role. All these things are now said to be mental illnesses or the symptoms of such illnesses.

Malingering as Mental Illness

The metamorphosis of malingering from the imitation of illness to mental illness illustrates my foregoing thesis.

As we saw, before Charcot entered on the stage of medical history, a person was considered to be ill only if there was something wrong with his body. Persons who imitated illness, or who were thought to imitate illness, were considered to be malingerers and hence the legitimate objects of the physician's scorn. It is, after all, a natural reaction to feel angry toward those who try to deceive us. Why shouldn't physicians feel angry toward those who try to deceive them? This view of malingering made it medically and morally acceptable for physicians to act antagonistically and punitively toward such persons. Although this perspective on malingering is old-fashioned, it is by no means passé: it is still held by respectable physicians and published in prestigious journals—as the following excerpt from the *Journal of the American Medical Association* illustrates:

Physicians in the United States may be unaware of the patient who spends his time going from place to place, resulting in wide travels,

and presenting himself to hospitals, with a fanciful history and extraordinary complaints. It is not uncommon for these patients to have many surgical scars crisscrossing their abdomens, and willingly to allow further surgical procedures to be performed, regardless of the dangers. Publicizing case histories of such patients seems to be the only way of coping with the problem, which exploits medical services that could be put to better use.[7]

The article concludes with the following paragraph:

The case of a 39-year-old merchant seaman is a remarkable example of hospital vagrancy and spurious hemoptysis. Similar patients in Britain have been said to have Münchausen's syndrome because their wide travels and fanciful histories are reminiscent of the travels and adventures of fiction's Baron Münchausen. Such patients constitute an economic threat and an extreme nuisance to the hospital they choose to visit, for their deception invariably results in numerous diagnostic and therapeutic procedures. Publicizing their histories in journals, thereby alerting the medical profession, seems the only effective way of coping with them. Appropriate disposition would be confinement in a mental hospital. Such patients have enough social and mental quirks to merit permanent custodial care, otherwise their exploitation of medical facilities will go on indefinitely.[8]

These excerpts show that physicians often play the medical game without self-reflection, unaware of the rules by which the game is played. It is important to note, also, that the author advocates the "permanent custodial care" as the proper punishment—although he calls it "care"—of those persons who try to deceive physicians into believing they are sick. Since physicians often have the social power to make such punishment enforceable, this view is not without serious consequences.[9]

Freud and the psychoanalysts created a new system of psychiatric classification, especially with respect to hysteria and malingering. Bodily illness remained, of course, class A, so to speak. Hysteria was still regarded as a type of counterfeit

illness, but as a very special form of it: the patient himself did not know he was simulating. And the concept of malingering, too, was retained, but it was redefined as the conscious imitation of illness. Classes B and B′, hysteria and malingering, were thus distinguished by whether the patient's imitative behavior was "unconscious" or "conscious."

The role of the psychiatrist-as-arbiter changed accordingly: previously his task was to distinguish bodily illness from all that did not fit into this class; now it became, in addition, to distinguish the "unconscious" imitation of illness, or hysteria, from the "conscious" imitation of it, or malingering. These judgments are, of course, even more arbitrary than were the previous ones. This is why, in part, the concepts of hysteria, neurosis, and mental illness have come to be used in an increasingly capricious and strategic, rather than consistent and descriptive, way. Typical is Freud's assertion that "There are people who are complete masochists without being neurotic."[10] Of course, Freud never explained which masochists are neurotic and which are not.

The disposition to view virtually all forms of personal conduct—especially if it is unusual or is studied by the psychiatrist—as illness is reflected by the contemporary psychoanalytic view of malingering. According to it, malingering is an illness—in fact, an illness "more serious" than hysteria. This is a curious logical position, for it amounts to nothing less than a complete denial of the human ability to imitate—in this instance, to imitate certain forms of disability. When simulation of mental illness is regarded as itself a form of mental illness, the rules of the psychiatric game are so defined as to explicitly exclude the class of "counterfeit illness." Only two classes are recognized: A—illness, and non-A—nonillness. Counterfeit illness, or malingering, is now defined as itself an illness. The good imitation of a masterpiece is redefined as itself a masterpiece! Since a good imitation of a masterpiece is as pleasing to the eye as the original, this is not an entirely

unreasonable point of view. But it entails a radical redefinition of the idea of forgery. In the case of so-called psychiatric illnesses, such redefinitions have apparently occurred without anyone quite realizing what had happened.

It was probably Bleuler who first suggested that the simulation of insanity be regarded as a manifestation of mental illness. In 1924 he writes: "Those who simulate insanity with some cleverness are nearly all psychopaths and some are actually insane. Demonstration of simulation, therefore, does not at all prove that the patient is mentally sound and responsible for his actions."[11]

The view that malingering is a form of mental illness became popular during the Second World War, especially among American psychiatrists, when it was believed that only a "crazy" or "sick" person would malinger. Eissler's interpretation of malingering is typical of this modern psycho-imperialistic attitude toward moral and political problems of all kinds:

> It can be rightly claimed that malingering is always the sign of a disease often more severe than a neurotic disorder because it concerns an arrest of development at an early phase. It is a disease which to diagnose requires particularly keen diagnostic acumen. The diagnosis should never be made but by the psychiatrist. It is a great mistake to make a patient suffering from the disease liable to prosecution, at least if he falls within the type of personality I have described here.[12]

This proposition has obvious advantages for the physician. For one thing, it buttresses the potentially shaky morale of the erstwhile civilian psychiatrist conscripted into the military service. It supports—at the patient's expense, of course—the physician's uncritical endorsement of the aims and values of the war effort. Although the patient might have been treated more or less kindly when regarded as sick, he was, at the same time, deprived of this particular opportunity to rebel against the demands placed on him. This form of protest was dis-

allowed, and those who resorted to it were labeled "mentally ill" and were given "N.P. discharges."[13]

Concluding Remarks on Objects and Their Representations

The unifying thread that runs through this chapter is the idea of similarity. An iconic sign—say, a photograph—resembles the object it represents; a map represents the terrain of which it is a two-dimensional model. Photographs and maps imply, moreover, that they merely represent "real" things. In everyday life, it makes a vast practical difference whether objects are clearly recognized as representations or are accepted and treated as objects in their own rights. The difference between stage money and counterfeit money illustrates this point. Although stage money might look like real money, it is usually clearly identified as make-believe. It is of course possible to imagine a situation in which stage money is mistaken for real money. My point here is that the context of a message forms an integral part of the total communicational package. Thus, whether bills are regarded as stage money or counterfeit may depend not so much on how the objects appear as on who passed them to whom, where, and how. The stage setting itself implies that the monies used are props. Similarly, the setting of an economic transaction implies that the monies are real, and if they are not real, that they are counterfeit.

Let us apply these considerations to the problem of hysteria. Now it is disabled behavior that is under scrutiny, but the communicational package must include the situation in which such behavior is presented. If it is presented in a physician's office, we must ask: should the disabled behavior be viewed as an object in its own right or as a representation? If the phenomena presented are regarded and treated as real objects, then they must be classified as illness or as malingering, depending solely on one's definition of what constitutes

illness. If, however, the phenomena are regarded as representations—the metaphors, models, or signs of other things—then a totally different interpretation becomes necessary. We may then speak of illness-imitative behavior. This, however, can under no circumstances be called illness unless we are prepared to do the nonsensical thing of placing an item and its known imitation in the same class.

Even if there is agreement that both malingering and hysteria refer to illness-imitative behavior, there still remains the uncertainty concerning the cognitive quality and the intent of the imitation. Is it deliberate or unwitting, conscious or unconscious? Is the person doing the imitation seeking to advance his own interests, or is he doing it for some other reason? In the theater, for example, it is clear that both actors and spectators know that what looks like money is in fact an imitation, a prop. In ordinary life, on the other hand, only the counterfeiters know that the bills they pass to others are counterfeit; those to whom the bills are passed, and who may pass them on to others, do not know this. Believing that they possess a real object when in fact they only possess its imitation, they are deceived.

What, then, is the comparable situation with respect to the imitation of illness? Does the so-called hysterical patient believe that he is "really ill," or does he know that he only "feels ill" but is not? Some insist that the patient offers illness in good faith; others insist that he is faking. There is often evidence to support both of these views. As a rule, the question cannot be answered unequivocally. Indeed, the patient's failure to come to grips with whether he suffers from bodily disease or personal problems, whether his message is about objects or representations, is one of the most important characteristics of his behavior.[14]

So much for the patient, in his role as actor or message sender. What about the spectators, the recipients of the message? Their reaction to the drama of hysteria will depend on

their personality and relationship to the patient. Stranger and relative, foe and friend, nonpsychiatric physician and psychoanalyst—each will react differently. I shall comment briefly on the characteristic reactions of the last two only. The nonpsychiatric physician tends to view and treat all forms of disability as objects proper, not as representations: that is, as illness or potential illness. On the other hand, the psychoanalyst tends to view and treat the same phenomena as representations: that is, as symbols or communications. But since he fails to clearly recognize and articulate this distinction, he persists in describing his observations and interventions as if he were talking about objects instead of representations. The latter are, of course, just as "real" as the former. A photograph of a person is just as real as the person in the flesh. But the two are clearly not the same, and do not belong in the same class.

If we take this distinction seriously, we shall be compelled to regard psychiatry as dealing not with mental illness but with communications. Psychiatry and neurology are therefore not sister sciences, both belonging to the superordinate class called *medicine*. Rather, psychiatry stands in a *meta relation* to neurology and to other branches of medicine. Neurology is concerned with certain parts of the human body and its functions *qua* objects in their own rights—not as signs of other objects. Psychiatry, as defined here, is expressly concerned with signs *qua* signs—not merely with signs as things pointing to objects more real and interesting than they themselves.

3 The Social Context of Medical Practice

Traditionally, psychiatrists have regarded mental illness as a phenomenon apart from and independent of the social context in which it occurred. The symptomatic manifestations of diseases of the body, for instance of diphtheria or syphilis, are indeed independent of the sociopolitical conditions of the country in which they occur. A diphtheritic membrane was the same and looked the same whether it occurred in a patient in Czarist Russia or Victorian England.

Since mental illness was considered to be basically like bodily illness, it was logical that no attention was paid to the social conditions in which the alleged disease occurred. This is not to say that the effects of social conditions on the causation of illness were not appreciated. On the contrary, this sort of relationship had been recognized since antiquity. It was known, for example, that poverty and malnutrition favored the development of tuberculosis, or sexual promiscuity the spread of syphilis; but it was held, and rightly so, that once these diseases made their appearance, their manifestations were the same whether the patient was rich or poor, nobleman or serf. The phenomenology of bodily illness is indeed independent of the socio-economic and political character of the society in which it occurs. But this is emphatically not true for the phenomenology of so-called mental illness, whose manifestations depend upon and vary with the educational, eco-

nomic, religious, social, and political character of the individual and the society in which it occurs.

When persons belonging to different religions or social classes become ill—for example with pneumonia or bronchogenic carcinoma—their bodies display the same sorts of physiological derangements. Hence, for a given bodily disease all patients might, in principle, receive the same treatment. This, indeed, is considered to be the scientifically correct position regarding the treatment of bodily diseases. If mental illnesses are truly like ordinary diseases, it becomes logical, and in fact necessary, to apply the same medical standard of treatment to them. This use of the medical model—namely, the idea that psychiatric treatment must be based on psychiatric diagnosis—has, in my opinion, led to a disastrous abuse of patients.

To demonstrate the importance of social and cultural influences on all therapeutic relationships, and in particular to show the differential effects of such influences on psychiatric interventions, I shall briefly review the therapeutic situations typical of three different socio-cultural settings; namely, the situations characteristic of late-nineteenth-century Europe, of the contemporary Western democracies, and of the Soviet Union.

I shall use the term "therapeutic situation" to refer to both medical and psychotherapeutic practice. And, because the connections between social contexts, moral values, and therapeutic arrangements are numerous and complex, I shall focus on two particular aspects of this problem. They may be best stated in the form of questions: (1) Whose agent is the therapist? (2) How many persons or institutions are directly involved in the therapeutic situation?

Nineteenth-Century Liberalism, Capitalism, and Individualism

Since antiquity, medical care was regarded much as were other economic goods or services. It was a commodity that

could be purchased by the rich only. To the poor, when given, it had to be given free, as charity. This social arrangement was firmly established by the time modern scientific advances in medicine began, during the latter half of the nineteenth century. It should be recalled, too, that this period was characterized by the flowering of liberal thoughts and deeds in Europe, as manifested, for example, by the abolition of serfdom in Austria-Hungary and Russia.

As industrialization and urbanization flourished, the proletariat replaced the socially unorganized peasant class. Thus, a self-conscious and class-conscious capitalism developed, and with it recognition of a new form of mass suffering and disability, namely, poverty. The phenomenon of poverty, as such, was of course nothing new. However, the existence of huge numbers of impoverished people, crowded together within the confines of a city, was something new. At the same time, and undoubtedly out of the need to alleviate mass poverty, there arose "therapists" for this new "disease" of the masses. Among them, Karl Marx is, of course, the best known. He was no solitary phenomenon, however, but rather exemplified a new social role and function—the revolutionary as "social therapist." Along with these developments, the ethics of individualism also gained momentum. The basic value of the individual—as opposed to the interests of the masses or the nation—was emphasized, especially by the upper social classes. The professions, medicine foremost among them, supported the ethics of individualism. This ethic gradually became pitted against its opposite, collectivism.

Although the ethics of individualism and collectivism are polar opposites, their present forms were achieved through a simultaneous development, and they often exist side by side. This was already the case, to some extent, in the days of Charcot, Breuer, and Freud. This contention may be illustrated by some observations concerning the therapeutic situations characteristic of that period.

The physician in Charcot's Paris, or in his counterpart's Berlin, Moscow, or Vienna, was usually engaged in two diametrically opposite types of therapeutic practices or situations. In one, he was confronted by an affluent private patient. Here the physician served, by and large, as the patient's agent, having been hired by him to make a diagnosis and, if possible, achieve a cure. The physician, for his part, demanded payment for services rendered. He thus had an economic incentive, in addition to other incentives, to help his patient. Furthermore, since some bodily illnesses were considered shameful—among these being not only venereal diseases but tuberculosis and certain dermatological ailments as well—a wealthy person could also avail himself of the social protection of privacy. In fact, just as a wealthy person could buy a house large enough to provide several rooms for his sole occupancy, so he could also buy the services of a physician for his sole use. In its extreme form, this amounted to having a personal physician, much as one had a valet, maid, or cook. This custom is by no means extinct. In some parts of the world, wealthy or socially prominent people still have personal physicians whose duty is to care only for them or perhaps their families. A modification of this arrangement is the private, two-person medical situation, which affords the patient the time, effort, and privacy necessary for his care but leaves the physician free to care for other patients within the limits of his available time and energy. The development and safeguarding of therapeutic privacy are, of course, closely tied to the individualistic-capitalist socio-economic system. Such privacy cannot be maintained, and is even officially devalued, in collectivistic-communist societies, where the physician's primary loyalty is to the state rather than to the patient.

It is implicit in this discussion that having access to a private therapeutic relationship is something desirable. Why is this so? The answer lies in the connections between illness or disability and shame, and between shame and privacy. The

feeling of shame is closely related to what other people think of one. Exposure and humiliation are feared both as punishments for shameful acts and as stimuli for increasingly intense feelings of shame. Secrecy and privacy protect the person from public exposure and hence from shame. Regardless of whether the shame is occasioned by physical disability, psychological conflict, or moral weakness, it is more easily acknowledged if it is shared with only a single person—as it is in the confessional or in private psychotherapy—than if it is communicated to many people. Privacy in medical or psychotherapeutic relationships is thus useful because it protects the patient from undue embarrassment and humiliation, and thus facilitates psychological mastery of his problem.

In addition, privacy and secrecy in the therapeutic situation are desirable and necessary also to protect the patient from "real"—that is, social rather than emotional—harm. Social isolation and ostracism, loss of employment, and injury to family and social status are some of the hazards that threaten a person should his condition or diagnosis become public knowledge. In this connection, such possibilities as syphilis in a schoolteacher, psoriasis in a cook, or schizophrenia in a judge should be kept in mind. These, however, are merely illustrative examples. The possibilities both of reward and penalty for publicly established diagnoses are virtually limitless. The precise character of the rewards and penalties will vary, once again, with the moral, political, and scientific character of the society.

The second type of therapeutic situation I want to consider is charity practice. The differences between it and private practice are often overlooked as a result of concentrating on the patient's disease and the physician's alleged desire to cure it. In traditional charity practice, the physician was not the patient's agent. Hence, a truly confidential relationship between patient and physician could not develop. The physician was professionally and legally responsible to his superiors and

employers. He was, therefore, bound to orient himself for his rewards, at least to some extent, to his employer, rather than to his patient. It is often maintained nowadays that removing the financial involvement with the patient enables the physician better to concentrate on the technical task at hand—provided that he is adequately remunerated. While this might be true in thoracic surgery, it is assuredly not true in psychotherapy. In any case, it is clear that the financial inducement which the private patient offers the physician is absent in charity practice. The main features of these two types of therapeutic situations are summarized in Table 1.

The contrast between private and public medical care is often represented as if it were like the difference between a palace and a hovel. One is fine and expensive; anyone who could afford it would be foolish if he did not secure it, especially if he needed it. The other is inferior and second-rate; at

Table 1. Private Versus Charity Practice

Characteristics of the Situation	*Private Practice*	*Charity Practice*
Number of participants	Two (or few) Two-person situation "Private"	Many Multiperson situation "Public"
Whose agent is the therapist?	Patient's Patient's guardian's (e.g., pediatrics) Patient's family's	Employer's (e.g. institution, state, etc.)
Sources and nature of the therapist's rewards	Patient: money, referrals, etc.	Employer: money, promotion, prestige through status
	Patient's relatives and friends: satisfaction from having helped Self: satisfaction from mastery Colleagues: satisfaction from proven competence	Patient's relatives and friends: satisfaction from having helped Self: satisfaction from mastery Colleagues: satisfaction from proven competence

best, it makes life livable. Hence, although physicians and politicians have tried to assure the poor that their medical care was equally as good as that of the rich, this pious message usually fell on deaf ears. Instead, people have tried to raise their standard of living. In this effort, so far the people of the United States, Japan, and some European countries have been the most successful. This has resulted in certain fundamental changes in the patterns of medical care—and hence in the sociology of the therapeutic situation—in these countries. I shall comment on these changes now, and shall then consider the socio-medical situation in the Soviet Union.

Contemporary Society and Its Pattern of Health Care

Progressive technological and socio-cultural sophistication has led to the development of several means of protection against future poverty, want, and helplessness. One of these is insurance. We shall here be especially concerned with the effects of health insurance on medical and psychotherapeutic relationships.

Insured Practice

From our present point of view it matters little whether protection from illness is guaranteed for the individual by a private insurance company or is furnished by the state.

Health insurance introduces a completely new phenomenon into the practice of medicine. The most significant feature of insured practice—a name which I suggest to distinguish it from both private and charity practice—is that it is neither private nor public. The physician-patient relationship is so structured that the doctor is neither the patient's sole agent nor that of a charitable institution. This arrangement cannot

be reduced to the old patterns of medical care and cannot be understood in their terms. It is commonly believed that the insured situation does not differ significantly from the private practice situation, the only difference being that the physician is paid by the insurance company instead of by the patient. Rarely is insured medicine regarded as similar to charity practice. I submit, however, that there are more important similarities between insured and charity practice than between insured and private practice. For the insurance arrangement, like the charitable one, makes a two-person, confidential relationship between doctor and patient virtually impossible.

Without penetrating further into the sociological intricacies of insured medicine, I should like to offer some generalizations which may be useful for our understanding of the problem of mental illness. It appears to be a general rule that the more clear-cut, objective, or socially acceptable a patient's disease is, the more closely insured practice resembles private practice. For example, if a woman slips on a banana peel in her kitchen and fractures her ankle, her treatment may not be significantly influenced by who pays for it—she, or an insurance company, or the state.

On the other hand, the more an illness deviates from something that happens to a person, and the more it is something that the person does or makes happen, the greater are the differences between the insured situation and the private, two-person situation. For example, if a woman falls in a factory rather than in her kitchen, she will not only receive compensation for her injury, but will also be granted a medical excuse to stay away from work. Furthermore, if she has a young child at home whom she would like to care for herself, she will have a powerful incentive to be disabled for a longer period than she might be otherwise. Obviously, this sort of situation requires an arbiter or judge to decide whether a person is or is not sick and disabled. The physician is the logical candidate

for this role. It may be argued that physicians in private practice also perform this task. But this is not so. The physician in private practice is primarily the patient's agent. Should there be a conflict between his opinion and the presumed "real facts"—as may occur when the patient is involved with draft boards, insurance companies, or industrial concerns—the latter groups rely on the judgments of their own physicians. In the case of the draft board, for example, the examining physician has absolute power to overrule a private physician's opinion. And if he does not have such power, as in the case of an industrial concern, the conflict of opinion is arbitrated in a court of law.

In the case of insured practice, the answer to the question, Whose agent is the physician? is not—and indeed cannot be—clearly defined. As a result, the physician may sometimes be for the patient and sometimes against him—it being understood that "for" and "against" are here used in accordance with the patient's judgments of his own needs and wants.

In short, so-called mental illnesses share only a single significant characteristic with bodily diseases: the sufferer or "sick person" is, or claims to be, more or less disabled from performing certain activities. The two differ from one another in that mental illnesses can be understood only if they are viewed as occurrences that do not merely happen to a person but rather are brought about by him (perhaps unconsciously or unwittingly), and hence are of some value to him. This assumption is unnecessary—indeed, it is unsupportable—in the typical cases of bodily illness.

The premise that the behavior of persons said to be mentally ill is meaningful and goal-directed—provided one is able to understand the patient's behavior from his particular point of view—underlies virtually all forms of psychotherapy. Furthermore, if the psychotherapist is to perform his task properly, he must not be influenced by socially distracting considerations concerning his patient. This condition can be met

best if the relationship is rigidly restricted to the two people involved in it.

The Private Practice Situation

It is necessary now to refine our conception of private practice. So far I have used this term in its conventional sense, to denote the medical activities of any physician not employed by an agency, institution, or the state. According to this definition, such a physician is engaged in private practice regardless of how he is paid or by whom. This definition will no longer suffice. Instead, we shall now have to adopt a much stricter definition of private practice. I suggest that we define the Private Practice Situation as a contract between a patient and a physician: the patient hires the doctor to assist him with his own health care and pays him for it. If the physician is hired by someone other than the patient, or is paid by another party, the medical relationship will no longer fall in the category of Private Practice Situation. This definition highlights, first, the two-person nature of the relationship; and second, the autonomy and self-determination of the patient. I shall continue to use the expression "private practice" in its conventional sense, to refer to all types of noncharity, noninstitutional practice; and shall reserve the term Private Practice Situation (with initials capitalized) to designate the two-person therapeutic situation (see Table 2).

It is important to note, in this connection, that affluence fosters not only health insurance but also private practice. In the United States, a considerable proportion of the latter is psychiatric or psychotherapeutic practice. This proportion becomes even more significant if it is considered not in relation to the general category of private practice, but rather in relation to the narrowly defined Private Practice Situation. Psychotherapeutic practice is, indeed, the most important contemporary representative of a truly two-person therapeutic

Table 2. Private Practice Situation Versus Insured Practice

Characteristics of the Situation	*Private Practice Situation*	*Insured Practice*
Number of participants	Two Two-person situation	Three or more Multiperson situation
Whose agent is the therapist?	Patient's	Therapist's role is poorly defined and ambiguous: Patient's agent, when in agreement with his aspirations Society's agent, when in disagreement with patient's aspirations His own agent, trying to maximize his own gains (e.g., compensation cases)
Sources and nature of therapist's rewards	Patient: money, referrals, etc. Self: satisfaction from mastery Colleagues	Patient: cure, gratitude, etc. Self: satisfaction from mastery Colleagues System or state: money, promotion, etc.

relationship. Deterioration in the privacy of the traditional medical situation may in fact be one of the reasons for the increased demand for psychotherapeutic services. Since the general physician ceased to be the true representative of the patient, the suffering person has turned to the psychiatrist and to the nonmedical psychotherapist as new representatives of his best interests.

To be sure, increasing economic affluence also serves to stimulate the demand for psychotherapeutic services. As soon as people have more money than they need for whatever they

consider the necessities of life, they expect to be happy. And since most people still will not be happy, some will use some of their money to seek happiness through psychotherapy. From this point of view, the social function of psychotherapy is similar not only to that of religion, but also to that of alcohol, tobacco, cosmetics, and various recreational activities.

These considerations touch on the relationship between social class, mental illness, and the type of treatment received for it. It has always been known that educated, rich, and important persons receive very different kinds of psychiatric treatments than do uneducated, poor, and unimportant persons. The validity of this impression was solidly established by the careful studies of Hollingshead and Redlich,[1] who demonstrated that, in the United States, affluent psychiatric patients are generally treated by psychotherapy, while poor patients are treated by physical interventions.

The over-all social impact of economic affluence on medicine generally, and on psychiatry in particular, is complex and contradictory; it seems both to promote and to inhibit the free play of a confidential two-person therapeutic situation. Better education and economic security favor the conditions necessary for a two-person therapeutic contract; whereas the spread of insured health protection and government-sponsored medical care impair the conditions necessary for it. It is also worth noting that while the Private Practice Situation is being displaced by patterns of insured care in the democracies, in the Soviet Union it was liquidated when physicians became state employees. I shall now turn to a survey of medical practice in Soviet Russia. This will help us to sharpen the contrast between the role of the physician as agent of the patient and as agent of the state.

Soviet Medicine

Most of the Russian people depend on medical services furnished by the state. Private practice exists but is available only

to persons occupying the uppermost layers of the Soviet social pyramid. One of the characteristic features of the Russian medical scheme is the consequence of the government's strong emphasis on agricultural and industrial production. The necessity of hard work is impressed on the people in every possible way. It follows that those who wish to avoid working find in falling sick and remaining disabled one of the few means of escape from what they experience as a sort of enslavement. Since the presence of genuine illness is not always obvious to the layman, it falls upon the physician to act as expert arbiter: he must decide which persons claiming to be ill are "really ill," and which only "malinger." Here is how Field describes this situation:

It stands to reason that certification of illness cannot be left, under most circumstances, to the person who claims to be sick. This would make abuses too easy. It is the physician, then, as the only person technically qualified to do so, who must "legitimize" or "certify" sickness in the eyes of society. This means, in turn, that abuses of the patient's role will consist in conveying to the physician the impression that one's sickness is independent of one's conscious motivation—whereas it actually is not. This possibility beclouds the classical assumption that the person who comes to the physician must necessarily be sick (independently of motivation): on the contrary, in certain cases, just the opposite assumption may be held. . . . [A] society (or social group) which, for any number of reasons, cannot offer its members sufficient incentives of motivation for the faithful and spontaneous performances of their social obligations must rely on coercion to obtain such performances. Because of the presence of coercion such a society will also generate a high incidence of deviant behavior to escape coercion. Simulation of illness (technically known as malingering) will be one form of such behavior. Malingering can be considered as a medical, a social, and a legal problem. It is a medical problem only insofar as it is the physician's task to certify who is a *bona fide* patient and who is a faker. It is a social problem insofar as the assumption that the person who comes to the physician must neces-

sarily be sick (independently of motivation) is no longer tenable. The opposite assumption may sometimes be just as valid. It is often a legal problem because a fraud has been perpetrated.

Malingering may have far-reaching consequences because the "business" of society (or the group) is not done and because ordinary social sanctions are inadequate to close this escape valve. This means, in turn, that some provision must be made, some mechanism devised, to control the granting of medical dispensations. The logical point at which to apply this control is the physician.[2]

Field further notes that, because of a widespread anxiety among physicians that every patient is a potential spy or *agent provocateur,* doctors are afraid to be lenient with individuals who do not suffer from objectively demonstrable diseases.

Most Russian physicians are women, and their social status is relatively low—comparable to that of American schoolteachers or social workers. Indeed, the members of these three groups share an important feature: each of them functions as an *agent of society*. In other words, persons fulfilling these roles are employed by the government or the state to minister to the "needs" of certain socially defined and designated groups—for example, schoolchildren, persons on relief, the sick, and so forth. These agents—who are quite literally "social workers"—are generally not sought out, and are never paid, by their customers, clients, or patients, and hence do not owe their primary loyalties to them. In fact, they may not feel that they owe any loyalty to their clients at all, whom they may regard more as wicked persons to be controlled than as sick persons to be treated.

A revealing similarity between the role of the modern Soviet physician on the one hand, and that of the nineteenth-century European physician doing charity work on the other hand, now emerges. Both were given to diagnosing many of their patients as malingerers. The reasons for this are now evident: in each case the physician is an agent of society (or

of some social agency) and not of the patient; and in each case the physician tacitly espouses and supports society's dominant values, especially as these relate to the patient's "proper role" in the group. The Soviet physician is identified with, and serves the interests of, the communist state: he believes, for example, that hard work where "one is needed" is necessary for the welfare of both the individual and society. Similarly, the nineteenth-century European physician was identified with, and often served the interests of, the capitalist state: he believed, for example, that the woman's duty was to be wife and mother. Escape from either role—that is, from that of downtrodden worker or downtrodden wife—was and is left open along only a few routes, illness and disability being perhaps the most important among them.

In his study of Soviet medicine, Field remarks on how intensely the Russian physician is committed to the role of agent of society, if necessary in opposition to the personal needs of any particular patient:

> It is perhaps significant to note that the Hippocratic oath, which was taken by tsarist doctors (as it is in the West), was abolished after the revolution because it "symbolized" bourgeois medicine and was considered incompatible with the spirit of Soviet medicine. "If," continues a Soviet commentator in the *Medical Worker,* "the prerevolutionary physician was proud of the fact that for him 'medicine' and nothing else existed, the Soviet doctor on the other hand is proud of the fact that he actively participated in the building of socialism. He is a worker of the state, a servant of the people . . . the patient is not only a person, but a member of socialist society."[3]

The Hippocratic oath was abolished, I submit, not because it symbolized "bourgeois medicine"—for charity practice is as much a part of bourgeois medicine as private practice—but rather because the oath tends to define the physician as an agent of the patient. For the Hippocratic oath is, among other things, a Bill of Rights for the patient. In short, the conflict

Table 3. Western Versus Soviet Practice

Characteristics of the Situation	*Western Practice*	*Soviet Practice*
Number of participants	Two or few Private, insured, state-supported	Many State-supported
Whose agent is the therapist?	Patient's Employer's His own	Society's Patient's (insofar as patient is positively identified with the values of the state)
	Physician's role is ambiguous	Physician's role is clearly defined as agent of society
Ethical basis of therapeutic actions	Individualistic	Collectivistic
Relative social status of physician	High	Low

with which the Russian physician struggles is an ancient one—the conflict between individualism and collectivism. (A brief summary of the contrasting characteristics of Western and Soviet medical systems is presented in Table 3.)

The Significance of Privacy in the Physician-Patient Relationship

Two features of Soviet medicine—first, the Russian physician's fear lest by being sympathetic with an agent-provocateur-malingerer he bring ruin on himself, and second, the abolition of the Hippocratic oath—make it necessary to examine further the role of privacy in the therapeutic situation. The first shows that the privacy of the physician-patient relationship is not solely for the benefit of the patient. The belief that it is stems, in part, from the Hippocratic oath, which explicitly commands that the physician not abuse his patient's trusted communications. The contemporary legal definition of confi-

dential communications to physicians lends support to this view, since it gives the patient the power to waive confidentiality. The patient "owns" his confidential communications: he can, to a large extent, control when and how they will be used.

However, in the psychoanalytic situation—at least as I understand it[4]—the contract is that the therapist will not communicate with others, regardless of whether or not the patient gives permission for the release of information. Indeed, even the patient's explicit request for such action on the part of the analyst must be denied if the two-person, confidential character of the relationship is to be preserved.

The common-sense view that confidentiality serves solely the patient's interests makes it easy to overlook that the privacy of the physician-patient relationship provides indispensable protection for the therapist as well. By making the patient a responsible participant in his own treatment, the therapist is to a very large extent protected against the patient's accusations of wrongdoing. If the patient is kept at all times fully informed as to the nature of the treatment, it becomes largely his responsibility to assess his therapist's performance, to make his demands known, and to leave his therapist if he is dissatisfied with him.

In short, the private, two-person therapeutic situation maximizes mutuality and cooperation in the relationship between the participants; whereas the public, multiperson therapeutic situation maximizes deception and coercion in the relationship among them. In Western institutional psychiatry as well as in Soviet medicine, physicians and patients can thus force one another to do things they do not want to do: for example, physicians can coerce patients by "certifying" them as insane, or by certifying or refusing to certify that they are genuinely ill; and patients, in retaliation as it were, can sue physicians for illegally imprisoning them, or can denounce them to the authorities on a wide variety of charges.[5]

These considerations also help to account for the nonexis-

tence of psychoanalysis, or of any other type of confidential psychotherapy, in the Soviet Union. The communists attribute their antagonism to these practices to the various theoretical claims of psychotherapists. It seems to me, however, that the reason for the conflict between psychoanalysis (and other forms of confidential psychotherapy) and communism lies simply in the fact that, in a collectivist society, therapeutic privacy poses an intolerable affront against the core-value of the political system.

The Physician and the Poor

The roots of the physician's role as "social worker" may be traced to antiquity. The fusion of priestly and medical functions made for a strong bond which was split asunder only in recent times—then to be reunited, explicitly in Christian Science, implicitly in some aspects of charity practice, psychotherapy, and Soviet medicine. Rudolf Virchow (1821–1902), the great German pathologist, supposedly asserted that "The physicians are the natural attorneys of the poor."[6] This concept of the physician's role must now be scrutinized and challenged. There is, of course, nothing "natural" about it; nor is it clear why it should be desirable for doctors to act as if they were attorneys.

I have suggested earlier[7] that the change from diagnosing some persons as malingerers to diagnosing them as hysterics was not a medical act, but rather an act of social promotion. Charcot had indeed acted as an "attorney for the poor." Since then, however, social developments in Western countries have resulted in the creation of social organizations whose explicit duty is to be "attorneys for the poor." Socialism and communism were among the earliest of these. There were many others as well—the labor unions, social work agencies, private philanthropies, and so forth. The modern, scientifically trained and equipped physician may have many duties, but being the protector of the poor and oppressed is hardly one of them. In

the United States, the poor and downtrodden have their own representatives, and the American Medical Association is not one of them. They have, instead, the Salvation Army, the National Association for the Advancement of Colored People, and a host of other organizations. If we value explicitness and honesty in such matters, then this is all to the good. If an individual or group wishes to act in behalf of the interests of the poor—or the Negro, the Jew, the immigrant, etc.—it is desirable that this be made clear. By what right and reason, then, do physicians arrogate to themselves—as physicians—the role of protectors of this or that group? Ironically, among contemporary physicians, it is the psychiatrist who, more than any other specialist, has assumed the mantle of protector of the downtrodden.

Concurrently with the development of appropriate social roles and institutions for the protection of the poor, the medical profession has witnessed the development of countless new diagnostic and therapeutic techniques. For two good reasons, then, it is now quite unnecessary and inappropriate for the physician to function as an "attorney for the poor." First, the poor have genuine attorneys of their own and hence need no longer to cheat their way to humane treatment by means of faking illness. Second, as the technical tasks which the physician is expected to perform have become more complex and difficult—that is, as modern pharmacotherapy, radiology, hematology, surgery, and so forth have evolved—the physician's role became more sharply defined by the particular technical operations in which he actually engages.[8] Hence, most contemporary physicians have neither the time nor the inclination to act as "attorneys for the poor."

Medical Care as a Form of Social Control

It is evident that anything that affects large numbers of people and over which the government or the state has control may

be used as a form of social control. In the United States, for example, taxation may be used to encourage or inhibit the consumption of certain goods. In the Soviet Union, medicine may be used to control personal conduct and mold society in a desired direction. Moreover, just as taxation is also used as a method of social control in Russia, so medicine is also used in this way in the United States.

I have remarked already on the similarities between Soviet medicine and American social work. Both are, fundamentally, systems of social care and control. Both meet certain personal and social needs, while, at the same time, both may be used—and, indeed, are used—to exert a subtle but immensely powerful control over those cared for. Both systems are thus admirably suited for "gently" keeping "in line" the discontented and dissenting members or groups of society.

Employing medical care in such an ambivalent manner—that is, to care for some of the patient's needs and at the same time to oppress him—is not a new phenomenon invented in the Soviet Union. It was flourishing in Czarist Russia as well as in nineteenth-century Europe. The severity of life in Czarist prisons—and perhaps in jails everywhere—was mitigated by the intercessions of a relatively benevolent medical personnel, the latter themselves constituting an integral part of the prison system.[9] This sort of arrangement was and is extremely common; we are, therefore, justified in placing a far-reaching interpretation on it. It is, I believe, a characteristic example of the way tensions generated in an oppressive social system are managed—and tranquilized, as it were. This sort of homeostasis is displayed perhaps most obviously for us today in the classic autocratic-patriarchal family—where the father is a brutal tyrant, cruel and punitive toward his children, domineering and deprecatory toward his wife; and the mother is gentle, kind, and all-suffering, who, through her protective intercessions, makes life bearable for the children. The Soviet state, ever-menacing and demanding of work and sacrifice, is

like such a father; the Soviet physician and medical system, like such a mother; and the Soviet citizen, like a child in such a family.

In such a system, the protector—whether doctor or mother—not only shields the victim from the victimizer, but, by virtue of his or her very intervention, also shields the victimizer from the potentially more fully developed wrath of the victim. Such an intermediary thus serves to maintain a familial or political homeostasis, whose disruption may in turn depend heavily on the breakdown or cessation of the role of the intermediary.

The Soviet medical arrangement also represents a dramatic re-enactment of the basic human problem of dealing with so-called good and bad objects. The autocratic patriarchal family structure just mentioned offers a simple but quite effective solution for this problem. Instead of fostering the synthesis of love and hate for the same persons, with subsequent recognition of the complexities of human relationships, the arrangement permits and even encourages the child—and later the adult—to live in a world of devils and saints: the father is a monster, the mother a madonna.[10] This, in turn, leads the grown child to feeling torn between boundless righteousness and bottomless guilt. In Russia, communism is the idealized, nurturing-protective mother, the perfect "good object"; and, if need be, the physician is the perfect "bad object." Medical care in Russia is supposed to be both free and faultless; if it fails to fulfill these promises, the blame lies with the physician. Once again, the citizen-patient is caught in the struggle between good and evil, the glorified state and the vilified doctor. This view is supported by the fact that the Russian press gives much space to public accusations against physicians.[11] Although these complaints may be loud, the complainants have no real power. The Russian patient, unlike his American counterpart, cannot sue his doctor for malpractice, as doing so would be tantamount to suing the Soviet state itself. The

relationship in Russia between doctors and patients continues to exemplify the wisdom of the old proverb that "He who pays the piper may call the tune": this arrangement—which gives enough power to both patients and doctors to harass each other, but not enough to alter their own situation—thus serves best the government that supports it.

The famous "doctors' plot" of early 1953 lends further support to the foregoing interpretation.[12] It was alleged then that a group of highly placed physicians—for good measure, many of them Jewish—had murdered several high-ranking Soviet officials and were also responsible for Stalin's rapidly declining health. After Stalin's death, the plot was branded a fabrication. The point I want to emphasize here is that, whatever might have been the specific political conflicts that triggered these charges, physicians—the erstwhile co-architects of the Soviet state[13]—were now accused of destroying the very edifice they had been commissioned to build.

In sum, I have tried to show that therapeutic interventions have two faces: one is to heal the sick, the other is to control the wicked. Since sickness is often considered to be a form of wickedness, and wickedness a form of sickness, contemporary medical practices—in all countries regardless of their political makeup—often consist of complicated combinations of treatment and social control. The temptation to embrace all medical interventions as forms of therapy, or to reject them all as forms of social control, must be firmly resisted. It behooves us, instead, to discriminate intelligently and to describe honestly the things doctors do to cure the sick and the things they do to control the deviant.

II

HYSTERIA: AN EXAMPLE OF THE MYTH

■

4 Breuer and Freud's *Studies on Hysteria*

The Historical Background

Freud's studies under Charcot centered on the problem of hysteria. When he returned to Vienna in 1886 and settled down to establish a practice in so-called nervous diseases, a large proportion of his clientele consisted of cases of hysteria.[1] Then, even as today, the hysterical patient presented a serious challenge to the physician whom he or she consulted. The comfortable and safe course lay in adhering to accepted medical attitudes and following established procedures. This meant that the patient as a person could be the object of sympathy, but could not be the object of medical or scientific interest. Medical science was interested only in afflictions of the body. Personal problems—problems of human living or existence—were either ignored or treated as if they were the manifestations of physical illnesses. Living and working in this setting, Breuer and Freud's singular achievement lay in adopting an attitude toward neurotic suffering that was at once humane and inquiring, compassionate and critical. Their actual observations still merit the closest possible attention; at the same time, we must bear in mind that most contemporary

physicians and psychiatrists practice under entirely different circumstances.

It is often said that psychoanalysts no longer encounter the type of "hysterical illness" described by Breuer and Freud. This alleged change in, or even the disappearance of, hysteria is usually attributed to cultural changes, especially to a lessening of sexual repressions and to the social emancipation of women. Be that as it may, the social role of the physician has also changed. Thus, although it is true that psychoanalysts in their private offices rarely if ever encounter so-called classical cases of hysteria, general practitioners and various specialists in large medical centers do.[2] Indeed, there is little doubt that hysteria, much as Breuer and Freud described it, is still prevalent in America as well as in Europe. However, those who "suffer" from it do not, as a rule, consult psychiatrists or psychoanalysts. Instead, they consult their family physicians or internists and are then referred to neurologists, neurosurgeons, orthopedic and general surgeons, and other nonpsychiatric specialists. These physicians rarely define such a patient's difficulty as psychiatric. To do that would require redefining the patient's "illness" as personal rather than medical, a task they are, understandably, not eager to undertake.

Physicians also fear missing an "organic diagnosis." They tend to distrust psychiatry and psychiatrists and find it difficult to understand what psychotherapists do. These are the main reasons why hysterical patients have become relatively rare in private psychiatric practice. Finally, for reasons to be discussed later, conversion hysteria tends nowadays to be an affliction of relatively uneducated, lower-class persons. Hence, they are encountered least often in the private offices of psychoanalysts and most often in free or low-cost clinics or in state hospitals. The few hysterics who do finally consult a psychotherapist will have had so many medical and surgical

experiences that they will no longer communicate in the pure language of "classical hysteria."

A Re-examination of the Observations

In their classic study, Breuer and Freud cite many examples of persons complaining of various bodily feelings, usually of an unpleasant nature. They mystify and prejudge the problem before them, however, by accepting all such persons as "patients," by regarding their complaints as "symptoms," and by viewing these symptoms as the manifestations of some obscure disorder in the physiochemical machinery of the complainant's body. In other words, Freud assumed and wrote as if everyone who consulted him as a patient were a patient. He thus failed to ask, Is the person sick? and asked instead, In what way is he or she sick? His observations were thus systematically misdescribed, as the following excerpt illustrates:

> A highly intelligent man was present while his brother had an ankylosed hip-joint extended under an anaesthetic. At the instant at which the joint gave way with a crack, he felt a violent pain in his own hip-joint, which persisted for nearly a year. Further instances could be quoted. In other cases, the connection is not so simple. It consists only in what might be called a "symbolic" relation between the precipitating cause and the pathological phenomenon—a relation such as healthy people form in dreams. For instance, a neuralgia may follow upon mental pain or vomiting upon a feeling of moral disgust. We have studied patients who used to make the most copious use of this sort of symbolization.[3]

Freud speaks here in a language that is a complicated mixture of object and metalanguages[4]—of things one can observe and of things one cannot. For example, it is possible to observe a person who vomits or who is in pain or is disgusted; but it is impossible to observe a person who has "mental pain" or feels "moral disgust."[5]

Further, Freud speaks of "neuralgia" when he really means

"like neuralgia"; the former implies that the person has some sort of neurological disease, a disorder of his bodily machinery; the latter implies only that the pain resembles neuralgia and may or may not signify the presence of a bodily disease.

Although Freud regarded hysteria as a disease, he clearly understood it far better than his language allowed him to express it. He was in a sort of semantic and epistemological straitjacket from which he freed himself only rarely and for brief periods. The following passage is an example of description in plain language, unencumbered by the need to impress the reader that the "patient" is truly ill and a genuine patient:

> Here, then, was the unhappy story of this proud girl with her longing for love. Unreconciled to her fate, embittered by the failure of all her little schemes for reestablishing the family's former glories, with those she loved dead or gone away or estranged, unready to take refuge in the love of some unknown man—she had lived for eighteen months in almost complete seclusion, with nothing to occupy her but the care of her mother and her own pains.[6]

But where is the "illness" in this passage—or "patient"? Freud lets the cat out of the bag here and provides his critics with ammunition to justify their charge that he is not a "real doctor" dealing with genuinely sick patients; in other words, that he, Freud, does not identify and treat diseases of organisms or bodies, as they do—but discourses on the troubles and unhappiness of human beings or persons, as moralists and writers do.

In Freud's day, the medicalization of personal problems was rooted in part also in the perennial dilemma which doctors faced in connection with so-called hysterical patients—namely, having to decide whether the patient had an organic illness or "only" hysteria. The business of having to make a "differential diagnosis" was never far from the mind of the young Freud or his neuropsychiatric colleagues. He men-

tions—with unconcealed and indeed justifiable pride—a "case" referred to him as one of hysteria in which he made the correct diagnosis of a neurological disease.[7] The presumption that every person who consults a doctor is sick was also consistent with and supported the presumption that the physician's first task is to make a differential diagnosis. Whereas formerly this often involved distinguishing between real and faked illness, in Freud's day it meant mainly distinguishing between organic and functional illness or between bodily and mental illness—and, in particular, between neurological illness and conversion hysteria. The following excerpt is illustrative:

In the autumn of 1892, I was asked by a doctor I knew to examine a young lady who had been suffering for more than two years from pains in her legs and who had difficulties in walking. All that was apparent was that she complained of great pain in walking and of being quickly overcome by fatigue both in walking and in standing, and that after a short time she had to rest, which lessened the pains but did not do away with them altogether . . . I did not find it easy to arrive at a diagnosis, but I decided for two reasons to assent to the one proposed by my colleague, viz., that it was a case of hysteria.[8]

Why this was a case of hysteria rather than a case of malingering or a case of no disease at all, Freud never says. In the passages cited, Freud describes an unhappy young woman and the bodily feelings and complaints by means of which she communicates her unhappiness—to herself and others. And elsewhere he remarks on how his work resembles the biographer's more than the regular physician's.[9] In short, if we stick to Breuer and Freud's observations as closely as possible, we would have to say that their patients were unhappy or troubled persons who expressed their distress through various bodily complaints. In none of these cases was there any evidence that that patient suffered from an anatomical or physiological disorder of his or her body. This did not deter Breuer

and Freud, however, from entertaining an "organic" hypothesis regarding the "cause" of this "disease."

A Re-examination of the Theory

In his discussion of the case of Fräulein Elizabeth von R., Freud explains his original conception of hysterical conversion in this way:

> According to the view suggested by the conversion theory of hysteria, what happened may be described as follows: She repressed her erotic idea from consciousness and transformed the amount of its affect into physical sensations of pain.

> This theory calls for closer examination. We may ask: What is it that turns into physical pain here? A cautious reply would be: Something that might have become, and should have become, mental pain. If we venture a little further and try to represent the ideational mechanism in a kind of algebraical picture, we may attribute a certain quota of affect to the ideational complex of these erotic feelings which remained unconscious, and say that this quantity (the quota of affect) is what was converted.[10]

Here, then, is the problem of conversion hysteria in *statu nascendi.* Freud asks: What is being converted (to physical pain)? Why does the patient have physical pain? Implied are the additional questions: What causes conversion? How does a conflict, or affect, become converted to physical pain?

Freud answers these questions by taking recourse to what Colby has aptly called a "hydraulic metaphor."[11] It seems evident, however, that no such complicated explanation is required. All that is necessary is to frame our questions differently. We might then ask: Why does a patient complain of pain? Why does the patient complain about his or her body when it is physically intact? Why does the patient not complain about personal troubles? If we ask the second set of questions, then the answers must be phrased in terms of the

complainant's personality and situation. Actually, Breuer and Freud's accounts of their patients go far in answering these questions.

How profoundly the idea of hysterical complaints as symptoms of bodily diseases has confused rather than clarified our problems is illustrated by the following passage:

> The mechanism was that of conversion: i.e., in place of mental pains which she avoided, physical pains made their appearance. In this way a transformation was effected which had the advantage that the patient escaped from an intolerable mental condition: though, it is true, this was at the cost of psychical abnormality—the splitting of consciousness that came about, and of a physical illness—her pains, in which an astasia-abasia was built up.[12]

In this statement—which is typical of many others like it—the words "mental" and "physical" appear as if they described observations, when in fact they are theoretical concepts used to order and explain the observations. I submit, therefore, that the so-called problem of conversion hysteria is epistemological rather than psychiatric: there is no problem of conversion, unless we insist on so framing our questions that we inquire about physical disorders where, in fact, there are none.

Thus, despite the apparent novelty of some of Breuer and Freud's claims, their philosophical orientation was anything but novel or unorthodox. Both men were imbued with and committed to the contemporary scientific Weltanschauung, according to which science was synonymous with physics and chemistry. There was a tendency, therefore, to squeeze psychology into behaviorism or, that failing, to reduce it to its so-called physical and chemical bases. This goal of reducing psychological observations to physical explanations—or at least to "instincts"—was espoused by Freud from the very beginning of his psychological studies, and he never relinquished it.

Breuer and Freud approached hysteria as if it were a disease, essentially similar to physicochemical disorders of the

body, for example, syphilis. The main difference between the two was thought to be that the physicochemical basis of hysteria was more elusive, and hence more difficult to detect with the methods then available. Hence, investigators had to content themselves with pursuing psychological methods of diagnosis and treatment until discovery of a physicochemical test of hysteria and its appropriate organic treatment became available. We might recall in this connection that when *Studies on Hysteria* was published—in 1895—the Wassermann test had not yet been devised, and proof of the syphilitic etiology of general paresis had not yet been histologically documented. The prevalent attitude toward psychopathology was—as it often still is—that the detection of physicochemical disorders in the human bodily machinery is the proper task facing the investigating physician. All else is an inferior substitute and must be relegated to a second-class position. Thus, psychology and psychoanalysis were given only second-class citizenship in the land of science, their emancipation remaining contingent on the discovery of the physicochemical basis of "mind" and behavior.

In my opinion, this sort of search for the biological and physical causes of so-called psychopathological phenomena is motivated more by the investigator's craving for prestige and power than by his desire for understanding and clarity. I have suggested earlier that patterning his beliefs and behavior on the medical model enables the psychiatrist to share in the prestige and power of the physician. The same applies to the psychiatric and psychological investigator or research worker. Because theoretical physicists enjoy greater prestige than theoreticians of psychology or human relations, psychiatrists and psychoanalysts stand to gain from claiming, as they do, that, at bottom as it were, they too are in quest of the physical or physiological causes of bodily illnesses. This impersonation makes them, of course, pseudo-physicists and pseudo-physicians, and has many regrettable consequences. Yet, this imitation of the natural scientist has been largely successful, at least

in a social or opportunistic way: I refer to the widespread social acceptance of psychiatry and psychoanalysis as allegedly biological—and hence ultimately physicochemical—sciences, and to the prestige of their practitioners based, in part, on this connection between what they claim they do and what other scientists do.

A Summing Up

In effect, then, Freud's theory of hysterical conversion was an answer to the question, How and why does a psychological problem manifest itself in a physical form? This question rearticulated the classic Cartesian dualism of mind and body and generated the new psychoanalytic riddle of the so-called "jump from the psychic into the organic"[13]—which psychoanalysis, and especially the theory of conversion, then allegedly sought to clarify.

I consider this whole medical-psychoanalytic perspective false and misleading. In particular, I view the connection between the psychological and the physical not as a relationship between two different types of occurrences or processes, but as a relationship between two different types of languages or modes of representation.[14]

Despite its evident shortcomings, which have often been remarked on, the psychoanalytic theory of hysteria lingers on. The principal reason why it does is, I think, institutional and social. The notion of hysteria as a mental disease, the psychoanalytic theory of hysteria, and especially the idea of conversion have all become the symbols of psychoanalysis as a medical technique and profession. The psychoanalytic theory of hysteria, and of neurosis patterned after it, made it easy for physicians and others in the mental health professions to retain a seemingly homogeneous scheme of diseases.[15] According to this medical model, diseases are either somatic or psychical; and so are treatments. Any psychological phenome-

non may thus be regarded as a mental disease or psychopathology, and any psychological intervention a form of mental treatment or psychotherapy. The only viable alternative to this familiar but false perspective is to abandon the entire medical approach to mental illness and to substitute new approaches for it appropriate to the ethical, political, psychological, and social problems from which psychiatric patients suffer and which psychiatrists ostensibly seek to remedy.

5 Hysteria and Psychosomatic Medicine

Conversion and Psychogenesis

The concept of hysterical conversion was modern psychiatry's answer to the question, How does the mind influence the body? As I have noted earlier, this is asking the wrong question: it is using "mind" as if it were brain.

Nevertheless, because the concept of conversion hysteria has had a profound impact not only on psychiatry but, through what has become known as psychosomatic medicine, also on medicine itself, it will be worth our while to critically review the connections between the theory of hysterical conversion and psychosomatic theories purporting to explain the "psychogenesis of organic symptoms."

To properly examine this problem, we must first identify what is meant by "organic symptoms." Like the meaning of any such term, its meaning must be inferred from the way psychiatrists use it. They use it in three distinct ways: first, to describe complaints about the body, for example, pain, palpitation, or itching; second, to denote bodily signs, for example, cough, tremor, or unsteady gait; and third, to identify certain special observations made on patients, for example, heart murmur, cardiac enlargement, or elevation of blood pressure. Calling all these things simply "organic symptoms" is like calling coal, graphite, and diamond simply "carbon." Let us

try to disentangle this jumble and then turn to the so-called problem of psychogenesis.

The first category, bodily complaints, comprises what are often called "symptoms," and the second, bodily signs, what are often called "signs." From the point of view of the physician, both of these relate to observations made with the unaided eye and ear, whereas the third class of "symptoms" requires the use of certain extensions of our sense organs. Bodily complaints are observed by means of hearing: the patient communicates his complaint to the physician. Bodily signs are observed by means of vision: the patient displays his disability to the physician. These two classes of phenomena thus stand in exactly the same sort of relation to each other as do spoken and written words. This connection is not only remarkably unappreciated in medicine and psychiatry, but is actually often misapprehended—physicians believing that bodily signs are more reliable guides to diagnosis than bodily complaints. This is not necessarily true. To be sure, most people find it easier to utter deliberate falsehoods than to display faked bodily signs; in other words, people more often lie than malinger. But obviously, in any particular case, the observer cannot be certain of the veracity of either bodily complaints or signs; both can be, and often are, falsified.

The third class of "organic symptoms" also consists of records of observation,[1] but of a particular kind: these observations are obtained by special methods, often called "tests," which not only supplement the physician's unaided eye and ear, but also circumvent the patient's mind or self. This is why tests are considered to be more "objective" and reliable guides to ascertaining what ails the patient than bodily complaints: the patient can falsify complaints, but he cannot, as a rule, falsify tests. Tests, then, do not lie or deliberately misinform, although those who perform them may. Accordingly, while tests can eliminate errors of diagnosis due to the patient's deceptions, they can introduce fresh errors due to the acci-

dental errors or deliberate fabrications of those who do the tests. For example, a shadow on a chest X-ray may be interpreted as a sign of tuberculosis, when it might actually be the sign of coccidioidomycosis or an artifact.

It is sometimes assumed that all three of the foregoing types of observations point, as it were, to bodily diseases; in other words, that bodily diseases "cause" certain symptoms, the symptoms being the "effects" of the diseases. While on rare occasions this rather simplistic view is correct enough, it is, as a general principle, quite false. Statements or records concerning bodily functions are observations; statements or hypotheses concerning diseases are inferences. The relationship between observations and inferences is the same in medicine as it is in any empirical science. As singular events, diagnostic inferences may be verified or falsified—for example, when a surgeon operates for a peptic ulcer: he either finds the ulcer or he does not. As generalizations, however, assertions of the type "All persons who complain of X symptoms . . . or who display Y signs . . . have Z diseases" can neither be verified nor falsified. Actually, some such patients will have Z diseases, and others will not.

To be sure, some inferences, whether diagnostic or other, are more accurate than others. What distinguishes accurate from inaccurate inferences? The essential connection between observations and correct inferences is that of regularity. Indeed, the modern conception of causality is nothing but the assumption that certain regularities will persist in the future: if you drop a glass, it will shatter; if you exsanguinate an animal, it will die; and so forth. Herein, too, lies the crucial distinction between physical causation and human volition: one is an account of recurrent regularities; the other is an account of an agent making something happen. For example, peptic ulcers do not "compel" patients to have pains in the same sense as lenders compel borrowers to repay loans.

Although there is never a point-to-point correlation be-

tween observations of bodily functions and inferences concerning bodily diseases, some observations are obviously more reliable than others. Since the context in which the observation is made is part of the observation, no simple generalizations about the connection between medical observation and medical inference can be offered. In ordinary or obvious cases, the simplest observations may suffice: for example, when we see a man who has just been hit by an automobile lying in the road bleeding, we need no further evidence to infer that he has been injured. On the other hand, we might come upon a similar scene staged for making a film, and mistake ketchup for blood and an actor for a patient. Finally, in obscure cases of suspected serious illness, simple observations of bodily complaints such as fatigue can of course never suffice as evidences for drawing a medical inference; for example, it would be absurd to base a diagnosis of leukemia on fatigue. In such cases, only repeated observations based on appropriate laboratory examinations can serve as the grounds for the inference of illness.

This empirical-scientific perspective on medical diagnosis has several implications which I now want to articulate.

One is that anyone, whether he complains of his body or not, may be healthy or sick, in the sense that he may or may not have a demonstrable physicochemical abnormality of his body. It is illogical, incorrect, and unwise to assume, as physicians and patients often do, that anyone with bodily complaints is sick until proven otherwise. This is simply a presumption of illness, analogous to a presumption of guilt in some codes of criminal law. In English and American law, of course, a person accused of a crime is considered innocent until proven guilty. As humane and rational physicians and patients, we should assume a similar posture vis-à-vis illness: we should assume that a person who complains that he is ill, or about whom others complain that he is ill, is healthy until it is proven—if not beyond a shadow of a doubt, at least to a

degree of reasonable likelihood—that he is ill.[2] This, of course, would be a presumption of health. My point here is that in such situations we must be careful not to deceive ourselves: we either presume health or illness, or keep an open mind presuming neither.

A second important implication of this perspective is that we must realize, and act as if we realized, that anyone who complains of being ill might indeed be ill, but that—if, as proof of illness, we accept only demonstrable physicochemical alterations of the body—we may not now have the means to detect such alterations. A hundred years ago, physicians did not know how to detect paresis; fifty years ago, they did not know how to detect pellagra; no doubt there are diseases that they do not know how to detect today. But it is one thing to admit this, and quite another to maintain that, because of these historical facts, the persons psychiatrists now call schizophrenic suffer from an as yet undetectable form of organic disease, and that it is only a matter of time and research until medical science discovers the lesions "responsible" for this disease.

In all this, we must not lose sight of our criteria for diagnosing illness: they are either certain kinds of demonstrable physicochemical alterations of the body, or certain kinds of psychosocial communications about it. This brings us back to our core problem—namely, whether the mimicry of neurological illness, such as the hysteric exhibits, is to be regarded as a "physicochemical alteration" or as a "psychosocial communication," a happening or an action, an occurrence or a strategy.

Whereas the idea of mental illness is firmly rooted in the notion of complaint, whether by the patient or about him, the idea of bodily illness (in the sense defined above) is independent of it. It is easy to imagine cases—and such cases are of course quite real—where a person has an illness, even a very serious illness, but where neither he nor anyone else has any

complaints referable to it. For example, a person may have a significant elevation of his blood pressure, but have no symptoms of it; we would nevertheless consider such a person to be suffering from the disease called "essential hypertension." Indeed, in their early stages, many serious diseases, such as arteriosclerosis, diabetes, or cancer, may be said to be present in a person without his or anyone else's knowledge of it or complaint about it. My point is that to speak of elevated blood pressure and hypertension, of sugar in the urine and diabetes, all as "organic symptoms," and to place them in the same category as hysterical pains and paralyses is a misuse of language; it is nonsensical; and it creates a linguistic and epistemological muddle which no amount of "psychosomatic research" can clarify. Long ago the philosopher Moritz Schlick warned that "The so-called 'psycho-physical problem' arises from the mixed employment of both modes of representation in one and the same sentence. Words are put side by side which, when correctly used, really belong to different languages."[3]

Here is a typical example of this muddle. The passage is from a paper by Leon Saul, characteristically titled "A Note on the Psychogenesis of Organic Symptoms":

> Some psychogenic organic symptoms, such as tremor or blushing, are the *direct* expressions of emotions or conflicts, while others are only their *indirect* results. Examples of the latter are (a) the effects of acting out, such as catching cold from throwing off the bedclothes during sleep, (b) the incidental soreness of an arm due to an hysterical tremor.[4]

A sore arm, a hysterical tremor, and the common cold are here lumped together, each a member of the class called "psychogenic organic symptoms." A sore arm is a complaint; "it" might be a lie. A hysterical tremor is a psychiatric inference; "it" might be an organic tremor. And the common cold is a microbiological inference; "it" might be a bacterial infection or an allergic reaction.

Although it is a part of the unquestioned and unquestionable dogma of psychosomatic research to call all these phenomena organic symptoms, I maintain that these are not organic symptoms—indeed, that there are no such things as organic symptoms. A sore arm, as I have remarked, is a complaint; a tremor is a sign; and the common cold is a disease. If a sore arm is "organic" merely because it involves the body, then everything that people do with their bodies—from playing bridge to making love—is also "organic." And if all these things are "psychogenic" because they are preceded by some sort of conduct to which they might be related, then every illness is psychogenic, as every illness could be shown to be related to some antecedent act. In short, "psychogenic organic symptoms," like "mental illnesses," are phrases which are the products of linguistic misuse, palmed off on the public as the products of "psychosomatic research."[5]

Conversion and Organ Neurosis

Until the 1930s, all sorts of bodily complaints, signs, and diseases were, if they were thought to be "mental," called "hysteria." Accordingly, pains, paralyses, false pregnancies, asthma, diarrhea, and many other bodily symptoms were conceptualized as conversion hysteria and were so labeled. The early psychosomaticists wanted to distinguish among these phenomena and suggested that two separate classes be distinguished: conversion hysteria and organ neurosis. Ostensibly, this proposal was a matter of nosology, resting on accurate clinical description and adequate logical distinction. Actually, it rested on neither of these criteria, but was based simply on the well-known anatomical and physiological distinction between the cerebrospinal and autonomic, or the voluntary and involuntary, nervous systems. The person most responsible for these ideas was Franz Alexander, to whose pertinent views we shall now turn.

Recognizing the philosophical underpinnings of this problem, Alexander asserts that, in his view, "there is no logical distinction between 'mind' and 'body,' mental and physical";[6] and adds that while the division of medical disciplines into physiology, medicine, neurology, psychiatry, and so on "may be convenient for academic administration, . . . biologically and philosophically these divisions have no validity."[7] Alexander ignores the linguistic and legal, epistemological and social, and all the other distinctions between psychological and physiological events and pursuits, and simply asserts that "psychic and somatic phenomena take place in the same biological system and are probably two aspects of the same process."[8]

All this flies in the face of the most obvious objections which I do not want to belabor further.[9] Suffice it to say that if psychology and medicine are the same, why are religion and medicine not also the same? or law and medicine? or politics and medicine? For my part, I prefer the view of those contemporary philosophers who suggest that we regard the relationship between body and mind as similar to that between a football team and its team spirit.[10]

In any case, we cannot have it both ways: we must choose between the psychophysical symmetry of modern psychosomatic medicine, fashionable in medicine and psychiatry today, and the psychophysical hierarchy of modern philosophy, opposing contemporary efforts to medicalize moral problems.

It is interesting, and indeed revealing of the state of the art of psychiatry and psychoanalysis, that despite wide differences among various schools of thought, the distinction between hysterical conversion and organ neurosis has been embraced by workers of the most divergent orientations. Such consensus is, of course, no proof of correctness. In this case, it rests on and reflects, in my opinion, the widespread passion to describe the most diverse human experiences and phenomena in medical or pseudomedical terms.

As the distinction between these two types of neuroses was most clearly drawn by Alexander, let us consider his original statement on it:

It seems advisable to differentiate between hysterical conversion and vegetative neurosis. Their similarities are rather superficial: both conditions are psychogenic, that is to say, they are caused ultimately by a chronic repressed or at least unrelieved tension. The mechanisms involved, however, are fundamentally different both psychodynamically and physiologically. The hysterical conversion symptom is an attempt to relieve an emotional tension in a symbolic way, it is a symbolic expression of a definite emotional content. This mechanism is restricted to the voluntary neuromuscular or sensory perceptive systems whose function is to express and relieve emotions. A vegetative neurosis consists of a psychogenic dysfunction of a vegetative organ which is not under control of the voluntary neuromuscular system. The vegetative symptom is not a substitute expression of the emotion, but its normal physiological concomitant.[11]

All this sounds rather attractive, especially to those whose ears are attuned to the music of medical metaphors. I shall limit my following critical remarks to those aspects of Alexander's views on which I have not touched before.

In writing about certain bodily phenomena Alexander calls them "vegetative symptoms." It is not mere quibbling, however, to insist that body parts cannot have symptoms; only persons can. Alexander's usage, which is traditional in psychiatry, leads to a hopeless confusion of affects with body parts, and of complaints with bodily diseases. One result of this confusion, which I discussed in detail elsewhere, is the characteristic psychiatric perspective on phantom pain: since in such cases persons lack certain body parts and yet assign painful feelings to them, physicians tend to deny the "reality" of such experiences and regard them as similar to "delusions."[12]

In describing why conversion symptoms are "pathological,"

Alexander uses the neurologistic language of old-fashioned psychoanalysis: it is because "substitute innervations never bring full relief."[13] Here is the familiar hydraulic metaphor again: one can "substitute" one choice for another, but how does one substitute one "innervation" for another? In the best—or worst—tradition of psychoanalytic theorizing, Alexander here mixes metaphor with observation and offers the old psychoanalytic theory of "personal neurosis" as the new psychosomatic theory of "vegetative neurosis": "A vegetative neurosis is not an attempt to express an emotion but is the physiological response of the vegetative organs to constant or to periodically returning emotional states."[14] Alexander's theory of the "psychogenesis" of hysteria and of organ neurosis may thus be paraphrased as follows: if dammed-up libido is discharged via the cerebrospinal system, it causes hysteria; and if via the autonomic system, it causes vegetative neurosis. It is a seemingly elegant expansion of the theory of hysteria. But what, exactly, does it tell us? What good is it?

To advance our analysis of this problem, let us consider an actual example of a case of vegetative neurosis. Alexander's paradigm of this illness is chronic gastric hypersecretion which, in time, may lead to a gastric or duodenal ulcer: ". . . emotional conflicts of long duration may lead as a first step to a stomach neurosis which in time may result in an ulcer."[15] The terminology is, again, crucially important: Alexander regards the ulcerated stomach as a regular "organic disease" and calls only the antecedent physiological dysfunction, the hypersecretion, a "vegetative neurosis." This is an utterly senseless distinction, not because hypersecretion without ulceration is not different from hypersecretion with it, but because objectively demonstrable gastric hypersecretion is an organic illness just as, say, objectively demonstrable pancreatic hyposecretion is an organic illness.

It is clear, then, that Alexander actually offers no clue of how we are to ascertain whether or not a person has a

vegetative neurosis. Is having gastric hypersecretion a sufficient criterion? Or must the patient also have complaints referable to the stomach? Or must he also have an ulcer? As I noted before, in the case of hysteria it would be absurd to say that someone suffers from it who has no complaints and displays no disability. But in Alexander's usage, one could say that someone suffers from an organ neurosis, even though he has no complaints and displays no disability. In this respect, the concept is identical to that of ordinary bodily illness, say diabetes. But then why call it a "neurosis"? Perhaps because by the time Alexander invented vegetative neurosis it was no longer clear what any neurosis was! Actually, the term "neurosis" has long been used to denote three quite distinct things: observable behavior, such as a paralyzed arm; reported behavior, such as a facial pain; and a medico-psychiatric theory regarding the pathogenetic process allegedly responsible for certain kinds of disabilities—such as conversion hysteria as the pathogenetic theory of certain kinds of seizures. In traditional psychoanalytic usage, the third meaning of the term is the one most favored.[16]

It is this traditional psychoanalytic model of conversion hysteria that is responsible for the idea of vegetative neurosis. According to this model, which identifies hysteria with certain kinds of accumulations and discharges of libido, not only can persons be neurotic but so can parts of the body. For example, in a phobia, the dammed-up impulses are imagined to be in the person; in stuttering, in the speech organs; and in peptic ulcer, in the stomach. This is what happens when explanatory metaphors are mistaken for the things they are supposed to explain.

Energy Conversion and Language Translation

Traditional psychoanalytic theory, as well as modern psychosomatic theory of the sort reviewed above, is based on the

physical model of energy discharge, of which a hydraulic system is an instance.[17] In such a system, a body of water behind a dam, representing potential energy, "seeks" release, and may be discharged through several pathways. First, through its proper channel into the riverbed into which the water is intended to flow; that is, through "normal" behavior. Second, through some other route, such as through a leak at one side of the dam; that is, through hysterical conversion. And third, through another route, such as through a leak at another side of the dam; that is, through organ neurosis.

I suggest that we entirely abandon this metaphor and model of energy conversion in psychiatry and psychoanalysis and replace it with the metaphor and model of language translation.[18] Let me indicate briefly some of the practical consequences of such a change in perspective.

By translation we mean rendering a message from one idiom into another, say a Hungarian sentence into an English sentence. When the translation is successfully consummated, we have two statements about which we say that they "mean the same thing." In such a process, neither energy nor information is transferred—from one place or person to another. What, then, is the point of translation? The answer to this question lies in the social situation that motivates the translation and gives sense to it. Typically, translation is necessary because two or more people who do not speak the same language want to communicate with one another; to do so, someone must translate for them or they must do so for themselves. In short, translation is that act which makes certain sorts of communications possible, which, as it were, unblocks blocked communication.[19] This, in my opinion, is the model that best fits the situation of the so-called mental patient facing himself and others. A hypothetical example will illustrate this.

A patient who speaks only Hungarian visits a physician who speaks only English. The patient wants help and the

physician wants to help him. How are they to proceed? How can they communicate with each other? There are four discreet possibilities in this situation: 1. The patient learns to speak English. 2. The physician learns to speak Hungarian. 3. An interpreter is brought in who translates from Hungarian into English and vice versa. 4. The patient not only learns to speak English, but realizing and reflecting upon the problem of communication which he faces, also undertakes an explicit study of his own problems.

To understand hysteria, we must substitute complaints about the body for Hungarian/patient, and demonstrable bodily disorders for English/physician. (For other mental diseases, we must substitute the patient's particular complaints or symptoms for Hungarian, and the psychiatrist's particular orientation or perspective for English.) Every patient knows how to tell others how he feels; this, as it were, is the mother tongue of all sick persons. Similarly, every physician knows how genuine diseases express themselves; this, as it were, is the way physicochemical disorders betray themselves to medical experts. In short, the patient speaks (listens) in the language of complaints; and the physician listens (and speaks) in the language of illness. The task that faces them is therefore similar to the task I sketched above; in this case, it is to translate from the language of complaints to the language of illness and vice versa. The same four choices are now open to the participants.

1. The patient learns to address the physician in the language of illness. He seeks and finds physicians who will take medical action in the face of slight or nonexistent evidences of bodily malfunctioning. He may thus receive vitamins, tranquilizers, or hormones, or may have his teeth or her uterus removed.

2. The physician learns to speak hysterical body language and understands the patient's message on the patient's terms rather than his own.

3. An interpreter is brought in who translates from body language to the language of bodily illness: this usually means that the patient is referred to a psychiatrist who talks to both patient and referring physician and mediates between them.

4. The patient not only learns to speak the language of real illness, but, realizing and reflecting upon the problem of communication he faces with physicians, also undertakes an explicit study of his own problem. He learns both about his own communications and about those of physicians; in particular, he learns about the history, aims, and uses and abuses of each of these languages. The patient may accomplish this either by undergoing psychoanalysis or some similar form of psychotherapy, by association with wise friends, or by reading and contemplation.

6 Contemporary Views of Hysteria and Mental Illness

In studying human behavior, we face the disconcerting fact that psychiatric theories are nearly as numerous and varied as psychiatric symptoms. This is true not only in historical and international perspectives but also within single nations. Thus, it would be difficult to identify and compare, say, American and English, or American and Swiss psychiatry, for none of these countries presents a psychiatrically united front. The reasons for this state of affairs, and its important implications for our efforts to build an internationally respectable science of psychiatry, cannot be considered here. I should like to emphasize only that I believe that much of the difficulty in the way of building a coherent theory of personal conduct lies in our inability—or sometimes unwillingness—to separate description from prescription. Questions such as, How *do* persons conduct themselves? and, What *are* the relations between society and the individual? can and must be separated from questions such as, How *should* persons conduct themselves? and, What *should* be the relations between society and the individual?

Actually, contemporary psychiatry is characterized by a multitude of diverse, competing, and often mutually exclusive beliefs and practices. In this respect—and indeed not only in

this respect—psychiatry resembles religion rather than science, politics rather than medicine. In religion and politics we expect to find conflicting systems or ideologies. Broad consensus concerning the practical management of human affairs, and the ethical systems utilized in governing and justifying particular types of group formations, are regarded merely as a measure of the political success of the dominant ideology. In contrast, scientific theories do not, as a rule, concern vast populations. Hence, broad consensus concerning such matters is not an issue. At the same time, it is unusual for scientists widely and persistently to disagree among themselves concerning the ideas and actions appropriate to their special areas of competence. There is, for instance, relatively little disagreement among scientists concerning basic physiological, biochemical, or physical theories—even though individual scientists may believe in different religions, or in no religion, and may be members of different national groups. This is emphatically not true for psychiatry. In this chapter I want to remark briefly on a few of the principal contemporary views on hysteria and mental illness.

Psychoanalytic Theories

Fenichel, the author of a highly respected psychoanalytic text, distinguishes anxiety hysteria from conversion hysteria. He identifies anxiety hysteria, which is also a synonym for phobia, as the "simplest compromise between drive and defense."[1] The anxiety motivating the defense becomes manifest, he says, while the reason for the anxiety remains repressed. In other words, the person experiences anxiety without knowing why. Fenichel illustrates this process by citing the example of "Small children [who] are afraid of being left alone, which for them means not being loved any more."[2] The psychology of anxiety hysteria is laid bare here as simply a connection, on the part of the child, between being left alone and being

unloved. Since it is considered normal for children to feel anxious when they are unloved, their being anxious for this reason is not considered to be "abnormal." However, being left alone, as such, is not considered to be a sufficient reason for feeling anxious. Hence, if such a reaction occurs, it must be due to something else. The *meaning* of being left alone is then advanced as the *cause* of the "abnormal reaction" called a "phobia."

Furthermore, the child's experience of anxiety on being left alone is open to two antithetical interpretations. First, it may be considered pathological—that is, "bad"— if it is assumed that the reaction signifies excessive susceptibility to feeling unloved. Second, it may be considered normal—that is, "good"—if it is assumed that the reaction signifies the child's ability to make connections between more or less dissimilar situations. According to the latter view, a phobia—and, indeed, nearly all "psychopathological symptoms"—are similar to scientific hypotheses. Both the making of mental symptoms and the making of hypotheses rests on the fundamental human propensity to construct symbolic representations and to use these as guides to action.

In his discussion of conversion hysteria, Fenichel consistently uses the mixed physical and psychological language which I have criticized earlier. For example, he writes about "physical functions" providing unconscious expression for repressed "instinctual impulses."[8] As in Breuer and Freud's writings, complaints about the body or communications by means of bodily signs are here erroneously described as alterations in physical functions. The following is an example of these sorts of unrecognized epistemological errors typical of psychoanalytic writings on hysteria:

A patient suffered from pain in the lower abdomen. The pain repeated sensations she had felt as a child during an attack of appendicitis. At that time she had been treated with unusual tenderness by her father. The abdominal pain expressed simultaneously a

longing for the father's tenderness and a fear that an even more painful operation might follow a fulfilment of this longing.[4]

Here is a contrasting account of the same sort of phenomenon, written by a theoretical biologist. The account concerns a girl who developed abdominal pain and consulted a surgeon.

> He [i.e., the surgeon] recommended an operation for the removal of the appendix and this was accordingly performed. But after recovery and convalescence the girl again complained of abdominal pain. This time she was advised to consult a surgeon with a view to treatment for adhesions resulting from the first operation. But the second surgeon referred the girl to a psychiatrist from whose inquiries it transpired that the girl's education had been such that she believed it to be possible to become pregnant by being kissed. The first abdominal pain had appeared after the experience of being kissed by an undergraduate during his vacation. After the recovery from the operation this girl was again kissed by the same undergraduate with a similar result.[5]

In an earlier passage, Fenichel speaks of a patient's "original physical pain," and contrasts this with his present "hysterical pain." In the passage cited, he translates "abdominal pain" into a "longing for tenderness." All such statements ignore the crucial issue of validating the nature of the complainant's pain. After all, Fenichel's patient's pain could conceivably have been "caused" by, say, a tubal pregnancy, and could also have "meant" that she longed for her father's love.

The problem of whether the "meaning" of pain could also be its "cause," and if so in what way, is far more complicated than the psychoanalytic theory of hysteria would have it. According to the latter, some pains are "organic," others "hysterical." Thus a longing, a wish, a need—broadly speaking, psychological "meanings" of all sorts—are regarded as "causal agents" similar, in all significant respects, to tumors, fractures, and other bodily lesions. Clearly, nothing could be

more misleading, since fractures and tumors belong in one logical class, while desires, aspirations, and conflicts belong in another.[6] I am not saying that psychological motives can never be regarded as the "causes" of human conduct, for evidently this is often a useful way of describing social behavior. It should be kept in mind, however, that my desire to see a play is the "cause" of my going to the theater in a sense very different from that in which we speak of "causal laws" in physics.

Glover adheres to the usual psychiatric classification of hysteria. He asserts that "two major types of hysteria exist, namely, conversion hysteria and anxiety hysteria."[7] He thus implies that "hysteria" is an entity found in nature rather than an abstraction made by man. And he too uses a mixed physical and psychological language—for example, in speaking of "physical symptoms" and "psychic contents."

However, Glover makes a distinction which is both valid and important—namely, that conversion symptoms possess "specific psychic content," whereas so-called psychosomatic symptoms do not.[8] In other words, conversion symptoms are intentional signs: they are bits of behavior that are intended to convey a message. This is why they must be regarded as communications. In contrast, so-called psychosomatic symptoms are unintentional signs: they are occurrences, not actions, and are not intended to convey a message. This is why they must not be regarded as communications. They may, nevertheless, be interpreted as signs by certain observers—who may be astute and knowledgeable, or stupid and mistaken, as the case may be.

All this, though not clearly articulated, is implicit in the early papers of Freud and Ferenczi. The communicational possibilities of diseases of all types, and not only of a few specially labeled as "psychosomatic," for both diagnosis and treatment, inspired Groddeck[9] to propose far-reaching, and at

times fantastic, interpretations of these phenomena. But Groddeck's ideas, though unsystematized and unverified, led to a better appreciation of the communicational significance of all human behavior.

In the 1930s, psychoanalysts began to place increasing emphasis on so-called ego psychology—which meant, among other things, emphasis on communicative behavior rather than on instinctual drives. At about the same time, Sullivan provided the impetus for an explicitly interpersonal—sociologic and communicational—approach to psychiatry and psychotherapy. He thus spearheaded a trend that soon became incorporated into psychoanalysis. I refer to the increasingly explicit recognition by psychoanalysts that human experiences and relationships—and especially human communications—are the most significant observables with which they actually deal.

Although I consider Sullivan's contribution to psychiatry impressive, many of his early theoretical formulations—especially those concerning so-called psychiatric syndromes—were modifications of, rather than improvements on, Freud's ideas. For example, in *Conceptions of Modern Psychiatry,* Sullivan proposes this definition of hysteria:

> Hysteria, the mental disorder to which the self-absorbed are peculiarly liable, is the distortion of inter-personal relations which results from extensive amnesias.[10]

This statement of Sullivan's, though unencumbered by physiologizing about behavior, is open to the same criticisms as I have leveled against the traditional psychoanalytic concept. Sullivan, too, speaks of hysteria as if it were a disease entity, and as if amnesias caused it. But how could amnesia "cause" hysteria? Is this not like saying that fever "causes" pneumonia? Moreover, Sullivan's interpretation was only a modification of Freud's classic dictum that "hysterical patients suffer from reminiscences."[11]

There can be little doubt, of course, that both Freud and Sullivan were correct in identifying painful memories, their repression, and their persistent operation as significant antecedents in the personal and social behavior of hysterically disabled individuals. In his later work, Sullivan describes hysteria as a form of communication and lays the ground for viewing it as a special type of game-playing behavior. I will discuss his views on hysteria again in connection with the presentation of a game-model theory of this phenomenon.[12]

So far, Fairbairn has been one of the most successful exponents of a consistently psychological formulation of psychiatric problems. Emphasizing that psychoanalysis deals with observations of, and statements about, "object relationships" —that is, human relationships—he has reformulated much of psychoanalytic theory from the vantage point of this ego-psychological—and by implication communicational—approach. In his paper "Observations on the Nature of Hysterical States" he writes:

> Hysterical conversion is, of course, a defensive technique—one designed to prevent the conscious emergence of emotional conflicts involving object-relationships. Its essential and distinctive feature *is the substitution of a bodily state for a personal problem;* and this substitution enables the personal problem as such to be ignored.[13]

I am in agreement with this simple yet precise statement. According to it, the distinctive feature of hysteria is the substitution of a "bodily state" for communications by means of ordinary language concerning personal problems. As a result of this transformation both the content and the form of the discourse change. The content changes from personal problems to bodily problems, while the form changes from verbal (linguistic) language to bodily (gestural) language.

Accordingly, hysterical conversion is best regarded as a process of translation—a conception first proposed by Freud. It was Sullivan and Fairbairn, however, who gave impetus to

the fuller appreciation of the communicative aspects of all types of occurrences encountered in psychiatric and psychotherapeutic work.

Organic Theories

I shall make no attempt here to review the principal organic—that is, biochemical, genetic, neuropathological, etc.—theories of hysteria. I shall only state my position vis-à-vis organic theories of hysteria, and mental illness generally, and their relation to the present work.

To begin with, I do not contend that human relations, or mental events, take place in a neurophysiological vacuum. It is more than likely that if a person, say an Englishman, decides to study French, certain chemical (or other) changes will occur in his brain as he learns the language. Nevertheless, I think it would be a mistake to infer from this assumption that the most significant or useful statements about this learning process must be expressed in the language of physics. This, however, is exactly what the organicist claims.

Notwithstanding the widespread social acceptance of psychoanalysis in contemporary America, there remains a wide circle of physicians and allied scientists whose basic position concerning the problem of mental illness is essentially that expressed in Carl Wernicke's famous dictum: "Mental diseases are brain diseases." Because, in one sense, this is true of such conditions as paresis and the psychoses associated with systemic intoxications, it is argued that it is also true for all other things *called* mental diseases. It follows that it is only a matter of time until the correct physicochemical, including genetic, "bases" or "causes" of these disorders will be discovered.[14] It is conceivable, of course, that significant physicochemical disturbances will be found in some "mental patients" and in some "conditions" now labeled "mental illnesses." But this does not mean that all so-called mental diseases have bio-

logical "causes," for the simple reason that it has become customary to use the term "mental illness" to stigmatize, and thus control, those persons whose behavior offends society—or the psychiatrist making the "diagnosis."

Let us sharply distinguish here between two epistemological positions. The first, extreme physicalism, asserts that only physics and its branches can be considered sciences.[15] Hence, all observations must be formulated in the language of physics. The second position, a sort of liberal empiricism, recognizes a variety of legitimate methods and languages within the family of science.[16] Indeed, since different types of problems are considered to require different methods of analysis, a diversity of scientific methods and expressions is not merely tolerated, but is considered necessary. According to this position, the value, and hence the scientific legitimacy, of any particular method or language depends on its pragmatic utility, rather than on how closely it approximates the ideal model of theoretical physics.

It is well to recognize that both of these attitudes toward science rest on certain value judgments. Physicalism asserts that all of the sciences should, as far as possible, be like physics. If we adhere to this view, the physical bases of human performances will be regarded as most significant. In contrast, the second type of scientific attitude—which may be called empiricism, pragmatism, or operationism—focuses on the value of instrumental utility, that is, on the power to explain the observed and to influence it.

It seems to me that most of those who adhere to an organicist position in psychiatry espouse a system of values of which they are unaware. They imply that they recognize as scientific only physics (and its branches), but instead of asserting this, they say that they object to psychosocial theories only because they are false. Here is a typical example:

From the results of this investigation, it seems proper to suggest that the diagnosis of hysteria might be made by following the

standard procedure used in the general field of diagnostic medicine: that is, determining the facts of the chief complaint, past history, physical examination and laboratory investigation. If the relevant symptoms of hysteria are known, this method can be applied by any physician without the use of special techniques, dream analysis or prolonged investigation of psychological conflicts. These studies give no information about the cause of hysteria or about the specific mechanisms of symptoms. It is believed that these are unknown. Further, it is believed that they will be discovered by scientific investigation, rather than by the use of non-scientific methods, such as pure discussion, speculation, further reasoning from the dictums of "authorities" or "schools of psychology" or by the use of such pretentious undefined words as "unconscious," "depth psychology," "psychodynamics," "psychosomatic," and "Oedipus complex," and that fundamental investigation must rest on a firm clinical basis.[17]

In short, we may conclude that the psychologically minded psychiatrist and his organicist colleague, though often members of the same professional organizations, do not speak the same language and do not have the same interests. It is not surprising, then, that they have nothing good to say to or about each other, and that when they do communicate, it is only to castigate each other's work and point of view.

Part Two

▪

Foundations of a Theory of Personal Conduct

III

SEMIOTICAL

ANALYSIS OF

BEHAVIOR

7 Language and Protolanguage

The definitions of such terms as "language," "sign," and "symbol" will be indispensable for our further work. The concept of sign is the most basic of the three, and I shall start with it. Signs are, first of all, physical things: for example, chalk marks on a blackboard, pencil or ink marks on paper, sound waves produced in a human throat. According to Reichenbach, "What makes them signs is the intermediary position they occupy between an object and a sign user, i.e., a person."[1] For a sign to be a sign, or to function as such, it is necessary that the person take account of the object it designates. Thus, anything in nature may or may not be a sign, depending on a person's attitude toward it. A physical thing is a sign when it appears as a substitute for, or representation of, the object for which it stands with respect to the sign user. The three-place relation between sign, object, and sign user is called the *sign relation* or *relation of denotation*.

The Structure of Protolanguage

According to strict symbolic-logical usage, to use signs is not the same as to use language. What, then, are nonlinguistic signs? We may distinguish, still following Reichenbach, three

classes of signs. In the first class may be placed signs that acquire their sign function through a causal connection between object and sign: smoke, for example, is a sign of fire. Signs of this type are called *indexical*. The second class is made up of signs that stand in a relation of similarity to the objects they designate: for example, the photograph of a man or the map of a terrain. These are called *iconic signs*. In the third class are placed signs whose relation to the object is purely conventional or arbitrary: for example, words or mathematical symbols. These are called *conventional signs* or *symbols*. Symbols usually do not exist in isolation, but are coordinated with each other by a set of rules, called the rules of language. The entire package, consisting of symbols, language rules, and social customs concerning language use, is sometimes referred to as the *language game*. In the technical idiom of the logician, we speak of language only when communication is mediated by means of systematically coordinated conventional signs.

According to this definition, there can be no such thing as a "body language." If we wish to express ourselves precisely, we must speak instead of communication by means of bodily signs. This is not mere pedantry. The expression "bodily sign" implies two significant characteristics. First, that we deal here with something other than conventional, linguistic symbols. Second, that the signs in question must be identified further as to their special characteristics. In speaking of bodily signs, I shall generally have in mind phenomena such as so-called hysterical paralyses, blindness, deafness, seizures, and so forth. These occurrences speak for themselves, as it were, and hence communication by means of such signs need not involve speech. In this, they are distinguished from certain other bodily signs, such as pain, which may be communicated either verbally or by pantomime—that is, by behavior suggesting to the observer that the sufferer is in pain. Finally, since speech

itself makes use of bodily organs, it too could loosely be called a "bodily sign." This, however, would be a vague and nontechnical use of this expression.

So much for initial definitions. Let us now take up the question posed earlier: What are the characteristic features of the signs employed in so-called body language?

The concept of iconic sign fits exactly the phenomena described as body signs. The relationship of iconic sign to denoted object is one of similarity. A photograph, for example, is an iconic sign of the person in the picture. Similarly, a hysterical seizure is an iconic sign of a genuine (organic) epileptic seizure; or, a hysterical paralysis or weakness of the lower extremities may be an iconic sign of weakness due to multiple sclerosis or tabes dorsalis. In brief, body signs are best conceptualized as iconic signs of bodily illness. This interpretation is consistent with the fact that communications of this type occur chiefly in interactions between a sufferer and his helper. The two participants may or may not be specifically defined as patient and physician. The point is that body signs, as iconic signs of bodily illness, form an integral part of what might best be called the *language of illness*. In other words, just as photographs as iconic signs have special relevance to the movie industry and its patrons, so iconic signs pertaining to the body have special relevance to the "healing industry" and its patrons.[2]

Philologists classify languages in accordance with their own interests and needs. They thus distinguish individual languages, such as English, German, French, Hungarian, and so forth; and families of languages, such as the Indo-European, Finno-Ugric, Indian, and others.

Logicians and philosophers, under the impetus of Whitehead and Russell,[3] have developed a completely different kind of language classification, distinguishing among languages according to the level of complexity of the logical descriptions or

operations involved. The first, or lowest level, is called *object language.** The signs of this language denote physical objects, for example, cat, dog, chair, table, and so on. We may next introduce signs referring to signs. The words "word," "sentence," "clause," and "phrase" are signs belonging to (the first-level) *metalanguage.* This iteration of the coordination of signs and referents may be repeated *ad infinitum.* Thus, progressively higher levels of metalanguages can be constructed, by forever introducing signs which denote signs at the next lower logical level. The distinction between object language and metalanguage (and metalanguages of increasingly higher orders) is the single most significant contribution of symbolic logic to the science of language. Only by means of this distinction did it become apparent that in order to speak about any object language, we need a metalanguage. It must be remembered, of course, that on both of these levels of language, the same linguistic stock may be used. As Jakobson remarked, "We may speak in English (as metalanguage) about English (as object language) and interpret English words and sentences by means of English synonyms, circumlocutions, and paraphrases."[4] So-called ordinary language consists of a mixture of object and metalanguages.

For our present purposes, it is especially important to note that, in this scheme, the lowest level of language is object language. There is no room here for what goes in psychiatry by the name of body language. This is because body language is composed of iconic signs. Hence, it constitutes a system

* The word "object" is used in several different senses in this book, depending on the context in which it appears. It is used in a technically specialized fashion in two situations. In connection with object relations, "object" usually means a person, less often a thing or idea. In connection with logical hierarchies, say of languages, the term "object" denotes a level of discourse about which one may speak only in a metalanguage. The logical relationship between object and meta levels is always a relative one. Thus a first-level metalanguage may be considered an object language with respect to a second-level metalanguage.

logically more primitive than the operations of object language.

Inasmuch as conventional signs (or symbols) make up the lowest level of language, and signs of signs the first-level metalanguage, and so on, a communication system employing signs that denote less, as it were, than do conventional signs may be regarded as forming a level of language below that of object language. I suggest, therefore, that we call this type of language a *protolanguage*. This seems fitting since the word "metalanguage" denotes that languages of this type are later, beyond, or higher than object languages. The prefix "proto," being the antonym of "meta," refers to something that is earlier or lower than something else (as in "prototype").

A hysterical symptom, say a seizure or paralysis, expresses and transmits a message, usually to a specific person. A paralyzed arm, for instance, may mean: "I have sinned with this arm and have been punished for it." It may also mean: "I wanted or needed to obtain some forbidden gratification (erotic, aggressive, etc.) by means of this arm." But what exactly is meant when it is stated that a symptom has such and such a meaning? This problem raises such related questions as: Does the patient—the sender of the message—know *that* he is communicating, and *what* he is communicating? Does the receiver of the message—physician, husband, wife, etc.—know *that* he or she is being communicated with, and *what* is being communicated to him or her? If they do not know these things, how can they be said to be communicating?

Although Freud never raised these questions, at least not as I have framed them, he gave some good answers to them. Perhaps precisely because they were so useful, his answers obscured the original questions which raised them but which were never explicitly stated. Freud suggested that we distinguish two basically different types of "mentation" and "knowledge," one conscious, the other unconscious. Unconscious

activity is directed by so-called primary processes, while conscious mentation is logically organized and is governed by so-called secondary processes.[5]

Freud never clearly identified what he meant by the term "conscious," and used it in its conventional sense. He was much more concerned with defining what he meant by the term "unconscious," a concept he later differentiated from the "preconscious."[6] It is enough for us here that Freud spoke of the unconscious partly as if it were a region in or part of the mental apparatus, and partly as if it were a system of mental operations. He assumed the existence of such alleged phenomena as unconscious knowledge, unconscious conflicts, unconscious needs, and so forth, and used these expressions to describe them.

Unfortunately, this terminology obscures rather than clarifies some of the very problems that must be solved. It is a fundamental postulate of science as a social enterprise that we recognize as knowledge only that which can be made public. This is why the scientific idea of knowledge—as contrasted with mystical or religious versions of it—is so inextricably tied to the idea of representation by means of language or other conventional signs. What cannot be expressed in either object or metalanguage cannot, by definition, be scientific knowledge. It may, of course, be some other kind of "knowledge." For example, a painting may be interesting and beautiful, but its "meaning" is not "knowledge."

A further, related distinction that must be made here is that between knowledge and information. Cloudy skies or books contain information, as their messages may be read, deciphered, and understood by human beings. But only persons contain, and can communicate, knowledge.

If we accept and adhere to this more precise terminology, we must conclude that body languages of the type we have been considering convey not knowledge but information; persons who send such messages claim to send them not as agents

but as bodies. This is why, both for a common-sense understanding of these phenomena and even more for any kind of "rational" psychotherapy with such persons, it is necessary to translate their protolanguage into ordinary language. Freud expressed a similar idea when he spoke of making the patient's unconscious conscious. However, he never conceptualized the "unconscious" as a language, and as *nothing but* a language: that is, not a mysterious mental landscape, but a form of communication. Hence, although the idea of translating protolanguage into ordinary language describes some of the same things Freud described as rendering the unconscious conscious, the two schemes are by no means identical.*

We may now reconsider the question concerning the connection between the use of protolanguage and the sender's "conscious knowledge" of the message he so communicates. The relationship here is an inverse one: while it is evidently impossible to speak about something one does not know, it is possible to express, by means of protolanguage, something which is not clearly understood, explicitly known, or socially acknowledged. The reason for this is that learning and knowledge on the one hand, and symbolic codification and communication on the other, are interdependent and develop together.[8] Since the use of iconic body signs is the simplest communicational device available to man, communication of this type varies inversely with knowledge and learning. The proposition that relatively less sophisticated persons are more likely to use protolanguage is consistent with our knowledge concerning the historical and social determinants of so-called hysterical symptoms. We may recall here the time when human beings tried literally to be the *icons* of Christ on the cross, exhibiting so-called hysterical stigmata. "Conversations" in this sort of protolanguage can occur only if the participants in the communicational process do not easily speak a higher

* There are also some similarities between what I call *protolanguage,* and what von Domarus and Arieti call *paleologic.*[7]

level of language. As a more skeptical attitude developed toward religion, this form of protolinguistic communication began to disappear, and was replaced by one making use of the imagery of illness and treatment.

The Function of Protolanguage

Thus far I have considered only two aspects of the body language characteristic of so-called hysterical symptoms. First, I identified the elements of this language as iconic signs and suggested that it be called protolanguage to set it apart from, and bring it into relation to, object and metalanguage. Second, I analyzed the relationship between the iconic signs of body language and the objects they denote. I was thus concerned with the cognitive uses of languages. The purpose of this type of inquiry is to clarify the meaning of signs by elucidating the relationship between them and the objects to which they refer.

In the science of signs, concern with the cognitive uses of language is designated *semantics*. Semantics refers therefore to the study of the relationship between signs and objects or denotata. Truth and falsehood are semantical indices of the relationship between sign and object. Semantics may now be contrasted with *pragmatics,* which adds the dimension of reference to persons. In pragmatics, one studies the threefold relationship of sign-object-person. The statement "This sentence is a law of physics" illustrates the pragmatic use of language (metalanguage), for it asserts that physicists consider the sentence true. Although the term "semantics" has a conventional, everyday meaning, designating all sorts of studies dealing with verbal communications, I shall use it here in its strict sense.

Let us, following Reichenbach, distinguish three functions, or instrumental uses, of language: the informative, the affective, and the promotive.

The questions in which we are here interested are: What kind of information is communicated by means of iconic body signs, and to whom? How effective is this mode of communication? What are its sources of error?

In order to answer these questions—that is, to identify the *pragmatics of protolanguage*—it is necessary to express our findings in ordinary language or in some logical refinement of it. Thus, we must translate our initial observations into a symbol system other, and logically higher, than that in which they are first articulated.

The principal informative use of a typical hysterical body sign—once again, let us take as our example a hysterically paralyzed arm—is to communicate the idea that the sender is disabled. This may be paraphrased as: "I am disabled," or "I am sick," or "I have been hurt," etc. The recipient for whom the message is intended may be an actual person or may be an internal object or parental image.

In everyday situations—and especially in medical practice—the pragmatic use of body language is regularly confused with its cognitive use. In other words, when we translate the nonverbal communication of a nonfunctioning arm into the form "I am sick" or "My body is disordered," we usually equate and confuse a nonspecific request for help with a request for a specific—that is to say, medical—type of assistance. But insofar as the patient's statement is promotive, it should be translated simply as "Do something for me!"

Although a purely cognitive analysis of this type of message may be irrelevant and misleading, when physicians perform a differential diagnosis for a hysterical symptom they address themselves to body signs as if they constituted cognitive communications. As a result, they come up with the answer "Yes or No," or "True or False." But to say to a patient with a so-called conversion symptom, "Yes, you are ill"—which is what Breuer and Freud said; or "No, you are not ill, you malinger"—which is what physicians before them said, are both

incorrect. Only semantically can an utterance be said to be true or false. Pragmatically, the issue is whether or not the recipient of the message believes what he has been told. Hence, since psychiatry is concerned with sign users rather than with signs—herein lies one of the differences between it and, say, semiotic—a purely semantic analysis of communications will fail to take into account some of the most important aspects of the problems psychiatrists study and try to unravel.

From a pragmatic standpoint, then, viewing illness-imitation as malingering represents a disbelief in, and rejection of, the legitimacy of this sort of communication. It is as if the skeptical physician said to the malingerer: "You can't talk to me like that!" Conversely, viewing illness-imitation as hysteria represents a belief in, and acceptance of, the legitimacy of this sort of communication. It is as if the devout psychoanalyst said to the hysteric: "Tell me more!" To be sure, the analyst, if he is worth his salt, implies more than this; what he usually implies is something of this sort: "I believe that you believe that you are sick (in the sense that your body is ailing). Your belief, however, is probably false. Indeed, you probably believe that you are sick—and want me to believe it—so that we should not have to deal with your real troubles—which are personal, not physical." But as a rule none of this is actually said. And so both patient and analyst come to believe that the patient is somehow truly sick—though just how remains inexplicit.

To properly identify various communicational situations, we must know whether a particular pattern of communication is informative or noninformative. For example, persons making small talk participate in an easygoing, pleasant human relationship. To communicate significant messages is not a part of this situation. A person teaching a class, on the other hand, is expected to convey a certain amount of novel information to his students.

The same distinction must be made with respect to medi-

cine and psychiatry. Each of these disciplines takes a different interest in and attitude toward body signs. Physicians, concerned with the functioning and breakdown of the human body as a machine, are committed to viewing body language as if it spoke in terms of indexical signs. For example, tightness in the chest with pain radiating into the left shoulder and arm in a middle-aged man is viewed as a message informing the physician of a coronary occlusion. Psychoanalysts, concerned with the functioning and breakdown of the human person as an agent, are committed to viewing body language as if it spoke in terms of iconic signs. For example, the same tightness in the chest and pain mentioned above might be viewed as a sign that the patient felt "oppressed" by his wife or employer. And, accordingly, while the physician's task is to diagnose and treat disease, the psychoanalyst's is to foster a self-reflective attitude in the patient toward his own body signs (and other "symptoms"), to facilitate their translation into ordinary language. This process of translation, although easy to describe in the abstract, is in practice often a very difficult undertaking. It constitutes, in my opinion, the core of what has been so mistakenly and misleadingly labeled "psychoanalytic treatment" and "cure."

Another function to which language may be put is to arouse certain emotions in the listener and so induce him to undertake certain actions. Reichenbach calls this the suggestive, and I shall designate it as the affective, use of language. Poetry and propaganda typically serve this function. Few utterances are entirely free of an affective and promotive component.

The significance of the affective use of body language—or generally, of the language of illness—can hardly be exaggerated. The impact of hysterical pantomime, to use Freud's felicitous metaphor, is a matter of everyday knowledge. It is part of our social ethic that we ought to feel sorry for sick people and should try to be helpful to them. Communications by means of body signs may therefore be intended mainly to

induce the following sorts of feelings in the recipient: "Aren't you sorry for me now? You should be ashamed of yourself for having hurt me so! You should be sad seeing how I suffer. . . ." and so forth.

There are, of course, many other situations in which communications are used for a similar purpose. Among these are the ceremonial occasions during which the image of the crucified Christ is displayed. This spectacle affects the spectator as a mood-inducer, commanding him to feel humble, guilty, overawed, and in general mentally constricted—and, hence, receptive to the messages of those who claim to speak for the man and the deed of which the icon is an iconic sign. Similarly, the *grande hystérie* seen at the Salpêtrière, or the flamboyant "schizophrenic bodily feelings" encountered today, represent communications in the contexts of specific social situations. Their aim is to induce mood rather than to convey information. They thus make the recipient of the message feel as if he had been told: "Pay attention to me! Pity me! Scold me!" and so forth. It is indeed common knowledge that body language is much more effective in inducing mood than is ordinary language: children and women often can get their way with tears where their words would fall on deaf ears—and so can patients with symptoms.

The point is that when some persons in some situations cannot make themselves heard by means of ordinary language—for example, speech or writing—they may try to make themselves heard by means of protolanguage, for example, weeping or "symptoms." Others in other situations may try to overcome this obstacle in exactly the opposite way, that is, by shifting from ordinary language spoken in a normal tone of voice to ordinary language spoken in a shout or in a threatening tone. Obviously, the weak tend to use the former strategy, and the strong the latter. When a child cannot get his mother to listen, or a wife her husband, each might try tears; but when a mother cannot get her child to listen, or a husband his wife, each is likely to shout.

This, then, is the essential communicational dilemma in which many weak or oppressed persons find themselves vis-à-vis those who are stronger or who oppress them: if they speak softly, they will not receive a hearing; if they raise their voices literally, they will be considered impertinent; and if they raise their voices metaphorically, they will be diagnosed as insane.

But all this—familiar to ordinary people, poets, and playwrights long before "scientists" studied "psychology"—has apparently eluded psychiatrists, and even ordinary common sense. As a result when persons in authority, or so-called love objects, on whom others depend or feel entitled to make demands, fail or refuse to listen to those who depend or make demands on them; and when, in fear and frustration, rage and retaliation, the complainants then address them by means of iconic signs—the authorities, lay and legal, medical and psychiatric, all conclude that the complainants' communications are "psychiatric symptoms" and that the complainants are "psychiatric patients." We have thus come to speak of all these silent and not-so-silent cries and commands, pleas and reproaches—that is, of all these endlessly diverse "utterances"—as so many different mental illnesses! Evidently, in the modern world many people prefer to believe in various kinds of mental illnesses, such as hysteria, hypochondriasis, and schizophrenia—rather than admit that those so diagnosed resemble plaintiffs in courts more than they do patients in clinics, and are engaged in making various communications of an unpleasant sort, as might be expected of plaintiffs.

The informative use of language thus requires not only that the messages exchanged be cognitively significant but also that the participants be more or less equal or that the situation be free enough for them to act as they wish. Under such circumstances, information may produce the desired action or generate some sort of appropriate counterinformation. When, on the other hand, a weak person seeks aid from a strong one, he must usually resort to affective language. A direct request for help would only further expose his own weakness. Whereas an

indirect request for it, say through the exhibition of suffering, may be effective in securing the sought-for help.[9]

The third function of language, the promotive, is to make the listener perform certain actions. Commands such as "Thou shalt not steal" or "Turn right" illustrate this usage. Employing the imperative form makes the promotive use of language explicit. However, indicative sentences may also be used promotively, as for example, in the sentence "All men are created equal." Although ostensibly a descriptive assertion, it is clear that the statement was intended to be, and can only be, prescriptive and promotive.

Only descriptive assertions or indicative sentences can be said to be true or false. The appropriate response to prescriptive assertions or imperative sentences is agreement and compliance, or disagreement and noncompliance. Having been asked to shut the door, we may either do so or refuse to do so.

Reichenbach has suggested a simple method for transforming imperative sentences into indicative ones—namely, by including the sign user in the statement: "Thus to the imperative 'Shut the door' we can coordinate the indicative sentence 'Mr. A. wishes the door to be shut.' This sentence is true or false."[10] The indicative sentence, however, does not have the promotive power which the prescriptive sentence has.

To be sure, seemingly descriptive sentences may actually play the role of prescriptive ones, and these often have the greatest promotive impact. It is a fundamental characteristic of the language of psychiatry that imperative sentences habitually masquerade in it as indicative ones. This is invariably the case when the communicative situation involves third parties—that is, persons other than the psychiatrist and his patient. For example, the statement "John Doe is psychotic" is ostensibly indicative and informative. Actually, however, it is promotive and prescriptive, and may be translated—by explicitly including the sign users—roughly as follows: "Mrs.

John Doe does not like the way her husband is acting. Dr. James Smith believes that men preoccupied by jealousy are mentally ill and potentially dangerous. Hence, both Mrs. Doe and Dr. Smith want Mr. Doe to be confined in a hospital." Clearly, however, these indicative sentences do not have nearly the same promotive impact as does the much shorter assertion that "John Doe is psychotic."

If language is used promotively and expresses neither truth nor falsehood, how does one respond to it? By offering another promotive communication. Words like "right" and "wrong," which are themselves imperatives, perform this function. The command "Thou shalt not steal" may thus be countered by saying either "right" or "wrong," depending on whether we agree or disagree with this rule.

The most obvious function of body language is its promotive use. By communicating through such "symptoms" as headache, backache, or menstrual pains a housewife who feels overburdened or dissatisfied with her life may be able to make her husband more attentive and helpful toward her. And if not her husband, then perhaps her physician. And if not her physician, then perhaps some specialist to whom he might refer her. And so forth. This action-inducing meaning of iconic body signs may be paraphrased as follows: ("I am sick, therefore . . .) Take care of me!—Be good to me!—Make my husband do such and such!—Tell my draft board to stop bothering me!—Tell the court and the judge that I was not responsible!" And so forth.

Symbolization in Hysteria: A Critical Example

I will now illustrate my thesis by means of an excerpt from Breuer and Freud's *Studies on Hysteria.* The following is from Freud's account of his treatment of Frau Cäcilie M.:

In this phase of the work we came at last to the reproduction of her facial neuralgia, which I myself had treated when it appeared in

contemporary attacks. I was curious to discover whether this, too, would turn out to have a psychical cause. When I began to call up the traumatic scene, the patient saw herself back in a period of great mental irritability toward her husband. She described a conversation which she had with him and a remark of his which she had felt as a bitter insult. Suddenly she put her hand to her cheek, gave a loud cry of pain and said: "It was like a slap in the face." With this her pain and her attack were both at an end.

There is no doubt that what had happened had been a symbolization. She had felt as though she had actually been given a slap in the face. Everyone will immediately ask how it was that the sensation of a "slap in the face" came to take on the outward forms of a trigeminal neuralgia, why it was restricted to the second and third branches, and why it was made worse by opening the mouth and chewing—though, incidentally, not by talking.

Next day the neuralgia was back again. But this time it was cleared up by the reproduction of another scene, the content of which was once again a supposed insult. Things went on like this for nine days. It seemed to be the case that for years insults, and particularly spoken ones, had, through symbolization, brought on fresh attacks of her facial neuralgia.[11]

Here, as elsewhere, Freud speaks of a process of "symbolization" by means of which an insult is transformed into pain. And he calls this process "conversion," thus perpetuating the so-called riddle of the jump from the psychic into the organic. Freud could just as well have said that the patient spoke metaphorically and then mistook her own metaphor for a fact: the insult that was *like* a slap in the face thus became a *real* slap in the face. If so, all one needs to do is to reverse the process and translate literalized metaphor back into true metaphor—that is, facial pain back into humiliation; neurological disease or hysteria back into marital conflict or anger.

I assume that at least one of the reasons why Freud failed to carry through consistently with the model of translation was that he did not grasp exactly what type of symbolization he had identified. How can a slap on the face be "converted" to

(what looks like) trigeminal neuralgia? How can the one be a symbol for the other? Freud did not answer these questions nor, in fact, did he raise them. Instead, he proceeded as follows. First, he assumed that the symbolization described above is essentially similar to that obtaining between verbal symbol and referent. Next, he proceeded as if this had been a fact instead of an unverified—and, as it turned out, incorrect—assumption. And finally, he interpreted hysterical symptoms as if the translation they required were no different from, say, rendering ancient Greek into modern English. Furthermore, he approached the reason for or motives behind the symbolization through the traditional model of medicine. The problem thus became: Why does "conversion" occur? Or, stated more generally: Why does a "patient" develop "hysteria"? In this way, Freud ended up with a classic medical problem: namely, with the problem of the "etiology of hysteria." However, if hysteria is a language, looking for its "etiology" is about as sensible as looking for the "etiology" of English. A language has a history, a geographic distribution, a system of rules for its use—but it does not have an "etiology."

We may now consider the type of symbol which Freud described in the case history cited. How can a facial pain represent a slap in the face? Why should an insult be so denoted? This symbolization is actually of two types.

The first is based on *similarity:* the pain of a slap in the face is similar to the pain of facial neuralgia (or, for that matter, of any other facial pain). Hence, Frau Cäcilie's facial pain is an iconic sign of the pain due to a certain kind of neurological illness affecting the face. Indeed, to some extent, every pain constitutes a potential iconic sign of every other pain. For as in a picture of an egg we recognize every egg we have ever seen, so in each pain we remember every pain we have ever had.

The second is based on *causation:* being slapped in the face and having facial pain stand in a cause-and-effect relationship to one another. Hence, the patient's facial pain is an

indexical sign of facial injury. We know, or can infer, "slaps" from "pains," even though this may not be the only way in which such information can be obtained. Hence, a pain can be an indexical sign of being slapped in the face or of having trigeminal neuralgia—in the same way as having a fever can be an indexical sign of an infection. Both types of sign relations enter into the actual communicational patterns we are here considering. For example, a woman communicating facial pain to her husband may "sound" to him—especially if he has hurt her—as if she were saying: "Do you see now how you have injured me?" The same woman making the same communication to her physician may, on the other hand, "sound" to him as if she were saying: "I have trigeminal neuralgia." Although both husband and physician interpret the pain as a sign at once iconic and indexical, they read it quite differently depending on their specific position in the three-place relation holding between sign, object, and interpreter of sign. It is because of his special position in this three-place relation that the psychoanalyst tends to read the facial pain as an iconic sign—that is, as: "This looks like neuralgia but probably is not."

There remains the question of why a slap on the face should be denoted by facial pains. It should suffice to note here[12] that the use of this type of body language is fostered by circumstances that make direct verbal expression difficult or impossible. The custom of referring to sexual organs and activities by Latin words rather than in one's native tongue affords a typical illustration. Translation from what could be, or had been, ordinary language into protolanguage serves a similar purpose. It makes communication about an important but delicate subject possible, while at the same time it helps the speaker disown the disturbing implications of his message. The specific choice of body signs is generally determined by the unique personal and social circumstances of the sufferer, in accordance with the principles discovered by Freud.

8 Hysteria as Communication

In his Introduction to Wittgenstein's *Tractatus,* Russell declares that "the essential business of language is to assert or deny facts."[1] Only a logician, mathematician, or natural scientist, or someone having these enterprises in mind, could make such a statement. In ordinary life, language is used far more often for purposes other than to assert or deny facts than it is for it: in advertising, in friendly conversation, in religion, politics, psychiatry, and the so-called social sciences—in all these fields and situations and in many others language is used to express emotions, influence actions, and make some sort of verbal contact with other persons. These distinctions point to still another criterion for classifying languages, namely their *discursiveness.*

Discursive and Nondiscursive Languages

Discursiveness is a measure of the degree of arbitrariness in the symbolization. When a mathematician says "Let x stand for a bushel of apples," or "Let g stand for the force of gravity," he is using fully discursive symbols: that is, symbols at once completely arbitrary and completely conventional. Any symbol may be used to denote the force of gravity; its

actual use depends on agreement among scientists on that particular symbol.

On the other hand, when a painter uses certain colors or forms to express his despair, or when a housewife uses certain bodily signs to express hers, the symbols they use are not conventional but idiosyncratic. In short, in art, dance, and ritual—and in so-called psychiatric illness—the characteristic symbols are lawful rather than arbitrary, and yet personal rather than social.

Many philosophers have contended, and continue to contend, that when communications do not convey facts, they are mere "noises" expressing the inner feelings of the speaker. In *Philosophy in a New Key,* Langer criticizes this view and asserts her belief in the necessity of "a genuine semantic beyond the limits of discursive language."[2] One of my aims in this book is to do just this: namely, to provide a systematic semiotical analysis of a language form hitherto regarded as purely expressive—that is, of the language of certain bodily signs.

In contrast to the arbitrariness of the symbols of discursive languages, one of the most important characteristics of the symbols of nondiscursive languages is their nonarbitrariness. This is best illustrated by means of the picture as a symbol: as Langer points out, the photograph of a man does not describe the person who posed for it but rather presents a replica of him.[3] Nondiscursive symbolism is hence often called *presentational.* Further, while discursive symbols are typically abstract, having general referents, nondiscursive symbols are characteristically concrete, having specific objects or persons as their referents. For example, the word "man" refers to every conceivable man—and even woman!—in the universe, but points to no specific person. On the other hand, the photograph of a man represents and identifies a particular person.

In the earliest forms of written language, representation was achieved by means of iconic signs—that is, by hiero-

glyphs, which are a form of picture writing. According to Schlauch,[4] the two simplest elements in written language are pictographs and ideographs. Both express their messages by means of pictures that *resemble* the object or idea to be conveyed. They are the earliest prototypes of what we now call the analogic type of codification. Psychoanalysis and "kinesics"[5] are modern attempts to explore and understand the hieroglyphics that a person writes, not on marble tablets, but on and with his own body.

The advantages of discursive symbolism for transmitting information are obvious. The question is whether nondiscursive symbolism has any function besides that of expressing emotions? As I shall now show, it has several such functions.

Since verbal symbols describe the objects they denote in a relatively general, abstract fashion, the identification of a specific object requires much circumlocution (unless it has a name, which is a very special kind of discursive sign). Because of this, Langer notes that

> . . . the correspondence between a word-picture and a visible object can never be as close as that between the object and its photograph. Given all at once to the intelligent eye, an incredible wealth and detail of information is conveyed by the portrait, where we do not have to stop to construe verbal meanings. That is why we use a photograph rather than a description on a passport or in the Rogue's Gallery.[6]

Similarly, so-called hysterical body signs are pictures which bear a much greater similarity to the objects they depict than do words describing the same objects.* To exhibit, by means of bodily signs—say, by paralyses or convulsions—the idea

* Treating certain forms of behavior as pictures, used to communicate messages, also helps us to comprehend such everyday acts as wearing certain distinctive articles of clothing, such as caps or jackets. Uniforms are used deliberately to bestow a specific identity or role on a person. In all these situations we deal with the social uses of iconic signs.

and message that one is sick is at once more impressive and more informative than simply saying: "I am sick." Body signs portray—they literally present and represent—in exactly what way the sufferer considers himself sick. In the symbolism of his symptom, the patient could be said to present his own complaint and—albeit in a highly condensed form—even his autobiography. This is tacitly recognized by psychoanalysts who often treat the patient's presenting symptom—if he has one—as if it contained the whole history and structure of his "neurosis." When psychoanalysts say that even the simplest symptom can be understood fully only in retrospect, they mean that in order to understand the patient's "symptom" we must be acquainted with all the historically unique aspects of his personal development and social circumstances.

The situation in regard to cases of typical organic disease is quite different. The patient's symptom—say, chest pain due to coronary insufficiency—is not autobiographical. The symbolism is, in other words, not personal and idiosyncratic, but anatomical and physiologic. Chest pains cannot, for example, be the sign of, say, a fractured ankle. Knowledge of pathological anatomy and physiology thus makes it possible to interpret the medical "meaning" of certain bodily symptoms. To interpret iconic symbols, however, it is of no use to be familiar with the language of medicine. What is needed, instead, is familiarity with the personality of the sign user, including his personal history, religion, occupation, and so forth.

Because so-called psychiatric problems have to do with difficulties which are, by their very nature, concrete human experiences, presentational symbolism lends itself readily to the expression of such problems. Human beings do not suffer from Oedipus complexes, sexual frustration, or pent-up anger, as abstractions; they suffer from their specific relationships with parents, mates, children, employers, and so forth. The

language of psychiatric symptoms fits this situation perfectly: iconic body signs point to particular persons or events.

The Nondiscursiveness of Hysteria

To better appreciate just why the communicative aspects of hysterical symptoms are incomprehensible in terms of the logic of everyday speech, let us reconsider some of Freud's clinical observations, cited earlier. Remarking on the differences between organic and hysterical pains, Freud states:

> I was struck by the indefiniteness of all the descriptions of the character of her pains given me by the patient, who was nevertheless a highly intelligent person. A patient suffering from organic pains will, unless he is neurotic in addition, describe them definitely and calmly. He will say, for instance, that they are shooting pains, that they occur at certain intervals, that they seem to him to be brought on by one thing or another. Again, when a neurasthenic describes his pains, he gives an impression of being engaged in a difficult intellectual task to which his strength is quite unequal. He is clearly of the opinion that language is too poor to find words for his sensations and that these sensations are something unique and previously unknown, of which it would be quite impossible to give an exhaustive description.[7]

Freud's account shows how exceedingly difficult it is for the patient to find words for his so-called sensations. The same holds true for patients expressing bodily feelings associated with psychiatric syndromes other than hysteria. This loss for words by the psychiatric patient has been attributed either to the patient's having unusual experiences which are difficult to articulate precisely because of their peculiarity, or to the patient's being generally impoverished in the use of words. I would like to suggest still another possible reason for it—

namely, that the patient's experience—for example, a bodily feeling—is itself a symbol in, or a part of, a nondiscursive language.[8] The difficulty in expressing such a feeling in verbal language would then be due to the fact that nondiscursive languages do not lend themselves to translation into other idioms, least of all into discursive forms. The referents of nondiscursive symbols have meaning only if the communicants are attuned to each other. This is consistent with the actual operations of psychoanalysis: the analytic procedure rests on the taçit assumption that we cannot know—in fact, must not even expect to know—what troubles our patients until we have become attuned to them.

The Informative Function of Iconic Body Signs

In what way can nondiscursive languages be used to transmit information? This question has occupied philosophers and students of signs for a long time. The informative function of a particular nondiscursive language, namely, of so-called hysterical body signs, has been of special interest to psychiatrists. Although hysteria has been approached as if it were a language, it has never been systematically so codified. Let us therefore consider the informative uses of iconic body signs as a system of nondiscursive language. The following remarks will, of course, apply not only to hysteria but also hypochondriasis, schizophrenia, and many other "mental illnesses," insofar as the patient exhibiting them makes use of body signs. Where traditional psychiatric nosology emphasizes "diagnosis," I emphasize here the use of iconic symbols in a medical or psychiatric context.

The informative use of language depends generally on the referents of its symbols. The radical positivist view, rarely held any more, maintains that nondiscursive languages have no referents at all: messages framed in this idiom are considered

to be meaningless. A more balanced and today more widely accepted philosophical position regards the difference between discursive and nondiscursive languages as a matter of degree rather than kind: nondiscursive languages, too, are considered to have referents and cognitive meaning.

Rapoport has suggested that the referents of nondiscursive symbols are the "inner states" of the communicants.[9] While acknowledging that nondiscursive languages have referents, he has continued to adhere to a traditional "out there–in here" distinction between them. Although nondiscursive communications tend to be simple and concrete, they are often not just expressions of the sender's inner experience. Let us consider, in this connection, the example of people fleeing a burning theater. The panicky behavior of some members of the audience may signify—even to someone who neither sees flames nor hears anyone shout "Fire!"—more than mere panic. At first, perhaps, one may respond to the purely affective function of body language: "People around me are panicky: I, too, feel panicky." But closely connected with this, there is also a communication of a quasi-cognitive message: "I am in danger! I must flee to save myself!"

I cite this case to show that the referent inside a communicant—say, his affect—cannot be completely severed from the experiencing person's relationship to the world about him. This is because affects are at once private—"inner referents"—and public—indices of relationships between ego and object(s), self and others.[10] Affects are thus the primary link between inner, private experiences and outer, publicly verifiable occurrences. Herein lies the ground for assigning more than only subjective, idiosyncratic meanings to the referents of nondiscursive languages. Accordingly, the limitation of iconic body signs does not lie only in the subjectiveness of the experience and its expression—that is, in the fact that no one can feel another's pain; it lies, also, in the fact that such signs

present a picture—say, of a person writhing in pain—which, standing alone, has a very limited cognitive content.

The role of gestural communication is pertinent in this connection. Gesture is the earliest faculty of communication, the "elder brother of speech,"[11] which is consistent with the relatively primitive cognitive use to which it may be put, and with the equally primitive learning—by imitation or identification—which it subserves. In semiotical terms, gesture is a highly iconic system of signs, verbal speech is only slightly iconic, while mathematics is completely noniconic.

Hysteria, Translation, and Misinformation

When hysterical body signs are used to transmit information, they exhibit the same limitations as do nondiscursive languages generally. Weakly discursive languages cannot be readily translated into more strongly discursive ones. When such translation is attempted, the possibilities for error are enormous, since virtually any discursive rendition of the original message will, in a sense, be false. There are two basic reasons, then, why hysterical symptoms so often misinform: one is the linguistic difficulty, just noted, of rendering nondiscursive symbolism into discursive form; the other is that the message may actually be intended for an internal object and not for the recipient who actually receives and interprets it.

To be sure, misinformation—whether it be a mistake or a lie—may be communicated by means of ordinary language as well as by iconic body signs. We speak of a lie when the misinformation serves the speaker's interests and when we believe that he has sent the false message deliberately. And we speak of a mistake when the misinformation appears to be indifferent and when we believe that the speaker has not sent the false message deliberately. Hence, there can be no such

thing as a "deliberate mistake," but mistakes out of accident, ignorance, or lack of skill are possible.

In formulating this distinction between lies and mistakes I have deliberately avoided the concept of consciousness. The traditional psychoanalytic idea that so-called conscious imitation of illness is "malingering" and hence "not illness," whereas its allegedly unconscious simulation is itself "illness," that is, "hysteria," creates more problems than it solves. I think it is more useful to distinguish between goal-directed and rule-following behavior on the one hand, and indifferent mistakes on the other. In psychoanalytic theory there is no room for indifferent mistakes—because it is tacitly assumed that all action is goal-directed. It then follows that a person's failure to perform adequately cannot be due to his ignorance of the rules of the game or to his lack of skills in playing it. Instead, the failure itself is regarded as a goal, albeit an unconscious one. This perspective is useful for the therapeutic attitude it inspires. But it is obvious that not all human error is of this purposive kind. To insist on this view is to deny the very possibility of genuine error.

Furthermore, when discovered, people caught in a lie usually utter more lies or say they were merely mistaken (which itself may be lie), whereas people caught in a mistake usually apologize for it. From a cognitive point of view, of course, both lies and mistakes are simply falsehood; from a pragmatic point of view, lies are acts for which we hold persons responsible, whereas mistakes are occurrences for which we do not hold them responsible. Accordingly, whether a particular communication is considered to be a lie or a mistake depends in part on the observer's attitude toward the speaker and his judgment of the speaker's character and conduct. In short, we have a choice between regarding hysteria as a lie or as a mistake. I believe it is cognitively more accurate, and morally more dignified, to regard it as a lie than as a mistake: empiri-

cal evidence favors this view as description or theory; and the desirability of treating persons as responsible agents rather than as inert things favors this view as prescription or strategy.

Language as a Means of Making Contact with Objects*

The study of hysteria, and of psychiatric problems generally, places Donne's famous utterance "No man is an island, entire of itself" in a fresh perspective. Human beings need other human beings. This need cannot be reduced to other, more elementary needs. Freud himself went far in elucidating the young child's immense need for and dependence on his parents, especially his mother or mother surrogate. The theory of object relationships—so central to contemporary psychoanalytic theory—presupposes the need for objects. The essential task of psychoanalysis may even be said to be the study and clarification of the kinds of objects people need, and the exact ways in which they need them. Indeed, much of recent psychoanalytic literature deals with the various mechanisms for seeking and maintaining object relationships. This perspective has made it possible to interpret such things as touching, caressing, cuddling, and, of course, sexual intercourse itself as various means of making contact with objects.

There is no reason to assume that what is true for gestural communications is not also true for verbal language. Since all communicative behavior is addressed to someone, it has, among other functions, also the aim of making contact with another human being. We may call this the object-seeking and relationship-maintaining function of language. The significance and success of this function varies with the discursiveness of the language used. If the principal aim of the com-

* I use the term "object" here in the psychoanalytic sense to refer to persons or to objects invested with personal qualities, such as dolls.

munication is to establish human contact, the language used to achieve it will be relatively nondiscursive—for example, small talk, dancing, "schizophrenic" bodily symptoms. Because of this, we are justified in treating relatively slightly discursive communications mainly as methods of making contact with people rather than as methods of communicating information to them.

This viewpoint is especially relevant to the interpretation of such things as the dance, music, religious ritual, and the representative arts. In all of these, one person can enter into a significant relationship with another by means of a nondiscursive sign system. Using a pharmaceutical analogy, it is as if the language—dance, art, etc.—were the vehicle in which the active ingredient—human contact—is suspended and contained. Many things that people do together have mainly this function, whether it be playing tennis, going hunting with a friend, or attending a scientific meeting.

The object-contacting function of language is most important during the early years of life. With psychological development, its significance is replaced by the informative function of communication. This transformation is shown in condensed form in Table 4. The foremost aim of the child's earliest communications is often to seek objects and to maintain contact with them. Gradually, this "grasping" function of language diminishes. Children then learn to use language abstractly. Serious psychological commitment to reading and writing implies an orientation to persons not physically present. While verbal language, as well as the special languages of science, retain an object-seeking aspect, this becomes increasingly less personal.

Abstract symbol systems, such as mathematics, are especially valuable for object-seeking for schizoid personalities. By means of such symbolizations, object contact may be sought and obtained, while at the same time a psychological distance

Table 4. Development of the Object-seeking Function of Language

Developmental Stage	*Typical Communications and Their Effects on the Recipient*	*Linguistic Characteristics*	*What Is Gained and/or Learned?*
The baby's cry	Crying, weeping, bodily manifestations of suffering and discomfort: "Feel like me!" "Come to me!"	Nonverbal, nondiscursive, high degree of iconicity	Early identifications; maintenance of the organism
The child's verbal complaint	"It hurts!" "I can't sleep!" "Take care of me!" "Don't leave me!"	Verbal, nondiscursive, reduced degree of iconicity	Internalization of objects and building of the self
The child's questioning	"What is it called?" "Where does it come from?" "Can we have some?"	Verbal, increasingly discursive, noniconic (conventional) signs	Internalization of objects; acquisition of information or knowledge
The adolescent's intelligent conversation	Intellectual curiosity: "Talk to me." "Be interested in me (my mind)." "Respect me for my thoughts and knowledge."	Verbal, increasingly discursive	Same as above; identification as adult by relating to adult objects; increasing emphasis on knowledge as a source of self-esteem
The (young) adult student's communicative attitude toward his teacher	The wish for personal instruction: "Teach me!"	Verbal or special discursive symbol systems	Symbols, skills, and knowledge. (Gradually diminishing interest in teacher as person)

Communication with books	The wish to learn impersonally: "Teach me!" as a message addressed to a physically absent person	Same as above	Same as above in a context of individual achievement
Communication with others in a cooperative situation	The wish to learn in a cooperative enterprise; not "Teach me!" but rather "We shall participate together, exchange ideas and skills, and learn from each other."	Same as above	Same as above in a context of cooperative achievement

may be maintained between self and other; it is virtually impossible to have a personal relationship and at the same time to maintain such distance.

Hysteria as Indirect Communication

Highly discursive languages, such as mathematics, permit only direct communications. Mathematical signs have clearly defined referents, accepted by the mutual agreement of all who engage in "conversation" in this idiom. Ambiguity and misunderstanding are thus reduced to a minimum.

The principal linguistic cause of misunderstanding is ambiguity. In ordinary language many signs are employed in several different senses, a circumstance that allows for much ambiguity and hence misunderstanding. At the same time, referential ambiguity allows one to make indirect communications intentionally, by employing expressions known to be interpretable in more than one way.

The difference between indirectness and nondiscursiveness may now be stated. A language is called nondiscursive not because its signs have a multiplicity of well-defined referents, but rather because the referents are idiosyncratic and, hence, poorly defined. Directness and discursiveness overlap at one end, in that highly discursive expressions are also direct. They do not overlap at the other end, for nondiscursiveness itself is no guarantee that the language is useful for indirect communications. For this purpose a language of some discursiveness, such as ordinary language, is more useful than one that is completely nondiscursive, such as music.

There are many terms for various kinds of indirect communications—such as hinting, alluding, speaking in metaphor, double talk, insinuation, implication, punning, and so forth. Significantly, while hinting is neutral in regard to what is being alluded to, insinuation refers only to depreciatory allusions. Moreover, insinuation has no antonym: there is no

expression to describe insinuating something "good" about someone. Although flattery might at times be communicated by allusion, the fact that no special word exists for it provides linguistic support for the thesis that hinting serves mainly to protect a speaker who is afraid of offending.

When the relationship between two people is emotionally significant but uncertain—or when either one feels dependent on or threatened by the other—then the stage is set for the exchange of indirect messages between them. There is good reason for this—namely, that indirect messages serve two important functions—to transmit information and to explore and modify the relationship between the communicants. The exploratory function may include the aim of attempting, however subtly, to change the other person's attitude to make him more receptive to the speaker's needs and desires.

Dating and courtship provide many examples of indirect communications. The young man may want sexual intercourse. The young woman may want marriage. In the initial stages of the dating game neither knows just what the other wants. Hence, they do not know precisely what game they are going to play. Moreover, in our culture direct communications about sexual interests and activities are still felt to be discouraged, even prohibited. Hinting and alluding thus become indispensable methods of communication.

Indirect messages permit communicative contacts when, without them, the alternatives would be total inhibition, silence, and solitude on the one hand, or, on the other, communicative behavior that is direct, offensive, and hence forbidden. This is a painful choice. In actual practice, neither alternative is likely to result in the gratification of personal or sexual needs. In this dilemma, indirect communications provide a useful compromise. As an early move in the dating game, the young man might invite the young woman to dinner or to the movies. These communications are polyvalent: both the invitation and the response to it have several "levels" of

meaning. One is the level of the overt message—that is, whether they will have dinner together, go to a movie, and so forth. Another, more covert, level pertains to the question of sexual activity: acceptance of the dinner invitation implies that sexual overtures might perhaps follow. Conversely, rejection of the invitation means not only refusal of companionship for dinner but also of the possibility of further sexual exploration. There may be still other levels of meaning. For example, acceptance of the dinner invitation may be interpreted as a sign of personal or sexual worth and hence grounds for increased self-esteem, whereas its rejection may mean the opposite and generate feelings of worthlessness.

Freud was a master at elucidating the psychological function of indirect communications. Speaking of the patient's associations to neurotic symptoms, he writes: "The idea occurring to the patient must be in the nature of an *allusion* to the repressed element, like a representation of it in indirect speech."[12] The concept of indirect communication occupies a central position in Freud's theory of dream work and neurotic symptom formation. He compared dream formation to the difficulty which confronts "the political writer who has disagreeable truths to tell those in authority."[13] The political writer, like the dreamer, cannot speak directly. The censor will not allow it. Each must avail himself of "indirect representations."[14]

Indirect communication is also a frequent source of jokes, cartoons, and humor of all sorts.[15] Why is the story of the rich playboy asking the aspiring actress to come to his apartment to view his etchings funny? It is evident that the man is not interested in showing his etchings, nor the woman in looking at them, but that both are interested in sex. The man is interested because it will give him pleasure, the woman perhaps because she will be rewarded in some material way. The same message conveyed in direct language—that is, tell-

ing of a man offering a woman, say, fifty dollars to go to bed with him—would be informative but not humorous.

A linguistic interpretation of humor would thus attribute its pleasurable effects to the successful mastery of a communicative task. If a joke is taken literally—as it often is by children, persons who do not speak the language well, or so-called schizophrenics—it is no longer funny.

The Protective Function of Indirect Communications

The protective function of indirect communications is especially important when they convey embarrassing or prohibited ideas or wishes, such as sexual and dependency needs and problems about money. Faced with such "delicate" matters, indirect communications permit the expression of a need and its simultaneous denial or disavowal. A classic example from medical practice is the physician's avoidance of discussing fees with patients and his assigning this task to a secretary or nurse. The physician communicating through his employee is simultaneously asking for money and not asking for it. The first message is contained *explicitly* in the secretary's request; the second is contained *implicitly* in the doctor's avoidance of the subject. Since the secretary acts as the physician's agent, the physician is, in effect, asking for money. However, by not discussing financial matters openly, the physician is implying that money is of no importance in his relationship with the patient. Much of what is called hypocrisy is this sort of indirect communication, serving, as a rule, the interests of the speaker and infringing correspondingly on the interests of the listener.

Whether a person considers bodily diseases and personal problems acceptable or unacceptable will depend on his particular problems as well as on his system of values. In today's

health-conscious atmosphere, most bodily diseases are acceptable, but most problems in living—lip service to the contrary notwithstanding—are not. Indeed, they are especially unacceptable in a medical setting. Both patients and physicians are thus inclined to deny personal problems and to communicate in terms of bodily illnesses: for example, a man worried about his job or marriage may seek medical attention for hyperacidity and insomnia; and his physician is likely to treat him with antacids and tranquilizers.

Dreaming and Hysteria as Hinting

The main advantage of hinting over more direct forms of communication is the protection it affords the speaker by enabling him to communicate without committing himself to what he says. Should the message be ill received, hinting leaves an escape route open. Indirect communications ensure the speaker that he will be held responsible only for the explicit meaning of his message. The overt message is thus a sort of vehicle for the covert message whose effect is feared.

Any reported dream may be regarded as an indirect communication or a hint. The manifest dream story is the overt message, while the latent dream thoughts constitute the covert message to which the dreamer alludes. This function of dreaming—and of dream communication—is best observed in the psychoanalytic situation, since in it the recounting of dreams is a fully acceptable form of social behavior. Analytic patients often produce dreams that refer to the analyst. Frequently, such dreams reveal that the analysand has some feelings or knowledge about the analyst which he finds distressing and is afraid to mention lest the analyst become angry. For example, the analyst might have been late or might have greeted the patient absentmindedly. The patient now finds himself in the difficult position of wanting to talk about this, to restore a more harmonious relationship with the analyst, yet being

afraid to do so, lest by mentioning it he alienate the analyst still more. In this dilemma, the patient may resort to a dream communication. He might then report a dream alluding to the distressing occurrence, omitting perhaps the person of the analyst from it. This makes it possible for the patient to make the dangerous communication while keeping himself protected, since the analyst can interpret the dream in many different ways.[16]

If the analyst is able and willing to accept the patient's reproach, he can so interpret the dream. Its covert communicative aim will then have been achieved: the embarrassing message was dispatched, the relationship to the analyst was not further endangered, and a more harmonious relationship between patient and analyst was established. On the other hand, if the analyst is upset, defensive, or otherwise unresponsive to the dream's hidden message, he might interpret the communication in some other way. Although this is clearly less desirable for the course of the analysis, it is preferable for the patient to making an overt accusation and being reprimanded for it. The misunderstanding at least does not place an additional burden on an already disharmonious relationship.

The idea that dreams are allusions is not new, Freud himself having suggested it.[17] However, he paid less attention to dream communications as interpersonal events than he did to the mental or intrapsychic aspects of dreaming. Ferenczi went further: in a short paper provocatively titled "To Whom Does One Relate One's Dreams?"[18] he dealt with dreams explicitly as indirect communications.

Just as any reported dream may be regarded as a hint, so may any reported hysterical symptom. Freud attributed the multiplicity of meanings characteristic of hysterical and other psychiatric symptoms and of dreams to a "motivational overdetermination"—that is, to the multiplicity of instinctual needs which the symptom satisfied. I approach the same phe-

nomena here from a semiotical rather than from a motivational point of view: accordingly, instead of an "overdetermination of symptoms," I speak of a diversity of communicational meanings.

The hinting function of hysterical symptoms may be illustrated by the following example. Freud's patient Frau Cäcilie M. suffered from hysterical facial pain, which had at least two distinct meanings.

1. Its overt meaning, directed to the self, significant objects, physician, and others, might be stated as follows: "I am sick. You must help me! You must be good to me!"

2. Its covert meaning, directed principally to a specific person (who may have been either an actual person, or an internal object, or both), might be paraphrased as follows: "You have hurt me as if you had slapped my face. You should be sorry and make amends."

Such communicational interactions, common between husbands and wives and between parents and children, are fostered by situations which make people closely interdependent, requiring that each person curb some of his desires in order to satisfy any of them. Moreover, having curbed some of his needs, the person then demands that his partner(s) do likewise. Thus, the open, undistorted expression of needs is discouraged, and various types of indirect communications and need-satisfactions are encouraged. This sort of arrangement must be contrasted with those situations in which one person supplies the needs of another because of his special knowledge or skills, rather than because of a special relationship between them.

Institutionally based, restrictive relationships, such as those among family members or professional colleagues, must thus be contrasted with instrumentally based, nonrestrictive relationships serving the aims of practical pursuits, such as those between freely practicing experts and their clients or between sellers and buyers. In instrumentally structured situations it is

not necessary for the participants to curb their needs, because the mere expression of needs in no way compels others to gratify them, as it tends to do in the family.[19] Indeed, not only is the frank expression of needs not inhibited, but it is often encouraged, since it helps to identify a problem or need for which someone might have a solution or satisfaction.

Two proverbs illustrate these principles. "Honesty is the best policy" is a familiar English saying. In Hungarian, an equally familiar saying is "Tell the truth and get your head bashed in." The contradiction between these two proverbs is more apparent than real. In fact, each refers to a different social situation; and each is valid in its own context. Honesty is the best policy in instrumentally oriented relationships, but is dangerous in institutional settings. Einstein was rewarded for telling the truth in the open society of science; Galileo was punished for it in the closed society of the Church.[20]

Hysteria: From Illness to Idiom

Although the idea that psychiatry deals with the analysis of communications is not new, the view that so-called mental illnesses are idioms rather than illnesses has not been adequately articulated, nor have its implications been fully appreciated.

I submit that hysteria—meaning communications by means of complaints about the body and bodily signs—constitutes a special form of sign-using behavior. This idiom has a twofold origin: first, the human body—subject to disease and disability, manifested by means of bodily signs (for example, paralysis, convulsion, etc.) and bodily feelings (for example, pain, fatigue, etc.); second, culture and society—in particular the seemingly universal custom of making life easier, at least temporarily, for those who are ill. These two basic factors account for the development and use of the special language of hysteria—which is nothing other than the "language of

illness." People use this language because they have not learned to use any other, or because it is especially useful for them in their situation.

The implications of viewing and treating hysteria—and mental disorders generally—as confronting us with problems like those presented by persons speaking foreign languages rather than like those presented by persons suffering from bodily diseases are briefly as follows. We think and speak of diseases as having "causes," "treatments," and "cures." However, if a person speaks a language other than our own, we do not look for the "cause" of his peculiar linguistic behavior. It would be foolish—and fruitless—to search for the "etiology" of speaking French. To understand such behavior, we must think in terms of learning and meaning. Accordingly, we might conclude that speaking French is the result of living among people who speak French.

It follows, then, that if hysteria is an idiom rather than an illness, it is senseless to inquire into its "causes." As with languages, we shall be able to ask only how hysteria was learned and what it means. It also follows that we cannot meaningfully talk about the "treatment" of hysteria. Although it is obvious that under certain circumstances it may be desirable for a person to change from one language to another—for example, to discontinue speaking French and begin speaking English—we do not call this change a "cure." Thus, speaking in terms of learning rather than in terms of etiology permits one to acknowledge that among a diversity of communicative forms each has its own *raison d'être,* and that, because of the particular circumstances of the communicants, each may be as "valid" as any other.

Finally, while in treating a disease the physician does something to a patient, in teaching a language the instructor helps the student do something for himself. One may get cured of a disease, but one must learn a (foreign) language. The perennial frustration of psychiatrists and psychotherapists thus

comes down to the simple fact that they often try to teach new languages to persons who have not the least interest in learning them. When his patients refused to profit from his "interpretations," Freud declared them to be "resistant" to "treatment." But when immigrants refuse to speak the language of the country in which they live and stick to their old habits of speech, we understand their behavior without recourse to such mysterious pseudomedical explanations.

IV RULE-FOLLOWING ANALYSIS OF BEHAVIOR

9 The Rule-Following Model of Human Behavior

Psychoanalytic explanations are typically couched in terms of motives or wishes: people do one thing or another in order to satisfy the desire which, as we say, "motivates" their behavior. While this sort of explanation is of some value, its worth is easily exaggerated. For example, a psychoanalyst might say about a person who takes up parachute-jumping as a hobby that he is motivated by a suicidal impulse. Regardless of whether or not this account assigns the correct motive to the actor, it obviously fails to explain why he expresses his suicidal propensity through parachute-jumping rather than through some other dangerous and potentially self-destructive activity. In other words, motives explain actions in a general or abstract way; they do not tell us why a particular person acted in a particular way at a particular time. To explain specific actions in concrete ways, we must know other things besides what motivates the actor. The concepts of rule and role are indispensable in this connection.

Motives and Rules

The distinction between motives and rules as explanations of behavior is explored by Peters in his essay *The Concept of*

Motivation. He correctly remarks that in order to foresee and foretell what a person will do, it often is not necessary to know much about him as an individual. It is enough to know the role he is playing:

We know what the parson will do when he begins to walk toward the pulpit in the middle of the penultimate hymn or what the traveller will do when he enters the doors of the hotel because we know the conventions regulating church services and staying at hotels. And we can make such predictions without knowing anything about the causes of people's behaviour. Man in society is like a chessplayer writ large.[1]

From this, Peters concludes that the first things we must know about human actions are the norms and goals that regulate the actor's conduct. The basic sciences of human action are, therefore, anthropology and sociology, for it is these disciplines that are concerned with exhibiting, in a systematic manner, the framework of norms and goals which are necessary to classify actions as being of a certain sort. Psychiatry and psychoanalysis, too, deal with these problems, although they often do so inexplicitly. For example, in the psychoanalytic study of perversions—indeed in the very definition of what constitutes a "perversion"—the observer is concerned with norms and goals. However, by tacitly supporting the socially accepted norms, and by couching the discussion in the language of "psychosexual functions," the psychoanalyst makes it appear as if he were not concerned with norms at all, but only with "biological processes."[2] This is just what Freud did in his *Three Essays on the Theory of Sexuality*[3] and in much of his other work as well.

Another way of putting this matter is to say that psychoanalytic theory offers causal explanations of behavior, whereas role theory[4] offers conventional explanations of it. Causal explanations are, furthermore, mechanistic, often make use of "hidden factors," and frame their hypotheses in

terms of antecedently acting events or forces, such as instincts, drives, or libido. In contrast, conventional explanations are vitalistic, often make use of concepts like choice and will, and frame their hypotheses in terms of behavior-regulating conventions and goals, such as are articulated in religious and professional codes of conduct.

Actually, Freud entertained both causal and conventional explanations, relying on the former for psychoanalytic theory and on the latter for psychoanalytic therapy. Hence the epistemologically and ethically confusing character of psychoanalysis as developed by Freud and his followers.

I have offered examples of Freud's use of causal and motivational explanations, and now want to remark briefly on his use of conventional explanations. Especially in his so-called clinical or therapeutic work, Freud was concerned mainly with a general class of activities—composed of such things as dreams, obsessions, phobias, and perversions—which, according to Peters, are characterized by the fact that they seem "to have no point or a very odd point. . . . By extending the model of purposive rule-following behaviour to cover the unconscious,"[5] Freud reclaimed these phenomena for the "scientific psychology" he called "psychoanalysis." However, because like others in his time and place, Freud equated "conscious" rule-following behavior with the notions of responsibility and punishability, and because he wanted to treat hysteria, and mental illnesses generally, in a nonjudgmental "scientific" fashion, he mystified the very discovery he had made—namely, that "symptomatic" behavior also obeys the principles of rule-following actions. His famous therapeutic dictum, "Where id was, ego shall be," could thus be translated into our present idiom to mean that "obscure and inexplicit rule-following shall be replaced by clear and explicit rule-following." In the following chapters I shall describe and

comment on the precise rules which hysterical behavior follows, how such behavior originates, and why it persists.

Nature and Convention—Biology and Sociology

A fundamental principle of modern science is that there is a logical gulf between nature and convention.* As Peters puts it: "Movements *qua* movements are neither intelligent, efficient, nor correct. They only become so in the context of action."[6] It follows, then, that whether a given phenomenon involving human participation is regarded as *action* or *happening* will have the most profound consequences, because happenings "cannot be characterized as intelligent or unintelligent, correct or incorrect, efficient or inefficient. Prima facie they are just occurrences."[7] For happenings, causal explanations are appropriate and conventional ones are not; for actions, it is the other way around.

Further, Peters notes that when a person is asked to state the motives for his actions, it is often implied that he might be up to no good; and when it is said that his motives are unconscious, it is implied that he is not only up to no good but does not even know it. In other words, there is an important difference between giving a *reason* for one's action and giving a *justification* for it. We hear of causes and reasons in contexts which are ostensibly morally neutral; whereas we hear of motives and justifications in contexts in which moral considerations are essential ingredients. The psychoanalytic effort to supply a motivational analysis of mental illnesses has thus fulfilled more than just a need to offer a scientific explanation of behavior: it has also supplied a covert moral justification for the patient's deviant or offensive behavior, and for the

* This distinction is obscured—or perhaps one should say denied—in the essentially religious concept of "natural law."

psychiatrist's interest in the patient and his efforts to cure, rather than control, him.

Rules, Morals, and Psychoanalysis

Nontechnical terms such as "ethics" and "morals" refer to the rules which persons follow in the conduct of their lives, and sometimes also to the study of these rules. The psychoanalytic term "superego" refers to much the same things: it denotes both a set of rules which the person follows, and sometimes also the scanning and study of his own rules and the rules of others. Furthermore, as I have suggested already, the word "psychoanalysis" itself sometimes refers to the study, and the approval or disapproval, of certain rules of personal conduct. The upshot is that we face here a plethora of terms, some a part of ordinary language and others a part of the specialized language of psychoanalysis, all of which mean approximately the same things. To cut through this morass, I shall simply speak of rule-following and of the consciousness of rules.

The fundamental moral limitation of psychoanalytic theory stems from the fact that Freud was more interested in denouncing the defects inherent in a "morality of infantilism," which is often displayed by "neurotics," than he was in defining the sort of morality he considered appropriate for the "mentally healthy" adult.

Still, it would be an error to believe that psychoanalytic theory makes no contribution to describing and assessing different types of ethical conduct. The crucial notion in this connection is the relative rigidity or flexibility of the superego. The childish, immature, or neurotic superego is rigid; it is characterized by slavish adherence to rules which, moreover, may not be clearly understood. The mature or normal superego, on the other hand, is flexible; it can evaluate the situation at hand and modify the rules accordingly. Thus, in an early,

classic paper, Strachey suggested that the basic aim of psychoanalytic treatment is to make such "mutative interpretations" as would help to render the patient's "rigid superego" more "flexible."[8] Like the psychoanalytic theory of the superego, on which it is based, this view suffers from the limitation of being silent on what sort of rigidity is considered bad or undesirable and what sort of flexibility is considered good or desirable. In short, Freud and other psychoanalysts have persistently dallied with normative systems without ever committing themselves on normative standards.

Indeed, when it came to confronting openly the issue of normative standards, Freud refused the challenge. He went so far as to reiterate the simple, common-sense belief which many people hold—namely, that what is right is what they do. "Many years ago," Jones tells us, "Freud conducted a private correspondence with Putnam on the subject of ethics. Putnam showed it to me and I remember these two sentences: Ich betrachte das Moralische als etwas Selbstverständliches. . . . Ich habe eigentlich nie etwas Gemeines getan."[9]

To assert that morality is self-evident and that one had never done a mean thing are strangely revealing statements to come from the lips of a person whose object of study was man, himself included. It reflects, I believe, Freud's unshakable determination to be a moralist in the guise of a scientist.[10] In this endeavor, he succeeded only too well: as a crypto-moralist, Freud became the founder of a sort of secular religion which has had immense influence on popular contemporary thought and life. As a philosopher, moralist, and psychologist, however, the source of Freud's success was also the source of his failure. Virtually all behavior with which the psychoanalyst and psychiatrist deal is learned behavior. Since such behavior cannot be properly described or analyzed without dealing explicitly with the norms and standards that regulate it, and with the goals it seeks to attain, psychoanalytic

theory is foreordained to being unable to offer an adequate account of such conduct.

Rules and Responsibility

The distinction between happening and action is crucial to my argument, not only in this chapter but throughout this book. I have suggested that, in general, we view physicochemical disorders of the body—for example, cancer of the colon—as happenings; and that we view so-called mental illnesses or psychiatric disorders—for example, a hand-washing compulsion—as actions.

Sometimes the line of demarcation between happening and action is not clear. The point at which a passively incurred event becomes transformed into a role-playing situation, provided that the person affected is neurologically intact, will depend on his own attitude toward his human condition. By "attitude" I refer here to whether he is hopeful or dejected, oriented toward active mastery or passive endurance. To illustrate this, let us consider the hypothetical case of a man involved in a train collision on his way to work. He is injured, is rendered temporarily unconscious, and is taken to a hospital: all this happens to him. On regaining consciousness, he finds himself in the patient role: henceforth his behavior must be viewed in terms of rule following and role playing. Indeed, no other analysis could adequately account for his personal conduct once his total loss of control due to unconsciousness is replaced by a measure of self-control due to his recovery of consciousness. While this may be obvious, I emphasize it because people in quandaries so often regard themselves as utterly helpless, the "victims of circumstances."

Actually, people may or may not be victims of circumstances. Usually, unfavorable circumstances and personal "styles of life"[11] both play a role in shaping the fates of men. The point is that even though a person may experience and

define his situation as if he played no part in bringing it about, this may in fact not be true. On the contrary, such a claim often serves a defensive purpose. In other words, when choices are made—either by specific action, or more often by inaction—and when these lead to unhappy consequences, people often feel that "it was not their fault" that things turned out as they did. In a purely conventional moral sense they might be correct. But this is simply because common sense assigns guilt or blame only to the specific commission of acts—much less often to omissions—and even among these usually only to acts whose deleterious effects are immediate or short-range. In any case, I would insist that, to some extent at least, all people do shape their own destinies, no matter how much they might bewail the superior forces of alien wills and powers.

Rules and Antirules

To assert that man follows rules implies more than that he is inclined to act on the basis of rules which he has been taught; it implies that he is also inclined to act in diametrical opposition to these rules.

In this connection, Freud's[12] observations concerning the antithetical meanings of so-called primal words are pertinent. He noted that certain basic words of a language may be used to express contrary meanings; in Latin, for example, *sacer* means holy and accursed. This antithetical meaning of certain symbols is an important characteristic of dream psychology. In a dream, a symbol may stand for itself or for its opposite—for example, tall may signify tall or short, or young may stand for young or old. I have suggested that this principle also applies to affects.[13] For example, feeling afraid may signify that one is afraid—or that one is vigilant and prepared for danger; feeling guilty, that one is guilty—or that one is conscientious; and so forth. This antithetical signification seems to be inherent in the nature of man's capacity to form and use

symbols: it applies to affects, iconic signs, words, rules, and systems of rules (games), each of which may signify or, more often, suggest both the referent and its opposite.

Antirules are especially significant in the behavior of children or other psychosocially unsophisticated individuals. Such persons tend to perceive and order their world mainly in terms of the rules they have been given and their opposites. It must be noted, too, that while positive rule following tends to assure social harmony, it often fails to satisfy the human need for personal autonomy. To satisfy this latter need, it is necessary to follow one's own rules. The earliest and simplest rules which we experience as our own are antirules. Thus, as early as during the first year of life, when babies are urged to eat, they often protest by refusing to eat. The so-called negativism of young children probably constitutes the earliest instances of negative rule following—or the following of antirules. This is well understood by intuitive persons and is expressed by such remarks as "If I want him to do something, I must ask him to do the opposite." The proverbially stubborn mule can be made to advance only if his master acts as if he were trying to make him back up. And then there is the familiar rule about forbidden fruit tasting sweeter. The importance of this principle for antisocial and delinquent behavior is well known to psychologists and even to laymen. The notion of antirules which I suggest here is, however, of wider scope, as it includes both proscriptive and prescriptive rules.

Thus, some of the rules set forth in the Ten Commandments are prohibitions—for example, of murder and theft; others are prescriptions—for example, to honor one's father and mother. Clearly, each of these implies and suggests its opposite. To be told not to kill or steal creates the idea that one might. To be sure, people no doubt entertained such ideas even before the Ten Commandments were promulgated. It would be fair to assert, therefore, that most criminal laws are aimed at curbing propensities that exist prior to their legislative prohibition.

Still, this does not negate the fact that laws—especially many modern laws—also create and encourage propensities to engage in the very behaviors which they prohibit.

A Classification of Rules

We are ready now to examine the function and transmission of rules. Children growing up in contemporary Western cultures must learn a large variety of rules. These may be conveniently divided into three classes: (1) natural laws or biological rules; (2) prescriptive laws or social (religious, moral) rules; and (3) imitative or interpersonal rules.

Biological Rules

Biological rules form a special part of the larger category commonly called the Laws of Nature. These rules are concerned with the physics and chemistry of the human body in relation to its material or nonhuman environment. The implicit aims of biological rules—made explicit by man—are survival of the individual as a physicochemical machine and survival of the species as a biological system. Many basic biological rules are learned by direct experience, but some, at least in a rudimentary form, may be said to be inborn. More sophisticated knowledge concerning biological rules must be learned by the methods of science. The basic medical sciences could be said to serve this end.

In this connection, the question arises as to whether animals "know" certain basic biological rules. In one sense, the answer must be that they do, for without "obeying" them they would perish. It is important, however, to be clear about the sense in which animals "know" such rules. This knowledge consists of the appropriate responses to certain objects in their environment; it is automatic, conditioned, and not self-reflective. In a hierarchy of learning and knowing, this type of knowledge would have to be considered the simplest and most basic. It

consists of responding to objects as objects, not as signs, and may be called object learning.

Animals do not know any other types of rules—that is, metarules. Although monkeys play games, and some other animals—for example, bears and seals—can readily be taught to follow rules by imitation and practice, it appears that the animal's limited capacity for symbolization restricts his use of rules to those which are nonreflective. In short, animals cannot use rules intelligently, with an awareness or knowledge that they are using rules: they cannot modify rules in accordance with the demands of a particular situation, nor can they learn metarules.[14]

Social, Religious, or Moral Rules

In the class of social, religious, and moral rules belong all prescriptive laws governing social relationships, whether these are said to originate from a single God, a multiplicity of deities, or culture and society. These laws differ from so-called natural laws with respect to geographical scope or distribution and also in the nature of the sanctions. Natural laws hold for all parts of the world, although, as it is now realized, they may not apply in situations outside of it, for example on another planet.

The term "social rules" designates all the rules that originate from the prevailing practices of a social group. If these are significantly disobeyed, the person will perish. The emphasis here is on the word "person," for our focus has shifted from biological to social survival—which depends on adapting to the social rules or changing them to suit one's needs, much as biological survival depends on adapting to biological rules.

Imitative or Interpersonal Rules

Imitative or interpersonal rules are learned, principally in childhood, by imitating someone else's example. In innumer-

able instances children look, literally as well as metaphorically, to their parents, siblings, or peers, to see how they should act. Their conduct is based on example, much as a mock-up model in engineering serves as an example after which a particular product to be manufactured is fashioned.

The boundary between imitative and social rules is not always sharp or clear. Some social rules are acquired by imitation. Moreover, since imitative rules are learned chiefly in the family, they form a subgroup of the larger class called "social rules." Nevertheless, it is useful—especially for our present purpose in regard to hysteria and mental illness—to draw as sharp a distinction as possible between these two types of rules. Let us therefore pay special attention to the differences between social and interpersonal rules.

Imitative rules usually refer to trivial, everyday matters, such as how to eat, dress, care for one's body, and so forth. Instead of being articulated in verbal form, these rules are displayed in the actual everyday behavior of the older members of the family or group. Children acquire these rules by "blind imitation." The "blind" quality of this sort of learning must be emphasized, because—in contrast to, say, attempting to forge another person's signature—this type of imitation is unconscious or unreflective. For example, in learning to speak one's mother tongue, one is not aware of imitating others.

In contrast to the trivial nature of many of the acts learned by imitative rule following, and to the inexplicit nature of these rules, social rules refer to the regulation, by explicit rules, of more complex behavioral situations. Imitative rules thus articulate customs, while social rules articulate moral-religious prescriptions or secular laws. The sanctions for each vary accordingly: failure to learn or comply with imitative rules leads merely to being thought of as eccentric, stupid, foolish, or naughty; deviance from social rules, however, brings serious consequences upon the offender, ranging from stigmatization to expulsion from the group, and even to death.

Table 5. A Classification of Rules: Biological, Social, and Interpersonal

	Biological Rules	*Social Rules*	*Interpersonal Rules*
Example	"You must eat to live; otherwise you will starve to death."	"You must worship God to live; otherwise you will be expelled from the group."	"If you are a male, you must grow up to be self-reliant, so that you can provide for your wife and children; otherwise you will not be able to consider yourself a grown man."
Subject matter studied by	Biological sciences	Anthropology, Sociology	Anthropology, Psychology, Psychoanalysis
Aims of the rules	Survival of physical body and/*or* species. Biological identity	Survival of (large) group as a social organization. Social (group) identity	Survival of small group (family) or individual, as social being. Individual identity
Sanctions for breaking the rules	1. Illness or disability of the body 2. Dissolution of the physical body: "biological death"	1. Socially deviant behavior and "punishment"; "crime," "sin" 2. Expulsion from the group; loss of social identity; "social death"	Interpersonal conflict; personal defeat, frustration, and unhappiness; "mental illness"; "human failure"
Sanctions codified as	Natural laws	Legal (or religious) "laws"	Customs, codes of personal conduct
Rewards for successfully modifying the rules	Extension of life span and increase in physical effectiveness and health	Enlarged scope of fraternity and cooperation (e.g., supranational versus national interests and identity)	Creative self-determination; enhanced sense of identity and freedom
Rate of change	Nil or very slow	Gradual	Most rapid

By and large, sociologists study social rules; psychologists and psychoanalysts study imitative or interpersonal rules; and anthropologists study both types. (See Table 5 for a schematic summary of the characteristics of these three classes of rules.)

The Need for Rules

The existence and durability of social rules—irrespective of the sources to which man may have attributed them—is evidence of the intensity of the human need to follow rules. Indeed, man's need for rules and his propensity to follow them is equaled only by his desire to reject rules and be free of them. As I will try to show later,[15] this antithetical disposition is a special instance of a more general human ambivalence—namely, the simultaneous needs for intimacy and solitude. Alternating attitudes of submission to and rebellion against people and rules may be best viewed as manifestations of this fundamental human paradox. One of the most useful methods for resolving this dilemma is our capacity for abstraction which makes it possible to construct progressively higher levels of symbolization; these constructs, in turn, lead to a lessening of the feeling of compulsion attached to rules explicitly understood as rules. Thus, for each set of rules we can, in principle, construct a set of metarules. The latter are made up of the specifications governing the formation of the rules at the next lower (logical) level. Explicit awareness of metarules implies an understanding of the origin, function, and scope of the (next lower level) rules. Acquiring such understanding constitutes a form of mastery. Only by practicing what may be called the metarule attitude—which is actually a special case of the scientific attitude applied to the domain of rules—can we acquire a secure yet flexible integration of rules as behavior-regulating agencies. Finally, the metarule attitude enables us to increase our range of choices about whether or not to comply with rules, and whether or not to try to change them.

10 The Ethics of Helplessness and Helpfulness

I have suggested that the concept of hysteria refers to the expression and communication—chiefly by means of non-verbal, bodily signs—of a state of disability or illness. The implicit aim of such communication is to secure help. If the problem of hysteria is framed in this way, it becomes logical to ask where the idea originates that the rules of the game of life ought to be such that those who are weak, disabled, or ill should be helped? One answer is obvious: this is the game typically played in childhood. Every one of us was, at one time, a weak and helpless child, cared for by adults; without such help we would not have survived and become adults.

Another, almost equally obvious answer is that the prescription of a help-giving attitude toward the weak is embodied in the dominant religions of Western man. Judaism, and especially Christianity, teach these rules by means of parable and prohibition, example and exhortation, and by every other means available to their representatives.

In this chapter I shall try to present a systematic exposition of these two general systems of rules. The first might be regarded as the rules of the family game; the second, those of the religious game. I have singled out these rules because they provide much of the historical basis and continuing rationale

for the strategies of so-called hysterical behavior as well as for those of many other mental illnesses. In short, men and women learn how to be mentally ill by following the rules of these two games.

Childhood and the Rules of Helplessness

The belief that human beings want to remain children and that becoming an adult is always and inescapably painful is at the very heart of the psychoanalytic theory of human development and personality. Freud himself was inordinately fond of this idea and never ceased to make use of it in his speculations. He thus claimed that the human inclination toward immaturity and childishness is innate or biologically "given," but that the inclination toward maturity and adulthood is reactive to frustration and is not biologically "given." In Freud's view, personal and cultural development is the result of instinctual—principally sexual—frustration imposed by "external" reality: hence the irreconcilable conflict between "selfish" instinctual satisfaction and the satisfaction of "social" interests or needs.[1] One of the important implications of this theory is that the human disposition to resume immature or childish patterns of behavior, which Freud called "regression," is regarded as satisfying a biological need similar to other biological needs, such as that for food or water. This makes it unnecessary to look for, or to attribute, regressive behavior to learning and to certain particular social influences. This whole scheme is, I think, quite absurd: according to it, only those things which Freud categorizes as mature or progressive are learned; all other things, categorized as immature or regressive, are the results of a quasi-automatic biological process called "regression."

Moreover, not only is this psychoanalytic account not scientific, it is also not new: Freud's view of the man-child being driven out of his immature state by "frustration" is a

thinly disguised restatement of the Biblical account of the Fall. The story of Genesis implies that Adam and Eve liked living in the Garden; why else would they have had to be "expelled" from it? Similarly, Freud's story implies that human beings like to be children; why else would they have to be "frustrated" out of childishness? In both the religious and the psychoanalytic accounts, regressive goals are primary. This, it seems to me, flies squarely in the face of the most elementary observations about how children usually feel about being children and about growing up.

I submit that Paradise Lost is still another myth. The pleasures of childhood and regression are vastly overrated in psychoanalysis, and those of adulthood and competence vastly underrated. Many observers of the human condition have offered quite different accounts of how people develop, giving much greater weight to innate drives toward maturation.[2] Susanne Langer has emphasized especially the human drive toward symbolization, a view with which I am in full agreement.[3] I believe, moreover, that human beings have maturational drives not only with respect to symbolization but also with respect to object contact or human relationships.[4]

All this is not to deny that learning is often difficult and painful: it requires diligence, self-discipline, and perseverance. Since being childish is, in a sense, a habit, it must, like all habits one wants to change, be overcome. Nor must the labor-saving aspects of being childish be minimized. At the same time, it is important to keep in mind that saving effort is attractive only for those who are lazy or lethargic, sick or stupid. A healthy and energetic person, especially when young, has an urge to expend effort, not to conserve it; and, depending on how he expends it, he is likely to enjoy the effort.

In short, I submit that the significance of religious, cultural, legal, and familial prohibitions against learning and competence have been astonishingly neglected in most scientific

theories of human development. I offer the following brief examples not to document but only to illustrate this contention.

1. The Jewish and Christian religions attribute man's fall from divine grace to the partaking of the fruit of the "tree of knowledge."

2. For centuries, the Roman Catholic Church maintained an Index of prohibited books. Secular authorities in most countries continue to prohibit the printing or distribution of certain books, pictures, and films.

3. Countless more subtle but equally powerful social forces prevent people from learning elementary facts about birth and death, medicine and law, religion and history. National narcissisms and religious, racial, and sexual prejudice all encourage and reward various kinds of overt or covert ignorance and infantilism.

4. In the family, and in other small groups, individuals often foster stupidity and dependency in others—for example, parents in children, husbands in wives or vice versa—in order to enhance their own self-esteem and security.

Biblical Rules Fostering Disability and Illness

Jewish and Christian religious teachings abound in rules that reward sickness and stupidity, poverty and timidity—in short, disabilities of all sorts. Moreover, these rules or their corollaries threaten penalties for self-reliance and competence, and for pride in health and well-being. This is a bold assertion, although not a particularly novel one. I shall try to support it by citing adequate evidence. I do not argue, of course, that prescriptions fostering disability constitute the whole or the essence of the Bible, which is a complex and heterogeneous work from which countless rules of conduct may be inferred. Indeed, the religious history of the West illustrates how, by taking one or another part of this work, it is possible to sup-

port or oppose a wide variety of human behaviors—from slavery to witch burning, and from celibacy to polygamy.

Personally, I support respect for the autonomy and integrity of one's self and others, but shall not make any attempt to justify these values here. I believe, however, that in a work of this kind it is necessary to make one's moral preferences explicit, to enable the reader to better judge and compensate for the author's biases.

My approach to religious rules and rule following is socio-psychological, not theological. Whether my interpretations of religious rules are "theologically correct" is, I believe, somewhat irrelevant. What is relevant is whether I have inferred correctly or falsely from the actual behavior of persons professing to be religious the rules that govern and explain their conduct.

In addressing myself to Scriptural passages as written statements, I try to assume the role of a critical interpreter. I shall scrutinize certain Biblical rules, not to praise or condemn them, which has been done enough—but rather to make explicit the values they approve or disapprove, endorse or reject. Naturally, some of my interpretations will conflict with the interpretations of modern clergymen trying to make Scriptural texts fit for modern consumption. Contemporary "liberal" interpretations of religious documents, whether Christian or Jewish, serve mainly one aim, namely to sell religion to modern man—an unenviable task if ever there was one. It is only right for vendors to wrap their merchandise so as to make it attractive for the buyer—in this case, to make these religions as compatible as possible with the political and scientific ideas and institutions of modern Western nations.

The motif that God loves the humble, the meek, the needy, and those who fear Him is a thread running through both the Old and New Testaments. Man's fear of being too well off lest he offend God and make Him envious is deeply ingrained in the Jewish religion as well as in ancient Greek pantheism. It is

an element common to most primitive religions—that is, religions in which man conceives of God in his own image: God is like man, only more so. The deity is a kind of superman with his own needs for self-esteem and status which mortal men are enjoined to threaten at their own peril. The legend of Polycrates, the overly lucky king of Samos, illustrates this theme.[5]

This attitude, which is basically a dread of happiness generated by a powerful fear of envy, is fundamental to the psychology of the person seriously committed to the Judaeo-Christian ethic. The defensive, self-protective character of this maneuver is evident. For such a tactic to be effective, it is necessary to assume, first, the presence of another person (or persons) and, second, the operation of certain rules by which this person conducts himself.

Who is man's partner-opponent in this game of "I-am-not-happy"? What are the specific rules of this game that make this a good tactic? As to the identity of the opponent, we may say, without going into unnecessary details, that it is God and a succession of other powerful figures vis-à-vis whom the player occupies a subservient position. The power differential between the two players is crucial, for it alone can account for the fear of envy. In a dominant-submissive relationship, only the submissive member of the pair needs to fear arousing the envy of his partner. The dominant player has no such fears, because he knows that the other is powerless to injure him seriously.

In general, then, the open acknowledgment of satisfaction is feared only in oppressive situations—for example, by the much-suffering wife married to a domineering husband. The experience and expression of satisfaction (joy, contentment) are inhibited lest they lead to an augmentation of one's burden. This dilemma must be faced, for example, by persons who come from large, poor families and do moderately well financially while the other family members remain poor. If

such a person manages to become very wealthy, he will be able to take care of all the other family members who want to be dependent on him. However, if he is only moderately well off, he will be faced with the threat that, irrespective of how hard he works, the demands of his poor relatives will prevent him from enjoying the fruits of his own labor, thrift, and perhaps good luck. Their needs will always be greater than his assets.* If our hypothetical moderately successful man wants to prevent antagonizing his poor relatives, he will be prompted to "malinger" in regard to his financial situation. He will pretend to be less well off than he really is.

There is thus a close similarity between misrepresenting health as illness on the one hand, and wealth as poverty on the other. Although, on the surface, both maneuvers seem painful and self-damaging, closer inspection of the social context in which they occur reveals that they are defensive operations. Their purpose is to sacrifice a part to save the whole. For example, in wartime, bodily survival may be safeguarded by simulating ill-health. Or financial possessions may be safeguarded by pretending to be poor.

The fear of acknowledging satisfaction is a characteristic feature of slave psychology. The "well-worked" slave is forced to labor until he is exhausted. To complete his task does not mean that his duties are finished and that he may rest. On the contrary, it only invites further demands. Conversely, although his task may be unfinished, he might be able to influence his master to stop driving him—and to let him rest—if he exhibits the appropriate signs of imminent collapse, whether genuine or contrived. However, displaying signs of exhaustion—irrespective of whether they are genuine or contrived—is, especially if it is habitual, likely to induce a feeling of fatigue or exhaustion in the actor. I believe that this explains many of the so-called chronic fatigue states of which harassed people complain: such persons are unconsciously "on strike"

* Progressive taxation may create similar feelings in people.

against individuals (actual or internal) to whom they relate subserviently and against whom they wage an unceasing and unsuccessful covert rebellion. In contrast to the slave, a free man can, depending on his circumstances, set his own pace: he can work although tired, and rest though rested—and can enjoy both his labor and its fruits.

Let us now consider some specific rules which make disability or illness potential or actual advantages. In certain situations, these rules prescribe that when man (subject, son, patient) is healthy, independent, rich, and proud, then God (king, father, physician) shall be strict with him and punish him. But should man be sick, dependent, poor, and humble, then God shall care for him and protect him. It might seem that I have exaggerated this rule. I do not believe so. Rather, this impression reflects our spontaneous antagonism to such a rule when it is clearly and forcefully stated.

Many Biblical passages could be cited to support this thesis. For example, in Luke we read:

> Now when Jesus heard these things, he said unto him, Yet lackest thou one thing: sell all that thou hast, and distribute unto the poor, and thou shall have treasure in heaven: and come, follow me. And when he heard this, he was very sorrowful: for he was very rich. And when Jesus saw that he was very sorrowful, He said, How hardly shall they that have riches enter into the kingdom of God! For it is easier for a camel to go through a needle's eye, than for a rich man to enter into the kingdom of God.[6]

The Sermon on the Mount[7] is probably the best-known illustration of Biblical rules fostering dependency and disability. Here, Jesus blesses the poor in spirit, the meek, the mourner, and so forth. This passage articulates most clearly the basic rules by which the Christian God plays His game with Man. What does God pledge Himself to do? And what type of behavior does He demand of Man? To frame my answers properly, I have paraphrased the Beatitudes by translating the Biblical phrasing "blessed are" into "should," and

by supplementing each prescription so obtained by the corresponding proscription. The Beatitudes then read, in part, as follows:

The Biblical text (Matthew 5:3, 5, 8)	*Its logical corollary* (My interpretation)
Blessed are the poor in spirit: for theirs is the kingdom of heaven.	Man should be "poor in spirit"—i.e., stupid, submissive: Do not be smart, well-informed, or assertive!
Blessed are the meek: for they shall inherit the earth.	Man should be "meek"—i.e., passive, weak, submissive: Do not be self-reliant!
Blessed are the pure in heart: for they shall see God.	Man should be "pure in heart"—i.e., naïve, unquestioningly loyal: Do not entertain doubt (about God)!

Stated in this form, it is evident that these rules constitute a simple reversal of rules generally governing rewards and punishments for man on earth. As a result, defects and deficiencies are codified as positive values. Elsewhere man is explicitly enjoined to "take no thought for the morrow."[8] In other words, man should not plan for the future, should not try to provide for himself and for those who depend on him; instead, he should trust and have faith in God.

Rules rewarding "negative possessions"—that is, not having foresight, happiness, or wisdom—pervade the whole Christian ethic. The rewards of being poor,[9] hungry,[10] and emasculated are specifically emphasized, the latter in the following famous passage: "For there are some eunuchs, which were so born from their mother's womb: and there are some eunuchs, which were made eunuchs of men: and there be eunuchs, which have made themselves eunuchs for the kingdom of heaven's sake."[11]

Man's emasculation is here codified as one of the ways of courting God's love. The themes of self-castration and im-

potence—or, more generally, of lust and its vicissitudes—are the dominant images, first, in many parts of the Bible; second, in the documents dealing with witchcraft and justifying the persecution of witches;[12] and third, in the case histories and speculations of the early psychoanalysts.[13]

It is implicit in these Biblical rules of helplessness that the disabled may regard their weakened status as *prima facie* evidence of merit, which must be rewarded by the appropriate theological, medical, or psychiatric interventions. In the hysterical transaction, disability is used as a coercive tactic to force others to provide for one's needs. It is as if the patient were saying: "You have told me to be disabled—to be stupid, weak, and timid. You have promised that you would then love me and take care of me. Here I am, doing just as you have told me, it is your turn now to fulfill your promise!" Much of psychoanalytic psychotherapy may revolve around the theme of uncovering exactly who taught the patient to behave in this way, and why he accepted such teachings. It may then be discovered that religion, society, and parents have conspired, as it were, to inculcate this code of conduct, even though it is so tragically ill-suited to the requirements of our present social conditions.

Some Historical Comments on Rule Reversal

As I have implied earlier, the beliefs and practices of Christianity are best suited for children and slaves; this is hardly surprising when we recall the social circumstances in which this creed emerged.

Taken as a whole, I would offer the following generalization about the Bible: although some of its rules aim at the mitigation of oppression, their general sense nevertheless fosters the same oppressive spirit from which these rules arose and with which their creators must inevitably have been imbued. Moreover, since oppressed and oppressor form a

functional pair, their respective orientations to human relationships tend to be similar. This effect is further enhanced by the basic human tendency for persons to identify with those with whom they interact. Hence, each slave is a potential master, and each master a potential slave. It is extremely important to keep this in mind and to avoid the misleading contrast between the psychology of the oppressed and that of the oppressor. Instead, the similar orientation of each should be contrasted with the orientation of the person who wants to be neither slave nor master—but only his fellowman's equal. Abraham Lincoln has put this with memorable perfection: "As I would not be a slave, so I would not be a master. This expresses my idea of democracy. Whatever differs from this, to the extent of the difference, is not democracy."[14] If we define a free, self-governing person as Lincoln saw him, then we have an individual into whose scheme of life the Biblical rules do not fit at all.

How are new social rules created and enforced? Forceful subjugation is one obvious method for enforcing new rules. It is available, however, only for the strong. The weak must rely on more subtle methods of persuasion. The early as against the later histories of many groups—Christianity and psychoanalysis among them—illustrate the uses of these methods. When Christianity arose, its supporters were weak; hence, they had to depend on noncoercive methods to spread their views. However, after they gained power, they did not hesitate to use coercive measures. The persecuted became the persecutors.

Another method, which oppressed individuals and groups characteristically use, is rule change of the type "the first shall be the last, and the last shall be the first."[15] On the face of it, such a proposal often seems to be merely a modest effort to improve the lot of the oppressed; but if it is successful, it often turns out to be an effort to reverse positions, making the oppressed the oppressors, and vice versa.

The historical model of the rule reversals advocated by Jesus was that used by Moses and the Jews. Dissatisfied with their real-life situation, the Jews apparently seized upon the inspired idea that, although they were having a poor time of it in their everyday life, they were actually God's Chosen People. Now, to be a chosen or preferred person implies that something especially good will happen to one, even if it is only to receive the love of an unseen God. If it works, this is a psychologically excellent maneuver: it helps to bolster the believer's weakened sense of self-esteem; and he may thus reject his degraded status as slave and rise to a more fully human stature.

The general usefulness of this maneuver was, however, seriously hampered by its unavailability: Judaism was not a proselytizing religion. The Jews thus imitated the slaveholder group: they, too, formed an essentially exclusive club.

Resting on this historical base, Jesus democratized the spirit of emancipation from slavery. In democratic societies, social status is based on achievement, not on ancestry. Early Christianity represents a forerunner of this modern arrangement: Jesus proclaimed that the New Rules shall apply to all who wish to embrace them. This far-reaching democratization of Judaism no doubt contributed heavily to the immense social success of Christianity over the next two millennia.

By New Rules I refer, of course, to some of the rules set forth in the New Testament. The New Testament must not be contrasted with the Old Testament, for the New Rules reversed not those of Judaism but rather those of the social order which prevailed at that time. What were these rules? That it was better to be a free citizen of Rome and a believer in Roman polytheism than not to be; that it was better to be healthy than sick, wealthy than poor, admired and beloved rather than persecuted and hated, and so forth. The New Rules, as set forth by Jesus and Saint Paul, consisted of a radical reversal of these real-life rules. Henceforth the "last"

shall be "first"—the "loser" shall be the "winner": faithful Christians will be the winners, pagan Romans the losers; healthy, wealthy, and admired people will be punished, while the sick, poor, and persecuted will be rewarded.

The New Rules possessed several features that helped to make them popular and successful. In the early days of Christianity, there were, of course, many more slaves, sick, poor, and unhappy people than free, healthy, and satisfied ones. This remains true even today. Accordingly, while the rules of the earthly game, as practiced in Roman society, held out a promise of opportunity to only a few men, the rules of Christianity held out the promise of bountiful rewards in a life hereafter to many. In this sense, too, Christianity constituted a move toward democracy and populism.

We know only too well by now, however, that a social rule useful at one time and for one purpose may be useless and harmful at another time and for another purpose. Although Biblical rules once had a largely liberating influence, their effect has long since become both psychologically and politically oppressive. Alas, this transformation has characterized the course of most revolutions, the initial phase of liberation being quickly succeeded by a new phase of oppression.[16]

The general principle that a liberating rule may, in due time, become another method of oppression has broad validity for rule-changing maneuvers of all types. This is the reason why it is so dangerous today wholeheartedly to espouse new social schemes that offer merely another set of new rules. Although, if social life is to continue as a dynamic process tending toward ever-increasing human complexity and self-determination, new rules are constantly needed; but much more than mere rule changing is necessary to attain this goal. In addition to exchanging new rules for old, we must be aware of the rationale of the old rules and guard against their persistent effects. One such effect is to form new rules that are covert reaction-formations against the old ones. Christianity,

the French Revolution, Marxism, and even psychoanalysis—as a revolution in medicine against the so-called organic tradition—all succumbed to the inescapable fate of all revolutions, the setting up of new tyrannies.

The effects of religious teachings on contemporary Western man is still a delicate subject. Psychiatrists, psychologists, and social scientists tend to avoid it. I have tried to reopen this subject by re-examining some of the values and rules of the Judaeo-Christian religions. If we sincerely desire a scientifically respectable psychosocial theory of man, we shall have to pay far more attention to religious—and perhaps even more to professional—rules and values than we have heretofore.

The Ethics of Paternalism and Therapeutism

As the infant's cry galvanizes his parent into succoring action,[17] so the adult's metaphoric cry for help, expressed in the verbal or nonverbal claim of illness, mobilizes the physician into therapeutic action. Revealingly, physicians, following in the footsteps of their predecessors, the priests, often refer to their occupation as a "calling"—implying, perhaps, that not only are the sick calling them, but so is God. The helpers thus hasten to the side of the helpless—the ill, the injured, and the disabled—and minister to him to restore him to health. In this imagery, the sick person is entitled to help simply because he is sick; if we don't help him, especially if we could, we incur moral blame for our neglect. To the extent that these principles are considered to be applicable to patients, they encourage malingering and the exploitation of physicians. And to the extent that they are considered to be binding on physicians, they encourage resentment of and retaliation against patients.

It is clear that the foregoing arrangement represents the same sort of emotional blackmail in a medical setting as that with which we are familiar in the family: the parent must take care of the child because the child is small and helpless; the

physician must take care of the patient because the patient is sick and helpless. Therapeutism recapitulates paternalism.

To be sure, this parallel between children and patients is quite incomplete. Traditionally, patients have paid doctors for their services. But this exchange of money for medical services has always been treated as if it were a source of embarrassment for both parties. Today, it is being obscured as perhaps never before. Realizing that such a hypocritical stance toward the medical contract was incompatible with the practice of psychotherapy, Freud addressed himself to this problem much more frankly than did his predecessors, colleagues, or followers.[18] He deserves much credit for recognizing that patients cannot act autonomously so long as they are treated paternalistically; that their autonomy requires a frank discussion of the fee-arrangement between them and their doctors; and for constructing the psychoanalytic situation in such a way as to free the patient at least from this restraint.[19]

We must continue to scrutinize all therapeutic attitudes and arrangements attributed to benevolence, keeping in mind that, until proven otherwise, such arrangements serve to debase the patient and elevate the physician. We should recall here the traditional relationship between the slaveowner and his Negro slave: the good master treated his servant kindly—often more kindly than the Negro might have been treated in a northern industrial jungle—his benevolence being part and parcel of the paternalistic code of slaveholding.

I submit that in much the same way most of what now passes for "medical ethics" is nothing but a set of paternalistic rules whose aim is to diminish the patient while aggrandizing the physician. Genuine improvement in medical, and especially psychiatric, care requires the liberation and full enfranchisement of the patient—a change that can be accomplished only at the cost of full commitment to the ethic of autonomy and reciprocity. This means that all persons—whether sick or wicked, bad or mad—must be treated with dignity and re-

spect—and that they must also be responsible for their conduct. If such a change in medical perspective were instituted, what patients would gain in dignity and control over the medical situation, they would lose in no longer being able to use illness as an excuse.

One of the thinkers who first recognized the moral implications of illness and treatment which we have been considering, and who noted especially the problems which rules favoring disability might pose for a society, was Herbert Spencer. A brief review of his relevant views will amplify this presentation of the ethics of helplessness and helpfulness.

Spencer, often considered one of the founders of modern sociology, was profoundly concerned with the problem of helping the helpless. Influenced by Darwin's evolutionary biological ideas, he noted that in the case of every higher species of animal, "the early lives of its members and the adult lives of its members, have to be dealt with in contrary ways."[20] Animals of "superior types" are comparatively slow in reaching maturity; having matured, however, they are able "to give more aid to their offspring than animals of inferior types."[21] He then formulated the general law that "during immaturity, benefits received must be inversely as the power or ability of the receiver. Clearly, if during his first part of life benefits were proportioned to merits, or rewards to deserts, the species would disappear in a generation."[22]

Next, Spencer contrasted the "*régime* of the family group" with the "*régime* of that larger group formed by the adult members of the species."[23] At some point in their lives, mature animals are left to themselves—to fulfill the requirements of life or to perish:

> Now there comes into play a principle just the reverse of that above described. Throughout the rest of its life, each adult gets benefit in proportion to merit, reward in proportion to desert: merit and desert in each case being understood as ability to fulfill all the requirements of life—to get food, to secure shelter, or to escape

enemies. Placed in competition with members of its own species and in antagonism with members of other species, it dwindles and gets killed off or thrives and propagates, according as it is ill-endowed or well-endowed. . . . The broad fact then, here to be noted, is that Nature's modes of treatment inside the family-group and outside the family-group are diametrically opposed to one another; and that the intrusion of either mode into the sphere of the other, would be fatal to the species either immediately or remotely.[24]

Spencer insisted that men can no more flout this Law of Nature than can animals. While he thought it necessary, and therefore proper, that children should be sheltered by their families, he felt strongly that a similar arrangement with respect to adults would bring disaster on the human species. In the true spirit of rugged individualism, Spencer pleaded for the self-reliant responsibility of man as opposed to the ministrations of the paternalistic State:

Surely none can fail to see that were the principle of family life to be adopted and fully carried out in social life—were reward always great in proportion as desert was small, fatal results to the society would quickly follow; and if so, then even a partial intrusion of the family *régime* into the *régime* of the State, will be slowly followed by fatal results. Society, in its corporate capacity, cannot without immediate or remoter disaster interfere with the play of these opposed principles under which every species has reached such fitness for its mode of life as it possesses, and under which it maintains that fitness.[25]

I do not believe that quite such a direct application of biological principles to the social—and hence inherently ethical—affairs of man is ever justified. I cite Spencer's views not so much for their political implications as for their historical significance. Spencer was a senior contemporary of Freud's. His thesis concerning the significance, especially for social organization, of the basic biological relationship between parent and young became a cornerstone of psychoanalytic

theory. Roheim built an elaborate anthropological theory of man on essentially nothing more than a Spencerian notion of prolonged fetalization.[26]

Although Spencer's argument is plausible, we must be careful lest we use it to explain too much. Emphasizing the human infant's biologically determined dependence on its parents in order to explain "neurosis" may be a reversal of cause and effect. It seems more probable that the human child remains dependent for so long not because his prolonged childhood is biologically determined, but because it takes him a long time to learn all the symbols, rules, roles, and games which he must master before he can be considered a fully grown human being—and not just a biologically mature organism.

Let us now reconsider the similarities between being young (or immature) and being disabled (by illness or otherwise). For practical tasks, such as gathering food, building shelter, fighting off enemies, and so forth, children are useless. In fact, they are liabilities. The physically disabled, or those who, for whatever reason, refuse to play the game are similarly useless to society, and constitute a liability for it. Why, then, do human societies tolerate persons with such disabilities? Evidently because societies have concerns other than those for which disabled individuals are useless.

Because disabled adults are functionally similar to children, they fall readily into the same type of relationship to the able as children do to their parents. The disabled need help and will not survive without it. The able are capable of providing help and are motivated to do so. Besides the biological tendencies which parents and adults have to provide for their children and for others in need, there are often practical incentives promoting succoring behavior. In primitive social groups, for example, children could be counted on to assist, as soon as they were able, with the physical labor necessary for survival. Thus, caring for them when they were weak meant gaining helpers and allies when they were stronger.

The weakest link in Spencer's argument is his failure to make allowance for the fundamental change in man from biological organism to social being. With respect to rule-following behavior, this transformation means a change from acting automatically to acting self-reflectively. Rules may be "followed" regardless of which of these attitudes is maintained toward them: in the first case, they are followed in an obligatory manner, for the person or animal has no opportunity to deviate from them; in the second, they are followed self-consciously, with an opportunity to make a choice—that is, whether to obey or disobey the rule. Furthermore, rule-awareness leads to a fresh condition—namely, to the deliberate creation of occurrences designed for the purpose of bringing the operation of certain rules into play. Thus, as soon as men became intelligent, sign-using animals and hence aware of the kinds of relationships that invariably obtain between children and parents, the stage was set to imitate childishness to gain certain ends. The stage for the genesis of hysteria, too, was set at this early phase of human social development. The necessary conditions for the development of hysteria are, first, the biologically determined but socially implemented rule that parents (or well-functioning individuals) care for their children (or for ill-functioning individuals); and second, man's growth to self-reflection and awareness, made possible by the development of speech and symbolization. From this point of view, hysteria is a creative achievement or "progression," rather than a mere disability or "regression."

11 Theology, Witchcraft, and Hysteria

Educators, especially those concerned with inculcating religious teachings, have always endeavored to get hold of their pupils in early childhood. The idea that indoctrination during this period will have a lasting effect on the child's personality antedates psychoanalysis by many centuries. Freud reasserted this opinion when he claimed that a person's character is firmly fixed during the first five or six years of life. Although I do not share Freud's view, it is undoubtedly true that the rules on which a human being is fed, as it were, in the early years of life, profoundly affect his later behavior. This is especially true if a person's "rule diet" in later years does not differ markedly from that of his childhood. It seems to me that a great deal of a person's later education—say, between the ages of six and early adulthood—is often composed of an educational pabulum containing many of the same nonsensical rules he had been fed earlier. It is foolish to draw far-reaching conclusions about the effects of early learning experiences if these experiences are reinforced, rather than modified or corrected, by later influences. Among these reinforcing influences, I refer here specifically to the values and rules inherent in religious, national, and professional myths which foster the perpetuation

of childish games and mutually coercive strategies of human behavior.

What I have called religious, national, and professional myths are games the main purpose of which is to glorify the group to which the individual belongs (or to membership in which he aspires). Such "closed" games must be contrasted with "open" games in which all who are capable of adhering to the rules can participate. Game rules based on such a suprareligious and supranational morality would seriously conflict with many of our current habits in living. Nevertheless, I believe that a social trend toward worldwide human equality—in the sense of equal rights and obligations, or of participating in all games according to one's abilities—need not be a threat to men and women. On the contrary, it represents one of the few values still deserving our admiration and support.

In this chapter, I shall try to show that, today, the notion of mental illness is used chiefly to obscure and explain away problems in personal and social relationships; and that the notion of witchcraft had been used in the same way during the declining Middle Ages. We now deny moral, personal, political, and social controversies by pretending that they are psychiatric problems: in short, by playing the medical game. During the witch hunts, people denied these controversies by pretending that they were theological problems: in short, by playing the religious game. The religious rules of life and their effects on man in the late Middle Ages thus not only illustrate the principles of rule-following behavior, but also display the belief in witchcraft as a historical precursor of the modern belief in mental illness.

The Medical Theory of Witchcraft

It is often asserted that the medieval women accused of witchcraft actually suffered from what we now know to be hysteria.

Numerous medical and psychiatric authors advocate such a psychiatric view of witchcraft.

For example, Zilboorg[1] maintains that witches were misdiagnosed mental patients, a view he bases largely on his interpretation of Krämer and Sprenger's *Malleus Maleficarum.*[2] It is clear, however, that Zilboorg is determined to prove that witches were mentally sick persons, and that he disregards all evidence suggesting other interpretations. He thus ignores the fact that the *Malleus* shows a much greater resemblance to a legal than to a medical document. The ferreting out of witches and the proving of witchcraft were preliminary to their sentencing. Although Zilboorg notes that a large part of the *Malleus* deals with the legal examination and sentencing of witches, he fails to draw the logical inference that witches were criminals or, to put it more neutrally, offenders against the prevailing social (theological) order. On the contrary, he suggests that "the *Malleus Maleficarum* might, with a little editing, serve as an excellent modern textbook of descriptive clinical psychiatry of the fifteenth century, if the word *witch* were substituted by the word *patient*, and the devil eliminated."[3]

A hundred pages later, however, Zilboorg offers another opinion, partly contradicting his earlier assertion: "Not all accused of being witches and sorcerers were mentally sick, but almost all mentally sick were considered witches, or sorcerers, or bewitched."[4]

Furthermore, although Zilboorg notes that medieval man was engaged in playing a game quite different from that we now play, he proceeds to cast Krämer and Sprenger's observations into a medical and psychiatric mold. He writes:

> This passage from the *Malleus* is perhaps the most significant statement to come out of the fifteenth century. Here, in a concise and succinct paragraph, two monks brush aside the whole mass of psychiatric knowledge which had been so carefully collected and preserved by almost two thousand years of medical and philosophic

investigation; they brush it aside almost casually and with such stunning simplicity that no room is left for argument. How can one raise objections to the assertion, "but this is contrary to true faith"? The fusion of insanity, witchcraft, and heresy into one concept and the exclusion of even the suspicion that the problem is a medical one are now complete.[5]

Further on, he adds:

The belief in the free will of man is here brought to its most terrifying, although most preposterous, conclusion. Man, whatever he does, even if he succumbs to an illness which perverts his perceptions, imagination, and intellectual functions, does it of his own free will; he voluntarily bows to the wishes of the Evil One. The devil does not lure and trap man; man chooses to succumb to the devil and he must be held responsible for this free choice. He must be punished; he must be eliminated from the community.[6]

Following Zilboorg, it has become popular for psychiatrists to assume—indeed, to insist—that witches were unfortunate women who "fell ill" with "mental illness." This interpretation must be challenged. The notion that so-called witches were mentally ill persons discredits the entire theological world view underlying the belief in witchcraft and enthrones the concept of mental illness as an explanatory theory of wide scope and unchallenged power.

Zilboorg asserts that the authors of the *Malleus* had brushed aside two thousand years of medical and psychiatric knowledge. But what medical and psychiatric knowledge was there in the fifteenth century that would have been relevant to the problems to which the theologians addressed themselves? Surely, the ideas of Galenic medicine would have been irrelevant. In fact, medieval man possessed no "medical" knowledge relevant to the problem of witchcraft. Nor was any such knowledge needed, for there was abundant evidence that charges of witchcraft were commonly trumped up for the purpose of eliminating certain people, and that confessions

were extorted by means of cruel tortures.[7] Finally, if the belief in witchcraft was a "medical mistake"—codifying the misdiagnosis of hysterics as witches—why was this mistake not made more often prior to the thirteenth century?

To explain witchcraft, Zilboorg offers what seems like a medical explanation, but without specifying how it is to be understood or used. To what sort of illness did the witches now said to be "mentally ill" succumb? Did they succumb to diseases such as paresis or brain tumor, or to problems in living, arising from or precipitated by family and social pressures, conflicting goals, and so forth? No such questions are raised, much less answered, by the proponents of the medical theory of witchcraft. Zilboorg's interpretation that the imputation of witchcraft signified a fanatical belief in free will is simply false. It contradicts the most obvious fact—namely, that the majority of witches were women, and especially old, poor, and socially readily expendable women. Moreover, when people were considered to be possessed by the devil, this was generally not attributed to their free will, but was viewed rather as having occurred against their own "better judgment." Accordingly, the witch hunters were regarded as the agents of their unfortunate clients, and executing witches was defined as "therapeutic." This totalitarian definition of what constitutes "therapy" and of who is a "therapist" has persisted to our day with respect to all involuntary psychiatric interventions.[8]

The medical theory of witchcraft ignores two obvious social determinants of the belief in witches and its corollary, witch hunts. First, a preoccupation with God, Jesus, and Christian theology cannot be arbitrarily separated from a belief in bad deities and their cohorts, devils, witches, sorcerers. Second, concern with the sexual activities of witches and devils was a counterpart, a mirror image, of the officially antisexual attitude of the Catholic church. The torturing and burning of witches must be viewed in the light of medieval man's theo-

logical world view, according to which the body is weak and sinful, and the only goal worthy of man is the eternal salvation of his soul.[9] Burning human bodies at the stake was a symbolic act which expressed adherence to the official rules of the game. This dramatic, ritualized affirmation of the faith insured the continued existence of an important social fiction or myth.[10] Burning accused witches during the witch hunts may thus be compared to destroying confiscated whisky during Prohibition. Both acts gave official recognition to a rule which few people followed in their actual conduct. During the Middle Ages, sexual conduct was, actually, exceedingly promiscuous, if measured by our current standards.[11] In both instances, then, the law expressed high ethical ideals to which most people had no intention to adhere. Their goal became, instead, to evade the laws, to appear as if they were law-abiding, and to make sure that there were suitable scapegoats available to be caught and punished. In situations of this sort, it is the scapegoat's social function to play the role of the person who violates, or is said to violate, the rules, is caught, and is duly punished.[12] We might thus view bootleggers and the entire class of so-called organized gangsters—all of whom came into being during Prohibition—as the scapegoats who were sacrificed at the altar of the false god of abstinence. The greater the actual discrepancy between prescribed rules of conduct and actual social behavior, the greater the need for scapegoat sacrifices as a means of maintaining the social myth that man lives according to his officially declared ethical beliefs.

The Scapegoat Theory of Witchcraft

I submit that witchcraft represents the expression of a particular method by means of which men have sought to explain and master various ills of nature. Unable to admit ignorance and

helplessness, yet equally unable to achieve understanding and mastery of diverse physical, biological, and social problems, men have sought refuge in scapegoat explanations. The specific identities of the scapegoats are legion: witches, women, Jews, Negroes, the mentally ill, and so forth. All scapegoat theories postulate that if only the offending person, race, illness, or what-not could be dominated, subjugated, or eliminated, all manner of problems would be solved.

While medical men subscribe enthusiastically to the idea that witches were hysterical women who had been misdiagnosed, social scientists lean toward the view that they were society's scapegoats.[13] I am in substantial agreement with this latter interpretation and shall try to show exactly in what ways the scapegoat theory is superior to the medical one. In addition, I shall argue that not only is it misleading to consider witches misdiagnosed hysterics, but it is also misleading to regard people currently "ill" with hysteria or other mental illnesses as belonging in the same category as those ill with bodily ailments.

With respect to the scapegoat theory of witchcraft, we might raise the following questions: Who were considered to be witches? How were they tried and who profited from their conviction? What did those people who did not believe in the reality of witches think of witchcraft? Did they think that witches were ill? Or did they believe that the problem was not one of witchcraft at all, but that it was a matter of trumped-up charges? In discussing these questions, I shall try to develop the similarities between the medieval belief in witchcraft and the contemporary belief in mental illness; and I shall try to show that both are false explanations that conceal certain difficult moral problems. Moreover, both serve the interests of a special group—the one, the interests of the clergy, the other, those of the medical profession. Finally, both fulfill their function by sacrificing a special group of persons on the altar

of social expediency: in the Middle Ages the scapegoats were the witches; today, they are the involuntary mental patients, and the mentally ill generally.

In comparing witchcraft with mental illness, it is important to bear in mind that the traditional concept of illness rests on the simple facts of pain, suffering, and disability. Hence, the sufferer, the patient himself, first considers himself ill and is then usually so considered by others. In sociological terms, the sick role in medicine is typically self-defined.[14]

The traditional concept of mental illness, or insanity, rests on precisely the opposite criteria. The alleged sufferer (especially the "psychotic") considers himself neither sick nor disabled; but others insist that he is both. The role of mental patient is thus often imposed on persons against their will. In short, the sick role in psychiatry is typically other-defined.

This distinction between assuming the role of patient voluntarily and being placed in it against one's will is all-important: the mentally sick role is self-defined usually in the expectation that doing so will help to secure certain types of help, for example private psychotherapy; in contrast, when this role is imposed on a person against his will, it serves the interests of those who define him as mentally ill. In other words, whereas the patient role is assumed in the hope of a personal cure, it is ascribed in the hope of social control.

How did people ascertain, during the Middle Ages, that someone was a witch? Of course, individuals rarely "discovered" that they themselves were witches. Rather, some persons or groups claimed—and it was subsequently ascertained by the methods then prescribed—that someone else was a witch. In short, the witch role was characteristically other-defined: in this crucial respect it was identical to the contemporary role of involuntary mental patient.

Most people accused of witchcraft were women. The word "witch" implies "woman," as did the word "hysteric." Janet

and Freud, it will be remembered, were pioneers in asserting that there were "male hysterics."* In this respect, the parallels between being a witch and being a hysteric are striking. According to Parrinder, out of two hundred convicted witches in England, only fifteen were men.[15] He interprets this as a sign that women were a persecuted minority in a world ruled by men.

In addition to the high incidence of women, most persons accused of witchcraft were members of the lower classes. They were poor, stupid, socially helpless, and often old and feeble. Making a "diagnosis" of witchcraft then—much as calling someone mentally ill today—was an insult and an accusation. Obviously, it is safer to accuse socially unimportant persons than those who are socially prominent. When highly placed persons were accused of witchcraft, as happened occasionally, it was safer as well as more effective if the charge was made by large groups, as for instance a whole nunnery, rather than by a single person. Then, as now, there was safety in numbers—the assumption being that if many people claimed something, it had to be true. Nevertheless, the educated and the well-to-do could better protect themselves from being branded witches, and being treated for it by burning at the stake, much as well-informed and wealthy persons today can better protect themselves from being diagnosed as mentally ill against their will, and being treated for it with lobotomy.

Actually, the medieval inquisitors themselves were impressed by the discrepancy between the patently feeble and harmless character of the women accused of witchcraft and

* The discovery of "male hysteria," like Charcot's conversion of malingerers to hysterics, was another step in the democratization of misery. Freud was obviously more eager to acknowledge equality between the sexes in regard to their susceptibility to neurosis than in regard to their potentialities for creative performance. His assertion that men, too, may suffer from hysteria must be contrasted with his equally firm conviction that women are incapable of the same "sublimations" and "mental development" as men.

their allegedly diabolical and potent actions. Parrinder remarks:

The explanation was given that their evil deeds had been performed by the help of the devil, but that, like the deceiver he is, he had abandoned his disciples in their moment of need. . . . This was very convenient for the inquisitors, for it meant that they could handle these dangerous women without risk to themselves.[16]

Although Parrinder calls these antifeminine beliefs and actions "ridiculous," this should not distract us from the fact that similar attitudes were prevalent in Europe well into the twentieth century. In fact, such prejudices are by no means extinct today, even in so-called civilized countries. In the economically underdeveloped areas of the world, the systematic oppression and exploitation of women—much like slavery and the exploitation of alien races—are still the dominant customs and rules of life.

While these historical and cultural considerations are of momentous importance insofar as any progress toward an internationally meaningful science of human behavior is contemplated, what is even more significant, especially in relation to hysteria, is the cultural attitude toward women in Central Europe at the turn of the century. This was the time and place of the origin of psychoanalysis, and through it, of the entire body of what is now known as "dynamic psychiatry." That the status of women in that social situation was still one of profound oppression, while well known, is easily forgotten or relegated to a position of unimportance. Generally, women were then economically dependent on their parents or spouses, had few educational and occupational opportunities, and were regarded—perhaps not quite explicitly—as the mere bearers of uteri. Their "proper" roles were marriage and motherhood. Accordingly, they were considered biologically inferior to men in regard to such traits as intellectual ability and finer ethical feelings. Some of Freud's opinions about

women were not unlike those of Krämer and Sprenger, as the following passage illustrates:

It must be admitted that women have but little sense of justice, and this is no doubt connected with the preponderance of envy in their mental life; for the demands of justice are a modification of envy; they lay down the conditions under which one is willing to part with it. We also say of women that their social interests are weaker than those of men, and that their capacity for the sublimation of their instincts is less.[17]

I cite this opinion of Freud's about women not so much to criticize it—that has been adequately done by others[18]—but to emphasize the significance of scapegoating in the phenomena called witchcraft, hysteria, and mental illness.

The belief in witches, devils, and their cohorts was, of course, more than just a matter of metaphysics or theological theory. It affected public behavior—most glaringly in the form of witch hunts and witch trials. In a way, these were the opposites or mirror images of saintly miracles. Alleged acts of witchcraft or miracle-working could be officially recognized only after they had been passed on and approved as valid by the holders of appropriate social power—in this case, the high-ranking clergy of the Roman Catholic church. Hence the expression "witch-trials." Clearly, a trial is neither a medical nor a scientific affair.

The distinction between legal and scientific disputes was recognized by medieval man, no less than by the ancients. Yet, this important distinction was obscured by the medical theory of hysteria. Legal contests serve to settle disputes of conflicting interests. Medical procedures serve to settle the nature of the patient's illness and the measures that might restore him to health. In such a situation, there are no obvious conflicts of interest between opposing parties. The patient is ill and wants to recover; his family and society also want him to recover; and so does his physician.

The situation is different in a legal dispute where the problem is a conflict of interests between two or more parties. What is good ("therapeutic") for one party is likely to be bad ("noxious") for the other. Instead of a situation of cooperation between patient and physician, we have one of conflict or conciliation between two contending parties, with the judge serving as arbitrator of the dispute.

In European witch-trials it was customary for the judge to receive a portion of the convicted heretic's worldly possessions.[19] Today, we take it for granted that, in free societies, the judge is impartial. His task is to uphold the law. Hence, he must occupy a position outside of the socio-economic interests of the litigants. While all this may seem dreadfully obvious, it needs to be said because, even today, the impartiality of the judge toward the litigants is often an unrealized ideal. In totalitarian countries, for example, so-called crimes against the state fall in the same class as witch-trials: the judge is an employee of one of the contesting parties. Even in free societies, in crimes violating cardinal moral and social beliefs—such as treason or subversion—judicial impartiality is often thrown to the wind—and we have "political justice." This is why "political criminals" may become "revolutionary heroes," and should the revolution fail, revert once more to the status of "criminals."

In witch-trials the conflict was officially defined as between the accused and God, or between the accused and the Catholic (later Protestant) church, as God's earthly representative. There was no attempt to make this an even match. The distribution of power between accuser and accused mirrored the relations between king and serf—one had all the power and the other none of it. Once again, we encounter the theme of domination and submission. Significantly, only in England—where, beginning in the thirteenth century with the granting of the Magna Charta, there gradually developed an appreciation of the rights and dignities of those less powerful than the

king—was the fury of witch hunting mitigated by legal safeguards and social sensibilities.

Behind the ostensible conflict of the witch-trial lay the usual conflicts of social class, values, and human relationships. Furthermore, there was strife within the Catholic church itself which later became accentuated by the antagonisms between Catholics and Protestants. It was in this context, then, that witches and sorcerers, recruited from the ranks of the poor and oppressed, played the role of scapegoats. They thus fulfilled the socially useful function of acting as social tranquilizers.[20] By participating in an important public drama, they contributed to maintaining the stability of the existing social order.

Games of Life: Theological and Medical

Life in the Middle Ages was a colossal religious game. The dominant value was salvation in a life hereafter. Emphasizing that "to divorce medieval hysteria from its time and place is not possible,"[21] Gallinek observes:

> It was the aim of man to leave all things worldly as far behind as possible, and already during lifetime to approach the kingdom of heaven. The aim was salvation. Salvation was the Christian master motive.—The ideal man of the Middle Ages was free of all fear because he was sure of salvation, certain of eternal bliss. He was the saint, and the saint, not the knight nor the troubadour, is the veritable ideal of the Middle Ages.[22]

However, if sainthood and salvation formed one part of the Christian game of life, witchcraft and damnation formed another. The two belong together in a single system of beliefs and rules, just as, say, military decorations for bravery and punishments for desertion belong together. Positive and negative sanctions, or rewards and penalties, form a complementary pair and share equally in giving form and substance to the

game. A game is composed of the totality of its rules. If any of the rules is changed, the game itself is changed. It is important to keep this clearly in mind to avoid the sentimental belief that the essential identity of a game may be preserved by retaining only what is desirable (the rewards) and eliminating all that is undesirable (the penalties).

On the contrary, if preservation of the game—that is, maintenance of the social (religious) status quo—is desired, this can be best achieved by enthusiastically playing the game as it is. Thus, searching for and finding witches constituted an important maneuver in the religious game of life, much as looking for and finding mental illness is an important tactic in the contemporary medical-therapeutic game. The extent to which belief in and preoccupation with witchcraft constituted a part of the theological game of life may be gleaned from Parrinder's description of "Pacts with the Devil."[23]

It is significant that the criteria for "diagnosing" witchcraft and heresy were of the same type as the criteria for establishing the possession of genuine belief. Both were inferred from what the person said. As evidential proof, *claims* were thus raised over *deeds*. This was true equally of claims that aggrandized and flattered, and of those that accused and injured. Claims of having seen the Holy Virgin thus counted for more than decent behavior and honest work; and claims of having seen one's neighbor fly off on a broomstick counted for more than common sense and respect for others.

The importance of confession, even if extracted under torture, was an integral part of this reliance on words instead of on acts, which characterized the inquisitorial mentality. Moreover, the witch hunts and witch-trials took place in a social setting in which brutal behavior—especially by noblemen toward serfs, men toward women, adults toward children—was an everyday matter. Its very ordinariness thus dulled men's sensibilities and turned their attention from it. It is not easy to remain interested in what is commonplace—such as

man's everyday brutality vis-à-vis his fellow man. Oh, but the dastardly behavior of persons in the grip of the devil: that was another, more interesting matter! Since this could not be directly observed, the "diagnosticians" of sorcery and witchcraft had to rely heavily on verbal communications. These were of two kinds: accusations against persons concerning the commission of evil deeds or peculiar acts, and confessions of misdeeds.

Let us now examine the values of a social system that encourages the "diagnosis" of hysteria. Clearly, one of the principal values of our culture is science. Medicine, regarded as a science, is thus an integral part of this value system. The notions of health, illness, and treatment are thus the cornerstones of an all-embracing modern medical-therapeutic world view.[24]

In speaking of science as a widely shared social value, I do not refer to any particular scientific method, nor have I in mind such things as the search for truth, understanding, or explanation. I refer rather to science as an institution, similar to organized theology in the past. It is to this aspect of science, sometimes called "scientism," that increasing numbers of people turn in their search for practical guidance in living. According to this scheme of values, one of the most important things for man to achieve is to have a strong and healthy body—a wish that is the true heir to medieval man's wish for a virtuous soul. A healthy body is regarded as useful, not, it is true, for salvation, but for comfort, sex appeal, happiness, and a long life. Great efforts and vast sums are expended in pursuit of this goal of having a healthy—and this has of late included an attractive—body. Finally, having a healthy mind has been added to this value scheme by regarding the mind as if it were simply another part of the human organism or body. In this view, the human being is endowed with a skeletal system, digestive system, circulatory system, nervous system, etc.—*and* a "mind." As the Romans had put it, *Mens sana in*

corpora sano: "In a healthy body, a healthy mind." Curiously enough, much of modern psychiatry has been devoted to this ancient proposition. Psychiatrists who search for biochemical or genetic defects as the causes of mental illness are, whether they know it or not, committed to this perspective on human misery.

Even if we do not believe in reducing psychiatry to biochemistry, the notion of mental illness implies, first, that mental health is a "good thing"; and second, that there are certain criteria according to which mental health and illness can be diagnosed. In the name of this value, then, the same sorts of actions may be justified as were justified by medieval man marching under the banner of God and Christ. What are some of these actions?

Those who are considered especially strong and healthy—or who contribute to these values—are rewarded. The athletes, the beauty queens, and the movie stars are the modern-day "saints"—and the cosmetics manufacturers, doctors, and psychiatrists are their assistants. They are honored, admired, and rewarded. All this is well-known and should occasion little surprise. Who are the people who fall in the class of the witches and sorcerers; the people persecuted and victimized in the name of "health" and "happiness"? They are legion. In their front ranks are the mentally ill, and especially those who are so defined by others rather than by themselves. The involuntarily hospitalized mentally ill are regarded as "bad" and valiant efforts are made to make them "better." Words like "good" and "bad" are used here in accordance with the dominant value system of society. In addition to the mentally ill, elderly persons and people who are ugly or deformed find themselves in a class analogous to the now defunct category of witches and sorcerers.

The reason why individuals displaying such characteristics are considered "bad" is inherent in the rules of the medical game. Just as witchcraft was an inverted theological game, so

much of general psychiatry—especially the so-called care of the involuntary mental patient—is a kind of inverted medical game. The rules of the medical game define health—which includes such things as a well-functioning body and happiness—as a positive value; and they define illness—which includes such things as a badly functioning body and unhappiness—as a negative value. It follows, then, that insofar as people play the medical game, they will, at least to some extent, dislike and demean sick persons. This penalty, which is an integral part of the sick role and cannot be severed from it without altering the basic rules of the medical game—is, in practice, mitigated by the sick person's submission to those who attempt to make him well and by his own efforts to recover from the illness. However, patients with hysteria and with most so-called mental illnesses do not make "appropriate" efforts to get well. Indeed, they usually make no such efforts at all, and try, instead, to be authenticated as "sick" in the particular ways in which they want to be, or see themselves as being, sick. In hysteria, as we have seen, the patient offers the dramatized representation of the message "My body is not functioning well." In depression, he offers the dramatized proposition "I am unhappy." To the extent to which such persons want to assume sick roles of such sorts and reject efforts to dislodge them from these roles, they forfeit the ordinary person's and the physician's disposition to treat them well as patients and invite instead their latent disposition to treat them badly as deviants.

In the framework of traditional medical ethics, the patient deserves humane attention only insofar as he is potentially healthy and is willing to be healthy—just as in the framework of traditional Christian ethics, the heretic deserved humane attention only insofar as he was potentially a true believer and was willing to become one. In the one case, people are accepted as human beings only because they might be healthy citizens; in the other, only because they might be faithful

Christians. In short, neither was heresy formerly, nor is sickness now, given the kind of humane recognition which, from the point of view of an ethic of respect and tolerance, they deserve.

It is easy, of course, to be skeptical of a belief that is no longer fashionable; but it is not easy at all to be skeptical of one that is. This is why contemporary intellectuals find it so easy to scoff at religion and witchcraft and find it so difficult to scoff at medicine and mental illness. In the Middle Ages, the suggestion to regard heresy as just another way of life would have seemed absurd, or worse. Today the suggestion to regard mental illness as just another way of life seems equally absurd, or worse.

V

GAME-MODEL ANALYSIS OF BEHAVIOR

■

12 The Game-Playing Model of Human Behavior

Much of what I have said so far has utilized a game model of human behavior, first clearly articulated by George Herbert Mead.[1] In Mead's view, mind and self are generated in a social process, with linguistic communication as the capacity most responsible for the differences between the behavior of animals and men.

Human Actions as Games

Mead considered games as paradigmatic of social situations. Playing a game presupposes that each player is able to take the role of all the other players. Mead also noted that children are intensely interested in game rules and that their increasing sophistication in playing games is crucial to the social development of the human being.

The social situation in which a person lives constitutes the team on which he plays and is, therefore, important in determining who he is and how he acts. Man's so-called instinctual needs are actually shaped—and this may include inhibiting, fostering, or even creating "needs"—by the social games prevalent in his milieu. The view of a dual, biosocial determi-

nation of behavior has become incorporated into psychoanalytic theory through increasing emphasis on ego psychology and object relationships. Useful as these modifications of classical psychoanalytic theory have been, explanations in terms of ego functions are not as satisfactory for either theory or therapy as those couched in terms of rules, roles, and games.

In this connection, let us briefly reconsider a problem that clarifies the connections between psychoanalysis and game theory (in the sense used here)—namely, the problem of primary and secondary gains. In psychoanalysis, gains derived from playing a game profitably—say, by being protectively treated for a hysterical illness—are regarded as secondary. As the term betrays, these gains are considered less significant as motives for the behavior in question than primary gains, which are derived from the gratification of unconscious instinctual needs.

If we reinterpret these phenomena in terms of a consistently game-playing model of behavior, the need to distinguish between primary and secondary gains disappears. The correlative necessity to estimate the relative significance of physiological needs and dammed-up impulses on the one hand, and of social and interpersonal factors on the other, also vanishes. Since needs and impulses cannot be said to exist in human social life without specified rules for dealing with them, instinctual needs cannot be considered solely in terms of biological rules, but must also be viewed in terms of their psychosocial significance—that is, as parts of the game.

It follows that what we call "hysteria" or "mental illness" can be properly understood only in the context of a specified social setting. While diseases such as syphilis and tuberculosis are in the nature of *events* and hence can be described without taking cognizance of how men conduct themselves in their social affairs, hysteria and all the other so-called mental illnesses are in the nature of *actions*. They are made to happen

by sentient, intelligent human beings and can be understood best, in my opinion, in the framework of games. Mental illnesses thus differ fundamentally from bodily diseases, and resemble, rather, certain moves or tactics in playing games.

I have used the notion of games so far as if it were familiar to most people. I think this is justified as everyone knows how to play some games. Accordingly, games serve admirably as models for the clarification of other, less well-understood, social-psychological phenomena. Yet the ability to follow rules, play games, and construct new games is a faculty not equally shared by all persons. It will be helpful now to review briefly the child's development in regard to his ability to play games.

Piaget[2] has conducted many careful studies on the evolution of games during childhood, and has suggested that moral behavior be viewed as a type of rule following. He writes: "All morality consists in a system of rules, and the essence of all morality is to be sought for in the respect which the individual acquires for these rules."[3] Piaget thus equates morality, or ethical feeling and conduct, with the individual's attitude toward and practice of various rules. This perspective provides a rational basis for the analysis of moral schemes as games, and of moral behavior as the players' actual conduct.

Piaget distinguishes two distinct features of rule-following behavior: one, the practice of rules, that is, the ways in which children of different ages apply rules; the other, the consciousness of rules, that is, self-reflection about the rules and role-taking behavior. Children of different ages have quite different ideas about the character of game rules: young children regard them as obligatory, externally imposed, and "sacred," whereas older children regard rules as socially defined and, in a sense, self-imposed. Piaget traces rule-following and game-playing behavior from early childhood stages of egocentrism, imitation, and heteronomy, to the later, mature stage of co-operation, rational rule following, and autonomy.[4]

Piaget identifies four discrete stages in the practice or *application of rules*. The earliest stage is characterized by the automatic imitation by the preverbal child of certain behavior patterns he observes in others. Piaget calls these motor rules, which later become habits.

The second stage begins some time after the second year of life, "when the child receives from the outside the example of codified rules."[5] His play during this phase is purely egocentric: he plays in the presence of others, but not with them. This type of rule application is characterized by a combination of imitation of others with an idiosyncratic use of the examples received. For example, everyone can win at once. This stage usually ends at about the age of seven or eight years.

During the third stage, which Piaget calls "the stage of incipient cooperation," children "begin to concern themselves with the question of mutual control and of the unification of rules."[6] Nevertheless, play remains relatively idiosyncratic. When, during this period, children are questioned about the rules of the game in which they are engaged, they often give entirely contradictory accounts of them.

The fourth stage appears between the ages of eleven and twelve years and is characterized by the codification of rules. The rules of the game are now clearly understood, with a correspondingly high consensus among the children about what they are. The game rules are now explicit, public, and conventional.

This scheme may be supplemented by the development of the *consciousness of rules*—that is, the person's experience in regard to the origin and nature of the rules, and especially his feeling and conception about how they obligate him to obey the rules. Piaget identifies three stages in the development of rule consciousness. During the first stage "rules are not yet coercive in character, either because they are purely motor, or else (at the beginning of the egocentric stage) because they are received, as it were, unconsciously, and as interesting

examples rather than as obligatory realities."[7] During the second stage, which begins at about the age of five years, rules are regarded as sacred and untouchable. Games composed of such rules are called heteronomous. The rules emanate from the adults and are experienced as lasting forever: "Every suggested alteration strikes the child as a transgression."[8] The third and final stage begins when the child regards rules as acquiring their obligatory character from mutual consent. Such rules must be obeyed because loyalty to the group, or to the game, demands it. Undesirable rules, however, can be altered. It is this attitude toward games that we usually associate with and expect of an adult in a free society. Such a person is expected to know and feel that just as the rules of a game are man-made, so are the laws of a nation. This may be contrasted with the rules of the game of a theocratic society, in which the citizen is expected to believe that the laws are God-given. So-called autonomous games, in contrast to heteronomous ones, can be played only by individuals who have reached the last stages in the foregoing developmental sequences.

The evolution of the child's concept of games and rules parallels the development of his intelligence. The ability to distinguish biological from social rules thus depends on a certain degree of intellectual and moral development. This makes it easy to understand why it is during adolescence that children begin to have doubts concerning the rationality of Biblical rules. It seems to me, therefore, that much of what has been labeled "adolescent rebelliousness" may be attributed to the fact that it is only at this time that children have enough sense to be able intelligently to scrutinize parental, religious, and social demands as systems of rules. The Bible lends itself especially well to criticism by the developing logical sense of the adolescent, for in it biological and social rules are often undifferentiated, or deliberately confused. In Piaget's terms, all rules are treated as if they were parts of heteronomous

games. This type of game fits best into the world of a less than ten-year-old child.

Since children, especially very young children, are completely dependent on their parents, their relative inability to comprehend other than externally imposed, coercive rules is not surprising. In the same way, to the extent that adults depend, or are made to depend, on others rather than on themselves, their game-playing aptitudes and attitudes will be like those of children.

A Logical Hierarchy of Games

I have treated games so far as if they were all more or less of the same kind. This point of view will no longer suffice. Since games consist, among other things, of bits of communicative action, it is not surprising that a hierarchy of games analogous to a hierarchy of languages is easily constructed. Linguistic signs point to referents, such as physical objects, other words, or more complex systems of signs. Similarly, games consist of systems of rules which point to certain acts—the rules standing in the same relation to the acts as the words to their referents. Accordingly, games with rules that point to the simplest possible set of patterned acts will be called "object games." Games composed of rules which themselves point to other rules will be called "metagames." Typical examples of object games are patterns of instinctive behavior. Their goals are physical survival, release of urinary, anal, or sexual tension, and so forth. Hence, playing object games is not limited to human beings. In the medical setting, the reflex immobilization of an injured extremity would be an example of a "move" in an object game.

Clearly, the learned and distinctively human elements of behavior are wholly on the level of metagames. For example, first-level metagames would be the rules determining where to urinate and where not to, when to eat and when not to, and so

forth. Ordinary or conventional games—such as bridge, tennis, or chess—all consist of mixtures of complex metagames.

Let us apply the concepts of game hierarchy to the analysis of an ordinary game, say tennis. Like any game of skill and strategy, tennis is characterized, first, by a set of basic rules which specify such things as the number of players, the layout of the court, the nature and use of rackets and balls, and so forth. Actually, although these rules are object rules to tennis, they are metarules with respect to such logically anterior games as the proper laying out of courts or the manufacturing of rackets. When we play tennis, however, we are not usually concerned with games lying on levels lower than the basic game of tennis itself. These infra-tennis games might, however, be important for those who want to play tennis but are prevented from doing so by insufficient funds to purchase the necessary equipment.

Beginning at the level of the basic rules—assuming, that is, the presence of players, equipment, and so forth—it is evident that there is much more to an actual, true-to-life tennis game than could be subsumed under the basic rules. This is because there is more than one way to play tennis, while still adhering to these rules. For example, one player might aspire at winning at any cost; another at playing fairly. Each of these goals implies rules specifying, first, that in order to play tennis one must follow rules A, B, and C, and second, how one should conduct oneself while following these rules. The latter prescriptions constitute the rules of "metatennis." In everyday language, the term "tennis" is used, of course, to denote all of the rules of this game. The fact that ordinary games may be played in more than one way—that is, that they contain games at different logical levels—leads to conflict whenever different types of players meet.

When two wildly competitive youngsters play tennis, the game is so constituted that both players regard winning as their sole aim. Style, fair play, one's state of health, and every-

thing else may become subordinated to this goal. In other words, the players play to win at any cost—adhering only to the minimal basic rules of the game.

A next higher level of tennis may be distinguished—a "metatennis game," as it were—which, in addition to the basic rules, contains a new set of rules which refer to the basic rules. These might include prescriptions about style, the tempo of the game, courteous behavior, etc. Playing according to these higher-level rules, or metarules, implies, first, that the players will orient themselves to and follow a new set of rules, these being additional to, rather than substitutes for, the old set; and second, that the players will adopt as their own the new goals implicit in the new rules. In tennis, this might mean to play fairly or perhaps elegantly, rather than to win at any cost. It is important to note now that the goals of the object game and of the metagame may come into conflict, although they need not necessarily do so. Adherence to the rules and aims (ethics) of the higher-level game usually implies that its rules and goals take precedence over those of the basic game. In other words, for a properly socialized Englishman, it is better—that is, more rewarding in relation to both the spectators and his own self-image—to be a "fair loser" than an "ugly winner." But if this is true, as indeed it is, then our everyday use of the words "loser" and "winner" no longer do justice to what we want to say. For when we speak of James as a "fair loser," especially if he is contrasted with an opponent considered an "ugly winner," what we mean is that James lost the basic game but has won the metagame. But we cannot say anything like this in ordinary language—except by circumlocution—for example, by saying that "James played a good game but lost."

Everyday life is full of situations similar to the example sketched above. Men are constantly engaged in behavior involving complicated mixtures of various logical levels of games. Unless the precise games which men play are clarified—and also, whether they play them well, badly, or in-

differently—there is little chance of understanding what "is actually going on" or of altering it.

If we ask, What rules do men actually follow in their daily lives? the metaphorical net we cast is so wide that we catch more than we can handle. Let us, therefore, narrow our question to the case of a "simple man." We seek to understand only the basic rules of living, and only one version of them—for example, the Biblical rules of life. The Ten Commandments may then be likened to the directions one receives when purchasing a new appliance. The buyer is told that he must follow certain rules if he wants to derive the benefits the machine has to offer. If he fails to follow the directions, he will have to suffer the consequences. Thus, in case of a breakdown, the manufacturer's warranty is honored only if the machine has not been misused. Here is a fitting analogy for legitimate illness (manufacturing defect), as contrasted to sin or other types of illegitimate illness (misuse of the machine). The Ten Commandments—and Biblical teachings generally—are the rules man must follow if he expects to obtain the benefits which the manufacturer of the game of life (God) offers the purchaser (man).

However, in the case of real-life games, the situation is more complicated. It often happens that the game rules instruct the player that in order to "win" he must "lose." Let us recall here some of the Biblical rules discussed in Chapter 9; for example, the following two prescriptions for "good living": (1) "Blessed are the meek: for they shall inherit the earth";[9] (2) "Blessed are they which are persecuted for righteousness' sake: for theirs is the kingdom of heaven."[10] There is a tacit premise behind these rules—namely, that it happens that some people are meek and that others are persecuted. Being meek and persecuted are assumed to be occurrences not deliberately sought. But are they not? And might they not be?

In the days of early Christianity, much as today, aggressive

men often tended to get the better of their less aggressive neighbors. Apparently, ethical rules came into being in an effort to provide for the sort of things which the British call fair play. This complicated matters considerably, for games of increasingly higher orders were thus generated.

Looking at problems in living from this point of view, it seems apparent that much of what goes by the names of "growing up," "becoming sophisticated," "getting treated by psychoanalysis" (and by other methods as well) are all processes having one significant characteristic in common: the person learns that the rules of the game—and the very game itself—by which he has been playing are not necessarily the same as those used by others around him. For example, he learns that others are not interested in playing the game which he has been so avidly pursuing; or, if they are, that they prefer some modifications of the game rules. All this, however, applies only to more or less ordinary persons in ordinary circumstances, and does not apply to persons of extraordinary influence. Individuals who wield vast powers can persuade, seduce, or coerce others to play their own games. This explains why such persons never consult psychiatrists and are never defined as "mentally ill"; and why, after they have lost their power—in particular, after they have died—they are often declared to have been "obviously mad."[11]

In short, then, unless a person finds others to play his own game, according to his own rules—or can coerce others to accept life on his terms—he has a choice among three options.

First, he may submit to the other person's coercive rules and accept the submissive role offered.

Second, he may renounce, and withdraw from, many socially shared activities and cultivate solitary pursuits. These may be considered and labeled artistic, religious, scientific, neurotic, or psychotic according to various—often poorly defined—criteria. While we cannot consider here what these criteria are, it may be noted that the issues of social utility and

the power to define what constitutes such utility play important roles in articulating these standards.

Third, he may become increasingly aware of the precise character of the games he and others play, and may try to accommodate and shape each to fit the other. This is an arduous and unceasing undertaking which, moreover, can never be wholly successful. Its main attraction lies in the protection it affords for the freedom and dignity of all concerned. However, because of the burdens it places on those who so try to conduct themselves, it need not surprise us if many persons prefer easier means leading to what they consider more important ends.

Personality Development and Moral Values

I submit that the concept of a distinctively human, normal, or well-functioning personality is rooted in psychosocial and ethical criteria. It is not biologically given, nor are biological determinants especially significant for it. I do not deny, of course, that man is an animal with a genetically determined biological equipment which sets the upper and lower limits within which he must function. I accept the limits, or the general range, and focus on the development of specific patterns of operation within them. Hence, I eschew biological considerations as explanations, and instead try to construct a consistently moral and psychosocial explanatory scheme.

Clearly, different societies exhibit different values. And even within a single society, especially if it is composed of many individuals, adults and growing children have certain choices about which values to teach and which to accept or reject. In contemporary Western societies, one of the principal alternatives is between autonomy and heteronomy, between "risky" freedom and "secure" slavery.

The French Revolution, for example, was waged in the names of *Liberté, égalité, et fraternité.* Two of these values—

equality and fraternity—imply cooperation rather than oppression. Yet the cooperative value ideals of the philosophers who provided the original impetus for the revolution soon gave way to the pragmatically held values of the masses. These values, in turn, did not differ greatly from the values by which the oppressed masses had been ruled by sovereign royalty. Power, coercion, and oppression thus soon replaced equality, fraternity, and cooperation.

In the next major European revolution, the moral values of the lower classes received a more unconcealed expression. The Marxist revolution promised a dictatorship of the proletariat: the oppressed shall become the oppressors! This was rather similar to the Scriptural program which promised that "the last shall be the first." The main difference between the two lay in their respective means of implementation.

Piaget, as we have seen, describes the evolution of children's games and, through it, of the human moral sense, as a developmental sequence that starts with heteronomy and proceeds toward autonomy. If we rephrase this in terms of interpersonal rules or strategies, we could say that as children develop, they move from regulation by external controls toward regulation by self-control, from coercion toward cooperation. Although Piaget has well described the psychological and social dimensions of this process of personal development, he has completely neglected its ethical dimensions. For whether one speaks of psychosexual development, as Freud did, or of the development of games, as Piaget does, one deals with what is at bottom moral behavior: coercion and cooperation, autonomy and heteronomy, and all the other concepts and criteria which Piaget uses to describe various styles of game-playing behavior, are moral criteria.

In particular, it seems to me that what Piaget identifies as the "normal" development of the child is actually the sort of development which he considers desirable; and which many members of the middle and upper classes of contemporary

Western societies would also consider desirable. He thus declares:

In our societies the child, as he grows up, frees himself more and more from adult authority; whereas in the lower grades of civilization puberty marks the beginning of an increasingly marked subjection of the individual to the elders and to the traditions of his tribe.[12]

As I have shown, however, this endorsement of the value of autonomy is by no means as unqualified even today as Piaget's foregoing statement would make it seem. Indeed, Piaget himself remarks on some of the forces that foster coercive, power-dependent, heteronomous conduct:

It looks as though, in many ways, the adult did everything in his power to encourage the child to persevere in its specific tendencies, and to do so precisely in so far as these tendencies stand in the way of social development. Whereas, given sufficient liberty of action, the child will spontaneously emerge from his egocentrism and tend with his whole being towards cooperation, the adult most of the time acts in such a way as to strengthen egocentrism in its double aspect, intellectual and moral.[13]

Although I agree with Piaget that some types of adult behavior foster the child's egocentrism, I doubt that the child would emerge from this stage and move toward autonomy spontaneously. Autonomy and reciprocity are complex values which must be taught and learned. Naturally, they cannot be taught coercively, but must be practiced and displayed as examples for the child to imitate.

Piaget singled out the adult's coercive or autocratic attitude toward the child as a cause for his persistent subservience in later life. But such rules abound in religious, medical, and educational codes and situations. Consequently, those exposed to them—for example, patients committed to state hospitals, candidates in psychoanalytic institutes, etc.—are subjected to pressures to adapt by assuming the required postures of help-

lessness.[14] This leads to behavior judged appropriate or "normal" within the system, but not necessarily outside of it. Resistance to the rules may be tolerated to varying degrees in different systems, but in any event tends to bring the individual into conflict with the group. Hence, most persons seek to conform rather than to rebel. Others try to adapt by becoming aware of the rules and of their limited, situational relevancy; this may make it possible to get along in the system, while also allowing the actor to maintain a measure of inner freedom.

What are the specific connections between these considerations and the problems posed by hysteria and mental illness? If we regard psychiatry as the study of human behavior, it is evident that it is intimately related to both ethics and politics. This relationship was already illustrated by means of several examples. With respect to hysteria, the connections between ethics and psychiatry may be highlighted by asking: What kinds of human relationships and patterns of mastery does the so-called hysteric value? Or, phrased somewhat differently: What kind of game does such a person want to play? And what sort of behavior does he regard as playing the game well and winning? I shall try to answer these questions in the next chapter.

13 Hysteria as a Game

Interpersonal Strategies in Hysteria

By slightly modifying Piaget's scheme of the development of the capacity to follow and be aware of rules,[1] I propose to distinguish three stages, or types, of mastery of interpersonal processes: coercion, self-help, and cooperation. Coercion is the simplest rule to follow, self-help is the next most difficult, and cooperation is the most demanding of them all.

The hysteric plays a game consisting of an unequal mixture of these three strategies. While coercive maneuvers predominate, elements of self-help and cooperation are also present. A distinct achievement of this type of behavior is a synthesis of sorts among three separate and to some extent conflicting games, values, and styles of life. In this lies its strength as well as its weakness.

Because of an intense internal contradiction in the hysteric's life style, he fails to play well at any one of the three games. To begin with, the hysteric places a high value on coercive strategies. True, he may not be aware that he has made a choice between coercive and other tactics. His wish to coerce others may be unconscious—or at least inexplicit. In psychotherapy, it is generally easily recognized by the therapist and readily acknowledged by the patient. The point I want to emphasize here is that although the hysteric tacitly

espouses the value of coercion and domination, he cannot play this game in a skillful and uninhibited manner. To do so requires two qualities he lacks: a relatively indiscriminating identification with the aggressor, and a large measure of insensitivity to the needs and feelings of others. The hysteric has too much compassion to play the game of domination openly and successfully. He can coerce and dominate with suffering, but not with "selfish" will.

To play the game of self-help well requires committing one's self to it. This often leads to isolation from others: religious, artistic, or other work investments tend to displace interest in personal relationships. Preoccupation with one's body or with suffering and helplessness interfere, of course, with one's ability to concentrate on the practical tasks that must be mastered to play such games well. Moreover, the tactic of dominating others by displaying helplessness cannot be maintained unaltered in the face of a high degree of demonstrable competence in important areas of life. The aim of coercing others by exhibiting helplessness may still be maintained, but the tactics by which this goal is pursued must be modified. The proverbial absentminded professor is a case in point: here is a person who is highly competent in his specialized work but who is, at the same time, virtually helpless when it comes to feeding himself, putting on his galoshes, or paying his income tax. Exhibitions of incompetence in these areas invite help in exactly the same way as bodily complaints invite medical attention.

Finally, the game of cooperation implies and requires a value which the hysteric may not share at all. I believe that, in hysteria, we are confronted with a genuine clash of values—namely, between equality and cooperativeness on the one hand, and inequality and domination-submission on the other. This conflict of values actually takes place in two distinct spheres: in the intrapersonal system of the patient, and in the interpersonal system of therapy.

In psychiatry, the problem of hysteria is not formulated or seen in this way. Psychiatrists prefer to operate with the tacit assumption that whatever their own values are, their patients and colleagues share them—or should share them! Of course, this cannot always be the case. If, however, value conflicts of this sort are indeed as important in psychiatry as I am suggesting, why are they not made explicit? The answer is simple: because doing so would threaten the cohesion of the group—that is, the prestige and the power of the psychiatric profession.

Actually, the idea that hysterical—and other neurotic—symptoms are "compromises" is a cornerstone of psychoanalytic theory. At first, Freud thought in terms of compromise formations between instinctual drives and social defenses, or between selfish needs and the requirements of social living. Later, he asserted that neuroses were due to conflicts and compromises between id and ego, or id and superego. I now want to describe hysteria as still another kind of compromise, this time among three different types of games.

Typical of the coercive game we call "hysteria" is the powerful promotive impact of iconic body signs on those to whom they are directed. The patient's relatives tend to be deeply impressed by such communications, often much more deeply than they would be by similar statements framed in ordinary language. The display of sickness or suffering is thus useful for coercing others. This aspect of hysteria, perhaps more than any other, accounts for its immediate and immense practical value for the patient.

The game of self-help is also discernible in most cases of hysteria. Traditionally, hysterical patients were said to exhibit an attitude of indifference toward their suffering. I suggest that this manifest indifference signifies, first, a denial that the patient has in fact made a coercive communication and, second, an affirmation that the patient aspires to a measure of self-sufficiency. Hysterics are thus not wholly coercive in their

relationship to others. However, they attend to their self-helping strategies only halfheartedly, being ready to coerce by means of symptoms should other methods of mastery fail. Also, they feel that learning new tactics of self-help or cooperation is very difficult; moreover, such learning is often not encouraged in the social setting in which they live.

Hysterics play the cooperative game imperfectly. This is to be expected, as this game requires and presupposes a feeling of relative equality among the players. Persons employing hysterical methods of communication feel—and often are—inferior and oppressed. In turn they aspire to feeling superior to others and to oppressing them. But they also seek equality of sorts and some measure of cooperation as potential remedies for their oppressed status.

Hysteria is thus mainly a coercive game, with small elements of self-help and still smaller elements of cooperation blended in. This view implies that the hysteric is unclear about his values and their connection with his behavior.

We might again note here that several of the patients reported in the early psychoanalytic literature were young women who became "ill" with hysteria while caring for a sick, usually older, relative. This was true in the case of Breuer's famous patient Anna O.:

> In July, 1880, the patient's father, of whom she was passionately fond, fell ill of a peripleuritic abscess which failed to clear up and to which he succumbed in April, 1881. During the first months of the illness Anna devoted her whole energy to nursing her father, and no one was much surprised when by degrees her own health greatly deteriorated. No one, perhaps not even the patient herself, knew what was happening to her; but eventually the state of weakness, anaemia and distaste for food became so bad that to her great sorrow she was no longer allowed to continue nursing the patient.[2]

Anna O. thus started to play the hysterical game from a position of distasteful submission: she functioned as an oppressed, unpaid, sick-nurse, who was coerced to be helpful by

the very helplessness of a sick person and by her particular relationship to him. The women in Anna O.'s position were—as are their counterparts today, who feel similarly entrapped by their small children—insufficiently aware of what they valued in life and of how their own ideas of what they valued affected their conduct. For example, young middle-class women in Freud's day considered it their duty to take care of their sick fathers. Hiring a professional servant or nurse for this job would have created a moral conflict for them, because it would have symbolized to them as well as to others that they did not love their fathers. Similarly, many contemporary American women find themselves enslaved by their young children. Today, married women are generally expected to take care of their own children; they feel that they are not supposed to delegate this task to others. The "old folks" can be placed in a home; it is all right to delegate their care to hired help. This is a complete reversal of the social situation which prevailed in upper- and middle-class European circles until the First World War and even after it. Then, children were often cared for by hired help, while parents were taken care of by their adult children.

In both situations, the obligatory nature of the care required generates a feeling of helplessness in the person from whom help is sought. If a person cannot, in good conscience, refuse to provide help—and cannot even stipulate the terms on which he will supply it—then truly he becomes the help-seeker's slave. Similar considerations apply to the relationship between patients and physicians. If physicians cannot define their own rules—that is, when to help and in what ways—then they, too, are threatened with becoming the hostages of patients.

The typical cases of hysteria cited by Freud thus involved a moral conflict—a conflict about what the young women in question wanted to do with themselves. Did they want to prove that they were good daughters by taking care of their

sick fathers? Or did they want to become independent of their parents, by having a family of their own, or in some other way? I believe it was the tension between these conflicting aspirations that was the crucial issue in these cases. The sexual problem—say, of the daughter's incestuous cravings for her father—was secondary (if that important); it was stimulated, perhaps, by the interpersonal situation in which the one had to attend to the other's body. Moreover, it was probably easier to admit the sexual problem to consciousness and to worry about it than to raise the ethical problem indicated.[3] In the final analysis, the latter is a vastly difficult problem in living. It cannot be "solved" by any particular maneuver but requires rather decision making about basic goals, and, having made the decisions, dedicated efforts to attain them.

An Illustration of the Hysterical Game: Sullivan's "Hysterical Dynamism"

Although Harry Stack Sullivan persisted in using many traditional psychiatric concepts, he used the game model in one of his actual descriptions of hysteria:

> The hysteric might be said in principle to be a person who has a happy thought as to a way by which he can be respectable even though not living up to his standards. That way of describing the hysteric, however, is very misleading, for of course the hysteric never does have that thought. At least, it is practically impossible to prove that he has had that thought.[4]

Sullivan here asserts that the hysteric is a person who impersonates respectability—in short, someone who cheats. In the tradition of psychoanalysis, he hastens to add that the hysteric does not do this consciously. While it does not seem that the hysteric carefully plans his strategy, it is a mistake to emphasize the unwitting quality of his behavior. The question of precisely "how conscious" a given mental act is has plagued

psychoanalysis from its earliest days. I think this is largely a pseudo-problem, for consciousness—or, self-reflective awareness—depends partly on the situation in which a person finds himself. In other words, it is partly a social characteristic rather than simply a personal one.

In the following passage Sullivan provides an explicitly game-playing account of hysteria:

> To illustrate how the hysteric dynamism comes into operation, let us say that a man with a strong hysterical predisposition has married, perhaps for money, and that his wife, thanks to his rather dramatic and exaggerated way of doing and saying things, cannot long remain in doubt that there was a very practical consideration in this marriage and cannot completely blind herself to a certain lack of importance that she has in her husband's eyes. So she begins to get even. She may, for example, like someone I recently saw, develop a neverfailing vaginismus, so that there is no more intercourse for him. And he will not ruminate on whether this vaginismus that is cutting off his satisfaction is directed against him, for the very simple reason that if you view interpersonal phenomena with that degree of objectivity, you can't use an hysterical process to get rid of your own troubles. So he won't consider that; but he will suffer terribly from privation and will go to rather extravagant lengths to overcome the vaginismus that is depriving him of satisfaction, the lengths being characterized by a certain rather theatrical attention to detail rather than deep scrutiny of his wife. But he fails again and again. Then one night when he is worn out, and perhaps has had a precocious ejaculation in his newest adventure in practical psychotherapy, he has the idea, "My God, this thing is driving me crazy," and goes to sleep. . . .
>
> Now the idea, "This thing is driving me crazy," is the happy idea that I say the hysteric has. He wakes up at some early hour in the morning, probably at the time when his wife is notoriously most soundly asleep, and he has a frightful attack of some kind. It could be literally almost anything, but it will be very impressive to anyone around. His wife will be awakened, very much frightened, and will call the doctor. But before the doctor gets there, the husband, with

a fine sense of dramatic values, will let her know, in some indirect way, that he's terribly afraid he is losing his mind. She is reduced to a really agitated state by that. So when the doctor comes, the wife is in enough distress—in part because of whatever led to her vaginismus—to wonder if she might lose her own mind, and the husband is showing a good many odd symptoms.[5]

Sullivan's gift for portraying psychiatric diseases as problems in living is beautifully demonstrated here. The mutually coercive relationship between husband and wife is especially noteworthy; and so is the patient's impersonating or taking the role of the mentally ill person.

Sullivan then proceeds to describe the "hysterical dynamism" as a form of unconscious or inexplicit malingering without, however, using this term. He calls hysteria a form of "inverted sublimation"—meaning that the patient "finds a way of satisfying unacceptable impulses in a personally satisfactory way which exempts him from social blame and which thereby approaches sublimation. But the activity, if recognized, would not receive anything but social condemnation."[6] These remarks illustrate once again the use and function of nonverbal or indirect communications in hysteria, and also the close connection between hysteria and malingering. Phrased in terms of game playing, the hysteric is here described as someone who would gladly take advantage of cheating if he believed he could get away with it. His cheating is so staged, moreover, as to lead those around him to interpret it not as a selfish stratagem but as unavoidable suffering.

Another aspect of the game the hysteric plays—or of the sort of player he is, which, after all, determines the game he plays—may be discerned from the following passage:

The hysteric has a rather deep contempt for other people. I mean by this that he regards other people as comparatively shadowy figures that move around, I sometimes think, as audience for his own performance. How does this show? Well—hysterics may be said to be the greatest liars to no purpose in the whole range of human personalities—nothing is good enough as it is. It always

undergoes improvement in the telling; the hysteric simply has to exaggerate everything a little. . . . When they talk about their living—their interests, their fun, their sorrows and so on—only superlative terms will suffice them. And that, in a way, is a statement of the inadequacy of reality—which is what I mean when I say that hysterics are rather contemptuous of mere events and mere people. They act as if they were accustomed to something better, and they are.[7]

Sullivan here touches on the fact that the hysterical game is relatively unsophisticated. It is well suited to children, uneducated people, the oppressed, and the fearful; in brief, to those who feel that their chances for self-realization and success on their own are poor. Hence, they resort to impersonation and lying as strategies of self-advancement.

Most of the "dynamisms" mentioned by Sullivan thus far illustrate the use of coercive maneuvers. This is consistent with my thesis that hysteria is predominantly a coercive type of game.

Concerning hysterical conversion—that is, the use of iconic body signs—Sullivan writes:

Now, when there is this conversion, it performs a useful function; and that function occurs principally within the self-system. . . . There one discovers sometimes the almost juvenilely simple type of operation set up to profit from the disabling system. The patient will often tell you in the most transparent fashion: "If it were not for this malady then I could do—" and what follows is really quite a grandiose appraisal of one's possibilities. The disability functions as a convenient tool of security operations.[8]

This, of course, is only one aspect of conversion, albeit a significant one. Sullivan's formulation is another way of saying that the hysteric plays at being sick because he is afraid that, if he tried to participate competently in certain real-life activities, he would fail. At the same time, by adopting this strategy, the hysteric invites and assures his own defeat.

Sullivan's concluding remarks concerning hysteria strongly support the thesis that persons who tend to play this sort of

game do so because they are impoverished in their game repertoire:

> The presence of the hysteric dynamism as the outstanding way of meeting difficulties in living seems to me to imply that the patient has missed a good deal of life which should have been undergone if he was to have a well-rounded personality with a rather impressively good prospect for the future. Because hysterics learn so early to get out of awkwardnesses and difficulties with a minimum of elaborate process, life has been just as they sound: singularly, extravagantly simple. And so, even if one could brush aside the pathogenic or pathologic mechanisms, one would have persons who are not at all well-suited to a complex interpersonal environment. There they just haven't had the experience; they have missed out on an education that many other people have undergone.[9]

All this highlights the moral underpinnings of psychological and psychoanalytic theories and therapies. What a person considers worth doing or living for, or not worth it, will depend on what he has learned or taught himself to value. In this respect, especially, mental illnesses are much like religions: one man's devotion is another man's delusion. It is quite obvious, although psychiatrists have almost succeeded in obscuring it, that there are many persons for whom playing hysterical—or other so-called psychopathological—games is a perfectly acceptable and reasonable thing to do. Psychiatric theories now deny this fact, and psychiatric therapies view the game-playing habits of patients less as habits patients want to keep than as happenings they want to lose. I think psychiatric theories ought to recognize the moral choices inherent in psychiatric symptoms and syndromes, and psychiatric therapies ought to view the game-playing habits of patients more as habits the patients want to keep than as happenings they want to lose.

Lying: A Specific Strategy in Hysteria

It is unfashionable nowadays for psychiatrists to speak of lying. Once a person is called a "patient," psychiatrists cease

to consider the possibility that he might be deceptive or mendacious; if in fact he is, they regard the lies as symptoms of a mental illness which they call hysteria, hypochondriasis, schizophrenia, or some other "psychopathology." As a result, anyone who continues to speak of lies and deceptions in connection with psychiatric problems is immediately regarded as "antipsychiatric" and "antihumanitarian": in other words, he is dismissed as both mistaken and malevolent.

I have long considered lying as one of the most important phenomena in psychiatry, a view I have formed partly by taking some of Freud's earliest observations seriously. Let us recall here how emphatically Freud condemned certain social and medical hypocrisies, which are, after all, simply lies of a certain kind. Freud was especially critical of the deceitful habits of both physicians and patients with respect to sex and money. This is the gist of Freud's recollection of his encounter, early in his medical career, with the Viennese obstetrician-gynecologist Chrobak. Chrobak had referred a patient to Freud, a woman who, because her husband was impotent, was still a virgin after eighteen years of marriage.[10] The physician's moral obligation in such cases, so Chrobak told Freud, was to shield the husband's reputation by lying about the patient's condition. I mention this case only to show that lying—on the parts of both patients and physicians—was an important issue in psychoanalysis from its very inception. Indeed, I believe that certain psychoanalytic concepts came into being in order to deal with the *idea of lies*, for example, the unconscious and hysterical conversion; and that certain psychoanalytic arrangements came into being in order to deal with the *management of lies*, for example, free association and the psychoanalytic contract.

The medical situation, like the family situation which it often imitates, is, of course, a traditionally rich source of lies. The patients, like children, lie to the doctor. And the physicians, like parents, lie to the patients.[11] The former lie because they are weak and helpless and cannot get their way by

direct demands; the latter lie because they want their wards to know only what is "good" for them. Infantilism and paternalism are thus the sources of and models for deception in the medical and psychiatric situations.

The following illustration, based on the psychoanalysis of a young woman, may be useful in forming a fuller picture of hysteria as a game. I shall say nothing about why this woman came for help or what sort of person she was, but shall concentrate on only one aspect of her behavior—namely, her lying. That she lied—in the sense that she communicated statement A to someone when she knew perfectly well that statement B was the truth—became apparent early in the analysis and remained a prominent theme throughout it. She felt, and said, that the main reason she lied was because she saw herself as a trapped child confronted by an oppressive and unreasonable mother. As a child, she discovered that the simplest and most effective way she could cope with her mother was by lying. Her mother's acceptance of her lies encouraged her use of this strategy and firmly established lying as a habitual pattern in her life. When I saw her, many of her friends and especially her husband apparently or ostensibly accepted her lies, much as her mother had done before. Her expectation in regard to her own untruthful communications was revealing. On the one hand, she hoped that her lies would be accepted as truthful statements; on the other hand, she wished that they would be challenged and unmasked. She realized that the price she paid for lying successfully was a persistent psychological dependence on those to whom she lied. I might add that this woman led a socially perfectly normal life and did not lie indiscriminately. She was inclined to lie only to people on whom she felt dependent or toward whom she felt angry. The more she valued a relationship, the more convinced she was that she could not risk any open expression of personal differences; she then felt trapped and lied.

Lying thus became for this patient an indirect communication similar to hysterical conversion or dreaming. As we familiarized ourselves with the type of game she was playing, it became increasingly evident that, much of the time, the people to whom she lied knew that she was lying. And, of course, she did too. None of this diminished the usefulness of the maneuver whose main value lay in controlling the behavior or response of the other player(s). In terms of game playing, it was as if she could not afford to take the chance to play honestly. Doing so would have meant that she would have had to make her move and then wait until her partner-opponent made his or hers. The very thought of this made her unbearably anxious, especially when she felt at conflict with someone close to her. Instead of playing honestly and exposing herself to the uncertainties and anxieties this entailed for her, she preferred to play dishonestly: that is, she lied, making communications whose effects she could predict with a high degree of confidence. Her whole marriage was thus a complicated and ceaseless game of lies, her husband ostensibly accepting her falsehoods as truths, only the better to manipulate her with them. This, then, gave her fresh ground for feeling oppressed and for lying to him. The result was a highly predictable series of exchanges between them, and a quite secure marriage for them.

Uncertainty and Control in Game-Playing Behavior

One of the important psychological characteristics of playing games honestly is the absolute freedom of each player to make his moves as he sees fit, and hence the relative unpredictability of the behavior of each by the other. For example, in chess each player is free to make whatever move the game rules allow. Unless the players are extremely unevenly matched—in which case one can hardly speak of a real chess game at all—neither player can foretell with any great certainty what the

other's moves will be. This, indeed, is the very point of certain games: the players are presented with risks and uncertainties which they must bear and master. And this, too, is why games are either pleasurably exciting or painfully disturbing.

To play a game, and especially to play it well, it is necessary, therefore, to be able to tolerate a measure—often a very large measure—of uncertainty. This is true no less for the metaphorical games of human relationships than it is for literal games such as chess or roulette. In social relations, too, if a person conducts himself honestly, he will often be unable to predict how others will react to him and to his behavior. Suppose, then, that for some reason a person wants to control and predict the behavior of those with whom he interacts: he will then be tempted to lie and cheat. Such a person may even be said to be playing a different game than he would be playing if he were playing honestly, even though, formally, the two games are the same. An example will make this clear: in playing chess honestly, the player's aim is to master the rules of chess; in playing it dishonestly, his aim is to beat his opponent. In one case, winning is secondary to playing well and learning to play better; in the other, winning is primary and all that counts. Honest game playing thus implies that the players value the skills that go into playing the game well; whereas dishonest game playing implies that they do not value these skills. It is evident, then, that honest and dishonest game playing represent two quite different enterprises: in the one, the player's aim is successful mastery of a task—that is, playing the game well; in the other, his aim is control of the other player—that is, coercing or manipulating him to make certain specific moves. The former task requires knowledge and skills; the latter—especially in the metaphorical games of human relations—information about the other player's personality.

These considerations have the most far-reaching implications for social situations in which those in authority are concerned not with their subordinate's performance, but with

their personality. Characteristically, in such situations, superiors not only tolerate but often subtly encourage inadequate task performance by their subordinates; what they want is not a competent subordinate but a subordinate they can dominate, control, and "treat." One of the most ironic examples of this is the psychoanalytic training system, in which the trainers are avowedly more concerned with the personality of the trainees than with their competence as psychoanalysts.[12] The workings of countless other bureaucratic and educational organizations, in which superiors seek and secure psychological profiles and psychiatric reports on their subordinates, illustrate and support this interpretation: in these situations, the superiors have replaced the task of doing their job competently, with the task of managing their personnel "compassionately."

Lying, as in the marriage game described earlier, serves this function of relationship management well, especially if it is mutual. This value of lying derives not so much from its direct, communicative meanings as it does from its indirect, metacommunicative ones. By telling a lie, the liar in effect informs his partner that he fears and depends on him and wishes to please him: this reassures the recipient of the lie that he has some control over the liar and therefore need not fear losing him. At the same time, by accepting the lie without challenging it, the person lied to informs the liar that he, too, needs the relationship and wants to preserve it. In this way, each participant exchanges truth for control, dignity for security. Marriages and other "intimate" human relationships often endure on this basis.

As against such secure though often humiliating arrangements, relationships based on truthful communications tend to be much more vulnerable to dissolution. This accounts for the ironic but intuitively widely understood fact that bad marriages are often much more stable than good ones. I use the words "good" and "bad" here to refer to such values as dignity, honesty, and trustworthiness, and their opposites. The

continuation of a marriage or its dissolution by divorce, as mere facts, codifies only the legal status of a complex human relationship; it conveys no information whatever about the true character of the relationship. This is one reason why it is so hopelessly naïve and foolish to regard—as psychiatrists often do—contracting or sustaining a marriage as a sign of successful game playing—that is, as a sign of maturity or mental health; and dissolving a marriage by separation or divorce as a sign of unsuccessful game playing—that is, as a sign of immaturity or mental illness.

On Changing the Hysterical Game

As an illness, hysteria is characterized by conversion symptoms. As a game, it is characterized by the goal of domination and interpersonal control; the typical strategies by which this goal is pursued are coercion by disability and illness, and by deceitful gambits of various kinds, especially lies.

Diseases may be treated. Game-playing behavior can only be changed. Accordingly, if we wish to address ourselves to the problem of the "treatment" of hysteria (or of any other mental illness), we must first come to grips with the patient's life goals and values and with the physician's "therapeutic" goals and values. In what directions, toward what sorts of game-playing behavior, does the patient want to change? In what direction does the therapist want him to change? As against the word "change," the word "treatment" implies that the patient's present behavior is bad—because it is "sick"; and that the direction in which the therapist wants him to change is better or good—because it is "healthier." In this, the traditional psychiatric view, the physician defines what is good or bad, sick or healthy. In the individualistic, autonomous "psychotherapy" which I prefer, the patient himself defines what is good or bad, sick or healthy. With this arrangement, the patient might set himself goals in conflict with the therapist's

values: if the therapist does not accept this, he becomes "resistant" to helping the patient—instead of the patient being "resistant" because he fails to submit to the therapist. It seems to me that any sensible description of psychotherapy ought to accommodate both of these possibilities.

In short, accounts of therapeutic interventions with so-called mental patients, and of modifications in their life activities, should be couched in the language of changes in the patient's game orientations rather than in the language of symptoms and cures. Thus, in the case of hysterical patients, changes which might be categorized as "improvements" or "cures" by some might occur in any of the following directions: more effective and ruthless coercion and domination of others; more passive and masochistic submission to others; withdrawal from the struggle over interpersonal control and increasing isolation from human relationships; and, finally, learning to play other games and acquiring interest and competence in some of them.

A Summing Up

"When one psycho-analyses a patient subject to hysterical attacks," wrote Freud in 1909, "one soon gains the conviction that these attacks are nothing but phantasies projected and translated into motor activity and represented in pantomime."[13] In suggesting that the hysterical symptom is in effect a type of pantomime or dumb-show—the patient expressing a message by means of nonverbal, bodily signs—Freud himself acknowledged that hysteria is not an illness but an idiom or language, not a disease but a dramatization or game. For example, pseudocyesis, or false pregnancy, is the pictorial representation and dramatization of the patient's belief that she is pregnant even though she is not.

In short, hysteria is a type of language in which communication is effected by means of pictures (or iconic signs),

instead of by means of words (or conventional signs). Hysterical language thus resembles other picture languages, such as charades. Those who want to deal with so-called hysterical patients must therefore learn not how to diagnose or treat them, but how to understand their special idiom and how to translate it into ordinary language. In a game of charades, one member of a team enacts an idea or proverb, and his teammates try to translate his pantomime into ordinary, spoken language. Similarly, in a game of hysteria, the "patient" enacts a belief or complaint—which is what makes him the "patient"; and his teammates—family members, physicians, or psychiatrists—try to translate his pantomime—now called "hysterical conversion"—into ordinary language.

14 Impersonation and Illness

Impersonation and Role-Taking

The concept of impersonation refers to the assumption or imitation of someone else's appearance, character, condition, or social role. Impersonation is a ubiquitous phenomenon and is not, as such, considered to constitute a psychiatric problem. Indeed, everyday speech offers numerous terms for a variety of impersonations or, more precisely, impersonators; for example, charlatan, confidence man, counterfeiter, forger, impostor, quack, spy, traitor, and so forth. Two impersonators, the malingerer and the hysteric, have been of special interest to psychiatrists. I have remarked on them both in the previous chapters of this book.

A definition of impersonation is now in order. According to Webster, to impersonate is "to assume or act the person or character of. . . ." This definition provokes some interesting difficulties: if role-taking behavior is universal, as Mead and others have suggested,[1] how do we distinguish ordinary role-taking from impersonation? I suggest the following answer: role-taking refers to consistent or honest role-playing, in the context of a specific game—whereas impersonation refers to inconsistent or dishonest role-playing, in the context of everyday life. For example, taking the role of a vendor and approaching another person as a prospective customer implies

that the seller either owns the goods offered for sale or is authorized to act in the owner's name. When a person sells something he does not own, he impersonates the role of an honest vendor and is called a "swindler."

Since role-taking is a permanent and universal characteristic of human behavior, it is evident that practically any action can be interpreted as a type of impersonation. The so-called Don Juan may thus be said to impersonate a man of acrobatic virility; the transvestite, the social role and sexual functions of a member of the opposite sex; and so forth. Simone de Beauvoir offers this account of role-taking as impersonation:

> Even if each woman dresses in conformity with her status, a game is still being played: artifice, like art, belongs to the realm of the imaginary. It is not only that girdle, brassiere, hair-dye, make-up disguise body and face; but that the least sophisticated of women, once she is 'dressed,' does not present herself to observation; she is, like the picture or the statue, or the actor on the stage, an agent through whom is suggested someone not there—that is, the character she represents, but is not.[2]

If what de Beauvoir says is true about women, it is even more true about children, who spend much of their time impersonating others. They play at being fireman, doctor, nurse, mother, father. Since the child's identity is defined in predominantly negative terms—that is, in terms of what he cannot do, because he is not allowed to do it or is incapable of doing it—it is not surprising that he should seek role fulfillment through impersonation. A child's real identity or social role is, of course, to be a child. But in an achievement-oriented culture, as opposed to a tradition- and kinship-oriented one, being a child tends to mean mostly that one is unable or unfit to act in certain ways. Thus, childhood itself may be viewed as a form of disability.*

* Similar considerations hold for old age. As old persons become unemployed and unproductive, and particularly if they are economically and physically disabled, their principal role becomes being old.

Let us now briefly reconsider the impersonations which children, say between five and ten, characteristically engage in. From the adult's point of view, what is perhaps most striking about these play-acts is their transparency as impersonations. How could anyone possibly mistake a child playing doctor or nurse for a real doctor or nurse? The question itself is ludicrous—because the task of distinguishing impersonated role from genuine role is here nonexistent. A blank sheet of typewriter paper is not an imitation of a twenty-dollar bill; nor is a five-year-old playing doctor an impostor. In part, it is of course the child's size that stamps a clear identity on him, and vitiates his effort at any credible imitation of an adult role: he is simply too small and looks too unlike an adult to be able to assume an adult role. He may, of course, possess the skills of an adult, and more—as, for example, a musical prodigy does; but he cannot possess the social role of an adult.

Although the child's impersonations are so obvious as to present no problem at all for adults to recognize, there are others which are so subtle, or require such specialized informations and skills, that most adults are quite incapable of recognizing them. Many people cannot tell a quack from a licensed physician, or an art forger from a recognized artist. Similarly, most people cannot readily distinguish between a clinical psychologist and a psychiatrist, or a psychiatrist and a "regular" physician: to make these distinctions—that is, to see how psychologists impersonate psychiatrists, and psychiatrists regular physicians—requires that one possess certain kinds of specialized information not generally available.[8]

Impersonation, then, is an integral part of childhood. Another way of saying this is by asserting that children learn how to grow up by imitating adults and by identifying with them. For the reasons I have just noted, the problem of distinguishing between successful and unsuccessful impersonation does not arise until after the person has attained physiological and social maturity. Only an adult can fake another.

Nevertheless, psychiatrists and psychoanalysts have systematically failed to distinguish between impersonation, which is the general class, and imposturing, which is but one type of impersonation. Helene Deutsch, who has written extensively on this subject, actually equates, and thus confuses, these two concepts and phenomena.[4] Some of her observations apply to impersonating, and others to imposturing, as the following passage illustrates:

> The world is crowded with "as-if" personalities, and even more so with impostors and pretenders. Ever since I became interested in the impostor, he pursues me everywhere. I find him among my friends and acquaintances, as well as in myself. Little Nancy, a fine three-and-a-half-year-old daughter of one of my friends, goes around with an air of dignity, holding her hands together tightly. Asked about this attitude she explains: "I am Nancy's guardian angel, and I'm taking care of little Nancy." Her father asked her about the angel's name. "Nancy" was the proud answer of this little impostor.[5]

Deutsch is correct that the world is full of people who act "as if" they were someone else. Alfred Adler noted the same phenomenon and called it the "life-lie."[6] In this connection, we might also recall Vaihinger's important work, *The Philosophy of "As If,"*[7] which influenced both Freud and Adler.

The point is that not all impersonators are impostors, but all impostors are impersonators. In illustrating impersonation, which she erroneously calls imposturing, Deutsch cites examples of the behavior of children. But, as we saw, children must impersonate others because they are nobodies. Deutsch concludes that the essence of imposturing lies in "pretending that we actually are what we would like to be."[8] But this is merely a restatement of the common human desire to appear better than one actually is. It is not a correct formulation of imposturing, which implies deceitful role-taking for personal gain. Impersonation is a morally more neutral name for a class that contains role pretensions which are both objectionable and unobjectionable, blameworthy and praiseworthy.

The desire to be better or more important than one is is likely to be strongest, of course, among children, or among persons who are, or consider themselves to be, in inferior, oppressed, or frustrating circumstances.* These are the same persons who are most likely to resort to various methods of impersonation. Conversely, those who have been successful in realizing their aspirations—who, in other words, are relatively well satisfied with their actual role achievements and definitions—will be unlikely to pretend to be anyone but themselves. They are satisfied with who they are and can afford the luxury of telling the truth about themselves.

Varieties of Impersonations

Since, in principle at least, every human activity or role can be imitated, there are as many types of impersonations as there are human performances. From this rich variety of impersonations, I shall select and briefly comment here on a few which seem to me especially relevant to psychiatry and to the present study of it.

Lying is the logical example to begin with. The liar impersonates the truth-teller. We speak of lying usually in relation to verbal or written communications; and then only when there is an expectation that the communicants are supposed to be truthful. Poets speak in metaphor, and politicians in rhetoric, and we do not call their utterances lies. Witnesses in courts of law, on the other hand, are explicitly enjoined to tell the truth, and are guilty of perjury if they do not.

Cheating is like lying, but in the context of games. The cheat impersonates the honest player, to unfairly enhance his chances of winning. We speak of cheating only when the rules of the game are clearly codified and generally known. For

* I do not wish to imply that children are always oppressed, or that their lack of a firm inner identity is due to oppression. Indeed, the role of being oppressed can itself be the core of one's identity. The lack of firm personal identity in childhood is a reflection mainly of the child's incomplete social and psychological development.

example, a person may be cheated in a business venture, or a husband by his wife or vice versa. When the game rules are uncertain or unknown to the players, we give other names to rule breaking. In psychiatry, for example, instead of saying that persons cheat in the medical game, we say that they suffer from hysteria or hypochondriasis; in politics, instead of saying that office holders cheat, we say that they are patriotic or protect the general welfare.

Malingering, which I have discussed in detail earlier and elsewhere,[9] is impersonating the socially legitimatized sick role. What constitutes being correctly sick depends, of course, on the rules of the illness game. If the medical game recognizes the legitimacy of the sick role only for persons who are bodily ill, then those who assume this role without being bodily ill will be considered to be malingerers; whereas if it also recognizes the legitimacy of the sick role for persons who are not bodily ill, then those who assume the sick role without being bodily ill will be considered to be mentally ill.

Although it may be obvious and a truism, I want to emphasize that a person who did not know the rules of the illness game could not malinger. This is like asserting that a person who did not know that a canvas by Picasso was valuable could not, and hence would not, try to sell a painting which he believes to be a fake Picasso for a large sum. This, then, lets us deal more clearly with the problem of error and self-deception in impersonation. In the case of illness, a person might sincerely believe that he is bodily ill when in fact he is not; and he might then represent himself as sick. Such an individual is like a person who has unknowingly purchased a fake Picasso, who sincerely believes that it is an original, and who then represents and tries to sell it as a genuine Picasso. Clearly, there is a difference between what this man is doing and what the forger is doing. In psychiatry and psychoanalysis, malingering has traditionally been seen as similar to a forgery, and hysteria as similar to the unwitting possession and sale of a forgery. It is, I

think, helpful to see both as impersonations—of possessing a genuine Picasso in the one case, and of possessing a genuine illness in the other. Whether the impersonation is conscious and deliberate, or otherwise, is usually easily ascertained—by communicating with the potential impersonator and by investigating his claims and possessions.

So-called mental illnesses are best conceptualized as special instances of impersonation. In hysteria, for example, the patient impersonates the role of a person sick with the particular disease or disability which he displays. Many psychiatrists more or less recognize and admit that this is what the hysteric does, but hasten to add that the hysteric does not know what he is doing. This belief flatters the psychiatrists, for it means that they know more about their patients than the patients know about themselves—which is usually not true. The hysteric's seeming ignorance of what he is doing may also be interpreted as his not being able to afford to know it, for if he knew it he could no longer do it; in short, that the patient cannot bear to tell himself the truth about his own life or some particular aspect of it. He must therefore lie both to himself and others. As I have indicated already, I consider this to be the correct view.

The so-called hypochondriac and schizophrenic also impersonate: the former takes the role of certain medical patients, whereas the latter often takes the role of other, invariably famous, personalities. The hypochondriac may thus claim that he has cancer, just as a quack may claim that he is a doctor. And the schizophrenic may assert that he is Jesus, just as a child may assert that he is a daddy. These examples also show why and when psychiatrists, and the public, resort to labeling persons crazy or psychotic: the more publicly unsupported a person's impersonation is, and the more stubbornly he clings to it despite the attempts of others to reject it, the more he courts being defined and treated as a madman or psychotic.

Another type of impersonation is that exemplified by the

confidence man who pretends to be trustworthy only to defraud his victim.[10] This sort of impersonation is conscious, is frankly acknowledged to self and friends, and is concealed only from intended victims. In confidence games, the swindler's gains and the victim's losses are obvious, at least in retrospect.

There remains one particular type of impersonation which deserves special attention—namely, acting, or impersonation in the theater. In this setting, role-taking is explicitly identified as impersonation by the context in which it occurs. The actor who plays Lear or Lincoln is not Lear or Lincoln, and both actors and audiences know this. Theatrical impersonation is, in many ways, the model of all impersonations. Although such impersonation is characteristically confined to the theater, the actor being himself when he is offstage, the actor's real life, or at least the public's image of it, is often profoundly affected by his theatrical roles, especially if these are consistently of the same sort. I refer here to what in the theater and movies is known as "typecasting" and "being typed," phenomena which, as we shall presently see, are of considerable importance for psychiatry and ordinary social relations as well. If actors or actresses appear in the same sorts of roles over and over again, they are likely to create the impression in the public that they are "really" like the characters they are portraying. One immediately thinks in this connection of the actors who are always the gangsters, or the actresses who are the sex bombs. To many Americans, Boris Karloff *was* Frankenstein, Raymond Massey *was* Lincoln, and Ralph Bellamy *was* Franklin Roosevelt. Moreover, the actors' assumed identities may prove convincing not only to their audiences but to themselves as well. They may then begin to act offstage as if they were on it. Roles can and do become habits. In many chronic cases of mental illness, we witness the consequences of playing hysterical, hypochondriacal, schizophrenic, or other games

over years and decades, until they have become deeply ingrained habits.

The Ganser Syndrome

A type of impersonation of special interest and importance to psychiatrists is the so-called Ganser syndrome, which, simply put, is the strategic impersonation of madness by a prisoner. Yet for decades psychiatrists have argued about whether this alleged illness is a form of malingering, a form of hysteria, a form of psychosis, or whether it is an illness at all.[11] I suggest that we regard the Ganser syndrome as a special kind of impersonation of the sick role, occurring under the conditions of prison life as defined by judges, wardens, and prison psychiatrists.

The Ganser syndrome was first described, or perhaps I should say was created, by a German psychiatrist of that name in 1898.[12] He called it a "specific hysterical twilight state," the chief symptom of which he identified as *vorbeireden*. Other psychiatrists subsequently named it "paralogia," or the "syndrome of approximate answers," or the Ganser syndrome. Here is the description of this alleged illness from a standard American text, Noyes's *Modern Clinical Psychiatry:*

> An interesting type of mental disorder sometimes occurring in the case of prisoners under detention awaiting trial was described by Ganser. It develops only after commission of a crime and, therefore, tells nothing about the patient's mental state when he committed the offense. In this syndrome, the patient, being under charges from which he would be exonerated were he irresponsible, begins, without being aware of the fact, to appear irresponsible. He appears stupid and unable to comprehend questions or instructions accurately. His replies are vaguely relevant to the query but absurd in content. He performs various uncomplicated, familiar tasks in an absurd manner, or gives approximate replies to simple questions.

The patient, for example, may attempt to write with the blunt end of his pencil, or will give 11 as the product of 4 × 3. The purpose of the patient's behavior is so obviously to appear irresponsible that the inexperienced observer frequently believes that he is malingering. The dynamics is probably that of a dissociative process.[13]

It should be noted that, in this account, the person exhibiting such conduct is labeled a "patient," and his behavior a "mental disorder." But how has it been shown that he is "sick"?

Here is another interpretation of the Ganser syndrome—this one by Fredric Wertham:

A Ganser reaction is a hysterical pseudo-stupidity which occurs almost exclusively in jails and in old-fashioned German textbooks. It is now known to be almost always due more to conscious malingering than to unconscious stupefaction.[14]

If the Ganser "patient" impersonates what he thinks is the behavior of the mentally sick person—to plead irresponsibility and avoid punishment—how does his behavior differ from that of a person who cheats on his income tax return? One feigns insanity, the other poverty. Nevertheless, psychiatrists continue to view this sort of behavior as a manifestation of illness and to speculate about its nature, causes, and cures.

This fact is itself significant and points to the parallels between the impersonations of the Ganser patient and of the actor who has been typecast. Persons diagnosed as suffering from the Ganser syndrome have succeeded, to an astonishing degree, in convincing both themselves and their significant audience that they are, in fact, sick—disabled, not responsible for their "symptomatic" behavior, perhaps even suffering from some obscure physicochemical disorder of their body. Their success in this respect is exactly like that of the actor who

comes to believe that he is, say, irresistible to women, and about whom others come to share the same belief.

Roles: Assumed, Impersonated, and Genuine

When an actor has been typecast, he has succeeded in making his assumed role so believable and accepted that people will think he no longer "acts" but "plays himself." Similarly, if a person diagnosed as suffering from malingering, hysteria, or the Ganser syndrome has been accepted as truly ill, as a sick patient (even if the sickness is mental sickness), then he too has succeeded in making his assumed role so believable that people will think he no longer "acts" but "is sick." This phenomenon is actually encountered in all walks of life, and there is nothing mysterious about it. Our image of the world about us is constructed on the basis of our actual experiences. How else could it be constructed? The proverbs tell us that "Seeing is believing" and that "Four eyes can see better than two." In other words, we build our world on the basis of what we see and what other people tell us they see. Complementary channels of information thus form an exceedingly important corrective of and support for our own impressions and experiences. For example, by listening only, we may not be able to distinguish a person's voice from a recording of it; by looking at the source of the sound we can easily resolve this problem. When the complementary channel of information is another person, his agreement or disagreement with us can be similarly decisive in shaping our own experience and judgment.

We may state this more generally by asserting that the concept of impersonated role has meaning only in contrast with the concept of genuine role. The method for differentiating impersonated or false roles from genuine or real ones is the familiar process of verification. This may be a social

process, consisting of the comparison of opinions from various observers. Or it may be a scientifically more distinctive operation, consisting of testing assertions or hypotheses against observations or experiments. In its simplest forms, verification involves no more than the use, as mentioned above, of complementary channels of information—for example, sight and hearing, checking the patient's statements against certain official documents, etc. Let us consider the case of a person who claims to be Jesus. If we ask such a person for evidence to support his claim, he may say that he suffers and soon expects to die or that his mother is the Virgin Mary. Of course, we don't believe him.

This, however, is perhaps too crude an example. It fails to confront us with the more subtle and difficult problems in validating the sick role, such as occur characteristically with persons who complain of pain. Here the question becomes: Does the patient "really" have pain—that is, is he a genuine occupant of the sick role? Or is his pain "hysterical"—that is, does he impersonate the sick role? In this sort of case we cannot rely on asking other people whether they think that the patient is "sick" or "malingering." The criterion for differentiating between the two roles must be scientific rather than social. In other words, it will be necessary to perform certain "operations" or "tests" to secure more information on which to base further inferences. In the case of differentiating bodily from mental illness, the principal method for gathering further information is the physical, laboratory, and psychological examination of the patient.

Viewing impersonation and genuine role-playing in terms of games, they could be said to represent two fundamentally different games.[15] In genuine role-playing, the actor commits himself to the game with the goal of playing as well as he can: for example, the surgeon tries to cure the sick person by the proper removal of the diseased organ. In impersonated role-playing, the actor commits himself to imitating the well-

playing person: for example, the man who impersonates a physician tries to convince people that he is one so that he can enjoy the economic and social rewards of the physician's role.

In impersonation, then, the goal is to look like the imitated person: that is, to effect an outward, or "superficial," similarity between self and other. This may be achieved by dress, manner of speech, symptom, making certain claims, and so forth. Why some persons seek role imitation rather than competence and task mastery need not concern us here.

The desire for unnecessary surgical operations—"unnecessary," that is, from the point of view of pathophysiology—is often a part of the strategy of impersonation. In this situation, the impersonator plays the illness game and tries to validate his claim to the sick role. The surgeon who consents to operate on such a person performs a useful function for him, albeit his usefulness cannot be justified on surgical grounds. His intervention legitimizes the patient's claim to the sick role. The surgical scar is official proof of illness: it is the diploma that proves the genuineness of patienthood.

In genuine role-playing, on the other hand, the individual's purpose, usually consciously entertained, is to acquire certain skills or knowledge. The desire for a certain kind of similarity to another person—say, to a surgeon or scientist—may be operative here also. But the goals as well as the rules of this game require that the similarity be substantive rather than superficial. The goal is learning, and hence an alteration of the "inner personality" rather than a mere "outer change" such as occurs in impersonation.

The Psychiatric Authentication of Impersonated Roles as Genuine

In the case of malingering, hysteria, and the Ganser syndrome—and, indeed, in all cases of so-called mental illness—psychiatrists actually confirm the patient's self-definition as ill and so help to shape his illness. This psychiatric authentication

and legitimization of the sick role for those who claim to be ill, or about whom others make such claims, has the most profound implications for the whole field of psychiatry, and beyond it, for all of society. When physicians and psychiatrists began to treat those who impersonated the sick role as genuinely ill patients, they acted much as an audience would if it treated Raymond Massey or Ralph Bellamy as Presidents of the United States. This sort of feedback to the actor means not only that he can no longer rely on his audience for a corrective definition of reality and his own identity in it, but also that, because of the audience's response, he must doubt his own perceptions about who he really is. In this way, he is encouraged to acquiesce in the role which in part he wants to play, and which his audience wants him to play. While actors are sophisticated about the risks of typecasting, persons playing on the metaphorical stage of real life are usually quite unsuspecting of this danger. Hence, few persons who launch themselves on a career of impersonating the sick role reckon with the danger of being authenticated in this role by their families and by the medical profession. On the contrary, they usually expect that their impersonated roles will be opposed or rejected by their audience. Just as swindlers expect skepticism and opposition from their intended victims, so malingerers have traditionally expected skepticism and oppositions from physicians. However, as on the stage so also in real life, an audience's resistance to an actor's impersonated role is strongest when the play is first put on stage. After a run of initial performances, the actor is either accepted in his role—and the play goes on for a longer run; or he is rejected in it—and the play closes down. Moreover, the longer the actor plays his role, the less will his critics and audience scrutinize his performance: he is now "in." This is a familiar process in many phases of life. For example, if a student does well early in his courses and becomes defined as a good student, his teachers will scrutinize his subsequent performance much less

closely than they will that of a bad student. In the same way, actors, athletes, financiers, and others of proven ability tend to be much more immune to criticism than those who are not yet so accepted.

The distinction between genuine and impersonated roles may be described in still another way, by making use of the concepts of instrumental and institutional groups and the criteria for membership in them.[16] Instrumental groups are based on shared skills. Membership in them, say in a Davis Cup team, implies that the person possesses a special skill. We consider this role genuine because such a person really knows how to play tennis. Institutional groups, on the other hand, are based on kinship, status, and other nonfunctional criteria. Membership in a family, say in a royal family, is an example. When the king dies, the crown prince becomes the new king. This transformation from nonking to king requires no new knowledge or skills; it requires only being the son of a dead king.

Impersonation may be summed up in one sentence; it is a strategy of behavior based on the model of hereditary monarchies. Implicit in this strategy is a deep-seated belief that instrumental skills are unimportant. All that is needed to succeed in the game of life is to "play a role" and gain social approval for it. Parents often hold up this model for their children to follow. When they do follow it, they soon end up with an empty life. When the child or young adult then tries to fill the void, his efforts to do so are often labeled as some form of "mental illness." However, being mentally ill or psychotic —or killing someone else or himself—may be the only games left for such a person to play.

A Summing Up

In playing a role, the actor's main task is to put on a good performance. If the role is genuine—by which I mean that it pertains to an *instrumentally* definable task, such as playing

chess or driving a car—then successful role-playing simply means successful task mastery, and unsuccessful role-playing means unsuccessful task mastery.

If, however, the role is impersonated—by which I mean that it pertains to an *institutionally* definable task, such as convincing others that one possesses certain qualities whether one does or not—then the possibilities for failure are doubled. The person may fail, first, by putting on an inadequate performance and failing to persuade the audience to authenticate him in his impersonated role; and, second, by putting on a performance that is so convincing that the audience authenticates his impersonated role as his genuine role. I remarked on how this may happen to actors as well as to so-called mental patients. I might add here that this hazard is greatest for the competent and successful performer. In other words, those who play the games of hysteria or mental illness poorly or half-heartedly are likely to be repudiated in their roles by their families or physicians. It is precisely those who play these games most skillfully whose performances are likely to prove successful and whose identities will therefore be authenticated as sick—that is, as mentally sick. I submit that this is the situation in which most persons called mentally ill now find themselves. By and large, such persons impersonate* the roles of helplessness, hopelessness, weakness, and often of bodily illness—when, in fact, their actual roles pertain to frustrations, unhappinesses, and perplexities due to interpersonal, social, and ethical conflicts.

I have tried to point out the dangers which threaten such impersonators and those who accept their impersonations—the main danger being the creation of a culturally shared myth. I believe that "mental illness" is such a myth.

Contemporary psychiatry thus represents a late stage in the

* I do not wish to imply that this impersonation is always a consciously planned strategy, arrived at by deliberate choice among several alternatives—although often it is.

mental illness game. In its beginning stages—that is, before the end of the nineteenth century, when alienists aspired to be neurologists and neuropathologists—psychiatrists were violently opposed to those who impersonated the sick role. They wanted to see, study, and treat only "really" sick—that is, neurologically sick—patients. They believed, therefore, that all mental patients were fakers and frauds.

Modern psychiatrists have swung to the opposite extreme. They refuse to distinguish impersonated from genuine roles—cheating from playing honestly. In so conducting themselves, they act like the art expert, mentioned earlier,[17] who decides that a good imitation of a masterpiece is also a masterpiece.

Conceptualizing psychiatric illness on the model of medical illness, psychiatrists leave themselves no choice but to define psychiatric treatment as something that can be "given" only to persons who "have" a psychiatric illness! This leads not only to further unmanageable complications in conceptualizing the true nature of so-called psychiatric diseases and treatments, but also to an absurd dilemma with regard to persons who impersonate the role of the mentally sick patient.

Once a role is socially accepted, it must, in principle at least, be possible to imitate or impersonate it. The question then is: How shall the person who impersonates the role of mental patient be regarded—as malingering insanity or as insane? Psychiatrists wanted to claim such persons as patients so that they could "treat" them. They could do so only if those who pretended to be mentally sick were also conceptualized and defined as "sick"; hence, they were.

Thus, without perhaps anyone fully realizing just what was happening, the boundaries between the psychiatric game and the real-life game became increasingly blurred. The lonely, romantic movie fan, enchanted with his idolized actress on the screen, may gradually come to feel that she is actually becoming a close, lifelike, and intimate figure. What is needed for this is a convincing performance and a receptive audience.

And, indeed, just as men need a Marilyn Monroe, or women a Clark Gable, so physicians need sick people! I submit, therefore, that anyone who acts sick—impersonating this role—and does so vis-à-vis persons who are therapeutically inclined, runs the grave risk of being accepted in his impersonated role. And in being so accepted, he endangers himself in certain, often unexpected, ways. Although ostensibly he is requesting and receiving help, what is called "help" might be forthcoming only if he accepts the patient role and all that it may imply for his therapist.

The principal alternative to this dilemma lies, as I have suggested before, in abolishing the categories of ill and healthy behavior, and the prerequisite of mental sickness for so-called psychotherapy. This implies candid recognition that we "treat" people by psychoanalysis or psychotherapy not because they are sick but, first, because they desire this type of assistance; second, because they have problems in living for which they seek mastery through understanding of the kinds of games which they, and those around them, have been in the habit of playing; and third, because, as psychotherapists, we want and are able to participate in their "education," this being our professional role.

Finally, the concept of impersonation is useful for understanding the role not only of the psychiatric patient but also that of the psychiatric practitioner. The two are engaged in a reciprocal impersonation, each fitting into the role of the other like a key and a lock. The psychiatric patient impersonates, or is impressed into, the sick role: the so-called hysteric acts as if he were sick and invites medical treatment; the so-called paranoid is regarded as if he were sick and treatment is imposed on him against his will. In both cases, the person is defined, by himself or others, as a patient. Reciprocally, psychiatrists, psychoanalysts, and many clinical psychologists engage in a complementary act of impersonation: by accepting the problems of their clients as the manifestations of an illness,

or by assigning such problems to the category of illness, they assume the roles of medical practitioners and therapists. This professional impersonation occurs also independently of the conduct of clients: it is actively fostered and supported by contemporary psychiatric, psychoanalytic, and psychological organizations and their members, and by other institutions and individuals, such as courts and schools, lawyers and educators.

The upshot is the professional credo of mental health professionals: that mental illness is like medical illness, and mental treatment like medical treatment. In fact, however, psychotherapists only look like doctors, just as hysterics only look like patients: the differences between the communicational interventions of psychotherapists and the physicochemical interventions of physicians constitute an instrumental gulf that no institutional dissembling can convincingly narrow.[18]

Until recently, this impersonation of the medical role by the psychiatrist and psychotherapist has served the apparent interests of both psychiatric patients and practitioners. Hence, not many concerned parties were left to protest this modern variation on the ancient theme of the emperor's clothes. I believe the time is now ripe to announce that the emperor is naked: in other words, that the medical aspects of psychiatry are just as substantial as was the fabric from which the emperor's legendary cloak was fashioned. As will be recalled, that material was so fine only the wisest could see it: to claim that the emperor was naked was, therefore, an affront against a powerful person as well as a self-confessed stupidity. It has been, and continues to be, much like this with psychiatry, whose similarities to medicine are so subtle that only the best-trained professional can see it: to claim that these similarities are insubstantial or nonexistent is thus an affront against the powerful social institutions of medicine and psychiatry, as well as a self-confessed stupidity. I hasten to plead guilty to both of these potential charges.

15 The Ethics of Psychiatry

The game-playing model of human behavior seems to me best suited for explicitly reintroducing ethical considerations into the study of psychiatry, psychology, and the so-called mental health professions. Games have payoffs or ends, such as winning a sum of money or besting an opponent, which constitute moral conceptions; and they must be played according to certain rules, with adherence to and deviance from the rules constituting further matters of moral concern. Whether a particular game is worth playing and whether particular rules are worth respecting and following are issues that often vex persons whose predicaments are now defined as psychiatric in character.

The game-playing model of behavior is also a useful bridge between ethics and psychoanalysis, and particularly between ethics and the theory of object relations, in which explanations are couched in terms of interactions between the self and others, the latter being called "objects."[1] In game theory, all the participants, whether self or others, are called "players," and their engagements, for which there is no special term in psychoanalysis, are called "games." Clearly, the perspectives of object relations and game-playing resemble each other at many points. In this concluding chapter I shall try to develop

some of these similarities and point the way toward a synthesis of moral, psychoanalytic, semiotical, and social or game-playing approaches to an understanding of psychiatric problems in particular, and of personal conduct in general.

Object Relations and the Game Model

The similarities between object relations theory and game theory are most apparent in connection with the phenomena characteristically associated with the loss of objects and of games. Persons need stable and supporting objects: if they lose them, they tend to become depressed. Similarly, groups need stable and supporting games: if they lose them, they tend to develop anomie—a term popularized by Emile Durkheim,[2] who meant by it social apathy and disorganization as a result of a loss of previously valued aspirations, goals, or norms.[3]

A great deal of contemporary psychiatric and sociological writing rests on the premise that loss of objects and its vicissitudes characterize the frame of reference of personal conduct; and that loss of norms and its vicissitudes characterize the frame of reference of social conduct.[4] What I want to suggest now is that norms and normlessness also affect the individual; that, in other words, persons need not only other people but also rules worth following—or, more generally, games worth playing.

Men suffer grievously when they find no games worth playing, even though their object world might remain quite intact. To account for this, we must consider the relationship of the self to games. Otherwise, we are forced to reduce all sorts of personal misery and suffering to considerations of object relationships. At the same time, we might regard the loss of game as another, more comprehensive, aspect of what has heretofore been called loss of object. Furthermore, as the loss of a real or external object implies the loss of a player from the game—unless a perfect substitute for him can be found, which

is unusual and unlikely—such loss inevitably results in certain changes in the game. It is evident, then, that "players" and "games" describe interdependent variables that together make up complex social systems—for example, families, organizations, societies, and so forth.

The connections between object and game outlined above may be illustrated by the following examples. A child that loses its mother loses not only an object—that is, a person invested with affection and other feelings—but is also precipitated into a human situation that constitutes a new game. The mother's absence means that other persons must care for some of the child's needs, and that he will henceforth have to relate to these persons.

Similar considerations hold for marriage. This game, traditionally conceived, lasts until death terminates it. So long as the players adhered to this rule, it provided them with great security against the trauma of game loss. It seems probable, indeed, that the institution of marriage has evolved—and has persisted as long as it has—not so much because it provides an ordered system of sexual relationships, nor because it is useful for child rearing, but rather because it provides men and women with an extremely stable human relationship, in the context of a relatively unchanging game. Marriage has achieved this goal better than probably any other institution except the organized religions, which tend also to be very stable. What many people find attractive about these games is that, having once learned how to play them, they can stop learning and changing.

Loss of a parent in childhood, or loss of a spouse in adulthood, are situations in which loss of object and loss of game go hand in hand. There are other situations, however, in which loss of object and loss of game occur separately—for example, the immigration of a whole family. In such a case, especially if the immigrants are accompanied by friends and servants, we have a situation in which people have lost certain

important games without having lost significant personal objects. As a rule, such families either readily adapt themselves to new ways of living, a new language, and so forth—or go on living as if they had never left home.

The concept of learning, so clearly indispensable for any explanation of human behavior, is an integral part of game theory, but is not a part of object relations theory at all. One learns to play games, but one does not learn to have object relations. Certain key psychoanalytic concepts must thus be reinterpreted in terms of learning—a reinterpretation which is sometimes carried out by psychoanalysts quite casually and inexplicitly. For example, tranference might be viewed as a special case of "playing an old game." And so we find Greenacre, in a paper on this subject, remarking that "One thinks here of Fenichel's warning that not joining in the game is a principal task of handling the transference."[5]

Furthermore, although probably few analysts still believe that transference occurs only in the context of the psychoanalytic situation, many hold that this phenomenon pertains only to object relationships. I submit, however, that the characteristic features of transference can be observed in other situations as well, especially in the area of learned skills.[6] Thus, speaking a language with a foreign accent is one of the most striking everyday examples of transference. In the traditional concept of transference, one person (the analysand) behaves toward another (the analyst) as if the latter were someone else, previously familiar to him; and the subject is usually unaware of the actual manifestations of his own transferred behavior. In exactly the same way, persons who speak English (or any other language) with a foreign accent treat English as if it were their mother tongue; and they are usually unaware of the actual manifestations of their transferred behavior. Such persons think of themselves as speaking unaccented English: they cannot hear their own distortions of the language when they speak. Only when their accent is pointed

out to them, or, better, only when they hear their recorded voices played back to them, do they recognize their linguistic transferences. These are striking parallels not only between the stereotyped behavioral acts due to previous habit, but also between the necessity for auxiliary channels of information outside the person's own self for recognizing the effects of these habits. This view of transference rests on empirical observations concerning the basic human tendency to generalize experiences.*

Further connections between the theory of object relations and game theory may be developed by re-examining affects and attitudes from the point of view of game-playing. From the standpoint of object relations, "being interested in" someone or something is an affect irreducible to other elements. Psychoanalysts call this "libidinal cathexis" or "investment" or "investment in objects." But from the standpoint of the experiencing person, objects do not even exist except insofar as they are invested with interest. Positive interest, such as love, is of course preferable to negative interest, such as hate, but either is preferable to no interest, such as apathy or indifference, which threatens the very existence of the personality or self.

To live meaningfully, man must be interested and invested in more than just objects. He must have games he finds worth playing. The principal affective manifestations of an eagerness to engage in life are curiosity, hope, and zest. As a loving attitude implies interest in persons—that is, in parents and children, wives and lovers—so a hopeful attitude implies interest in games—that is, in work and play, religion and social affairs.

Hope, then, is an expectation of successful participation in social interactions. This might imply winning, or playing well, or just enjoying the game. The point is that an unflagging

* A remarkably perceptive early formulation of this phenomenon was provided by Ernst Mach in 1885, who called it the "principle of continuity."[7]

interest in playing various games is an indispensable requirement for successful social living—that is, for what is often referred to as "mental health." This is illustrated by the significance of work for psychological integrity, especially when the occupation is self-selected and is socially valued. For people who do not possess inherited wealth and who must therefore work to earn a livelihood, doing a job they like and doing it well is usually the most important game in their life. Furthermore, by remaining interested in working, men can avoid boredom and apathy on the one hand, and scrutiny of the self and its objects and games on the other. In other words, people who work might be said to be "playing" the work-game, whereas the so-called idle rich "work" at playing. For the latter, sports, travel, social gatherings, philanthropy, and other activities provide outlets for their need for meaningful games.

These remarks merely touch on the complicated subject of the relationship between hope and religion, the essence of which might be put as the question, "What should man be hopeful about?" Without trying to answer this question here, let me emphasize only that investing hope in religious faith is perhaps one of the best psychological investments a person can make. This is because by investing a small amount of hope in religion—especially in the Christian religions, which promise lavish gratifications and rewards of all sorts—one gets back a great deal. Few other enterprises, other than fanatical nationalisms, promise as much. The rate of return on hope invested in religion is thus much higher than on hope invested in, say, rational work-a-day pursuits. Hence, those with small capitals of hope may do best by investing their "savings" in religion. And this indeed is what they often do.

Psychoanalysis and Ethics

In the foregoing pages, I have touched repeatedly on the connections between ethics and psychiatry, psychoanalysis,

and the mental health professions, and have tried to make explicit the inexplicit moral values, judgments, and prescriptions inherent in psychiatric and psychoanalytic principles and practices. The ethical values embodied in, and enforced by, contemporary psychiatry—so-called general psychiatry—are too numerous and diverse to be encompassed in a brief discussion or to permit any kind of easy generalization. The situation is much simpler with respect to psychoanalysis, and I want to offer a few concluding remarks about the ethical values inherent in it and implemented through it.

First, what are the main sources of these values? I would briefly list them as follows: the tradition of medicine as a healing art; nineteenth-century science, and especially physics; philosophers, especially those of classical Greece and Rome and of the Enlightenment, and some moderns, such as Schopenhauer and Nietzsche; the great Western religions, especially Judaism and Roman Catholicism; and, of course, Freud's personal preferences and temperamental dispositions.[8]

And what is the nature or substance of these values? I would briefly identify them as rationalism, self-awareness, self-discipline, and the preservation of prevailing familial, social, and political arrangements. The idea that self-knowledge is a good is, of course, the ethics of rationalism and science applied to the self as a part of nature. An integral part of this scientific ethic is the principle that knowledge should be clearly stated and widely publicized and that it should never be kept a secret, especially from those who want to acquire it or might be affected by it. In particular, knowledge must not, according to this ethic, be kept secret by a small group and used as a source of power to mystify and control, stupefy and dominate, other individuals or groups. Although psychoanalysts espoused this scientific ethic in principle, they betrayed it in practice as soon as they had a chance to do so: when their numbers became sufficient to organize themselves into a

group, they hastened to transform psychoanalytic thought from inquiry into dogma, and psychoanalytic practice from an instrument for liberating the individual into one for oppressing him.[9]

I wish to re-emphasize here that Freud never made explicit the moral values which animated his work and which he incorporated into the theory and practice of psychoanalysis. Indeed, what characterizes his voluminous writings—in contrast, as we shall see, to those of Adler for example—was his persistent effort to represent his work as purely "scientific" and "therapeutic." This is why it is so easy to answer the question, What is the psychoanalytic view of a *bad* human relationship or marriage? while it is quite impossible to answer its corollary, What is the psychoanalytic view of a *good* human relationship or marriage? In short, by couching his observations and interventions in the language of medicine and pseudomedicine, Freud made it appear as if he were morally detached or neutral. But in the social sciences—or, generally, in human affairs—no such detachment or neutrality is possible. Moreover, nothing is easier than to show, point by point, which values Freud and other psychoanalysts supported, and which others they opposed. A few examples must suffice here: Freud not only "discovered" infantile sexuality, he also advocated the sexual enlightenment of children; he not only studied the effects of sexual seductions on children, he also opposed this practice; he not only speculated about the nature of homosexuality, but he also deplored it as a "perversion."

With respect to paired human relations, Freud believed that they always are, and should be, based on the domination of one partner and the submission of the other. His political beliefs were essentially Platonic, favoring an intellectual and moral elite dictatorially governing the masses. I have remarked earlier[10] on Freud's misogyny. His insistence that the psychoanalytic relationship between analyst and analysand be

that of "a superior and a subordinate" is equally remarkable—and shocking.[11] He did not seem to regard genuine cooperation between equals as either possible or desirable.

As against Freud, Adler clearly articulated his concept of the morally desirable or "mentally healthy" human relationship.[12] It was characterized by a high degree of social interest and cooperativeness. He also stressed the values of truthfulness and competence. At the same time, he placed less emphasis than Freud on self-knowledge.

In short, whereas Freud disguised and obscured, Adler revealed and discussed, the moral values inherent in his observations, theories, and therapies. I think this is one of the reasons for the different receptions that Freudian and Adlerian psychologies have received. Freud's work bore the stamp of the impartial, cool-headed natural scientist. It required the work of many scholars to expose the values inherent in Freudian psychology and psychotherapy. Not so for Adler's work, which from early on diverged from medicine and psychiatry, and even from psychotherapy, and became associated with child-rearing, education, and social reform.

I have suggested elsewhere that certain aspects of the psychoanalytic procedure require a high degree of mutual cooperation between two relatively equal participants.[13] By this I mean that although analyst and patient are quite unequal with respect to certain skills and the knowledge of how to use them, they are, or should be, relatively equal with respect to power over each other.

If we judge by what psychoanalysts say, write, and do—and how else can we judge their work?—we would have to conclude that there is not one psychoanalytic ethic but that there are two, each antithetical to the other. According to the one, the ethical ideal of psychoanalysis is paternalism: the relationship between analyst and analysand, and as many other relationships as possible, should conform to the model of leader-follower, domination-submission. According to the other, its

ideal is individualism: the relationship between analyst and analysand, and as many other relationships as possible, should conform to the model of cooperation and reciprocity between equals. Insofar as psychoanalytic practices are consistent with the latter ethic, I support them; and insofar as they are inconsistent with it, I oppose them.

In short, I believe that the aim of psychoanalytic therapy is, or should be, to maximize the patient's choices in the conduct of his life.[14] This value must be entertained explicitly and must be espoused not only for the patient but for everyone else as well. Thus our goal should not be to indiscriminately enlarge the patient's choices; this could often be achieved easily enough by reducing the choices of those with whom he interacts. Instead, our goal should be to enlarge his choices by enhancing his knowledge of himself, others, and the world about him, and his skills in dealing with persons and things. As psychiatrists and psychotherapists, whether of psychoanalytic or some other persuasion, we should thus try to enrich our world and try to help our patients to enrich theirs, not by diminishing the efforts and achievements of our fellow man, but by increasing our own.

Psychiatry as Social Action

The proposition that psychiatric operations are a species of social action—and hence, ultimately, a species of moral action—does not, I hope, require further proof. It is indeed difficult to see how this simple fact could have been so long and so successfully concealed from both popular and professional awareness. Psychiatrists do things with and to patients, and vice versa, and the things they do pertain to the moral convictions and conduct of each. Although the moral implications and practical impacts of psychiatric practices are more obvious in such interventions as involuntary mental hospitalization than in psychoanalysis, both of these practices, and all others, are, as I have tried to show throughout this book, instances of

moral, political, and social action. To bring some order to an otherwise bewildering variety of psychiatric interventions, I propose to distinguish three classes of psychiatric actions, according to the psychiatrist's participation in the games of his patients, of their families, and of the society in which they all live.

1. The psychiatrist as theoretical scientist or ethicist. In this role, the psychiatrist acts as an expert on the game-playing behavior of psychiatric patients, families, groups, and the society in which they live: he shares his knowledge with those who hire him as an expert and who wish to learn from him as an authority.

2. The psychiatrist as applied scientist or ethicist. In this role, the psychiatrist acts as counselor, social repairman, or "therapist": he sorts out and classifies players according to their game-playing interests and skills and assigns them, with their consent, to games which they can, or ought to, play.

3. The psychiatrist as social engineer or controller of social deviance. In this role, the psychiatrist acts as priest and policeman, arbitrator and judge, parent and warden: he coerces and manipulates, punishes and rewards, and otherwise influences and compels people, often by relying on the police power of the state, to play, or to cease to play, certain games.

Another way of distinguishing among the various psychiatric interventions is by dividing them into two classes—voluntary and involuntary. The typical voluntary psychiatric interventions are psychoanalysis, the various types of individual and group psychotherapy, and a great variety of both office and hospital psychiatry employing psychological or physical methods of treatment with the informed consent of the patient. Typical involuntary psychiatric interventions are commitment or measures carried out under the threat of commitment, and psychiatric "diagnoses" and "treatments" imposed on persons by parents, schools, courts, military authorities, and other social or governmental agencies.

Although all of these interventions constitute interferences in the moral life of the so-called patient, they differ widely according to whether the intervention is sought by the client or is imposed on him against his will, and whether its aim and probable consequence is an enlargement or diminution of the client's freedom and self-determination.

I am opposed, on moral and political grounds, to all psychiatric interventions which are involuntary; and, on personal grounds, to all such interventions which curtail the client's autonomy. But, regardless of my moral, political, or personal preferences, I believe it is imperative that all of us—professionals and nonprofessionals alike—keep an open and critical mind toward all psychiatric interventions and, in particular, that we not accept or approve any psychiatric intervention solely on the ground that it is now officially regarded as a form of medical treatment.

Conclusions

It is customary to define psychiatry as a medical specialty concerned with the study, diagnosis, and treatment of mental illnesses. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living.

I have argued that, today, the notion of a person "having a mental illness" is scientifically crippling. It provides professional assent to a popular rationalization—namely, that problems in living experienced and expressed in terms of so-called psychiatric symptoms are basically similar to bodily diseases. Moreover, the concept of mental illness also undermines the principle of personal responsibility, the ground on which all free political institutions rest. For the individual, the notion of mental illness precludes an inquiring attitude toward his conflicts which his "symptoms" at once conceal and reveal. For a society, it precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients.

Although powerful institutional forces lend their massive weight to the tradition of keeping psychiatric problems within the conceptual framework of medicine, the moral and scien-

tific challenge is clear: we must recast and redefine the problem of "mental illness" so that it may be encompassed in a morally explicit science of man. This, of course, would require a radical revision of our ideas about "psychopathology" and "psychotherapy"—the former having to be conceived in terms of sign-using, rule-following, and game-playing, the latter in terms of human relationships and social arrangements promoting certain types of learning and values.

Human behavior is fundamentally moral behavior. Attempts to describe and alter such behavior without, at the same time, coming to grips with the issue of ethical values are therefore doomed to failure. Hence, so long as the moral dimensions of psychiatric theories and therapies remain hidden and inexplicit, their scientific worth will be seriously limited. In the theory of personal conduct which I have proposed—and in the theory of psychotherapy implicit in it—I have tried to correct this defect by articulating the moral dimensions of human behaviors occurring in psychiatric contexts.

Epilogue

In Pirandello's play *The Rules of the Game* the following conversation takes place:

> LEONE: Ah, Venanzi, it's a sad thing, when one has learnt every move in the game.
> GUIDO: What game?
> LEONE: Why . . . this one. The whole game—of life.
> GUIDO: Have you learnt it?
> LEONE: Yes, a long time ago.[1]

Leone's despair and resignation come from believing that there is such a thing as the game of life. Indeed, if mastery of the game of life were the problem of human existence, having achieved this task, what would there be left to do? But there is no game of life, in the singular. The games are infinite.

Modern man seems to be faced with a choice between two basic alternatives. On the one hand, he may elect to despair over the lost usefulness or the rapid deterioration of games painfully learned. Skills acquired by diligent effort may prove to be inadequate for the task at hand almost as soon as one is ready to apply them. Many people cannot tolerate repeated

disappointments of this kind. In desperation, they long for the security of stability—even if stability can be purchased only at the cost of personal enslavement. The other alternative is to rise to the challenge of the unceasing need to learn and re-learn, and to try to meet this challenge successfully. Leone's problem is the dilemma of a man so far withdrawn from life that he fails to appreciate, and hence to participate in, the ever-changing game of life. The result is a shallow and constant life which may be encompassed and mastered with relative ease.

The common and pressing problem today is that, as social conditions undergo rapid change, men are called upon to alter their modes of living. Old games are constantly scrapped and new ones started. Most people are totally unprepared to shift from one type of game-playing to another. They learn one game or, at most, a few, and desire mainly the opportunity to live out life by playing the same game over and over again. But since human life is largely a social enterprise, social conditions may make it impossible to survive without greater flexibility in regard to patterns of personal conduct.

Perhaps the relationship between the modern psychotherapist and his client is a beacon that ever-increasing numbers of men will find themselves forced to follow, lest they become spiritually enslaved or physically destroyed. By this I do not mean anything so naïve as to suggest that "everyone needs to be psychoanalyzed." On the contrary, "being psychoanalyzed" —like any human experience—can itself constitute a form of enslavement and affords, especially in its contemporary institutionalized forms, no guarantee of enhanced self-knowledge and responsibility for either patient or therapist. By speaking of the modern psychotherapeutic relationship as a beacon, I refer to a simpler but more fundamental notion than that implied in "being psychoanalyzed." This is the notion of being a student of human living. Some require a personal instructor for this; others do not. Given the necessary wherewithal and ability to learn, success in this enterprise requires, above all

else, the sincere desire to learn and to change. This incentive, in turn, is stimulated by hope of success. This is one of the main reasons why it is the scientist's and educator's solemn responsibility to clarify—never to obscure—problems and tasks.

I have tried to avoid the pitfalls of obscurantism which, by beclouding these problems, fosters discouragement and despair. We are all students in the metaphorical school of life. Here none of us can afford to become discouraged or despairing. And yet, in this school, religious cosmologies, nationalistic myths, and lately psychiatric theories have more often functioned as obscurantist teachers misleading the student than as genuine clarifiers helping him to help himself. Bad teachers are, of course, worse than no teachers at all. Against them, skepticism is our sole weapon.

Summary

The principal arguments advanced in this book and their implications may be summarized as follows.

1. Strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness.

2. "Mental illness" is a metaphor. Minds can be "sick" only in the sense that jokes are "sick" or economies are "sick."

3. Psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others.

4. Those who suffer from and complain of their own behavior are usually classified as "neurotic"; those whose behavior makes others suffer, and about whom others complain, are usually classified as "psychotic."

5. Mental illness is not something a person has, but is something he does or is.

6. If there is no mental illness there can be no hospitalization, treatment, or cure for it. Of course, people may change their behavior or personality, with or without psychiatric intervention. Such intervention is nowadays called "treatment," and the change, if it proceeds in a direction approved by society, "recovery" or "cure."

7. The introduction of psychiatric considerations into the

administration of the criminal law—for example, the insanity plea and verdict, diagnoses of mental incompetence to stand trial, and so forth—corrupt the law and victimize the subject on whose behalf they are ostensibly employed.

8. Personal conduct is always rule-following, strategic, and meaningful. Patterns of interpersonal and social relations may be regarded and analyzed as if they were games, the behavior of the players being governed by explicit or tacit game rules.

9. In most types of voluntary psychotherapy, the therapist tries to elucidate the inexplicit game rules by which the client conducts himself; and to help the client scrutinize the goals and values of the life games he plays.

10. There is no medical, moral, or legal justification for involuntary psychiatric interventions. They are crimes against humanity.

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