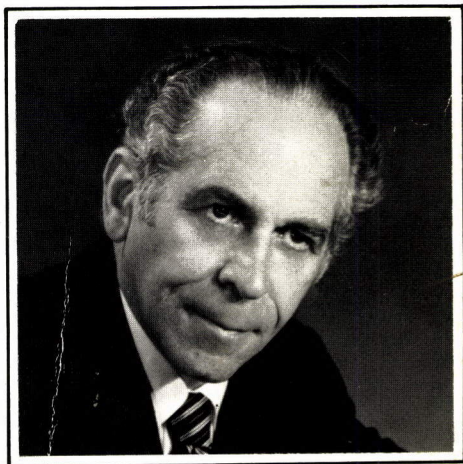


Thomas Szasz

primary
values and
major
contentions



An introduction to the writings and thought of
America's most controversial psychiatrist

edited by **Richard E. Vatz**
and Lee S. Weinberg

with a Foreword by Thomas Szasz

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and
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FOREWORD

I have devoted much of my professional life to an effort to clarify what is conventionally considered to be the riddle of mental illness. Perhaps because I was strongly influenced by an empiricist-rationalist education, and perhaps because I was endowed with a stubborn sense of independence, it seemed to me obvious, even before I reached my teens, that what people call mental illness is not like ordinary illness: typically, neither the so-called patients nor their would-be healers behave like ordinary patients and doctors.

That much has been obvious to many other people as well, of course. The vexing problems that insight creates have, however, been evaded by some such reasoning as this: "Mental patients behave the way they do because they have a mental illness. The illness is due to, or is a manifestation of, a brain disease. They must be treated for that disease to help them recover from it. It is the task of psychiatric science to discover the causes of mental illness, and of psychiatric practice to provide scientifically rational care for mental patients."

This reasoning sounds very persuasive. If it didn't, it would not have persuaded generations of psychiatrists to follow the path it laid out for them, nor would it have persuaded generations of lay persons to accept the coercive social practices based on it. However, this reasoning is persuasive not because it is sound but because it is rhetorically powerful.

It is possible, indeed it is likely, that there are brain diseases as yet undiscovered by medical science. But that fact has no bearing on what is conventionally considered to be the problem of mental illness.

What, then, is the so-called problem of mental illness really about? It is

about two disconcerting facts. The first fact is that there is no mental illness: The term is simply a socially validated verbal construct. The second one is that psychiatric inquiry and practice are not empirical, rational, or scientific: Indeed, how could they be if their aim is to empirically investigate and treat an alleged disease, mental illness, that cannot be empirically identified? Such reflections have led me to look for the answer to the riddle of mental illness in scrutinizing not the *condition* of mental illness, which has proved so elusive and refractory a quarry to scientific investigation, but the observable facts or practices associated with this *idea*. By observable facts I refer to two simple sets of objectively verifiable phenomena: What so-called mentally ill persons (especially *qua* mental patients) do, and what other persons (especially, but not solely, psychiatrists) do when they call individuals mentally ill and treat them as mental patients. Because of the sorts of things these protagonists in the drama of psychiatry actually do, matters psychiatric have always been deeply involved with legal, moral, and political considerations and hence, inevitably, with profoundly important and yet often elusive linguistic considerations as well.

What, then, do mental patients and psychiatrists do? Many so-called mental patients engage in disturbing or illegal behavior: they starve themselves, attack members of their families, commit arson or theft, kill prominent persons. The psychiatrists reciprocate with two characteristic acts: they inculcate and imprison the innocent, calling it civil commitment and psychiatric treatment; and they exculpate and imprison the guilty, calling it the insanity defense and criminal commitment. Although psychiatrists perform many other acts as well, these two sets of psychiatric performances stand as important reminders of what I regard as the central moral-philosophical act of psychiatry: transforming individuals from responsible moral agents into non-responsible, insane patients. To be sure, psychiatrists claim that it is not they but the dreaded illness they call "psychosis" that transforms men and women from moral agents into organisms that deserve neither blame nor praise but only pity and therapy. This controversy will not, of course, be further pursued here, especially since the reader will find it amply illuminated in the materials assembled in this volume.

I should like to close with expressing my appreciation and thanks to my good friends Richard Vatz and Lee Weinberg for this synoptic presentation of my views. It is particularly gratifying to me that this exposition and interpretation of my writings should have been undertaken by a professor of rhetoric and a professor of legal studies. Their professional identities symbolize and forewarn of the cognitive quantum jump that is expected of the reader interested in transcending the perspectives of conventional psychiatry.

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PREFACE

Having taught thousands of students to grapple with the ideas of Thomas Szasz, we have repeatedly encountered three problems with the available published materials: first, Szasz's own writings are voluminous and cannot practically be read in a single term; second, students who have grasped some of Szasz's ideas begin to demand answers to a variety of questions concerning "what Szasz would think about" certain specific issues; and third, both friendly and hostile student readers frequently want to know the nature of the major criticisms levelled at Szasz by other professionals and how such criticisms might be answered.

These difficulties are not dissimilar to the problems encountered in endless debates, discussions, and arguments on Szasz that we have had with scores of colleagues. In fact, with colleagues and other professionals there has been the additional obstacle that, as Charles Krauthammer wrote in *The New Republic*, "Szasz is the kind of author no one reads, but everyone knows about. . . ." Students and professionals alike are in need of an introduction to the writings of Szasz illustrating his value system, the central tenets of his view of human behavior, and the nature of the debate over these views. This has been our goal in preparing the present volume. There is no single volume that comprehensively presents Szasz's basic premises and arguments by carefully selecting samples of his own writings as well as those of his critics and defenders. The need for such a volume is evident in view of the fact that Szasz's work is studied, taught, and criticized in a wide range of disciplines including: psychiatry, sociology, rhetoric, law, criminal justice, political science, health science, psychology, philosophy, and others. His ideas cut across academic disciplines; his writings are assigned to

college classes in a variety of subject areas; and his work has achieved a readership in an equally broad array of professions both in the United States and abroad. (Much of Szasz's work has been translated and made available to readers in Asia and Europe).

To accomplish the above stated goals for students, professionals, and other interested readers we have undertaken a complete examination of virtually all of Szasz's writings in order to identify his primary values (Part One), his central contentions (Part Two), some of the major criticisms levelled against him on these two fronts, and responses to these criticisms (Part Three). To distill the ideas of Thomas Szasz into one compact volume required careful selection and editing to assure that no central components were omitted, inadequately explained, or unnecessarily repeated. We have organized this material into categories that we believe most clearly reflect the major values and contentions contained in Szasz's prolific writings. In addition, the reader has been provided with sub-headings or brief summary statements which will further explicate crucial elements of Szasz's thought. It should be noted that the excerpts from Szasz's work contained herein have been edited only to delete footnotes and to provide continuity within the organization of the present volume.

We come from the disciplines of rhetoric, politics, and law, which, along with the mental health fields, are perhaps the areas most conspicuously enriched by the work of Thomas Szasz. To us the personal and professional benefits of his work have been, and continue to be, profound. While neither we nor the readers of this book should unquestioningly accept all of his arguments (Szasz discourages such sycophancy), we hope that this volume captures the essence and richness of Thomas Szasz so that others may enjoy the same stimulation and insight that his works have afforded us over the years.

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INTRODUCTION

Since the publication in 1961 of *The Myth of Mental Illness*, which served originally to thrust him into the center of the debate over the nature of "mental illness" and the proper role of psychiatry, the ideas of Dr. Thomas Szasz have enlightened, provoked, inspired, challenged, and angered millions of readers, not only those within psychiatry but also many outside its confines. Through nearly a score of books and over four hundred articles and reviews, Szasz has sought to demystify and demythologize the "science" of psychiatry by revealing it as an essentially political and moral enterprise operating under the mask of medicine. The primary approach taken by Szasz in his voluminous writing might best be characterized as rhetorical in that he analyzes the ways in which language and symbols have been used by psychiatry to influence the allocation of power; to control the lives, perceptions, and self-perceptions of millions of people; and to interact with the legal system in the assignment of responsibility for human actions. While rhetorical analysis constitutes the common methodological thread running through all of Szasz's work, strict libertarianism constitutes the political thread, and individual responsibility the moral thread. Recognition of this linkage of rhetoric, politics, and ethics provides the starting point for an understanding of Szasz's thought.

For Szasz, the central struggle faced by each human being is to defend against those who would impose upon him their own definitions of who he is and what constitutes his best interests. The battlefield upon which this struggle for definition is fought is largely linguistic and the ultimate meaning of behavior and events is established by the victors in the battle of words. Reality, from the rhetorical perspective of Szasz, is imbedded in the language

used to describe it, and one cannot escape from this reality unless one controls the language itself (Szasz: "the struggle for definition is veritably the struggle for life itself. . . . In ordinary life, the struggle is not for guns but for words: whoever first defines the situation is the victor; his adversary, the victim. . . . In short, he who first seizes the word imposes reality on the other; he who defines thus dominates and lives; and he who is defined is subjugated and may be killed" [*Second Sin*]).

Thus, in his best known work, *The Myth of Mental Illness*, Szasz argues that "mental illness" is a myth; that is, the behaviors that "mental health" professionals and others define as "mental illness" are simply misunderstood and/or disapproved language and action. This defining, Szasz believes, is strategic rhetoric that serves the purposes of the definers and those who benefit from the definitions, often at the expense (economic, political, moral, or otherwise) of the defined. Moreover, he maintains, the labelling of people as "sick" or "disturbed" is successfully accomplished largely because psychiatry has managed to clothe itself in "the logic, imagery, and the rhetoric of science, and especially medicine" (*Ideology and Insanity*). Yet, Szasz points out, the connection between psychiatry, science, and medicine is at best tenuous: "Not only is there not a shred of evidence to support this [connection], but, on the contrary, all the evidence is the other way, and supports the view that what people now call mental illnesses are, for the most part, *communications* expressing unacceptable ideas, often framed in an unusual idiom" (*Ideology and Insanity*). However invalid or misleading, the rhetoric of mental illness is persuasive to many, primarily due to its "scientific" status.

Central to the rhetorical method of Szasz is the concept of metaphor, which he employs in most of his analyses. In stating that "mental illness" is a myth, therefore, Szasz is not arguing that the behavior labelled "mental illness" does not occur, but rather that "mental illness" and related categories are purely metaphoric explanations, not medical ones. As Szasz states (and states often), we have incorrectly, either innocently or not so innocently, taken this metaphoric "illness" to be literal illness. The seemingly endless array of categories and sub-categories of mental "illnesses" and "disorders," which psychiatrists continue to "discover" and revise, are in fact nothing more than descriptions of the unlimited variety of human behaviors, especially those violating social or psychiatric norms. This misleading literalization of metaphor furthers the interests of psychiatrists and society, if not the interests of the "mentally ill." To Szasz, the use of strategic metaphors—especially the camouflaged use of such metaphors—deprives humankind of its greatest freedom: autonomy. Unlike religious and democratic political persuaders who claim no false identity and implicitly recognize man's autonomy, psychiatrists present themselves as scientists and explicitly deny the right of autonomy to those whom they choose to define and control.

Having devoted much attention to the argument that everything considered bad is not "sickness," Szasz more recently has argued in *The Myth of Psychotherapy* that everything considered good is not "therapy." Thus, only through rhetoric and mystification does the conversation of a troubled person with a listener become "therapy" within which "symptoms" are "diagnosed" by physicians. In short, Szasz's penetrating rhetorical analysis demonstrates how ". . . coercion and conversation become analogized to medical treatment," with the result being that anything at all can become a form of "therapy" if carried out under the watchful eye of an appropriately credentialed physician, psychiatrist, or, in fact, any other "therapist." Thus, reading can become "bibliotherapy," volleyball can become "recreational therapy," and solicitation of a variety of sex partners can become "sex therapy." No one is suggesting that these activities cannot make a person happier or at least feel better; they unquestionably may have this effect. The point is that these activities are in no way medical, because, in order to be medical, they must be applied to an illness, and since the "patients" being "treated" with these "therapies" have only metaphoric "illnesses," these activities, at best, can only be metaphoric "therapies." In a sense, the concept of "sex therapy" represents to Szasz the ultimate extent to which the "mental illness" ideologues have run amuck: the medicalization of sexual knowledge and behavior. Szasz attacks the pseudo-medical pretensions of sexologists in general, and Masters and Johnson in particular. Of the latter, Szasz writes, "They are the foremost base rhetoricians of modern sexology . . . [who] are skillful in concealing and communicating their sexual ethic and sexual prescriptions as if they were the results of their 'scientific research' and the products of their 'professional' expertise" (*Sex by Prescription*).

Szasz's comprehensive rhetorical insights and unmaskings regarding behavioral medicine are perhaps even more apparent in his analysis of sexuality than of "mental illness," though the logic and conclusions are virtually the same. For if the medical metaphor is employed for understanding sex, then any deviation from the norm may be looked upon as an "illness," with the sufferer becoming a "patient." He or she would then seek "doctors" who specialize in sexual "dysfunctions" (a category comprised of virtually inexhaustible maladies). If, on the other hand, a metaphor of interpersonal relations is used, individual differences will no longer be considered diseases, but may be understood as disagreements of preference or freedom of choice. A humorous but instructive illustration of these competing perspectives took place when Dr. Szasz appeared on a television talk show in Baltimore. A female caller asked his advice on what she believed to be a medical problem in her marriage: her husband insisted that she watch him masturbate. Dr. Szasz asked her "Do you want to watch him?" When she replied "No," his "medical" advice was "Then don't!" Beyond this initial humorous response, Dr. Szasz explained that the caller needed to discuss *this* marital disagreement with her husband, as she would *any* marital disagreement.

A doctor is no more required when reaching agreement on sexual issues than would be the case if a couple sought to reach agreement on budgetary matters or any other marital issue. Just as the medical metaphor for sex results in the transformation of prostitutes into “sexual surrogates” and pornography into “sexual therapy,” the caller’s disagreement with her husband regarding his sexual conduct was transformed in her mind into a disease requiring medical advice and, perhaps, care.

While many of the works of Thomas Szasz should be characterized primarily as theoretical rather than activist in nature, Szasz does not shrink from making specific recommendations to policy makers — especially when individual liberties are threatened by a legal system that typically accepts the medicalization of deviant behavior. Szasz has argued against involuntary treatment or hospitalization, which he claims violate even the traditional *medical* norms supporting patient autonomy. Thus, while rejecting the medical model for behavior, Szasz insists on a medical model for consent, which, he maintains, should be adopted even by those who accept the former if they are to be consistent. Whereas psychiatrists often claim that, unlike other patients, “mental patients” lack the rationality to judge what is in their best interests, Szasz claims that psychiatrists have no special insight into rationality or what constitutes the patient’s best interests. Moreover, he claims that we must presume a patient’s autonomy and rationality to the point that whatever choices they make will, *ipso facto*, be assumed to be in their best interests. Therefore, the ethical issue of who has the right to determine a person’s best interest has been resolved by Szasz in favor of the individual. This argument, in effect, eliminates any subsequent debate as to whether in a particular instance a person (who has the “right” to decide what is in his best interest) has chosen “correctly.”

Thus far we have seen individual freedom afforded protection through Szasz’s notion of autonomy; but, to Szasz, autonomy is a double-edged sword protecting freedom on the one hand, while requiring responsibility on the other. On the issue of criminal responsibility in particular, Szasz has sought, in *Law, Liberty, and Psychiatry* and elsewhere, explicitly to oppose the availability of the insanity defense by arguing that one always has the choice of committing or not committing a criminal act. An individual’s health, “mental” or otherwise, should not serve to excuse him.

Much like the general controversy surrounding mental illness, the issue of legal sanity rests upon an attempt to reconcile two incompatible and competing assumptions: 1) that criminal behavior is a result of free choices made by autonomous human beings, and 2) that there is “mental disease” that strikes some people, making them criminal offenders, and therefore mitigates their criminal responsibility. Further, this second assumption implies that however vague or broad the range of diseases may be, there are medical experts who can diagnose not only their existence, but whether they have destroyed a lawbreaker’s autonomy.

Szasz argues that the choice of assumptions regarding individual autonomy has critical implications for the legal system. In fact, he emphasizes the decisive importance of autonomy assumptions for questions of legal sanity, just as he does for questions of the rights of the “mentally ill” in general. Like infancy and involuntary intoxication, the plea of insanity is an assertion that the accused lacked autonomy, i.e., the mental ability to choose or formulate a criminal intent. Unlike infancy, however, where one need only prove the fact of infancy and not that the defendant’s thoughts were “infant thoughts,” in insanity the existence of “insane thoughts” constitutes proof that insanity is present! Any one of these three types of incapacity would function as a complete defense to a criminal charge, provided that the existence of the incapacity could be successfully argued. Writers as far back as Aristotle argued that **blameworthiness was a condition antecedent to the attachment of criminal responsibility**, and, in turn, is conditioned upon the existence of free choice. Thus, in a sense, autonomy was and is the *sine qua non* of criminal law. Without the assumption that people possess free choice, Szasz implies, the whole of criminal law is vitiated.

The views of Thomas Szasz, which have been compiled in this volume, are well within the mainstream of traditional American beliefs and values regarding individual freedom. That this is not recognized may be due in part to the fact that, as earlier noted, Szasz has been subjected to more criticism than thoughtful study. Ironically, this has led his critics to call him a “radical psychiatrist.” In fact, nothing could be further from the truth, for a basic conservatism is central to Szasz’s work. All of his writing reflects one major rhetorical-philosophical argument: human freedom is based upon the right to define oneself and one’s own best interests without the interference of others, and the obligation to take responsibility for the choices one has made without psychiatric or other forms of exculpation.

PART ONE

PRIMARY VALUES

Introduction

In Part One the reader is introduced to Thomas Szasz's central values, which serve as the foundation for his major contentions and policy recommendations regarding the proper role of law, medicine, and the state *vis-à-vis* human behavior. Chapter 1 presents Szasz's advocacy of his most cherished value: autonomy.

The significance to Szasz of the idea of autonomy can hardly be overstated. In his writings one finds repeated references to the crucial nature of this value; numerous policies are supported and justified in its name. Szasz defines autonomy as ". . . freedom to develop one's self—to increase one's knowledge, improve one's skills, and achieve responsibility for one's conduct. And it is freedom to lead one's own life, to choose among alternative courses of action so long as no injury to others results" (*The Ethics of Psychoanalysis*).

In two senses Szasz's writings clearly show his commitment to the principle of autonomy. In the *normative* sense of autonomy, Szasz believes that people ought to be free to make choices about their lives. In the *descriptive* sense of the term, he believes that when people act without physical coercion, such actions should be interpreted as representing freely chosen behavior.

For Szasz, the idea of (descriptive) autonomy comes close to defining the essential nature of human behavior; it is a paramount concept in all of his writings and it is the cornerstone principle of all of his arguments. Both non-criminal behavior and criminal behavior represent choices for which individuals bear total responsibility unless coerced, not unless "irrational" or "ill" or both. Behavior that is offensive, befuddling, or otherwise upsetting, but not illegal, should not be interfered with (e.g. by involuntary

hospitalization or other incarceration), thus ensuring the (normative) autonomy of humanity.

In this chapter we present Szasz's discussion of what he regards as the most conspicuous violation of both types of autonomy: societal and psychiatric interference with and/or persecution of those who wish to commit suicide. Last, we set forth Szasz's argument that psychiatry need not violate the principle of autonomy. Here he specifically explains how psychiatry may indeed *promote* autonomy.

In Chapter 2 passages have been included illustrating Szasz's strong adherence to authenticity and humanism. Like Erving Goffman, Szasz writes that one must not misrepresent oneself to others. Szasz maintains that physicians are inauthentic in a variety of ways, ranging from the more obvious act of cloaking nonmedical endeavors in medical or scientific garb to the less obvious attempt to camouflage specific interests (e.g., the court-appointed psychiatrist who hides his allegiance to the court from the accused), and subtle misrepresentations of the nature of their quasi-medical work (e.g., the representation of an abortion as a *medical* as opposed to a *surgical* procedure). These deceptions, writes Szasz, promote the subjugation of freedom and constitutional rights. Furthermore, the crucial aid of seductive rhetoric serves to minimize criticism. When forcible drugging is called "drug therapy" and forced interrogations are called "psychiatric examinations," the traditional muckrakers seem paralyzed. As Szasz indicates in these excerpts, the medical-scientific imprimatur is for many so mystifying that there is a general suspension of the critical faculties necessary to unmask patently nonmedical, heinous practices.

Finally, in this chapter we offer Szasz's views on humanism, an often abused concept. It is here that Szasz most eloquently expresses his belief that humanism represents a sincere, non-ritualistic celebration of freedom, a freedom inextricably linked to honest uses of language and rhetoric.

1

Autonomy

When the psychiatrist approves of a person's actions, he judges that person to have acted with "free choice"; when he disapproves, he judges him to have acted without "free choice." It is small wonder that people find "free choice" a confusing idea: It looks as if "free choice" is something that qualifies what a person being judged (often called the "patient") *does*—when it is actually what a person making the judgment (often a psychiatrist or other mental health specialist) *thinks*.¹

One person's liberty may be enhanced at the expense of another's, as, for example, the master's is at the expense of the slave's. Thus liberty may be in conflict with liberty. Is is not so with dignity. One person's dignity is never enhanced by another's indignity. Hence, in ordering our values, perhaps we should place dignity even above liberty.²

Autonomy is a double-edged sword of freedom and responsibility.

Descriptive Autonomy: Man's actions represent free choices for which he is responsible, but for which he may rhetorically seek to avoid responsibility, most prominently through attributing behavior to literal and/or figurative gods. The traditional Judeo-Christian monotheistic god would be an example of the former, while physicians might be classified as the latter.

The crucial moral characteristic of the human condition is the dual experience of freedom of the will and personal responsibility. Since freedom and responsibility are two aspects of the same phenomenon, they invite comparison with the proverbial knife that cuts both ways. One of its edges implies options: we call it freedom. The other implies obligations: we call it responsibility. People like freedom because it gives them mastery over things and people. They dislike responsibility because it constrains them from satisfying their wants. That is why one of the things that characterizes history is the unceasing human effort to maximize freedom and minimize responsibility. But to no avail, for each real increase in human freedom—whether in the Garden of Eden or in the Nevada desert, in the chemical laboratory or in the medical laboratory—brings with it a proportionate increase in responsibility. Each exhilaration with the power to do good is soon eclipsed by the guilt for having used it to do evil.

Confronted with this inexorable fact of life, human beings have sought to bend it to their own advantage, or at least to what they thought was their advantage. In the main, people have done so by ascribing their freedom, and hence also their responsibility, to some agency outside themselves. They have thus projected their own moral qualities onto others—moralizing them and demoralizing themselves. In the process, they have made others into puppeteers and themselves into puppets.

Evidently, the oldest scheme for constructing such an arrangement is religion: only deities have free will and responsibility; people are mere puppets. Although most religions temper this imagery by attributing some measure of self-action to the puppets, the importance of the underlying world view can hardly be exaggerated. Indeed, people still often try to explain the behavior of certain self-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.³

Normative autonomy: Human actions should be interfered with or constrained *only* when those actions violate the freedom of others, or when interference is requested. Simply because an attempt is made to justify the interference by referring to it as “medical” makes it no more acceptable philosophically.

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 momentarily 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 thereof.” Let me indicate briefly how I think that guaranty, and the moral and political principles it embodies, applies to our contemporary conditions.

Everyone now recognizes the reality of spiritual suffering—that is, of the fact that men, women, and children may be, and often are, distressed because they can neither find nor give meaning to their lives, or because they can neither accept nor create satisfactory standards for regulating their personal conduct. Although these circumstances result in untold suffering, no one in the United States—certainly, no judicial or legal authorities—would contend that such unhappiness justifies the forcible imposition of certain religious beliefs and practices on the sufferers. Such an intervention, even if it proved “helpful” in relieving the suffering, would violate the First Amendment guaranty against the “establishment of religion.”

This principle applies, and ought to be applied, to medical or so-called therapeutic interventions as well. I maintain, in other words, that suffering caused by illness—regardless of whether it is actual bodily illness or alleged mental illness—cannot be the ground, in American law, for depriving a person of liberty, even if the incarceration is called *hospitalization*, and even if the intervention is called *treatment*. I contend that such use of state power—whether rationalized as the necessary deployment of the police power or as the therapeutic application of the principle of *parens patriae*—is contrary to the ideas and ideals enshrined in the First Amendment to the Constitution.

To join this argument, we need not consider what the state might do, or ought to do, to citizens who are *not* suffering in order to do something for those who *are*. The recipients of social security or welfare payments are not subjected to the police power of the state: they are not incarcerated and are not compelled to submit to medical treatments. However, we must consider what is being done in the United States—and, of course, elsewhere too—to people who are suffering, or who are alleged to be suffering, ostensibly to help them. It is

precisely at this point that the theology of medicine—and especially the theology of psychiatry and of therapy—is writ clear and large.

For example, on February 6, 1976, *Psychiatric News*, the official newspaper of the American Psychiatric Association, published a front-page interview conducted by Robert Pear of the *Washington Star* with Dr. Judd Marmor, the president of the American Psychiatric Association. After alluding to my objections to involuntary psychiatric interventions, Pear asks Marmor, “But if a person who is supposedly ill doesn’t recognize his illness and doesn’t request treatment—should society intervene?” To which Marmor replies, “Yes, because these individuals are suffering and it’s in the nature of their suffering very often that they are in no position to evaluate the fact that they are mentally ill.”

This modern therapeutic view seems to me identical to the traditional theological view according to which some persons are suffering and it’s in the nature of their suffering very often that they are in no position to evaluate the fact that they have strayed from the true faith.

The framers of the Constitution opposed such sophistry and such policy. They reasoned—I think rightly—that even if the case were exactly as Marmor, for example, presents it, it should be enough for those solicitous for the welfare of such “sufferers” to offer them their “help.” That would remove the sufferers’ supposed ignorance about their own suffering and about the help available for its relief. Neither the existence of such suffering, real or alleged, nor the existence of help for it, real or alleged, could justify, in this view, an alliance between church and state and the use of the state’s power to impose clerical help on unwilling clients. Just so, I insist, it cannot justify imposing clinical help on them.

How, then, has it come about that medicine has succeeded where religion has failed? How has therapy been able to breach the wall separating church and state where theology has been unable to do so? Briefly put, medicine has been able to achieve what religion has not, primarily by a radical violation of our vocabulary, of our conceptual categories; and secondarily, through the subversion of our ideals and institutions devoted to protecting us from reposing power in those who would help us whether we like it or not. We have done it before 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. 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.⁴

Violations of descriptive and normative autonomy are made possible by rhetorical deceptions and mystifications.

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.

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.

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, or to belittle, its scientific and technical dimension does so at his own peril. [These views are] addressed to those persons who understand the difference between why a priest wears a cassock and a surgeon a sterile gown, between why an orthopedic surgeon uses a cast and a psychoanalyst a couch. Unfortunately, many people don't.

Why don't they? Why indeed should they? Why should anyone want to distinguish between technical and ceremonial acts, roles, and words? There is probably only one reason—namely, the desire to be free and responsible. If a person longs to submit to authority, he will find it useful to bestow ceremonial powers on those who wield technical skills, and vice versa; it will make the authorities seem all the more useful as priests and physicians.

People who possess certain intellectual knowledge or technical skills are obviously superior, at least in those respects, to people who do not. Thus, unless people long for a dictatorship of technicians—say, of physicians—they ought to make sure that the expert's favorable social position due to his having special skills is not further enhanced by attributing ceremonial powers to him as well. Conversely, unless they long to be fooled by fakers—say, by psychiatrists—they ought to make sure that the expert's favorable social position due to his having special ceremonial skills, or to such skills being attributed to him by others, is not further enhanced by crediting him with technical powers he does not possess.

Formerly, people victimized themselves by attributing medical powers to their priests; now, they victimize themselves by attributing magical powers to their physicians. Faced with persons endowed with such superhuman powers—and, of course, benevolence—ordinary men and women are inclined to submit to them with that blind trust whose inexorable consequence is that they make slaves of themselves and tyrants of their "protectors." That is why the framers of the Constitution urged their fellow Americans to respect priests for their faith but to distrust them for their power. To enable them to do so, they erected a wall separating church and state.

I hold, similarly, that people should respect physicians for their skill but should distrust them for their power. But unless the people erect a wall separating medicine and the state, they will be unable to do so and will succumb precisely to that danger from which the First Amendment was supposed to protect them.⁵

The most conspicuous violation of both senses of autonomy is manifested in the societal and psychiatric perspectives and practices regarding suicides. This violation requires for its successful perpetration profound rhetorical deception.

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." 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."

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. The process of reclassification affects our views on suicide. I shall [show this] 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."

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."

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

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 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. . . ." 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.

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.

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 detailed my reasons why elsewhere and need not repeat them here. 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 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 anti-suicidal 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.⁶

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The absurdity of the medical-psychiatric position on suicide . . . 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.” 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.”

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.

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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

Psychiatry *could* (but does not) honorably serve the ends of descriptive and normative autonomy.

In psychiatry the burning question is: Which methods are justified, and which are not, for promoting and enforcing so-called mental health? I am opposed to coercive methods in the mental health field. I also believe it is important for lawyers, psychiatrists, and the public to think about this problem and to reach conclusions of their own.

The redefinition of moral values as health values will now appear in a new light. If people believe that health values justify coercion, but that moral and political values do not, those who wish to coerce others will tend to enlarge the category of health values at the expense of the category of moral values. We are already far along this road.⁸

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Why do I place so much emphasis on autonomy? What is the special merit of this moral concept? Let us define what we mean by autonomy, and its value will then become evident. Autonomy is a positive concept. It is freedom to develop one's self—to increase one's knowledge, improve one's skills, and achieve responsibility for one's conduct. And it is freedom to lead one's own life, to choose among alternative courses of action so long as no injury to others results.

In a modern society, based more on contract than on status, the autonomous personality will be socially more competent and useful than its heteronomous counterpart. Moreover, and very significantly, autonomy is the only positive freedom whose realization does not injure others. Other freedoms—for example, to struggle for nationalistic or religious goals—are likely to injure others; indeed, many such goals cannot be pursued meaningfully unless there is opposition to them. To be sure, self-development may also “injure” others; the better bricklayer might displace the one who is less proficient.

But there is a radical difference between the injury inflicted on others by an individual who has superior skill and by one who coerces them or harms them bodily. Indeed, to argue that, because of his excellence, the more proficient person harms his less skillful fellows is like accepting the proposition that a sadist is one who refuses to hurt a masochist. Of course it is true that a less proficient person may indeed suffer in a freely competitive society that makes no provisions for the dignified survival of those who, for any number of reasons, fare badly in competition. This is, however, better corrected by rewarding poor players for playing better than by penalizing good players for playing well.

Because of the intimate, personal relationship between psychotherapist and patient, the concept of freedom is not an abstract, academic issue in analysis. Though at first the analyst occupies a role somewhat external to the analysand's struggles for freedom—from his inhibitions, symptoms, or "internal object"—the situation soon changes. In the first place, the patient has real, extra-analytic relationships—with his mother, father, brother, employer, wife, son, and so forth; second, he has a real relationship with the analyst. In various ways, the analysand is likely to feel constrained and imprisoned, not so much by his "inner personality structure" as by actual persons. The question is: What will be the analyst's attitude toward the people in the patient's life? And, as analyst, what will be his attitude toward the patient? In both ways, the analyst is bound to influence the patient in his search for or avoidance of personal freedom.

If he practices autonomous psychotherapy, the analyst must support the patient's aspirations toward freedom from coercive objects. This does not mean that he must encourage the patient to behave in any particular way—for example, to rebel against a domineering parent, spouse, or employer. But it does mean that the analyst must candidly acknowledge and interpret the nature of the patient's significant relationships, leaving him absolute freedom to endure, modify, or sever any given relationship.

The same problem is likely to arise in the analytic situation itself. If the patient feels habitually constrained in his human relationships, he will almost surely also feel constrained by the analyst. This will be an integral part of the analysand's transference neurosis. The reason for it is that we all tend to play the games we are used to playing. Thus, the patient will come to feel that the analyst is constraining him. Herein lies the most critical reason for avoiding all coercion in analysis. Indeed, this is why I insist that analysis cannot be *anything but* autonomous psychotherapy.

If the analyst lays down restrictive rules, as Freud advocated, he cannot show the patient the difference between transference and reality; how can he, when in fact there is no difference? Conversely, if the analytic situation is contractual and free of coercion, the patient will realize it. The analytic relationship will thus not only provide the conditions necessary for a certain kind of learning experiences, but will also furnish a model of the autonomous, noncoercive relationship.

The ethic of the analytic relationship is communicated by what actually occurs between analyst and analysand. What distinguishes this enterprise from others is that, although the analyst tries to help his client, he does not "take care of him." The patient takes care of himself. Furthermore, the analysand realizes that he is "expected to recover," not in any medical or psychopathological sense, but in a

purely moral sense, by learning more about himself and by assuming greater responsibility for his conduct. He learns that only self-knowledge and responsible commitment and action can set him free. In sum, autonomous psychotherapy is an actual small-scale demonstration of the nature and feasibility of the ethic of autonomy in human relationships.

The analyst conducts himself autonomously and responsibly, subordinates himself to the terms of a contract regardless of the patient's subsequent conduct, and avoids coercing the patient in any way. Given these conditions, the patient will have an opportunity to free himself of those constraints that prevent him from becoming the autonomous, authentic person he wishes to be.⁹