Debate

PSYCHIATRIC ETHICS

Psychiatry and the control of dangerousness: on the apotropaic function of the term "mental illness"

T Szasz

The term "mental illness" implies that persons with such illnesses are more likely to be dangerous to themselves and/or others than are persons without such illnesses. This is the source of the psychiatrist's traditional social obligation to control "harm to self and/or others," that is, suicide and crime. The ethical dilemmas of psychiatry cannot be resolved as long as the contradictory functions of healing persons and protecting society are united in a single discipline.

Life is full of dangers. Our highly developed consciousness makes us, of all living forms in the universe, the most keenly aware of, and the most adept at protecting ourselves from, dangers. Magic and religion are mankind's earliest warning systems. Science arrived on the scene only about 400 years ago, and scientific medicine only 200 years ago. Some time ago I suggested that "formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak, men mistake medicine for magic".[1]

We flatter and deceive ourselves if we believe that we have outgrown the apotropaic use of language (from the Greek *apostropaios,* meaning "to turn away").

Many people derive comfort from magical objects (amulets), and virtually everyone finds reassurance in magical words (incantations). The classic example of an apotropaic is the word "abracadabra," which *The American Heritage Dictionary of the English Language* defines as "a magical charm or incantation having the power to ward off disease or disaster". In the ancient world, abracadabra was a magic word, the letters of which were arranged in an inverted pyramid and worn as an amulet around the neck to protect the wearer against disease or trouble. One fewer letter appeared in each line of the pyramid, until only the letter "a" remained to form the vertex of the triangle. As the letters disappeared, so supposedly did the disease or trouble.

I submit that we use phrases like "dangerousness to self and others" and "psychiatric treatment" as apotropaics to ward off dangers we fear, much as ancient magicians warded off the dangers people feared by means of incantations, exemplified by "abracadabra". Growing reliance on compulsory mental health interventions for protection against crime and suicide illustrate the phenomenon. Physicians, criminologists, politicians, and the public use advances in medicine and neuroscience to convince themselves that such interventions are "scientific" and do not violate the moral and legal foundations of English and American law. This is a serious error. There is no scientific basis whatever for preventive psychiatric detention, also known as involuntary mental hospitalisation or civil commitment. And the procedure is a patent violation of due process and the presumption of innocence.

We call all manner of human problems "(mental) diseases", and convince ourselves that drugs and conversation (therapy) solve such problems. Solutions exist, however, only for mathematical problems and some medical problems. For human problems, there are no solutions. Conflict, disagreement, unhappiness, the proverbial slings and arrows of outrageous fortune are challenges that we must cope with, not solve. Only after we admit that our solutions are illusions can we begin to develop more rational and more humane methods for dealing with "mental illness" and the "dangerous mental patient".

We are proud that we do not punish acts or beliefs that upset others, but do not injure them and hence do not constitute crimes. Yet, we punish people—albeit we call it "treatment"—for annoying family members (and others) with behaviours they deem "dangerous" and also for "being suicidal". To be sure, persons who exhibit such behaviours—labelled "schizophrenics", "persons with dangerous severe personality disorders," and "suicidal patients"—frighten others, especially those who must associate with them. Unable to control non-criminal "offences" by means of criminal law sanctions, how can the offended persons and society protect themselves from their unwanted fellow men and women?

One way is by "divorcing" them. However, this method of separating oneself from an unwanted companion—especially when it involves relations between disturbing and disturbed spouses or between disturbing adult children and their disturbed parents—strikes most people as an unacceptable rejection of family obligation. Psychiatrists offer to relieve the disturbed person of the burden of coping with his disturbed relative by incarcerating the latter and calling it "care" and "treatment".

How do psychiatrists do this? By allying themselves with the coercive apparatus of the state and declaring the offending individual *mentally ill and dangerous to him or herself or others*. This magic mantra allows *us* to incarcerate *him* in a prison we call a "mental hospital". Ostensibly, the term "mental illness" (or "psychopathology") names a *pathological condition* or disease, similar say to diabetes; actually, it names a *social tactic* or justification, permitting family members, courts, and society as a body, to separate themselves from individuals who exhibit, or are claimed to exhibit, certain behaviours identified as "dangerous mental illnesses". This tactic is dramatically illustrated by the following "advice" appearing on the web site of the

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Debate

National Alliance for the Mentally Ill (NAMI), a mental health advocacy organisation that identifies itself as representing "more than 200 000 families, consumers, and providers across the country". As will be evident, NAMI represents the interests of mental patients the same way that the Ku Klux Klan represented the interests of black Americans.

> Sometime, during the course of your loved one's illness, you may need the police. By preparing now, before you need help, you can make the day you need help go much more smoothly. ... It is often difficult to get 911 to respond to your calls if you need someone to come & take your MI [mentally ill] relation to a hospital emergency room (ER). They may not believe that you really need help. And if they do send the police, the police are often reluctant to take someone for involuntary commitment. That is because cops are concerned about liability. ... When calling 911, the best way to get quick action is to say, "Violent EDP", or "Suicidal EDP". EDP stands for Emotionally Disturbed Person. This shows the operator that you know what you're talking about. Describe the danger very specifically. "He's a danger to himself" is not as good as "This morning my son said he was going to jump off the roof." ... Also, give past history of violence. *This is especially important if the person is not acting up*. ... When the police come, they need compelling evidence that the person is a danger to self or others before they can involuntarily take him or her to the ER for evaluation. ... While AMI/FAMI [Alliance for the Mentally Ill/Florida Alliance for the Mentally Ill] is not suggesting you do this, the fact is that some families have learned to "turn over the furniture" before calling the police.[2]

Giving false information to the police is a crime, unless it is in the cause of "mental health".

In the United Kingdom, unlike in the United States, there still are physicians, psychiatrists, and medical journals that view these developments with concern, if not alarm. The publication of a United Kingdom government white paper for a new mental health act, in 2000, that would provide for the psychiatric detention of persons diagnosed as having a "dangerous severe personality disorder" has duly alarmed some doctors in Britain.[3–5] I am afraid, however, that their lamentations are too feeble, and come too late.

THE DANGER OF THE CONCEPT OF "DANGEROUSNESS"

In *The Myth of Mental Illness,* I showed that the idea of mental illness implies dangerousness and thus requires and justifies psychiatric coercions.[6] To civilly commit a person, a psychiatrist (or physician) must certify that the subject suffers from a mental illness and is dangerous to himself and/or others. It is not by accident that when psychiatry was a young and marginalised medical specialty, its primary social function was controlling persons dangerous to others ("mad"); and that now, when it is a mature and respected medical specialty, its primary function is controlling persons who are dangerous to themselves ("suicide risks").

In his classic treatise on schizophrenia, Eugen Bleuler complained: "People are being forced to continue to live a life that has become unbearable for them for *valid reasons*. ... Even if a few more [patients] killed themselves, does this reason justify the fact that we *torture* hundreds of patients and *aggravate* their disease?" (emphasis added).[7]

Why are psychiatrists expected to prevent suicide by depriving the "suspect" of liberty? The idea of suicide makes us nervous. We cannot decide whether killing oneself is a "right" or a wrong, an element of our inalienable personal liberty or an offence of some sort that ought to be prohibited and perhaps punished. We are too uptight about suicide to recognise that killing oneself is sometimes a reasonable and right thing to do, sometimes an unreasonable and wrong thing to do, but that, in either case, it ought to be treated as an act that falls outside the scope of interference by the state.[8]

The right to kill oneself is the supreme symbol of personal autonomy. Formerly, the church allied with the state prohibited and punished the act. Now, psychiatry, as an arm of the state, prohibits the act and "treats" it as if it were a symptom of an underlying disease (typically, depression or schizophrenia). The deprivation of liberty intrinsic to such an intervention is viewed not as a human rights violation but as a human rights protection. The modern reader may be surprised, perhaps even shocked, at seeing the words "prohibition" and "suicide" bracketed. Lack of familiarity with the long history of the religious prohibition against self murder, together with unquestioning acceptance of coercive psychiatric suicide prevention as "therapy," make such a reaction a virtual certainty. This is unfortunate.

Formerly, religious doctrine defined the permissible uses of the body. Its impermissible uses—self abuse (masturbation), sex abuse (homosexuality and other "perversions"), substance abuse (drunkenness and gluttony), and self murder (suicide)—were sins, crimes, or both, punished by informal or formal sanctions. Substituting medical for religious doctrine, the modern state, in collaboration with psychiatry, transformed each of these behaviours into diseases of the mind, a view that prevailed through most of the 19th and 20th centuries. After the second world war, and more rapidly in recent decades, some of these mental maladies were divested of their disease status. In my own lifetime, masturbation ceased to be a mental disease or a cause of disease, and homosexuality became not just normal but a "right" others were legally obligated to respect. Yet, during the same period, political, psychiatric, and popular condemnation of self medication and self killing intensified. Using substances decreed to be "dangerous" and illegal is now viewed as an "international plague", justifying a worldwide "war on drugs".[9] Rejecting life and wanting to kill oneself is defined as a severe mental illness characterised by "dangerousness to self," and is treated as a quasi-crime with coercions called "treatments" (especially involuntary "hospitalisation" and forced drugging). Success in committing suicide is regarded as a "waste," a preventable medical tragedy, often attributed to medical negligence.[10]

It is fundamental principle of English and American law that only persons charged with and convicted of certain crimes are subject to imprisonment. Persons who respect other peoples'

rights to life, liberty, and property have an inalienable right to their own life, liberty, and property. Having a disposition or propensity to break the law is not a crime.

Serious debate about matters regarded as mental health problems, especially suicide, is taboo. Liberals have a love affair with coercion in the name of mental health. Conservatives—fearful lest they be dismissed as not compassionate enough about the mentally ill and not scientific enough about mental illness—join in the celebration of psychiatric statism. A columnist for the conservative magazine *National Review* agrees with the psychiatric dogma that "it is *mental illness that causes most suicides*: depression, manic depression, and schizophrenia. ... The conservative critique of the therapeutic culture", he warns, "will not get a hearing until conservatives *face up to the reality of mental illness*".[11]

Speaking about, much less supporting, a right to suicide strikes most people as unimaginably uncompassionate. This opinion is the result of viewing suicide as caused by depression, and depression as a kind of unnecessary, curable unhappiness. We regard this perspective as enlightened and scientific, when in fact it is naive and conceited. Toward the end of *Brave New World*—a scientistic dystopia in which all conflicts and discomforts have been eliminated—the human remnant Huxley calls the Savage, and his opponent, the "Controller" Mustapha Mond, engage in the following dialogue:

... "We prefer to do things comfortably" [said the Controller].

"But I don't want comfort. I want God, I want poetry, I want real danger, I want freedom, I want goodness, I want sin."

"In fact", said Mustapha Mond, "you're claiming the right to be unhappy."

"All right, then," said the Savage defiantly, "I'm claiming the right to be unhappy."[12]

For the person who kills himself, suicide may be the realisation of diverse aspirations and expectations. For society, suicide is, first and foremost, an act of *lese majeste* (literally, "injured majesty"). *Webster's Dictionary* defines the term as "an offense violating the dignity of a ruler as the representative of a sovereign power; detraction from the dignity or importance of a constituted authority".

For millennia, suicide was *lese majeste* against the church/state, the supreme representation of legitimate authority for people who worship a god and want a good life in the hereafter. Today, suicide is *lese majeste* against the Therapeutic State, the supreme representation of legitimate authority for people who worship health and want to stay alive as long as possible.

Regarding the issue of "dangerousness to others" as a quasicrime—once we cease to regard "it" as a "condition caused by mental illness"—there is not much to say.

In the current climate of opinion, however, things are no longer that simple. People fear, often for good reasons, persons not susceptible under our legal system for detention in prison. Persons called "sex offenders" are the most widely publicised offenders who fall into this class. In 1997, in *Kansas v Leroy Hendricks,* the US Supreme Court declared: "States have a right to use psychiatric hospitals to confine certain sex offenders once they have completed their prison terms, even if those offenders do not meet mental illness commitment criteria".[13] In February 2000, Wisconsin's oldest prison inmate, a 95 year old man, was "resentenced" as a sexual predator, after a psychologist "testified ... [that] psychological tests performed on Ellefson indicated if he was given a chance, he would commit a [sex] crime. ... After only minutes of deliberation, the jury found that Ellef J Ellefson should be committed for mental treatment under the sexual predator law."[14]

As I noted, the practice of preventive psychiatric detention has not gone unremarked by British commentators. John J Sandford, a British forensic psychiatrist, complained: "The preventive detention of those with untreatable mental disorders is already widely practised in England. Under the Mental Health Act (1983) people ... [are] detained indefinitely in hospital regardless of response to treatment and on grounds of risk to self as well as others. Secure and open psychiatric hospitals are full of such patients."[15] Derek Summerfield, also a psychiatrist, commented: "The growing pressures on them [psychiatrists] to deliver public protection was perhaps inevitable, given the rise of biopsychomedical paradigms as explanations for the vicissitudes of life in modern Western society. Psychiatrists have played their part by assuming the authority to explain, categorise, manage, and prognose in situations where well defined disease (arguably their only clear cut remit) was not present."[16]

CONCLUSION

Psychiatry is part law and part medicine. It is the psychiatrist's social mandate to function as a double agent: that is, to help voluntary patients cope with their problems in living and to help relatives and society rid themselves of certain unwanted persons, under medical auspices. The latter task requires coercing the denominated patient; the former is rendered impossible by the slightest threat of coercion, much less its actual exercise. The psychiatrist's mandate violates Jesus' injunction, "Render therefore unto Caesar the things which are Caesar's; and unto God the things that are God's".[17]

True psychiatric reform is contingent on separating the psychiatrist's two, mutually incompatible roles and functions.

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Debate

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Commentary on Szasz

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Szasz argues that the threat of harm to self or others cannot be understood as a symptom of mental illness, and that there is an irresolvable tension between the traditional medical ethical duty to heal, and any notion of a medical duty to protect the public.[1] I think these are two distinct arguments which could each be the subject of extended analysis, and this commentary is of necessity limited.

Professor Szasz has consistently raised concerns about the political abuse of psychiatry as a way of controlling dissidence. Many of his arguments remain as cogent and unanswered as when they were first put 30 years ago. But as sympathetic as I am to some of his criticisms, it seems to me that many are too sweeping; especially the first claim that there is no such thing as mental illness, but only persons whose expressed intentions involve taking a stance which is contrary to certain social rules.

I do not propose here to discuss the so called "hard" problem of consciousness—that is, exactly how brain states give rise to intentional psychological experience, or indeed, the extent to which "brain" and "mental" can be used synonymously. If we accept that mental states give rise to intentions, then different mental states will give rise to different intentions, and there is no reason not to think that there might be abnormal mental states that might give rise to abnormal intentions. The question then is what we mean by the word "abnormal". Clearly it is possible for abnormal to be defined as "socially inappropriate", which is Szasz's concern. In that case, political and social dissidence is then turned into a symptom by the language of medicine, and thus becomes not a social matter, but an individual's personal problem.

But "abnormal" could be defined with reference to the individual, and not the group—that is, this state of mind is abnormal for Jim, rather than the group to which Jim belongs. For example, if Jim is diabetic and becomes hypoglycaemic, he may become stressed and anxious. His perception of threat may be lowered, and his ability to monitor his external world is reduced. In a confused and agitated state of mind, he forms the intention to hit his wife. What are we to make of this intention?

If Jim is not regularly in the habit of hitting his wife, we might want to argue that this intention is highly abnormal for Jim, and we would be inclined to say that this intention is the product of an abnormal mental state. We might want to stop Jim from doing this, not because hitting wives is socially deviant, but because we have a sense that Jim does not really "own"'this intention; it is not really "him". If we are trying to be respectful of other persons (an essential medical ethical duty, and arguably a fundamental human ethical duty), then we certainly want to respect their intentions, but we want to be sure that they are sincerely held and integral to the actor's identity and values.

It is therefore essential to find out first, whether Jim is in the habit of hitting his wife, and second, whether Jim was hypoglycaemic. If he is not an established batterer, and did miss a meal after insulin, then it seems reasonable to argue that he was in an abnormal mental state for him, and that his intention to harm another was a symptom. If he is a regular batterer, then we may not be so sure that the intention to harm is a symptom. It is not possible to say that the intention to harm others is always a symptom of abnormal mental states; however, it is also not possible to say it is never so. Context and history are more important than behaviour for assessing intentions; because it is the meaning of the intention to the person who does it, that tells us about its abnormality. It is also the meaning of the intention that will be used later to attribute responsibility and blame.

Szasz restricts most of his article to a passionate defence of the right to commit suicide, arguing that respect for individual autonomy requires us to let people hurt themselves. Of course, the political tension here is between the interests of the individual and those of the group. It is naïve, however, to think that no other person is harmed when individuals kill themselves, as the recent case of Miss B indicates.[2] Other commentators noted the effect on the medical staff around her, and other disabled people.[3 4] I do not have the space (nor is it entirely relevant) to present all the arguments against a right to commit suicide; I can only at this point make the point that others may not be wronged by such an act, but they may be harmed. People who live together in social groups do reserve the right to make rules that limit individuals' capacities to harm each other, and it seems therefore reasonable to be cautious about an unlimited right to suicide. Furthermore, liberty to do something is not the same as the licence to do anything. The whole structure of law may be seen as based on the notion that there are "wise restraints that make men free".[5] Lastly, there is some factual evidence to suggest that the wish to commit suicide

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