

(2008). Psychiatry. Entry in *The Encyclopedia of Libertarianism*, edited by Ronald Hamoway, Washington, D.C: Cato Institute. <http://www.schaler.net/psychiatry.pdf>

## Psychiatry

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Psychiatry appears at first to be like any other medical specialty, but upon closer examination it deviates significantly from the practice of “normal” medicine such as orthopedics or urology.

Normal physicians are trained in explaining the workings of the body and in what to do if a disease is identified. Psychologists are trained in the study of mental processes and behavior, while psychiatrists are trained in mental health and mental disease. Controversy arises over who “mental illness” belongs to, psychologists or psychiatrists. Economic interest plays no small part in turf wars of this sort: psychology, psychiatry, and medicine are trade professions, and like all businesses, the seller seeks to convince consumers to buy his product rather than that of his competitor. Libertarians are guilty of *a priori* contradiction when it comes to the liberty of self-ownership and coercive psychiatry: If libertarians truly believe that a person owns his body, then surely they would oppose suicide prevention efforts sanctioned by the state and detention in a mental hospital for failed suicide attempts. The proper role of the state is to protect us from one another. The state has no place protecting a person from himself. Nowhere is this principle more true than when it comes to the right to suicide (Szasz, 2004).

Differences between psychiatry and normal medicine includes (a) how we define and treat a person labeled as a “patient,” (b) how diseases are defined and diagnosed, and (c) how psychiatry and the state interact, particularly in terms of who the psychiatrist serves: Is a psychiatrist his patient’s agent and advocate? Or, is a psychiatrist first an agent of the state, feigning patient advocacy, disregarding the sacred medical ethic of *primum non nocere* by placing the interests of society over those of the patient? In the normal practice

of medicine, most people assume that the doctor acts with the patient's welfare in mind. This is not always clear in the case of psychiatry.

The psychiatric relationship can be contractual, that is, one based in consent and mutual respect between doctor and patient (client), or the relationship can be "institutional," that is, one based in coercion and paternalism (Szasz, 1970; 1965; Szasz and Hollender, 1956). Contractual psychiatry is like any other practice of medicine in terms of the doctor-patient relationship. A person chooses to purchase a psychiatrist's services, the choice is mutual, and the patient-as-consumer can terminate the relationship at any time. This is referred to as "psychiatry between consenting adults." A person with cancer or severe osteoarthritis can choose not to have chemotherapy or radiation treatment for his cancer or choose not to have a knee replacement. People may try to persuade him to do otherwise, but ultimately his right-of-refusal must be accepted. In either case, choosing to reject medical advice will likely result in harm to self. While a person may choose to purchase an institutional psychiatrist's services, there may come a point when the patient cannot terminate the relationship. He is held in treatment against his will because the psychiatrist asserts that he poses a threat to himself or others.

Psychiatric and normal medicine differ in the way that diseases are defined, diagnosed, classified, and treated. In psychiatry, behavior is considered a disease. Psychiatric diseases are classified based on how much a behavior or symptom deviates from the norm, the duration, intensity, and frequency of mental and emotional discomfort, behavioral and social maladaptation and maladjustment. Psychiatric disorders are not found in standard textbooks on pathology and are not found in a cadaver at autopsy (Cf. *Robbins and Cotran Pathologic Basis of Disease*, 2004). Among other differences between behavior and normal disease: Behavior is something that a person does, disease is something that a person has. Behaviors are the expression of a person's values. Diseases are value free, they refer to alteration and destruction of tissue. Diagnosing behavior as sick or healthy is a moral judgment. Diagnosing tissue

as sick or healthy has nothing to do with morality. Finally, the relationship between psychiatry and the state is different from the relationship between normal medicine and the state.

Psychiatry is deeply involved with the law, particularly in the courtroom, where a psychiatrist's expert testimony is often given tremendous latitude. This is most obviously true in terms of the insanity defense and involuntary commitment to a mental hospital. Psychiatric opinion regarding insanity bears heavily on our experience of justice. Psychiatric opinion regarding involuntary commitment bears heavily on our experience of liberty.

According to Thomas Szasz, the theocratic state (union of church and state) has metamorphosed into the therapeutic state (union of medicine and state): "Although we may not know it, we have, in our day, witnessed the birth of the Therapeutic State. This is perhaps the major implication of psychiatry as an institution of social control" (Szasz, 1963, p. 212). Institutional psychiatry functions as legal fiction in court and the psychiatric examination of a defendant—with or without his consent—is used to circumvent basic constitutional protections regarding due process of law. Innocent persons are deprived of liberty and guilty persons of justice on the basis of the idea of mental illness and its legal corollary "insanity" (Szasz, 1987); any legally-binding contract can be declared invalid based on psychiatric examination and testimony (testamentary capacity and a valid will), and a person can be declared incompetent to stand trial and detained in perpetuity even though the legal criteria for competency to stand trial are met. Psychiatry's dependence on its involvement with the law is so extensive that were psychiatrists to be forbidden to testify in court, the profession would likely cease to exist.

While in normal medicine a patient is free to refuse medical advice even to his own detriment, this is not allowed when it comes to the opinion of an institutional psychiatrist. Moreover, even though the court and others believe that psychiatrists can ascertain whether a person is likely to be a threat to others, there is no scientific evidence to support the idea that we can predict,

with an accuracy beyond that expected by chance, who is likely to be dangerous to others and who is not. Thus, a person who is normally regarded as innocent until proven guilty is deprived of liberty without due process of law and the deprivation of liberty is applied in an arbitrary manner, characteristic of the Rule of Man rather than the Rule of Law.

Psychiatrists diagnose behavior as disease. In normal clinical medicine, based on the science of pathology and nosology, diseases are regarded as cellular abnormalities, lesions, changes in physical tissue. This is the gold standard for disease definition as established by German pathologist Rudolf Virchow (1821–1902; 1858). In psychiatric medicine a person is diagnosed with a putative disease based on a patient's symptoms alone, not signs. In cases of brain disease, there are signs of brain disease, but in cases of mental disease there are no bodily signs. Contrary to a widespread impression, there is no way to tell who is and who is not mentally ill by taking pictures of the brain or by drawing blood and assessing levels of neurotransmitters (Andreasen, 2007; Sarbin, 1990).

Normally, diseases are diagnosed on the basis of signs, not symptoms. (There are some diseases that are diagnosed by symptoms alone, for example, migraine, but the exact disease that causes migraine symptoms is described based on signs, not symptoms.) Since psychiatrists diagnose mental illness on the basis of behavior, and behavior is the expression of a person's values, the diagnosis of mental illness inevitably involves moral judgments. A person's values, morality, and ethics have nothing to do with the nature of cancer, and so the diagnosis of cancer has nothing to do with the values of the person discovering or diagnosing cancer.

There are three situations where treatment for real disease may proceed without a person's consent: (1) When a person is literally unconscious. Here, the person does not have the capacity to refuse treatment, so medical personnel err in the direction of saving a person's life by administering medical treatment. (2) When a person is literally a child, treatment is coerced because a child does

not have the mental capacity to comprehend the consequences of refusing treatment. (3) A person is treated without consent when he has a contagious disease. A person is quarantined and treated for a contagious disease to protect others, not to help the person with a contagious disease.

Institutional psychiatrists modify these three conditions to justify treatment without consent in the following ways: (1) A person who refuses treatment for a mental illness is said to be metaphorically unconscious when he is literally conscious. The symptoms of metaphorical unconsciousness are “lack of insight” into the nature and course of mental illness when a patient disagrees with a psychiatrist about the diagnosis of mental illness. For example, one symptom of schizophrenia or depression is when the patient denies that he is schizophrenic or depressed. (2) A person with mental illness is treated as if he is a child when he is literally an adult. The metaphorical child is allegedly incapable of being responsible for himself and thus a danger to himself. (3) Finally, a person with mental illness is treated against his consent when psychiatrists assert that he is metaphorically contagious, that is, when he allegedly poses a threat to himself and others (Schaler, 2004).

“Mental illness” refers to behavior that is disturbing or embarrassing. Psychiatrists define abnormal behavior as mental illness or disease. There are four ways this is done: (1) Behavior is considered abnormal when it deviates from the norm. This is the most objective way of defining abnormal behavior. Abnormal or deviant behavior does not necessarily mean something bad or negative. A person who is exceptionally skilled at a task may be clearly abnormal or deviant. (2) Behavior is abnormal when there is a persistent experience of subjective discomfort, beyond that established within a normal range. Everyone feels depressed at one time or another, but when depression becomes “clinical depression,” the experience goes on “too long,” beyond that considered “normal.” We see that psychiatric illness is socially constructed based on prevailing cultural mores. This is not true for normal disease. (3) Behavior is considered abnormal when a person has difficulty adapting to the

demands of social intercourse, demands that are considered necessary to function in relation to others, for example, work, family, school, and any number of other normal social relations. In this sense, mental illness is considered to be maladapted behavior. (4) And finally, behavior is considered abnormal when a person has a difficult time adjusting to some major life change, in the sense that his adjustment again deviates significantly from the norm.

Psychiatrists generally group mental illnesses in four categories: (a) Anxiety-based disorders are behaviors that are abnormal according to the four criteria listed above as a result of fear; (b) Mood or affective disorders are behaviors that meet the four criteria above as a result of sadness, despondency, despair, and depression, either alone or cycling with what is called “mania,” “excessive” excitement, and hyper-vigilance. (c) “Personality disorder,” in which an individual meets the four criteria for abnormal behavior when his behavior centers on trouble in relationships. Each of these categories of mental illness or abnormal behavior exists along a spectrum of intensity. On one end of the spectrum are problems forming mutually satisfying, meaningful and intimate relationships with others. On the other end are various degrees of criminal and predatory behavior; (d) The fourth area of mental illness is characterized by “thought disorder.” Here we have persons labeled as schizophrenic and with delusional disorders. Schizophrenia is characterized by hallucinations (self-reported imaginings) and delusions (false beliefs).

While organic problems could cause any of the symptoms listed in these four categories of mental illness – problems such as brain tumors, multi-infarct dementia (mini strokes), Dementia of the Alzheimer’s Type, HIV dementia, the result of head injury—there are no signs or physiological markers that can be used to predict membership in one category versus another; and there are no signs that can be used to differentiate between people who are mentally ill from those who are not.

The four categories of mental illness can be explained using four models or paradigms. The four explanations commonly used for mental illness are (1)

theological—here mental illness is said to be the result of evil spirits, possession, the manifestation of a religious or spiritual anomaly; (2) biological—here mental illness is said to be the result of a structural or functional problem in the brain; or mental illness is said to be a defect in the way neurons communicate with one another, for example, a mutation in a gene that builds a specific neuroreceptor; (3) psychological—here mental illness is explained using any number of personality theories, from psychoanalysis to behaviorism and learning theory to social cognitive theory and to humanistic psychology; and finally; (4) sociocultural—here mental illness is explained based on the cultural context within which the behavior is both occurring and being studied. A “God-man” roaming the plains of northern India wrapped in nothing more than a shawl, drinking rainwater and eating seeds, meditating for fifteen hours a day, is said, by people of his immediate culture, to be engaged in valued religious experience. Take that same person and have him walk across the mall in Washington, D.C. and he most likely will be arrested and committed to a psychiatric facility where he would probably be diagnosed as “paranoid schizophrenic.”

Contractual and institutional psychiatry have particular consequences in four areas. These are the legal, clinical, public, and social policy domains.

Depending on how mental illness is defined and explained, consequences for legal policy may vary based on the extent to which legal authorities hold a person responsible for his behavior. If he commits a crime, and the criminal behavior is attributed to mental illness, he may be exculpated or forced into a mental institution, with an indeterminate sentence. If he has committed no crime, but his mental illness is interpreted as posing a threat to himself or others, he may be swept off the street or taken from his home, deprived of his freedom, and placed in a mental institution for the rest of his life—without having ever received a trial or conviction, that is, without any due process of law.

In the clinical domain, he may choose to receive treatment or choose not to receive treatment, depending on whether contractual or institutional

psychiatrists are involved. If the psychiatrists believe that behavior cannot be a disease, and a psychological theory offers the most logical explanation for the client's behavior, he may engage in conversation called "psychotherapy." If the psychiatrist believes in a biological explanation for mental illness, he may receive any number of drugs that change the way neurons communicate with one another, or he may receive electroconvulsive therapy (ECT)—where electricity is passed through his brain for a few seconds, causing seizures and then short term memory loss, which may assist in his not being able to remember what was bothering him.

Public policy, depending on how we differentiate it from social policy, may be the focus of formal social control, and if so, this is where institutional psychiatry would most likely flourish. "Mental health screening" days, sponsored by the federal and state governments, held at public schools and through federally-subsidized businesses and organizations help to gather up people for diagnosis and treatment (Santora and Carey, 2005; Lenzer, 2004). When psychiatrists and other "mental health professionals" participate in these state activities, we have institutional psychiatry functioning within the context of formal social control (formal social controls are any means of control implemented by the state).

Social policy refers more to relational and self control, both forms of informal social control, where people are left to their own devices, and as such, contractual psychiatry would most likely be at home here. Drug prohibition is a function of formal social controls. If repeal of drug prohibition were to occur, informal social controls, in the form of relational and self controls, would replace state control of drugs and the subsequent punishment for manufacture, distribution, sale, purchase and possession would be abolished. Institutional psychiatry would necessarily be abolished, and contractual psychiatry would flourish or die depending on demand.



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