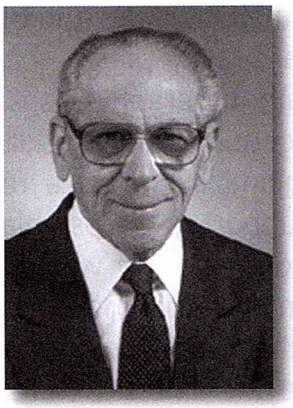

Extract from Thomas Szasz, CRUEL COMPASSION (1994), Syracuse: Syracuse University Press, pp. 152-165.

PSYCHOANALYSIS IS NOT A PART OF PSYCHIATRY

For centuries, psychotics and psychiatrists alike were banished to madhouses, located on the outskirts of cities or in the countryside. The typical psychiatrist worked in a public insane asylum, overseeing desolate scenes of human misery. Between roughly 1935 and 1955, two events radically transformed both the image and the reality of American psychiatry. One was the influx of European psychoanalysts, the other the introduction of psychiatric drugs.

Most of the European psychoanalysts who managed to escape from Nazism emigrated to the United States. London, where Freud died, became the shrine of the Freudian cult. The United States, especially New York City, where the influential analysts and their wealthy backers settled, became the movement's new power base.

Psychoanalysts were generally better educated and more cultured then psychiatrists. Thrown together in the Armed Forces, the analysts outshone the psychiatrists. Furthermore, General William Menninger, the Armed Forces' Chief Psychiatrist and the younger brother of famed Karl Menninger, was an accredited psychoanalyst. Both Menningers were talented promoters of what, in fact, was traditional, hospital-based psychiatry cloaked in the beguiling mantle of psychoanalysis. For young psychiatrists in the late 1940s, the psychoanalyst -- with cigar, or at least cigarette or pipe, perpetually between his lips -- became an irresistible role model. As a result of American psychiatry's war experience, the profession became seemingly psychoanalytic. I say seemingly because the influence of psychoanalysis on psychiatry was purely cosmetic, imparting to it its pretentious jargon and bogus therapeutic claims, but not its authentic spirit.

Drafted into the Service, psychiatrists left their hospitals and offices, donned uniforms, mingled with other physicians and, presto, became accepted as real doctors, on equal footing with other physicians. The military mad-doctor did not need to display any genuine medical skills. His status as a medical officer was enough to legitimize him as a regular physician. Also, a crucial fact of military life lent support to the psychiatrist's becoming recognized as a real doctor. Being tired of the war was defined as a bona fide disease, "battle fatigue"; servicemen exhibiting symptoms of it were diagnosed as "neuropsychiatric casualties"; and, mirabile dictu, many of these patients were easily cured. Since the illnesses were non-existent, this should not have surprised anyone. For the serviceman, psychiatric disability was an honorable escape from the dangers of war. For the military bureaucracy, it was a convenient method of getting rid of unwanted personnel. Naturally, this was not the way military psychiatrists interpreted their patients' behavior, which they regarded as genuine diseases; or their own ministrations, which they regarded as genuine treatments.

When the war ended, the victorious psychiatrists returned to civilian life, determined to conquer America for psychiatry. Deutschland uber Alles lost. Psychiatry uber Alles won, and was let loose on the American population.

Meanwhile Psychiatry Loses Medical Legitimacy on the Home Front

Ensconced behind the war zone, military psychiatrists thrived on malingerers, defined as neuropsychiatric casualties. Meanwhile, back on the home front, the prisoners of America's snake pits languished in the wretchedness to which they and their keepers had become accustomed. The returning psychiatric veterans, who spent their formative years in the Service, found state mental hospital conditions appalling, reminiscent of the horrors of concentration camps. Even makeshift psychiatric wards in military hospitals provided a far more humane environment than did the best civilian state hospitals. The perennial complaints of mental patients, together with a fresh spate of exposes in the press, suddenly acquired credibility. Phrases such as snake pit and shame of the states, lifted from the titles of best-selling books, quickly gained popularity. The medical legitimacy of psychiatry, qua state hospital psychiatry, reached

its nadir. The word was out that psychiatrists were merely warehousing people. Like the picture of Dorian Grey, the portrait of the American state hospital underwent a sudden transformation, from hero to villain. The following two statements -- excerpted from the addresses of presidents of the American Psychiatric Association separated by thirty years -- tell the whole story:

***William A. White (1925): "The state hospital, as it stands today, is the very foundation of psychiatry." ***Harry C. Solomon (1958): "The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete ... [It is] bankrupt beyond remedy... and should be liquidated as rapidly as possible."

Unfortunately, both the psychiatrists' blind support of the state mental hospital as a therapeutic institution and their righteous rejection of it as an anti-therapeutic institution were insincere and wholly self-serving.

THE PSYCHOANALYTIC INTERLUDE

The advent of psychoanalysis and office-based psychotherapy in the early decades of the twentieth century introduced a new element into the established social-economic order of psychiatry. Traditionally, being a psychiatrist meant being an employee of a state hospital. In most of Europe, Jewish doctors could therefore not become psychiatrists. However, they could become general practitioners and neurologists, or so-called nerve doctors, listen and talk to their patients, call it "psychotherapy" or "psychoanalysis," and sell their services to fee-paying customers. Psychoanalysis thus came into being as part of the private practice of medicine, then one of the so-called free professions. The psychoanalytic patient, like the customer of any service supplied by entrepreneurs in the free market, sought out the analyst, went to his office, received a service, and paid a fee for it. The client was on top, the therapist on tap.

The practice of psychoanalysis sprouted in the soil of the free market and depended on it for its integrity and survival. But Freud and the early analysts neither understood the market nor supported its values. They only took advantage of it, like spoiled children taking advantage of wealthy parents. No sooner did Freud get on his feet, economically and professionally, than he embraced the style of the conquering hero, to

which he always aspired. In 1900, he wrote: "I am not at all a man of science, not an observer, not an experimenter, not a thinker. I am by temperament nothing but a conquistador -- an adventurer, if you want it translated..." Four years later, he added: "I have never doubted [my] posthumous victory." To Jung he announced that psychoanalysis must "conquer the whole field of mythology." Freud's self-image as a "conquistador" thus meshed perfectly with his ambition to conquer psychiatry for psychoanalysis. Clearly, neither Freud nor the Freudians had any intention of honoring the promises implicit in the psychoanalytic contract.

Freud and his expansionist followers were not satisfied with limiting themselves to their contractually defined role, aspiring instead to be magical healers in the grandiose tradition of medical-messianic quacks. They claimed, and themselves came to believe, that they were treating real diseases and that their treatment was more scientific and more efficacious than that offered by other medical specialists. Few European or British psychiatrist bought this boast. However, many influential American psychiatrists did. This is the reasons why psychoanalysis was so readily integrated into American psychiatry. Fifteen years after visiting the United States, Freud reminisced: "As I stepped on to the platform at Worcester to deliver my Five Lectures on Psycho-Analysis, it seemed like the realization of some incredible day-dream: psycho-analysis ... is recognized by a number of official psychiatrists as an important element in medical training." After World War I, American state hospital psychiatrists embraced psychoanalysis, and the analysts gratefully reciprocated by embracing coercive-statist psychiatry.

Psychoanalysis Has Its Moment of Glory

Unlike in Europe, psychoanalysis was well received in the United States. However, this friendly reception, as I noted, rested on the totally mistaken belief that psychoanalysis was an effective method for treating mental illness. During World War II, the status of psychoanalysis was elevated, while its integrity was utterly destroyed, by the analysts' uncritical acceptance of their role as agents of the Armed Forces.

Long ago, civilian society delegated to the psychiatrist the task of separating the sane from the insane. In the military, he was assigned the analogous task of separating those fit and willing to fight and die for

their country from those unfit and unwilling to do so. This job required fabricating appropriate pseudomedical explanations for why people are unwilling to die in battle. Psychoanalysts, adept at explaining why anyone did anything, took to their military role like the proverbial duck to water. Many were recent refugees from Nazism. Grateful to their adopted country, they were happy to do the bidding of the military authorities: They found "neuropsychiatric casualties" by the millions. The pragmatic necessities of the military thus found a loyal ally in psychoanalytic theory. This was an utterly phony, albeit expedient, use of psychoanalysis. The upshot was that psychiatrists spouting psychoanalytic jargon enjoyed a brief moment of glory as professionals valued for their arcane knowledge and ardent patriotism.

During the war, psychoanalysis and psychiatry were joined together, much as a veneer of fine mahogany may be bonded to the body a cabinet made of common pine. For a brief period, the glamor and prestige of this superficially psychoanalyticized psychiatry carried over into civilian life. But it was all show, devoid of substance. Chairmen of psychiatry departments in medical schools, directors of state hospitals, and psychiatrists in private practice who used ECT (electroconvulsive therapy) on their patients all displayed psychoanalytic credentials and spoke in psychoanalytic jargon. In the process, the tiny nucleus of truth in psychoanalysis vanished, and "psychoanalysis" became a corrupt cult that had forsaken and forgotten its core values.

The Incompatibility of Psychiatry and Psychoanalysis

Like the core elements of the classic concept of liberty, the core elements of psychoanalysis are best stated as negatives, that is, as the absence of factors antagonistic to its aims and values. Political liberty is the absence of the coercions characteristic of the traditional relations between rulers and ruled. Similarly, psychoanalysis is the absence of the coercions characteristic of traditional relations between psychiatrists and mental patients. Consider the contrasts. The psychiatrist controls and coerces, the psychoanalyst contracts and cooperates. The former wields power, the latter has authority.

Political liberty is contingent on the state's respect for private property and its non-interference with acts between consenting adults.

Psychoanalysis is contingent on the therapist's respects for the client's autonomy and his non-interference with the client's life. This (ideal) psychoanalytic situation represented a new development in the lunacy trade, introducing into psychiatry and society a new form of "therapy," one in which the expert eschewed coercing deviants and housing dependents, and confined himself to conducting a particular kind of confidential dialogue. In the psychoanalytic situation, there is, in the medical and psychiatric sense, neither patient nor doctor, neither disease nor treatment. The dialogue between analyst and patient is therapeutic in a metaphorical sense only. Purged of jargon, the psychoanalytic "procedure" consists only of listening and talking. So conceived, psychoanalysis undermined rather than supported psychiatry as a medical specialty and extra-legal system of social control.

When Freud remarked "that analysis fits the American as a white shirt the raven," he would have been closer to the mark if, instead of "American," he had said "psychiatrist" or "psychiatry." Psychiatry did not acquire, and could not possibly have acquired, any of the real substance of psychoanalysis. The two enterprises rested on completely different premises and entailed mutually incompatible practices. The typical psychiatrist was a state-employed physician who worked in a mental institution; the typical psychoanalyst (often not a physician) was a self-employed provider of a personal service who worked in his private office. The typical psychiatric patient was poor, was cast in the patient role against his will, and was housed in a public mental hospital. The typical psychoanalytic patient was rich (usually wealthier than his analyst), chose to be a patient, and lived in his own home (or a hotel). The marriage between the psychiatrist and the psychoanalyst was a misalliance from the start, each party disdaining and taking advantage of his partner. Psychiatry acquired the worst features of psychoanalysis -- a preoccupation with sex and the past, an elastic vocabulary of stigmatizations, and a readiness for fabricating pseudo-explanations. Psychoanalysis acquired the worst features of psychiatry -- coercion, mental hospitalization, and disloyalty to the patient. Bereft of professional integrity, post-war American psychiatry relapsed into its old habit of embracing prevailing medical fashions, which, as it happened, was more-drugs-and-less-discourse. The curtain was now ready to go up on the next act in the drama of modern psychiatry, the tragi-comic episode called "deinstitutionalization."

I want to insert a personal note here. In 1955, when the Mental Health Study Act was passed by Congress, I was a lieutenant commander in the U.S. Naval Reserve, serving my required tour of duty at the National Naval Medical Center in Bethesda, Maryland. In 1961, when Action for Mental Health appeared, I was a professor of psychiatry at the SUNY Health Science Center in Syracuse, New York, and had just published my book, The Myth of Mental Illness. It seemed to me then -- and I have had no reason to change my opinion -- that there was something ominous about the Congress of the United States of America removing mental illness from the nether regions of psychiatry, law, journalism, and popular prejudice, and placing it, with the stroke of a legislative pen, in the category of genuine illness. Yet, psychiatrists, the families of mental patients, and the general public regarded, and continue to regard, using the political process to define mental illnesses as brain diseases as momentous scientific as well as moral progress. Laurie Flynn, Executive Director of the National Alliance for the Mentally Ill (NAMI), declared:

Spurred on by the aggressive advocacy of NAMI families, the federal government has finally taken action to place the brain back into the body. Congress in June [1992] approved legislation to return the National Institute of Mental Health under the umbrella of the National Institutes of Health. ... Moving NIMH to NIH sends an important signal that mental illness is a disease, like heart and lung and kidney diseases.

Two hundred years ago, to unite North and South in a political marriage of convenience, the Founding Fathers classified black slaves as a "three-fifths persons." Since the 1960s, to manage certain human tragedies and political-economic problems, the leaders of our Therapeutic State have classified millions of troubled and troublesome persons as patients, like diabetics, but yet also as unlike diabetics, their mental illnesses justifying doctors to hospitalize and treat them against their will.

indeed: The federal government behaved as if it really believed the psychiatric cliche that "mental illness is like any other illness."

Prior to deinstitutionalization, it was generally acknowledged that real doctors did not want to treat mental patients, real hospitals did not want to admit them, and real patients did not want to associate with them. Accordingly, people with bodily diseases were treated in regular

hospitals, and people with mental diseases were treated in psychiatric hospitals. The time had come to abolish psychiatric segregation. Medical patients and mental patients were "integrated" by means of the familiar combination of coercion and bribery.

For reasons with which we are familiar, the cost of medical care, especially hospital care, began to rise rapidly after the war. Soon there was an outcry for cost controls. The quickest way to accomplish that was by limiting reimbursement for the most expensive type of medical service, namely, inhospital care. This decision led to dramatic reductions in hospital stays for medically and surgically ill patients. Many diagnostic and therapeutic procedures, previously performed on inpatients, were transferred to outpatient settings. Before long, hospitals stood half empty. Between 1965 and 1985, thanks to "Medicare's new prospective-payment system plus other cost-containment measures ... occupancy rates at many hospitals [fell] to less than 50 percent." Yet, this did not result in the creation of thousands of homeless arthritics, diabetics, and hypertensives living on the streets and assaulting people on subway platforms.

The story of the integration of medical and mental patients under one roof does not end here. Indeed, this is where the serious part of saga begins. In psychiatry, coercion is never far from center stage. Prior to 1965, most health insurance policies provided no coverage for mental diseases, just as most life insurance policies did not cover suicide. Medicare and Medicaid changed this too. State legislatures began to compel the health insurance industry to cover the cost of hospital treatment for mental illness as if it were like any other illness. Again, psychiatrists were ecstatic. A jubilant editorial in the American Journal of Psychiatry declared: "The 'remedicalization' of psychiatry ...[and] the provision of psychiatric care within the mainstream of medical economics [have generated] ... a broad movement toward the privatization of health care [that] is now a 'megatrend' in mental health economics." Since psychiatric patients rarely pay for their care, calling this trend "privatization" is perhaps an even more egregious misuse of language than calling misbehaviors "diseases" and madhouses "hospitals."