THIRTY-THREE

INTERVIEW

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THE NEW PHYSICIAN: Dr. Szasz, what do you mean when you say that mental illness is a myth?

SZASZ: Disease means bodily disease. Gould's *Medical Dictionary* defines disease as a disturbance of the function or structure of an organ or a part of the *body*. The mind (whatever *it* is) is not an organ or a part of the body. Hence, it cannot be diseased in the same sense as the body can. When we speak of mental illness, then, we speak *metaphorically*. To say that a person's mind is sick is like saying that the economy is sick or that a joke is sick. When metaphor is mistaken for reality and is then used for social purposes, then we have the makings of myth. I hold that the concepts of mental health and mental illness are mythological concepts, used strategically to advance some social interests and to retard others, much as national and religious myths have been used in the past.

THE NEW PHYSICIAN: But why are people called mentally ill, if, as you say, they are not *really* ill?

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SZASZ: Modern psychiatry may be said to have developed from the refinements of three interrelated phenomena: neurological diseases, malingering, and conversion hysteria. Neurological diseases are diseases of the nervous system, like neurosyphilis or multiple sclerosis. They present no conceptual problem. The problem for modern psychiatry really begins with persons who appear to have a neurological disease—seem to be paralyzed or blind—but who, when medically examined, display no abnormal neurological signs. In other words, they are physically normal and only mimic the picture of a neurological illness. Until the second half of the 19th century, persons of this kind were generally categorized as malingerers; that is, not sick. Modern psychiatrists, beginning with Charcot, and then much more actively, with Freud, claimed that these people were sick suffering from an illness called "hysteria," and that they ought to be treated as patients. Two very important things were involved in this process of reclassification. One was the extension of the concept of illness from bodily disorder per se to what only looks like a bodily disorder but is actually a so-called mental disorder. The second was the recognition of the *sick role* as a sufficient criterion of illness (even in persons with healthy bodies), so that hypochondriacs,

homosexuals, criminals, and people with all kinds of other deviant conduct could be, and were, classified as ill, mentally ill. With the development of modern psychiatry, the whole concept of illness has expanded; indeed it has become an almost infinitely elastic category capable of including anything psychiatrists want to place in it.

THE NEW PHYSICIAN: Dr. Szasz, could you elaborate on the distinction between illness as a bodily disorder and the sick role, as a social performance?

SZASZ: Yes, I think this is a very important distinction. I believe that much confusion in psychiatry is due to a failure to distinguish between these two elementary concepts and the phenomena they designate.

Strictly speaking, an illness is a biological or physicochemical abnormality of the human body or its functioning. A person is sick if he has diabetes, a stroke, or cancer. Such diseases are physicochemical events, similar to natural events like solar eclipses or typhoons—except that they happen to the human body. It is important to emphasize that medical diseases are things that *happen* to human bodies, rather than things that people *do* with their bodies.

The sick role, on the other hand, is not a biological condition but a social status; it refers to a status of claiming illness by, for example, complaining of pain, fever, or weakness, and/or seeking medical attention. Like other social roles, such as father, husband, soldier, or college student, the sick role denotes a certain kind of relationship to other people in society.

THE NEW PHYSICIAN: Could you give an example?

SZASZ: The example of the person afflicted with cancer is a good starting point. Inasmuch as he suffers from a malignant growth it might be perfectly obvious to himself and others that he *is* sick; that is to say, he has an abnormal biological condition. This is a fact, just as it is a fact that he has brown eyes or blue.

If this man wants medical help he goes to a doctor or a hospital, then he assumes the role of patient, the sick role. This, too, is a fact. It's a social fact—just as real as that he is rich or poor, Christian or Jewish.

Finally, this individual—and note my choice of the word "individual," *not* "patient"—may choose not to go to a doctor or to a hospital. Indeed, let me make the point strongly, if he decides, because he fears physicians or thinks poorly of what medicine could do for him, that he just wants to stay at home, live as long as he can in peace and quiet, and then commit suicide—then this person cannot, and must not, be considered a patient. In other words *he is sick, but he is not a patient.* This may sound strange, at first hearing, because we—and I mean especially physicians, but to a lesser extent everyone—are used to calling everyone who is sick a patient. This is, of course, terribly sloppy thinking and speaking; it's like calling everyone who breaks the law, or is suspected of breaking the law, a criminal—instead of reserving this term only for those convicted of lawbreaking.

THE NEW PHYSICIAN: You mean that a person is a patient only if he volunteers for the role?

SZASZ: No, it's more complicated than that. But first, I must restrict my comments to medical patients. We must clarify our ideas with respect to this group before we can hope to see clearly the problems posed by so-called mental patients.

The concept of "medical patienthood" implies three distinct variables: (a) the individual's actual state of bodily illness or health; (b) his claim to, or rejection of, the status of patient; and (c) the acceptance or rejection by others of his claim to that status. Let me indicate the permutations that this makes possible; these are real, everyday situations.

(1) The person is sick; claims to be sick; and is perceived as sick by others. This is the "ordinary" sick patient.

(2) The person is sick; claims to be sick; but is

perceived as not sick by others (e.g., the diagnosis is missed, as in an early case of cancer of the pancreas).

(3) The person is sick; claims to be not sick; and is perceived as sick by others (e.g., drug-intoxicated individual). This is the sick involuntary patient.

(4) The person is sick; claims to be not sick; and is perceived as not sick by others (e.g., the ill person in the latent or prediagnostic period of his illness).

(5) The person is not sick; claims to be sick; and is perceived as sick by others. This is the person who "malingers" and whose pretended illness and claim to patienthood are accepted by others.

(6) The person is not sick; claims to be sick; and is perceived as not sick by others. This is the person who "malingers" and whose pretended illness and claim to patienthood are rejected by others.

(7) The person is not sick; claims to be not sick; but is nevertheless perceived as sick by others (e.g., the healthy person mistakenly diagnosed as sick).

(8) The person is not sick; claims to be not sick; and is perceived as not sick by others. This is the "ordinary" healthy person.

THE NEW PHYSICIAN: In other words, biological illness and the sick role vary independently.

SZASZ: Yes, exactly. This can be illustrated very simply. A person may be ill, and often is, but may prefer not to assume the sick role. We often do this, for example, when we have a cold but go to the office or theater. Conversely, a person may not be ill, but may prefer to assume the sick role; we often do this, for example, when we offer illness as an excuse for avoiding an unpleasant obligation, like going to a party or meeting. Soldiers, housewives, and other oppressed people have traditionally assumed the sick role, to avoid the dangers of combat or the drudgeries of child-care. Whether this is "malingering," "hysteria," or some mysterious disease of the brain caused by a lack of vitamins, enzymes, or God-knows-what, or whether it is best conceptualized as not a disease at all—this is what much of psychiatric theory and controversy is all about.

THE NEW PHYSICIAN: Now, how do you apply these concepts to mental illness? To schizophrenia, for example?

SZASZ: I view all behavior—"well" or "sick"—in the framework of symbolic action, or roles and games (in the serious, not frivolous, sense). This means that we can't talk about the problem as one of "mental illness" or "schizophrenia." Instead, we must identify it in behavioral terms, or, as I like to put it, in plain English. For example, let us assume that when we are talking about schizophrenia we mean a social situation where a person makes a patently false, self-aggrandizing claim. A poor, socially insignificant man may thus claim that he is Jesus; or a poor, socially insignificant woman, that she is the Holy Virgin. If you look at this phenomenon simply, without any complicated psychiatric preconceptions or pretentions, you will notice that, whatever the *reason* for their action, such people make *false claims* about themselves. They impersonate; they pretend to be someone or something they are not. To me this is more like cheating in a game, or like fraudulent advertising—than it is like cancer or pneumonia.

The simple fact, then, is that in such cases we deal with conflicting claims, not with diseases. One man says he is Jesus, and another says he is not. The second half of this sentence—namely, that the psychiatrist says, indeed *insists*, that the person is not Jesus—has been completely overlooked in psychiatry. Why should the psychiatrist do this? The man who says he is Jesus is *not complaining—he is boasting!* Why shouldn't the psychiatrist leave him alone? These questions highlight the psychiatrist's role in such a situation.

But my point here is that a psychiatric problem or diagnosis (or at least one very common type of

such problem or diagnosis) does not arise until there is a conflict of claims such as I have sketched earlier. For example, when Fleming made certain claims about penicillin, the claims were verified, and he was acclaimed as a great man. When Ivy made certain claims about Krebiozen—well, you know what happened. But we should not get lost here in the problem of who is right. Sometimes correct claims are contradicted and disallowed—that's what happened to poor Ignaz Semmelweis. Sometimes incorrect claims are accepted and honored—that's how I, at least, view the awarding of a Nobel Prize to Egas Moniz for his great discovery of how to treat schizophrenia: by amputating the frontal lobes of the brain!

In certain cases of interpersonal and social conflict, then, it sometimes happens that one party defines the other as "mentally sick" or "schizophrenic." This is one of the "solutions" our society provides for resolving such conflicts. In this sense, "schizophrenia" is an assigned or ascribed role—like convict or draftee. If we only looked at the "psychotic" as an individual cast in a role he does not want to be in—cast in it by his "loved ones," by his employer, by his psychiatrist, by society generally—we would at least be in a position to start to deal honestly with what we now call, quite misleadingly, the problem of "serious mental disease."

THE NEW PHYSICIAN: How does your emphasis on the fact that the psychiatrist deals with conflict, rather than disease, relate to your views on what the psychiatrist does?

SZASZ: In the face of conflict, there are three alternatives, and three only: you side with one party, or with the other, or you try to remain neutral and act as an arbitrator. Psychiatric interventions, so-called psychiatric "treatments," are actually a confused and confusing mixture of these kinds of social actions.

THE NEW PHYSICIAN: Can you give examples of each?

SZASZ: Yes. When a person goes, on his own accord, to a psychotherapist, a psychoanalyst, pays him for his services, and enlists his aid to help him pursue his self-defined interests—for example, to become sexually more potent, or to be able to secure a divorce without feeling excessively guilty—in such cases, if indeed the therapist *contracts* to deliver this kind of service to the patient, we deal with psychiatric interventions on behalf of the patient. On the other hand, when a person is committed to a mental hospital as a schizophrenic—by his mother or wife—the psychiatrist has a contract with the state to do something *against, not for,* the patient's self-defined interests. This should be obvious. In the case of involuntary mental hospitalization, the patient's self-defined interest is, first of all, to be left alone by the psychiatrist. The very fact that the psychiatrist accepts this individual as a "patient" defines him as the patient's adversary, not his ally. Finally, when the psychiatrist is paid to "evaluate" individuals—for the draft board, the Peace Corps, and so forth—then he acts, or tries to act, as an arbitrator or judge.

THE NEW PHYSICIAN: Which of these psychiatric functions do you consider the most important?

SZASZ: From a psychotherapeutic point of view, the most important intervention is when the psychiatrist acts as the patient's agent. Morally, if not technically, this is similar to what the physician does. He helps, or tries to help, his patient. If the patient does not want help, he leaves the physician. Although what happens technically may be largely under the control of the physician, *the fact that it happens* is entirely under the control of the patient. I refer here to the fundamental civil right, in American society at least, to *reject medical treatment.* The individual in a totalitarian society does not have this right. Ostensibly, he has a "right to treatment," but actually, this means that the doctor, as an employee of the state, is in control of the medical relationship. This same type of control—that is, power over the patient, backed by the coercive apparatus of the state—has characterized the role of the alienist, of the psychiatrist, for the

past 300 years. This is why, from a social point of view, I consider the most important psychiatric intervention the commitment, the involuntary mental hospitalization, of the so-called mentally ill.

THE NEW PHYSICIAN: Why do we have commitment?

SZASZ: One of the standard contemporary justifications for commitment is the claim that mental patients do not know they are mentally ill and hence must be confined for their own protection. In my opinion, it's pure rhetoric. Look how similar this contemporary psychiatric claim is to the medieval religious claim that individuals who rejected the beliefs of the religious authorities were "misguided" and had to be converted to the "true faith," for their (that is, the victims's) own benefit. This posture justified the use of unlimited force and fraud by inquisitors against heretics, and now justifies the use of unlimited force by and fraud by institutional psychiatrists against involuntary mental patients.

As I see it, the basic issue in commitment is the need for the control of social relationships and social conduct, and the problem of by whom and how this control should be exercised. As I mentioned, in the past such *social control*—for that's what we are talking about—was exercised under the aegis of religious ideologies and by religious institutions. Since the scientific revolution, there have been two principal methods of exercising such controls: the criminal law and the mental hygiene law. Those who break the law may be controlled by means of the criminal law. Those who do not break the law but annoy or disturb others—or whom others can successfully persecute or make into scapegoats—may be controlled by means of the mental hygiene law; that is, they can be stigmatized as "crazy" and locked up in mental hospitals.

THE NEW PHYSICIAN: Are you saying that the intervention of the medical doctor is for the patient, whereas that of the psychiatrist is for society?

SZASZ: Not quite. As you know, I make a very sharp distinction between at least two kinds of psychiatry. One is to help the patient, even if it harms society; the other is to help society, even if it harms the so-called patient. The two have nothing in common; indeed, they are mutually antagonistic. I analogize these two psychiatric functions to the two typical functions of the law in the criminal trial: prosecution and defense. These are not two similar interventions, they are antagonistic interventions. Most of psychiatry—historically, socially, economically—is prosecutorial psychiatry; it is psychiatry to help society, and harm the "patient." Now, what I can't emphasize too much is that it is a central characteristic of contemporary psychiatry *not* to make this distinction—indeed, not to allow it to be made. To insist on the difference, as I do, is sometimes considered unprofessional conduct. After all, the conventional psychiatrists say that the psychiatric physician always tries to help his "patient." You see, this is why it is so useful to define the "psychotic" as someone crazy, someone who does not know what's wrong with him and what he needs. Once this imagery is accepted, the psychiatrist can define anything he does—no matter how harmful to the patient, no matter how much resisted by the patient—as "therapeutic," serving the "patient's best interests." Look through any textbook on psychiatry, and you will not find this distinction between the two psychiatries. The "diagnosis" and "treatment" of voluntary and involuntary patients is all lumped together, as if it were all the same thing. Well, if that's how you start, how far can you get?

THE NEW PHYSICIAN: This distinction between voluntary and involuntary patients is evidently crucial to your whole thinking about psychiatric problems. Is it because of your view that the psychiatrist deals with human conflicts rather than medical diseases?

SZASZ: Yes. But, actually, my analysis of psychiatric problems rests not only on a distinction between the practice of psychiatry on voluntary and involuntary patients, but also on two related

distinctions. The first is that between what constitutes a "psychiatric problem" for the self (the client or patient), and what constitutes such a problem for others (the "patient's" relatives, institutional psychiatrists, etc); and the second is the distinction between the assumption of the role of "mental patient" by the self and its ascription to others.

THE NEW PHYSICIAN: Do the people who work in state mental hospitals make this distinction between voluntary and involuntary patients, and the two corresponding kinds of psychiatric interventions?

SZASZ: Of course, they realize this distinction privately and I think they often suffer from the conflicts and turmoil of their work. But, officially, they do not make such a distinction. How could they? It would render their work, first, nonmedical—and the institutional psychiatrists, perhaps because what they do is so obviously nonmedical, always insist that their work is medical and can be done only by doctors; and second, it would render it non-therapeutic, indeed, antitherapeutic or noxious. This explains, I think, why institutional psychiatrists—even more than psychoanalysts (though they do it, too)—cast their activities into the idiom and imagery of medicine and therapy. After all, when you control bleeding in an accident victim, you are "treating" the person whether or not he has consented to your intervention. Wouldn't it be just lovely if the same imagery would apply to the maniacal "patient" whose "illness" consists of drinking too much and assaulting his wife, and perhaps also assaulting the policemen who come to take him to the mental hospital? When he is given Thorazine—if necessary, by injection while being held down by burly attendants—is that similar to or different from the accident victim's treatment? And when such a person's imprisonment—for weeks, months, years, often for life—can also be defined as "treatment," as commitment is, obviously we have a professional imagery and rhetoric that's immensely useful for those who deal with involuntary mental patients.

THE NEW PHYSICIAN: You are describing a rhetoric of helpfulness used to conceal interventions which the patient experiences as punitive. Is that your objection to it? If the nature of the services or interventions was made clear as penalties for certain kinds of behavior, I take it you would favor that.

SZASZ: Not quite. Certainly, I would favor making a clear and honest distinction between psychiatrists who are for and those who are against the patient—as we now do between district attorneys and defense attorneys. When someone is in trouble with the income tax authorities or is accused of a criminal offense, he does not go to the district attorney for help. So one really can't speak of "services" as "penalties"—that's a contradiction. A service may be useless, even harmful, but it can't be a penalty. To have a penalty, to impose a penalty on a person—one must use force or fraud on him. In other words, one must either fool him or coerce him or preferably do both. If the distinctions I have outlined were made more openly, and were recognized more generally, several consequences would follow. First, some of the things now considered "services" could not be offered under that rubric; second, some other "services"—like commitment to mental hospitals—might not even be tolerated as criminal sanctions.

Again, the point here is that contemporary psychiatry and what is often, I think euphemistically, called "mental health education," is devoted to confusing, not to clarifying the distinction between voluntary and involuntary psychiatry, or between the psychiatrist as the patient's agent and the agent of the patient's adversaries, or between psychiatric interventions for "therapy" and for "punishment."

THE NEW PHYSICIAN: Dr. Szasz, you seem to be opposed to involuntary mental hospitalization under any circumstances. Are there no situations

when commitment, involuntary medication, or shock treatment, and similar psychiatric procedures, are good things, useful interventions?

SZASZ: There are none. I am unqualifiedly opposed to involuntary mental hospitalization and treatment. To me, it's like slavery: the problem is not how to improve it, but how to abolish it.

Now, as to the question of the "usefulness" of commitment and other involuntary psychiatric interventions—to me, this is not a question of *when* such things are useful, but rather *for whom*. To put this sort of thing in terms of "indications" as if it were penicillin or digitalis is quite false. There are *always* indications for commitment, and there are *never* indications for it. It depends on whether you are for it or against it.

From a purely practical point of view, whenever commitment occurs, it *is* indicated or useful. Otherwise it would not occur. Someone has to *want* to commit a person, otherwise that person would not be committed. Now, for the person who wants the commitment, it's useful. It's as simple as that. In other words, commitment is *always* useful for the committers, for the patient's "loved ones," and others who are annoyed or disturbed by him. My analogy between commitment and slavery is not just a dramatic figure of speech. It should be taken quite seriously. When you ask, "When is commitment useful or when is it indicated?" you might as well ask, "When is Negro slavery useful or indicated?" The answer is obvious. Negro slavery is always a good idea for white men, assuming that they prefer not to work and have Negro slaves do the work for them. Similarly, commitment is always a good idea. It's always indicated, for those on the outside, for the "mentally healthy." That's why it's so popular. As long as there are more people outside of mental hospitals than inside, commitment will probably have some appeal. Similarly, so long as there are more white men in a country than black, some kind of discrimination against black men, if not their outright enslavement, will be popular, and vice versa (at least until human nature changes in some fundamental way). You see, I believe there is such a thing as evil. Most of my psychiatric colleagues never use that word; they prefer the term "mentally ill."

THE NEW PHYSICIAN: But how about the suicidal person? We prevent his suicide, and the chances are that when he recovers from his depression he will thank us for saving his life.

SZASZ: You are talking medicalese and psychiatrese. Let's speak English. What depression? What recovery? You have raised a complex moral question but are dealing with it as if it were a medical question. I just won't go along with that. I have discussed this problem in detail in my book, *Law, Liberty, and Psychiatry*,[1] and can only give you my conclusions. First, you must ask the question, "Who owns a person's life?" If the person does, then perhaps he has the "right" to destroy it; if he doesn't, then other implications follow. Second, you imply that good ends, namely, the prolongation of life, justify questionable means, namely, locking someone up in an insane asylum and probably stigmatizing him for life. I, for one, don't believe that. Third, you imply that physicians, especially psychiatrists, know when a person is going to kill himself, when he is a "suicidal risk." Well, of course, sometimes they do, and sometimes they don't. But there is obviously nothing easier than to *ascribe* suicidal intent to someone in order to justify controlling him, committing him. You don't say anything about what kinds of safeguards might be necessary to prevent such false ascription, even if one were to grant (as I don't for a minute) that the prevention of suicide by means of force and fraud (that is, involuntary hospitalization and deceptive diagnostic rhetoric) is a legitimate psychiatric activity.

THE NEW PHYSICIAN: Still, what about a person who, having taken an overdose of pills, comes to an emergency room voluntarily thereby putting himself in a position where he can be committed to a mental hospital?

SZASZ: Well, of course, that's the way things are now. But by not succeeding with the suicidal act—that is, by not being dead, but instead by being a chemically poisoned, and hence sick, person—such an individual has, in effect, made himself into a medical patient. The proper place to treat him therefore is a medical hospital. Moreover, since he comes to the hospital voluntarily, there is obviously no need to commit him. It is precisely because such a person runs the risk of commitment that he may not go to a doctor or a hospital. Commitment is antitherapeutic. There are people who want medical and other care for their depression or dissatisfaction with life, and their suicidal ideas, and their case is jeopardized by the present concepts and legal status of psychiatry.

THE NEW PHYSICIAN: How should this be changed?

SZASZ: Involuntary mental hospitalization should be abolished just as Negro slavery was abolished. It is an unqualified moral evil. There should be no such thing. There should be no place called a hospital from which a person cannot walk out without any further ado or by signing a piece of paper—that is, leaving against medical advice.

THE NEW PHYSICIAN: But would it be possible to do away with involuntary mental hospitalization? There are hundreds of thousands of people in mental hospitals, most of them on a committed status. What would happen to them if you just opened the doors and said, "O.K., you can leave"?

SZASZ: Well, of course, it would be possible.

THE NEW PHYSICIAN: What would happen?

SZASZ: What do you think would happen?

THE NEW PHYSICIAN: Many would stay.

SZASZ: Correct. Many would stay because they are poor, disabled, have no other place to go. In this sense, the mental hospital is an asylum. That's a nice, old term for insane asylum—but without the "insane." Civilized people ought to provide such places. The Salvation Army does, for example. Homes for the homeless. Orphanages for adults. But this has nothing to do with medicine. You don't need doctors to run such places. You don't even need psychologists or social workers. Just decent people.

THE NEW PHYSICIAN: That way there would be no need for medicine or psychiatry to feel guilty that there are so few doctors in state mental hospitals.

SZASZ: Right. But it goes further than that. Millions of dollars could be saved that now go to prop up the stage-settings, so to speak, of a fraudulent and wasteful pseudomedical enterprise. This could be spent simply on food and lodging and the kind of help that people who would stay in such places would want and could use, like rehabilitation, job training. Also such a place could be just a haven where people could be left alone, away from annoying relatives.

THE NEW PHYSICIAN: What about those people who, if there were no commitment, would want to leave, but who are considered dangerous or who are criminals?

SZASZ: Here again I should like to refer you to *Law, Liberty, and Psychiatry*, where I answer this question in detail. Briefly, my position is that no one should be deprived of liberty without due process of law and, to me, due process includes the concept that the only justification for loss of liberty is the commission of an illegal act. In other words, if someone is suspected of lawbreaking, he should be accused, tried, and, if convicted, sentenced. If the sentence calls for loss of liberty, he should be confined in an institution that's penal, not medical, in character. I don't think doctors should be jailers. That's what hospital psychiatrists are now. I say, a man who locks up someone is a jailer, even if he has an MD and wears a white coat. If jails are bad, and of course many are, they should be improved. Placing lawbreakers, or suspected law-breakers, in mental hospitals against their will is not a proper substitute for prison reform.

THE NEW PHYSICIAN: Many people who are committed to mental hospitals are diagnosed as schizophrenic, like a person who says he is Jesus Christ. What should be done with them?

SZASZ: It's very important to specify who these people are, what they do and to whom, and so forth. For example, is your hypothetical schizophrenic a clerk in the post office, doing a perfectly acceptable job, not bothering anyone, but who is expressing some peculiar ideas at home to his widowed mother? If so, then the problem, on the first level, at least, is what can she tolerate, how can she handle the son. She could throw him out if it's her house and if she is prepared to live alone; but, of course, it's easier for people in this sort of situation to define their offending relative as crazy and have him committed.

Let's change the situation a little, and assume that the person offends people in society—in stores, bars, at the office. Let's assume that the person goes around and makes some sort of megalomaniacal claim to anyone who will listen. He is a general nuisance. We deal here with socially deviant, obnoxious behavior, but with behavior which does not qualify as lawbreaking, as crime. The correct analogy here is not to disease (like cancer or pneumonia) but to religious deviance in a theological society. In other words, much of what we now call schizophrenia (and mental illness, generally) is similar to being Jewish in 15th-century Spain. In medieval Spain, you were supposed to be a Catholic, not a Jew; in contemporary America, if you are an insignificant clerk or blue-collar worker, you are supposed to be that and not make fraudulent claims about who you are or want to be. The question is how much tolerance does society show toward certain kinds of deviance? What kinds of deviance are permitted, and what kinds prohibited?

THE NEW PHYSICIAN: So some people who somehow or other fall outside of what society allows may end up in mental hospitals labeled as schizophrenic.

SZASZ: That's what the label really means. Still, people are looking for chemical abnormalities in the brain. Of course, some people may have brain diseases which we don't know anything about yet; and some of the people with these, as yet unknown, brain diseases may be "schizophrenics"—and others may not be, they may be "normal" citizens. I do not deny or minimize the importance of the body as a physicochemical machine that may malfunction. On the contrary, it's because I value so highly the basic biological understanding of how the body and brain work that I want to distinguish clearly between biological abnormalities and deviant role performances. Both are important.

THE NEW PHYSICIAN: But how do you know that schizophrenia is a deviant role performance?

SZASZ: I did not say that "schizophrenia" was a deviant role performance. I am not quibbling. I don't know what schizophrenia *is*. Or rather, it's just a word. When I was speaking about role deviance what I meant was that if Dr. Smith considers Mr. Jones's behavior socially deviant in certain ways, then he is likely to call Mr. Jones a schizophrenic. This is a statement about their relationship, not just about Mr. Jones or his "mind."

Another way of putting this would be to say that "schizophrenia" is a strategic label, like "Jew" was in Nazi Germany. If you want to exclude people from the social order you must justify this to others but especially to yourself. So you invent a justificatory rhetoric. That's what the really nasty psychiatric words are all about: they are justificatory rhetoric, legitimizing the removal of the people so labeled from society. It's like labeling a package "garbage"; it means: "take it away," "get it out of my sight," etc. That's what the word "Jew" meant in Nazi Germany; it did not mean a person with a certain kind of religious belief. It meant "vermin," "gas him!" I am afraid that "schizophrenia" and "sociopathic personality" and many other psychiatric diagnostic terms mean exactly the

same thing; they mean "human garbage," "take him away!" "get him out of my sight!"

THE NEW PHYSICIAN: This calls into question the whole enterprise of psychiatric diagnosis. Is diagnosis an appropriate task for psychiatry, and if so, what is its purpose?

SZASZ: Well, we are getting back to our starting point here. Unless we define clearly, and keep in mind steadfastly, what kind of psychiatry we are talking about, it is impossible to answer the question you ask. As I have explained in my various writings, there are *at least* five different kinds of psychiatry. First, there is a psychiatry that is the study and treatment of diseases of the brain; second, one that is the study and treatment of "diseases" of the mind; third, one that is the study and influencing of human behavior; and, fourth and fifth, and these are, of course, different kinds of categories, there is a psychiatry that is practiced on voluntary patients, and another that is practiced on involuntary patients. In contemporary "scientific" psychiatry, all this is mixed up. Now, if we think of psychiatry as the diagnosis and treatment of organic brain disease—paresis, toxic psychoses, etc.—then, of course, making diagnosis is just as reasonable, and indeed potentially beneficial to the patient, as it is in general medicine. On the other hand, if we think of psychiatry as the labeling of personal conduct and as a method of social intervention in such conduct, then diagnosis is just using the rhetoric of medicine to conceal the exercise of social power. In short, in the latter case, making psychiatric diagnoses is a kind of socially tolerated name-calling or libeling—like when Senator Goldwater was diagnosed schizophrenic in the newspapers. This kind of labeling is simply an effort to demean someone, to impose a social handicap on him, to destroy him socially.

THE NEW PHYSICIAN: How about the private practice of psychotherapy, where a patient comes for help to the psychiatrist and wants him to be his agent? Is diagnosis important there?

SZASZ: No, not in the traditional, medical, or psychiatric sense. There is no need to diagnose such persons. Indeed, I would say there is nothing "to diagnose." What the psychotherapist needs to establish is whether he wants to take on the individual as his patient, and whether the patient is able and willing to pay his fee. To do this properly and honestly, the therapist must, of course, make clear to his would-be client what he is "selling" and for how much. Otherwise, the potential patient cannot make an informed choice.

THE NEW PHYSICIAN: Can the diagnosis be useful to see what type of approach should be made and how long therapy will take?

SZASZ: No, I believe it can only be detrimental to these tasks.

THE NEW PHYSICIAN: Why detrimental?

SZASZ: Because a psychiatric diagnosis creates the impression in the mind of both the client and the therapist that there is some kind of disease entity or process that is being attended to, rather than some kind of simply personal, social—human—sort of thing, the same sort of thing that Shakespeare or Goethe or Arthur Miller talks about. Again, you have raised an important and complex issue, and my answer here must of necessity seem too simple or at least too brief. I have dealt with the role of diagnosis in psychotherapy in my book *The Ethics of Psychoanalysis*.[2]

THE NEW PHYSICIAN: In other words, it's not even useful to distinguish between neurosis and psychosis?

SZASZ: If you mean in psychoanalysis, or what I like to call (though it's not synonymous) private, contractual psychotherapy, then certainly it's not useful. Not only is it not useful, it's nonsense. Useful for whom? For what? If, as a therapist, you are offering to sell psychotherapy, then what you want to know is whether the patient wishes to buy it or not. If he doesn't, you may want to call him "psychotic," but if you do that, you are simply maligning him, though you may sincerely believe

that you have made some sort of highly scientific diagnosis.

THE NEW PHYSICIAN: How would you sum up your work in psychiatry?

SZASZ: I would sum it up by saying that I have tried to develop concepts and methods appropriate to a psychiatry whose problems are not medical diseases but human conflicts; whose criteria of value are not conformity to social norms or "mental health," but self-determination and responsible liberty; and which is dedicated to diminishing man's coerecive control over his fellowman and increasing his control over himself.

THE NEW PHYSICIAN: It sounds like the changes you wish to see are so great, so profound, that if they were to occur it would have to be in the distant future. I wonder what you would like to see in the near future. What goals could be worked for by physicians, psychiatrists, medical students, people interested in this whole question?

SZASZ: I should like to say, and I think this is obvious from my writings, that although the changes which I should like to see are quite major, I am firmly opposed to sudden, revolutionary changes in social affairs. Meaningful, significant, and lasting changes in human affairs can come only in a slow, gradual fashion. The problems we have been talking about pertain to human nature and to the organization of society. How does man achieve personal significance and self-esteem? Is it by creative work or by robbing others of their self-esteem? The latter alternative has always been frightfully popular, and it still is. Yet, there have been significant moral and social changes over the years. Whether mankind is "improving" or "deteriorating" morally I am certainly not prepared to discuss here and now. But the fact is that we used to have slavery, and slavery was abolished. Women, especially married women, used to be a kind of domestic chattel, and they no longer are. The criminal law used to be unbelievably harsh, prescribing the chopping off of hands for picking pockets; it has become more tame. So that insofar as psychiatry, that is, institutional psychiatry, is a repressive social institution, there is no reason to believe that it too will not be altered so that its power to oppress and victimize will be reduced.

Those who are interested in working in this direction—that is, toward reducing the coercive power of psychiatry and increasing its ability to help those, and only those, who want and seek such help—such persons could best do so, I think, by demythologizing the medical and coercive ideology of contemporary psychiatry and by putting it on a solidly humanistic, legal, and communicational foundation. I can't say more about this, it's too complex. May I refer you in this connection to *The Myth of Mental Illness*.[3]

THE NEW PHYSICIAN: You might consider yourself in a position like that of an abolitionist of the 1850's. Does this sum up your conclusion on this subject?

SZASZ: Yes, I do like to think of myself, as far as this aspect of my work is concerned, as a kind of abolitionist. Emerson has always been one of my heroes.

The logic of the situation demands either expansion or restriction—whether in slavery or involuntary mental hospitalization. If slavery is a good thing, a noble institution, beneficial both for master and slave—then why indeed not to extend its scope? Why not have more slave territories and more slaves? Similarly, if involuntary mental hospitalization is a noble medical enterprise, beneficial for both doctor and patient—then why indeed should we not extend this "service" to more and more people? That's precisely what has been happening.

THE NEW PHYSICIAN: One last question, Dr. Szasz. I know you have some ideas about why the idea of mental illness is so popular in our day. Could you conclude with a few words about this?

SZASZ: As I see it, there are tremendously powerful ideological and economic interests in Western society—especially in American society—which demand that ever-greater numbers

of people in the population be mentally disabled, or that they be regarded and treated as mentally disabled. This has to do in part with the fact that in the industrially advanced nations people are becoming increasingly superfluous and unnecessary as producers. So they must be consumers of goods and services, and what better service to consume than "mental health care"? When people consume *that,* they elevate the dignity and self-esteem of those who are doing the "servicing." How people love to volunteer nowadays for "mental health work"! In this way, people are slowly being transformed into a product on whom other people can work. We thus live in an age characterized by a tremendous need for vast numbers of "madmen" upon whom, as products or things, a large part of the rest of the population can work, and which the non-mad part can proudly support. The result is what I call "The Therapeutic State"—a state whose aim is not to provide favorable conditions for the pursuit of life, liberty, and happiness, but to repair the defective mental health of its citizens. The officials of such a state parody the role of physician and psychotherapist. It's a neat arrangement: it gives life-meaning to the therapists by robbing the "patients" of their life-meaning. Truly, this is the new frontier. We can persecute millions of people, all the while telling ourselves that we are great healers, curing them of mental illness. We have managed to repackage the Inquisition and are selling it as a new, scientific cure-all. How right Santayana was when he said that "Those who do not remember the past are condemned to relive it."

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