

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 *apostropaiois*, 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 psychi-

atric 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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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 quasicrime 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 scientific 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; detracting 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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Commentary on Szasz

G Adshead

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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may be fleeting and unstable, and may sometimes be the product of an abnormal mental state. It is therefore necessary to be cautious about automatically accepting any expressed intention to commit suicide as an inalienable right to individual liberty that must be respected. This is especially so since the choice to waive one's right to life is irrevocable.⁶

The really difficult task then is the discernment of when an intention is competently made, and when it does not reflect the real wishes of the person concerned. To begin with, there is a problem with the word "real". Peoples' intentions may change for many reasons, and are influenced by context and interpersonal relationships. Both Primo Levi⁷ and Tzvetan Teodorov⁸ describe how, in terrible circumstances, people can come to make both morally affirming and morally appalling choices. Our intentions towards people we know differ from those towards people we don't know because our relationships are different.

There are also different levels of intentionality or choice making process. There is a primary level of intention, where choices are simple: shall I put on a coat or not? A secondary level of intention involves a more complex choice making procedure, involving a degree of reflection: what do I feel about this? A third level of intention involves more complex choices still, involving not only reflection on one's own mental states, but also on those of others: how should I treat others? What sort of person do I want to be?

It is at this third level of intention that we want to be able to assess the competence of the actor: to know that her wishes represent a complex level of decision making about herself and her values. Unfortunately, we know more about how mental disorders might affect the first and second levels of intention than the third. Any mental disorder that affects perception and interpretation of percepts is likely to interfere with first level intentions, and these in turn may affect the second level. I am unlikely to be able to tell the difference between a Rembrandt and a Bacon unless I can tell the difference between eggs and bacon.

But it is at the third level of intentions that actors enter the moral domain; the discourse of "ought and should" not "can and will". We do not know very much about how or whether abnormal mental states give rise to abnormal third level intentions. The decision to commit suicide has third level intentional components in it: I'm better off dead, no one will miss me, and it doesn't matter if I am dead. Deciding that this is an intention that is really coherent is not an easy process, and neither psychiatry nor neuropsychology has much to say about it. And if the decision to harm oneself is a complicated procedure, then how much more so is the decision to harm another person.

The intention to harm others is a complex third level intention, even in those cases where there appears to be little thought about it. Many factors go into making this decision, of which abnormal mental states may just be one. Just as it is meaningless to say that all violence is a symptom of mental disorder, it is equally meaningless to say that it never is. Research on violence in the community shows that some types of abnormal mental state do give rise to violence, or increase the

likelihood of it happening. Social and demographic factors are more important than individual ones; but individual ones do count for something.

The question then is so what? Szasz deals briskly with the question of the threat of violence as a symptom, saying there is not much to say. But it seems to me that there is a great deal to say. If violence represents a breaking of social boundaries controlling aggression, then the intention to commit violence will always involve not only the individual perpetrator and victim, but also the social group to which they belong. People who do violent things put themselves outside their social group, to the same extent as that same group then rejects them. This is why violence can be (and probably most often is) an expression of political dissidence, rather than individual pathology.

What should psychiatry's response be? Optimists will see the empirical glass as half full: there is little connection between mental disorder and violence, and so psychiatry can get on with looking after the needs of the ill, and caring for them. Pessimists can say that the glass is half empty, and that if there is a connection, then psychiatry has a duty to prevent the patient causing harm to others, in the same way that they have a duty to relieve other symptoms.

The difficulty here is that helping others to behave better is not normally understood as a medical duty; moral health is not the same as medical health. This is particularly true for psychiatry, where there has been a long struggle to make clear that not everyone who behaves oddly is morally deviant. One can't then, however, have it both ways: if someone behaves in ways which are defined as morally deviant, it is going to be hard to argue that it is not "really" so, but that they are in fact medically ill. The only way to know is to find out more about the person's intentions at the time, and that can be a long drawn out process.

The other difficulty that Professor Szasz might have mentioned (as he has done in the past) is how psychiatrists discriminate against the mentally ill when they get involved in violence prevention. Apart from the mentally ill, no other group of citizens is required to behave better as evidence of their mental health, and no other group of citizens are assumed to be ill because they behave badly.

The main justification for psychiatrists being involved in violence prevention relies on the association, although small and rare, between abnormal mental states and violence. Given that this association does exist, it might also be argued that society has a claim on expert professional knowledge that might assist in keeping the social group safe. On what grounds can it be argued that professional knowledge can be used only for the benefit of individuals, and not the groups to which they belong? On this argument, there would be no public or occupational health. Although a refusal by psychiatry to engage in public protection might seem like a liberal position in terms of respect for autonomy, it also reflects a deeply conservative position in terms of seeing the relationship between the state and the individual as adversarial. Doctors are always understood to support the individual patient against an intrusive and controlling state; but

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what if it is the patient who is doing the intrusion and coercion?

Where I agree with Professor Szasz is in the importance of language in the medicalisation process, and I wish he had said more about this. The morally distasteful aspect of the psychiatrist as agent of social control lies in the deceit, and the linguistic sleight of hand that takes place when relieving social fear is reframed as doing good to the needy. If it is true that expert psychiatric knowledge has information of value in terms of risk reduction and prevention, then society could retain independent psychiatric experts to use this knowledge on society's behalf. We could have special police psychiatrists and court risk assessors, whose relationship with the assessed would not be that of the traditional doctor and patient, but that of the forensicist and client.⁹ It seems to me that *transparency*, *objectivity*, and *honesty* are the key words here.

Professor Szasz has left open some even bigger questions about the ethical identity of doctors, and social harms. Do we ever stop being doctors? If so, how do people get to be our patients, and who gets to decide? What is the nature of the relationship between the doctor and society? And does it make sense to treat violence as a public health problem?

In the film *Minority Report*, highly specialised individuals "see" into the future, and also "see" the murderous intentions of others before they become an action. Their knowledge is used by the state to prevent violence from happening. A colleague and I noted the links with current psychiatric and social preoccupations with risk¹⁰; we also noted the dangers. We also pose the question:

to what extent must individuals pay the price for the security of the group? It seems certain that psychiatry and psychology may have information that could contribute to social security; what seems much less certain is whether and to what extent it may be ethically justifiable to use it.

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Dangerousness, mental disorder, and responsibility

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While the UK Home Office's proposals to preventively detain people with what it has called dangerous severe personality disorder (hereafter DSPD) have been subjected to debate and criticism the deeply troubling jurisprudential issues in these proposals have not yet entered into public debate in a way that their seriousness deserves.¹ It is good that a commentator as well known as Professor Szasz is speaking out on this issue.

Professor Szasz focuses upon a crucial question by calling into question the medicalisation of terms like dangerousness and mental illness.² There is a great temptation for legislators and the public to treat these terms as if they are purely scientific terms and to think of risk assessment as a precise science. I don't share Professor's Szasz's worry about how psychiatry is using these terms but I think there are some important questions about how these concepts function in the public sphere.

This issue is important enough to justify the use of some rhetorical claims because such claims can serve to bring out what are neglected and important issues. In raising the following objections I am not attempting to refute the message that is in Szasz's article or to say that he is not making an important point but rather to attempt to sharpen the issues and to suggest ways that we can respond to Professor Szasz's challenge.

Psychiatry has progressed in a number of ways since Professor Szasz wrote *The Myth of Mental Illness*.³ The science is much better, we have much better medications, and psychiatrists (at least all the psychiatrists that I know) are acutely aware of the tension between treating their patient and their obligations to the public interest.

So when Professor Szasz says: "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'", this is a fairly prejudiced and outdated view of

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what psychiatrists do when placing a person under a compulsory treatment order. It would be more accurate to say that when care and treatment are appropriate families may be relieved of the burden of coping with a mentally unwell relative.

The major thesis of *The Myth of Mental Illness* and Professor Szasz's article is that mental illness is essentially linked with dangerousness. This link creates a huge tension within psychiatry between its obligation to heal patients and to protect the public.

While I think there are some good reasons for taking this thesis seriously when considering the history of psychiatry it is not an accurate way to describe contemporary psychiatry. I have a number of major worries about the idea that there is some intrinsic link between mental disorder and dangerousness.

While dangerousness, or perhaps more accurately social or economic disutility, was an important rationale for the incarceration of the insane⁴ it is no longer the *telos* of psychiatry. Dangerousness is no longer sufficient for incarcerating the mentally ill, except in the most extreme circumstances, under British and Commonwealth mental health legislation. The wording and actual effect of these acts means that people who are a danger to other people or unable to care for themselves but who do not fall into the legally defined categories of mental disorder are routinely not placed under compulsory treatment orders. This in itself is sufficient to refute the claim that there is an essential connection between dangerousness and mental disorder in the wording and effect of the law.

Second, it's not accurate to say that dangerousness is the overriding concept when thinking about compulsory treatment. The key moral concept (in fact you could almost call it a suppressed premise) in compulsory treatment is responsibility or the lack thereof. It is because of the effect that mental illness can have upon an individual's ability to autonomously choose and act on a treatment decision when this treatment decision is related to a significant risk of harm to others or self that we might be justified in compelling people to be treated.

Not all mental health acts make this point explicit. The 1983 UK Mental Health Act requires that a person meet one of the defined categories of mental disorder, be a danger to others or not be able to care for themselves and that their condition is treatable. While the majority of people sectioned under the UK act will lack responsibility or competence there is a theoretical possibility that a person may be competent to make treatment decisions, have a treatable condition, not be able to look after themselves, and have a disorder that meets the relevant definition of mental disorder.

One interesting example of legislation that does make the link between responsibility and civil commitment explicit is the 1992 New Zealand Mental Health Act (for further discussion of this issue see Dawson).⁵ The New Zealand act requires that in order for a person to be placed under a compulsory treatment order it must be the case that their inability to care for themselves or their dangerousness to others results from a disorder of mood, cognition, or volition. When a disorder of mind is causally related to harm to self

or others then this is a strong moral reason for not treating this behaviour as an expression of autonomy. Furthermore this impairment of autonomy is tied to a serious risk of harm to self or others and this creates an important threshold for when people can be treated against their will. So in effect both dangerousness that results from diminished autonomy and diminished autonomy are necessary for justifiable compulsory treatment in New Zealand.

RESPECTING AUTONOMY

The two classic explanations for the importance of autonomy and liberty come from Immanuel Kant and John Stuart Mill.^{6,7} While Mill and Kant had different explanations for why autonomy is important, both of them thought rationality was important for the autonomy of others being binding upon us. Mill thought that a full set of liberties should only be fully extended to

... human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury (Mill, p 14).⁷

Mill doesn't tell us much about what constitutes a state in which a person must be protected from their own actions but it is fairly clear that he has in mind states in which the exercise of freedom would be at odds with what is important about having liberty. For Mill this would be when the exercising of a freedom does not further an individual's interests, or capacity for interests and when this results in harm to self or others. So if we turn back to one of the classic justifications for the importance of liberty, impaired autonomy can reasonably be thought of as undermining the right to a full set of liberties. While mental disorders often do not give us reason to restrict liberty they can, and in such circumstances we may be justified in treating against an individual's stated wishes.

SUICIDE

Just as considerations about diminished autonomy can underpin the morality of compulsory treatment they also furnish us with a response to Professor Szasz's position on suicide.

Rejecting life and wanting to kill oneself is defined as a severe mental illness characterised by "dangerousness to self", and is treated as a quasicrime with coercions called "treatments" (especially involuntary "hospitalisation" and forced drugging) (p 228).

While there is something to the idea that suicide becomes medicalised in psychiatry it seems very harsh to say that psychiatry views this as a quasicrime; it is more often a tragedy that we had sound moral reasons for wishing we had prevented.

Although it is foolish to ignore the history of our views about the morality of suicide this claim doesn't ring true for contemporary discussion about taking our own lives. Public opinion (at

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least in the UK) is, in general, sympathetic towards euthanasia and assisted suicide. Requests by an individual for help in bringing to an end an existence that has become intolerable to them (such as the request of Diane Pretty) are not treated as symptomatic of a disease nor a “quasicrime” but as reasonable requests given intolerable personal circumstances. When a person’s situation is such that nothing can be done to make their life better this strengthens our conviction that this is a reasonable request.

There are, however, some crucial differences when the person who wants to commit suicide is mentally unwell. Successful suicide is irreversible so while there are instances of suicide where we should not interfere or criticise morally those who offer aid, there is an onus on being sure that an individual is not making a big mistake. Second, disturbances of mood, cognition or volition can make people want death when they would not if these disturbances were alleviated. In such cases it is reasonable for us to take their preference when not influenced by a disturbance of mind as a better indication of what they want. A third disanalogy that will hold even when a person *really* does want to take their own life is whether anything can be done to make their existence more tolerable. While the predicament faced by Diane Pretty was one that offered her no hope that her condition might improve it is much more difficult to be so sure when the predicament is related to factors such as feeling that one’s life is of no value.

Professor Szasz thinks that suicide can be reasonable and that it is the ultimate expression of personal autonomy. There are some famous dissenters to this view. Kant thought that suicide, far from being an expression of self rule, was the antithesis of self rule in that it involved undertaking an action that aims at the obliteration of the self. For what it’s worth I’m with Professor Szasz on this point and think that suicide is an act that exhibits the most significant amount of control over a life that an individual can exercise. But this shouldn’t distract us from being certain that a person knows what they are doing, is doing what they really want, and does not want this simply because of material conditions that are in the power of another person to alter.

PREVENTIVE DETENTION

Irrespective of his views about suicide Professor Szasz is correct to question how dangerousness is used in the Home Office proposals for the preventive detention of people with DSPD.

It is a 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 (p 228).

It is important to clarify that nobody is saying that dangerousness or a disposition or propensity to break the law is sufficient for a person to be found guilty of a crime. The Home Office proposals do not recommend that preventive detention be like prison. One of the functions of imprisonment (which ought only to occur when a person

has in fact committed a crime) is punitive. For this reason conditions in prisons are designed to deprive prisoners of some of the comforts that the rest of us enjoy. If, as we have reason to believe on the basis of the Home Office report, institutions for the preventive detention of the very dangerous are to be well funded and well staffed care institutions then they will not be prisons in many of the important senses. The fact that the detained person will not, however, be guilty of any crime, means they will not be sentenced and therefore will not have a release date. So those who are deemed to continue to present risk could in effect be preventively detained indefinitely.

I’ve suggested that the answer to the challenge of Professor Szasz is to justify compulsory treatment on the grounds of diminished autonomy and risk to self and others. This suggestion seems to damn the Home Office proposals for managing those with DSPD. Making a case for those with DSPD having diminished autonomy is a much more difficult matter than making such a case for somebody who is in the grip of an acute schizophrenic episode. While there are often causes for the behaviour of those with the most severe personality disorders, using this as grounds for diminished autonomy places us in difficult territory where it may no longer be clear how any of us can be considered to be autonomous (for more on this idea see Elliott).⁸

The difficulty of predicting risk with the degree of accuracy that is required for preventive detention is one of the major difficulties with the Home Office proposal. If we could know with a very high probability that we were preventing a rape or murder by preventively detaining an individual then this is a compelling reason in its favour. This degree of certainty might, however, be closer to science fiction than to the reality of risk assessment. Nigel Walker has suggested that, “the harm a person has done is more than a mere indicator of what he is capable of doing. It is our only sound justification for infringing his right to be treated as harmless”.⁹ The thought here is that all of us should be presumed to be harmless unless we have proven otherwise. It doesn’t follow from the fact that a person has performed terrible acts that they will do so again but it is the best indicator that we have.

These two major challenges must be overcome by the wording of new legislation, the way in which proposed new institutions are organised, and, crucially, how dangerousness is assessed and threshold of risk required for preventive detention.

CONCLUSION

I think that we need to tread very carefully on the issue of preventive detention. There is a risk that dangerousness becomes an all too easy justification for us to use. The deep anger and outrage at the recent abduction and murder of two young Cambridgeshire schoolgirls could easily move us towards profoundly illiberal approaches to those who may present a risk to others. If we were to ask the public about the appropriateness of preventively detaining individuals with a predisposition towards acts of that kind the reaction is likely to be quite predictable.

The decision to preventively detain a person with DSPD involves a delicate balancing of their

interests, the extent to which their ability to act autonomously is impaired, and the seriousness of the danger they present to other persons. A bare minimum for whatever policy is adopted is that it is carefully underpinned by awareness of the importance of respecting and enhancing autonomy and balancing this against the probability and severity of risk.

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Psychiatry and the control of dangerousness: a comment

G M Sayers

The paper by Szasz is about mental illness and its meaning, and like Procrustes, who altered hapless travellers to fit his bed, Szasz changes the meanings of words and concepts to suit his themes.¹ Refuting the existence of "mental illness", he suggests that the term functions in an apotropaic sense. He submits that in this sense it is used to avert danger, protect society, and hence (superstitiously) justify preventive detention of "dangerous" people.

But his arguments misrepresent the precise meaning of the term "apotropaic", which is an adjective, defined in Webster's, Chambers and the New Shorter Oxford dictionaries as averting or turning aside *evil*. It is possible that amulets and incantations ward off evil, in the same way as garlic repels vampires, but evil and danger are different concepts. Yet Szasz talks of using phrases like "'dangerousness to self and others' as apotropaics to ward off dangers we fear", and the word "evil" does not appear in his paper.

I will argue that "dangerousness to self and others" and "psychiatric treatment" have a prosaic rather than an apotropaic function.

The word "danger" is familiar rather than arcane, and includes many risks. A predatory paedophile is usually both dangerous and evil, but many dangerous people are not evil. For example, a child who plays with a box of matches is dangerous, as is a demented person who drives a car, or a schizophrenic who, acting on delusional beliefs, arms herself with a knife and roams the streets believing she is an avenging angel.

Suppose we accept that mental illness is not a disease but rather, as Szasz himself suggests, "not something a person has, but something he does or is".² After all, it does not matter whether mental illness is a disease like diabetes or merely a particular state of mind. What matters, is that the mind, however it is conceived, initiates thoughts that may prompt behaviour.

This behaviour can be judged in moral terms as good or bad, in human terms as harmless or dangerous, in psychiatric terms as normal or abnormal, and in legal terms as lawful or criminal. If judged criminally culpable, the law ensures that both *actus reus* (bad deed) and *mens rea* (evil mind) are present, otherwise the person cannot be held responsible for their action, sometimes through reason of insanity.³

The fact that the substance of psychiatry is subject to reconstruction does not mean it has no substance. It is an evolving discipline that deals with the mind. The mind cannot be measured in the way depth is plumbed. It can only be assessed by way of its manifestations, which are thought content and behaviour. Psychiatry addresses abnormal thinking and acting.

Szasz rightly points out that the notion of normality is linked to social relativism, but he implies this is reason for psychiatrists and psychiatry to be discredited. A more credible approach would relate psychiatry to prevailing social values. Thus homosexuality, previously classed as a mental disorder, is now considered normal. This is because societal beliefs and attitudes change with time. "Witches" no longer being burnt at the stake, but instead practising their craft undisturbed in Glastonbury, does not discredit the legal system, it simply demonstrates that over time the law is subject to revision.

When it comes to real rather than mystical "danger", there are two types to consider in conjunction with this paper. People described as having "dangerous severe personality disorders", who do understand the nature of their actions, do appreciate reality, and are both legally and morally accountable for their actions, may cause harm. And psychotic individuals, who cannot be held legally or morally responsible for their actions because they are divorced from reality, may be dangerous to themselves and others.

Debate

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Some psychotic individuals manifest irrational homicidal behaviour and kill their victims, sometimes strangers to the patient. Some display irrational suicidal behaviour. Recently, a schizophrenic man entered the lion enclosure at London Zoo. Assuming he had the mistaken belief that he was Daniel would not make his behaviour rational, if only because he was not Daniel and got eaten, which was not what he intended.

Szasz cites the NAMI web site, and ironically likens the manipulative tactics of patient advocates trying to help relatives of emotionally disturbed patients, to the Ku Klux Klan representing the interests of black Americans. The validity of this statement depends on how interests are to be defined. Most relatives care about the harm that could be caused by a disturbed individual to himself or others, and threatened violence needs to be communicated rapidly and unambiguously to the police.

Szasz interprets this protective action as the relatives' attempt to "divorce" themselves from the disturbed, or disturbing, family member. If this were so, the parent described would allow her son to jump off the roof, thus facilitating the ultimate "divorce". Szasz, however, believes such relatives use psychiatrists to incarcerate their family members and call it "care" and "treatment". The psychiatrists manage this, in his view, by using the magic mantra: *mentally ill and dangerous to himself and others*.

Szasz then introduces what could be a justifiable debate on whether it is medically, legally, and morally permissible to involuntarily detain, under psychiatric auspices, patients with dangerous severe personality disorders before they commit a crime. These people manifest "bad" behaviour and some of their actions are thought to be evil. They are therefore of more interest to lawyers than psychiatrists. They also interest politicians who have to satisfy societal needs for safety.

It is this debate which approximates the dangerousness of "danger",⁴ and if the English Mental Health Act is changed in order to prevent potential crime, by permitting the detention of people with a violent propensity who do not require psychiatric treatment, it would do much to support what Szasz maintains about social control. However, he uses the Draft Mental Health

Bill,⁵ as a springboard from which to leap into the murkier waters of whether suicidal patients should ever be involuntarily detained and treated.

If Szasz is correct, and suicidal patients should be allowed, unhampered, to kill themselves as a manifestation of their autonomy, we need to ask whether physicians should treat them for their overdoses when they fail, or simply place them in comfortable surroundings to die. If Szasz's arguments are plausible, it follows logically that doctors should not intervene with antidotes. Yet how are they to know which one of these patients reasonably intends suicide, which is too disturbed to sustain rational intentions, and which intends simply to attract sympathy or attention?

Finally, let us consider double agents, "Caesar" and "God". Szasz believes that psychiatrists play two incompatible roles. One is to "help voluntary patients cope with their problems in living", and the other is to "help relatives and society rid themselves of certain unwanted persons, under medical auspices". It interests me that he refers only to the former group as "patients". It is the "unwanted persons", however, who may be the most disturbed and most in need of help. They may lack the autonomy to ask for help as, unlike the former group, they often have no insight into their problems. Because they do not perceive their mental state as abnormal, they are likely to refuse treatment.

Are these "unwanted persons" then deemed the responsibility of the state ("Caesar")? If they are neither detained nor treated because psychiatrists ("God") ought not submit psychotic individuals to coercive intervention, and they then kill, should they be punished by execution or life imprisonment even though the law considers them to be criminally insane? Jesus also said: "Father, forgive them: for they know not what they do".⁶

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Response to: comments on psychiatry and the control of dangerousness: on the apotropaic function of the term "mental illness"

T Szasz

I appreciate Professor Boyd's offer to respond to the respondents of my essay, as it gives me an opportunity to thank them for their carefully considered comments.¹⁻³

In *The Subjection of Women*, John Stuart Mill sought to clarify the traditional subjection of women to men by comparing the institution of marriage with the historically hallowed, religiously sanctified, and legally sanctioned institution of slavery.⁴ For almost 50 years, I have tried to do the same thing with respect to the traditional subjection of "mental patients" to psychiatrists by comparing the legally sanctioned institution of psychiatry with slavery.⁵ Instead of re-engaging in a discussion of the difficult problems before us, I would like to rest my case—if I may use such forensic terminology—by citing Mill's reflections about the obstacles he faced in presenting his case against the subjection of women:

So long as an opinion is strongly rooted in the feelings ... the worse it fares in argumentative contest, the more persuaded its adherents are that their feeling must have some deeper ground, which the arguments do not reach; and while the feeling remains,

it is always throwing up fresh intrenchments of argument to repair any breach in the old. ... the understanding of the majority of mankind would need to be much better cultivated than has ever yet been the case, before they can be asked to place such reliance in their own power of estimating arguments as to give up practical principles in which they have been born and bred and which are the basis of much existing order of the world, at the first argumentative attack which they are not capable of logically resisting.

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