

THE LYING TRUTHS OF PSYCHIATRY

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We have been forced to stop all intercourse between Adler's splinter group and our own association, and our medical guests are also requested to choose which of the two they will visit. . . . It is not my purpose, my dear lady, to enforce such limitations in your case. I only request of you that with due regard for the situation you make use of an artificial psychic split, so to speak, and make no mention there of your role here and vice versa.

Sigmund Freud (1912)¹

During my whole life I have endeavoured to uncover truths. I had no other intention and everything else was completely a matter of indifference to me. My single motive was the love of truth.

Sigmund Freud (1930)²

Of all the lying truths popular today, one of the most important is surely the mendacity inherent in the term "mental illness." In addition to asserting a falsehood concealed as a truth, this term also generates and justifies a host of related mendacious propositions and deceitful practices. As I noted in *Heresies*, "The subject matter of psychiatry is neither minds nor mental diseases, but lies—the 'patient's' and the 'psychiatrist's.'" These lies begin with the names of the participants in the transaction—the designation of one party as "patient" even though he is not ill, and of the other as "therapist" even though he is not treating illness. They continue with the lies that form the very substance of the discipline—psychiatric "diagnoses," "prognoses," and "treatments." And they end with the lies that follow ex-mental patients like shadows through the rest of their lives—the records of imprecations and imprisonments called "depression," "schizophrenia," and "hospitalization."³

The Nature and Scope of Psychiatric Lies

The concept of mental illness is the pivotal mendacity of psychiatry. How this literalized metaphor is affirmed and used as if it were a scientific truth is

best conveyed by means of illustrative quotations (a few of which follow without internal comment).

"Mental Illness is Top U.S. Health Problem"

Mental illness is "America's primary health problem," afflicting at least 10 percent of the population, the National Institute of Mental Health said today.⁴

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Mental Health in America: 1978

For the past few years the most commonly used estimate has been that, at any one time, 10 percent of the population needs some form of mental health services. . . . There is new evidence that this figure might be nearer 15 percent of the population. . . . As many as 25 percent of the population are estimated to suffer from mild to moderate depression, anxiety, and other indicators of emotional disorder at any given time.⁵

* * * *

"The Unmotivated Patient Syndrome"

The unmotivated patient syndrome, characterized by a reluctance to accept treatment and an unwillingness to cooperate in therapy, pervades the spectrum of services for the emotionally disturbed. . . . Yesterday's 'brat' is today's hyperkinetic youngster, and the 'drunk' has become the alcoholic with deeply rooted psychosocial problems. These new target populations represent diverse aspects of psychopathology.⁶

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"Birth of a New Specialty—"Torture-ology"

"Torture is a disease that can be treated and cured just like many other diseases," said Dr. Inge Kemp Genefke of the Danish Medical Group. . . . "The medical profession is responsible for dealing with the problem of those doctors who are torturers themselves," said Dr. Erik Karup Pedersen. "We are all responsible for recognizing that torture is a disease. . . ."⁷

The status of these statements as lying truths is obvious from the fact that they are Sunday truths: on weekdays, men and women display their belief in truths that belie these psychiatric prevarications. For example, opinion polls about which diseases Americans fear the most consistently fail to mention mental illness as a disease they fear at all. According to a 1976 Gallup poll, Americans fear cancer the most, 58 percent of the population ranking it first.⁸ Deafness is trailing the list, 1 percent rating it as the most feared. Not on the list at all: mental illness. Likewise, survey after survey reveals that although the American media ceaselessly evangelize mental illness as "just like any other illness," American behavior testifies that mental illness carries a stigma and that the mental hospital is a prison. From a report entitled "Mental care at bottom of list," we learn:

Most Americans have been trained to call a doctor when they feel sick . . . but when it comes to mental health, the majority would rather suffer in silence. . . . Two of the biggest obstacles are the fear of being thought 'nuts' and the fear of being 'locked up' once psychiatric care is sought. Until these misconceptions are cleared up, mental health care is going to come last on the list.⁹

Ironically, the correct perception of the truth is here labeled a "misconception." Let us consider the specifics of this "misconception."

Just how severe is the stigma attached to mental illness was revealed by another recent survey: "Employees seeking psychiatric care are less likely to be promoted in their jobs than others, according to a survey of 126 supervisors in Philadelphia. . . . Bosses surveyed reported a more negative attitude toward employees under treatment for mental illness than toward those who smoked marijuana on weekends, are obese, had a heart ailment, were age 60, being treated for skin cancer, atheists, or part of a racially mixed marriage."¹⁰

This popular perception of psychiatry is, of course, consistent with psychiatry's intimate involvement with murder and mayhem—and, more specifically, with the psychiatrists' insistence that murder and mayhem are the manifestations of mental illness curable by means of compulsory psychiatric interventions. Furthermore, because this popular perception rests on the fact that psychiatrists, unlike other physicians, use legally formalized and enforced compulsion both in "hospitalizing" and in "treating" persons who refuse to consent to psychiatric interventions, psychiatric apologists and propagandists—unwilling to acknowledge, much less alter, the realities of psychiatry—systematically lie about its supposedly false image. For example, responding to an article in *Newsweek* magazine in which hospitalized mental patients were called "inmates," Rosalynn Carter, Honorary Chairperson of the President's Commission on Mental Health, writes:

I was dismayed . . . by your use of the term "inmate" in describing these individuals. Many of the difficulties they face stem from negative public attitudes toward the mentally ill. Inaccurate labeling feeds the public's fear of those with mental problems. Mental patients are not inmates and are rarely dangerous.¹¹

But individuals incarcerated in institutions are correctly labeled "inmates," notwithstanding Mrs. Carter's efforts to deny that fact. The reality we face here is, of course, painful: hundreds of thousands of individuals innocent of lawbreaking are deprived of their liberty by psychiatrists and incarcerated in so-called hospitals. Confronted with this fact, we have only two real options: we can acknowledge the evil inherent in compulsory psychiatry and oppose it; or we can deny that evil by believing the lying language of madness and mad-doctoring.

Psychiatric coercion sticks in the throats of the psychiatric apologists. In trying to rid themselves of this threat, which they correctly perceive as a danger to the very survival of psychiatry, they only incriminate themselves more deeply. Thus, in an article in the *Washington Post* devoted to an analysis of the "rights of the mentally ill," Alan Stone, a professor of law and psychiatry at Harvard University, offers the following comment on "dangerousness" as a requisite for civil commitment:

No one, including psychiatrists or judges, can predict with 100 percent certainty who will become dangerous. But waiting for a person to commit an overt act simply won't work. If we just wait until someone has already committed a crime, we'll just collapse the civil commitment procedure into the criminal justice system. Mentally ill persons will have to be treated as criminals.¹²

Without civil commitment laws then, according to Stone, "mentally ill" persons would "have to be treated as criminals." In fact, "mentally ill" persons would then have to be treated like everyone else—which is the avowed goal of those who most loudly bewail the stigma of mental illness! Like so-called normal people, some so-called mentally ill persons break the law; they should be regarded as criminals, not because they are mentally ill, but because they broke the law. And like most "normal" people, most "mentally ill" persons do not break the law; they should be regarded as innocent persons no more subject to involuntary confinement and treatment than anyone else.

The Lies of Psychiatric History

Psychiatric history, insofar as it pretends to be the history of the diagnosis and treatment of mental illnesses, is largely a tissue of lies. Actually, the history of psychiatry is the history of the stigmatization, persecution, and incarceration of individuals exhibiting various types of socially deviant behavior. Evidence supporting this interpretation abounds. For example, Philippe Pinel, hailed as the "liberator" of the madman, offered the following recommendation for apprehending individuals deemed insane:

As he [the manager of the madhouse] advances he speaks to him [the madman] in a firm and menacing tone, and gives his calm advice or issues his threatening summons, in such a manner as to fix the attention of the hero exclusively upon himself. This ceremony is continued with more or less variation until the assistants have had time, by imperceptible advances, to surround the maniac, when, upon a certain signal being given, he finds himself in instant and unexpected confinement.¹³

For dealing with the madman who seeks his freedom, Pinel recommended the following policy: "Improper application for liberty, or any other favour,

must be received with acquiescence, taken graciously into consideration, and withheld under some plausible pretext."¹⁴ Pinel also embraced deception as a form of treatment, illustrating its effectiveness by the report of a case in which the cure failed because the mad-doctor's mendacity was exposed.¹⁵

Benjamin Rush, the undisputed father of American psychiatry, regarded deception as a veritable panacea. The following account is paradigmatic of his practice:

If our patient imagines he has a living animal in his body, and he cannot be reasoned out of a belief of it, medicines must be given to destroy it; and if an animal, such as he supposes to be in his body, should be secretly conveyed into his close stool, the deception would be a justifiable one, if it served to cure him of his disease.¹⁶

I cite another similar account to illustrate how deeply deception was ingrained in the mind of the man who wrote the first American textbook of *Diseases of the Mind*:

Cures of patients, who suppose themselves to be glass, may be easily performed by pulling a chair, upon which they are about to sit, from under them, and afterward showing them a large collection of pieces of glass as the fragments of their bodies.¹⁷

Psychiatric patients often propound lies, and psychiatric physicians counter-lies. Much of modern psychiatry rests on the compounding of such prevarications—an interpretation dramatically illustrated by Freud's early psychiatric experiences.

The prevarications of Freud's hysterical patients—who claimed they were seduced as children by their fathers or other male authority figures—have achieved a psychoanalytic status bordering on the legendary.¹⁸ However, although the story of Freud's life and work is well known, the fact that psychoanalysis rests squarely on two crucial deceptions has somehow eluded both the adherents and critics of this mendacious cult. The first deception was perpetrated by the patients on Freud; the second was perpetrated by Freud on his followers, the public, and perhaps himself. The patients lied about sexual activity, claiming they had been subjected to traumatic sexual acts as children; Freud lied about the etiological significance of childhood sexual traumas in hysteria, claiming that these traumas caused that "disease," regardless of whether the sexual seductions actually occurred. A brief recounting of these lies and the psychoanalytic legends based on them deserves our attention here.

It is important to keep in mind that, at the beginning of his career, Freud thought of himself as a psychopathologist. Accepting the literal reality of mental diseases, he sought to discover their causes or "etiologies," just as other medical investigators had discovered the causes of the major infectious

diseases that then plagued mankind. In "The Aetiology of Hysteria" (1896), Freud asserts that he possesses a special method for investigating the "etiology" of this "disease" and that its etiology is invariably a sexual trauma in childhood:

But the most important finding that is arrived at if an analysis is thus consistently pursued is this. Whatever case and whatever symptom we take as our point of departure, *in the end we infallibly come to the field of sexual experience*. So here for the first time we seem to have discovered an aetiological precondition for hysterical symptoms.¹⁹

Freud's view that hysteria is a disease (which has an "etiology") must, in fairness, be regarded as evidence of his acceptance of the conventional perspective on it rather than of his making any special claims about it. It is Freud's proposition that he has discovered the etiology of hysteria that deserves our special attention. That claim was solely his and it is fair to hold him fully responsible for it.

Only the most laborious and detailed investigations [writes Freud] have converted me, and that slowly enough, to the view I hold today. If you submit my assertion that the aetiology of hysteria lies in sexual life to the strictest examination, you will find that it is supported by the fact that in some eighteen cases of hysteria I have been able to discover this connection in every single symptom, and, where circumstances allowed, to confirm it by therapeutic success.²⁰

Freud here elevates his own *interpretations* of various symptoms to the status of scientific discoveries. Moreover, he claims that his therapeutic successes support his etiological speculations. That sort of reasoning—inferring etiology from intervention—has long been popular among mad-doctors. The same reasoning prevails today in psychiatry—when, for example, a chemical etiology of the psychoses is inferred from their allegedly successful chemical treatment.

Freud's claims could hardly have been more grandiose: he had discovered, he insisted, both the cause and the cure of one of the most common and disabling mental illnesses of his age:

Now we are really at the end of our wearisome and laborious analytic work, and here we find the fulfillment of all the claims and expectations upon which we have so far insisted. . . . I therefore put forward the thesis that at the bottom of every case of hysteria there are *one or more occurrences of premature sexual experience*, occurrences which belong to the earliest years of childhood but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of the *caput Nili* [source of the Nile] in neuropathology.²¹

Freud here claims to have made a medical or scientific "discovery"—namely, of the etiology of hysteria. The questions I now want to raise are:

Was his assertion about the cause of hysteria true? If not, what did he do about his erroneous or false claim? Here are Ernest Jones's answers to these questions:

Up to the spring of 1897 he [Freud] still held firmly to his conviction of the reality of these childhood traumas. . . . At that time doubts began to creep in, although he made no mention of them in his records of his progress he was regularly sending to his friend Fliess. Then, quite suddenly, he decided to confide to him "the great secret of something that in the past few months has gradually dawned on me." It was the awful truth that most—not all—of the seductions in childhood which his patients had revealed, and about which he had built his whole theory of hysteria, had never occurred.²²

Why Freud should have believed the stories of "mental patients"—whose reputation for veracity was no better than that it is now—need not concern us here. The fact is that Freud believed these stories or acted as if he did. What we need to consider is what Freud did when it became impossible for him to deny that he had been wrong. He did two things: he stopped believing his patients; and he concluded that, although his patients had deceived him, he was still right. Jones says that this crisis "was a turning point in his [Freud's] scientific career, and it tested his integrity, courage, and psychological insight to the full. . . . It was at this moment that Freud rose to his full stature."²³ I submit, and shall document, that this, too, is a mendacity. Actually, Freud resolved this crisis by a daringly deceptive strategy: abandoning all efforts to demonstrate empirically the validity of his claims, Freud shifted the ground on which his "depth psychology" rested from the "actual reality" of science to the "psychical reality" of his patients' minds—as that "reality" was revealed to him (and his loyal lackeys) by means of the "psychoanalytic method." It is this shift and the resulting arbitrary—and usually demeaning—judgments of persons, on and off the analytic couch, that I have elsewhere identified as the "base rhetoric" characteristic of psychoanalysis.²⁴ The evidence for the foregoing interpretation lies, first of all, in a letter to Wilhelm Fliess dated September 21, 1897. Freud writes:

Let me tell you straight away the great secret that has been slowly dawning on me in recent months. I no longer believe in my *neurotica*.²⁵

Freud then gives Fliess four convoluted reasons for having decided to no longer believe his patients' supposed recollections of their childhood experiences—reasons that seem to impress Jones very deeply indeed. What Freud fails to mention is that these stories were so patently contrived that when he presented this theory of the etiology of hysteria to a group of physicians in April, 1896, Richard von Krafft-Ebing, then professor of psychiatry at the University of Vienna, called it a "scientific fairy tale."²⁶ Perhaps Freud did not mention that to Fliess because he had already decided to transform his fairy tale into the epistemological bedrock of his

new science of psychoanalysis. In the same letter to Fliess, Freud writes:

Were I depressed, jaded, unclear in my mind, such doubts [about the "explanation of neurosis"] might be taken for signs of weakness. But as I am in just the opposite state, I must acknowledge them to be the result of honest and effective intellectual labor. . . . It is curious that I feel not in the least disgraced, though the occasion might seem to require it. Certainly I shall not tell it in Gath, or publish it in the streets of Askalon, in the land of the Philistines—but between ourselves I have a feeling more of triumph than of defeat (which cannot be right).²⁷

Why was Freud so exuberant? Because he hit upon the formula that enabled him to be free, once and for all, of the burden of tailoring his theories to fit the facts of external reality. Henceforth, he could fit the facts to his conjectures. His formula, in effect, was this: when he was right, he was right; and when he seemed to be wrong, he was still right, because his seeming error actually embodied the "*psychical reality*" of his patients (as "discovered" by the "psychoanalytic method"). This boundlessly arrogant, and amazingly successful, re-interpretation of the etiology of hysteria became the linchpin of psychoanalytic theory. This is Freud's own account of it in "The History of the Psycho-Analytic Movement" (1914):

Influenced by Charcot's view of the traumatic origin of hysteria, one was readily inclined to accept as true and aetiologically significant the statements made by patients in which they ascribed their symptoms to passive sexual experiences in the first years of childhood—to put it bluntly, to seduction. When this aetiology broke down under the weight of its own improbability and contradiction in definitely ascertainable circumstances, the result at first was helpless bewilderment. . . . The firm ground of reality was gone. . . . At last came the reflection that, after all, one had no right to despair because one has been deceived in one's expectations; one must revise those expectations. If hysterical subjects trace back their symptoms to traumas that are fictitious, then the new fact which emerges is precisely that they create such scenes in phantasy, and this psychical reality requires to be taken into account alongside practical reality.²⁸

Here Freud displays his skills as a master con-man. He writes as if he had been deceived, when he was, in fact, the deceiver. Hysterical patients were always ready to attribute their illness to whatever they believed would flatter their doctors' vanity. Freud grew up in an atmosphere saturated with the admonition not to believe the claims of mental patients. Thus, if Freud believed some of his hysterical patients' claims, it was not because he was deceived, but because he wanted to believe them (or pretended to believe them) in order the better to deceive his listeners about his "etiology of hysteria." Then, when he realized that it was hopeless to maintain that the sexual seduction stories of his patients were true, instead of scuttling his theory, Freud merely transformed actual unreality into "*psychical reality*," historical falsehood into mental truth. Such is the mendacity on which psychoanalysis—pretending to be a scientific procedure—rests.

The Lies of Psychiatric Diagnosis

The fact that healthy persons assume the sick role or impersonate patients, has, of course, always been known. Called "malingering," the phenomenon was, for centuries, correctly categorized as a species of counterfeiting. In the nineteenth century, such counterfeiting became redefined as itself a form of sickness—a "mental illness." This then led to defining feigned mental illness as itself a severe mental illness, demonstrating the limitless possibilities of deceptions masquerading as diagnoses.²⁹

In *The Myth of Mental Illness*, I showed that the concept of psychopathology rests on the misleading metaphorization of personal displeasure or social deviance as bona fide illness or pathology. In view of the ideological, economic, and political interests of psychiatry—as well as its relation to the modern nation states that support it and that psychiatry, in turn, supports—mental illness is bound to be an omnivorous category, swallowing up any behavior displeasing to a person himself or to certain others.³⁰ That such is the case is supported by the perusal of any contemporary newspaper or magazine.

For example, in 1977, the Vatican newspaper, *L'Osservatore Romano*, declared that feminists demonstrating for sexual freedom and abortion on demand "represented a pathological phenomenon."³¹ In a similar defense of traditional sexual values, a psychiatrist writing in the *American Journal of Psychiatry* claimed to have identified a new "pathological symptom" called "pathological tolerance." This term, he explained, "refers to the acceptance of the triangular relationship by the member of the primary dyad who is the same sex as the triadic addition."³² In other words, "pathological tolerance" is not being jealous of your sexual partner when the psychiatrist believes you ought to be jealous of him or her. The deception of defining such a personal judgment as a "pathological symptom"—requiring "treatment"—is concealed by the additional deception of couching it in an opaque and pretentious pseudomedical jargon.

The prevarications implicit in psychiatric diagnoses are perhaps most obvious when such diagnoses are affixed to prominent political figures. For example, in 1968, Dr. Robert Cancro, an authority on schizophrenia, declared that if he had been asked "to screen the candidacy of Charles de Gaulle for the presidency of France a few years ago, he might have said de Gaulle was a paranoid with delusions of grandeur."³³

President Carter's wife, Rosalynn, seems to be another devout psychopathologist. In the 1978 presidential commission *Report* on "Mental Health in America," she enthusiastically endorsed the proposition that 25 percent of her countrymen are mentally ill. Especially distressed by the madness of black Americans, she categorized that group, en masse, as psychiatrically "underserved."³⁴ Mrs. Carter's psychiatric judgment about Americans, and especially black Americans, is, to say the least, astonishing, if it is compared

to one of her earlier remarks, offered in response to a question about Idi Amin's mental health. "I do not think," she said, "that Amin Dada is crazy. He is a very intelligent man."³⁵ It is worth recalling, in this connection, that in 1972, President Amin sent a telegram to Secretary General Kurt Waldheim of the United Nations in which he not only urged the removal of all Israelis from the Middle East to Britain, but also endorsed Hitler's policies. "When Hitler was the Prime Minister and Supreme Commander," declared President Amin, "he burnt over six million Jews. This is because Hitler and the German people knew that the Israelis are not people who are working in the interests of the people of the world."³⁶ Displeased with Amin's words and deeds (such as his expulsion of 55,000 Asians from Uganda), Harold Wilson, then the leader of the British Labor Party, had not the slightest difficulty in diagnosing the Ugandan President as an "unbalanced paranoiac."³⁷

I submit that Mrs. Carter and Mr. Wilson are both wrong. Idi Amin may be called a good or bad president of his country, a good or bad person. However, calling him mentally healthy or mentally sick is a dangerous mendacity.

The contention that psychiatric diagnoses are themselves deceptions may be further illustrated by certain metamorphoses in modern American psycho-diagnostics. For example, in 1974, with much fanfare, the American Psychiatric Association dropped homosexuality from its official list of mental diseases. In the years since then, psychiatrists have labored mightily to make up for that loss. They have thus invented several new psychopathological conditions, listed in the proposed draft of the third edition of the Association's official roster of mental illnesses. For children, the mad-doctors manufactured the "Academic Underachievement Disorder," which they identify as follows:

The essential feature is a clinical picture in which the predominant disturbance is failure to achieve in most school tasks despite adequate intellectual capacity, supportive and encouraging social-environment, and apparent effort. . . . The disorder is relatively common and found equally in males and females.³⁸

If this fails to compensate psychiatrists for the loss they suffered relinquishing homosexuality "per se" as a disease, another newly discovered illness should more than make up for it. The new mental disease is "Tobacco Use Disorder," a diagnostic entity that converts a good part of mankind into psychiatric cannonfodder. Here is what the Task Force on Nomenclature and Statistics of the American Psychiatric Association says about this disease:

This is the first time that certain forms of tobacco use are included in this classification of mental disorders. . . . Chronic use of tobacco has been shown conclusively to predispose to a variety of medical diseases. . . .

Health authorities have estimated that 15% of the annual mortality in the United States is directly due to diseases caused or aggravated by the consumption of tobacco. Tobacco use is therefore clearly a major health problem. . . . In this manual, the use of tobacco is considered a disorder either when the use of the substance is directly associated with distress at the need to use the substance repeatedly; or there is evidence of a serious tobacco-related physical disorder in an individual who is judged to be currently physiologically dependent upon tobacco.³⁹

Concerning the “prevalence and sex ratio” of Tobacco Use Disorder, its discoverers have this to say:

A large proportion of the adult population of the United States uses tobacco, with the prevalence among men greater than among women. . . . The prevalence of Tobacco Use Disorder as defined here is not known. . . . However, since surveys have shown that approximately 50% of smokers express a desire to be able to stop, and since tobacco-related physical problems that are aggravated by smoking are common, Tobacco Use Disorder is obviously common. Assuming that the prevalence of smoking does not decline rapidly, that there are no breakthroughs in the development of a “safe” cigarette, that social acceptability for tobacco use will decrease, and that restrictions in public use will become more widespread, then it follows that the proportion of smokers who are distressed by their inability to stop will increase, and therefore the prevalence of Tobacco Use Disorder will increase.⁴⁰

Evidently, psychiatrists have come to believe their own lies—a mental condition which, although not a disease, is exceedingly dangerous to the body politic. It has often been observed that no one is as zealously intolerant as a person intoxicated with abstinence. Traditionally the heaviest of smokers, psychiatrists, once they embrace anti-smoking, can be counted on to be as hard on smokers as they have been on other psychiatric scapegoats. Indicative of the nascent psychiatric passion against smoking is the invention of still another mental disease related to smoking: Tobacco Withdrawal. Concerning this disease, we learn:

Withdrawal is not seen in all smokers, but in many heavy cigarette smokers, changes in mood and performance which are probably related to withdrawal can be detected within two hours after the last cigarette. The sense of craving appears to reach a peak within the first 24 hours after the last cigarette. . . . The most common symptoms of withdrawal are irritability, restlessness, dullness, sleep disturbances, gastrointestinal disturbances, headache, impairment of concentration and memory, anxiety, and increased appetite. . . . The diagnosis is usually self-evident and the disappearance of symptoms upon resumption of smoking is confirmatory.⁴¹

In view of the obviousness and severity of these symptoms, one wonders why the disease of Tobacco Withdrawal was not discovered until now. But then perhaps it was discovered: Mark Twain, in his inimitable style, once

remarked that it was exceedingly easy to stop smoking; he had done it himself a thousand times. If the American Psychiatric Association had a sense of humor, it would have called Tobacco Withdrawal the Mark Twain Syndrome.

The Lies of Psychiatric Treatment

As in *The Myth of Mental Illness* I showed that any behavior disapproved by oneself or others may be categorized as psychopathology, so in *The Myth of Psychotherapy* I showed that any behavior approved by oneself or others may be categorized as mental treatment.⁴² The lying truth inherent in the term "mental illness" is likewise evident in the term "mental treatment" (and its synonyms).

Clairvoyance was not necessary, in the past, to recognize many prevailing methods of psychiatric treatment as dangerous and harmful, just as clairvoyance is not necessary now to recognize many presently fashionable methods of psychiatric treatment as dangerous and harmful. Venesection, sadistic restraints, and incarceration in the madhouse were among leading psychiatric treatments in the nineteenth century; insulin shock, electric shock, psychosurgery, powerful "antipsychotic" drugs, and incarceration in the mental hospital have been and are some of the leading psychiatric treatments in the twentieth century. Insulin shock and lobotomy have few defenders any more. Their passing, however, has not affected either psychiatric mendacity or public gullibility about the supposed therapeutic benefits of electroshock and the so-called antipsychotic drugs.

Of course, not all psychiatric treatments are dangerous in the same ways as the procedures mentioned above; that is, they do not all cause brain damage or loss of liberty. Indeed, some psychiatric treatments are harmless, even helpful—because they do not go beyond conversation and because they increase rather than diminish the client's autonomy. Nevertheless, even these benign methods are, in my opinion, deceptive if they pretend to be bona fide treatments of bona fide diseases. My point here is that just as everything bad in the world is not a disease, so everything good in it is not a treatment. Yet there is hardly any pleasant or health-promoting activity that has not been mendaciously proffered as a psychiatric treatment. Thus everything from reading books ("bibliotherapy") to engaging in sexual activity ("sex therapy") is now psychiatrically promoted, and often popularly accepted, as a mental treatment. A typical example of this psychotherapeutic con-game came in the mail as I was writing this essay. It was an article entitled "Antidepressant Running: Running as a treatment for non-psychotic depression," published in the June, 1978 issue of *Behavioral Medicine*.⁴³ The senior author, John Greist, was identified as an associate professor of psychiatry at the University of Wisconsin, and one of the junior authors, Mr. Roger R.

Eischens, as a “running therapist.” This could be, and indeed is, funny—but psychiatrists, politicians, and the Internal Revenue Service take it all quite seriously. This particular six-page article contains two very scientific-looking tables and a special set of instructions on “Treatment techniques,” duly medicalizing the subject, transforming just plain running into “running therapy.”

The Lies of Psychiatric Research

With the growth of psychiatric research in the modern era, deception—long the stock in trade of the mental patient and the mental healer—became a favorite methodological device of the psychiatric investigator as well. Although accounts of modern psychiatric research are singularly lacking in information that is both significant and reliable, they display a remarkable array of lies.

For example, in 1972, Dr. David Rosenhan and his associates set out to deliberately deceive a number of hospital psychiatrists by assuming the role of what they called “pseudopatients”: pretending to be hearing voices, they called mental hospitals and gained admission to them on the basis of that complaint.⁴⁴ Once inside the “insane” asylum, regardless of how “sane” the pseudopatients acted, they continued to be regarded as crazy. “With the exception of myself (I was the first pseudopatient and my presence was known to the hospital administrator and chief psychologist, and, so far as I can tell, to them alone),” wrote Rosenhan, “the presence of the pseudopatients and the nature of the research program was not known to the hospital staff.” This deception was supposedly necessitated by the problem to be investigated. “However distasteful such concealment is, it was a necessary first step to examining these questions,” explained Rosenhan. The questions to which he was referring were: “If sanity and insanity exist, how shall we know them?” and “. . . whether the sane can be distinguished from the insane (and whether the insane can be distinguished from each other).” But this “experiment” was not premised on concealment (as are double-blind studies), but rather on deception: the “researchers” impersonated psychotics and deliberately lied to the psychiatrists whose help they ostensibly solicited. Nevertheless, not only was this study accepted for publication in *Science*, it was also hailed as an important piece of research—supposedly proving the “labeling theory” of mental illness and the “unreliability” of the psychiatric-diagnostic process. To me it proved only that it is easy to deceive people, especially when they don’t expect to be deceived.

Two recent events illustrate the prevalence of deception in contemporary psychiatric research. One is reported in a letter to the editor of *Psychiatric News*, by Natalie Shainess, recounting a personal encounter with such “research” at the annual meeting of the American Psychiatric Association in

Atlanta, in May, 1978.⁴⁵ "Arriving late in the evening at the Omni Hotel," she writes, "I was unpacking when my phone rang at about 11:30 p.m. Wondering who might be calling at that hour, I picked up the phone receiver to hear a man's voice say, 'Would you like us to send up a gentleman to pleasure you?'" Offended by this offer, Dr. Shainess interrogated the hotel manager about the incident, only to learn that "a member of the American Psychiatric Association was conducting a piece of sex research and had arranged for 25 women arriving alone to receive this call." By representing himself as a scientific investigator, this unidentified psychiatrist deceived not only his victims, but also the hotel manager. It remains to be seen what steps, if any, the American Psychiatric Association will take to expose and punish this "researcher."

The other event involves some of the most prominent "scientific" investigators of mental illness in the United States. On January 12, 1978, four researchers published a paper in the *New England Journal of Medicine*, entitled "Are paranoid schizophrenics biologically different from other schizophrenics?"⁴⁶ Their answer was yes. They claimed to have demonstrated that the blood platelets of chronic non-paranoid schizophrenics exhibited a significantly lower level of monoamine oxidase activity than did the platelets of chronic paranoid schizophrenics or normal controls. In the same month, five researchers published a paper in the *American Journal of Psychiatry* entitled "Platelet monoamine oxidase in chronic schizophrenic patients."⁴⁷ Their conclusion was that "There were no significant differences between the mean platelet MAO activities of 20 chronic paranoid schizophrenic patients compared with 18 chronic undifferentiated schizophrenic patients." What makes these two articles uniquely relevant is that both were co-authored by Dennis L. Murphy, Chief, Clinical Neuropharmacology Branch, National Institute of Mental Health, Bethesda, Maryland, and Richard J. Wyatt, Chief, Laboratory of Clinical Psychopharmacology, St. Elizabeths Hospital, Washington, D. C.

The discrepancy between these two reports has created a furor in the pages of the *New England Journal of Medicine*—but not, so far, in the pages of the *American Journal of Psychiatry*. On May 18, 1978, the *New England Journal* published a series of letters, as well as a scathing editorial note, concerning this affair. In the lead letter, Dr. Karen Pajari notes the contradiction between the two articles cited, and concludes with this observation: "It seems worthwhile to clarify how the same authors can come to such diametrically opposed conclusions—a clarification that I have been unable to extract from either article."⁴⁸

In their reply, the authors "explain" their action by asserting that "We could not previously address ourselves to the then unpublished study by Berger *et al.* because it has been our policy not to discuss unpublished data in a published paper."⁴⁹

The editors were not satisfied. "We are as puzzled as Dr. Pajari," they wrote, "by the virtually simultaneous publication of two apparently contradictory papers, one in the *Journal* and the other in the *American Journal of Psychiatry*. Despite the fact that these papers share two co-authors in common, neither manuscript, as submitted, referred to the existence of the other. . . . We cannot be satisfied with the explanation given of this bizarre event. . . . To dismiss one's own discrepant results as being 'unpublished data' and therefore not open to comment defies common sense and is, to say the least, disingenuous."⁵⁰

Such discrepancy may defy common sense, but it does not defy—has never defied—psychiatric sense. Psychiatrists never had difficulty reconciling other troublesome discrepancies—such as the discrepancy between asserting that schizophrenia is a disease of the brain like pellagra or Parkinsonism, and yet claiming a special legal status for it to justify its involuntary treatment; between asserting that "mental illness is like any other illness," and yet insisting that mere talking is treatment ("psychotherapy"); or between denouncing psychiatric coercion in Russia, and yet practicing such coercion, on an even larger scale, in America.

Viewed in a psychiatric rather than a scientific context there is, therefore, nothing "bizarre" about Murphy and Wyatt reporting in one paper, published in January, 1978, that there is a significant difference in the platelet monoamine oxidase activities of chronic paranoid schizophrenics and chronic non-paranoid schizophrenics, and reporting in another paper, published in the same month, that there is no such difference between them. By psychiatric context, I refer, for example, to a moral arena in which Leonardo da Vinci is defamed as a homosexual and Barry Goldwater as a schizophrenic—and where such defamation is officially accredited as diagnosis.⁵¹ Such conduct, practiced consistently over many generations, inexorably affects every aspect of psychiatry—from the deceptive manipulation of the mental patient in the name of treatment to the deceptive manipulation of research methods and results in the name of science.

The Lies of Psychiatric Education

The lies of psychiatric education are inherent in, and follow from, the lies inherent in the concepts of psychiatric illness, diagnosis, hospitalization, and treatment. Ostensibly, psychiatric education consists of training the young physician in the diagnosis and treatment of mental diseases; actually, it consists of indoctrinating him into the theory and practice of psychiatric mendacity and violence.

In 1972, a psychiatrist actually performed an experiment which, albeit unwittingly, illustrates the deliberate use of deception in psychiatric education as well as the pervasively mendacious content of that education. Inde-

pendently of David Rosenhan's scheme to deceive psychiatrists by means of pseudopatients, Donald Naftulin, a University of Southern California psychiatrist, devised a scheme to deceive mental health educators by means of a pseudopsychiatrist.⁵² The result was predictable: just as psychiatrists were unable to distinguish pseudopatients from real patients, so mental health educators were unable to distinguish the pseudopsychiatrist from real psychiatrists. In fact, the pseudopsychiatrist was rated an outstanding psychiatrist.

The purpose of this experiment, according to the investigators,

was to determine if there is a correlation between a student's satisfaction with a lecturer and the degree of cognitive knowledge acquired. . . . We hypothesized that given a sufficiently impressive lecture paradigm, even experienced educators participating in a new learning experience can be seduced into feeling satisfied that they have learned, despite irrelevant, conflicting, and meaningless content conveyed by the lecturer.

To this end, the team hired a professional actor "who looked distinguished and sounded authoritative," named him Dr. Myron L. Fox, bestowed upon him the persona of "an authority on the application of mathematics to human behavior," created a bogus curriculum vitae, and coached him in a speech entitled "Mathematical Game Theory as Applied to Physician Education." The experimenters coached "Dr. Fox" to teach "charismatically and non-substantively on a topic about which he knew nothing," instructing him to use double talk and other trickery in the question-and-answer period and to intersperse the nonsense "with parenthetical humor and meaningless references to unrelated topics." The lecture was first presented to a group of 11 psychiatrists, psychologists, and social work educators and was videotaped. The tape was then shown to a group of 11 psychiatrists, psychologists, and psychiatric social workers, and finally to a group of 33 educators and administrators taking a graduate course in educational philosophy. All 55 subjects were asked to answer a questionnaire evaluating their response to the lecture. The audience loved "Dr. Fox": "All respondents had significantly more favorable than unfavorable responses. . . . One even believed he [had] read Dr. Fox's publications." Among the subjective responses quoted by the investigators were the following: "Excellent presentation, enjoyed listening. . . . Good analysis of the subject. . . . Knowledgeable."

What does this experiment about the "pseudopsychiatrist as educator" prove? To Naftulin and his colleagues, it proves that "If a lecturer talks at a group, with no participation permitted to the group [a question-and-answer period was, however, permitted], then a mellifluous, trained actor might do just as well, possibly better, than an uncharismatic physician."* That is not

* This observation, by a group of respected academics, is astonishingly similar to Hitler's famous remark that, in politics, a big lie works better than a small one. Hitler did not

what it proves to me. Like the Rosenhan pseudopatient study, the Naftulin pseudopsychiatrist study proves only that when it comes to the institutionalized deception and gobbledygook of psychiatry, observers trained in mental health are unable to distinguish fake fakes from real fakes—not exactly a surprising conclusion. As if to support this contention, Naftulin and his co-workers offer this conclusion, couched in the appropriate gobbledygook: “[The] study supports the possibility of training actors to give legitimate lectures as an innovative educational approach toward student-perceived satisfaction with the learning process.” The authors do not explain why medical students (or their parents) would want to pay \$5,000 or more to listen to actors talk about nonexistent subjects they know nothing about. No doubt they envision a system of psychiatric education patterned in the tradition of psychiatric “diagnosis” and “treatment”—true facts being mendaciously misdescribed each step of the way.

CONCLUSION

Psychiatry, paraphrasing Ambrose Bierce, is the pretentious art of lying for one’s profession. The psychiatrist, paraphrasing Sir Henry Wotton, is a dishonest man sent to lie wherever he can for the good of his guild. The psychopathologist lies about the prevalence and severity of psychiatric illness, the psychotherapist lies about the efficacy and safety of psychiatric treatment, and the forensic psychiatrist lies about the “mental health” and “mental illness” of the defendant.

Behind the massive structure of psychiatric lies there are, of course, grains of genuine truths. These are the truths of real human suffering honestly expressed, and of real human succoring conveyed by honest healing words.⁵³ Unfortunately, but perhaps inevitably, organized psychiatry has been largely a struggle against, rather than for, such truths and “therapies.”

NOTES

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5. The President’s Commission on Mental Health, *Mental Health in America—1978* (Washington, D.C.: U.S. Government Printing Office, 1978), p. 8.
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mention truth at all; he knew it was useless for capturing crowds and was therefore not interested in it. In the main, psychiatrists and psychiatric patients exhibit the same thirst for big “mental health” lies as do crowds of disaffected people thirsting for the redemptive messages of messiahs, whether religious or political.

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27. Freud, *Origins, op. cit.*, pp. 216-217.
28. S. Freud, "On the History of the Psycho-Analytic Movement" (1914), in *The Standard Edition, op. cit.*, Vol. XIV, pp. 1-66; pp. 17-18.
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