The Therapeutic State | Thomas Szasz

The Medicalization of Suicide

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Everyone now knows that suicide is a medical problem. Not long ago everyone knew that it was a religious and criminal problem. Bereft of the power of critical thinking and lacking historical knowledge, the human mind is a sponge for absorbing and magnifying error. The great American humorist Josh Billings (Henry Wheeler Shaw, 1818–1885) said a mouthful when he opined, "The trouble ain't that people are ignorant: it's that they know so much that ain't so."

In the medieval world Saint Augustine and Saint Thomas Aquinas had declared that whoever deliberately took the life given to him by his Creator showed disregard for the will and authority of God and was guilty of a mortal sin. In the modern world "self-slaughter" was declared a crime. In Great Britain the crime of suicide was repealed by the Suicide Act of 1961; those who failed in the attempt would no longer be prosecuted.

After 1776 the United States adopted English criminal penalties against suicide, but American courts never enforced them. Nevertheless, as late as 1963 attempted suicide still was a felony in six states—North and South Dakota, New Jersey, Nevada, Oklahoma, and Washington. Today, everyone "knows" that suicide is a mental illness, proving the wisdom of Johann Wolfgang von Goethe's (1749–1832) observation, "In the newspapers and encyclopedias, in schools and universities, everywhere error rides high and basks in the consciousness of having the majority on its side."

Because medicalization suffuses our thinking about all manner of human problems, we bracket the term "suicide" with "prevention," implying a claim for which there is no evidence—namely, that suicide is a "medical problem." We prevent diseases but prohibit crimes. Disease is said to be prevented, not prohibited, even when a State mandate is involved, as with vaccination. Driving while intoxicated is a crime though the purpose of the law is to prevent accidents committed by drunk drivers.

Suicide prevention ought to be called "suicide prohibition." Why is this important? Because suicide is action-doing, not disease-enduring, and because the basic tool of the State is coercion not therapy. Preventive measures are aimed at keeping undesirable events from happening, prohibitions at preventing persons from engaging in behaviors defined as "dangerous" to themselves or others. The differences between these two modes of influencing/controlling the conduct of others are illustrated by the differences between the "war on cancer" and the "war on drugs." The former is fought with money and medical technology, the latter with laws and prisons.

The psychiatric perspective on life began to seep into the zeitgeist of modern Western culture in the nineteenth century and was ripe when Freud arrived on the scene in the 1880s. His influence

lay mainly in his successful elaboration and popularization of the language of psychopathology and psychotherapy. By the time he died, in 1939, Wystan Auden was moved to offer this marvelously perceptive memorial tribute to him: ". . . if often he was wrong and, at times, absurd, / to us he is no more a person / now but a whole climate of opinion / under whom we conduct our different lives."

"Mental Illness" and the Loss of Credibility

People know but do not experience that our everyday language refracts social reality in accordance with prevailing cultural beliefs. As long as a person remains unentangled in the State's psychiatric control system, he is not likely to understand its actual functioning and its threat to basic human rights. Once he becomes a "mental health consumer," he is considered credible only when he praises the system. When he criticizes it he is dismissed as lacking insight into his illness. (Psychiatric critics who are not mental health consumers are also likely to be dismissed.)

Today, suicide prohibition is a vast, bureaucratic legal-psychiatric enterprise. From the lawyer's and psychiatrist's point of view, it is medical treatment. From the would-be suicide's point of view, it is deprivation of liberty. The following excerpt from an email I received some time ago is a typical example of a "suicide prevention intervention" presented by and from the point of view of a "prevented" subject:

I am a doctoral student in psychology. . . . I was depressed and, seeking support, had called my parents and told them that I was suicidal. They promptly called the police, who arrived at my apartment, handcuffed me, and transported me to the local "psychiatric center." After many hours of waiting, the student—now called a "patient"—was "evaluated." The psychiatrist "spoke to me for approximately 10 minutes before she decided that it was in my 'best interest' for me to be committed to a psychiatric ward. I protested, of course, believing that wrenching me away from life would cause far more harm than good. She expressed no empathy, however. . . . I was finally released from the hospital five days after my arrival. I can certainly say that I received no benefit from my stay in the psychiatric ward. I am more depressed than I was before, having been traumatized by my experience with the mental health care system.

Educational authorities deny the real consequences of suicide prevention for college and university students and persist instead in restating their medicalized mendacities. Following three suicides within a period of a few months, Cornell University President David J. Skorton basks in his own platitudes: "On and off campus, there is an epidemic of suicide among young people. . . . As a father, teacher, physician and president of a university where we have recently experienced the horror of multiple suicides, I have long been concerned about this national public health crisis."

Every death is a crisis for the affected family, but three deaths, or 30 deaths, do not constitute an "epidemic" or a "national public health crisis" in a nation of 300 million people.

"What is the way ahead?" Skorton asks. His answer: "[W]e need more research into the factors that lead to suicide in this age group and how to identify those at greatest risk. . . . [S]tudents must learn that it is smart to ask for help."

This is a lie. The college student who trusts college mental health personnel is misguided. The psychiatrist, psychologist, or social worker employed by the college serves the interests of the college not the student: The student who seeks such a professional's "help" is more likely to be entrapped and harmed than empowered and helped.

So what can the parents of young-adult children, struggling with the hazards inherent to that period of life, do to protect them? They can avoid defining them as "mentally ill," enlighten them about the true function of school mental health services, and thus shield them from their "care." And they can continue to fulfill their responsibilities, as the parents of nearly grown-up children, to demonstrate their love by listening, advising, and supporting them in their struggle.

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