

Idleness and Lawlessness in the Therapeutic State

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From an economic point of view, persons may be divided into two groups, producers and parasites. Producers provide for their own needs by their labor or capital. Parasites do not. Some, for example infants and indigents, are unable to support themselves; called dependents, they receive food and shelter from parents, family, or the state, or perish. Others, for example criminals, are unwilling to support themselves lawfully; called predators, they use force or the threat of force to extract from producers the goods and services they want. Unless a person is able and willing to be a producer, he must become a dependent or a predator or perish. Thus, any circumstance—biological, cultural, economic, or political—that discourages or prevents peaceful market relations among productive adults encourages dependency, predation, or both.

How does the chronic mental patient (in this essay, I use certain terms and phrases—such as mental illness, mental patient, schizophrenia, psychiatric treatment—whose customary implications and conventional meanings I reject, but to avoid defacing the text, I have refrained from placing such prejudging expressions between quotation marks each time they appear; also, I use the masculine pronoun to refer to both men and women and the terms “psychiatrist” and “mental patient” to refer to all mental health professionals and their clients)—who is homeless, often breaks the law, begs for money and scavenges for food, and receives

disability payments from the Social Security system for schizophrenia—fit into this scheme? Is he a dependent or a predator or both? Before we can answer this question, we must reject the facile but fallacious assumption that there is an intrinsic connection between illness and idleness or between illness and lawlessness. Most chronically ill persons—for example, diabetics—are not idle, are not economically dependent, and are not inclined (because of their illness) to lawlessness. In contrast, most chronic mental patients—especially schizophrenics—are idle, economically dependent, and inclined (allegedly because of their illness) to lawlessness.

Evidence—and Lack of Evidence

Prior to this century, there was no schizophrenia. The diagnosis of dementia praecox—modeled after the grand old cause of madness, dementia paralytica (a form of tertiary syphilis affecting the brain)—was invented by Emil Kraepelin in 1889. In 1911 Eugen Bleuler replaced the term “dementia praecox” with “schizophrenia.” Although there was no evidence that these diagnoses identified genuine diseases, each term was eagerly accepted as the name of a brain disease (or a group of brain diseases). In fact, both Kraepelin’s and Bleuler’s original accounts show that they were aware that while their patients’ idleness was a reality, their illness was not. Kraepelin wrote:

Gentlemen,—You have before you today a strongly-built and well-nourished man, aged twenty-one.... The patient gives us a correct account of his past experiences. His knowledge speaks for the high degree of his education; indeed, he was ready to enter the University a year ago.... No physical disturbances can be definitely made out, except exaggerated kneejerks.... [I]n spite of his good education, he lies in bed for weeks and months, or sits about without feeling the slightest need of occupation.... [H]e declares that he is ready to remain in the hospital for the present.... As the illness developed quite gradually, it is hardly possible to fix on any particular point of time as the beginning.

Although this person exhibited no evidence of being ill, Kraepelin called him a "patient" and attributed his behavior to a devastating brain disease. Bleuler's account of schizophrenia resembles Kraepelin's. He wrote:

Idleness facilitates the predominance by the complexes over the personality; whereas regulated work maintains the activity of normal thinking. These recommendations cannot always be fulfilled since we are often dealing with *patients who are dependent on their parents and on others*.... Many schizophrenic Italians are quite willing to remain in the hospital and be fed, clothed, and cared for.

Similar descriptions of chronic mental patients abound in the modern psychiatric literature. Here are a few examples: "A working-class unemployed schizophrenic, recently discharged from hospital, sat at home all day, brewing tea and smoking, and playing records, and proving himself a great aggravation to his mother." The language is misleading. This man did not sit "at home." He sat in a house that was another person's home, to the maintenance of which he did not contribute, and where he was not welcome. In another case, a mother describes her schizophrenic daughter's presence in the parental home thus: "Whenever Ruth is at home, he [her father] feels continually irritated by her lack of purpose and idleness." A report in a psychiatric trade journal begins as follows: "John S. has chronic schizophrenia. For most of his 40 years he has lived at home with devoted parents.... John has frequent bouts of bizarre and uncontrollable behavior." Finally, a typical newspaper article recounts the odyssey of a physically

healthy fifty-year-old man who, after having spent virtually all of his adult life in mental hospitals, now "spends most of his time painting acrylic portraits, ocean scenes, and images with Oriental hummingbirds.... [He] takes long walks around the city, attends [baseball] games, and borrows mysteries from the main library."

Today, after a century of intensive research, there is still no evidence that schizophrenia is an illness. It is clear, however, that many persons called schizophrenic are idle and lawless. Which is cause, and which is consequence? Does schizophrenia cause individuals to be idle and lawless, or are individuals called "schizophrenic" because they are idle and lawless? I submit that the incentive for inventing this diagnosis/disease was to establish, by medico-legal fiat, that certain dependent and disorderly persons are sick and that their unwanted and unlawful behaviors are the unintended symptoms of their disease. At any rate, that is still the most conspicuous social function of the diagnosis of schizophrenia.

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The facts stare us in the face. "Lack of money," as Lord Bauer pithily put it, "is not the *cause* of poverty, it is poverty." Similarly, schizophrenia is not the *cause* of idleness and lawlessness, it is the *name* of the fictitious disease that we attribute to certain persons exhibiting such behaviors.

If we define deviance down, we increase the number of socially disruptive persons in society. By the same token, if we define competence up, we increase the number of unemployable persons in society. The *Wall Street Journal* (1 March 1994) quotes a French psychiatrist complaining that "to prescribe an anti-depressant to a jobless person whose benefits are running out may seem normal. But when the practice is repeated hundreds of thousands of times, it amounts to a sort of society-wide medical treatment of unemployment." This "treatment" is as fictitious as the alleged disease it supposedly combats. The truth is that, in the nineteenth century, Western societies began to use psychiatric diagnoses to validate idleness as illness, and then used the pretext of an incurable psychosis to justify psychiatric indoor relief—that is,

maintaining certain adult dependents as (involuntary) patients in mental hospitals. In the 1950s, psychiatrists began to administer neuroleptic drugs to mental hospital patients to validate the claim that formerly incurable mental diseases were treatable, and Western societies then used the pretext of drug-induced remission of schizophrenia to justify psychiatric outdoor relief—that is, maintaining certain adult dependents on drugs and disability checks.

Behavior as Illness

Bleuler's original account of the behavior of schizophrenic patients is also replete with remarks about their lawlessness, which, without any evidence, he also attributes to their alleged illness. He wrote:

A large part of the so-called impulsive behavior is automatic.... [The patient] suddenly breaks loose, strikes out, destroys in the wildest fury and anger.... Regrets after such releases are rare, of course, in schizophrenia. The patients feel their behavior is justified.... Often they assert that it was the "voice" that drove them to fury.

Not surprisingly, the relatives of schizophrenic patients welcome the view that their kinfolk's criminality is a symptom of their malady. This letter, from the mother of a mentally ill son, is typical:

Our adult son... is currently in jail as a result of extremely violent behavior caused by his illness. Because of his illness, he is dangerous to his family and others. The dangerous symptoms of our son's illness are not unique to him. In fact, through our contacts with the Massachusetts AMI and NAMI, we have found many, many families who have suffered the same fear and terror we have experienced *because of behavior caused by the mental illnesses of family members.*

To support her argument, the writer cites newspaper reports about "mentally ill individuals who... killed a parent [and] broke into parents' home and assaulted them." Another patient's sister writes: "The way I look at it, he is one of the most unfortunate individuals. He suffers from paranoid schizophrenia, and during a very psychotic episode, seventeen years ago... he caused a terrible tragedy. It ended in the loss of life to two people he was very close to.... he suffers from a no-fault neurobiological disorder."

Psychiatrists insist that schizophrenia is a brain disease like Parkinsonism, but it is also unlike Parkinsonism

(and other neurological diseases) because it causes the patient to display disorderly behavior. This alleged fact imparts unique status to mental illnesses as moral and legal justifications for depriving innocent persons of liberty (civil commitment) and for excusing guilty persons of responsibility for their crimes (the insanity defense). Moreover, science, medicine, law, and public opinion alike now accept the patently absurd claim that psychiatrists can distinguish brain diseases that cause idleness and lawlessness from those that do not.

The psychiatric perspective on behavior thus commits us to attributing a lawless and unproductive lifestyle to mental illness (as a "no-fault brain disease") and a law-abiding and productive lifestyle to the free will of a responsible moral agent (for which he deserves credit).

The Socially Competent Self

One of the greatest social problems facing American society today is that it produces an ever-increasing number of able-bodied young adults who are unproductive, idle, and lawless. Many are said to suffer from schizophrenia. According to the *Psychiatric Times* of November 1993, individuals diagnosed as schizophrenic "use 25 percent of all U.S. hospital beds, 40 percent of all long-term care days, and 20 percent of all Social Security days. The total economic costs associated with schizophrenia are estimated at \$33 billion."

Until relatively recently, many common behaviors—such as idleness (vagrancy), homosexuality (perversion), masturbation (self-abuse), and suicide (self-murder)—were considered to be crimes, sins, or both. In this century, all of these behaviors have become medicalized. Some—for example, masturbation and homosexuality—were first transformed into mental diseases and were then accepted as normal behaviors; others—for example, idleness and suicide—still tend to be viewed as illnesses or the manifestations of illnesses.

Why does one young person become a productive adult, and another an unproductive schizophrenic? To answer this question, we must begin with the plain fact that, to take his place in modern society, a person must achieve a certain level of social competence and economic usefulness, and that to do so, children and adolescents must develop self-discipline and acquire marketable skills. In short, young people must prepare themselves to be productive by being useful to others, as others define usefulness.

Although the development of a socially competent self is clearly of paramount importance for the fate of

both the individual and the society of which he is a member, this subject receives little or no attention in the psychiatric literature. Instead, that literature is replete with accounts that exaggerate the significance of the individual's experiences during early childhood, to which many experts attribute a destiny-determining role in the life of the adult. While the early years of life are important, the remaining years of childhood and youth—from, say, five to twenty-five—are even more important. It is during that period that the young person—nurtured or neglected by family, church, school, and society—must design, build, perfect, and test himself, as a future adult.

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Notwithstanding the contemporary American delusion that a good parent loves his child unconditionally, such tolerance has limits and imposes deadlines. The limits depend largely on the parents' expectations. The deadlines, for the most part, are set by society and comprise the various stages of the passage from childhood to adulthood. This passage begins with the child's expulsion from home to attend school, continues with his development from childhood to adolescence, and is completed with his transition from adolescence to adulthood. The entire process is expected to end during the third decade, at the latest. In short, between his teens and twenties, the young person must learn to become useful to others and stand on his own feet. If he fails to accomplish this task, he and his family are destined to face serious difficulties, nowadays often conceptualized in psychiatric terms, typically as the manifestations of schizophrenia.

If this process of maturation goes awry, the adolescent begins to envy his peers and to feel inferior to them. To dull the pain of this experience, he often protects himself by means of a self-destructive psychological defense. He tells himself he is better than others, becomes arrogant and conceited—psychiatrists call it “narcissistic”—and embraces the logic of hostile entitlement: “I am not a useless person. Others are unworthy of my doing anything for them. They have more than I do and ought to feel guilty and help me.” (There are important similarities between the antiproducer mentality of the chronic mental patient and the anti-

capitalist mentality of the socialist/communist, who, as it were, tells himself, “Everything the producers have, they have gained by exploiting others. I have a right to rob them of their possessions.” I realize, of course, that sometimes psychiatrists also call productive persons—for example, James Joyce and Ludwig Wittgenstein—“schizophrenic.”)

If parents and peers respond to the adolescent's failing struggle by treating him as an individual with “special problems,” which they often do, they compound the problem. Gradually, parents and teachers expect less and less of the “problem child,” and he does less and less for them and himself. Once past adolescence, he is likely to slide into continued dependence—on parents, as long as they support him, then on relatives or social and welfare agencies. Somewhere down this path, the young adult may commit or threaten to commit a violent act—against himself or others—which his family can no longer ignore. He is then brought into the presence of a psychiatrist, who diagnoses him as schizophrenic and launches him on the career of the chronic mental patient.

The point I want to emphasize is that an adolescent is not yet a functioning member of adult society. It is an error, therefore, to speak of his “dropping out.” First, he must “drop in.” If he fails to do so, he is likely to find himself in a situation similar to Holden Caulfield's predicament in J. D. Salinger's *The Catcher in the Rye*.

Management of Madness

Individual liberty is contingent on a social system that guarantees respect for private property and market relations. In turn, the game of market relations is contingent on players who understand the rules, possess the capacity to adhere to them, and can be held accountable for violating them. These requirements exclude children (persons under the age of consent). Does this mean that all chronological adults are able to participate in the market? If not, how do we separate those who are able from those who are not?

The inability or unwillingness of infants, idiots, and the insane to participate in the reciprocal human relations characteristic of the market has always been recognized. Since the Middle Ages, English law treated these three classes of persons as if they comprised a homogeneous group, characterized by the absence of the capacity for reasoning and self-control, rendering them unfit to participate in political society. Accordingly, they were deprived of the benefits of liberty and the burdens of responsibility were lifted from their shoulders.

Infancy and idiocy pose relatively few problems of definition and identification. As for insanity, for a long time it was a rare condition, because only individuals who behaved like the proverbial rampaging "wild beast" were categorized as mad. As long as there were few such persons in society, their management presented no special political problem. However, with the establishment of the trade in lunacy toward the end of the seventeenth century, the criteria for madness began to expand and the stage was quickly set for the development of the psychiatric problems that bedevil us today. Public madhouses soon became the rage and the plague of insanity descended on the Western world. Today it is psychiatric doctrine that mental illness is a virtually universal affliction. Nevertheless, the bracketing of the insane with infants has remained the operative justification for the legal control of the mentally ill. "Freedom," writes Milton Friedman, "is a tenable objective only for responsible individuals." He is right. But then he adds: "We do not believe in freedom for madmen or children." Let us examine in what ways madmen are like, and unlike, children.

The sole similarity between infants and insane persons is that both are treated paternalistically. The differences between them, however, could hardly be greater. Infants cannot live as homeless street persons, commit crimes, or kill themselves; insane adults can, and often do, all these things. Finally, even if we grant the claim that some mental patients are immature (childlike) and that it is therefore appropriate to treat them paternalistically, it does not follow that they are sick (in any meaningful sense of that term). Immaturity is not a disease. A childish adult needs to grow up, not to be involuntary drugged. Clearly, the analogy between children and madmen is strategic, not descriptive. G. K. Chesterton had it right when he observed that "the madman is not the man who has lost his reason. The madman is the man who has lost everything except his reason."

The ostensibly altruistic coercion of protesting adults should always arouse our suspicion. Adults—even immature, irrational, or insane adults—are not children. "There is," wrote René Descartes, "no soul so weak that it cannot, properly directed, acquire full control of its passions." Indeed, responsibility is not merely a personal trait of the Other; it is also an expectation we have of him. Thus, we hold young children and even dogs responsible (for controlling their urges to urinate in their pants and to bite people).

The modern management of madness has obscured the basic differences between children and adults and the rules appropriate for controlling the conduct of each group. Children are not small adults,

and schizophrenics are not children in adult bodies. The criteria for the misbehavior of children are laid down and enforced by parents and teachers, whereas the criteria for the misbehavior of adults are laid down by legislators and enforced by judges, juries, and prison guards. It is morally desirable that parents discipline their children, but it is morally undesirable that the state discipline adults. Instead, adults ought to be punished for their crimes (which may or may not have the effect of disciplining them). Both the aim and the effect of psychiatrizing the nature and control of the misbehaving adult is to obscure and abolish these fundamental distinctions. In our misguided effort to combine treating the sick with punishing the criminal, we have all but destroyed our fundamental ideas about moral agency, individual liberty, and personal responsibility.

The State as Therapist, as Tyrant

Individuals and institutions that enforce the law must have power. In theocracies, the sovereign is answerable only to God, who is above man-made law. Hence, the historic threat to personal liberty has been unlimited government, and the history of liberty, especially in the English-speaking world, has been the history of efforts to limit the sovereign's sovereignty.

In the democratic West today, however, the principal danger to liberty lies not so much in the state's naked power to oppress by lawlessness as in its subtle power to seduce and infantilize by offering to protect people from the vicissitudes of life, especially illness. Historically, this is a recent threat. Hence, political philosophy lacks a tradition of opposing the State as Therapist comparable to its tradition of opposing the State as Tyrant. Even Ludwig von Mises was blind to this threat. He wrote: "Even if we admit that every sane adult is endowed with the faculty of realizing the good of social cooperation and of acting accordingly, there still remains the problem of infants, the aged, and the insane. We may agree that he who acts antisocially should be considered mentally sick and in need of care." Although Mises recognized that "psychiatrists are vague in drawing a line between sanity and insanity," he stated: "It would be preposterous for laymen to interfere with this fundamental issue of psychiatry." But precisely because the psychiatrist's authority to "draw a line between sanity and insanity" forms the basis of his power to deprive persons of liberty and because laymen bear the ultimate responsibility for delegating that power to him, laymen *must* address the twin issues of insanity and psychiatric power.

I have long maintained that we should reject psychiatric paternalism and accord the same rights to and impose the same responsibilities on mental patients as we accord to and impose on persons with bodily illness or no illness. The principle of *parens patriae* suffices and is the sole appropriate mechanism for the care and control of incompetents, that is, of adults who are severely mentally retarded or have been rendered temporarily or permanently unconscious or demented by injury or illness. Such persons, exemplified by the comatose patient, can neither seek nor reject medical help.

Since the modern liberal sees the state as a protector, he welcomes therapeutic paternalism as enlightened scientific-humanitarian progress replacing archaic religious-judicial punitiveness. It is therefore especially noteworthy, and unfortunate, that classical liberals and conservatives—who tend to see the state as a threat—also welcome its coercive-therapeutic interventions, exemplified by its treatment of the mental patient as a childlike person who cannot be held responsible for his conduct. George F. Will declares: "Most [solitary homeless persons who live on the streets] are mentally ill." James Q. Wilson states: "Take back the streets. Begin by reinstitutionalizing the mentally ill." Charles Krauthammer agrees: "Getting the homeless mentally ill off the streets is an exercise in morality, not aesthetics.... Most of the homeless mentally ill...are grateful for a safe and warm hospital bed." But if they are grateful, why must they be coerced?

I agree with the tacit premises of these commentators. Public places belong primarily to the productive members of society. Regardless of whether we call individuals indigents or insane, homeless or mentally ill, persons who enjoy the benefits of liberty have no right to treat public places as their domiciles or otherwise interfere with the public order. However, I reject as hypocrisy calling troublesome persons "troubled," and punishing them under the guise of giving them medical treatment.

The history of psychiatry is eloquent testimony to the failure of coercion masquerading as care and cure. However, as soon as ostensibly altruistic interventions (political or psychiatric) result in so-called unintended consequences, plainly harmful to their denominated beneficiaries, the cry goes up that the interventionists had only good intentions. It is a singularly hollow claim. We cannot know another person's intentions; the coercive interventionist can justify his use of force only by proclaiming good intentions; and coercive interventions result in harm-

ful consequences for their denominated beneficiaries so regularly and indeed predictably that I believe we should conclude that these consequences are not unintended.

Because the self-correcting mechanism of the market is absent from both statist-economic and statist-psychiatric interventions, each diminishes the ostensible beneficiaries' freedom and self-defined best interests. Foreign aid increases the power and prestige of the political authorities who receive and administer it and impoverishes the people it is supposed to help. Psychiatric aid similarly increases the power and prestige of the psychiatric authorities who receive and administer it and diminishes the dignity and liberty of the people it is supposed to help; and by disjoining rights and responsibilities, it also places society at the mercy of a class of predators endowed with inalienable psychiatric excuses.

SUGGESTED FURTHER READING

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