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# The Psychiatrist as Moral Agent<sup>1</sup>

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I shall try to show that the psychiatrist's moral problems are not nearly as complicated as they seem. If a person seeks psychiatric help, the psychiatrist must decide whether, and on what terms, to help him. In free societies, the privately practicing psychiatrist is free to accept or reject patients as he desires. In such societies, the institutional (or hospital-employed) psychiatrist also remains free — to treat voluntary patients only on terms acceptable to himself and to the patients, and to quit his job if his employer requires him to engage in acts which he considers to be morally unacceptable.

The crux of the psychiatrist's moral dilemma thus lies in his attitude toward individuals deemed to be mentally ill who do not seek his services or who actively reject them. Toward such persons, the psychiatrist can adopt one of two antithetical postures: he can embrace coercion as compassion and therapy, or he can reject it as disrespect for the rights of others and capitulation to our craving to control people. The former posture is the official position of modern "scientific" psychiatry the world over. The latter posture expresses the sentiments of the American Enlightenment, as exemplified by Thomas Jefferson's beautiful statement of it in a letter to his grandson:

When I hear another express an opinion which is not mine, I say to myself, he has a right to his opinion, as I to mine, why should I question it? His error does me no injury, and shall I become a Don Quixote, to bring all men by force of argument to one opinion? If a fact be misstated, it is probable he is gratified by a belief of it, and I have no right to deprive him of the gratification. If he wants information, he will ask it, and then I will give it in measured terms; but if he still believes his own story, and shows a desire to dispute the facts with me, I hear him and say nothing. It is his affair, not mine, if he prefers error.<sup>2</sup>

Because a great deal of what we call mental illness is actually a difference of opinion between patient and psychiatrist; and because a great deal of what we call psychiatric treatment is actually the psychiatrist coercing the patient to change his opinion (psychiatrists now often refer to themselves as "change agents") — it follows that Jefferson's

admonition has the most urgent bearing on our present psychiatric-ethical concerns.

Like all human beings, mental patients and psychiatrists engage in various actions and offer certain justifications for them. Sometimes, each of them uses force. Since, simply put, politics is about the use of force and ethics is about the justifications for its use — the behaviors of both patients and psychiatrists are, partly or wholly, ethical and political in nature.

Looking at psychiatry as politics rather than medicine, as ethics rather than therapy, alerts us to the issue of power and allows us to see some simple, but all-important, facts about psychiatric patients and psychiatric physicians. For example, it allows us to see that mental patients often use fraud and force because they are weak and feel that that is the only way they can gain attention or achieve some other goal that they seek; and that psychiatrists often use fraud and force because they are strong and are expected, by society, to protect people from the annoyances and aggressions of mental patients. It allows us to see, also, that because the psychiatrist is typically the stronger of these two parties (and because he represents society's interests and values), the psychiatrist will fashion and control the vocabulary in which his own and his patients' actions and justifications are couched. The briefest illustration of this important phenomenon must suffice here.

Mental patients act: when their action involves deception, threat, or injury to self or others, we regard it as a *symptom* — the manifestation of *psychiatric illness*. Psychiatrists also act: when their action involves deception, threat, or injury to patients (or others), we regard it as a *treatment* — the expression of an effort to *cure the patient*.

Mental patients justify their actions: we call such accounts — especially if the patients are considered to be psychotic — *delusions*. Psychiatrists also justify their actions: we call such accounts — especially if the psychiatrists impose their interventions on involuntary patients — *therapeutic indications*.

In short, because in reality, the mental patient is typically a weak “aggressor” and the psychiatrist a strong “defender”; and because the psychiatrist defines what is justified or unjustified, right or wrong — it follows that, in the psychiatric imagery, the involuntary patient always appears as an aggressor, against himself or others — and the institutional psychiatrist always appears as a defender, of the patient's own best interests or of society itself. In order to get a handle on what we now regard as the moral problems of psychiatry, we must shift our focus and look at the patient, the psychiatrist, and the society in which they live from a different angle. One such angle is political philosophy — in particular, libertarian political philosophy.

Clearly, human beings are incapable of forming even a small group — much less a large, complex society — without resorting to some use of force. The practical question before us thus comes down to choosing between those uses of force of which we approve, and those of which we disapprove. In the libertarian political philosophy, only the reactive use of force is legitimate: that is, force may be used only in self-defense. The *active* use of force is never legitimate: that is, there is no acceptable justification for initiating the use of force. Accordingly, to a libertarian,

coerced psychiatric interventions and their justification on the grounds of therapy bear an alarming resemblance to coerced religious observances and their justification on the grounds of theology. On the other hand, to those who believe that health is more important than freedom, coerced psychiatric practices will appear to be justified by their therapeutic rationale, just as to those who believed that faith was more important than freedom, coerced religious practices appeared to be justified by their theological rationale.

These remarks should suffice as an outline of the general concepts and principles that, I believe, should inform our deliberations concerning contemporary psychiatric-ethical dilemmas. Without such principles to guide us, we are easily misled into trying to decide each case, ad hoc — on what seem to be its own merits; with them, we can steer our course through the troubled waters of psychiatry — ignoring the waves that beat against our ship and looking to the stars to lead us to our destination.

Like other professionals, the psychiatrist is a product of culture. There was a time, not long ago, when there were no psychiatrists (just as there were no computer programmers or airline pilots). The way the psychiatrist came into the world is important for understanding his subsequent development and present predicament.

The psychiatrist — as some might put it — was born twice. First, he was born as a child of the seventeenth century, from the womb of the institution that was then created to house society's human refuse — among them, the so-called insane. He was born again, as a child of the nineteenth century, from the womb of the privately practicing physician whose task was to care for the needs of his patients. This is familiar territory, but I shall do my best to throw some fresh light on it.

The psychiatrist's first identity — as alienist, madhouse-keeper, institutional psychiatrist — grew out of modern society's need to protect itself from some of its troublesome and offending members. This psychiatric role is not especially problematic: it presents us with the psychiatrist as jailer, colonist, parent — segregating and "caring" for individuals who are inadequately socialized, psychologically immature, or otherwise incapable of taking care of themselves. Whether couched in the positive terms of care and therapy, or in the negative terms of control and punishment — this psychiatric identity is coeval and continuous with the traditional roles of the Platonic politician and physician. Such a psychiatrist's relationship to his patients is that of a superior to a subordinate. Whether the arrangement benefits the former more than the latter is, for the moment, besides the point.

The psychiatrist's second identity — the born-again psychiatrist — came into being in the nineteenth century, in Western and Central Europe. Two of its most important and representative exemplars were Sigmund Freud and Carl Jung. These modern masters of psychotherapy came from, and embodied, a recent cultural tradition — namely, that of modern capitalism and individualism or so-called nineteenth century liberalism. What characterized this new ethos was that it extolled individualism and self-government. Indeed, there is a perfect parallel between the political ideals of the founding fathers and the psychiatric ideals of the founders of modern psychotherapy: as the national self-government of peoples is the ultimate political value for the former, so

the personal selfgovernment of individuals is the ultimate psychiatric value for the latter.

In this light, Freud and Jung were pioneers only in the sense that they were among the first physicians to apply the fundamental moral principles of the Enlightenment — and, more specifically, of nineteenth-century individualism — to so-called mental patients (but among them only to those classified as neurotic rather than psychotic). Although the road they travelled was difficult and uphill all the way, it was not a new path. On the contrary, it was in their day already well-travelled by the men (the women were excluded) who had founded the so-called free professions. That term, though it sounds old fashioned now, had some vitality up until the Second World War.

What did the term “free professions” mean? It meant mainly medicine and the law. Architecture and some of the performing arts were on the fringes of this category. The importance of this concept lay in the fact that it cut across the all-important intellectual distinction between the sciences and the humanities (in German, the *Naturwissenschaften* and *Geisteswissenschaften*), locating the “free professional’s” distinctive identity in his *freedom*. To do what? To sell his personal services, to another person, in the free market. Physics and chemistry, archeology and history, were thus not “free professions,” because their members sold their services to institutions or industries, instead of or to individuals. However, since this feature of the “free professional’s” work, taken in isolation, would have made him indistinguishable from the businessman, manufacturer, or even the laborer, physicians and lawyers were eager to identify themselves as both “free” (that is, selling their services to clients) — and “professional” (that is, having ideals “higher” than mere self-interest and profit). This was a noble ideal, celebrating — as did many of the economic, legal, and political arrangements of the nineteenth century — the value of individual effort, reward, and responsibility. The Protestant and capitalist roots of this ideology need not be belabored here. What needs emphasizing, instead, is that just as the free market, replacing the feudal order, liberated both the seller and the buyer from a certain kind of politically pre-ordained pattern of relating to one another — so the emergence of the free professions liberated both doctors (lawyers) and patients (clients) from relating to one another in a similarly predetermined manner. The result was that both the psychiatrist (or, more precisely, the “psychoanalyst”) and the patient (or “neurotic”) became free agents vis-a-vis one another.

But freedom needs to be regulated — if not from without, then from within. With the constraints of traditional mad-doctoring removed from it, whence will come and what will be the rules governing the relationship between psychiatric doctor and psychiatric patient? There were two important — and obvious — sources for such constraints.

If the relationship between the psychiatrist and the patient rests neither on the former’s superiority over the latter, nor on domination and submission, nor even on paternal love and filial duty, then it must be based on the same principle on which other service (and business) relationships rest — namely, contract. Simply put, this means that each party promises certain goods or services — or behaviors, in the case of psychiatry — to the other. If either party defaults on his promises, his

partner is free to break off the relationship (and seek legal redress for breach of contract).

Though all-important, contract is not the only principle regulating this new psychiatric relationship. There is the additional principle of professional loyalty. To be sure, this principle did not come into being in the nineteenth century — but it was powerfully reinforced at that time by the spirit of individualism and contract. Indeed, so long as the psychiatric relationship was paternalistic — not to say despotic — appeals to professional loyalty by psychiatrists were doomed to appear hypocritical (as, indeed, they still do in such circumstances). The point is that the ideal of professional loyalty could not truly come into its own, could not assume the character we now usually associate with it, until it was combined with the principle of contract between free agents.

The alloy formed by a combination of these two elements is much stronger than either of its component parts. Professional loyalty without contract is weakened by the physician's divided loyalties between his client and his peers (or the state) — as the Hippocratic Oath, for example, dramatically illustrates. According to that oath, the physician owes his primary loyalty to his fellow professionals. Contract without the principle of professionalism is weakened by the healer's existential advantage over the sick person in the bargaining situation — as the classic satires of physicians leading unsuspecting clients into a life of doctoring illustrates.

The splendid combination between professionalism and contract that thus developed was, moreover, strongly supported by the individualistic-democratic political ethos of nineteenth-century liberalism. The physician (like the defense lawyer) was set free of competing loyalties. He no longer had to render homage unto both Ceasar and God. He now could — indeed, was expected to — pledge his undevoted loyalty to his patient. This, in turn, made it possible for the patient to place his undivided trust in his physician. It was this situation that Freud seized upon and turned into the foundation upon which he built the edifice of psychoanalysis as a “technical procedure.” For what else is “free association” if not the transformation — into a quasi-medical, quasi-scientific “instrument” — of what is, at bottom, simply one side of a professional relationship characterized by the physician's undivided loyalty toward the patient? There would be no point in such total therapeutic loyalty to the patient — and in the patient's placing complete trust in the doctor — unless the patient had some weighty secrets to reveal that needed protection.

The psychoanalytic situation thus epitomizes the confluence of two powerful historical streams. One stream, as Freud himself acknowledged, came from religion — specifically from the Catholic confessional and the Protestant cure of souls. In these priestly duties, the clergyman owed undivided protection to his parishioner for his communications — a code of ethics with a noble history of fidelity to this ideal. However, except in his role as confessor or curer of souls, the Christian clergyman cannot be said to owe his primary loyalty to his parishioner/client. Clearly, his primary loyalty is to God (and his Church). Thus, although the psychoanalytic situation resembles the confessional, it also differs from it — the most obvious difference being that, in psychoanalysis, there is no God or Church to which the analyst owes allegiance or loyalty.

I am, for the moment and for the sake of clarification, stating the case here as a theoretical ideal, rather than as an historical actuality. As we know, Freud postulated "reality" and "science" as the gods to which the analyst owes allegiance. His followers quickly deified him and helped him turn psychoanalysis into a religion to which they then pledged allegiance.

The other great historical stream from which Freud drew was individualism, capitalism, and contract. Let us not forget that psychoanalysis — the way Freud had fashioned it and the way the psychoanalytic pioneers practiced it — was a business. It was a personal business. Psychoanalysts have been ashamed of this. I think they ought to have been proud of it.

Psychoanalysis thus rested on two pillars — religion and business, confidentiality owed to clients and money paid by them. Curiously, Freud was much less consciously aware of the business aspects of psychoanalysis than he was of its religious aspects — and Jung, though he endlessly emphasized its religious character, was well aware of its business aspects. However, this is not the time or place to pursue these themes further. Suffice it to say that this individualistic-capitalistic model of the psychiatrist precludes virtually all of the moral dilemmas we now associate with psychiatry. Remember, in this connection, how contemptuous Freud was of courtroom psychiatry, how he turned down a small fortune to testify in the Leopold and Loeb case; and compare and contrast it with the alacrity with which leading contemporary psychoanalysts and professors of psychiatry testify in court about the psychopathology of each and every mass murderer or other notorious criminal.

This aside advances my argument by an important step and brings me closer to my conclusion. Psychoanalysis, psychotherapy, psychiatry — call it what you will (it has been called all of these things and others still) began, and for some time flourished, as a free profession — that is, as a professional business, doctors selling their services to patients. But insofar as psychoanalysis was closely allied to psychiatry (though Freud was never a "psychiatrist" in the then prevailing sense of that word), and insofar as psychoanalysts worked in advanced, industrial nation-states, there lurked in their situation a fatal temptation. To this temptation, they succumbed as quickly as they could.

Anyone in the business of selling goods or services in the modern world has two potential sets of customers: individuals and the government (or state). For some products and services — for example, soft drinks or the services of singers — individual customers provide the most lucrative market. For others — for example, armaments or the services of social workers — the state provides a more lucrative market. When individuals are hard pressed for money, government agencies may offer a more secure and lucrative market for a vast variety of goods and services. Finally, under state capitalism (socialism, communism), the state becomes the best or only customer for nearly everything that is legal.

What has all this to do with the moral conflicts of the psychiatrist? It has everything to do with it. As I noted earlier and as we all know only too well, psychiatry originates from a statist matrix. First and

foremost, psychiatry was, and still is, "state hospital psychiatry." What happened when psychoanalysis came to America was thus fateful. What is usually emphasized in that story is that, in the United States, psychoanalysts found a more lucrative market for their services than anywhere else in the world. That is hardly surprising, since this was, and still is, the largest — the most populous and richest — capitalist country in the world. What is often much less emphasized is that it was also in the United States that psychoanalysis was quickly merged into and absorbed by psychiatry. Many of the early psychoanalysts who came here worked for the state hospital system — an arrangement that would have been practically impossible for Freud, and morally unthinkable for Jung. As a result psychiatrists became not only double agents (pledging their loyalties to clients in conflict with one another) — but also became increasingly confused about the moral ground on which they stood. That confusion has now reached a state of hyper-inflation — a myriad of moral imperatives clamoring for the psychiatrist's meager existential capital.

The moral situation of the psychiatrist working in an insane asylum a hundred years ago was clear and unambiguous: his primary duty was to protect society from the madman. Freud's and Jung's situation in their private offices in Vienna and Zurich were equally clear: their primary duty was to listen and talk to their clients and keep their communications confidential. There was — except rarely, perhaps, for its pioneers — neither much glory nor much profit in doing either one of these jobs.

The moral situation of the contemporary psychiatrist is, on the other hand, utterly amorphous. His activities, his accredited expertise, his own claims are all over the map. He works for government agencies, universities, insurance companies, courts, families, individuals. Adoption, kidnapping, divorce, homicide, suicide, the reinterpretation of history, the mental health of politicians — nothing is outside of his ken.

Still the fact remains that the psychiatrist always promotes the interests of some easily identifiable party. Confronted with the moral ambiguities which that stubborn fact generates, the modern psychiatrist often denies this — claiming, instead, that he promotes "mental health," "the patient's best interest," "society's protection from dangerous mental patients," or some other impersonal abstraction. In short, as a moral agent, he is sadly confused. And he is confused, perhaps more sadly still, because he wants to be all things to all people.

If the psychiatrist did not want to be confused, he could easily learn from others how they have coped with moral dilemmas similar to his. For the psychiatrist is not the only professional who purveys a service to clients who typically do not pay the expert whose services they receive. The social worker and school teacher, public defender and priest, and even the captain of a cruise ship each occupies a similar position in a triangular relationship: each is hired and paid by one party to do something for another. Each of these professionals straddles a potential conflict between society, the church, or some other group that supports him and a client whose interests he is expected to serve. Each of these professionals can do his job well or poorly, depending on how courageously each confronts his respective obligations to superiors and clients, and on whether, on balance, the interests of these parties coincide or conflict.

In short, in all those situations in which psychiatrists are not the unqualified agents of their patients — which includes most of the professional encounters in which psychiatrists now engage — it behooves them to render unto Caesar what is Caesar's, and unto God what is God's: that is, they must frankly acknowledge — to the parties concerned, to society, and above all, to themselves — the duties that, as professional persons, they owe to these various parties, and that, as moral agents, they promise faithfully to fulfill. Only such self-restraint can protect the psychiatrist from the lure of a grandiose delusion in his own infinitely-expansive expertise — a lure made the more tempting by his profession's support of its validity and by his society's support of its legitimacy. Basking in the glory of such a self-aggrandizing delusion, the psychiatrist seems to gain the whole world — only to lose his own soul in the process.

## NOTES

1. Reprinted (with revisions) from the *Whittier Law Review*, Vol. 4, 1982.
2. Letter from Thomas Jefferson to Thomas Jefferson Randolph (Nov. 24, 1808), *reprinted in* Jefferson's Letters 249 (W. Whitman arr. n.d.).

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