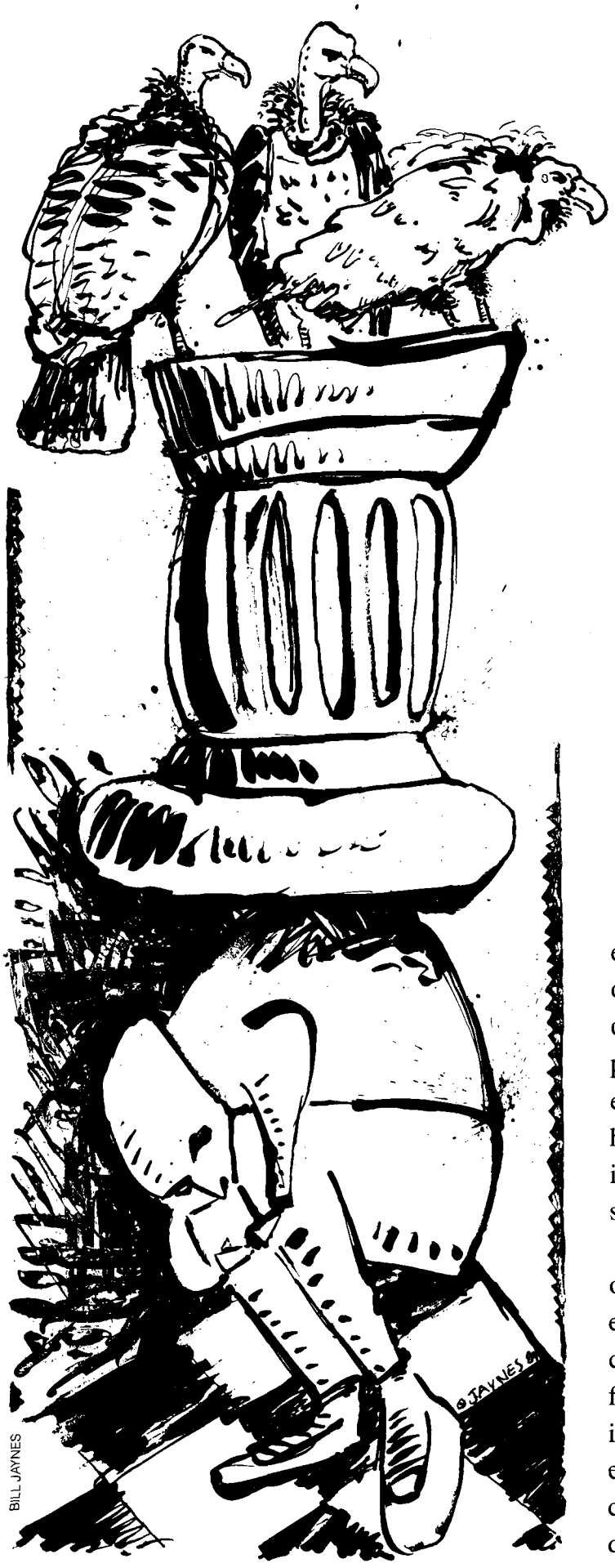

BILL JAYNES

PSYCHIATRY IN THE AGE OF AIDS

The doctors see a new chance to be jailers.

BY THOMAS SZASZ

Happiness and sadness, elation and depression are the emotions we normally experience in response to the good and bad cards life deals us. Suppose that a person of modest means desperately trying to win the lottery hits the jackpot. Suddenly he is rich, and he feels happy, even elated. Or suppose that a young and hitherto healthy person develops a debilitating and fatal illness. Suddenly he is sick and dying, and he feels sad, even depressed.

Obviously, one need not be a psychiatrist, or any other kind of expert, to think this way. That is exactly what is wrong with such a commonsensical formulation: It is too simple, and hence useless for the physician who wants to meddle—or forcibly intervene—in the elated or depressed person's life. To enable professional meddlers to engage in their specialty, it is necessary to define "extreme moods" as diseases. Consider how easy this is.

Experts at one of our leading medical institutions, the Johns Hopkins University Medical School, recently studied four patients suffering from AIDS who felt depressed. Did they view the patients' depression as a normal response to dying from AIDS? No. They interpreted it as itself a symptom, a psychiatric manifestation of AIDS. Why? To rationalize treating the patients with "electro-convulsive therapy" (ECT).

Rather than see depression as a normal response to dying, the psychiatrists called it a mental disorder to justify electro-shock treatment.

"Although major depression is not the most frequent psychiatric manifestation of infection with human immunodeficiency virus type I (HIV), it does occur in many patients," the researchers say in the June issue of *The American Journal of Psychiatry*. "Delusional depression has also been described in such individuals. The effectiveness of ECT for individuals with severe depression, especially those who do not respond to medication or who have delusions, is well established....We report here the successful treatment with ECT of four patients with major depression, three of whom were HIV-seropositive and one of whom had AIDS."

The technical details of this report need not concern us. What should concern us is that the authors do not mention whether any of their patients were involuntarily hospitalized and treated against their will. Since one of the patients tried to kill himself while in the hospital and another "had persistent suicidal ideation," it seems possible, if not likely, that some or all of these patients were the beneficiaries/victims of psychiatric coercion.

One patient was "a 35-year-old gay white man with AIDS [who] was transferred to our psychiatric ward after attempting suicide. He had tried to hang himself with pajamas while receiving inpatient psychiatric treatment in another hospital. The patient had a successfully treated episode of *Pneumocystis carinii* pneumonia four months before admission.....He believed he was a bad person and had persistent suicidal ideation....The patient received twelve ECT treatments, after which all of his depressive symptoms resolved....Response to treatment for depression: No relapse (patient died four months after discharge)."

This approach to the unhappiness of a young man mortally ill with AIDS nicely illustrates my old contention that conventional psychiatrists, especially those with a biological bent, perceive their task as exactly the opposite of the psychoanalyst's task as Freud defined it: "making the unconscious conscious." Obviously, this metaphoric process can flow in both directions: It is possible—indeed, easy enough—to make what is conscious unconscious, to repress, deny, obscure what is self-evident. When patients do this, psychiatrists call their reinterpretation of reality a delusion. When psychiatrists do it, they call it the successful treatment of depression with ECT.

Psychiatrists have latched onto the problems of AIDS patients as their ticket to renewed respectability within the medical profession. Says Dr. Stuart E. Nichols, Jr., chairman of the American Psychiatric Association's National AIDS Commission: "The AIDS epidemic presents unparalleled opportunities for psychotherapeutically oriented psychiatrists to rejoin the mainstream medical community....I think there are real opportunities with this illness for our profession to rejoin medicine and be a really valued, respected, esteemed medical specialty....This is a chance to demonstrate that psychotherapy can make a difference in people's lives....Every psychiatrist needs to be involved in this."

This is an absurd and arrogant assertion. Freud, Jung, Adler, and the other pioneer psychotherapists did not look to syphilis or gonorrhea or the many other devastating infectious diseases untreatable in their days as "a chance to demonstrate that psychotherapy can make a difference in people's lives." What makes Nichols believe that psychiatrists are able to relieve the perfectly realistic anxieties, depressions, and suicidal inclinations of AIDS patients? Or that doing so is, *prima facie*, morally praiseworthy?

Psychiatric involvement with AIDS does not stop here. Having no legitimate subject matter of their own, psychiatrists are ever eager to fill any vacuum that arises in the medico-social atmosphere. Such a vacuum now exists with respect to the management of the AIDS patient who knowingly—even deliberately, with malice aforethought—exposes others to infection. Psychiatrists and their lackeys have rushed to fill it.

In this case, as in many others, the psychiatrist's offer of help is simply a Trojan horse concealing the real agenda: coercion in the name of therapy. Indeed, psychiatrists are already offering their services as jailers. In the June issue of *The Psychiatric Times*, Dr. Lise Van Susteren describes a depressed patient who told her he had tested positive for the AIDS antibody but was continuing to engage in sexual activity without using condoms. Van Susteren suggested that he be admitted to a psychiatric hospital, and the patient agreed. But before long he was discharged.

Now Van Susteren became alarmed: "Soon he was back in my office....I asked him again about his sexual activities. I was devastated by his words—his threat to use his disease to 'conquer the world.' He told me that sometimes when he got angry with someone, an inner voice told him, 'Let's get this guy,' and he would try to have sex with him....I was convinced—by my understanding of his illness, by his history, by his demeanor,

and by the details of his sexual encounters—that he was telling the truth,...In a sweaty moment, I called a magistrate in Virginia to have the patient involuntarily hospitalized, in a forensic ward....He refused to swear out a warrant."

Van Susteren seems to have no doubt that such a person ought to be deprived of liberty and that the best place in which to imprison him is a psychiatric hospital. Not surprisingly, she has had no trouble finding support for her idea. Noting that there is a widespread belief that AIDS patients should be "quarantined," she laments: "However, there is no 'good' place to put such people." She then quotes a medical ethicist who further laments that "it is extremely difficult to have a patient who is not psychotic committed to a psychiatric hospital. And even if it is done, hospitals must ensure that other patients are not endangered."

Lest one dismiss this particular "ethicist" as just another justifier of legal expediency and psychiatric power, Van Susteren cites support for the psychiatric coercion of AIDS patients from a more impressive authority—the World Medical Association: "Many health officials believe that quarantining is the only effective answer for those few HIV patients who, despite attempts to educate or pressure them, cannot or will not stop putting others at risk. The World Medical Association recommends that authorities be notified of irresponsible patients in order to have them 'placed in a psychiatric hospital.'"

We must now ask: Exactly what sort of danger does an AIDS patient represent and to whom? Is his very freedom a threat to the community? Or does he endanger only some persons—for example, those who choose to share a needle or sexual favors with him? Van Susteren implicitly opts for the former view and cites a legal authority's reasoning to support her position: "Robert Goldstein, a law professor at the University of California at Los Angeles and a specialist in the law and psychiatry, asked, 'How is this patient different from the psychotic person who walks down the street with a gun, threatening to kill everyone?'" I find it shocking that Goldstein and Van Susteren, supposedly experts on psychiatry and law, see no difference between these two situations.

Exactly what sort of danger does an AIDS patient pose and to whom? Is psychiatric quarantine the answer? Psychiatrists think so.

In the first place, the gunman displays a lethal weapon; Van Susteren's AIDS patient does not. Second, the gunman publicly proclaims his intention to harm others; the AIDS patient does not. Third, the gunman commits an overt act that clearly violates the criminal law; the AIDS patient does not. Fourth, and perhaps most significant, the gunman's potential victims are passive, innocent bystanders vulnerable simply because they happen to be near him. By contrast, the AIDS patient's potential victims are active, vulnerable because, and only because, they have decided to engage in a sexual act with him. It is hard to say whether the analogy between the gunman and the AIDS patient is stupid or scheming, or both. But there is no valid analogy between the two at all.

Of course, this is not to say that Van Susteren's AIDS patient is not dangerous. Obviously he is. But not randomly. If one were looking for an analogy for the danger Van Susteren's "irresponsible" AIDS patient poses to society, it would not be the danger that a "gun-toting psychotic" poses; instead, it would be something rather like the danger a careless skydiver poses. Clearly, if a sensible person wished to engage in skydiving, he would not want such an unreliable individual to pack his parachute. Indeed, any self-respecting sky diver would want only someone whom he knew well and who had merited his trust to pack his parachute. Sex, especially, between males, is a similarly dangerous sport.

The encounter between the AIDS patient and the psychiatrist is thus another example of psychiatry's denial of moral agency and its war on responsibility. That, after all, is the bottom line in the analogy between the gunman and the AIDS patient: Since, in the psychiatric view, the AIDS patient endangers others regardless of their conduct, he is a threat to the general community who deserves to be incarcerated—for the protection of society and the treatment of his illness.

But why in a mental hospital? Whatever controversy there may be about the psychiatrist's proper social role, one thing is clear: It is not his job to forcibly isolate people who suffer from contagious diseases. Accordingly, the proposal that "irresponsible" individuals infected with AIDS be psychiatrically imprisoned ("mentally hospitalized") is both absurd and abhorrent. Nevertheless, the fact that so important an international organization as the World Medical Association endorses this policy should be a warning—as if the role that psychiatrists played in Nazi Germany and the Soviet Union were not warning enough—of how prone the psychiatric profession is to moral corruption by social and political fashions.

How is the psychiatrist's zeal to quarantine "irresponsible" AIDS patients to be reconciled with his behavior when he or a colleague is (potentially) HIV-positive or actually suffers from overt manifestations of the disease? In the hypocritical way typical of involuntary psychiatric interventions: They are for patients only!

A report in the June 2 issue of *American Medical News* describes a physician-patient whose psychiatrist helped him "find a hospital for AIDS-related treatment because the trainee did not want his colleagues and supervisors to learn of his

condition." After the patient died, the head of his department complained that "the patient's analyst was colluding" in keeping the illness secret. The analyst justified his behavior by explaining "how closeted the patient felt he had to be." Was that responsible behavior on the part of the physician-patient? Or his analyst?

Psychiatrists deplore the irresponsible behavior of AIDS patients, but the story's different when it comes to the doctors' own behavior.

The inconsistency between the psychiatrist's recommendation that the "irresponsible" AIDS carrier be quarantined and the psychiatrist's own behavior gets even more glaring. The *American Medical News* article quotes Nichols, chairman of the APA's National AIDS Commission: "'I've chosen not to get tested,' added Dr. Nichols, 'and I have to defend that position' to patients who ask his status. A number have asked him if he is facing reality by not undergoing an antibody test. 'Probably not,' he tells them, 'but it's my decision.'" Another psychiatrist "who said he also chose not to undergo HIV antibody testing said he can cope with the anxiety of not knowing his status more easily than he could with the knowledge that he was infected."

Are these psychiatrists behaving irresponsibly? Would they meet Van Susteren's and the World Medical Association's criteria for commitment to a mental hospital as "irresponsible" AIDS carriers? Or is this another case illustrating the Indian adage that it all depends on whose ox is gored?

So we see psychiatrists electroshocking AIDS patients to cure their depression and save them from suicide; giving AIDS patients psychotherapy to prove that psychiatrists are real doctors; seeking to incarcerate AIDS patients in mental hospitals to protect others from being infected by them, and, last but not least, just posturing to show what good guys they are. Declares Dr. Herbert Pardes, president of the APA: "At the least, mental health professionals must be prepared to do the following: help patients cope with the tremendous adversity associated with their disease...support partners and families...help strengthen community prevention efforts...fight discrimination against AIDS patients on all levels—local, state, national."

The last pronouncement is especially persuasive coming as it does from the president of a group with a special interest in stigmatizing people. But when it comes to breast-beating and self-congratulation, the psychiatrists are hard to outdo. Concludes Pardes: "Thus, the first step for all of us is to decide that AIDS is everybody's problem and that no one shall be left to suffer alone. I have already made my decision."

Unctuously parodying Mother Teresa, Pardes unwittingly betrays the psychiatrist's incurable propensity to meddle—not only in the AIDS patient's misery, but in everyone's life. For what business of Pardes is it to declare that "AIDS is everybody's problem"? In fact, nothing is a particular person's problem, unless he assumes responsibility for it or someone else forcibly imposes responsibility for it on him.

For centuries psychiatrists waged war on the homosexual, notwithstanding their sudden peace overture of 1973, when they repealed the classification of homosexuality as a disease. In AIDS the psychiatrists may have found the reinforcements needed to mount a new, even more promising crusade. With an estimated one million Americans testing positive for HIV waiting in the wings, happy days are here again for psychiatry.

Mad doctors once claimed that homosexuality was a disease and offered their services to protect the community from it by stigmatizing and segregating the so-called patient. Now they claim that depression experienced by a person suffering from AIDS is a symptom of the HIV infection and offer their services to cure the depression with electroshock treatment.

As a bonus, they generously throw in their willingness to imprison ("hospitalize") the "irresponsible" AIDS patient (who often happens to be a homosexual). How many psychiatrists currently agree with this position is uncertain. How many will agree with it in the future will clearly depend on how fashionable and lucrative it turns out to be.

We live in remarkable times, politically as well as psychiatrically. In the communist world, people clamor for democracy and freedom but seem not to have the least inkling that the term *democracy* refers to a type of social organization based on respect for private property and the rule of law, and that the term *freedom* is meaningless if it does not include the freedom to own, save, invest, and inherit property. We, in the free West, are similarly confused, not about the relationship between private property and individual liberty, but about the relationship between private health and individual liberty. We have lost sight of the fact that the term *freedom* is meaningless if it does not include the freedom to be sick, to remain sick, and to die in one's own way. The relationship developing between AIDS patients and the psychiatric profession is a case in point.

Clearly, *plus ça change, plus c'est la même chose*. Should we celebrate the reliability of the psychiatric physician, so loyally and eagerly rallying to society's every passing need to rid itself of its unwanted members? Or should we fear it as an ever-present danger built into this alleged medical specialty at its creation, against which we must always guard ourselves? Perhaps we should even consider the possibility that the actual and potential evils of psychiatric coercion so outweigh its alleged benefits as to justify the abolition of psychiatric slavery altogether.

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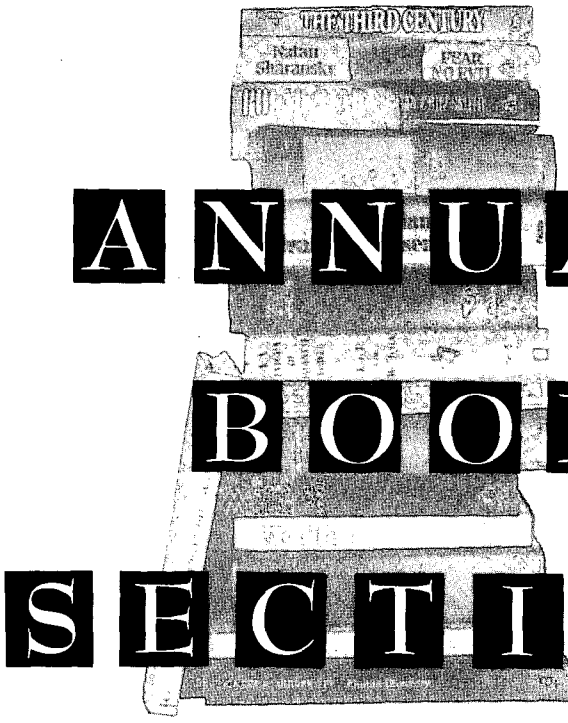

ANNUAL BOOK SECTION

The Best Things in Life

BY CHARLES MURRAY

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Robert Nozick's new book is finally out. Rumors of it have been circulating among his admirers for years, along with considerable excitement, for Nozick's 1974 book, *Anarchy, State, and Utopia,* was to many people—I'm one of them—one of those rare intellectual experiences that forever after alter one's way of looking at the world.

It has been a long wait. True, in 1981 he published the mammoth *Philosophical Explanations*, an admirable book, but one unmistakably written by a philosophy professor for other philosophy professors. In *The Examined Life*, the Nozick of *Anarchy* returns—not as antic as before, clearly older, but speaking with the inimitably Nozickian voice.

The voice returns, but not the same themes. Those who seek *Anarchy, State, and Utopia Revisited* will be disappointed. This time, Nozick writes about how life is to be lived. "I want to think about living and what is important in life," he begins, "to clarify my thinking—and also my life." And with that he sets out on a wide-ranging, thoughtful consideration of the best things in life, the most important things in life, and how they fit in with the ways we go about living our lives day by day.

It is a book like no other. Imagine that you have an extraordinarily intelligent friend, curious and witty, appallingly well-read, who drops by after dinner. The two of you retire to the library, perhaps with a snifter of something to sip on, put a fresh log on the fire, and talk deep into the night about things you care about. That's what reading *The Examined Life* is like.

The book meanders. Through the first nine chapters, with such diverse titles as "Dying," "Parents and Children," "Creating," "Sexuality," and "Emotions," the book seems to be a set of meditations on discrete topics—all interesting, all important, but disconnected. Beginning with the discussion of emotions, however, and becoming plainer in the subsequent chapters, the connecting theme slowly emerges, one so simple that it is difficult to describe. Roughly: Life should be intimately bound up with reality.

The Examined Life: Philosophical Meditations, By Robert Nozick, New York: Simon & Schuster, 320 pages, $21.95

The ramifications of this thought take Nozick another 18 chapters to tease out, but the point of departure is intuitively attractive, introduced by Nozick's "experience machine," a thought experiment from *Anarchy* that he resurrects for this book. If there were a machine that could perfectly simulate a perfect life (define "perfect" however you please), would you choose to be plugged into the machine and live the rest of your life hooked up to it instead of living in the real world? Hardly anyone would choose the experience machine. In effect, the core of *The Examined Life* explains why. There is intrinsic value in