

*Psychiatry and Morality*

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## I

It is difficult, as Erik Erikson has suggested, not to approach the subject of psychiatry and morality with a chip on each shoulder.<sup>1</sup> The very conjunction of the terms is calculated to make blood boil. There are psychiatrists on the one hand who insist that psychiatry is a medical science having nothing to do with morality. And there are philosophers and theologians who are repelled by the thought that modern psychiatry, particularly as influenced by Freud, has anything good or worthwhile to contribute to the subject of morality. I am reminded of a distinguished Harvard philosophy professor who while attending a symposium on psychoanalysis and philosophy was so outraged at the very conjunction of these two disciplines that he allegedly exclaimed “psychoanalysis is a dirty dishpan in the great ocean of philosophy.” I have no doubt that if he were here tonight he would express a similar opinion about the conjunction of psychiatry and morality. One can assume that his sentiments would run as follows:

The question of morality is the noblest question of mankind, involving the possibility of freedom, the grounding of morality in reason, or some ideal of an ordered society. Psychoanalysis and psychiatry, in contrast, are ignoble, small-minded, reductionistic, backward-looking, even somewhat prurient, and here I quote the Catholic theologian, Hans Kiing, psychoanalysis has been “identified in public opinion with irreligiousness and sexuality, with the

<sup>1</sup> *Young Man Luther* (New York: Norton, 1958), p. 21.

breakdown of religion, order and morality.”<sup>2</sup> Many other critics have suggested that modern psychiatry as influenced by Freud is to be blamed for all of the “decadence” of the “permissive society.”

These are not just the prejudiced opinions of outsiders. The same views have been echoed by voices within the field. Erik Erikson, for example, in his psychohistory *Young Man Luther*, writes,

Neurotic patients and panicky people in general are so starved for beliefs that they will fanatically spread among the unbelievers what are often as yet quite shaky convictions. Because we did not include this fact in our awareness, we were shocked at being called pansexualists. We were distressed at the spread of a compulsive attitude of mutual mental denuding. We were dismayed at a widespread fatalism according to which man is nothing but a multiplication of his parents' faults. We must grudgingly admit that even as we were trying to devise, with scientific determinism, a therapy for the few, we were led to promote an ethical disease among the many. (lc. 19)

Although there are aspects of this indictment which I think are true and which I shall rely on in my subsequent discussion, I would like to sound a cautionary note. It seems to me that it is too easy to blame too much on Freud. The American hunger for Freud is an appetite which itself needs to be explained. And there has been a similar loss of moral consensus, a similar cynicism about traditional moral authority, and a similar phase of breakdown in conventional religion, order, and morality in societies where Freud and modern psychiatry have had little perceptible influence. But whether or not Erikson is entirely correct about the etiology of the ethical disease, he is certainly ingenuous in asserting that the goal of psychoanalysis was to devise a therapy for the few. That has certainly not been *his* goal for most of his life nor was it what inspired Freud's work, from *The Interpretation of Dreams* to *Civilization and Its Discontents*. As Hans Küng rightly observes in

<sup>2</sup> *Freud and the Problem of God* (New Haven: Yale University Press, 1980), p. 55.

*Freud and the Problem of God*, “psychoanalysis was now applied to literature and aesthetics, to mythology, folklore and educational theory, to prehistory and the history of religion. It was no longer merely a therapeutic procedure but an instrument of universal enlightenment” (p. 27).

I would prefer to describe psychoanalysis as a descriptive developmental theory of human subjectivity, but “instrument of enlightenment” comes closer to the mark than Erikson’s scientific therapy for the few. Modern psychiatry, though less enthusiastic about psychoanalysis than an earlier generation, has been no less ambitious in its general claims of offering universal enlightenment. Particularly has this been the case in psychiatry’s contribution to contemporary problems of morality.

It is difficult to think of a pressing moral question on which my profession has not made “authoritative pronouncements.” Abortion, capital punishment, racism, sexism, nuclear disarmament, gun control, apartheid, pornography, terrorism, the Vietnam war, euthanasia, poverty, love and marriage are only some of the subjects on which we have felt that our professional expertise qualified us to speak. In fact, I should admit to you that I myself have contributed to psychiatric pronouncements on all of these issues. These two lectures are therefore in some sense confessional — an examination of my own professional conscience. How did psychiatrists presume so much, and how is it that we were permitted so much? One president of the American Psychiatric Association, using the jargon associated with the community mental health movement, announced to his colleagues that “the world is our catchment area.”<sup>3</sup> And he might have added, “man in the world is our subject matter.” He received a standing ovation and went on to become president of the World Psychiatric Association.

The grandiosity of modern psychiatry may seem unjustified today, but I believe it can be understood from a certain point of

<sup>3</sup> Cited in Alan A. Stone, “Presidential Response,” *American Journal of Psychiatry* 136:8 (August 1979), pp. 1020–22.

view. There is in Western thought a long tradition of understanding the human condition in terms of its abnormal manifestations. This tradition is by no means confined to psychiatry. It can be found in such unlikely places as Immanuel Kant; see for example his *Anthropology from a Pragmatic Point of View*. (I shall be making some comparative comments about Freud and Kant throughout these two lectures.) The intellectual tradition which Kant exemplifies attempts to isolate the abnormal, madness, at an extreme of the human spectrum as “the most profound degradation of humanity which seems to originate from nature.”<sup>4</sup> But having put madness to one side and isolated it, as though it had nothing to do with his understanding of the “normal,” in his analysis of the situation of the rest of humanity, Kant is somehow haunted by the analogy to madness: “to be subject to emotions and passions is probably always an illness of mind because both emotions and passions exclude the sovereignty of reason.”<sup>5</sup> For Kant emotion is akin to “apoplexy” and “passion is delusion.” Although Kant had important philosophical justifications for deriving morality from reason, his attempt to do this was set against this conception of passion as delusion. He also, in a way, anticipated contemporary psychiatry’s obsession with the problem of self-deception: that we are unaware of our own motives. He wrote, “the veil with which self love conceals our moral infirmity must be torn away.” Kant, I am sure, believed that the tearing away would be done by a rational moral philosophy, but psychiatry’s attribution of self-deception to the unconscious suggested that the veil must be lifted in some other manner.

One of psychiatry’s most convincing claims that it has a right to participate in moral discourse is bottomed on this assertion of unconscious self-deception. For example, many psychiatrists believe we have a professional as well as a personal justification for

<sup>4</sup> With an introduction by F. P. Van Der Pitte (Carbondale, Ill.: Southern Illinois University Press, 1978), p. 112.

<sup>5</sup> *Ibid.*, p. 251.

becoming involved in the movement for nuclear disarmament. We argue that many people are denying, repressing, or suppressing the frightening possibility of an atomic holocaust. These psychological mechanisms, which in this instance lead to moral and political inertia, are, we assert, a classic example of pathological self-deception. I shall return to this theme. But here let me just emphasize that a claim that someone is practicing self-deception, if it is to be a powerful claim, must also mean that the psychiatrist sees through the self-deception to the truth of the matter — what lies concealed behind the veil of self-deception. To know that is to know something about the “meaning of life.”

At any rate, it should be clear that the attempt to understand human nature in the metaphors of madness and self-deception did not begin with modern psychiatry. Freud would use language identical to Kant’s: “the id is the place of passions” and the ego of “reason and sanity.”<sup>6</sup> The tradition to which Kant and Freud belong sees the peril of humanity in the triumph of passion over judgment and reason. This tradition accepts the basic dichotomy of reason and passion as a given in human nature, Passion at war with reason remains even today one of the most compelling paradigms both of mental abnormality and of the human condition.

Modern biological psychiatry grounded in twentieth-century medical science has little professed interest in this rational humanist tradition. However, its practitioners share Kant’s opinion that madness originates from nature and they agree with Kant’s view that “the germ of derangement develops together with the germ of reproduction and is thus hereditary.”<sup>7</sup> But if madness is biological and genetic, how shall we understand the rest of the disorders of consciousness that stretch from madness at one end of the scale to normal human suffering at the other.

<sup>6</sup> *The Ego and the Id and Other Works*, trans. by James Strachey, standard ed., vol. 19 (London: Hogarth Press, 1927).

<sup>7</sup> Kant, *Anthropology from a Pragmatic Point of View*, p. 115.

Some psychiatrists have argued that this is no longer our business, the old psychiatry, they say, is dead, madness is part of the neurosciences, the rest is the human condition.<sup>8</sup> But even as biological psychiatrists say this, they are busily engaged in studying the whole spectrum of the disorders of consciousness and charting the biological substrate of the human condition. Nor are they hesitant to extend the reach of biologically determined mental illness further and further from the extreme of madness. And if we look to practice rather than theory, we find everywhere the prescription of chemicals to ease the pain and suffering of the human condition. Through the prism of medical science, the passions of everyday life become symptoms to be treated chemically. In analogy to Kant, biological psychiatry, after having declared madness a biological disorder, is haunted by biology in its understanding of the rest of humanity. The problem is and always has been for psychiatry whether it provides only a theory of madness or a more general theory of human nature as well. Or is it even possible in principle to make such a distinction? Can one explain madness without explaining human nature?

What is important for my purposes tonight is that when psychiatry begins to gain popular acceptance as in fact providing a theory of human nature, it begins to establish the context of moral action and moral obligation. It does this in at least two obvious ways. First, most Western notions of morality require as a fundamental premise the existence of a unified and continuous self and a will. Philosophers who construct theories of morality recognize the need to ground these fundamental premises on some assumptions about mind and mental functioning — a psychology, no matter how limited, is required. One can demonstrate this need for a psychology not only in Kant, but also in such contrasting moralists as St. Augustine in his *Confessions* and Sartre in *Being and Nothingness*. If morality must be constructed on a psychology, as I believe, then profound changes in the accepted psychol-

<sup>8</sup> E[dwin] Fuller Torrey, *The Death of Psychiatry* (New York: Penguin, 1975).



ogy inescapably raise questions about the accepted morality. Modern psychiatry as influenced by Freud seems to many observers to have produced just that result. Sartre recognized this and went to great lengths to repudiate the central Freudian construct of unconscious self-deception and to replace it with the formidable moral notion of bad faith.<sup>9</sup>

A second way in which modern psychiatry established the context of moral action and obligation was by producing convincing stories about what it means to be a person. It did this by “uncovering” the “true history” of human drives and by revealing, in Ricoeur’s phrase, “The archaeology of desire.”<sup>10</sup>

Psychoanalysis not only challenged the unity of the self; it privileged a certain account of virtues and vices which made the will a minor actor in the moral drama of life. Though there was for academics much to criticize in these Freudian revelations, they had a compelling influence on popular psychology and mass culture. Freudianism could not be kept out of the dialogue on the “meaning of life.”

From the moment American psychiatry embraced Freud, it had a unified theory of human nature from which its explanations of mental disorder and treatment could be derived. That, I believe, is what Freud intended, contrary to what Erikson suggests. If modern psychiatry, guided by Freud, started down the path that Kant and other theorists of human nature had taken, we reached a different destination. Modern psychiatry produced a vision of human nature in which morality was itself a passion at war with reason. Moral choices and decisions were based on unconscious determinants, all of which seemed incompatible with Kant’s idea of free moral agents choosing between right and wrong. Erikson wants to write this off as a kind of misunderstanding, a premature

<sup>9</sup> Jean Paul Sartre, *Being and Nothingness: An Essay on Phenomenological Ontology*, trans. by Hazel E. Barnes (New York: Philosophical Library, 1956). See particularly part I, ch. 2, “Bad Faith,” and part IV, ch. 2, “Doing and Having.”

<sup>10</sup> Paul Ricoeur, *Freud and Philosophy: An Essay on Interpretation*, trans. by Dennis Savage (New Haven: Yale University Press, 1970).

acceptance of tentative conclusions. But Freud intended on the basis of his theory of human nature to throw down the gauntlet before the idea of man as a free moral agent. What else could he have meant when he embraced Groddeck's words, "we are lived by unknown and uncontrollable forces,"<sup>11</sup> or when he placed Kant's categorical imperative in the id as the legacy of a phylogenetic past. The morality which had power over men came not from any higher authority, not from reason, but from an unknown moral passion, a stranger within. Immorality was equally mysterious and required deciphering.

Generations of American psychiatrists have tried to find ways around what more and more of them came to recognize as problematic and embarrassing. The best known and most beloved American popularizer of Freud's ideas, Karl Menninger, was moved to wonder, *Whatever Became of Sin?*<sup>12</sup> But it is not just psychoanalysis in modern psychiatry that called into question the ideal of a free moral agent. All of the dominant conceptual paradigms of modern psychiatry — biological, behavioral, psychodynamic, and social — conflict with traditional ideas about free moral agents. Although I am sure philosophers would say that this bald statement of conflict is wrong, I am equally sure that they would disagree on just how it is wrong. At least for psychiatrists who explain behavior in terms of biological transmethylation, reinforcement schedules, defective superegos, and demographic trends, there is still no convincing resolution of this problem.

Perhaps the most obvious practical implication of explaining morality and immorality in terms of the unconscious, the reinforcement schedule, or the DNA — and undermining the ideal conception of free moral agents choosing to do right or wrong — is that it undermines the theory of our criminal law. It makes it much more difficult to attribute moral blameworthiness to those

<sup>11</sup> Freud, *The Ego and the Id*, p. 23.

<sup>12</sup> New York: Hawthorn Books, 1973.

who break the law or who in some way offend. As Lord Devlin stated it, "Everywhere the concept of sickness expands at the expense of the concept of moral responsibility."<sup>13</sup> The concept of moral responsibility is of course what justifies punishment. Viewed from this perspective, modern psychiatry appeared as the antagonist of the principle of retributive punishment. It joined forces with Christian forgiveness in a secular version of "to understand is to forgive." Christopher Lasch makes Lord Devlin's point with more sweeping rhetoric: "But it is precisely this universal understanding, sympathy, and tolerance (which in any case does not conceal the persistence of intolerance at a deeper level) that reflect the collapse of moral consensus, the collapse of distinctions between right and wrong, the collapse of moral authority."<sup>14</sup>

But if psychiatry as influenced by Freud made people uncomfortable about punishing sinners, it soon became clear that in the alternative to punishment more was involved than simple forgiveness. Reviewing Karl Menninger's book *The Crime of Punishment*,<sup>15</sup> the late Professor Packer of Stanford Law School suggested that the impulse to treat and the impulse to punish originated in the same region of the psyche.<sup>16</sup> Foucault argues that at the end of the Middle Ages evil went out of the world and madness came in.<sup>17</sup> One might in that vein say about twentieth-century America that progressivism and psychiatry drove retribution out of our moral deliberations and replaced it with treatment.

Many critics began to find similar evidence that psychiatry, far from being a threat to conventional social morality, had become the very instrument of that morality. The criticism came from an

<sup>13</sup> P. Devlin, *The Enforcement of Morals* (London: Oxford University Press, 1959), p. 17.

<sup>14</sup> *Haven in a Heartless World: The Family Besieged* (New York: Basic Books, 1977), p. 221.

<sup>15</sup> New York: Viking Press, 1968.

<sup>16</sup> Review by Herbert Packer of Karl Menninger's *The Crime of Punishment* in *New York Review of Books*, October 23, 1969, p. 17.

<sup>17</sup> Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Pantheon Books, 1965).

entirely different direction than Erikson anticipated. Indeed, Erikson was himself a target of this attack. Far from being a corrupter of conventional social morality (or a liberating influence), psychoanalysis and psychiatry were identified as the chief vehicles of conventional social morality of oppression and of passing judgment on people. Of course this partly can be explained away in historical terms, the vanguard of social change had passed Freud by. The Freudian revolution becomes, over time, a counter-revolution; what was liberating for one generation becomes oppressive for the next. Another way to think of this is that Freud's descriptive theory of human nature was seized on, particularly in the United States, as a prescriptive theory. This is one way to account for the grandiosity of Modern Psychiatry: all deviance, including crime and morality, became a disease, and the psychiatrist presides over both the diagnosis and the cure.

At any rate, we now have encountered three perspectives on the involvement of psychiatry in moral issues. First, there is the notion that psychiatry, particularly as influenced by Freud, undermined the consensus of conventional social morality and traditional moral authority. Second, that psychiatry embodied and enforced conventional social morality and authority. Finally, that psychiatry undercut our fundamental conception of free moral agents whom we can justly punish. I shall attempt tonight to offer you a partial account of how all this happened.

Thomas Szasz, himself a psychiatrist and psychoanalyst, has made all three of these arguments against psychiatry.<sup>18</sup>

1. In *The Myth of Mental Illness*, he argues that Freud transformed what was in essence a kind of cheating, malingering, and lying into an illness, hysteria.

<sup>18</sup> *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, rev. ed. (New York: Harper and Row, 1974); *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (New York: Harper and Row, 1970); *Law, Liberty and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963).

2. In *The Manufacture of Madness*, he describes psychiatry as the continuation of the Inquisition — “the defense of the dominant ethic.” Just as the Inquisition invented witches, psychiatry invented the holy myth of schizophrenia.

3. Throughout his writing Szasz repeatedly attacks every psychiatric paradigm that undercuts the traditional view of the free moral agent. He is particularly obdurate in his demand that the insanity defense be abolished. Even the most obviously deranged person intends the consequences of his acts, and to deny this is to deny that person’s humanity. Although Szasz sometimes makes this claim as though it were an empirical fact, at other times it seems to be a normative or ideal view of human nature. In order to maintain this view, he has declared that even Kant is wrong about the extreme of madness. There is no mental illness, everything is the human condition. Perhaps the essence of Szasz’s criticism is that psychiatry is nothing but ideology masquerading as scientific objectivity.

Although Foucault suggests in *Madness and Civilization* that these charges against psychiatry have been true since the Middle Ages, the psychiatrist was at the periphery of society until the twentieth century. It was Freud who turned the attention of psychiatry from the madhouses to the middle class. It is against Freud and his influence that the ideological arguments are made. Although Freud had very little experience with psychotics himself, in the course of his work he conceived a coherent unified psychological theory of mental illness. He broke through the dividing line between the most profound degradation of humanity at one end and between the normal and the neurotic at the other end. One can no longer think of a continuum from madness to sanity; normality is no longer on the continuum. Freud literally believed that neurosis was the price we pay for civilization. Although American Freudians sacrificed this idea on the altar of therapeutic optimism, Freud had declared normality a nearly unattainable ideal. In this respect I doubt that he differed very much from Kant

or from certain other moral philosophers, if you allow me to analogize between Kant's assessment of the moral infirmity of mankind due to the veil of self-love and Freud's assessment of our neurotic infirmity due to the veil of unconscious repression.

There is another distinction in Freud's thought which is essential to my analysis. Freud believed that there were no qualitative differences between the mental processes of the psychotic and those of the rest of us. Ultimately, the only distinctions were quantitative. The only difference between a delusion and a fantasy was quantity. The only difference between a memory and a hallucination was quantity. Psychosis was dreaming while awake. Everyone had all variations of the Oedipus complex. The difference between heterosexual and homosexual was quantitative. I think it was Goethe who said no man ever had a fantasy that I have not had. Freud would have said the claim was believable.

But there is something deeply problematic about a theory which though it provides us an understanding of all mental processes, normal and abnormal, relies on unspecified quantities to explain all of the differences. This problem of quantity becomes more troubling when we recognize that the determinist conception of Freudian theory is grounded on these mysterious quantities which impel fantasy, emotion, thought, and behavior. In the end it is not clear whether Freud placed the categorical imperative in the id and rejected the notion of free moral agents based on empirical observations of how people actually behave—that is, on some empirical view of human nature or on some a priori assumption about human nature derived from the determinist theory of science. He often seems to be saying both at once. This, you will recognize, is the criticism I made of Szasz, only from the other direction. I believe that in both instances these are simply different intuitions about what it means to be a person. The way Freud imposed this intuition on his theory is by invoking the quantitative factor. In fact the quantitative factor can be used as a red flag, as one reads Freud, marking the places where descriptions of mental

processes and subjective experiences are transformed into explanatory determinist theories. The quantitative factor is central to the hydraulic theory of emotions, to the catharsis theory of therapy, and to Freud's mean conception of the human possibilities of freedom and love. It is on the basis of the quantitative factor that Freud ridiculed the biblical injunction to love thy neighbor, and the more mysterious injunction to love thine enemy.<sup>19</sup>

If one deprives Freud of this quantitative factor, one can no longer claim for him that he offers either a coherent theoretical explanation of mental disorder or a compelling account of human nature. The strongest claim one can make is that it is a description of a kind of subjective experience, the history of desire in the individual rendered in a deterministic and selfless discourse.

Freud said neurotics suffer from reminiscences, and we might say that reminiscences were Freud's subject matter. *Not* man in the world but man and his reminiscences. Out of that subject matter one can not get a complete explanation of the human condition or perhaps even a correct understanding of one of Freud's most important subjects, *guilt*.

But having said all these things, and there are other critical things to say about Freud, I find it hard to reject his most basic contribution to Western thought, the dynamic unconscious. After Richard Nixon had lost the presidential election to John F. Kennedy, he came back to California and eventually ran for governor of the state. Everywhere Nixon went on his campaign trail, reporters would ask the obvious question, was he running for governor in order to run again for president? Finally, after having been asked this again and again, at one press conference Nixon drew himself up, looked the reporter in the eye, and said, "Listen, I would like to tell the press once and for all, please stop asking this question. I can assure you that I will be fully satisfied if I am elected governor of the United States." We all now understand

<sup>19</sup> *Civilization and Its Discontents*, standard ed. (London: Hogarth Press, 1961), p. 109.

this error in a Freudian perspective, namely that the conscious and the mental are not identical, and I think most of us have some feeling that we do not fully understand our selves and that we are all capable of similar revealing Freudian errors. The basis of the psychoanalyst's claim to special knowledge is that by his methods he has access to our unconscious and understands the processes by which our repressed desires become known. We are trapped in our self-deceptions, and the psychoanalyst can see through us to the truth of the matter. We must now examine this supposed truth because in it are the concealed human values and the moral postures which have had such a great influence on modern life. It is by contributing the dynamic unconscious to our understanding of what it means to be a person that psychoanalysis has had its greatest influence on morality.

Freud believed that the truth about the unconscious and the shaping of personality, conscience, and passion came from two major sources — infantile experiences which were repressed to comprise infantile amnesia and the phylogenetic unconscious including the core of the superego. This phylogenetic element was Freud's sociobiology, and in retrospect it seems entirely speculative. Modern Freudians have tried to read this sociobiology out of Freud, but it was a crucial aspect of his theory and it was pervasive. It could not be removed by clean theoretical surgery and it contained the hidden ideology of psychoanalysis. It is equally important to recognize that Freud's theory of infantile experiences was only dubiously empirical; it was also structured by sociobiological assumptions and by Freud's intuitions about what it meant to be a person.

It was Freud's sociobiological assumptions and his emphasis on early infantile experiences within the family that allowed him to construct a theory of what it meant to be a person which was transcultural and transhistorical.<sup>20</sup> The limitations of such a theory and the errors in Freud's sociobiology now seem obvious to us. We

<sup>20</sup> Herbert Marcuse, *Eros and Civilization: A Philosophical Inquiry into Freud* (Boston: Beacon Press, 1955); see especially Epilogue, "Critique of Neo-Freudian Revisionism."



recognize that what Freud understood to be the truth of the matter was to a large extent ideological, and nowhere is this more obvious than in his truth about women.

Before turning to that, let me summarize and reformulate my thoughts. I have been trying to think through with you some of the moral ramifications of modern psychiatry; at the same time I have a more basic question, is it possible to have a theory of mental illness which does not imply a theory of human nature that in turn contextualizes the problem of morality? Now it is possible to minimize the apparent moral implications of psychiatry by limiting mental illness to an extreme as Kant and some contemporary biological psychiatrists would do. Madness comes from nature and the rest of our disorders perhaps from living. But even those who draw such lines find it difficult to keep the domains of madness and the human condition separate. Now by examining Freud I am hoping to show you the most powerful example of psychiatry's attempt to give a coherent unified theory of mental disorder and human nature and to tell us what it means to be a person. If we accept and apply these theories as valid self-descriptions, we have accepted the values and moral postures concealed in them. The appeal of Freud's theories to twentieth-century men and women as revealing self-descriptions is ultimately the key to his influence on contemporary morality. Even Jean Paul Sartre, who made elaborate arguments against Freud's unconscious and who created his own existential psychoanalysis partly in reaction to Freud, when it came to writing his autobiography, took as a central theme a Freudian self-description. He reports that a psychoanalyst had told him that because his father had died when he was an infant, Sartre did not have a superego. This seems to have delighted Sartre. He wrote that other men went through life weighted down by their fathers "like Aeneas carrying Anchises from the walls of Troy" but he, the philosopher of radical freedom, had no such burden.<sup>21</sup>

<sup>21</sup> *The Words*, trans. by Bernard Frechtman (New York: G. Braziller, 1964).

If his theories were attractive as valid self-descriptions even for philosophers skeptical of Freud, they were enormously attractive to bourgeois American men and women. Or as Kate Millett, the radical feminist, suggests, they were the ideas with which American men and women were indoctrinated. She writes, “The new formulation of old attitudes (bourgeois, patriarchal, moralism) had to come from science and particularly from the emerging social sciences . . . the most useful and authoritative branches of social control and manipulation. . . . New prophets arrived on the scene . . . . The most influential of these was Sigmund Freud, beyond question the strongest individual counterrevolutionary force in the ideology of sexual politics.”<sup>22</sup>

Freud summarized most of his theories about women in a brief lecture on “Femininity.” He begins by demonstrating that it is impossible to define male and female, therefore, “Psychoanalysis does not try to describe what a woman is — that would be a task it could scarcely perform — but sets about inquiring how she comes into being, how a woman develops out of a child with bisexual disposition.”<sup>23</sup> But Freud does not in fact begin his description of the course of a woman’s development with a bisexual child. As his many critics have repeatedly pointed out, Freud’s little girl is a bisexual defective boy. The supposed travails of this defective boy in reaching adult feminine sexuality are, I assume, well known to you. The ultimate achievement of mature female sexuality was a rare event in Freud’s view. There were other consequences of Freud’s theory of how woman “comes into being”: her weak superego, her failures of sublimation, her envy, and her deficiencies in a sense of justice. The woman who did internalize these Freudian self-descriptions would assuredly think of herself as erotically and morally inferior to men. But despite the many criticisms of these theories, many women did internalize them as

<sup>22</sup> *Sexual Politics* (Garden City: Doubleday, 1970), p. 178.

<sup>23</sup> “Femininity,” in *New Introductory Lectures on Psychoanalysis* (1933), trans. by James Strachey (New York: Norton, 1964), p. 116.

valid self-descriptions and particularly Freud's ideal of mature female sexuality. This Freudian truth about female sexuality based on a speculative sociobiology was widely accepted as a correct self-description. It led millions of women to believe they were sexually inadequate, a conclusion that millions of their husbands shared. For decades women would be told that their sexual "problem" was a manifestation of their masculine protest, as was their wish to have careers.

As a psychiatrist and psychoanalyst who has lived through all of the things I have been describing, you can perhaps imagine how discomforting all this has been to me. Freud's theory of human nature had been shown to be unnatural. Ironically, we were wrong about sexuality. The subject is more complicated and the answers still more elusive than Freud imagined. And if we were wrong about that, what else was wrong? When we penetrated the patient's veil of self-love and self-deception, what we had found was not the truth of the matter but our own ideology. And we had been guilty of a certain kind of immorality ourselves. We had treated our patients' self-descriptions as false. Indeed, the basic therapeutic posture of the psychiatrist raised moral questions because it was grounded on the premise that we should treat much of what the patient said about himself as self-deception.<sup>24</sup>

I shall have more to say about the moral aspects of the therapeutic relationship itself. The problems of domination, the undercurrents of love, the risks of vulnerability and attachment. But for now we should be clear that the supposedly nonjudgmental psychoanalyst had as the framework of his understanding of illness and treatment a prescriptive theory. That prescriptive theory was in many respects an ideology which some critics argued was designed or applied for the purpose of rationalizing interpersonal oppression of women by men, homosexuals by heterosexuals, and rebels by conservatives.

<sup>24</sup> See Sissela Bok, "Address to American Psychiatric Association," New Orleans, May 1981.

These criticisms raised questions not only about the enterprise of therapy but also about the whole conception of mental illness in American psychiatry. As attempts were made to revise the psychodynamic conception of mental illness by removing what was considered offensive, the explanatory power of Freud's theory of mental illness was lost. Psychiatry has entered a period in which there are no convincing connections between the diagnosis described in our Diagnostic Manual and our explanations of those diagnoses.<sup>25</sup> Increasingly we agree that the extreme of madness has a biological explanation, but as to the rest of the disorders of consciousness there is a struggle of competing views. Simple depression, for example, might be the result of an enzyme disturbance, a cognitive disorder of self-image, an unconscious introject, or a consequence of social isolation and alienation. The treatment the patient receives depends to a large extent on the psychiatrist's commitment to one of these approaches. Some psychiatrists seem to think there are four kinds of simple depression, depending on which of these etiological elements dominates. Others are eclectic, and the patient will be met at the door by a team of clinicians each applying a different approach. Each of these four paradigms—biological, behavioral, psychodynamic, and social—has its own problematic moral implications. But when they are all put together there is no coherent vision of the human condition and there is considerable confusion about what kinds of moral judgments are being made or evaded. If this is true for all of these paradigms put together, it is also particularly true for the psychodynamic paradigm.

Without a unifying theory about the truth behind self-deception, more and more psychodynamic psychiatrists are attracted to the possibility of listening to their patients without any theoretical preconceptions. Even if this is possible, and even if the therapist avoids imposing his definition of what it means to be

<sup>25</sup> See Alan A. Stone, "Presidential Address: Conceptual Ambiguity and Morality in Modern Psychiatry," *American Journal of Psychiatry* 137:8 (August 1980).

a person on the patient, there are still inescapable moral implications to this enterprise.

Many of our patients seek help in situations where they are struggling not just with depression, stress, or anxiety but also with moral problems. Should they get a divorce? Should they fight for custody of their children? Should they leave a job where they are needed and have made a commitment for one that pays more? Should they tell their spouse about their affair? Should they put their parents in a nursing home?

Psychiatrists tend to think that if we allow our patients to ventilate their feelings it will help them not only to understand themselves but also to attain greater clarity in making these moral decisions. The psychiatrist, without expressing his own potentially oppressive moral convictions or ideology, will help the patient get in touch with what seems right for him. But what seems right is often a conclusion reached as the result of exploring repressed desires, weighing competing inclinations. It is a kind of reflection in which the outside world shrinks and the self expands. This may be the correct way to get in touch with unconscious desires and to identify self-destructive impulses, but is it a sensible way to frame moral questions for oneself? Can moral questions be framed and resolved in a process where the self looms large and the world seems small?

I remember a patient, the wife of a scientist; they had several children. Her husband, she felt, was remote even in the rare instances when he was home. The patient came to me troubled about her unsatisfactory marriage; I encouraged her to explore her feelings and did little more than listen compassionately two hours a week. Within six weeks, this woman had met a wonderful new man, a real companion, was happily in love, and had decided to leave her husband and four children. Now whether this was good or bad, right or wrong, it seemed that I and the process of therapy were partly responsible both for her new-found great happiness and her moral decisions, all of which she ceremonialized by un-

expectedly bringing her new friend to the therapy hour for my seal of approval. Human problems do not come packaged in psychiatric bits and moral bits. There may be a moral cost even in nonjudgmental listening. Clearly cultural bias and concealed moral assumptions played a part in the fallacies of the theory of psychoanalysis. But is it possible that the introspective method of free association is itself a major factor in painting the false picture of human nature? After all, it is on reminiscences — free association — and not man in the world that the theoretical edifice was built.

Freud asked his patient to give free rein to his thoughts and report “everything that comes into his head, even if it is disagreeable for him to say it, even if it seems to him unimportant or actually nonsensical.” If the patient allows himself to free associate, “he will present us with a mass of material . . . subject to the influence of the unconscious.” That influence can then be examined and deciphered so that the patient comes to understand himself.<sup>26</sup>

But more than a century before Freud discovered this fundamental rule of psychoanalysis Kant had considered and rejected it. He writes in the *Anthropology*,

To scrutinize the various acts of the imagination within me, when I call them forth, is indeed worth reflection, as well as necessary and useful for logic and metaphysics. But to wish to play the spy upon one’s self, when those acts come to mind unsummoned and of their own accord (which happens through the play of the unpremeditatively creative imagination) is to reverse the natural order of the cognitive powers since then the rational elements do not take the lead (as they should) but instead follow behind. This desire for self investigation is either already a disease of the mind (hypochondria), or will lead to such a disease and ultimately to the madhouse. He who has a great deal to tell of inner experiences (for example of grace or temptations, etc.) may, in the course of his voyage to

<sup>26</sup> *Outline of Psychoanalysis*, standard ed., vol. 23 (London: Hogarth Press, 1964), p. 174.

self-discovery, have made his first landing only at Anticyra [the land of the insane].<sup>27</sup>

Although I do not entirely share Kant's opinion about "the natural order of the cognitive powers" or about the negative value of such "self-discovery," it may be that he is right as far as its value for framing moral questions. There is a tradition in moral philosophy of stepping back after you have attempted to explore and understand the facts of the situation, and then attempting to reexamine the case at hand in terms of some broader moral principle. But psychiatry has no such tradition of stepping back and no generally accepted moral principles if we did. Kant made these observations about free association in the *Anthropology*, where he argued that psychology generally would get nowhere so long as it relied on introspection. He advised psychologists to develop an anthropological method based on systematic observations of men and women in the world. He then offered the fruit of some of his own systematic observations. Although one can find evidence of Kant's uncontestable genius in this book, it is clear to any modern reader that Kant, this preeminent figure in Western moral philosophy, had nothing in his store of rational morality to protect his systematic observations against his personal biases and cultural prejudices — some of which he shared with Freud, particularly his attitudes toward women. The philosopher who introduces the English translation of Kant's *Anthropology* is "amazed at (Kant's) uncritical views" and asserts that "any failure on (Kant's) part to live up to the moral ideal must be ascribed to a lack of experience which permitted his prejudices to remain undetected."<sup>28</sup> But one might ask what then would correct Kant's "lack of experience."

Freud subjectively explored the unconscious and found his own biases. Kant objectively observed his fellow man and found his own biases. Is there no solution to this problem? If there is,

<sup>27</sup> Kant, *Anthropology from a Pragmatic Point of View*, p. 17.

<sup>28</sup> See pp. xix–xx of the Introduction by F. P. Van Der Pitte.

I am sure you do not expect to hear it from me. But I do have a sense of what has been missing from my own moral vision as a psychiatrist and psychoanalyst. First, I think we must recognize that even the most neutral and compassionate psychotherapy potentially misframes moral questions. We have to begin by acknowledging that to ourselves and to our patients. (Psychoanalysts in days gone by used to insist that their patients make no major life decisions during the process of psychoanalysis. The pace of life has quickened, and it is difficult to maintain this requirement.) Next, we have to think of ways of stepping back or better helping our patients to step back so that moral questions can come into focus. Third, we must rethink our conception of guilt.

If the psychotherapeutic situation does not bring moral problems into focus for the patient, it may also be true that the psychotherapeutic situation prejudices the attempt to set out the context of morality. I want to argue that there is a crucial confusion in modern psychiatry which has arisen in this way that has to do with our understanding of depression, guilt, and what Freud called moral anxiety. What we see in our depressed patients (and who is not “depressed”?) has little or nothing to do with moral obligations to others. This “superego” is not the inner voice of morality or the categorical imperative: it is the voice of self-loathing. The same patient who is tortured by what Freud called moral anxiety as he reflects on his life has little or no sense of his moral obligations to anyone else; in fact his self-loathing typically stands in the way of his moral ambitions and obligations. The patient will say that he is tortured by compulsive ideas, that he is really a fraud and worthless even though he is a distinguished professor at a great university. His psychoanalyst will say about this man that he has a strict superego which has initiated a critical moral attack upon his ego. But this professor typically has the same view of everyone else. If he has a strict superego it is not an inner voice commanding moral obligations, duty, or kindness to others. This voice from the unconscious is not the voice of morality, it is the



voice of self-loathing. Psychiatry influenced by Freud has confused self-loathing and moral conscience.

I once complained to a distinguished philosopher that he had failed to honor an obligation he had made to me. His immediate response was, "I thought you psychiatrists are supposed to help people *not* to feel guilty." He said this with a smile, but I think his humorous sally bespeaks the real confusion in ordinary language. Psychiatry needs to rethink the subject of guilt and we need to begin with a careful distinction between self-loathing arising because the self is not as perfect, as powerful, as lovable as the person believes it should be and guilt which arises because one has failed in one's moral obligations to others. Of course the enterprise of conceptualizing what it means to have moral obligations is not one that psychiatry can embark on alone. But we hope that in the future psychiatry will be one of a family of disciplines which knows that to study human nature is to study moral obligations. This enterprise will help us to remember what Kant learned from Rousseau—"What is truly permanent in human nature is not any condition in which it once existed and from which it has fallen, rather it is the goal for which and toward which it moves."<sup>29</sup>

## II

In my first lecture I described how modern psychiatry has been criticized: first for undermining conventional morality, then for enforcing conventional morality, and more generally for undercutting what seems to be essential to moral theory — the idea of an autonomous person choosing between good and evil. I suggested that the reason these criticisms were tenable was that modern psychiatry presented itself as offering not just a theory of mental disorder, but also a theory of the human condition. This

<sup>29</sup> Ernst Cassirer, *Rousseau, Kant, Goethe: Two Essays*, trans. by James Gutmann, et al. (Princeton: Princeton University Press, 1970), p. 20.

theory of the human condition contained certain moral postures and established a context for moral ambition.

At the same time, I was working through my own critique of psychoanalysis as a dominant theory of the human condition in American psychiatry. My presentation of that critique might have been easier to follow if I had begun by considering the method of Freud's "discovery," the situation in which the patient is asked to free-associate. I argued that this method develops a certain kind of evidence which prejudices the attempt to construct a theory of the human condition. I suggested that Freud's theory based on that evidence is not an explanation of the person in the world but rather a developmental description of human subjectivity. Two other ideas were important to this critique. First, that the way Freud made his descriptive theory seem like an explanatory theory was by invoking mysterious quantities. For example, it may be true that when we reminisce and free-associate about our parents we do evoke sensual feelings about them and fearful, hostile memories as well. It may even be true, as I think it is, that everyone who reminisces will eventually come upon such memories. But the mystery of how those memories explain our personality, our lives, and our current behaviors remains a mystery because Freud invoked an unknown quantitative factor as the crucial explanatory element in the connection.

The other point I tried to make is that the psychotherapeutic setting in which the self looms large and the world small is not an appropriate setting *in which* to frame moral questions or *from which* to conceptualize the possibilities of human morality. Psychiatrists are called head shrinkers, but from this perspective it is the world and not the head they shrink. I suggested two ways for changing this predicament, one clinical and one theoretical. At the clinical level it is necessary to acknowledge the problem and to develop a method for stepping back and reexamining human problems in a moral perspective. At the level of theory it is necessary to reconceptualize the superego and the idea of guilt. I dis-

tinguished between self-loathing arising out of the failure of the self to be perfect, powerful, or lovable; and guilt because one has failed in one's moral obligations to others. The former is the theme of narcissism and the latter of moral obligation. At the most general level I wanted to suggest to you that psychiatry has contributed to the general acceptance of a kind of discourse about the moral adventure of life in which the veil of self-love has not been torn away. Self-love has instead been reinterpreted as self-fulfillment or self-actualization.

The problem with self-fulfillment and self-actualization, like the problem of narcissism, is that these can be lonely modes of existence. If Freud's neurotics suffered from reminiscences, today our patients suffer from loneliness.

There was another theme in my last talk that I want to re-emphasize. The basic premise of any psychiatry that posits an unconscious is that the patient's self-description is a self-deception. The power and significance of this premise depends on whether the psychiatrist truly knows what lies behind the self-deception. I gave the example of Freud's truth about women to demonstrate that we did not know the truth about self-deception. Nonetheless, I continue to believe that the dynamic unconscious is real, that self-deception is crucial, and that if psychiatry is to understand the human condition it must understand self-deception. The problem is that with this presumption of the patient's self-deception, psychiatry teeters on the threshold of paternalism and of disrespect for the person. The charge of paternalism today confounds the psychiatrist at every turn. Whether treatment is voluntary or involuntary, whether it is a matter of diagnosis or prescription, whether the treatment helps or not, every interaction between psychiatrist and patient has taken on this political and controversial dimension of paternalism. If you disagreed with Freud for telling his women patients that their striving in the world outside the home was a masculine protest based on penis envy, you may agree with Karen Horney. She, in refuting Freud's influence, told her

women patients who wanted to be good mothers and homemakers to live lives more like men, because modern women invest too much of themselves in love and thus leave themselves too vulnerable to rejection and loss of self-esteem.<sup>30</sup>

But whatever your opinion of these two kinds of advice may be, you will acknowledge that both are implicitly a kind of paternalistic or maternalistic moral instruction implying that the patient has deceived herself about her goals in life and when the self-deception is stripped away the psychiatrist knows more than she about the true goals of women and the ideal relation between the sexes. If psychiatrists still practice moral instruction in the sense that they help patients to decide how to live their lives, from where do they get their vision of morality? Do they derive it from their psychological understanding of human nature? Do they import into psychiatry their own unexamined moral attitudes and beliefs? Or do they, as some claim, remain neutral and nonjudgmental, working entirely within the context of the patient, applying only the patient's values and moral convictions as they emerge in therapy? Philip Rieff, in his book *Freud: The Mind of the Moralizer*, suggests that Freud did have a moral perspective which derived from his theory of therapy.<sup>31</sup> What this "penultimate morality" amounts to is the duty to examine the history and the development of one's moral convictions.

I think Rieff's underlying assumption about Freud's morality might be expressed as follows. Human beings typically cling to some childlike illusory ideal (the parent as god-like redeemer and moral authority). When they come into analysis they project that illusory ideal onto the analyst. This parental ideal is somehow tied up with a person's deepest moral convictions, which are typically unexamined. During analysis he will work through his attachment to this ideal, reconsider his moral convictions, face up to reality and necessity and relinquish his illusions, including the

<sup>30</sup> Karen Horney, *The Collected Works* (New York: Norton, 1963).

<sup>31</sup> New York: Viking Press, 1959.

illusion of moral authority as symbolized by the omnipotent father. Life without illusions is the goal of this penultimate morality. It is Freud's relentless pursuit of this vision which has led critics to say that Freud's inspiration lacked all of the religious virtues: faith, hope, and charity.

But if Freud offered only self-knowledge, there have been other psychotherapists willing to go beyond the analysis of illusions. They offer implicit moral instruction based on their psychological theories. Let me give you a published example from a well-known psychologist. His patient has reported her guilt about not doing enough for her parents — her father had a long history of alcoholism, her mother had had breast cancer surgery, there had been other long-drawn-out family problems. The patient feels she has no life of her own. She reportedly says, "I was brought up with that! You always have to give of yourself. If you think of yourself, you're wrong." To this the therapist responds, "Now, why do you have to keep believing that — at your age? You believed a lot of superstitions when you were younger. Why do you have to retain them? We can see why your parents would have to indoctrinate you with this kind of nonsense, because that's their belief. But why do you still have to believe this nonsense — that one should be devoted to others, self-sacrificial? Who needs that philosophy? All it's gotten you, so far, is guilt. And that's all it ever will get you!"<sup>32</sup>

Here is explicit, straightforward, shall we call it moral, instruction. The therapist in fact, later in this very first interview, goes on to deride the patient for attempting to be Jesus or Moses. This therapist is unique only in the sense that he is so clear about what he does. His theory is that people are sick because of their crazy beliefs, among which are nonsensical moral obligations. The therapist reports that this patient dramatically improved as a result of the victory of rational self-interest over her insane moral obligations.

<sup>32</sup> Albert Ellis, *Growth Through Reason: Verbatim Cases in Rational-Emotive Therapy* (Palo Alto, California: Science and Behavior Books, 1971), p. 228.

Now, I do not know whether this psychotherapist believes that there are any sane moral obligations which are counter to rational self-interest. But it is clear that the essence of his psychological theory is that sanity is rational self-interest and his therapy is directed toward that goal.

The second possibility, that we have imported into our theories and our therapy our own moral attitudes and beliefs disguised as health values, continues to be, as I discussed at length in my first lecture, a subject of enormous controversy in psychiatry today.

But the question is, what shall we do about it now that we recognize the problems? Psychiatry is very much divided on this difficult matter. There are those who believe that we must acknowledge the truth of this argument and that psychiatry should import some explicit vision of morality into its work. This, however, creates a struggle over what kind of morality it should be, and that has divided psychiatry into sects within schools. Do psychiatrists then have an obligation to reveal their moral values to patients in advance? This is not just a bizarre example of pushing an argument to an extreme; there are now, for example, radical psychiatrists, gay psychiatrists, Christian born-again psychiatrists, feminist psychiatrists, and other examples of an explicit conjunction of psychiatry and some specific value orientation, moral or ideological system. It cannot have escaped you that each of these conjunctions will generate not only different therapeutic objectives but also different conceptions of what mental disorder and its cure are.

There are other psychiatrists, however, who are attempting to identify and remove the moral values from psychiatric theory and therapy. This purging of hidden morality has led to intense debate over which of the "health values" are "moral values." This is what happened in the case of the diagnosis of homosexuality.

Let me briefly summarize the problem. Psychiatrists were told by the gay community that the diagnosis of homosexuality was nothing but a moral value disguised as a health value. Being

called sick was damaging to their self-esteem; psychiatry was stigmatizing and harmful to their mental health. Now consider what happens when psychiatrists attempted to deal with a problem like this. There are, as I have already described, four major paradigms in modern psychiatry. The biological psychiatrist may believe that homosexuality is due to some enzyme imbalance. He may agree that the diagnosis of homosexuality is stigmatizing, but he will not agree that his scientific study of enzymes has anything to do with moral values. The behavioral psychiatrist may believe that homosexuality is the result of a certain kind of sexual reinforcement. He may also agree that the diagnosis of homosexuality is stigmatizing and harmful, but he will not therefore abandon his theory of how homosexual behaviors develop. The psychodynamic psychiatrist believes that homosexuality is the result of a negative Oedipus complex. He, too, may admit that the diagnosis of homosexuality is stigmatizing and harmful, but he is not about to give up his theory of the Oedipus complex. The social psychiatrist believes that homosexuality is associated with certain demographic, social, and cultural patterns. He is quite willing to agree that the diagnosis of homosexuality contributes to the unhappiness of homosexuals and that social change will alleviate this, but he is not going to forego his theories about the effect of demographics and social factors on the prevalence of homosexuality.

Each paradigm has a theory of homosexuality, and although eventually American psychiatry demonstrated its therapeutic good will and removed the diagnosis, very few psychiatrists changed their theories. What would be necessary to actually remove the moral value judgment about homosexuality from psychiatry is not just a change in nosology but a change in the basic underlying conception of the human condition and what salient aspects need to be explained.<sup>33</sup>

The third option of respecting the patient's own values and moral convictions and working within that framework is what

<sup>33</sup> Stone, "Presidential Address."

most psychiatrists would want to claim they do. The practical importance of this argument for the psychiatrist is that it implies that we are all able to treat patients whose values and moral convictions are antithetical to our own. I have been enormously impressed by the ability of some psychiatrists to do just this and to feel compassion not only for patients whose values and moral convictions are antithetical to their own, but also for patients who morally are terrible people by all conventional standards: drug pushers, rapists, child molesters, arsonists, etc. But one of the secrets of this therapeutic compassion is that the psychiatrist believes these patients are sick and that successful treatment will reduce their immoral behavior, and alter their values. Therapeutic compassion is not necessarily forgiving, but it is premised on the psychiatrist's ability to believe that immorality is psychopathological.

Many psychiatrists, I think, actually do believe this. There is a tendency for such psychiatrists to call every immoral act "acting out," implying that it is sick rather than bad. Many of these moral difficulties fade into the background when the psychiatrist stops being a concerned psychotherapist, ignores the patient's situation in life, and simply prescribes drugs. Then the psychiatrist need not even share the language of his patient. This situation has prevailed in many of our state hospitals.

This, I believe, is part of the great current attractiveness of biological psychiatry. Not only is there a claim of greater effectiveness, but also the hasty retreat toward explaining all psychopathology in terms of brain enzymes seems to promise an escape from the terrible moral dilemmas and entanglements which I have been rehearsing. "Scientific Psychiatry" wants to become the study of the organism, not of the person.

We have begun under this influence to reorder our conception of the categories of mental disorder so that they comport with our biological discoveries about the organism. It may well be that this is good and sensible; it is after all the way "normal" science progresses. It may be that psychosis should not be regarded as a



life experience but rather as a dangerous medical illness of the organism for which there is a rapid, safe, and usually effective chemical treatment. But suppose the biological psychiatrist discovers that parents whose children have died produce identical chemical disturbances in their bloodstream to those produced by psychotically depressed persons. Will we then conclude that these grieving parents are experiencing a *dangerous medical illness*? Will we believe it is appropriate to give them rapid, safe, and usually effective chemical treatment so that we can eradicate their biological depression? Or will we want to assert our own non-biological ideas about what it means to be human? Does such science not begin to offend our most important intuitions about human nature?

If the descriptions I have given you are correct, if psychiatry is really so confused about moral questions, then how is it that society for so long allowed us to be the arbiters of difficult moral problems? The answer, I believe, is that our moral ambiguity and confusion, our inability to frame hard moral questions, has been our greatest asset as society's decision-makers.

Whenever there are hard moral conflicts to be resolved, it is socially and politically convenient to have a group of professionals who can redefine some of the toughest cases in a way that allows us to avoid paying the full price of our principles.

Consider the difficult moral questions attendant on abortion. Ten years ago the law in most states allowed abortion only when necessary to save the life of the pregnant woman or to preserve her health.<sup>34</sup> As public pressure began to mount against these strict legal restraints, the debate began which we now know as freedom of choice versus right to life. Early on, however, psychiatrists increasingly began to take advantage of the exception to the strict rule, that is, "necessary to preserve the health or save the life

<sup>34</sup> For review of state abortion laws at that time see report of the Task Force on Family Law and Policy to the Citizens' Advisory Council on the Status of Women (Washington, D.C.: Dept. of Labor, 1968), pp. 28–29, Government Publication No. Y3.IN8/21:2F21.

of the woman.” They resolved the difficult moral question in individual cases by invoking the non-moral question — the mental health of the pregnant woman. The typical situation went like this: the woman who was desperate to have an abortion would be described by the sympathetic psychiatrist as “depressed and suicidal.” The abortion therefore was necessary to keep the woman from putting her own life in danger. Since psychiatrists in effect controlled the only available access to safe legal abortions, you can imagine that many women who wanted abortions would have felt that their only option was to simulate or exaggerate these sorts of symptoms.

I was one of a group of psychiatrists who were called together to try and step back and look at what psychiatry was doing. Whatever therapeutic justification there may have been for psychiatric abortion, the data we assembled demonstrated that with psychiatrists controlling the abortion decision, middle and upper class women were twenty times more likely to receive therapeutic abortions than lower class women. And we found that women dying after illegal abortions tended to be poor, black, and Hispanic. We concluded, among other things, that having psychiatrists control the scarce resource of therapeutic abortions worked in a race- and class-biased fashion.<sup>35</sup>

An equally powerful example of this same unfairness occurred during the Vietnam war, when suddenly it seemed that contrary to all previous demographic evidence psychiatric illness was more prevalent among the middle and upper classes than among the lower class. At least this was the case among young males excused from military service because of psychiatric illness.

The abortion and Vietnam examples are in my experience typical. The psychiatrist in the privacy of his office in sympathy with his patient renders a therapeutic solution of a moral problem. These decisions, when aggregated, reveal a discriminatory distri-

<sup>35</sup> See Alan A. Stone, “Right to Abortion: A Psychiatric View,” *Group for the Advancement of Psychiatry*, vol. VII, no. 75 (October 1969).

bution of psychiatric mercy. This happens even when psychiatrists are neither just plain dishonest nor partisan in their decisions. When we look closely we see that our notion of fairness is twice cheated: moral principles are bent and they are bent in an inequitable fashion.

After I had finished my first lecture, I was told that some members of the audience thought I had quite given up on psychiatry. I can assure you I have not. I cling to Hegel's aphorism that the owl of Minerva only spreads her wings at dusk. I admit, however, that it is well past nightfall. I want to end these Tanner Lectures with a description of a patient I have treated for twenty years. It will demonstrate at least that even a psychiatrist deeply influenced by Freud's vision has some faith, hope, and charity. But I also believe that this case will help me to explore with you how I think and feel about psychiatry and morality in the face of all the confusion I have described.

Immanuel Kant, at the conclusion of *Anthropology from a Pragmatic Point of View*, described a kind of thought experiment as follows, "It could well be that on another planet there might be rational beings who could not think in any other way but aloud. These beings would not be able to have thoughts without voicing them at the same time. . . . [U]nless they are all as pure as angels, we cannot conceive how [these beings] would be able to live at peace with each other, how anyone could have any respect for anyone else, and how they could get along with each other" (p. 250).

Now it turns out that Kant's imaginary beings of another planet exist in a certain way here on earth in the form of persons whom we psychiatrists describe as having schizophrenic disorder. It is not an uncommon symptom of such patients that they believe everyone else can read their minds. Thus, although there is no reciprocity in this mind reading, they suffer in some of the ways that Kant imagined. I have treated one such patient, as I said, for twenty years. She struggled to keep her mind as pure as an

angel's but, being human, she often failed and she would experience terrible feelings of shame and humiliation when people read her mind. These experiences entirely disrupted her life. She felt vulnerable, intruded upon, and defenseless. As Kant correctly predicted, she felt no one could have any respect for her. She twice had made serious suicide attempts. She was thought to be a hopeless process schizophrenic. When she began treatment with me, she had constant auditory hallucinations, many complicated delusions, had twice been hospitalized in catatonic episodes, and had no sustained benefit from extensive electroconvulsive treatments. I cannot detail for you the many years of psychoanalytic therapy which spanned the era before and after the development of appropriate drug treatment. When I began treating her, she quickly formed the kind of intense attachment psychiatrists call a psychotic transference. She was obsessed with her great love for me, or as I repeatedly told her, her great love for her mother whom she had rediscovered in me. All of her hallucinations and delusions rapidly disappeared. The only loss of reality on her part was her conviction that I was equally in love with her, but temporarily unable to admit it. Five years of disordered schizophrenic thought cured by falling in love with her psychiatrist. During this honeymoon phase, she described the many complicated delusions she had had: my patient, however, was much more interested in the subject of love. I repeatedly assured her that I was happily married and she repeatedly gave me a knowing smile and told me that she was ready when I was. Finally I arranged to have a woman social worker meet with her and her husband to plan for *their* future. This "rejection" was followed by an exacerbation of delusions and hallucinations which terminated in a long suicidal depression. During this time we began the long process of exploring in great detail the story of her illness and her life. Out of this story we constructed a new self-description relevant to her one persistent delusion — it has lasted twenty years — that her mind was being read.

The patient's mother had intended her to be another Shirley Temple, and with the family's small income she had been given all of the necessary training to become a child star. The patient had been an only child and her mother totally dominated her life. But her mother died when the patient was a young teenager. Nothing came of her theatrical training; she drifted through adolescence trying to be beautiful and into a marriage. But, at some level of consciousness, she never abandoned her mother's project; unconsciously it was her desire to be a star in the spotlight. Measured against this project, her life was a failure and she struggled against feelings of total inadequacy. Every social encounter was for her, at some level, a failed public appearance in which the spotlight was meant to be on her. It was from this perspective that I interpreted her delusion that her mind was being read by everyone in a rather standard way as the pathological fulfillment of a fear and a wish, the fear that everyone would see her inadequacies and the wish that everyone would notice her. The delusion that her mind was being read served to place a kind of spotlight on her. This new self-description allowed my patient to cope with what was both a feeling and a belief that her mind was being read. During therapy she began to realize that this feeling/belief came on in two kinds of situations — at times of particularly low esteem, when she was isolated, lost, and ignored in a social group, or in situations when others were in the spotlight and she was part of an anonymous crowd, for example at the theater. When she became very disturbed she would have the feeling/belief that the famous people she watched on television were reading her mind. The nature of these situations, I suggested, was confirming evidence for the fear/wish interpretation I had given her.

There are many aspects of this highly condensed example that one might discuss. Did we discover the truth about her life or did I merely indoctrinate her with one set of self-descriptions which have little or nothing to do with either her actual life or her delusion? And, even if these were in some sense correct self-

descriptions, are they an example of the logical fallacy of assuming that *understanding* her memories about the history of her life and her desires is the same as *explaining* her delusion, as though psychosis could be explained at the level of experience. Many psychiatrists today would consider this lengthy treatment process an absurd relic of a misguided era in psychiatry. They would attribute the relief of her symptoms to the drugs she was eventually given—a chemical imbalance in her brain no doubt explains her illness, and the drugs corrected that imbalance — and explain the cure. Understanding her life, they would argue, is a different enterprise from explaining her psychotic disorder.

I have no hard scientific rejoinder to these biological claims, but if her schizophrenia was only a biochemical imbalance, how is it that falling in love with me was sufficient to cure all of her psychotic symptoms but one. Falling in love had in fact temporarily transformed this disordered, distracted, hallucinating woman. I want to consider this question of my patient's love and her mind-reading delusion. Although my patient said she believed and understood the fear/wish self-description she had worked out with me, periodically her faith would weaken. She would come back to me for —what shall we call it — love, reassurance, reinforcement, or reindoctrination.

At these sessions I would ask her, how after all these years, two decades, could she still believe that her mind was being read. She never has been able to explain either to her own satisfaction or to mine why she periodically relives Kant's thought experiment, but one thing is clear to both of us: that she gets something from the human relationship when she sees me which is temporarily sufficient to overcome the delusional belief and renew her faith in the therapeutic self-descriptions sometimes for as long as three months. Now some of you may feel this therapy is merely a form of conditioning, a positive reinforcement, and it may be. My own understanding is that her mind-reading delusion is a passionate conviction about her vulnerable situation in the world. Her delu-

sion begins when she feels her self disappearing from other people's awareness. It requires both her understanding of what is happening and her sense of attachment to me to control this disappearance of self. In her case, at least, it is not enough to keep the interpretation of all this vividly in the forefront of her consciousness. She must also have a continuing sense of a loving connection with me, a sense that she exists in my awareness and I in hers.

Some of the description I have given is, I think, a commonplace experience for psychiatrists; it is the frustrating recognition that insight in the form of a new self-understanding is for many of our patients insufficient: they internalize the new self-understanding only as they idealize the therapist. The supposed goal of orthodox psychoanalysis was to work through this idealization of the analyst, but this goal is seldom fully attained, in my opinion. What studies there have been of patients who have been analyzed suggest that their failure to work through the idealized transference is a common occurrence. Enjoying this idealized transference is the secret vice of psychoanalysts. Even psychoanalysts themselves talk about their own psychoanalysts with a tone of reverence, or at least appreciation, which they rarely accord to mere mortals. But it may well be, as the example of my patient suggests, that these reverential feelings are in some way essential to the "cure" and to the stability of their new self-understanding.

We have reached the classic question: does psychotherapy cure by love or by insight? I would claim that there is an analogous question: does moral conviction come from loving the moral instructor or from the wisdom of his teachings? The answer seems to me clear: both are involved in both cases.

I shall talk only about psychotherapy. I will leave it to the moral philosophers to decide if there is, in fact, any parallel.

Psychiatrists are accustomed to think of disorders of consciousness in terms of the traditional distinction between thoughts and feelings. There are thought disorders and mood disorders. There

are irrational ideas and unnatural impulses. This dualism between cognition and affect is reflected in the notion of the struggle between reason and passion. Even our legal test of insanity reflects this dualism. There is on the one hand insanity manifested by the inability to *know* right from wrong, and there is insanity manifested by an irresistible *impulse*. But delusion is not just a false belief about the world; it is a passionate conviction. A phobia is not just a feeling of anxiety; it is also a false belief. Depression is not just a disorder of mood; self-loathing expresses a set of deep convictions about the self.

What I want to suggest to you is that all mental disorders are in some sense passionate convictions about the situation of the self in the world. They are not just false beliefs; they are not just peculiar feelings. Mental disorder is a passion in the different sense that Roberto Unger has given it, Passion exists at the point “where distinctions between desire (wanting something from the other person) and knowledge (viewing him and myself in a certain way) collapse.”<sup>36</sup>

Our patients, and I do not mean just our psychotic patients, seem reluctant or perhaps even unable to give up their passions. Passion is not so easily routed even by making the unconscious conscious. What I am trying to say by way of these arguments is that our most important convictions about ourselves and our situation in the world are passionate convictions, convictions which will change only when passion finds a new configuration. How does that happen in psychotherapy? Let us first consider therapy not performed by psychiatrists. My profession has for a long time recognized that alcoholics are better treated by Alcoholics Anonymous than by psychotherapy. Furthermore, it is clear that AA affords both powerful attachments to a new group and moral instruction about one's situation in the world. The dramatically cured alcoholic is often a fanatic. The same is often the case with cured drug addicts. And, of course, similar things happen in cults.

<sup>36</sup> R. M. Unger, “A Program for Late Twentieth Century Psychiatry,” *American Journal of Psychiatry* 139:2 (February 1982), p. 159.



There is a powerful attachment to a new group and a profound change in one's convictions about oneself and one's situation in the world. Many of these "cures" are achieved with some better understanding of one's past, at least there is a confessional element, but a new and passionate conviction about the situation of the self in the world seems to be a crucial element of change.

You will recognize that in the view I am suggesting there is a considerable overlap between religious conversion and what goes on in the psychotherapist's office. The transference involves both a kind of love and the acceptance of the therapist as an authority about the subject of the situation of the self in the world. At the same time, the kind of intense transference of love that I described in my patient constituted in itself a new and passionate conviction about her situation in the world. Love, after all, is a profound change in one's experience of the self and its situation in the world. Love is perhaps the most powerful example we know of an experience at the point where the distinction between desiring and knowing collapses. It is love — which, after all, is a passion — that suggests there is something wrong with the notion that life is a struggle between reason and passion. Love is such a powerful counter-example that it demands that we reconsider the traditional dichotomy. If delusions like love are, in fact, located at this point where the distinction between knowing and desiring collapses, perhaps that is why patients are not fully persuaded by psychological interpretations of how they come by their delusions and are not easily deprived of their idealized transference. This is not to say that psychological accounts like those I gave to my patient are without power. I believe that ideas have power to change people's lives, not just because reason can overcome inclination but also because ideas can sometimes rally the passions.

If it is true, as it seems to be, for many patients that they rarely succeed in the task orthodox psychoanalysis sets for them of working through their idealization of their psychiatrists, then the enterprise of psychotherapy takes on a different aspect.

The crucial consideration is the psychiatrist as a person, his moral character, the kind of ideal he presents to his patient. In the end, the most important thing about a psychiatrist is probably the kind of person he is and the kinds of relationships he establishes. The psychoanalyst goes to great lengths to conceal the kind of person he is and to deny the reality of the relationship. But at some point he must speak and respond, and what he reveals about himself in those moments is more important than he has been taught to believe.

The goal of self-fulfillment, the feeling of self-loathing, and the experience of loneliness: this is the neurotic syndrome of our time. Love and moral ambition seem to be the cure, but to many this sounds like a prescription to embrace vulnerability. They are trapped by the subjective experience that hostility and contempt seem to be what hold the self together. This inner toughness is the only security they know, and love and moral ambition threaten that security.

Here on the inner stage of the psyche is played out the same drama we see in the world. Perhaps this is only rhetorical analogy, but in both cases it seems that the fear of vulnerability becomes the enemy of life. In saying this, I risk making the error that Freud made of claiming to know the truth behind self-deception, of offering a prescriptive theory of the human condition. But you will have realized by now that I believe there is no alternative; the risk cannot be avoided. The therapist who has no vision of what it means to be human forfeits his own humanity and has none to offer the patient.