Dangerous Psychosocial Hypotheses

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Psychiatry seems unusually vulnerable to almost any fad which happens to drift into its amoeboid maw. We would have to start with psychoanalysis which became influential in psychiatry, especially U.S. psychiatry, at a time when the founder, dead for a decade, had long ago concluded that his brainchild had little to offer psychiatry. Yet the corpse was resuscitated with enormous vigor in spite of Freud's warnings against psychoanalysis becoming part of psychiatry.

Before this rebirth of psychoanalysis as dynamic psychiatry in the late 1940's and early 1950's, Maxwell Jones was using a "therapeutic community" for "inadequate people," sometimes labelled biological constitutional inferiors. He was quite explicit about the patients who benefited from his approach: they were not psychotic. I know because we used to send patients to him at his little mini-hospital or rehabilitation unit in Bellevue Hospital, Sutton, Surrey, England. He did not want schizophrenics. Yet within a few years the ebullient Maxwell Jones was urging his approach upon psychiatry as a whole, mental hospitals, mental health centers, acute psychiatric units in general hospitals and even prisons. While one can not blame an enthusiastic innovator for doing everything possible to push his invention, one can and ought to question the good sense of those who did not bother to ask themselves just why Maxwell Jones' methods, which had once been limited to "in-adequates," should now be generalized to all patients and indeed many non-patients and what was likely to happen.

Not long after this, Irving Goffmann came on the scene with his notions of Total Institutions in which he lumped together prisons, mental hospitals, boarding schools, etc. His main theme was, and apparently still is, that prisons and mental hospitals are much alike. Since he is currently president of the American Sociological Association his views have not been those of an outsider. Yet as Bob Sommer, Miriam Siegler and I showed long ago, mental hospitals and prisons are far more dissimilar than similar. In other words, Goffmann's hunch was interesting but mistaken. There is no reason why distinguished social scientists should not make mistakes, but what is interesting is that the psychiatric establishment made very little attempt to correct these easily observed errors. Young psychiatrists and psychologists were, by default at least, given to suppose that these were

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"valuable insights" rather than serious and avoidable mistakes based on a social scientist's ignorance and poor powers of observation.

At about the same time Scheff and others came along with what became labelling theory, which was simply the notion of giving a dog a bad name. It seemed to make little difference to this particular faction that mental illnesses had been occurring all over the world throughout recorded history, which suggested that this was no local whim of the 18th, 19th or 20th centuries. Some psychiatrists still pay lip service at least to labelling theory and behave as if it had some merit. They seem to be unaware that it is a dud which has never been plausible in view of the natural history and world wide distribution of mental illnesses. What is more, most mentally ill people do not find labelling theories help them particularly.

At about this time, largely by accident, another psychosocial theory received, for a time at least, widespread interest and support in psychiatry—the schizophrenogenic mother. This was later extended to the family as a whole and has done much to embitter the relationship between patients and their families and those who treat patients and their families. This led to an open season against the families of patients which still continues to some extent.

In the mid 1950's Gregory Bateson, an anthropologist, and Don Jackson, a psychiatrist, launched the double bind notion. It was said by enthusiasts for this idea that schizophrenia was due to a specific kind of interaction in which an ambiguous message was passed from parent to child. Not long before his death Bateson took psychiatrists to task for taking his theories too concretely. However, when Tom Paterson visited him in California about 1958, Bateson gave him to understand that the double bind theory was the explanation for schizophrenia. It seems that most human communication is more or less ambiguous and that in families where someone is schizophrenic it is even more ambiguous.

Tom Szasz and Ronald Laing constitute other approaches, mostly derivative from a variety of predecessors, which have been
adopted by some psychiatrists and have puzzled, dismayed and sometimes annoyed patients, their families and the public.

It is odd and ironical that psychiatry whose special concern is mental illness and which has always noted that social attitudes greatly affect the way in which the mentally ill are treated has been so uninterested in the potential for harm of these many and various psychosocial theories. Great and sometimes hostile attention has been paid to various biological theories and treatments but psychosocial theories have been handled as if they would probably help, but could not possibly harm.

It should not be impossible to examine a social theory and ask oneself supposing that it was true, what would normal people do? Freud's original seduction theory posed this question. If fathers regularly raped small boys and girls making them neurotic or psychotic what course of action would be most appropriate? Clearly one ought to deal with the cause of the disease, the badly behaved fathers. There is no evidence that Freud ever considered this. The variations on psychoanalytic notions were not likely to help families to get on better with each other. It once again became fashionable to blame parents for their children's mental illnesses. This blame seeped into literature, the stage, movies, etc. It was received with much respect because it was supposedly scientific. It was via literature etc. that most of the psychiatrists of the 1930's and 1940's learned about this new science. Few of them knew that by this time Freud was no longer interested in psychoanalysis as a medical or psychiatric tool. He would have been shocked and offended by the fate of his science after his death.

It was not difficult to recognize that as a treatment for the psychoses psychoanalysis never had much promise on simple logistical grounds. So that if the goal of psychiatry was to be that of effective treatment of its illest patients psychoanalytic training was of doubtful value. This could have as easily been discovered in the 1920's as in the 1970's.

Many of the problems which beset psychiatry derive from its lack of a useable map of normal human temperament. It is not unlike

the problems of medicine and surgery faced before normal human anatomy was understood. The Freudian human is seen in terms of psychopathology—which would be much the same as if we described a normal skeleton in terms of repaired fragments of bones. It would not be the same thing. It is here that a map of normal variability is much needed.

Psychosocial theories are often as powerful as biological theories but they have one quality which is seldom recognized; this is the assumption of innocence or innocuousness. It has been long recognized that biological approaches may do more harm than good. The goal is naturally that they should do more good than harm. As Claud Bernard emphasized the ideal treatments which are obligatory are those that can not harm and are likely to help.

Labelling theorists for instance have never discussed just what would happen supposing psychiatrists and their colleagues behaved as if labelling theory was true. There still would be crazy people who would be misbehaving, but as Dr. X at Massachusetts Mental Health Center said they must not be taught about illness, and since the first step in teaching about illness is diagnosis they would not be diagnosed—labelled. They would not be in the sick role. So they would either be in some other role or as Miriam Siegler and I have suggested they would become nothings, roleless non-persons.

There is plenty of evidence from medicine as a whole (excluding psychiatry) that a mis-diagnosis is from a social viewpoint much preferable to nothingdom. Yet what Rosenham and other labelling theorists are inviting us to do, if indeed they are serious, is to create more nothings. Tom Szasz has resolved the problem to his satisfaction by labelling most mentally ill people (he does not admit that this category exists) as being malingerers. I have heard him say this although he usually adds a warning that they are malingerers whose bad behavior has been induced by psychiatrists.

These chic psychosocial models from psychoanalysis on have done much avoidable damage to patients and their families. Many of them have not only resulted

in harming family relationships, sometimes ir-reparably, but have also been enormously expensive.

I hope we can take a new look at these psychosocial theories, treating them with the respect which their ability to do harm deserves. Labelling or diagnosis is an essential social process for maintaining roles. Medically, it is of course desirable to get the correct diagnosis, resulting in the best possible treatment, which allows the patient the sick role to the greatest advantage.