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Iatrogenic Helplessness in Authoritarian Psychiatry

Dr. Peter Breggin is a leading expert on some of the more iatrogenic treatments still in vogue (see his chapter 21 on shock treatment). He is also one of the prime movers of blending a scientist's data with an activist's techniques for change. Dr. Martin Luther King Jr. and others foresaw decades back that good intentions were never enough: a movement without a systematic search for truth would ultimately defeat itself by its own fresh dogma. Having identified some change that is clearly justified by data, one is left with generating the means to create that change. This chapter develops the process theory behind the professional behavior maintaining the iatrogenic content Breggin relentlessly opposes.

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Fear and helplessness are the twin problems of mankind. Fear underlies most of the painful emotions we commonly experience (e.g., guilt, shame and anxiety). Helplessness is the most debilitating response to this fear (Breggin 1980a).

Because human beings suffer from fear, and because they so often become helpless in the face of this fear, authority thrives in human life. Reliance upon authority is the individual's attempt to deal with feelings of fear and helplessness (Breggin 1980a).

In psychiatry, authority has often been promoted as *the* answer to the helplessness and fear which typically dominate psychiatric patients, as well as the rest of mankind. Indeed, the entire structure of psychiatry seems built upon the maintenance of authority over the patient.

To the extent that psychiatry promotes its own authority, it also promotes helplessness and fear. Authority, by its very nature, encourages fear and helplessness upon the part of the individual over whom it is exercised. Authority, and psychiatric authority in particular, can be said to cause *iatrogenic fear and helplessness*. The sources of the fear and helplessness are always there within the individual—within every living individual. We all find much to be afraid of within life, and much to be afraid of about death. We often struggle with a sense of helplessness which urges us to seek out the answers in one kind of authority or another, rather than within our own autonomous ability to reason and to make decisions. But nearly all forms of psychiatry prey upon this helplessness and fear, in order to gain further authoritarian control over the patient.

Fear

Fear is so much a part of human life that an analysis of fear is tantamount to an examination of life itself. All I can attempt here is to outline some of the major sources of fear and their relationship to guilt, shame and anxiety.

From a very early age, a child experiences fear. Probably it begins with pain—the pain of hunger, of indigestion, of uncomfortable positions, loud noises, and sometimes, of physical punishment. Very quickly fear also begins to generate in the child's relationships to others; the young infant will become "cranky" or uneasy when the parent is out of sorts or upset. Over the first few years of life, the child learns about abandonment, loss and disappointment of all kinds. The fear of death itself sets in early, certainly within the first few years. By the time the child is two or three years old, he/she can easily become dominated by fears which may explode in sheer terror at being left alone, or being punished, or being unloved or being threatened by imagined monsters.

Soon the parents or other authorities, including older siblings, become closely tied to *the production of fear* and *the protection from fear*. The authorities produce fear by inflicting pain upon the child, and by punishing in various other ways. They also inflict pain in unavoidable ways: by not always meeting the child's needs, and by leaving the child when it does not want to be left. But while the authorities, from the child's viewpoint, seem to cause much of its pain, they are also the child's sole source of protection from pain. The child becomes dependent upon the very people it fears. This ambivalent relationship becomes the prototype for later relationships with authorities, who will be seen as fearsome and yet needed.

Helplessness

Helplessness is the most debilitating response to fear (Breggin 1980a). In helplessness, the child, or grown individual, gives up or foresakes the concept that he/she cannot do anything about the fearful circumstance. Helpless according to the American Heritage Dictionary (1969) means:

1. unable to manage by oneself; defenseless; dependent.
2. lacking power or strength; impotent; ineffectual.
3. without help.
4. unable to be remedied.

In this typical definition, two aspects of helplessness are mixed, the subjective experience and the objective reality. From an objective viewpoint, there are times when we are more or less helpless. I cannot avoid eventual death. I probably cannot escape paying my taxes. The influence I can exert upon my wife, children or friends is limited. Whether this article is read and appreciated is somewhat out of my hands. These are objective limits.

But there is a more subjective aspect to helplessness, and this subjective helplessness disposes the individual to submit to authority. Subjective helplessness is a form of "giving up," a surrender of one's abilities and autonomy. In particular, it is a surrender of the ability that I call self-determination (Breggin 1980a). Self-determination is the capacity of the individual under any and all circumstances to "keep his head" or to maintain rationality. This rationality can then be used to exert whatever influence is possible over the inner world of subjective thoughts and feelings, and the outer world of events. The individual may be limited severely in his capacity to effect events: he may be locked in prison or suffering from a debilitating disease. Indeed, in so many ways, all of us are locked in various prisons, from our bodies to our nations, and all of us have a debilitating disease, the aging process. But if we remain self-determining, rather than helpless, we can rely upon ourselves to make the most of whatever situation in which we find ourselves. Above all else, we can attempt to control our personal, subjective responses to these situations. Helplessness, from the viewpoint of the psychology of self-determination, is an inner, subjective state, characterized by the giving up of self-control and self-direction. It can vary from slight feelings of "I can't do anything" to overwhelming panic and catatonia. Helplessness is one response to fear. Self-determination is the other.

Real or objective helplessness in regard to external events in the world is the obvious situation of the infant at birth. Subjective helplessness develops over the years. Certainly by the age of one or two, children can be observed to develop subjective helplessness. A child, for example, when stymied by a puzzle may become frustrated and upset, and refuse to try any further. The child may throw a temper tantrum over the failure, becoming wholly subjectively helpless.

Subjective helplessness often develops in the child as a response to authorities. Mom wants the child to get dressed by himself, but the child just cannot seem to get his arms and legs co-ordinated properly. It is a case of studied, chosen helplessness. Later this obviously volitional helplessness can become so embedded in the child's consciousness that the child is unaware that he/she once chose helplessness as a means of evading the commands of the parents. This is a typical example of what I mean in the *Psychology of Freedom* when I speak of how children choose their life styles of helplessness. They eventually forget that choices were made. Adult maturity requires undoing these original choices and deciding, instead, to become self-determining.

Guilt, Shame and Anxiety

Fear is the root emotion behind all the other negative emotions in life, such as guilt, shame and anxiety. Typically the process involves what I call self-oppression (1980a). The child is afraid of the authority, and cannot bear to have a confrontation with it. It is too dangerous to meet Mom or Dad head on in a fight or disagreement. So the child, instead of being afraid of the parent, and consequently angry at the parent, instead turns on itself and helplessly identifies itself as the cause of the problem.

The parent or other authority encourages this process. Thus, guilt is a form of turning anger on oneself in an effort to avoid confrontation with the authorities. Guilt becomes a form of helplessness in the face of fear, a subjective sense that one is "bad" and, therefore, cannot take any effective actions to remedy the situation.

Shame and anxiety are similar expressions of self-oppression in the face of a fearful confrontation. Shame says "I am worthless, meaningless or inconsequential and hence, I am helpless." Anxiety says, "I do not know what is going on, and hence, I am helpless." Either way, helplessness continues to dominate.

Ultimately, most forms of self-oppression, and hence, most forms of guilt, shame and anxiety can be understood as subjugation to authority. The individual who is not submissive to authority (either external authority or internalized authority) is a self-determining, rational being who can make independent choices.

Life Styles of Failure

In *The Psychology of Freedom*, I describe the origins of the various life-styles of failure. Here I can only summarize them briefly. *Paranoia* is a helpless response to fear in which the individual blames others or outside forces for his failure to remain self-determining. It does not matter if the outside force is real. Perhaps we *are* influenced by radio waves from outer space. Perhaps the Martians have landed. Certainly, real life threats can be included in the paranoid person's viewpoint. What matters is the *helpless* attitude.

Depression is still another form of helplessness in which the individual blames himself/herself, rather than others or outside forces. The depressed person feels or expresses self-hate, and says, in effect, "I am bad. I am no good." As in paranoia, the issue is not the truth or falsehood of the moral observation, but the helplessness with which it is felt and uttered. In depression, the self-blame is used as one more *excuse* for remaining helpless: "I am bad, therefore, I cannot do anything about the things in life that I fear."

In *anxiety*, unlike depression and paranoia, the individual blames no one and nothing. In effect, the individual becomes confused, stupid or unknowing rather than face his/her fears. This life style, like the others, can usually be traced back many years as a consistent method of dealing with the world.

Individuals frequently vacillate between depression, anxiety and paranoia. The common thread is the *helplessness*. When the individual decides no longer to be helpless, but rather to be self-determining, and in particular, to use reason in the service of dealing with the various fears in life, the individual begins to leave behind the life styles of depression, paranoia and anxiety, and the various associated emotions of guilt, shame and anxiety.

Schizophrenia, which Szasz (1976) has aptly called "the sacred symbol

of psychiatry," is nothing more than an expression of total helplessness, including helplessness in the control of one's own mind. The person who develops "loosening of associations" or "delusions" has become totally irresponsible, or totally helpless, in regard to control over the inner world (Breggin 1980a). Such a person feels at the mercy of his own thoughts, rather than in charge of his own thoughts. For the person who is bordering on "going crazy," these concepts can be immensely helpful. The individual can grasp responsibility for self-determination of his/her own mind.

Self-determination

In *The Psychology of Freedom* I develop the concept of self-determination as based upon the twin principles of personal sovereignty and personal freedom. *Personal sovereignty* designates the right and the capacity to be in charge of one's own internal, subjective world. It reflects the individual as an agent who can make moral and ethical decisions. Personal sovereignty has no known limits. Individuals are forever developing new thoughts and concepts, and making new decisions. Sometimes these experiences remain wholly private; at other times, they are communicated and become real to others as well.

Personal freedom designates the right and the capacity of the individual to implement his/her thoughts, feelings and decisions in the world. All philosophies advocate certain limits on personal freedom, especially a limit on infringing upon the liberties of others. "Thou shall not kill" is a paradigm of the moral limit on personal freedom. Personal freedom is also limited by objective reality. We all live in bodies, and that places grave limits on us.

The psychology of self-determination, based upon the libertarian principles of voluntary association, states that the individual can and should strive for ever-increasing degrees of personal sovereignty and personal freedom. The sole injunction is against the use of force (except in self-defense) (Breggin 1980a).

Types of Authority

The opposite of self-determination is other-determination, or subjugation to authority. Authority can take many forms (Breggin 1980a). The only benign form of authority from my viewpoint is the authority of expertise. In this context, it really should not be called authority. An individual may rationally decide that another person offers great expertise or sound advice. The individual, in this process, does not give up authority or dominion over himself. He retains the right to judge the value or reliability of the informant or guide with whom he is dealing. He is not forced or emotionally compelled to conform to the wishes of this individual. In contrast, most forms of authority are oppressive, and they encourage self-oppression. They encourage the individual, by emotional pressure or by force, to accept the control of the authority.

Moral authorities are those which rely mostly upon emotional pressure. They encourage guilt, shame and anxiety in the individual, rather than

rational decision-making. They emphasize faith rather than rational judgment. Nearly all religions are based on moral authority. The individual must sacrifice an element of self-determination, or rational decision-making, in order to "believe in" such an authority.

Political authorities are ones which enforce their position through a combination of emotional pressure and physical force. The state is the ultimate political authority. It fosters moral authority in the form of patriotism, but it *forces* itself upon the individual whether or not this emotional persuasion succeeds. Everywhere in the world individuals are born into nations and, in most cases, they have little opportunity to leave their countries. Based on the fear and helplessness first developed in childhood, these individuals go from believing in the authority of their parents to believing in the authority of the state. Along the way, public education, backed by parents and state alike, reinforces the transition from obedience to parents to obedience to state.

Religion, of course, plays a key role in the development of authority over the individual. In some nations, the power of religion is largely moral; it is maintained through emotional control. In other nations, religion is directly tied to state authority. In communist states, the dogma of communism (religious authority) is inextricable from state authority. Throughout the world, the vast majority of individuals out of fear and helplessness live their lives under the shadow of various authorities, including parents, priests and politicians.

Psychiatry and Authority

Psychiatry possesses both moral and political authority. In the Western world, and increasingly throughout the entire world, psychiatry as a moral authority has to a great extent replaced religion as the institution which enforces standards of ethical conduct for its citizens (Szasz 1965, 1974, 1976; Breggin 1974, 1975, 1980a). Under the old religious order, the question might be asked "Is homosexuality wrong?" Under the new psychiatric order, it is asked "Is homosexuality sick?" The language has changed somewhat, but the issue is the same—a positive or negative value judgment on conduct. In the Soviet Union, where official policy has set itself against religious authority, psychiatry has become the ultimate church-state combination. Deviation from state authority is called "mental illness," and deviants are "treated" in psychiatric prisons (Fireside 1979; Breggin 1981a).

Everywhere throughout the Western world, psychiatry is a formidable political authority. That is, psychiatry is maintained and backed by state authority. The most obvious political authority of psychiatry is the power of certification and commitment. Through certification, a physician, typically a psychiatrist, can determine that any particular citizen should lose his freedom, his civil rights and be forcibly admitted to a mental hospital. The grounds for this vary from place to place, and include "mental illness," "need for treatment" and "dangerousness to self and others." It

makes little difference. Fundamentally we are dealing with the power of one person, in the role of psychiatrist, to determine that another person no longer has the ordinary rights of citizenship because of his state of mind or non-criminal conduct that is considered "wrong" or "harmful."

In most places throughout the world, psychiatry has many more connections to the state than certification and civil commitment. In the United States, psychiatrists play various roles in the legal system. As an expert witness, the psychiatrist may be called upon in court to testify whether or not the individual was "sane" (the actual wording varies from state to state) during the commission of a crime. In effect, he is being asked to make a moral judgment upon the reprehensibility of the crime. He may be called upon to decide if the individual is fit to stand trial in the first place, and after conviction, he may be called upon to render an opinion that will influence the sentencing and disposition of the prisoner. When the parole period is reached, he may be called to render still another decision on the individual's fitness for parole.

Psychiatry is also tied into the state through various funding procedures. In the United States, psychiatry is supported by a variety of grants and legislative programs. More indirectly, psychiatry is supported and controlled through government policies concerning medical schools and medical licensure.

Jonas Robitscher, in *The Powers of Psychiatry* (1980), catalogues and questions many varieties of psychiatric authority. Among the more interesting is the moral-political role played by psychiatrists who wrote letters calling for the deferment of draftees on the grounds that they were "mentally ill." We might also note the adversary role played by the federally-employed psychiatrists who had the final say on whether or not the young men were indeed morally fit to serve in the army.

Psychiatric Authority and the Enforcement of "Craziness"

Authority lives upon fear and helplessness, and therefore, upon the various life styles of helplessness (paranoia, depression and anxiety) and the various emotions of helplessness (guilt, shame and anxiety). In the extreme, it is easy to see how a dictator bent upon whipping up a patriotic fervor in his subjects can play upon any one of these life styles and their associated emotions. The more helpless his subjects feel, the more likely they will respond to his authority. Psychiatry is no different from any other authority in this regard. Ultimately, most forms of psychiatry cannot "succeed" according to a value system based upon self-determination because they undermine self-determination. Thus psychiatry tends to produce *good patients* rather than *free and independent individuals*. Psychiatry has developed the art of *iatrogenic helplessness*.

The methods by which psychiatry enforces its own authority, and correspondingly, the helplessness of its patients, are legion. Nearly all the officially supported and sanctioned methods of psychiatry tend to be authoritarian. The aspects of psychiatry which I am now analyzing in this regard are obviously overlapping.

Civil commitment and certification—Every psychiatrist has the power to initiate and sometimes to carry out the process of depriving a citizen of his civil rights, placing him in confinement in a mental institution. The justification, it might be argued, is that the individuals in question are helpless and need someone to take over their lives for them. Indeed, most people who are committed are being subjectively helpless, or they would not fall into the psychiatric trap. But by declaring the individual helpless, and then treating him as if he is helpless, *psychiatry actually reinforces the individual's sense or conviction of helplessness*. Thus psychiatry reinforces the patient's problem and takes advantage of it, so that the patient who feels subjectively helpless is actually rendered still more helpless from an objective viewpoint. He is incarcerated, and worse, his mind will be blunted and disrupted by various physical "therapies." This is why psychiatric commitment and psychiatric treatment in general do so little good for anyone (except the psychiatrists); these processes prey upon the very helplessness that is already plaguing and even destroying the individual.

Like the child who both fears and needs the authorities around him, the mental patient comes to fear and to need the authorities around him. He needs their good will and approval if he is ever to get free of them. The child, at least, can look forward to emancipation as a routine matter of growing older. The patient remains a child at the discretion of the committing psychiatrists.

Diagnosis and the disease model (Szasz 1974)—This plays a crucial role in enforcing the psychiatrist's authority and the patient's helplessness. Psychiatric diagnosis reinforces the worst elements of paranoia, depression and anxiety as expressed by the patient himself/herself. The depressed person believes "I am bad, and therefore unable to do anything about my life." The diagnosing psychiatrist says, "No, you are not morally bad, you are biochemically bad. You have a disease. It is called manic-depressive disorder (or whatever). *You* are helpless in the face of it, but *we* have these treatments..." The patient, by conceiving of himself as morally bad, was at least on the right track. He knew, perhaps, that morality and ethics and ultimately choice might be involved in some way. The diagnosing psychiatrist removes the issue one step further away from human decision-making, and declares the problem utterly out of the hands of the patient.

The paranoid person says "I am being controlled by forces outside myself." The diagnosing psychiatrist says, "These forces are the environment, heredity or your hormones." Whatever the particular bias of the psychiatrist, the basic message is the same "Yes, you are helplessly at the mercy of forces beyond your control." Once this helplessness is confirmed, the psychiatrist can move in with his treatment.

The anxious person says, "I don't know what is happening to me." The diagnosing psychiatrist says, "We don't know the cause of your illness, but we have empirical treatments."

Every psychiatric diagnosis carries within it the same kernel of helplessness expressed by the life styles of paranoia, depression and anxiety. It does not matter a great deal whether the ideology involved is Freudian

(your unconscious controls you), behavioristic (environmental cues, in combination with heredity, control you) or biological (your aberrant neurotransmitters control you). In each case, the psychiatrist's authority goes up and the patient's authority over himself goes down. It is no wonder that "eclecticism" is so rampant nowadays; it is all cut from the same cloth of authority.

The mental hospital system—This is the epitome of an institution created to induce helplessness. The history of the state mental hospital system (Breggin 1964, 1971a, b; 1974, 1979) is the history of seizing relatively helpless individuals in order to render them still more helpless, and hence, docile within custodial institutions. Private psychiatric hospitals follow the same model. In none, is the autonomy or independence of the patient fostered. In all, being "improved" and "ready for discharge" means conforming to the authority of the institution. This authority aims at maintaining a helpless, child-like state in the individual.

Psychotherapy—With individuals, and sometimes with couples or groups, psychotherapy probably has the greatest potential to serve the individual as a self-determining being (Breggin 1980a; Szasz 1965). But as Szasz has thoroughly documented in *The Myth of Psychotherapy* (1978) and as I described in "Psychotherapy as Applied Ethics," (1971b) most psychotherapies, including classical psychoanalysis, reinforce the ethic of heteronomy, or submission to others. The very concept of "psychotherapy," drawn from medicine, smacks of authority. In *The Ethics of Psychoanalysis* (1965), Szasz describes a contractual approach to therapy which mitigates much of the authoritarianism inherent in the situation. In *Psychology of Freedom* (1980a), I systematically develop a psychology of self-determination based upon free will and personal freedom. Undoubtedly many individual psychotherapists in private practice treat many or most of their patients in an autonomous fashion. They do this on the basis of their own personal values. Almost anything they read and almost everything they have experienced in their psychiatric training will run counter to their more libertarian, autonomous practices.

Psychiatric technology—As a tool of oppression and control, psychiatric technology has already received an enormous amount of my attention. My efforts were at first focused upon the paradigm of destructive therapies, psychosurgery (Breggin 1980b, 1981c), then upon electroshock (1979, 1981b) and finally upon psychiatric drugs (1982). I developed the brain-disabling hypothesis which states that all the major psychiatric technologies *disable the normal brain* rendering the individual *more helpless*, and hence, easier to manage or to ignore. Each of the major psychiatric treatments—psychosurgery, electroshock, the major tranquilizers and lithium were originally developed in order to subdue and control unruly, difficult patients in the state mental hospital system (Breggin 1979, 1974, 1975, 1981a). Eventually each was rationalized as a "treatment" for "diseases," and their use spread from the state mental hospitals to private hospitals, clinics and private practices.

The brain disability (and associated mental dysfunction) produced by

the major psychiatric treatments is an iatrogenic illness. The illness is what the psychiatrist calls the "improvement."

The brain-disabling effects of psychosurgery are perhaps the most easy to understand. By producing lesions in the frontal lobes or the limbic system, the surgery reduces the higher capacities of the individual, rendering him less autonomous, and hence, less troublesome to others and possibly to himself. The therapeutic or clinical effect is only indirectly related to the loss of abstract reasoning, creativity, emotional sensitivity and other mental functions. It is most directly related to the inability to generate independent (and hence, inconvenient) choices and actions. Kalinowsky and others (Breggin 1979, 1982) have referred to the "emotional indifference" as the key to this treatment; but the emotional indifference is what makes the patient more manageable, less "symptomatic" and less troublesome to others. While this blunting usually results in varying degrees of apathy, it may also result in euphoria. If depressed patients become euphoric, they will be considered "improved" when actually suffering from an iatrogenic disease.

Electroshock is also relatively easy to understand in terms of the brain disabling hypothesis (Breggin 1979). All patients on electroshock become, to one degree or another, victims of an acute organic brain syndrome, which includes global disruption of all mental functions, including abstract reasoning, memory, judgment and emotional stability. The patient may become either apathetic or euphoric, but will no longer seem depressed. Depression, like all the life styles of self-oppression, requires a relatively well functioning brain. As the acute organic brain syndrome clears, the patient may be left with permanent mental disabilities (Breggin 1979). To the extent that it completely clears, the patient is likely to lapse back into depression, now complicated by his/her traumatic experiences at the hands of the psychiatrist.

My latest investigations of brain-disabling therapy, *Chemical Lobotomy* (1982), focus upon the effects of the major tranquilizers, antidepressants and lithium. All produce severe brain dysfunction, and should be considered neurotoxins. Instead of specifically ameliorating biochemical effects, they produce global brain dysfunction.

The antidepressants produce an acute brain syndrome (or toxic delirium), in many ways similar to electroshock, in a large proportion of patients, without producing as much strait-jacketing or apathy as the major tranquilizers. Hence, their apparent efficacy in retarded depressions.

The major tranquilizers (neuroleptics or antipsychotics) are especially effective in suppressing overactive, rebellious or difficult patients. The generalized neurotoxicity produces a pacifying or subduing effect on all individuals (and animals). The major tranquilizers share this effect with lithium and the antidepressants. But the specific dopamine disruption in the limbic system produces a virtual chemical lobotomy unique to these drugs. In addition, the various neurologic disorders can aid in controlling the patient by means of the chemical strait jacket. Unhappily, these drugs, in addition to producing tardive dyskinesia in many if not most patients,

also produce other associated defects in the higher centers of the brain, resulting at times in irreversible lobotomy, irreversible psychoses and dementia (Breggin 1981-2). The widespread use of the major tranquilizers is reaping a grim harvest of millions of brain-damaged individuals, many with severe, irreversible disorders of higher brain function.

Iatrogenic Denial

In order to designate an important effect of the major psychiatric technologies, I coined the term *iatrogenic denial*¹ (Breggin 1981c). Iatrogenic denial involves the infliction of brain damage and dysfunction upon the patient to encourage the patient in the process of denying the existence of both his personal problems and the iatrogenic brain damage.

Throughout history, medicine in general, as well as a multitude of quackeries, has relied upon the placebo effect and suggestion to achieve various effects in the patient. The authority of the physician or quack usually plays a key role in the process. Only in psychiatry, however, is the suggestion, "You are better now," reinforced by damaging the patient's brain and hence, his judgment, encouraging him to lapse into apathetic submission or an unrealistic high.

Denial and confabulation can be found in almost any brain damaged individual; the difference in iatrogenic denial is the purposeful infliction of the damage in order to encourage these primitive defense mechanisms and to enforce the authority of the physician (Breggin 1979; 1980b, 1980c).

The brain-disabled patient, above all else, is a fit subject for control by an authority. In the typical mental hospital today, where 90 percent or more of the patients are intoxicated with one or another brain-disabling agent, the authority of the physician and the institution are assured by the helpless state of the patient. The patient who enters into the psychiatric system because he subjectively *feels helpless* is rendered *objectively helpless* by mind-disabling treatments and by involuntary treatment and incarceration.

Conclusion

Life, for every individual, is fraught with fear. Too often the individual responds to these fears with an attitude of helplessness, rather than an attitude of self-determination. Once the route of helplessness has been taken, the individual tends to rely upon authority for guidance and for protection from the fears.

Psychiatric patients invariably suffer from an excess of helplessness in the face of their fears. They are primed to respond to authority. Psychiatry, instead of reversing this process, encourages the patient to spiral downward deeper into helplessness, and hence, more complete reliance upon the authority of the psychiatrist. Frequently, the psychiatrist will

... (1965) and 1 (1970, 1966) have promoted the ethic of autonomy as a more rational principle upon which to develop re-educational approaches to individuals suffering from personal helplessness.

In *The Psychology of Freedom* (1980a) I have developed a systematic psychology of self-determination based upon the individual's right and capacity to be his/her own authority in life. In this approach, personal or subjective helplessness in the face of fear is recognized as the fundamental cause of most human problems. Even the most debilitating "psychiatric syndromes," such as depression, paranoia and recurrent anxiety, can be understood as particular styles of ethical failure. Instead of reinforcing helplessness and submission to authority, the psychology of self-determination presents principles through which individuals can take rational control of their own lives.

FOOTNOTE

¹ Iatrogenic denial is one aspect of iatrogenic helplessness. I have elaborated upon the latter term for the first time in this chapter.

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