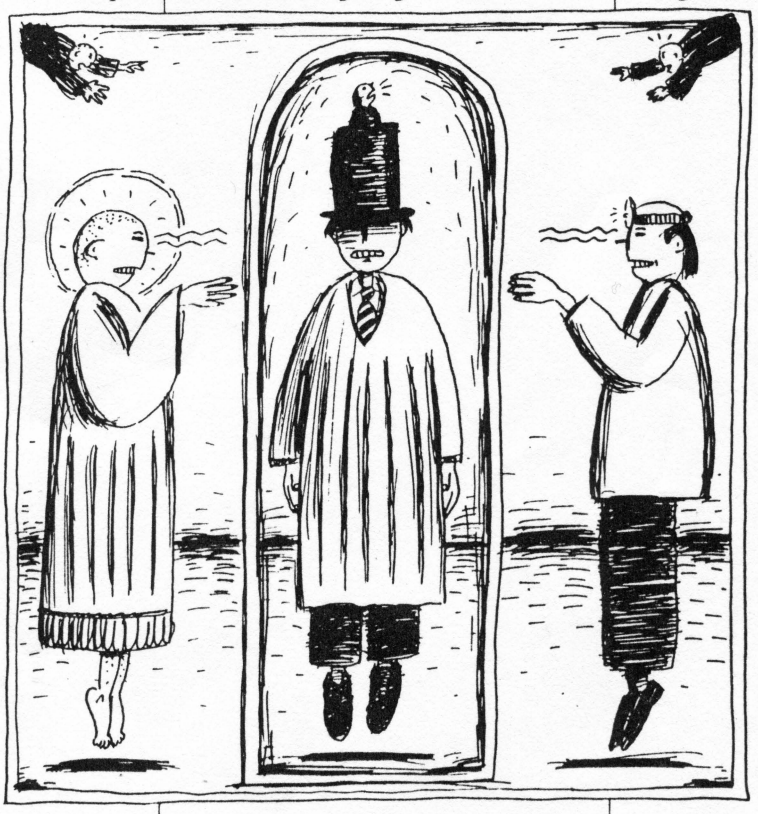
# A BRIEF HISTORY OF TROUBLE IN MIND

## I. DEMONOLOGY

Mental illness has been with us for about 75 years now, depending on your age. Its roots, however, are scattered across centuries. Near the beginning, the Catholic Church in Rome was charged by God with the task of defining the whole of reality and administering its Western branch. Those who effectively challenged the church's divine mandate were summarily thrown into primal scream therapy, with its techniques of burning, boiling and dismemberment.

The purpose of these punishing rituals was not punishment. It was to cast out Satan's demonic presence from the soul of the blasphemer, thereby elevating his, or more likely her, chances of spending eternity in God's heavenly garden. In the words of the canonical text, "Short-term pain for long-term gain." (It's more compelling in the Latin.)

Theoretically, torture and murder were the church's way of helping the sinner to feel good about herself. In practice, death was God's way of telling her He doesn't exist.



## II. MALINGERING

The scientific and industrial revolutions were not kind to the Catholic Church. Reality slipped from its administrative grasp as theocracy declined in the West. Secular rule, if not quite democratic, was an idea whose time had come. Enlightenment in social and political life revolutionized the treatment of the insane. The institutional care provided by the church gave way to the more humane and democratic treatments of the marketplace. The crackling and bubbling of bodies was seldom heard. Instead, like some other minorities, the deranged were often the victims of ostracism, robbery and assault. While these "therapies" represented a great advance over their theological forerunners, the theory behind them couldn't hold a candle to that of the church. The sophisticated and rococo concept-structures of demonology yielded to a pedestrian little idea called malingering.

What malingering meant, in a nutshell, was that lunatics were faking it. They weren't crazy. They were ordinary folk, as sane as anyone. They had one peculiarity, a bizarre need to fabricate madness in order to obtain or avoid a particular end. That's it, the whole theory. The intellectual pre-history of psychiatry had hit rock bottom. There was nowhere to go but up.

In a typical ruse, malingerers would venture out into public and engage in shouting matches with people who weren't there. God knows why they did it. All they got for their trouble was primary loss (abuse) and secondary loss (more abuse) – we'll return to these two concepts.

When psychiatry emerged on the scene in the mid-nineteenth century, it inherited a large pool of malingering patients. It soon learned what a stubborn diagnosis malingering can be. It was, for example, exceedingly difficult to convince a patient who lied about being Jesus Christ to stop lying about it. But psychiatry was in its infancy and its armamentarium was primitive. To turn Christ back into Joe Blow and then into a creature of its own making, what psychiatry needed was a good theory of its own.

## III. FREUD

Psychiatry has produced one genius and vice versa. When Freud appeared in the late nineteenth century, malingering's days were numbered. His theory of the mind was so subtle and complex – more so even than demonology's – that a diagnosis of simple lying, or malingering, was unthinkable. Freud was concerned with "lying," but of a different kind. The centrepiece of his theories is the unconscious mind. There, amid the hidden forces of self-deception and self-protection, lies the key to self-knowledge and personal redemption. The human mind, from its dreams to its slips of the tongue, had never before been described in such orderly detail.

In effect, Freud replaced the fraud of conscious malingering with the fact of unconscious life. In its clinical application, psychoanalysis sets in motion three related developments: the transfer of unconscious material into consciousness; a loosening of the patient

GARY CLEMENT

from her prison of conflict, anxiety and repression; and the transformation of neurotic misery into everyday unhappiness. These, at least, were the therapeutic goals.

Freud's work stands with Marx's and Einstein's as a pillar of modern intellectual thought. All three men claimed to be scientists. Only one claim was valid; it wasn't Freud's. Partly because psychoanalysis isn't scientific, it has never been particularly effective clinically. Freud's ideas have been in sharp decline for decades, both in psychiatry and in other academic fields. The epitaph of psychoanalysis might say it was the most impressive intellectual fad of modern times.

**Psychiatrists often see sabotage in the eyes of patients. There's a word for inappropriate suspicion, but psychiatry seldom applies diagnostic catagories to itself**

In present-day psychiatry, Freud's brilliance and daring have been supplanted by timid conservatism, intellectual poverty and incomes Freud would have called insane. Next to his landmark works, such as *The Interpretation of Dreams* and *The Psychopathology of Everyday Life*, post-Freudian psychiatry offers up titles like *I'm O.K., You're O.K., Feeling Good.* and *From Sad to Glad.* The authors of the three books, psychiatrists Thomas A. Harris, David D. Burns and Nathan S. Kline, respectively, are not mere popularizers. They are regarded as leading authorities in their field, and the ideas expounded in their books are accorded a place in academic psychiatry. One can't help wondering, though, what it means to be a leading authority in a field largely uncontaminated with knowledge. Psychiatry's journey from Freud to Kline is something like Warren Beatty's from *Reds* to *Dick Tracy*.

Freud was trained as a neurologist, and he had hopes that psychiatry would become respected as a medical discipline. He believed that both medicine and psychiatry would blossom into mature scientific fields. Medicine has travelled some distance, though it is still a weak science. The most that can be said for psychiatry is that it is still a weak pseudoscience.

### IV. SECONDARY GAIN

Malingering has bequeathed to psychiatry an heir by the name of secondary gain. The two are reminiscent of Freud's Oedipal complex, in which father and son compete for the sexual favours of the mother, with the usual outcome: the son avoids falling into bed with his mother by identifying with the father, adopting his traits in disguised form, and surviving him.

Primary gain refers to the initial, and deserved, benefits derived from an illness. (A woman suffering postpartum depression is hospitalized and relieved of the chores of child care, housework and her job.) Secondary gain, the next stage, refers to the ongoing, and illegitimate, benefits of an illness. (Here, the patient manipulates those around her and "uses her illness" to prolong the period of dependency and to escape the looming burden of responsibility.)

Psychiatry has peculiar ideas about the relationship between illness and gain. While laypeople would say that illness is related to loss, psychiatry has identified the two advantages of primary and secondary gain that are enjoyed by the mentally ill. Secondary gain is one of a number of concepts that fit under the general heading of manipulation, a term commonly used in everyday psychiatry. Manipulation is the opposite of assertiveness. Their concise definitions are best found in *The Mental Patients Liberation Dictionary*:

*ASSERTIVENESS: A technique used by the strong to exert their will over the weak.*

*MANIPULATION: 1. A technique used by the weak to exert their will over the strong. 2. A word used by the strong to stop them from doing it. 3. The act of accusing another of manipulation.*

The intent of concepts like manipulation is to firm up the lines of authority between patient and psychiatrist and to shift responsibility for the failure of therapy from psychiatrist to patient. The concept of resistance on the part of the patient provides another good example. In our dictionary, resistance is defined as "an artifact invented by psychiatry to explain its inability to cure its patients."

A psychiatrist told me a tale of secondary gain that has a place in psychiatric folklore. A fire broke out in a geriatric ward of bed-ridden women. Although incapacitated, they somehow managed to leave their beds and run through the flames to save their lives. In her chair, the psychiatrist playfully flapped her arms and legs, mocking the graceless old souls lumbering to safety. For years, they had been committing the crime of secondary gain, clinging to their illness in order to reap the benefits of a life in bed. The fable, surely apocryphal, reinforces prejudices that promote the interests of the profession. Psychiatrists often like to see sabotage in the eyes of patients. There is a word for inappropriate suspicion, but psychiatry seldom applies its diagnostic categories to itself.

Does secondary gain exist? Yes and no. Mostly, it's a figment of psychiatry's lack of imagination. In fact, the net occurrence of secondary gain is less than zero. Mental illness carries a heavy stigma, and surveys consistently show that the public regards mental patients as good people to stay away from. No group is more aware of the surrounding sea of hostility than psychiatry's patients. Most make it a way of life to disguise, deny and down-play their problems, not to fabricate or exaggerate them for minor concessions.

By paying disproportionate attention to the mouse of gain rather than the elephant of pain, psychiatry betrays a kind of moral dyslexia. One patient who belonged to the mental patients liberation movement summed it up when her psychiatrist accused her of secondary gain and asked whether she knew what it meant.

"Sure," she said, "Auschwitz? Yay! No homework!"

"You're manipulating again," replied the psychiatrist. TM

*Lanny Beckman is a Vancouver freelance writer. This article is one in the series "Psychiatry on the Brain."*

Leftovers / Lanny Beckman

# A BRIEF HISTORY OF TROUBLE IN MIND

## I. DEMONOLOGY

Mental illness has been with us for about 75 years now, depending on your age. Its roots, however, are scattered across centuries. Near the beginning, the Catholic Church in Rome was charged by God with the task of defining the whole of reality and administering its Western branch. Those who effectively challenged the church's divine mandate were summarily thrown into primal scream therapy, with its techniques of burning, boiling and dismemberment.

The purpose of these punishing rituals was not punishment. It was to cast out Satan's demonic presence from the soul of the blasphemer, thereby elevating his, or more likely her, chances of spending eternity in God's heavenly garden. In the words of the canonical text, “Short-term pain for long-term gain.” (It's more compelling in the Latin.)

Theoretically, torture and murder were the church's way of helping the sinner to feel good about herself. In practice, death was God's way of telling her He doesn’t exist.

## II. MALINGERING

The scientific and industrial revolutions were not kind to the Catholic Church. Reality slipped from its administrative grasp as theocracy declined in the West. Secular rule, if not quite democratic, was an idea whose time had come. Enlightenment in social and political life revolutionized the treatment of the insane. The institutional care provided by the church gave way to the more humane and democratic treatments of the marketplace. The crackling and bubbling of bodies was seldom heard. Instead, like some other minorities, the deranged were often the victims of ostracism, robbery and assault. While these “therapies” represented a great advance over their theological forerunners, the theory behind them couldn’t hold a candle to that of the church. The sophisticated and rococo concept-structures of demonology yielded to a pedestrian little idea called malingering.

What malingering meant, in a nutshell, was that lunatics were faking it. They weren't crazy. They were ordinary folk, as sane as anyone. They had one peculiarity, a bizarre need to fabricate madness in order to obtain or avoid a particular end. That's it, the whole theory. The intellectual pre-history of psychiatry had hit rock bottom. There was nowhere to go but up.

In a typical ruse, malingerers would venture out into public and engage in shouting matches with people who weren't there. God knows why they did it. All they got for their trouble was primary loss (abuse) and secondary loss (more abuse) – we’ll return to these two concepts.

When psychiatry emerged on the scene in the mid-nineteenth century, it inherited a large pool of malingering patients. It soon learned what a stubborn diagnosis malingering can be. It was, for example, exceedingly difficult to convince a patient who lied about being Jesus Christ to stop lying about it. But psychiatry was in its infancy and its armamentarium was primitive. To turn Christ back into Joe Blow and then into a creature of its own making, what psychiatry needed was a good theory of its own.

**III. FREUD**

Psychiatry has produced one genius and vice versa. When Freud appeared in the late nineteenth century, malingering's days were numbered. His theory of the mind was so subtle and complex – more so even than demonology's—that a diagnosis of simple lying, or malingering, was unthinkable. Freud was concerned with "lying," but of a different kind. The centrepiece of his theories is the unconscious mind. There, amid the hidden forces of self-deception and self-protection, lies the key to self-knowledge and personal redemption. The human mind, from its dreams to its slips of the tongue, had never before been described in such orderly detail.

In effect, Freud replaced the fraud of conscious malingering with the fact of unconscious life. In its clinical application, psychoanalysis sets in motion three related developments: the transfer of unconscious material into consciousness; a loosening of the patient from her prison of conflict, anxiety and repression; and the transformation of neurotic misery into everyday unhappiness. These, at least, were the therapeutic goals.

Freud's work stands with Marx's and Einstein's as a pillar of modern intellectual thought. All three men claimed to be scientists. Only one claim was valid; it wasn't Freud's. Partly because psychoanalysis isn't scientific, it has never been particularly effective clinically. Freud's ideas have been in sharp decline for decades, both in psychiatry and in other academic fields. The epitaph of psychoanalysis might say it was the most impressive intellectual fad of modern times.

In present-day psychiatry, Freud's brilliance and daring have been supplanted by timid conservatism, intellectual poverty and incomes Freud would have called insane. Next to his landmark works, such as *The Interpretation of Dreams* and *The Psychopathology of Everyday Life*, post-Freudian psychiatry offers up titles like *I'm O.K., You're O.K., Feeling Good,* and From Sad to Glad. The authors of the three books, psychiatrists Thomas A. Harris, David D. Burns and Nathan S. Kline, respectively, are not mere popularizers. They are regarded as leading authorities in their field, and the ideas expounded in their books are accorded a place in academic psychiatry. One can't help wondering, though, what it means to be a leading authority in a field largely uncontaminated with knowledge. Psychiatry's journey from Freud to Kline is something like Warren Beatty's from *Reds* to *Dick Tracy*.

Freud was trained as a neurologist, and he had hopes that psychiatry would become respected as a medical discipline. He believed that both medicine and psychiatry would blossom into mature scientific fields. Medicine has travelled some distance, though it is still a weak science. The most that can be said for psychiatry is that it is still a weak pseudoscience.

**IV. SECONDARY GAIN**

Malingering has bequeathed to psychiatry an heir by the name of secondary gain. The two are reminiscent of Freud's Oedipal complex, in which father and son compete for the sexual favours of the mother, with the usual outcome: the son avoids falling into bed with his mother by identifying with the father, adopting his traits in disguised form, and surviving him.

Primary gain refers to the initial, and deserved, benefits derived from an ill-

**Psychiatrists often see sabotage in the eyes of patients. There's a word for inappropriate suspicion, but psychiatry seldom applies diagnostic categories to itself**

ness. (A woman suffering postpartum depression is hospitalized and relieved of the chores of child care, housework and her job.) Secondary gain, the next stage, refers to the ongoing, and illegitimate, benefits of an illness. (Here, the patient manipulates those around her and "uses her illness" to prolong the period of dependency and to escape the looming burden of responsibility.)

Psychiatry has peculiar ideas about the relationship between illness and gain. While laypeople would say that illness is related to loss, psychiatry has identified the two advantages of primary and secondary gain that are enjoyed by the mentally ill. Secondary gain is one of a number of concepts that fit under the general heading of manipulation, a term commonly used in everyday psychiatry. Manipulation is the opposite of assertiveness. Their concise definitions are best found in *The Mental Patients Liberation Dictionary:*
*ASSERTIVENESS: A technique used by the strong to exert their will over the weak.*
*MANIPULATION: 1. A technique used by the weak to exert their will over the strong. 2. A word used by the strong to stop them from doing it. 3. The act of accusing another of manipulation.*

The intent of concepts like manipulation is to firm up the lines of authority between patient and psychiatrist and to shift responsibility for the failure of therapy from psychiatrist to patient. The concept of resistance on the part of the patient provides another good example. In our dictionary, resistance is defined as "an artifact invented by psychiatry to explain its inability to cure its patients."

A psychiatrist told me a tale of secondary gain that has a place in psychiatric folklore. A fire broke out in a geriatric ward of bed-ridden women. Although incapacitated, they somehow managed to leave their beds and run through the flames to save their lives. In her chair, the psychiatrist playfully flapped her arms and legs, mocking the graceless old souls lumbering to safety. For years, they had been committing the crime of secondary gain, clinging to their illness in order to reap the benefits of a life in bed. The fable, surely apocryphal, reinforces prejudices that promote the interests of the profession. Psychiatrists often like to see sabotage in the eyes of patients. There is a word for inappropriate suspicion, but psychiatry seldom applies its diagnostic categories to itself.

Does secondary gain exist? Yes and no. Mostly, it's a figment of psychiatry's lack of imagination. In fact, the net occurrence of secondary gain is less than zero. Mental illness carries a heavy stigma, and surveys consistently show that the public regards mental patients as good people to stay away from. No group is more aware of the surrounding sea of hostility than psychiatry's patients. Most make it a way of life to disguise, deny and down-play their problems, not to fabricate or exaggerate them for minor concessions.

By paying disproportionate attention to the mouse of gain rather than the elephant of pain, psychiatry betrays a kind of moral dyslexia. One patient who belonged to the mental patients liberation movement summed it up when her psychiatrist accused her of secondary gain and asked whether she knew what it meant.

“Sure,” she said, “Auschwitz? Yay! No homework!”
“You’re manipulating again,” replied the psychiatrist.

*Lanny Beckman is a Vancouver freelance writer. This article is one in the series “Psychiatry on the Brain.”*

MARCH/APRIL 1991 ISSUE