Chapter Four

Sin into Sickness: The Triumph of Official Benevolence

If every action which is good or evil in a man of ripe years were under pittance and prescription and compulsion, what were virtue but a name, what praise should then be due to well-doing, what gramercy to be sober, just, or continent?

John Milton

The personalist fervently advocates liberation, the liberation of the individual self from traditional institutional and conventional constraints. The unshackling of the personal self from the constraints of convention moves us toward the deliberate abandonment of self-restraint. Self-restraint has long been encouraged by ancient and modern moralists: the personalist, however, equates self-restraint with repression and judges it to be unhealthy. The desolation of our modern times is in part an unintended consequence of the destruction of self-restraint in the name of personal growth and self-development.

With the increasing bureaucratization and rationalization of modern life and its resulting fragmentation, the appeal and attractiveness of personalism has intensified over the last two hundred years. Personalism has restlessly expanded its reach and both broadened and refined its applications. It permeates our thinking and conditions many if not most of our assumptions about how we should give order to our lives, discharge our obligations, and develop our expectations of ourselves and others. It has deeply affected in numerous ways many or most of our
social institutions, as the previous chapter attempted to show.

Personalism has also changed our moral point of view. As proof one can point to a radical shift in the way in which we talk, and thus ultimately think about ourselves and our actions, specifically about our personal accountability for the things that we do and the kinds of people we want to become. The shift in vocabulary is an important measure of a basic transformation in the way we think about what principles we should live by, in the assumptions we make about how we ought to act as human beings and as members of communities bound by moral obligations. Our ethical figures of speech, our basic tools of moral articulation, if you will—applied to matters of individual accountability and moral character—have changed remarkably over the last fifty years and reflect what is a relatively new but increasingly dominant perspective of human conduct in our society.

This perspective is one of the most distinctive marks of our age. It rests upon an understanding of human behavior that regards conduct considered by our predecessors to be vicious, immoral or sinful, as a manifestation, more precisely, a “symptom” of sickness, illness or disease. This view of behavior reflects the outcome of perhaps the most important of the many twentieth-century revolutions, the medicalization of morality—morality overthrown by therapy. The entire sphere of human conduct to which moral evaluation and judgment have been applied (that sphere of human conduct in which the freedom of an individual to make choices and to be held accountable for those choices), has increasingly become subjected to evaluation by experts who employ a normalcy-pathology perspective of behavior. Human conduct under a medicalized view is regarded as a causally determined phenomenon: the method for dealing with problematic conduct, given this view, is a therapeutic one.

The science of medicine and the related practice of the therapeutic arts have been applied to problems of human conduct once considered as moral ones engaged in by beings once considered morally responsible and personally accountable. Thus, the sorts of deeds that traditional moralists have been usually disposed to consider as “immoral” conduct are now understood as the behavioral
effects of pathologically induced causes. As the medicalized perspective of moral conduct comes to dominate our thinking, the notion of immoral or sinful conduct upon which blame is properly directed and upon which punishment is justly applied must give way to the recognition that human wrong doing is ultimately a symptom of mental illness to which treatment must be given.

Late-twentieth-century America has witnessed the transformation of its social fabric through the medicalizing of morality. We view the moral core of our lives differently, and we act differently than we did before. Medicalizing the assumptions about human behavior de-moralizes our notion of moral conduct. This de-moralization process is captured in a vocabulary in which important moral words that have been traditionally applied to human wrong doing—immoral, evil, reprehensible, blameworthy—are conspicuously absent. The removal of the words that prescribe blame and punishment for wrong doing brings the disappearance of the notions behind the words. Then there follows the decline of the practice of blaming or punishing people for wrong doing. A medicalized approach to morality prescribes treatment rather than punishment for people who do things that they are not supposed to do. Punishment deliberately inflicts pain. Treatment, on the contrary, attempts to minimize pain and to change behavior that we disapprove of into behavior we approve of: so why intentionally inflict pain when it is unnecessary to do so? Such is the logic and the ethic of medicalization.

The medicalization of morality creates a dramatic turning away from our traditional moral practice of holding individuals accountable for their actions and the kinds of people that they become. One important and specific concrete measure of the extent to which the medicalization of morality has been successful in transforming our attitudes towards certain kinds of behavior and our practical responses to them can be seen with the passage by Congress of the Americans for Disability Act of 1990, a milestone in civil rights federal legislation signed into law by President George Bush. The ADA put the official and legal stamp of medical “disability” on many kinds of behavior that used to be commonly regarded as vices under the old nomenclature, such as habitual drunkenness and
gluttony—now alcoholism and eating disorders—along with a whole host of other addictive and compulsive “disorders” such as drug addiction and compulsive gambling. Institutions are responsible now not only for relinquishing any attachment to “judgmental” or moralistic views of these sorts of behaviors but, more importantly, must provide those who “suffer” from them with what the law makers have called “reasonable accommodation.” Sorting out the meaning of the highly disputable “reasonable” in a society already immersed in moral subjectivism and relativism and its implications for the obligations imposed upon institutions, of course, must ultimately be done by means of litigation with all of the attendant social and financial costs and with an enormous shift of formal power to the adjudicating legal system.

The permeation of the collective psyche by a medicalized view of human conduct is well underway. Evidence for this is the fact that the psychotherapeutic perspective has been taken up by so many of the cultural elite as the primary way to explain and interpret their behavior. When Anita Hill was attempting to explain in her testimony before a Senate committee why she continued to initiate friendly contact with Clarence Thomas long after the alleged episodes of sexual harassment had taken place, she responded by saying that, “It takes an expert in psychology to explain how that can happen, but it can happen because it happened to me.” Her behavior, even from her own perspective, she seemed to suggest, was inexplicable, or worse, inconsistent with how one would usually expect a person to act in such circumstances. But such behavior could, presumably, only be explained by an expert, someone capable of discerning the causal factors at work. None of her interlocutors, it seemed, found this confession at all peculiar or unsatisfactory and no one recognized how mysterious or evasive this response really was. Nor did any of them appreciate how tendentious this explanation for her behavior really was: the “it” that “happened” was some behavioral facet of her past that was dictated by the sexual harassment that must have occurred—a psychologist, and only a psychologist, would be able to confirm this.

The public has long been subjected to a privileged “theorizing” of
behavior by specialists and experts which makes vice into an “addictive behavior” that requires “treatment.” No single event late in the twentieth century better illustrates this phenomenon, perhaps, than the explosive sex scandal near the last century’s end that came to define the character of Bill Clinton and his Presidency.

The case is profoundly emblematic and for several reasons. First, the lead man in the production was the most politically prominent and powerful man in the country, our elected national leader. Second, the man himself was our first post-World War II-born President and, in some disturbing ways, a vintage “child of the sixties.” In his personal history with the rumors and questions that permanently floated around about his draft-dodging, war protesting, dope smoking and womanizing, there were large illustrative elements of the hedonistic, protest and anti-establishment ethos of the sixties which he seemed to personify. Third, and most relevant here, Mr. Clinton’s own political and rhetorical style has been heavily emotive and conspicuously, emphatically therapeutic. “I feel good about...” was one of his most resorted-to pieces of phrasing for describing and evaluating his work. He was often given to this kind of emotive self-referencing so characteristic of a therapeutic orientation. Much of Clinton’s appeal to voters in the 1992 campaign over the out-of-touch appearing George Bush came from his ability to project his message of “I feel your pain,” an empathetic, trademark which eventually became a target for parody and even ridicule. Clinton conversed fluently in the language of twelve-step recovery, and with no self-consciousness as he drew from his own personal experiences with an abusive, alcoholic stepfather and a drug addict brother. Clinton’s own family was text-book material, the paradigmatic “dysfunctional” family, composed of addicts, abusers, and enablers.

Clinton also made the therapeutic orientation which was so obvious in his political campaigning into an essential part of his governing style, an inevitable consequence, I would speculate, of the domination of it in his own outlook and personality. As James Nolan reports, shortly after Clinton became President, he brought his cabinet together for a professionally facilitated group meeting that
resembled an “encounter” session with an intimate sharing of personal histories where Clinton spoke of the trauma he suffered as an overweight child. Also, one of both Bill and Hillary Clintons’ “spiritual” advisors was psychotherapist Michael Lerner. Lerner was rich with therapeutically-oriented advice for the President and the First Lady. The consequences of following much of it would further extend the reaches of the therapeutic state. For example, Lerner proposed, that the government,

create a program to train a corps of union personnel, worker representatives, and psychotherapists in the relevant skills to assist developing a new spirit of cooperation, mutual caring, and dedication to work.

Soon after the details of the President’s proclivities for deceitfulness, recklessness and deviancy became public knowledge, there came the lucubration of our popular medical-moralists who produce the “real” explanations for this kind of “inappropriate” behavior for the benefit of those of us who might be disposed to be a bit judgmental and somehow not able to “feel” the President’s pain. One of the best productions of such privileged interpretation was The Clinton Syndrome: The President and the Self-destructive Nature of Sexual Addiction. In this work of clinical psychology Jerome D. Levin writes that: “[s]exual addictions,” such as that we see so luridly with Mr. Clinton,

are not about sex. They are about insecurity, low self-esteem, and the need for affirmation and reassurance. At the bottom, the sex-addict feels unloved and unlovable, and so looks obsessively for proof that this is not so.

Thus, as the American people attempted to comprehend this sex scandal that was not really about sex, a number of things seemed to follow from this “explanation” of the President’s misconduct, or rather, addictive behavior: Mr. Clinton, one of the most powerful, prominent men in the world, in spite of his political achievements and all the honor and esteem of the office he held, apparently suffered (note the passivity) from an insufficient level of self-esteem, a deficient condition that would likely worsen without the intervention of a
therapist, like Mr. Levin. (If someone like President Clinton was short on self-esteem, what must that mean for the rest of us?) Once assured that he was "loveble," the President might then desist from cavorting with his underlings and lying to and manipulating the people around him. That the elected leader of the most powerful country in the world felt so unloved and inadequate, Mr. Levin argues, should have aroused our understanding and sympathy.

These are the kinds of responses from the public President Clinton, with the assistance of his courtier-experts, skillfully sought to arouse with the contrived, highly attenuated expressions of remorse accompanied with the obligatory pronouncements about the necessity for "healing" for everyone. Since everyone needs healing, then it followed happily for the President that no one is to blame—really. In fact if, "at bottom," one does come to share this perspective of personality deficiency on this matter, it would be hard to do other than to feel deeply sorry for the President and wish him the very best therapist he could find. "Sexual addiction," affirms Mr. Levin, "is an illness, and its sufferers deserve our compassion." Compassion must trump moral judgment: sufferers should not be blamed.

Mr. Levin's diagnosis (rendered incidentally without any personal contact whatsoever with the President and based entirely from the journalistic writings about him) is a not an uncommon sort of explanation for despicable conduct advanced by the more sophisticated observers these days. Thus we begin to understand how radically a therapeutic interpretation of behavior departs from a tradition moral one. With the former, the interpretation of the events and the assessment of the individual focus not upon the resources and strength of an individual's character—or their absence, as with the traditional moral interpretation—but upon a pathological configuration of forces that affects and afflicts the personality. Moreover, the therapeutic interpretation of behavior has enormous implications for how an individual who does things he should not, like Mr. Clinton, ought to be regarded by others. Sympathy, understanding, and support are in order; blame, condemnation and punishment are not.
This remarkable and near complete metamorphosis of outlook—vice into sickness; virtue into health—has been under way for a long time and has moved at a highly accelerated pace in the last fifty years. The displacing of virtue by health has its origins in part in the late nineteenth-century expansion of confidence in the capacity of science to explain, and ultimately produce the technology to manipulate and control everything, including human behavior. The ugly, seamy, corruptive sides of human conduct and the human personality, regarded by our ancestors as the predictable works of sinfulness or the effects of vice, have come to be seen not as perennial manifestations of weaknesses or limitations inherent in human nature, but as technical problems that can be eliminated with the application of the right kind of technical knowledge. Vice, which is, and always has been, considered a perennial human propensity, becomes a “social problem” for which “cures” can be discovered and applied by social science experts. Perhaps no better articulation of this “social problem” view of vice—curable by enlightened, empowered, informed expertise—is the following, written in the 1980s by Berkeley sociologist Neil Smelser.

[A]nother necessary part of what defines a social problem is that we believe we can do something about it. It has to be something at which we can successfully throw resources; something we can ease by getting people to shape up; something that can be cured through social policy legislation and decisions and the application of knowledge; something that can be ameliorated. Otherwise it is seen as one of those ineradicable scars on the social body that we have to live with, a necessary evil, one of those inevitable frailties of human nature.

This summary is superb—succinct but complete—not only in content but in tone as well. Social problems—Smelser cites as examples crime, violence, alcohol, and drug abuse—are manifestations of human behavior that can either be viewed as an inevitable consequence of limitations of human nature (“frailties”) or as failures of social functions remedied with the enlightened application of “resources”.

“Human nature”, with recognized moral and social limitations, is a notion that Smelser desperately resists. Containment or correction is unacceptable when the problems can, in his words, “be cured.” The medical metaphor of the “cure”
he invokes, with all of its positive, healthful connotations, however, quickly gives way to the more literally-expressed means of practical application, which is political action and legal coercion, that is, “social policy and legislation.” The cure, in effect, for social problems becomes the right dosage of social policy: the real cure will be the direct result of incorporating social science research into law, a translation of social science theory into public policy. Coercion plays a large part in the cures.

Smelser’s declaration exudes enormous confidence, considering that it appeared in the late 1980s when the author had ample opportunity to observe how little so many of these social problems (crime, drug abuse, etc.) had yielded to decades of enlightened social policy. In almost every category in which “social pathology” could be measured, such as violent crime, juvenile delinquency, teen suicide, drug use, illegitimacy, divorce, etc., rates since 1950 have gone up drastically at the same time the government began, with the advice of policy makers informed by social science, to stand back and “throw resources” at the problems in copious amounts. Much of the theoretical support for the redistributionist policies that began with the 1960’s War on Poverty programs and the Great Society came from the mental health experts and policy makers. Moreover, when one contemplates the vast sums of money spent in attempting to apply the knowledge of social science to social problems and at the same time surveys the social desolation of the last thirty years, how can there be so much confidence in what it can do for us? Andrew Polsky asks,

How it is that the therapeutic apparatus has established itself so firmly that, despite substantial opposition, it can continue to expand even when its ineptitude is starkly evident?

Forty years earlier this confidence in the capacity of social science to solve social problems was at a supremely high level, and there were many sanguine predictions for its possibilities as a technology that would generate mental health—a healthy society would be an orderly society. Andrew Polsky notes that:

As an ideology, science gave rise to the conviction that objective knowledge could fundamentally reshape both society and human
Human behavior could be engineered, making it sufficiently rational, predictable, and orderly so that "undesirable" activity could be greatly reduced or eliminated. "Social and political psychology will become a psychology of social order and social control," predicted Gardner Murphy in 1945 at the war's end. Gardner, like many of his colleagues, recognized that the academic discipline of psychology had a destiny far beyond the confines of university campuses and classrooms. The discovery of the science of behavior brought enormous possibilities for extensive public policy applications. Psychology could be a useful tool of the State—social order and social control are, quite understandably, desired ends for the wielders of political power. Gardner accurately predicted the alignment and integration of psychological research and social science theorizing with governmental policy making, legislation and judicial decision making. The theorists of social and political psychology did in fact quickly seize the opportunity and make the most of it. They provided the agents of the State with both an ideology and technology of social control in exchange for the rich subsidies offered by a booming post-war economy and a share of their growing power and prestige. The history of this period is richly documented and carefully described in a book by Ellen Herman, *The Romance of American Psychology*.

Ellen Herman points out that *Brown v. Board of Education* in 1954, the landmark court case that resulted in legally ordered desegregation of American schools was the first Supreme Court judgment that made psychological evidence and argumentation a centrally determining factor in its decision. The Court rendered its judgment in part on the basis of clinical evidence produced by social scientists that demonstrated the devastation of racial prejudice and segregation on the formation of the personalities of African-American children. This evidence was compiled by a team of psychologists led by Kenneth B. Clark, the first African-American to obtain a Ph.D. in psychology at Columbia University, and who was instrumental in introducing Alfred Adler's concept of the "inferiority complex" into the litigation. Clark also testified some years later before the
Kerner Commission in 1967 about the causes of inner-city rioting. In his testimony Clark referred to himself as a "social diagnostician," and affirmed that psychologists well understood the causes of rioting and knew precisely what sort of "treatment" the inner-cities required to "cure" them of the violence and destructiveness with which they had been plagued.

Chief Justice Earl Warren's desegregation-ordering decision of *Brown* contained the famous "footnote 11" which cited a number of social scientific studies used to support the court ruling to integrate the public schools. Herman also points out that this initial celebration of the authority of social science in the Brown case later turned sour as the confident predictions of social repair made by the social diagnosticians failed to come to pass. Moreover, Black separationists, like Malcolm X, later came to reject the so-called evidence of low self-esteem in black children.

So what the integrationists, in my opinion, are saying when they say that whites and Blacks must go to school together, is that the whites are so much superior that just their presence in a Black classroom balances it out. I just can't go along with that.

Malcolm X echoed a growing suspicion that all of this so-called scientific theorizing about the psychological makeup of black people was a patronizing manifestation of white liberal ideology. Any research produced by white social scientists that purported to explain the experience of minorities was suspect because conditioning the selection and interpretation of the data were invalid "Eurocentric" assumptions. The theoretical apparatus of social science did not travel as well across social, cultural boundaries as did that of the natural sciences.

It was, however, in this area of the psychological investigation of race and race relations, and the impact of prejudice on the formation of the personality, that social-psychological concepts such as self-esteem, self-identity and self-worth began to acquire their theoretical-explanatory muscle and also began their course of "intellectual trickle down" making their way into and establishing a permanent home in the "psychological" vocabulary and perspective of the general public. These ideas first entered into the collective psyche as psychological explanatory
concepts advanced by experts—social science researchers and theorists. Then they became a standard subset of the vocabulary of the social reformer and the socially conscious intellectual, making their arguments with scientific support. Finally they achieved full normalization and were established as an enduring part of the general and widespread language of social discussion and evaluation. From discovery, or invention, to complete orthodoxy; these concepts were moved quickly into social reality and are firmly embedded in the assumptions that underlie even the most popular discussion of social issues.

For classical philosophers and Christian theologians “human nature” remained for centuries a fixed point of reference for deriving prescriptions for human conduct. It has become increasingly regarded as an outmoded, moralizing religious-philosophical notion used to rationalize the arbitrary configuration of status quo power relations and to resist stubbornly the progress of human understanding. (This is what Smelser is about, above, when he expresses his reluctance to regard social problems as the “inevitable frailties of human nature.” The notion of human nature itself turns out to be a constraint that can be scrapped given the enlightenment and understanding gained from the technologists of human behavior.) One considerable ironic consequence of this is that the result of a scientifically-inspired abandonment of the concept of human nature as a normative foundation for prescribing human conduct and ordering society has helped to create an orientation toward moral and social values which is relentlessly and thoroughly subjective.

G. K. Chesterton in the early years of this century had already observed with considerable apprehension and some irritation this important tendency of “enlightened” thought, indicated by the vocabulary shift, toward the medicalization of human behavior already in the making.

[T]his is the real objection to that torrent of modern talk about treating crime as disease, about making a prison merely a hygienic environment like a hospital, of healing sin by slow scientific methods. The fallacy of the whole thing is that evil is a matter of active choice whereas disease is not. If you say that you are going to cure a profligate as you cure an asthmatic, my cheap and
obvious answer is, ‘Produce the people who want to be asthmatics as many people want to be profligates.’... The whole point indeed is perfectly expressed in the very word which we use for a man in hospital; ‘patient’ is in the passive mood; ‘sinner’ is in the active. If a man is to be saved from influenza, he may be a patient. But if he is to be saved from forging, he must not be a patient but an impatient. He must be personally impatient with forgery. All moral reform must start in the active not passive will.\(^{19}\)

Moral reform or regeneration, argued Chesterton, must be self-initiated, and any such process presupposes the existence of individuals who possess at least some capacity to recognize and to feel troubled by moral transgressions, to acknowledge responsibility for them and to be willing to make acts of restitution or atonement. Patients are not properly the subjects of blame. Vice or sin, however, brings down blame upon the sinner, and blame is supposed to induce feelings of guilt. The conviction of guilt is supposed to motivate the wrong doer to take action to change. Becoming a patient enables one to evade the effects of blame. Never does he have to feel the pangs of guilt and the compulsion to atone. Nor does he have to try to change. Sin and blame and guilt and atonement—all of these are necessary, interlocking pieces of a moral system and a moral perspective: when any of the individual pieces is practically discounted, theorized away, or socially hollowed out, the system eventually ceases to function. The system ultimately dies or atrophies, and the reality which the perspective captures and reacts against is no longer recognizable; only the words remain, empty of meaning or incapable of inspiring action or guiding practice. Indeed, the strange, somewhat old-fashioned manner with which Chesterton’s words probably strike us is an indication of how much “progress” in the medicalization of our morals has been made in recent decades, how firm and unquestioned its assumptions are, and how normal many of its practices now seem to us.

Chesterton was prescient. He understood that a moral view of human beings in which disapprobative conduct was regarded as sin, and a medicalized view for which it was illness, were utterly irreconcilable. Behind these irreconcilable concepts are incommensurable normative models of human
conduct. Each of them carries quite different implications for our basic understanding of personal responsibility, ethical accountability, and culpability for wrong doing and moral character.

This tendency to medicalize vice, which Chesterton lamented, however, has not been the result simply of accumulated empirical discoveries about human beings and human conduct. This is an extremely important point to comprehend. Medicalized vice is rather the effect of a gradually altering, imperceptibly changing philosophical perspective about what kind of creatures human beings are and what levels of responsibility and accountability they ought to impose upon themselves. Chesterton anticipated the trend. He grasped its essential meaning. He recognized what a colossal moral transformation it would bring.

One of Chesterton’s contemporaries, Cesare Lombroso, a physician, stirred up the Italian medical and legal establishment with his book *Criminal Man* (1876) which argued for the notion that crime was determined by physiology. Lombroso regarded crime as a medical problem, to be addressed by medical procedures. Lombroso’s theories, notes Arthur Herman, “became an obsession among progressively-minded politicians and intellectuals in Italy, England, and particularly the United States.” Chesterton may have had Lombroso in mind when he penned his thoughts. Enrico Ferri, Lombroso’s disciple, helped to write the legal code for Mussolini’s regime that viewed crime as a causally determined phenomenon that was best dealt with by treatment and rehabilitation rather than by punishment.

The traditional moralist, like Chesterton, who resorts to the notions of sin and vice, operates arguably in a much larger and flexible moral universe than the medicalizing moralist. The traditional moralist can exercise compassion and forgiveness, levy blame and guilt, and even demand punishment because he views human beings as active, choice-making, imperfect moral creatures, free and in some measure accountable for their actions and the formation of their characters. Also, the traditional moralist, as one can see with Chesterton, proceeds with a conviction of the reality of evil and views human beings as possessing a natural
inclination to participate actively in it but yet having a capacity to resist it as well. Evil is chosen, but the choices are not inevitable.

The moral universe of the medicalizing moralist is a more constricted place: blame and guilt, for him, are largely worthless and unproductive as moral or psychological forces. Forgiveness is unnecessary (illness is to be cured or at least treated, not forgiven), and punishment is ineffectual because the active, free, choice-making nature of a human being that might respond to punishment, affirmed by the traditionalists, is an illusion. And evil, which is the concern (or invention) of theologians or traditional moralists, does not, cannot, exist as a medical category and so a consideration of it cannot function in making judgments about the causes of human behavior. Compassion, in the medicalized view, must be the dominant moral disposition, because the kind of conduct that was in times past judged to be sinful or vicious or immoral, is really the manifestation of sickness. Sick people suffer. They deserve compassion. Patients should receive the attention of experts who act competently, compassionately and provide relief, which is what any patient, anyone who suffers from any form of illness or disease, morally deserves.

The efforts to medicalize morality, Chesterton suggests, are the work of propaganda ("a torrent of talk"). To be effective propaganda requires repetition. Propaganda is not about truth. It is about action. The propagandist seeks to alter or overturn perspectives and attitudes that are contrary or resistant to the officially propagated ones by habitually talking differently, by insidiously imposing a new vocabulary that will redefine and redirect the discussion of human interests and ultimately redirect human action. Different vocabularies express and reflect differing philosophical outlooks and orientations which may be in direct conflict. Moreover, the capacity to formulate, control and disseminate a vocabulary which shapes and articulates moral ideas forms a crucial dimension of institutional power and political authority. Different vocabularies prescribe and proscribe quite different modes of conduct as well as describe them in a radically different fashion. This is apparent in Mr. Levin’s characterization of President Clinton’s
Desolation's March

conduct, cited above. As we begin to make the vocabulary which Levin uses to discuss human action our very own, we begin to think of and evaluate the way people act differently as well.

Propaganda has become one of the most powerful ways to maintain the control and domination of vocabularies: sophisticated electronic and telecommunications technologies developed and refined in the twentieth century have made it even more powerful. Propaganda as a sophisticated instrument of human control has played a much larger role in the twentieth century than ever before in human history. Its prominence in the history of the last century's totalitarian regimes can hardly be overstated.

Leonard Schapiro, historian of the Soviet Union and perceptive observer of one of the master propagandists of the era, Joseph Stalin, defined the goal of propaganda as that which intends "to produce a uniform pattern of public utterance in which the first trace of unorthodox thought reveals itself as jarring dissonance." 23 Shapiro expresses this notion in religious ("unorthodox thought") terms. Successful propaganda does in fact have the effect of making one who in any way departs from the uniform utterances of orthodoxy sound quite odd and, most importantly, appear conspicuous. The medicalization of morality, for good or bad, has been the work of extensive propaganda, much of it by the government and government supported agencies, an effort that was greatly accelerated after World War II with overwhelming success. Many forms of conduct that were once regarded as vices are now considered diseases.

The psychiatrist Thomas Szasz became prominent, or notorious, depending upon your view, in the 1960s and 1970s, because he wrote powerfully and critically of his own profession, modern psychiatry. Szasz was an articulate critic of the moral medicalizers. Psychiatrists, he argued, had become moralists fronting as doctors. The conversion of vice or sin to disease was a political and rhetorical act, not a scientific advance, but one that traded on the commanding prestige and authority of science and medicine. Medicalizing human conduct produces the desired effect of subjecting it to the expert authority of the
medicalizers. Medicalizing conduct, in effect, achieves a massive transfer of social power—from the theological-moral establishment (the traditional guardians of the social order) to the medical establishment (the doctors and therapists). Szasz states that:

[I]f we now classify certain other forms of personal conduct as psychotherapy, it is because most people believe that the best way to legitimize these activities is by authenticating them as medical treatments.\(^{24}\)

The point that Szasz drives home with great force is that these classification activities are essentially political and rhetorical acts, not scientific ones. Medicalizing moral notions thus confers considerable power upon the experts who claim the expertise.

Classifying human acts and actors is political, because the classification will inevitably help some persons and harm others. Categorizing religion, rhetoric and repression as psychotherapy primarily helps physicians and psychotherapists.\(^{25}\)

Medicalizing does not necessarily provide greater insight: it is a power-motivated change of nomenclature.

If, however, our aim in classifying psychotherapeutic interventions is to help others—in particular those who want to better understand the world they live in—then we shall categorize such interventions as what they are—religion, rhetoric, and repression.\(^{26}\)

One human reality that should never be forgotten is the extent to which any group, no matter how benevolently motivated they appear to be, can be trusted with power. Anyone who might be tempted to imagine that doctors, because their professional reason for existence is to heal and because they are scientifically trained to do it, are more to be trusted with great power than members of any other group would do well to remember the history of the twentieth century, particularly the extensive and notorious collaboration of the German medical profession with the Nazi regime and the criminal medical experiments that were performed. Psychiatry in the Soviet Union willingly served the Communist party and gave it medical cover for the suppression of political dissent and the
persecution of members of religious sects.

The extent to which untoward conduct has been exculpated by syndromes, disorders and addictive diseases is remarkable. I remember in the 1970s listening to public affairs messages on the radio by the National Council on Alcoholism that stated: “alcoholism is a disease.” These gave me pause. The American Cancer Society never devoted any of its resources to convincing anyone that cancer is a disease. No one thought differently, or, more importantly, was in the slightest way inclined to think differently. Not so with alcoholism. There were doubters, some who persisted in looking at the phenomenon of excessive drinking moralistically by judging or blaming the excessive drinker, which was, of course, the reason why the NCA ran the messages. The message by the NCA was not intended to be purely informative. In fact, little if any information was provided. The purpose was persuasion—many people had a different, “old fashioned” view and had to be convinced to think about the issue differently. That persuasion was done with the invocation of the substantial formal authority of a prestigious agency of the State. One does not hear such ads today—they were part of a completely successful campaign. We now believe: the conversion has been achieved. The propaganda was effective. Any residual doubt that might be publicly expressed today does indeed reveal itself, as Schapiro said, with a “jarring dissonance.” It was after World War II in 1956 that the American Medical Association first declared alcoholism to be a disease. With the official “diseasing” of the conduct came the demand for “treatment” which exploded in the 1970s and 1980s. Between 1977 and 1987, AA membership doubled. Between 1978 and 1984, the number of for-profit treatment centers for alcoholism in the U.S. increased by 350%.27

During this same period, it was discovered that not just the alcoholics themselves, but the people close to them—children and spouses—needed treatment. Entire families were enveloped by the addiction and became the objects of professional attention and care. “Children of alcoholics,” writes the founder of the National Association for Children of Alcoholics, “deserve and require treatment in and of themselves.”28
The American Disabilities Act of 1990, as mentioned above, helped to ensure that the medicalized vocabulary in which all the "public utterances" relative to alcoholism, drug addiction and many other addictive behaviors were discussed, would be official, pervasive and dominant. The view of them as certified diseases, addictions, or medical afflictions of some sort, became irrevocable.

The "talk" Chesterton complained of dominates. The perspective behind that talk has achieved orthodoxy. The domination of that perspective is what Philip Rieff has called the "triumph of the therapeutic." Evidence for this triumph is apparent in the pervasive application of that cluster of normative terms we routinely employ to give a context and meaning to various aspects of human conduct and to make sense of moral character. Our normative language used to turn around the concepts of virtue and vice. These have been abandoned for therapeutic terms. Vice has always been understood to be a failure of character, of self-governance, ultimately. Thus, the moral terms that compose the vocabulary of virtue and vice have also been used in a legal and political context. Plato used the State as a larger model for the human soul in his proposal in The Republic to develop his philosophical theory of justice as a virtue of the human soul. Governance, as a "ruling" moral metaphor, has remained with us for nearly two millennia. The language of traditional morality employs notions of culpability, judgment and punishment, notions that often have legal as well as moral applicability and meaning. Morality and legality have long possessed a large intermingling sphere of interaction with a shared or overlapping vocabulary. Both necessarily operate with an assumption of personal responsibility and accountability.

Sickness is a failure or an absence of health. Thus when our conversations about human conduct are dominated by terms which are medical (such as illness, disease and suffering) our prescriptions for misconduct are inevitably therapeutic—illness calls for treatment. Along with treatment go understanding and compassion, not blame, and certainly not punishment. Treatment and
compassion are natural corollaries as are guilt and punishment; and the two sets are themselves morally antithetical. The shift in application over the last fifty years has been from the latter to the former. Our social institutions, particularly our legal and educational ones, in the standards they have set for conduct and the measures of accountability they have imposed, reflect this orientation toward a health model of human behavior with many of its therapeutic assumptions. These changes of assumption in turn build the foundation for different norms of conduct. When the application of compassion and treatment to human misconduct supersede judgment and punishment, the expectations that arise are for quite different, more humane responses—for the better, many think and argue. But compassion is not omnipotent.

The most obvious and most remarkable measure of the strength and dominance of the therapeutic perspective is the phenomenal growth rate of the therapeutic profession itself, particularly psychology and psychiatry, since the end of the World War II. Ellen Herman in *The Romance of American Psychology* documents the veritable explosion in size and influence of this profession in the second half of the last century. In a little over fifty years, from 1940 to 1993 membership in the American Psychological Association climbed from 2,739 to approximately 75,000. The membership of the American Psychiatric Association in the same period of time grew from 2,423 to over 38,000.

It was World War II, with the initial deployment of psychiatrists and psychologists in mental testing and measurement and in developing and testing theories applicable to the morale and mental hygiene of soldiers, as Herman argues, that helped to establish a vast, post-war mental health industry. This industry became the recipient of enormous professional encouragement and financial and political support from the federal government, and in turn has exerted a powerful influence on the development of social policy and legislation as well as on public perceptions of mental health and mental illness. The National Mental Health Act of 1946 was a major piece of legislation that reflected the high priority of mental health issues for the federal government backed with material
resources. The National Institute of Mental Health came into existence at about this same time. Its budget history, an 8.7 million dollar budget in its opening year of 1950, to 315 million dollars just seventeen years later, indicates how serious was the commitment of tax support and reflects the importance of the issues of mental health at the federal level and the public confidence in the expertise to deal with them. This increase is all the more impressive in light of the fact that the total budget for health related research of all kinds had in 1947 been only twenty-seven million dollars.29

Herman quotes a prominent psychiatrist of the World War II period, Henry Brosin, brimming like many of them with a limitless optimism for the profession’s future and the benefits it could deliver, in some ways analogous to the delivery of consumer goods produced by the revitalized post war economy. “Good mental health or well-being is a commodity which can be created under favorable circumstances.”30 He could not have been more prescient, at least about the future commodity-nature of mental health. The favorable circumstances were the tremendous financial and political support from the government which in turn helped to create a widespread transformation of attitudes and to stimulate a high demand for services. Mental health has indeed become a highly marketable commodity for which demand has steadily escalated. Counseling is now almost a basic staple. Herman also cites a National Science Foundation projection that estimated a twenty-seven to thirty-nine percent increase of civilian employment in psychology by the year 2000, rates that far exceeded those for any other occupation.31

These numbers, as noted above, are just one substantial indication of what has emerged as a revolutionary change in the orientation of Americans toward ethical life in the late twentieth century. That change is one which can arguably be characterized as a mass conversion in world view (Weltanschauung), akin in some important ways to that of the overturning of the pagan religious cults by the world religion of Christianity in the first millennium A.D. That epical change of world view took several centuries to occur—the great advance of the technology of
telecommunication, however, with its vast powers for achieving mass communication and technologically crafted propaganda, makes it possible for one religious or ideological system to challenge and overthrow another much more quickly. This is what happened over the course of the twentieth century with particular acceleration in the latter half of it. Also, the high sophistication of information technology and the great refinement of the arts of communication have enabled that revolution to take place in an imperceptible and non-violent way— unlike the overthrow of paganism by Christianity which was accompanied by great persecution. As Herman herself says,

It no longer suffices to think of psychology as merely one category of expertise among others. Psychology in our time is a veritable world view.\textsuperscript{32}

It is indeed! Moreover, it represents a triumph of modern, secularized thinking over a religious perspective of the world. This confidence in psychology as the basis for a new world view was exhibited by at least some of the great therapeutic practitioners of the post-World War II period themselves. With a conspicuous absence of modesty, Abraham Maslow referred to the popular humanistic psychology of his own creation as offering "a new and general philosophy of life."\textsuperscript{33}

Sigmund Freud, more than any single individual, stands as an agent of this change in world view. Freud is the most famous psychologist of all times, one of those great theorists of the human condition whose ideas, for good or evil, really did change the world because it changed the way we thought about the world. As W. H. Auden rhapsodized of him:

To us he is no more a person
Now but a whole climate of opinion....

Indeed, psychoanalysis lives for us today not as a theoretical construct but as a perspective, a general, philosophical interpretation of daily experience.\textsuperscript{34} Freud's personality and career in many ways resemble more those of great religious founders than scientists or medical people. His theories of the unconscious and
the primacy of sexuality were initially taken up by his chosen disciples and they filtered their way over a few decades down into the generally educated lay population. Freudian psychological terminology, brought to the United States by his immigrant disciples like Alfred Adler and Karen Horney in the early and middle part of this century, began to enter the popular domain after World War II. Freudianisms—"neurosis," "superego," "id," etc.—are now relatively commonplace expressions and still occasionally appear in our characterizations of one another. Many of these have reached the full level of cliché: people use them who never heard of Freud and do not have a glimmer of what they mean in the context of Freud’s system or what the implications are behind them.

Freud created and articulated a revolutionary interpretation of human experience. Part of his genius, as one of his severest critics, Thomas Szasz, points out was to present his insights as scientific. Freud well understood that science, not religion, was "the great legitimizer of the age," and thus his discovery of psychoanalysis was to be presented as a science, and those who criticized it, anti-scientific, thus backward and reactionary. The scientific status of psychoanalysis was discarded, however, a long time ago. One, I believe, would be about as likely to find an orthodox Freudian today rattling on about penis envy and oedipal complexes as an orthodox Calvinist theologian holding forth on God’s foreordained damnation of the souls of the non-elect. As the philosopher of science, Karl Popper has pointed out,

as for Freud’s epic of the Ego, the Super-ego, and the Id, no substantially stronger claim to scientific status can be made for it than for Homer’s collected stories from Olympus. These theories describe some facts, but in the manner of myths. They contain most interesting psychological suggestions, but not in a testable form.

Like other great religious leaders and prophets, Freud had considerable talent for attracting capable and zealous followers who participated in the initial establishment of an orthodoxy under the leadership of a charismatic founder. The inevitable defections ensued. Freudianism gave way to neo-Freudianism and the
Great Inspiration splintered into Great Apostasies and lesser ones in their wake with the predictable sectarian divisions and the accompanying doctrinal squabbles and intense animosities. Psychoanalysis begat many variants and mutations.

Freud himself has long been passé: too patriarchal for the feminists, too Victorian for the sexually liberated secularized hedonists of the post-sixties, too dark and theoretically mechanistic for the self-actualizers, not rigorously empirical and scientific enough for the positivists and behavioralists. Psychoanalysis—expensive, protracted, and for many, valueless—spun off many trimmed down, no-frills, cheaper models for the less sophisticated, less leisurely, less well off masses.

The inhabitants of the expanding consumer society of the 1950s found Freud to be far too gloomy and pessimistic. Abraham Maslow’s psychology of self-actualization, and Carl Roger’s quest for personhood both operated with more sanguine views of human beings. They were much better suited for the throngs of middle class Americans about to seize upon late-twentieth-century opportunities in consumerism and amusement and soon to invade the wide-open prairies of sexual athleticism and adventuring opened up by the invention of effective birth control technology and the legislation of easy divorce in the 1960s.

In the 1950s, Barbara Ehrenreich observes, psychology discarded maturity as the ideal for the healthy self and went for growth. Part of “growth” in this context meant, ironically enough, stepping out of the shackles of conventional adulthood. Adulthood could bring an unhappy forfeiture of the diversion and amusement to which youth was naturally inclined. Thus commenced the rush toward all things youthful and the manic pursuit of an idealized freedom and spontaneity that culminated in the 1990s with the wide popularity of therapists who helped troubled adults to discover their “inner child.”

Psychiatrists in the 1940s and 1950s applied their therapeutic arts to the upper middle class sophisticates suffering from boredom and angst or to patients in state-run hospitals. By the 1990s psychologists, counselors, psychiatric social workers and pastoral counselors were out navigating the open seas of
psychotherapy battered by the high winds and waves of all the new and fearful psycho-pathologies affecting the masses. Compulsive shopping, addiction to video games, sex, exercise and work were just some the afflictions for which Americans began to seek "professional help." Eating disorders galore—bulimia, anorexia, etc.—made their way into the repertoire of addictive and compulsive "behaviors," with extensive media coverage. The whole of human behavior was caught up with behavioral and addictive pathologies and pathologists to deal with them.

The onslaught of addictions, disorders and syndromes was also a direct consequence of the growing, post-World-War II orientation toward medicalizing every aspect of human behavior, in part an aftermath of the antinomian 1960s. When the social constraints melted away like a late spring snow, and deviancy and excess came to be embraced as experimentation, exploration and self-expression, virtually every aspect of life was thrown open for growth and development, or, rapid descent into excess or perversity, depending on your perspective. In full creative deployment was an ideology that would help us to think of the dissipating and dissolute effects upon people of all of these "behaviors" as manifestations of illness. The fallout was enormous. An epidemic of "dysfunction" was unleashed with hordes of addicts and abusers swarming out of the middle class, each one usually with an enabler or two in tow, in quantities so vast that the phenomenon—dysfunction—could become the fifth horseman of the apocalypse; and professionals were needed to deal with all of it.

Therapies have come and gone like fad diets—primal scream therapy, existential therapy, nude therapy, transactional analysis, rational psychology, and a host of now discarded treatments for the soul and mind. John Bradshaw, a self-proclaimed spiritual and psychological healer, has achieved a popular following by helping people to alleviate their psychological suffering by the recovery of a lost "inner child." Psychological growth, ironically, takes one back to early childhood.

The recovery and self-help movements became the do-it-yourself attempts
to apply psychological technology to the problems of life. The genre of the self-help book was a post-World War II invention: "self-help" and "recovery" now comprise major browsing sections in bookstores. The event-calendar section of most any local newspaper lists the meeting times of enormous numbers of support groups—alcoholics anonymous, gamblers anonymous, overeaters anonymous, etc. The large numbers of the groups make one wonder how far into the community dysfunction reaches.

What consequences for moral and political conduct the triumph of the therapeutic approach to human conduct would bring were recognized at mid-century by a constitutional scholar, F. D. Wormuth. In a book, *The Origins of Constitutionalism*, published in 1949, he wrote:

> It is doubtful that democracy could survive in a society organized on the principle of therapy rather than judgment, error rather than sin. If men are free and equal, they must be judged rather than hospitalized.\(^3\)

Making judgments, moral judgments that is, about large areas of human conduct fifty years later, are just what we have largely given up doing. These areas have been deeded over to the therapists. Wormuth recognized the implications of Chesterton’s observations about the jettisoning of a traditional moral vocabulary that carried the important assumption of human beings as active moral agents. Are there not some things, Chesterton asked, we want everyone to do for themselves, even if they may do them badly?\(^4\) Andrew Polsky in *The Rise of the Therapeutic State* points to the collision between the ethos of therapy and individual freedom.

> Therapeutic intervention rests upon the premise that personal autonomy must be invaded to create a more desirable kind of autonomy. In a democratic society, such a move must be regarded as suspect.\(^5\)

A therapeutic relationship by its nature is a power relationship. That is, for therapy to be conducted, those who are to benefit from it must acknowledge the professional expertise of the therapist and submit to his or her authority. To get well, the patient must do as he or she is told. Ideally, that submission is self-
chosen and remains voluntary: one is supposed to be free to reject the instructions of the therapist and withdraw from the relationship whenever one so desires.\textsuperscript{42}

However, to the extent that therapy becomes institutionalized and a fundamental, integral part of the way institutions actually deal with individuals and typically form their expectations of them, submission becomes less voluntary, and voluntary withdrawal more difficult. When the State itself becomes a massive, powerful apparatus with heavily therapeutic aims as it has, and when its agents talk therapeutic talk and implement therapeutic solutions, the therapeutic relationships it imposes become insidiously coercive and, for most people, nearly irresistible. When therapy reaches deep into the core of the soul or personality as is its goal and as it in fact does, the power of the State over the individual has become pervasive and virtually unlimited. What is left of the individual or person that \textit{cannot} be attended to, reformed or reshaped as a normalizing, health requirement of the State and its agents? When the State itself becomes therapeutic, as Andrew Polsky says,

\begin{quote}
we embrace an exercise of power by the state that is at odds with our belief that some aspects of a citizen’s life should lie beyond its reach.\textsuperscript{43}
\end{quote}

What Wormuth warned against a half-century ago has happened. Therapy rules. Therapeutic concepts and the vocabulary to articulate them have seeped into almost every level of discourse, public and private, and are especially pervasive in the bureaucratic segments of our public life in areas such as politics, education and law. Its assumptions are embedded in our everyday speech; its practices are visible in the routines of our elites. Individuals in public life of prominence and power actively promote the broadening of therapeutic measures. The wife of former Vice-President Gore, Tipper, was a strong advocate for the mental health provisions of President Clinton’s national health care plan. She claimed that 50 million Americans suffered from mental illness, a figure that included 14 million children.\textsuperscript{44} The Center for Disease Control has declared hand gun violence an “epidemic,” one of the more extreme examples of the medicalizing of crime and
deviant behavior. One of Newt Gingrich’s first official acts after he became speaker of the House in 1995 was to bring to Capitol Hill a “corporate psychotherapist” to dispense advice to his Republican colleagues on “how to forcefully articulate the Republicans’ social agenda without appearing insensitive.” These few of many possible examples give a sense of the extent to which therapeutic thinking and conceptualizing of basic human interaction has become a regular feature of our institutions.

Even traditional religion has been co-opted by therapists or therapeutically oriented leaders. James Dobson, who heads Focus on the Family, a radio and television broadcasting empire that enthusiastically promotes “biblical Christianity,” is a professional marriage, family, and child counselor and a licensed psychologist with a Ph.D. in child development from the University of Southern California. He was also an Associate Clinical Professor of Pediatrics at the medical school at the University of Southern California.

What is especially remarkable about Dobson’s work, and somewhat bizarre even, is the prescriptive mixture he has put together of Christian biblical moral teaching with the full blown therapeutic apparatus of contemporary psychology and counseling. He has published numerous books related to counseling and therapeutic aspects, including at least one on self-esteem in children. In this curious merging of contemporary counseling theory with traditional Biblical teaching, Dobson has achieved spectacular success in promoting his religious message and creating a massive following. His radio and television broadcasts are heard or seen by millions of people a week, and he has sold millions of his “Christian psychology” books to his many devoted listeners and viewers. Much of Dobson’s success, I would heavily wager, is due to the weight of his credentials and experience within the modern Christian community as a professional psychologist and counselor. The language of therapy, which he speaks quite well, no doubt, strikes a resonant cord with an audience that though in some important ways is traditionally religious, is already completely immersed in our late-century ethos of psycho-therapy. Dobson has managed, in effect, to
invest his enterprise with high credibility and authority in the employment of what would seem to be two incommensurable normative models of human conduct.

Rendering evaluative judgments about human conduct in the medicalized setting we now live in has itself become morally opprobrious. Making moral judgments requires from us moral certitude and confidence. These have been gradually eviscerated by doubt and skepticism. Fixed standards are illusive. The dominance of the therapeutic ethos and the cloud it has thrown over traditional moralizing, however, has created a kind of incongruity or dissonance precisely because of its incompatibility with pre-theoretical or practical moral notions that are almost impossible to dispense with, notions of moral choice, personal responsibility and character. The medicalizing of morality has opened up a moral fissure of sorts, out of which both ambiguity and hard conflict must occasionally develop between practitioners and advocates of the therapeutic who constantly push to expand the boundaries of mental disability and illness, and the rest of us who, at least in some instances, find ourselves in opposition, or at least with some doubts—another skirmish point of the culture wars.

As the twentieth century moved restlessly toward its progressive conclusion, the traditional moral assumptions came increasingly under attack. One of the arenas of direct assault was in criminal law where notions of individual responsibility had long been in place as bedrock assumptions. Introduced into the procedures of criminal law has been a subversive theoretical apparatus that works by excusing individuals from the legal and moral responsibility of their actions. This apparatus wielded by the therapists has produced some high profile cases that have attracted enormous attention and comment precisely because the outcomes turn on the acceptance or rejection of the traditional assumptions. A kind of moral alchemy has been put into practice that attempts to make the theoretical gold of excuse (and exemption from blame) out of any and every possible contemptible act. A moral dissonance has thus developed because of attempts by the alchemists to excuse or attenuate acts of villainy by draping them with the mantle of victimhood. Some of these attempts have taken place in the
forum of the criminal trial, although they employ therapeutic assumptions and argumentation. In the trials the specialists—defense lawyers and psychiatrists—join forces to convince the non-specialists, ordinary people on juries, that individuals accused of vicious or depraved acts should be excused because of injuries, abuses, or indignities they (the accused) have suffered earlier in their lives.

The Menendez brothers trial in California in the early 1990s is one of the most salient examples and is in many ways emblematic of the way in which traditional moral assumptions have been disregarded and replaced by therapeutic ones. This sensational murder trial drew nation-wide attention precisely because the lawyer for two brothers (Eric and Lyle, ages eighteen and twenty-one at the time of the crime) who slew their parents with shotguns while they were watching television (fifteen shots at close range), launched a legal defense of their client’s action based on the so-called “battered child syndrome,” a variant of the “battered wife syndrome.” The “battered x” syndrome is essentially a “psychological” defense that is, built upon legally accepted “expert” testimony of psychologists who argue that the prolonged effects of abuse impair the mental state of any type of individual ‘x’ (child, spouse, etc.) who endures it, and hence the level of legal responsibility and culpability is diminished. With the assistance of a battery of experts who testified to the damaging and traumatic psychological effects on the Menendez brothers’ experience of child abuse, the defense lawyer was able to produce enough ambiguity in the minds of the jurors to produce a hung jury in the first trial. Theparents of these brothers had mistreated them as boys, and therefore, so the Orwellian-nature of the argument went, their calculated, murderous actions were so conditioned by these patterns of childhood abuse that they could actually be legally construed as a form of self-defense. Thus, argued their attorney, these two men were neither morally nor legally responsible for pumping, reloading, then firing more shots into mom and dad at close range. While Eric and Lyle seemed to show little remorse for the slayings (they had gone on a $700,000 spending spree with the insurance money), they were quite adept at
showing great emotion over their abused childhoods.

That such a defense by the experts, the elites, would even be contemplated, much less partially successful, in complete arrogant defiance of the most elementary common sense and the basic concepts of decency and responsibility, is in large part the effect of a substantial erosion of confidence in moral judgment. We now face off against all of the perennial human evils with severely diminished means to combat or resist them—a kind of insidious moral disarmament.

The last half-century has nearly completed what is a moral and ethical revolution with the most staggering consequences: the overthrow of the regime of “virtue” or “constraint” and the subsequent installation of the regime of health. Under the regime of health, a person’s character—his moral habits and history of conduct, if you will—is changed into something that resembles a medical history, a mental health history. Thus, if someone does something vicious, now “abnormal,” his past is inspected by experts. If the discovered biographical events are sufficiently traumatic (for example, abuse, poverty, etc.) and are considered sufficient to prevent that person from developing into a normal person, then these events are judged to be “disabling” causes, that explain, and ultimately excuse the person in question for the abnormality. This manner of thinking inevitably leads one into a quite different moral universe (perhaps an a-moral universe), one in which blasting your parents with a shotgun—firing lots of shots at point blank range just to be absolutely certain of the outcome—might be excused or mitigated if you could show that they mistreated you as a child. There is a clear, simple logic at work: the suffering that you inflicted was ultimately a result of the suffering that earlier was inflicted upon you. All wrongdoing is, with sufficient psychological excavation, ultimately the effect of some form of suffering and should be regarded with compassion.

This kind of moral universe, as it expands and envelops us, is one in which our social expectations and ethical standards must be attenuated and continuously adjusted. Also, it is one where we must be extremely flexible, ready to apply
radically different, or minimal standards of responsibility and decency in our moral judgments or evaluations, depending upon what sorts of evidence of material or psychological deprivation or conditions of social pathology from the past can be produced and what effects might be theoretically conjectured from their presence by the expert interpreters.

The well-being of a person, from the perspective of one who operates with a virtue model and thinks primarily in terms of the overall benefits of constraint, depends on the inculcation of habits and dispositions that involve the fulfillment of obligations (e.g., keeping one’s promises and honoring commitments), the application of forbearance and restraint (e.g., controlling one’s temper, restraining one’s sexual impulses), and the development of various states of character such as kindness, benevolence, trustworthiness, fidelity and the like. To be a good person, to be successful in life, to be admired or well-thought of, one must seek to cultivate these dispositions and acquire the character that results from the formation of such habits. Virtue comes in the form of habits or dispositions. It is inculcated through practice. If one is successful, virtue becomes a mantle of self-protection against the temptations to excess and the ravages of vice. Success and happiness in life, in short, are directly the result of a virtuous character that follows from the practice of virtuous conduct.

Virtue has always been closely and consistently linked to patterns and practices of restraint, that is, controlling one’s desires and impulses, submitting one’s self to what are sometimes onerous obligations. Also, virtue involves training and disciplining the self not to overreach, to subordinate immediate satisfaction to long term goals, and to consider respectfully the feelings and well being of others. That virtue is a necessary component of a good life rests upon an assumption, supported by experience, that without habits of restraint, without discipline, human beings come at best to little account or little good. At worst they become vicious and predatory. For one who affirms and espouses a virtue model of human morality and well-being, there is little natural or innate goodness to be regularly found in human beings; goodness is artificial, the imperfect
product of human conventions. Virtue comes from training and practice. For both the pagan Greeks and Romans, as well as the Christians, the acquisition of virtue was an extremely important aspect of living.

No longer. The demise of virtue as a normative ideal is in part obvious from the simple fact that virtue does not seem to be important to many people. It has become a meaningless or antiquated notion. The term itself is eschewed and has quietly dropped out of daily conversation. The entire constellation of virtue-terms has nearly disappeared from popular use, superceded by an abundance of fertile health metaphors expressed in an explicit, elaborate therapeutic vocabulary beneath which is an array of therapeutic assumptions. Virtue is an unworkable and unwelcome notion for the personalist who judges the life of an individual by its capacity for personal fulfillment and self-actualization. Constraints produce inhibitions. Inhibitions are "unhealthy." They are directly inimical to personal growth and the pursuit of self-actualization and the achievement of authenticity in the proto-modern Roussean sense. Virtue, unfortunately, produces many inhibitions. It has an archaic, old-fashioned ring to it and rubs a pleasure-loving, youth-oriented, amusement-pursuing people the wrong way. Virtue is often associated with benighted religious authority, harsh and puritanical clergymen, priests or rabbis who seek to repress the expression of the natural human functions and proclivities, particularly sexual ones, as wicked and sinful.

The notion of social or mental "health" not surprisingly has a much greater appeal for the personalist than virtue. It turns out to be extremely useful for dealing more affirmatively and humanely with what were once considered flaws or natural shortcomings of human nature, the personalist would argue. Moreover, the notion of "health," understood in a metaphorical sense of mental or social well-being, can be readily applied to almost everything of interest and importance to human beings including personal interaction with others, feelings of accomplishment and success, career satisfaction, and sexual satisfaction. Health in its many non-physical, non-literal permutations becomes an extremely vague and conveniently open concept, and by virtue of its vagueness and openness, can be
applied to almost every imaginable feature of social and personal life. Mental health professionals have no arena of life upon which they cannot stake out their expertise and into which they cannot seek to intervene.

Sexuality, because of its primal place in human experience, has always been a major battleground of social power and control. Religion, though long an agency of management and control of sexual impulses and conduct, has been displaced by the therapeutic manipulators. Sex, for time immemorial, the most personal, intimate and mysterious of human experiences, now has its advice-dispensing, technique-purveying, mystique-dispelling therapists. One of them in particular, who has long disseminated her insights and advice in newspaper columns, has achieved a kind of celebrity status, appearing on television talk shows and visiting on university campuses where she makes lively and humorous presentations. Her popularity is, as it is with many of these media produced celebrities, due in part to a combination of brazen self-assertion and a quirky personality, and in part to her ability to make the discussion of sex into another venue of amusement. Thus, two important modern elements of the demystification and naturalization of sex are at work with this person’s presentation of the subject: the reduction of it to therapeutic technique (lots of frank, matter of fact talk about penises, vaginas, clitorises, orgasms and the like, and how they ought to be handled and manipulated), and making the theme of sex itself into a non-taboo topic of family or youth amusement through a kind of comedic style of discussion. The operative notion seems to be that if you can dispense with the mystery that has long haunted sexuality, any attendant “dysfunction” can then be dispelled.

Sex, in fact, becomes nothing but sheer technique (proper manipulation) because it has no location or designation within a larger framework of meaning or human significance. This is fully emblematic of our times: that realm of human experience, at once subterranean and heavenly, so full of darkness and mystery, with many antinomies and inexplicable features, has become just one more everyday topic of casual therapeutic-style chit-chat, another routine human
preoccupation that is best pursued as an exercise in technique or amusement. The efforts of the therapists related to sex have been to attempt to de-moralize its practices, to detach them from the religious and institutionalized norms that have so long governed them. What has come to be a wide-spread acceptance of abortion as a form of birth control is probably one of the more notable consequences of the this modern day de-mystification of sexuality via sex therapy, that is, the reduction of sex to a category of mental health.\textsuperscript{46}

Health in the broad, metaphorical sense can be conveniently and more happily applied to the matters to which virtue once applied, and more—more happily, because it is, compared with virtue, free, ostensibly, of subjective conditions and inclinations and moralizing impulses. Health as a basic normative ideal would seem to be non-controversial. No one wants to be unhealthy, whereas morality has always been a matter of considerable dispute and contention, in large part because morality has been so closely tied to religious beliefs which have historically been the object of great dispute and controversy. Mental health, as an overriding social value, promised an escape from the constraints imposed by religious doctrines, an opportunity to evade the pious moralisms of the priests, rabbis and ministers. But health is also preferable to virtue because the methods of inculcating virtue also necessarily include the attribution of blame and the dispensing of punishment which, by intent, inflict pain. Pain, of course, is the nemesis of medicine and, rightfully, the object of reduction for all therapeutic endeavors.

It is obvious now that sin and vice have come to be viewed as illness. Virtue as a moral ideal, in the face of a dominant, therapeutic-oriented way of thinking about human conduct, has given way to health, more precisely, mental health. But what does it really mean to be mentally healthy? Or, to reformulate the question with a more operational thrust: how do we know when therapy (in whatever form it takes), applied to a mentally ill person, or applied preventively to a healthy person, has restored them to health, or has been effective in the prevention of mental illness? More generally, how do we recognize in any of
these therapeutic endeavors, success and failure? One small piece of the early post-World War II history of the mental health industry helps to give a sharp accent to this question. In 1949 a National Institute of Mental Health grant sponsored a conference in Boulder Colorado where seventy-one psychologists from the United States met to discuss and analyze the need to train individuals for careers as clinical psychologists, and the future of graduate school clinical training in psychology. This was a time, relatively speaking, early in the development of the modern mental health profession. What is particularly remarkable about this conference is the lack of any clear notion of what a clinical psychologist was or what he or she was supposed to do. As Ellen Herman says,

Although no one present at the conference seemed to know exactly what a clinical psychologist was or what a clinical psychologist did, they quickly agreed that a doctoral degree was necessary to do it.47

This conference, Herman points out, occurred during that early post-War period during which there was an enormous amount of public interest in and enthusiasm for the possibilities for psychotherapy and an obvious desire on the part of psychologists to deliver it to the public. But exactly what psychotherapy was and what it did for the public was not easy to say. She provides a telling observation recorded from one of the cynics at the conference. This person reported that from the conference it was apparent that,

Psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcome. For this technique we recommend rigorous training.48

Pointing to the general and basic uncertainty from the beginning of what psychotherapy was supposed to achieve raises what amounts to a perennial question: what is it that can be clearly recognized as success in the production of mental health? When stated in general terms like this, it is more obvious that the question being posed is a philosophical one with moral and religious implications: How ought human beings to conduct their lives? To consider the issue in this way suggests that this recent phenomenon of the medicalizing of morality has been a
monumental revolution, not simply one more piece of the modern march of progress.

The promotion of health, with its linkages to modern medicine, is backed with all of the considerable prestige of natural science. Modern science has enormously extended our understanding and, more importantly, our control of the physical world. And, since human beings are natural creatures then it would seem to follow that those same methods should enable the scientist to understand, and control or manage the entire scope of human concerns, not just their physical well-being or health but their psychological or moral needs as well. Science has long replaced theology as the paradigmatic form of knowledge. Ignorance, not vice, is the enemy of mental well-being. In its application to human behavior, the corollary of science is therapy. Medicine applied to the body is the model to be applied to the mind or to behavior. When our bodies are sick or injured, the proper approach is to understand—in natural causal terms—what the problems are and then apply the appropriate therapeutic remedies. When human beings fail in the social arena of behavior, it is more useful to determine what the causal forces are that determine the behavior, than to attribute the behavior to the absence of personal self-restraint or the presence of a moral defect. The aim and practice of science is to describe and to understand, not to pass moral judgment. With the physical sciences this is relatively easy.

But when we apply the methods of science to the study of human beings, it becomes much more difficult since so much of human behavior has evaluative consequences and because knowledge applied to human beings has an important reflexive component. In those very acts of studying and learning about ourselves we cannot but help change ourselves. Yet insofar as any method that studies human beings claims to be strictly scientific it must be morally neutral or value free. Science at its core is limited to describing and explaining, not prescribing, praising or condemning.

Thus we have observed the establishment over the last forty or fifty years, in the name of compassion and in the pursuit of tolerance, the full therapeutic
appropriation of vast regions of our moral conduct. It is extremely important to stress, once again, that this phenomenon represents a moral or philosophical revolution, a major overturning of assumptions about human nature, not a scientific discovery nor an accumulation of scientific knowledge about human behavior. The shift, for example, from regarding drunkenness as a sin or vice that is to be disapproved, to a disorder or disease that is to be treated—alcoholism—from viewing overeating as a sin—gluttony—to, again, a disorder or disease, reflects a moral rejection of the practice of characterizing excessive drinking or overeating as activities for which people should be judged. Moral judgment applies only to those dimensions of conduct for which people are to be held in some way accountable. Condemnation or judgment has nothing to offer us in dealing with illness or disease, and therefore are wrong, both morally and prudentially wrong, if they are applied to people who are really sick or disabled. And, so the ascendancy of the medical model over virtue model is not so much of a scientific "advance" as it is a profound change of basic moral orientation.

Mental, psychological and psychological disorders have greatly expanded over the last forty years. Or, perhaps it might be more accurate to say that behavior that was once subject to moral evaluation has come under medical jurisdiction and is subject to therapeutic treatment. This expansion of mental illness occurred not so much through the process of investigation and discovery as through the imposition of definition. It is a process that seems in many ways to resemble more the activity of corporate mergers and takeovers than anything scientific or medical.

The implicit moralizing component of mental health and illness is evident in the definitions of "disorders" cited below from The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the diagnostic manual of the American Psychiatric Association. The DSM-IV for example, describes something called "Conduct Disorder"—the label itself carries some unintended irony.

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated..... The
behavior pattern is usually present in a variety of settings such as the home, school, or the community. 49

Closely related, it would seem, is “Oppositional Defiant Disorder” which, is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months. 50

Also, there is “Borderline Personality Disorder,”

a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.... Individuals with Borderline Personality Disorder...may display extreme sarcasm, enduring bitterness, or verbal outbursts. 51

Finally, there is “Antisocial Personality Disorder.” The essential feature of this disorder,

is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood and continues into adulthood.... The specific behaviors characteristic of Conduct Disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violations of rules. 52

Most remarkable of these definitions is that the actual language which describes the phenomena of these mental illnesses—apart from the “disorder” labels attached to them—is largely devoid of medical or clinical terms. Common to these disorders is a focus on conduct that is assigned to what are traditional moral and legal categories, for example, “disobedience and opposition to authority figures,” “destruction of property,” “deceitfulness,” “theft,” etc. The terms employed are those of the traditional language of moral discourse—“deceitfulness” and “disobedience,” etc. The categories themselves—dishonesty, theft, violence, rebellion—are so primary and basic to our understanding and characterization of human conduct that they simply cannot be recast in any other comprehensible terms. Individuals who violate societal norms and act irresponsibly or viciously have, of course, always been with us and have always
presented those who must bear their abuse with the challenge of how to deal with them and how to limit their damage; so also those people who resort to sarcasm, make verbal outbursts and feel great bitterness. The notable difference now is that this kind of conduct has been medicalized, that is, made into the object of therapeutic intervention: the descriptions of vice and misbehavior now make their appearance in medical diagnostic manuals in an elaborately categorized system, with clinical-sounding labels attached to them—as if these were reports of medical discovery rather than acts of social appropriation—which makes the behavior described the specialty of doctors.

One may be tempted to view this phenomenal growth of mental disorders and diseases as part of a predictable course of a high growth industry, one greatly assisted with the discovery of extremely powerful pharmaceuticals. The reconstruction of the moral realm into the medical enlarges the social expanse over which medical professionals can claim expertise and increases the possibilities for the accretion of power, prestige and authority. This is the Thomas Szasz political interpretation of psychiatry. Whether one accepts it or not, it is indisputable that the influence and authority of mental health experts, particularly in the latter half of the twentieth century, has expanded greatly, particularly, as we will see below, in the area of criminal law.

For one who might be inclined to resist the political-moral interpretation of psychiatry’s expansion, a brief mention of the history of the American Psychiatric Association’s (APA) handling of homosexuality as a pathological form of human behavior provides an extremely interesting and challenging case with which to consider this perspective. Psychiatry, for years, certainly for most of the twentieth century, had regarded and treated homosexuality as a behavioral abnormality, a fairly severe one at that. A “disease” classification and attribution for so personally basic a thing as the conduct of one’s sexual behavior would, no doubt, be painfully felt as a stigma and bitterly resented, even more so, maybe, than having it called a sin. Sin, in our modern, secular times is less of a problem than disease: theology, which deals with sin, has less power and prestige than
The Triumph of Official Benevolence

medicine which prescribes treatment for disease.

The APA, however, in 1974 reversed its professional judgment and declared officially that homosexuality was no longer to be regarded as a disorder. This was after a long period of various "disorder"-characterizations such as homodysphilia, dyshomophilia, homosexual conflict disorder, amorous relationship disorder or ego-dystonic homosexuality. The actual process by which this de-classification event took place is interesting and, it would appear, was driven primarily by moral and political considerations. In 1970 the APA came under siege from members of well organized, highly militant gay activist groups who were demanding that homosexuality be dropped from the DSM, the APA's official diagnostic manual of mental illnesses. The APA professional conferences and conventions in the early 1970s became subject to many of the same tactics of protest and disruption that were used with such great success by the anti-war movement in the 1960s against the Federal government in its prosecution of the Vietnam War. For the gay activists and protesters, the chief issue of contention was neither medical nor scientific: it was a moral and political issue of civil rights. The labeling of homosexuality as an illness was regarded as an unjust stigmatization. The long time condemnation of homosexuality as a sin by medieval Christianity somehow got smuggled into modern psychiatry and was conjured into a medical disorder. Homosexuality as an illusion really reflected a prejudicial disposition of psychiatrists: the practice of homosexuality was a moral not a medical affair.

After years of militant confrontation, highly controversial discussion and emotional debate and conflict within the APA, this professional organization of physicians in 1974 voted to drop homosexuality from the DSM. And, off it went. Of the approximately 10,000 APA members who voted, only slightly more than half cast their votes for the change in status. The vote was close. Thus by fiat or declaration, behavior that at one moment was reflective of mental illness or disorder, became normal behavior the next. The "patient" was instantaneously, collectively cured, or more accurately, rendered by 51% of the doctors who
attended to this sort of thing, certifiably non-ill. Their affliction was dropped from
The Book, the DSM, that is. Moreover, this medical ukase descended from a
controversial process that turned more on political and moral considerations and
arguments than on medical or clinical ones. The corporate behavior of the APA in
dealing with this issue seemed to resemble more the hierarchy of the Catholic
Church in disposing of limbo or affirming the doctrinal infallibility of the Pope
than a body of physicians.

But since 1974 an even more remarkable shift in the medical classification
of behavior pertaining to homosexuality has occurred—namely, the heterosexual
disapprobation of homosexuality has itself become a disorder, and a well known,
widespread one—"homophobia". Homophobia is defined in the Psychiatric
Dictionary (7th ed.) as,

negative attitudes to homosexuals and homosexuality, reflecting
both conscious and unconscious fears.... Religious and other
cultural taboos against homosexuality are a part of early learning
and are reinforced by experience.

It should be noted that this long standing disapprobation has been completely
medicalized, that is, it has been characterized as a "phobia," a baseless, irrational
fear that requires some kind of professional assistance or intervention. A
homophobe, by definition, is a sick, irrational person.

This clinical rendering of moral disapprobation as a sickness does,
however, create a bit of a dilemma for many traditional practitioners of Judaism
and Christianity. These religions have long traditions of morally proscribing
homosexual conduct and official teachings against it. Practitioners of traditional
religions, under the late twentieth-century medical interpretation, thus become
homophobes, psychologically abnormal individuals who require correctional
treatment—traditional religious teachings and mental health norms thus come into
hard, direct, and open conflict.

Nowhere is the moral and philosophical polarity between the norms of
traditional virtue and traditional religion and the modern standards of mental
health more starkly and painfully apparent than with this clinical rendering of
traditionally religious views as a pathological aberration of the psyche or personality. Traditional religion, with its moral teachings about sex, marriage and human sexuality finds itself pitted against a modern self-realization model of human morality that is backed by the enormous prestige and authority of modern medicine. The conflict reflects a broader, monumental moral-philosophical contest, a culture war, with the odds of prevailing heavily in favor of the secularists.

This momentous conflict, like many of these kinds, exudes great irony. The traditional religious moralist highly disapproves of homosexuality, but tolerates it (even the most conservative Christian sects condemn the sin but preach love, forgiveness and acceptance for the sinner). Remember: toleration logically implies disapproval. The secularist finds the "mere tolerance" for homosexuality by the traditionally religious absolutely intolerable; toleration is not sufficient, only full approval and acceptance ("inclusion") will do. For the gay militant, any expressed disapproval of homosexuality equals homophobia. Everything short of affirmation and endorsement must be interpreted as a blow against gay self-valuation and self-esteem. Homophobia should not be tolerated and ought to be eradicated. By equating disapproval of homosexuality as a phobic, hateful, irrational reaction, religious attitudes and rationales can be dismissed as pathological and requiring counseling to cure. Social equality for gays means not just tolerance but complete acceptance and approval. Thus, of course, the irony: the traditionally religious person is tolerant of homosexuals (disapproves but tolerates); the "anything goes" secularists refuse to tolerate the traditionally religious. Homophobia must be eradicated; homophobes must not be tolerated. The traditionally religious, thus, are judged to be inherently bigoted, and their teachings must be controverted, their doctrines ridiculed, and their attitudes suitably adjusted by professional therapists and sensitivity trainers.

This conflict between doctrinal teachings of traditional religion with the norms advocated by the mental health profession is full of major moral and political dilemmas, one of which is to determine the amount of power the medical
establishment should derive from its alignment with the State and its proper limits in enforcing standards of "normalcy" that are supposed to govern human conduct. There are copious examples in our own time of egregious abuses of medical power for ideological purposes. Psychiatry in the post-Stalin Soviet Union was an instrument of State power in service to the official ideology and used coercively against dissidents, especially religious ones. Psychiatric confinement was used by the Soviet government to punish and control those who were critical of or unenthusiastic about the regime. Soviet Jews, particularly, were the compulsory beneficiaries of Soviet psychiatry. Andrei Sakharov, one of the great late-twentieth-century exemplars of courage, heroism and principle, was subjected to all of the rigors of Soviet practitioners of mental health. One might be tempted, at least from the perspective of the traditionally religious, to see some parallels in the United States. The mental health industry sets the standard of normalcy employing the secularized moral assumptions of the elites who run the amusement state. The traditionally religious who might dissent or are not sufficiently compliant are thus stigmatized as mentally sick.

Under the therapeutic model of morality, the primary emotive force that is supposed to be at work in human relations and form the basis for action is benevolence. But it is a benevolence of a special character—not that of a natural or spontaneous type such as a motherly or fatherly love, or the affection that family members or friends might feel and demonstrate for each other. The health model operates with an official, disinterested and "enlightened" benevolence, one that only members of a special professional class possess and dispense to those who come under their charge.

Two things are distinctive about this kind of officially dispensed benevolence. First, it has a virtually unlimited scope for expansion and application. Almost any aspect of an individual’s social and personal life, as noted above, may fall under its purview. Sex therapy, art therapy, music therapy, dance therapy, recreational therapy, family therapy, pre-marriage counseling, marriage counseling, divorce counseling, grief counseling—nearly every imaginable aspect
Sin into Sickness:
The Triumph of Official Benevolence

of modern life admits of a potential therapeutic component with its own specially trained "expert" who possesses a specialized knowledge and wields a unique therapeutic apparatus that applies to particular sets of pathologies, syndromes or disorders. Therapy or professional counseling has in fact become, as Andrew Polsky notes, a kind of social utility which "pointed...to an unbounded therapeutic sector, one indifferent to traditional notions of limited government."55

Grief counseling is one of the more salient examples of this phenomenon of a recently professionalized human communication and interaction. Whenever tragedy strikes or misfortune occurs, grief counselors are officially and ceremoniously ushered to the scene where they apply their talking arts of "healing." In the immediate aftermath of the 1995 Oklahoma City bombing of a Federal building, they descended in mass and remained for months. All of this assumes that people lack the resources of knowledge, character and personality to deal with life's adversities without the help of some talking expert. A stranger, with "expertise" in sympathy, is superior to a friend.

Second, as noted, this benevolence is the product of enlightenment. It is the benevolence of the trained professional, one that is conditioned and defined by the power that comes from the professional relationship. The professionals who dispense the benevolence are experts and possess an authority and respect that derives from the acknowledgment, the authority, of that expertise. They know and understand more about the particular area of difficulty than the patient. They are like physicians who heal, eliminate or reduce pain, and control or cure disease.

Benevolence is also a major component of the virtue model, but it is profoundly different in scope and application. It is limited and specific. Normal people, that is, most people, love their families and friends more than they love casual acquaintances or strangers. Only fanatics, demagogues, poseurs and saints possess, or claim to possess, unlimited benevolence for everyone. The television evangelist and political candidate running for office may tell us how much they love us, but only fools believe them.

Under the virtue model, the primary operative force at work is constraint
through rules and roles. Virtue is in fact an instrument of restraint. Virtue has almost always been an essential part of a traditionally religious perspective which itself has operated with some notion of sinfulness or inherent corruptibility. From this perspective, most of the tension, conflict and destructiveness that comes out of human interaction is the result of some kind of overreaching or disregard for others or selfishness, actions or omissions that involve a moral failure, and primarily a failure to constrain one’s desires or appetites. Moral failure is blamable. Individuals who morally fail must be regarded as moral agents who are supposed to be held accountable for their failures.

This contentious issue of personal accountability is a pivotal one between the traditional moralist and the therapist. The heart of the contention and the significance of it for understanding the therapeutic moral point of view can be grasped by considering briefly the work of one of the last century’s most prominent and influential representatives of the therapeutic point of view. The Kansas psychiatrist and social reformer, Karl Menninger, was a successful highly regarded and widely published advocate for the health model of behavior from the 1930s through the 1960s.

The Menninger family was a major force in the advancement in this country of psychiatry in its application to many issues of public and social policy. William Menninger, Karl’s brother, was an influential advocate for extending the use of psychotherapy into the military and was the first psychiatrist to achieve the rank of brigadier general. Karl Menninger’s long and productive life spanned most of the twentieth century. He died in 1990 at the age of ninety-six. He was described in Time magazine at his passing as the man “who brought mental therapy into the medical mainstream and transformed the nations’ way of thinking about the mentally ill and criminally disposed.” Indeed. Instrumental in this transformation of thinking were the many books Menninger wrote, including the first best seller ever on psychiatry, The Human Mind, in 1930, and a number of other popular and influential titles such as Man Against Himself (1938), Love Against Hate (1942), The Crime of Punishment (1968), and Whatever Became of
Sin into Sickness:  
The Triumph of Official Benevolence

Sin (1973). These were non-technical productions crafted primarily for a lay readership. They were intended to enlighten public opinion on matters of mental health, particularly as they related to the formation of public policy.

The zeal and ardent moralizing characteristic of the reformer are probably the most salient features of Dr. Menninger’s books. The presence of these are particularly ironic in Menninger’s case since he manages to sustain throughout his work a patronizing tone of self-righteous indignation toward the traditional moralizers, especially the religious ones, whom he disdains as ignorant and benighted. The reader is frequently reminded that the author is a medical doctor and thus, one is to understand, motivated by pure benevolence, informed by a scientifically-based understanding, and far removed from the ignorant superstition that has so determined the practices and institutions of the past.

Menninger’s works are probably little read today, in large part because they were reform-oriented pieces that completely achieved their purpose. As the Time obituary noted, he really did help to transform the thinking of the American people about mental illness and its relation to criminality. The interest these books hold for us now and any current importance they have are as examples of successful mid-century propaganda that helped to establish the perspective that would embrace a fully medicalized view of morality and personal responsibility.

Though he wrote brandishing his medical credentials, Menninger emerges from his writings as a full-fledged moralist, with his claims and arguments aimed primarily at promoting social and political goals. Consider this declamation, written in high dudgeon, from The Crime of Punishment, published in the late sixties. Here he urges the adoption of a public policy that treats law breakers as patients with medical treatment, rather than treating them as criminals with the traditional application of punishment.

I suspect that all the crimes committed by all the jailed do not equal in total social damage that of the crimes committed against them. In our vengeful ferocity toward this miserable minority of offenders, we overlook the major contributors to crime who operate openly, successfully, and undeterred.57
In tone and content this statement captures Dr. Menninger’s central theme: the traditional criminal justice system that both holds individuals responsible and punishes them for the crimes they commit is a fundamentally benighted institution that embraces practices that ought to have long been discarded. Punishment, he passionately argues, is itself a useless piece of vindictiveness, the social, pathological residue of atavistic, barbaric impulses harnessed to outmoded religious moralizing. Behind the practice of punishment is this barely disguised, beastly “vengeful ferocity,” which it is important to note, is “ours”, that is, gentle reader, yours, mine, everyone’s. Menninger’s affinity, when he bombards with his heavy moralizing guns, is for the collective, “we,” “our,” “us,” a tiresome piece of his rather condescending style, that means that society at large is the social entity responsible for the “social damage” done both to and by criminals or other malefactors. His is a notion of collective responsibility or no personal responsibility—they amount to the same thing. We are all, Menninger argues, criminals, if not actually then potentially. Any disdain or contempt we might be tempted to exude for those felons that our criminal justice system has managed to convict and incarcerate is, for Menninger, merely a self-deluded expression of collective hypocrisy. The murders, rapists, embezzlers, child molesters and drug dealers who populate the jails and penitentiaries are the ones who in life’s game of chance got the bad roll of the dice that society had thrown for them. They are society’s lowest and most unfortunate who just happened to fall, or more likely were pushed, into the maw of an impersonal, arbitrary, cruel system of “justice”—victims, if you will, of an uncaring society that really does not know what to do with them or to them.

Instead of morally judging and legally punishing these unfortunates, we should instead pity them and attempt to address the causes, such as poverty and ignorance, that produce the criminality into which they become immersed. Again, the problem from Menninger’s point of view is the lack of benevolence. Benevolence combined with psychological insight will remove the problems. Criminals—this is the key point—are, above all, victims: punishing them merely
inflates the pain, suffering and destructiveness that their activities inflict upon society. Punishment just stupidly adds more pain to the gross aggregate of human suffering—nothing constructive or worthwhile, just more needless, pointless agony.

This point is readily illustrated in his remarks about Lee Harvey Oswald’s slaying of President Kennedy, an event that was recent when Menninger wrote the book.

The public still thinks of it as Lee Harvey Oswald’s crime (with or without accomplice). Respected and dignified authorities solemnly accumulate volumes of evidence to prove that he, and he alone, did this foul deed. Our part in it is rarely, if ever mentioned. 58

Again, the long, bony finger of accusation swings deliberately around to point directly at the poor reader: here is the ominous, collective “our part” in this terrible crime. All of us who were around at the time, from the school teacher in Minnesota, to the insurance salesman in Florida, to the grape picker in California, apparently, had some complicity in the assassination of our thirty-fifth President. What was it? Menninger continues:

By our part, I mean the encouragement we give to criminal acts and criminal careers, including Oswald’s, our neglect of preventive steps such as had been recommended for Oswald long before he killed President Kennedy, and our quickly subsiding hysterical reactions to sensational cases. I mean our love of vindictive ‘justice,’ our generally smug detachment, and our prevailing public apathy. 59

Menninger’s therapeutic perspective here, again laden with his usual reformer’s outrage, could not be more clear and unambiguous. He is convinced that contemporary society itself is in some way disordered or diseased. Oswald, or any criminal for that matter, ultimately was sick, his crime an individual personal manifestation of the larger social disorder. Punishing an individual is merely mistaking a cause for a symptom. John Kennedy’s murder was not just “Lee Harvey Oswald’s crime.” The responsibility for it is collective, attributable to a system rife with indifference and ignorance (“the encouragement we give to
Menninger says that we should call the crime problem a "social safety problem." In the course of his campaign against punishment and against the criminal justice system, Dr. Menninger had developed a strong aversion even for the term "crime," perhaps in part, because crime is so naturally and so long associated with punishment. Also the term carries too much moral and punitive baggage: the morally neutral sounding "social safety problem" would suggest that the problem is more of a technical nature, one that should be handled by the appropriate technicians—in this case psychiatrists and other mental health experts. Crime, like small pox or polio, is preventable if the right kind of prophylactic methods are applied by the medical experts who know who to administer them. Crime comes out of ignorance; it is not a consequence of immorality or vice. When it does break out, the right kind of therapeutic prophylactic is the only appropriate response. Menninger’s sarcastic reference to the Warren Commission’s report, with its "solemnly accumulated of volumes of evidence," seems to suggest, dismissively, that this effort might not be, as many thought, a government cover up of a conspiracy, but rather just a plain waste of time and energy. Since we were all guilty of the assassination, why invest a lot of activity and resources to figure out who might have done it? This actually seems to be Menninger’s point of view.

As remarked above, Menninger’s works are little read today, in part because they accomplished their revolutionary purpose—to help bring about the complete medicalization of social morality. Nowhere, perhaps, has the medicalization of morality made a more dramatic and remarkable impact than in the criminal justice system, one of Karl Menninger’s greatest professional interests, as we have seen.

Of all the areas of human endeavor which have been turned over to the arts of the therapeutic, the medicalization approach to the treatment of criminals may be the most significant. Why? Because it brings about a such radically
different moral stance and attitude toward individuals who have been traditionally viewed as enemies of society, those who attack society and its members in the most basic and primal way—the murderers, rapists, thieves and the predators of the weak.

The profundity of this conflict is particularly well articulated by the philosopher, Robert Musil in his novel, *The Man without Qualities*. The central character of this book at one point finds himself struggling with one of those hard moral questions. Should he affirm the punishment of death for a murderer of low intelligence, a man whose capacity for fully understanding what he did is questionable? The philosophical crux of the problem turns on whether we can determine that the man has any real capacity for choice-making and whether we proceed with the assumption of the existence of a responsible subject who is morally and legally accountable for his choices. Punishment makes practical and moral sense only if we believe that human beings really possess that capacity to make choices in their action.

It is this ability to choose that makes a person liable to punishment. His liability to punishment makes him legally a person, and as a person in the legal sense he shares in the suprapersonal benefaction of the law. Anyone who cannot grasp this right away should think of the cavalry. A horse that goes berserk every time someone attempts to mount it is treated with special care, given the softest bandages, the best riders, the choicest fodder, and the most patient handling. But if a cavalryman is guilty of some lapse, he is put in irons, locked in a flea-ridden cage, and deprived of his rations. The reasoning behind this difference is that the horse belongs merely to the empirical animal kingdom, while the dragoon belongs to the logical and moral kingdom. So understood a person is distinguished from the animals—and, one may add, from the insane—in that he is capable, according to his intellectual and moral faculties, of acting against the law and of committing a crime. Since a person’s liability to punishment is the quality that elevates him to the status of a moral being in the first place, it is understandable that the pillars of the law grimly hang on to it.\(^6\)

Musil’s artful rendering of Immanuel Kant’s two “kingdoms” in which human beings reside conveys a deep intended irony. The treatment of the unmanageable cavalry horse resembles closely the treatment of a medical patient—the softest
bandages, the choicest fodder and the most patient handling. This "treatment" is intelligent, methodical, calculated and enlightened, a benevolent practice designed to get the most possible out of the horse. Punishing the horse, Musil's character seems to suggest, is futile. Punishment as we know from Dr. Menninger is stupid, pointless and a waste of resources. By contrast, the punishment meted out to the dragoon with its severity and cruelty, and incidentally mightily offensive to our twentieth-first century sensibilities, is a profound measure of the recognition of his ability to make free choices, of his conscious participation in a moral order where he is bound by obligations. He is unique from all other creatures. This is a uniqueness based upon moral and spiritual assumptions, assumptions rejected by the thoroughly naturalistic orientation of the secular society. Without this assumption of the existence of that active moral agency the institution of criminal law collapses ("the pillars of the law grimly hang on to it").

There is, I am afraid, something terribly grim about all of this. Human beings are flawed and at times act badly; yet they have the capacity to recognize their shortcomings and attempt to be better than they are. In this tension between the capacity to recognize and repudiate his own evil and the inclination to do evil lies the tragic reality of man's status as a moral creature. Evil cannot be repudiated without personal accountability, without some strong way to remind individuals when they are culpable of wrong doing. Punishment—the deliberate infliction of pain—is the most efficacious way of achieving this reminder. Thus, the grimness of it all. By following Menninger and the medical moralizers in renouncing punishment, we try to free ourselves from the tension created by the assumption that we are inherently flawed yet responsible for our misdeeds. We take up a confidence, embedded in illusion, in a technology of human behavior presided over by technologists who will make us better.

While the traditional notion of legal guilt and punishment was built on the assumption of the moral responsibility of the criminal and his ability to make free choices, the rites of punishment are not simply a recognition of the this reality and the practice of it is not just to exact restitution from the criminal or to deter others
from crime. Punishment is also a richly symbolic act, employed by human beings who are creatures with a great and natural affinity for symbols. The suffering that punishment brings, it brings deliberately. Within the human frame there is an emotional need for balance and restitution that punishment satisfies in a basic way. Moreover, punishment as a collective expression of moral outrage may help to clarify and focus certain basic moral impulses. The fact that most people are loath to inflict pain deliberately on others would seem to suggest how important those norms that have been transgressed and rules that are violated really are and that such transgression and violation are wrong and execrable. Punishment symbolizes, in a way that nothing else can, moral outrage. If the public standards of morality in a society collapse, then punishment ceases to symbolize anything.

This notion is well articulated by David Gelernter, who was a victim of one of the late-twentieth-century America’s more notorious, peculiar criminals. Gelernter is a computer science professor from Yale University. He was badly injured by a letter bomb that was intended to kill him mailed to him by the Unabomber, Theodore Kaczynski. One of the more interesting of the many murderers in our country, Kaczynski was a brilliant mathematician (degrees from Michigan and Harvard) who withdrew from society and over the course of many years inflicted—with a most remarkable symbolism—his intellectual rage on arbitrarily selected strangers. Kaczynski, Gelernter persuasively argues, was and is not insane: he is, rather, a fanatic, knowing exactly what he was doing and perfectly willing to conduct his cowardly executions in the service of his ideological fanaticism. For what he did Kaczynski deserved to be executed. In considering what kind of man Kaczynski was and what he was about Gelernter argues for the rightness of executing murderers.

Why execute murderers? To deter? To avenge? Supporters of the death penalty often give the first answer, opponents the second. But neither can be the whole truth. If our main goal were deterring crime, we would insist on public executions—which are not on the political agenda, and not an item that many Americans are interested in promoting. If our main goal were vengeance, we would allow the grieving parties to decide the murderer’s fate; if the victim had not family or friends to feel vengeful on his behalf,
we would call the whole thing off. In fact, we execute murderers in order to make a communal proclamation: that murder is intolerable. A murderer embodies evil so terrible that it defiles the community.

The application of punishment, particularly, severe punishment for severe crimes, is thus supposed to be a powerful indication of the existence of a communal moral self-confidence reflected in the willingness to inflict pain in order to affirm the importance of the norm which has been violated by the criminal. This kind of moral self-confidence has been fatally eroded by the subjectivity of late twentieth-century moral life. Gelernter makes this clear:

[T]he death penalty represents absolute speech from a position of moral certainty, and doubt is the black-lung disease of the intelligentsia—an occupational hazard now inflicted on the culture as a whole.

Indeed. The debilitating doubt and lack of moral self-confidence of which Gelernter speaks is one of the conspicuous, dominating features of our contemporary social landscape. This absence of self-confidence is particularly apparent in the criminal justice system where punishment has been superseded by treatment. The doubt and lack of confidence are also apparent in the protracted time now which it takes to conduct the trials and carry out the sentences even for mass murderers. The people of the State of Illinois had to wait about a decade and a half for the legal appeals and delays to be exhausted before officials were finally able to put an end to a man (John Wayne Gacy) who had murdered thirty-three people.

The traditional practice of punishment carries with it the assumption of the reality of deliberate wrong, of sin and evil in some basic, irreducible sense. Gelernter invokes the notion murder as an “evil,” a defilement of the community, not the sort of language typically found in capital punishment discussion these days. This way of talking and looking at the phenomenon are what we have largely given up. A fully medicalized social world of the kind sought after by Karl Menninger where everybody is considered a criminal of some sort, where individual responsibility has been theorized away, and punishment itself is
regarded as an act of collective criminality is our own early twenty-first-century society. The “moral kingdom” spoken of so eloquently by Musil has been gradually, imperceptibly evacuated.

If one were to envision this discussion as the consideration of a conflict or a battle between the medical and moral view of law, the victory would appear to be going to the medicalizers. James Nolan Jr., in *The Therapeutic State*, has extensively documented how the therapeutic approach has, with support of the federal and state governments, become a part of the criminal justice system with its rapidly expanding clientele. In 1962 the Supreme Court in *Robinson v. California* ruled that in itself drug addiction was not a crime and that drug offenders could be compelled by the state to participate in drug treatment programs.

In 1966 the U.S. Congress passed the Treatment and Rehabilitation Act which gave the courts power to compel drug offenders to enter drug treatment programs as an alternative to incarceration. As Nolan points out, these actions helped to set up an essentially therapeutic model for dealing with behavior that was once considered criminal activity. He quotes from testimony given to Congress by Matthew Cassidy, executive director of TASC, Treatment Alternatives to Street Crime, a Nixon White House sponsored entity that sought to link medical treatment processes with judicial processes.

TASC provides an objective and effective bridge between two groups with differing philosophies: the justice system and community treatment providers. The justice system’s legal sanctions reflect community concerns for public safety and punishment; whereas the treatment community recommends therapeutic intervention to change behavior and reduce the suffering associated with substance abuse and related problems.64

The two “philosophies” referred to by Cassidy are more than “differing”: they are, as discussed above, completely incommensurable. The therapist attempts to manipulate (“change behavior”)—here we have Musil’s “empirical animal kingdom” in place. In fact there is no “bridge” between these differing philosophies: the therapeutic supersedes the judicial, that is, the judicial
institutions (institutions which render legal judgments) have come increasingly to resemble medical institutions (institutions that dispense medical treatment). This is quite obvious from Nolan’s discussion of the development of “drug courts” originally in Dade County, Florida, now in Michigan, California, Texas, and several other states, where an individual charged with a drug crime has the opportunity to avoid going to prison if he is willing to undergo a court-monitored treatment program which includes extensive counseling. Counseling is the main component of the program. The “treatment” approach to crime is also, predictably, expanding beyond drug offenses. Nolan quotes a Los Angeles judge whose considerable enthusiasm for this type of approach stems from his view that the criminal offenders are such because they suffer from “low self-esteem.”

The drug court, therapeutic model of “treating” criminals rather than punishing them represents a profound transformation of our traditional institutions of criminal law and justice and points toward the culmination of a trend that has been underway for a long time. The depth of this transformation becomes apparent when one considers the major changes in the relationships and interaction of the principal parties involved in the formal legal process: the traditional adversarial relationship of the prosecutor and defense attorney who contest the criminal guilt of defendant has become a collaborative project of helping the defendant “recover” from his illness. The defendant is now, fully and completely, a patient, not an accused citizen who must, by an impartially applied set of rules and procedures, be proven guilty by the State and who employs someone whose job it is to defend him against the State. Criminal behavior, as Nolan observes, has been redefined in pathological terms as illness. The prosecutor, whose role has traditionally been to represent the interests of the state by convicting law breakers, now works collaboratively with the client’s (no longer called a defendant) attorney to move him into and through a recovery program. The role of the judge has changed profoundly as well, from a detached figure of authority who makes impartial rulings on the basis of legal rules and principles to a sympathetic, involved professional who embodies many aspects of
The more personal Drug Court judge has been variously described as a therapist, a social worker, a counselor, and a psychologist. The judge often engages the defendant directly, while the attorneys literally and figuratively take a back step.

The defendant, once confronted by a representative of the state who attempted to convince a jury of his guilt, is now enveloped by a system of officially directed benevolence. The reduction in the limitation of power in the latter case is quite dramatic. Each of these roles, the defense attorney, the prosecutor, the judge, has been radically transformed: they are all, collectively, agents of a therapeutic State.

The "drug court" therapeutic approach to crime represents a profound moral change in attitude, one which Karl Menninger would enthusiastically endorse. Moreover, given the general tendencies and directions of the therapeutic industry, one could be confident in predicting that this movement would eventually pervade the criminal justice system such that what has been dispensed as criminal justice would eventually become criminal treatment, that is, the whole criminal justice system would become a gargantuan enterprise of State-financed, State-imposed and State-applied therapy. One of the ironies of the treatment over the punishment approach is that its efficacy is probably no greater: treatment programs do not lower recidivism rates any more than conventional approaches. (Parenthetically, and more broadly, the efficacy of therapeutic programs, generally, has been thrown into question by long term studies by researchers such as Herbert Fingerette and Stanton Peele.) The irony, of course, is that the therapeutic approach is compelling and is embraced for reasons that are largely independent of how the outcomes compare with those of more traditional practices. Therapy has become an end and value in itself. It provides an opportunity for self-understanding and self-awareness. Whether or not one actually succeeds in getting off of drugs or alcohol, or changing criminal or anti-social behavior, the activity of undergoing a therapeutic experience is an intrinsically valuable experience, a self-affirming act of personal exploration and discovery.
Self-esteem has been a pioneer concept in our contemporary understanding of mental health. In a relatively short time the term "self-esteem" itself has become a necessary element of psychological and therapeutic discourse and is frequently invoked in serious normative discussions about how individuals ought to function in modern society. It has, of course, become a familiar idiom and durable notion, a seemingly indispensable element of our current psychological and sociological landscape and vocabulary. Self-esteem is a primary concept in current educational theory, and it has even become the central value of a massive social movement. In 1986 the Assembly of the State of California authorized the creation of the California Task Force to Promote Self-Esteem and Personal and Social Responsibility, an event that at first impression sounds like something out of a Kurt Vonnegut novel. The bill’s sponsor was John Vasconcellos, a friend and disciple of Carl Rogers, the well-known psychotherapist. In Rogers’ personalist, psychotherapeutic conception of human relations, Vasconcellos saw a socially transforming political philosophy, calling his approach “ultimately political in nature....[providing] a totally new, faithful, and hopeful basis for public-policy decision-making.” Vasconcellos firmly believed that the California state government should sponsor a tax-payer funded program to promote self-esteem.

In light of the emerging evidence, it seemed both morally and fiscally responsible to create a formalized effort to explore whether in fact self-esteem might be a social vaccine, a quality capable of strengthening people, making them less vulnerable to problem behaviors.

Note of course, again, the familiar resort to medical metaphors ("vaccine") when the real subject matter is actually social policy-making. The feat of raising self-esteem, assuming that there are people who know to produce and administer this vaccine properly, is proposed to be something analogous to an inoculation technique that protects society, just like smallpox and polio vaccines protect us from physical disability and disease. “[T]he major problems plaguing society,” says Neil J. Smelser, a University of California, Berkeley sociology professor,
“have roots in the low self-esteem of many of the people who make up society.”  
With this insight into the causes of social evils, it certainly does not take a Berkeley-affiliated sociologist to figure out what the general solution must be: raise the low self-esteem of the “many.” We must employ experts who possess the knowledge to identify those who suffer from this malady, and who know how to raise them to a level sufficient to alleviate the problems. With so “many” suffering from low self-esteem its elevation requires a transfer of power and resources.

How would it be possible to determine when the self-esteem of the populace (“the many of the people who make up society”) was raised? In short, how is the success of the self-esteem raisers to be measured or judged? When everybody acts the way they should. When everyone has everything they need, and society is perfect. The language and metaphors of the self-esteem advocates are medical, but the impulses, emotions and thinking are more analogous to those that impel religious and political movements. The self-esteem campaign seems to be a kind of secularized, evangelizing movement with the psychologists and other mental health related experts playing the part of the preachers and priests. “In religious verbiage,” writes James Nolan Jr., “the self is the new sacred, the new object of worship.”

Exploitation and self-esteem as social concerns have become causally linked by social science, a particularly powerful partnership in generating a kind of moral-political pressure to change social institutions. The instrument of change is social science technology via social policy. When Matthew Dumont, a high level National Institute of Mental Health administrator, reported to the Kerner Commission, set up by President Lyndon Johnson to investigate the causes of the urban rioting in the late 1960s, he delivered his characterization of this phenomenon completely in social-psychological terms, replete with a final “diagnosis” and implications for aggressive therapeutic redress. The language and the ideas are much the same as those of Kenneth Clark.

This, then, is the diagnosis. A riot is a symptomatic expression of deficits of stimulation, self-esteem, a sense of community, and
environmental mastery. The treatment of the condition is no secret and in inadequate dosages it has already been administered.\textsuperscript{73}

Again, for the benefit of the legislators, is a fully “medical”-sounding “diagnosis,” even with some quantitative language of “deficits” and “dosages.” Could any of these things of which there were supposedly deficits and dosages be satisfactorily quantified or measured? Could any direct causal relations be established between the rioting or non-rioting conduct of individuals and their sense of community and levels of self-esteem?

This notion of “deficits” may be important, central even, to understanding both the therapeutic and the moral implications of this way of thinking. The purpose of introducing such a notion is to convince everyone of the quite dubious proposition that people who act in undesirable, lawless or destructive ways should really be thought of as deficient or lacking in \textit{something} they ought to have.\textsuperscript{74} The reasoning behind this notion is that when they (“they” being those who break the law, do bad things, etc.) get what they really need, what they are in deficit of, then they will cease to do what they should not do. They will be healthier, happier, or whatever we want to call it, and will no longer \textit{need} to be criminals. They will act normally, at last.

Moreover, the fact that criminals don’t have what they need to be “healthy” must be someone’s or some group’s fault, not theirs. The work then of getting them what they need to be happy, healthy, and full of self-esteem—which will in turn alleviate the need to burn, loot, pillage, take drugs and beat their wives—does not simply involve getting them to change by persuasion or coercion or by whatever means works. Society itself must be completely restructured and overhauled. All of the essential social goods need to be redistributed so as to erase the deficits that lowered the self-esteem which in turn caused the social problems in the first place. “Rights” to resources must be legally created with the assistance of propaganda as moral support for the social and political restructuring initiatives that aim at eliminating the deficits and ultimately the lawlessness. What someone has a right \textit{to}, someone else has an obligation \textit{to provide}. This “deficiency”
assessments delivered by a high level representative of the federal government completely and radically reconstitutes the fundamental normative thinking that has long been applied to the behavior of those who conduct a riot—the most basic and open lawless attack on the social order there is—as symptoms of an illness.

Such a judgment illustrates not only the extent to which the medicalized model of behavior has come to govern the mentality of the ruling elites, but how the practical application of that mentality turns traditional moral and political norms completely on their heads. Riotous behavior, because it is a "symptomatic expression of deficits," is to be understood, even sympathized with as a predictable response to adverse conditions—"a cry for help," as it has often been characterized. But rioters should not be condemned and certainly not punished. Low self-esteem, as the "diagnosis" indicates, is declared to be the major cause of the riots. Exploitation causes low self-esteem. Exploited groups, particularly, suffer from it, and the forms of this deficiency are varied and many.

The diagnostician’s reference to "inadequate doses" of the obvious "treatment" seems, however, self-serving. What exactly was the treatment? Government programs created and sponsored by the elites, paid for by taxes. But since these programs had not yet worked, the only way they could not be regarded as failures was to pronounce them to be too little, in effect underfunded and deficiently administered "in inadequate dosages." The failure, as they view it, is not with the social clinician who perhaps made a bad diagnosis; rather it lies with someone else's lack of generosity and compassion. An assessment of this kind, of course, will always provide perfect insulation from having to consider the possibility of a failed diagnosis.

One wonders, barring the unlikely event of a complete disappearance of all the pathologies in question, how the diagnostician would determine that an adequate dosage had been administered. More to the point, why, given their therapeutic assumptions and their reputations, would they be inclined to make such a determination? How would it ever be possible to distinguish between an "inadequate dosage" and a failed diagnosis?
At the beginning of the twenty-first century we find that our traditional moral concepts have been theoretically pushed aside, but with enormous practical consequences. The medicalization of morality unfolded as the quietest but most society-altering revolutions of the twentieth century. It would be difficult to argue the contrary. Our moral world has been medicalized. We find ourselves fully immersed in a therapeutic view of social reality. This new moral world is filled with dependent people, co-dependents, enablers, the dysfunctional, and those who are “in recovery.” Patienthood is a rapidly growing condition of the American people. It is a natural complement to the pervasive condition of social victimhood. Our traditional institutions themselves have long been accused of churning out innumerable victims, individuals who have been fed into an uncaring, impersonal “system” and have emerged somehow psychologically or emotionally damaged and socially incapacitated. These victims are of various kinds, their suffering manifested in every pathology, inadequacy and dependency imaginable. Some of them are unhappy and unfulfilled. They may feel bad or inferior most of the time. Some cannot manage their own lives and must rely on others to maintain them and care for them. They eat or drink too much or submit themselves to some other debilitating forms of excess or indulgence. Many of the victims produced by society are abusers of some sort. They perhaps abuse themselves or they may abuse others either psychologically or emotionally or physically.

Criminals too are victims, as we learned from Dr. Menninger. They prey upon others in society, inflict incalculable harm, drain off resources, and create fear, mistrust and loathing. What they have in common, though, is their victimhood. They have become what they are and do what they do because the society in which they live either has not given them what they need to be normal and healthy, or has permitted them to be mistreated, abused or neglected. Such individuals require professional intervention: they have entered the greatly enlarged world of patienthood. In their residence there they will encounter an officially dispensed benevolence that will “heal” them. This is the vision of Karl
Menninger, a harbinger of the therapeutic mentality and one of the early American theorists and advocates of universal patienthood and the continuous enlargement of therapeutic benevolence. He argued passionately throughout his long life that society itself was sick and everyone in it was in some way and to some degree infected. With sickness everywhere, the ubiquitous presence of the therapist is natural and necessary. No resistance to the therapist is to be permitted.

While patienthood may seem now to be a natural or inevitable state for us, one only has to think of an earlier time, when our orientation was quite different and we thought of ourselves as citizens, in order to get a sense of the profundity of the change and just how revolutionary it is. Citizens in contrast with patients are active. They take responsibility for themselves. They hold each other accountable for the decisions they make and the actions that follow from them. Most importantly, citizens act as morally independent creatures. They prefer to make their own life-decisions, carry out their plans, and submit to the consequences without resorting to excuses. As much as possible, they want to maintain their own lives and cope with life's ambiguities and adversities without professional assistance and supervision.

In the vocabulary of citizens, important words now fade from use, words that articulate the values of independence and responsibility—honor, virtue, integrity and duty. Citizens have no desire to return to childhood or behave like adolescents once they are adults. They recognize life's moral as well as physical limitations and submit to them. They disdain the rationalizing and the pseudo-theorizing away of wrongdoing and malevolence. By vivid contrast, the important words of patienthood—recovery, co-dependency, twelve-step programs, treatment needs, self-esteem deficiency, negative self-concept, and negative self-worth—reflect a profound sense of moral passivity, ethical helplessness and social dependency. It is a language that reflects our current march of desolation.
Chapter Four Endnotes


64. Quoted from: Nolan, *The Therapeutic State*, 83, original italics.

Sin into Sickness:  
The Triumph of Official Benevolence


