HUMANIZING VERSUS DEHUMANIZING IN SOMATOTHERAPY AND PSYCHOTHERAPY

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Shortly before Christians began slaughtering each other in the name of Christ, Europe experienced a brilliant flash of social interest, a humanistic regard for man. One vehicle for this short-lived burst of mental health was the communicative form of the dialogue, as seen in the letters and works of Erasmus and More. The dialogue served to clarify points for further mentation rather than stun an antagonist into silence or advertise that he was malicious or paranoid. When the dialogue faded so did tolerance and rational communication between men of different beliefs. Four hundred years later there remains a lamentable shortage of peaceable protagonists who will take time from data gathering to puzzle present and future goals. Robert Walker's "Mistreatment of the Mentally Ill" (22) needs to be answered for cogent reasons — and perhaps a dialogue is born.

DISGUISED PUNISHMENT VERSUS RESPONSIBILITY

Walker equates a "psychogenic approach to 'problems in living'" (21) with a narrow orthodox psychoanalytic model, thereby constructing an unsavory alternative to the disease model of emotional disturbances. The key to Walker's caricature of non-medical models possibly lies in his view that the latter lead to cruel moralizing actions on the part of helping professions, and Walker and the present writer would concur that such dangerous reactions are anathema to mental hospitals — and harmonious living in general. The world has never made a good Christian with thumbscrews, or "cured" (i.e., educated toward maturity) a mental patient with locks and keys. Professional people who by their *actions* would be subsumed under the "moralic acid" label of Mairet (2) habitually react with disguised punishment based upon their own unverbalized needs rather than a careful study of the psychological needs of the victim (11). While acknowledging that punishment might prevent an action, this writer maintains that arbitrary punitive actions frequently increase the anxiety and hostility of the recipient and therefore do not promote maturity. Our mental hospitals became custodial dumping grounds not solely because of the medical approach to behavior, but because this orientation became a rationalization for such cultural callousness to human

questions. A scientifically more acceptable Darwinian fatalism when substituted for Christian charity had its stultifying effect, as did the Cartesian split of man into mind and body without consideration of the developing identifications. Humanistic identification (17) or social interest was not in the working vocabularies or life styles of the policy-making giants of American psychiatry. Both John P. Gray and Pliny Earle believed the mind was equivalent to the immortal immutable human soul and therefore incapable of disease, death or suffering. Then why expend money, time, and effort on essentially happy individuals, such as mental patients, beyond the detached study of presumably ill bodies (4, pp. 41, 50-51)? "Foreign insane pauperism" became a diagnostic phrase for an assumed disease state with its predestined bleak course and outcome. How neatly we had scientized our prejudices to cover the perplexing present and the wide interplay of uncontrolled variables!

It may be that Walker has seen his share of the demonological nature of popularized psychoanalytic biases (13) and equates all this with a psychogenic or psychotherapeutic outlook which then understandably repels him. It would be a rare institutional psychologist who had not been exposed on frequent occasions to such inanities as: (a) A patient is fearful of shock treatment but is subjected to it because "if he fears it so much he really wants it." (b) A patient without finances and training is summarily discharged with the remark that he will be experiencing only "reality anxiety."

One can well empathize with Walker for challenging the psychological theories when they analyze away fears and the lack of necessary talent without a serious effort to explore the patient's phenomenological world. In addition pseudo-psychotherapy usually has no explicit standards for a successful adaptation (14, pp. 178-179).

Walker's dislike of the responsibility concept may stem from its uses in our society: to ferret out and punish a culprit. Yet much of modern psychotherapy is predicated upon a "responsible living" goal. To Glasser, mental health means learning to satisfy one's needs without encroaching upon those of others (9, pp. 13-15). To live up to one's promises, not to conceive of oneself as a passive victim, and to admit mistakes are Shoben's criteria of the goals of therapy (20). Haley's definition of mental illness, along the same line, is the untoward behavior of a person who indicates he is not behaving and simultaneously cannot help it (11). All of these therapists talk of responsibility as an educative goal, yet do not discount the presence of

stressful organic conditions. But they would consider to a much greater extent than does Walker, the behavior and expectations that lead to hospitalization, especially when the medication administered there is only routine. The teaching of alternative behaviors to organic dysfunctions and the interdependence of psychological stress and the body would also be explored in the course of such treatment in a non-punitive re-educational setting.

Now when a therapist has a psychogenic orientation he is *not* ideally full of moralic acid and ready to punish. If he looks beyond unconscious motives (13) to causality in terms of the patient's narrow or negative identification he is not prone to fatalism or subtle cruelties. Furthermore if he has a "here-and-now" learning orientation he will believe that many contemporaneous factors lead to low self-esteem, compensatory fantasy and lack of humanistic identification (17, 18). Even granted that a patient may continue his unprofitable attitudes and resultant behaviors, through his habitual negative thoughts and learned reactions, punishment in itself will not make the better man. Ultimately the patient's self-esteem might depend on how he relates to others through outsight (understanding hopes and fears of others).

So the patient needs the valid experience of outside interests and work as Walker states. Psychogenic theories do not negate work if it is anchored around an ongoing commitment to mature identity, and not simply used as busy-work.

DEHUMANIZING VERSUS INDIVIDUALIZING

Somatogenic theories would be tactically acceptable if they reduced the influence of the dehumanization, but mental health professionals can talk in terms of diseases while their behaviors might be motivated by some other hidden philosophy (1, 10, 11). We are still rather arbitrary as to what behavior constitutes diseases, out of deference for the biases of society (1, 6). The alcoholic and homosexual, for example, frequently elicit immature reactions in would-be helpers, as does the implication that misbehavior is consciously motivated (11, 15, 19, 24). It seems that our traditionally unsuccessful way of quickly labeling certain patients with a "poor prognosis" is often a function not entirely of the patient's behavior but of the reaction of others to his subtle rejection of time, place, and person conventionalities. Speaking eternally of diseases and strongly implied physical determinism obscures the elements worthy of study: the avoidances

of the potential therapists and the question of learning alternative behaviors to stress for both patient and helper. When dehumanizers with either psycho- or somatogenic outlooks are in power in any human organization, withdrawal and apathy (or even "crazy talk") are one of the few actions rewarded (16): the reward is via removal of the negative stimuli—that is, the punishing one goes away. In other words if we double-bind a dependent person—and only the person who perceives himself as needing a savior can be the victim—and need the bindee to fulfill our goals, we are likewise potential victims. For in the helping professions to be a doctor one must have patients in the complementary style (23, pp. 7-9). But the patients can indirectly dictate our behavior by forcing retreat upon us through the symptoms of violence and muteness and can force pampering via the symptoms of unequivocal helplessness. If they would talk of their symptoms or metaphors in terms of the interpersonal, social, and economic factors which have spawned their immaturity, punishment-labeled-as-treatment would often follow. Better for their health (and finances), most patients seem to think, to control us by being skillful participant-observers in the hospital game. Like the symptom of the patient, disease-model thinking reduces the tension of the patient and staff players, but we are all victims when the search for knowledge is thereby tranquilized.

In his case for the somatogenic theory, Dr. Walker has pointed out a very significant point: psychogenic views can be dehumanized, mechanical generalizations about people *if* the individual's life style is discounted. History shows us that somatogenic theories *in practice* have done just this, and continue to do so. The essential matter is not a choice between the body or the psyche but a patient study of each individual without reducing his uniqueness into the jargon of chemistry or traumata in isolation. Once a man is thereby re-labeled and perceived as non-human, even if the motive is in the best of science, all forms of crippling evils and insanities can be released upon him. To this writer the motives or anomies which lead to negative overgeneralizations are the salient sins, evils, or illnesses of our times. We think we see this phenomenon repeated interminably by our chronic patients: the "I-am-weak-and-hopeless-and-others-are-evil-and-hateful" phenomenology and unusual avoidances. But the normal end of the continuum has its more typical overgeneralizations focussed on inconvenient people with high nuisance value and couched in scientifically respectable concepts. The psychogenic-somatogenic

antinomy from this vantage point appears to be but an epiphenome-non of dehumanization and dualistic preoccupations.

Between the Scylla of organicity and its neglect of social, economic, political (8), and human learning factors, and the Charybdis of psy-chogenesis with its tendency to blame-mongering and punishing is the way of the Adlerian life style (2, pp. xi-xiii). Labels are swept away in the search for each man's attitudes and behaviors toward goals. Once the life style is appreciated and the fears and stupidities of all of us are faced, the "simply-more-human" feeling emerges. The therapist helps the patient to build a relationship as the base of the therapeutic transaction and is not fearful and hostile about the pros-pect of "manipulation by" or "identification with" the patient. These latter errors seem to occur mainly when the therapist's demand for certain behaviors on the part of the patient is not dictated by aware-ness and appreciation of the patient's life style. Labeling and neglect of the patient is perhaps dictated more by our hidden habits of de-humanizing in the service of our paucity of humanistic identification. Sartre has classified man into cowards, stinkers, and the authentics (25). Those in the first category want to believe in strict determin-ism. People within the second also lack humanistic identification and probably prefer to follow the dictates of "survival of the fittest" rather than "love thy neighbor," thereby feeling less guilt and anxiety about their transactions. And the authentic is the Adlerian ideal: one who has the tolerance and humanity to involve himself with a minimum of demands and avoidances in identification-building in the present important moment. He tries to be aware of his own demands, as he is of the expectations of others, so overcomes the punishing aspects of traditional organic-psychological antinomies.

This writer joins Walker in applauding European psychiatry, but not alone because it supposedly harbors organic leanings, as he main-tains. Its forte is in uniting both extremes of etiology and thereby showing, at least in its literature, concern for human dignity and the advancement of psychotherapy. In three examples of European psychiatrists I recently met, there were such novel approaches as the schizophrenic being seen as a lost explorer who needs to be gently helped not punished with "degradation ceremonials" (12). Biological changes advanced through social reforms in the elimination of social stressors was another theme (7) which is possibly avoided by many because of our nationalistic fixations. Baruk (3) was a most apt ex-ample of thought innovation. Although he successfully experimented

in catatonigenic substances, he spoke of such novelties as real guilt and the prime causality of aberrant actions in societies where violence and deceit are rewarded. Such studies transcend our usual medical model where the focus of treatment is too often the person whose dependent and outsightless actions bother others, and not the agents which foster deficits in humanistic identification, the world's most pressing and timeless problems.

CONCLUSIONS

In summary my tune is this: the helping profession is still in the Dark Ages as far as systematized knowledge is concerned but should feel that its goals and aims are worthy enough to admit dissenting opinion.

The machinations of the subtle rejection and unconcern are not restricted to any profession but are manifestations of an authoritarian type of individual who revels in fatalism and hopelessness and turns at times to disguised punishment as "treatment of choice." Psychiatric history shows us that the great men in that field were the humanistically-oriented in their actions. Yet our institutions have often yielded to community pressures for mere removal of the behaviorally inept. Guilt is often avoided through psycho-and somatogenic theories in which only the patient is analyzed. When the stigma of patienthood is entirely reserved for the patient and the sole topic of exploration is past traumas and physical determinism, the advent of brainwashing is close at hand. When our own power needs force us to reject areas of treatment possibility, humanity will pay the price, for we are all victims when the search for knowledge is tranquilized.

An American psychiatrist with a rare sense of historicity and the tolerance for many avenues of knowledge stated, "The condition designated as 'mental illness' is not primarily, basically, or essentially so much a medical concern or responsibility as it is a vital concern of the sovereign state to provide sanctuary and relief and comfort and means of cure to those of its citizens who find their persons alienated from family, neighborhood, and community, and their personal rights placed in jeopardy" (5). Institutional psychotherapy when properly conducted aims at discovering attitudes and resulting behaviors which have culminated in hospitalization. Alternative, more beneficial responses are practiced and rewarded in an atmosphere which hopefully encourages patients to live less alienated lives through example and not punishment.

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