James Ring Adams

Looking for the Urban Poor

When Jimmy Carter gets around to unleashing his new "national urban policy," the fight against "urban poverty" is sure to be the main attraction. But even to hope to deal effectively with urban poverty, he will have to define it. This is not as easy as most people think.

The simplest guideline is money, specifically the income threshold used in federal statistics. According to this basic standard, nearly 26 million Americans, 12 percent of the population, were poor in 1975. Nine million of these lived in the central cities, some six million more lived in the surrounding metropolitan areas, and 11 million lived in the countryside.

Of the central-city poor, the Census says that slightly more were white than black. (But the Census has considerably confused the issue by counting Puerto Ricans, Mexican-Americans, and other Hispanics as white. In some large cities, these groups are worse off than blacks.) The vast majority of the non-city poor were white. The area of greatest poverty is the agricultural South; the area of the least is the industrialized North-central and Northeast.

The federal "poverty line" (actually a series of 124 income standards, varying by location and family size) can be seriously misleading. As specialists are increasingly complaining, the Census poverty index does not count "in-kind" income, such as government housing, food stamps, medicaid, and medicare. Thus it exaggerates the number of the truly poor and understates the impact of some very expensive social welfare programs. In a recent report which restated the Census to account for this aid, the Congressional Budget Office reduced the poverty population to one-third its previous size. Moreover, the CBO discovered that these programs were most effective in the northern industrial triangle, from Michigan to Maine, where, under the new count, the incidence of poverty was less than half that in the South.

These figures suggest a startling hypothesis—that poverty, strictly defined, is a *less* serious problem in the central cities, where social services are more readily available, than in the suburbs and countryside. This hypothesis is confirmed by a RAND Corporation study of New York City's welfare program, released in September 1976. This study reviewed more than 42,000 cases from the AFDC program (Aid to Families with Dependent Children), which is what people usually have in mind when they talk about welfare, and summed up the cash value of all the other benefits these families received—food stamps, medicaid, and so forth. The total income for the average case, assuming the family stayed on welfare the year round, was nearly $2,000 *above* the poverty line. In the only other states that have tried to figure out the worth of the total welfare package—California and Michigan—these results held true as well.

So who are the urban poor? Some, we admit, may be welfare families who are not on the rolls 12 months out of the year. Their actual benefits thus fall short of the annualized figure. The RAND study, which assumed its control group had no outside sources of income, estimated that up to 17 percent of AFDC families with four members might still fall below the poverty line.

But the bulk of the statistical poor hardly fit the conventional image. Most are probably single persons or childless couples. Although they are legally eligible for medicaid and food stamps available to AFDC families, there are fewer people from this group, because of either pride or simple ignorance, who take advantage of these programs. Some graduate students may fall into this class. A recent income-distribution study of New York City revealed that about eight percent of the family heads earning under $4,000 had four or more years of higher education. But the largest single factor may be age. The most miserable people in the city are not likely to be welfare mothers or unemployed black teenagers, but those elderly whose only source of income is social security.

The RAND Corporation, the Congressional Budget Office, and several revisionist scholars are now telling us that welfare and poverty are not synonymous, in fact that welfare has by and large abolished urban poverty. Our jubilation at this news, however, has been easy to restrain. The problem of the big-city poor has been alleviated to a large extent by replacing it with the problem of the big-city welfare recipient.

The current welfare levels in some cities actually discourage people from seeking work. According to the RAND study, 95 percent of the four-person AFDC families in New York City make more in total benefits than the family head would receive working full-time, year-round, at the minimum wage. In its cautious language, the study observed, "Welfare could clearly be an attractive alternative to employment."

This point explains the mysterious phenomenon so vividly described by Daniel Patrick Moynihan—sharply increasing welfare rolls at a time, the mid-sixties, when the unemployment rate was declining sharply.

But the initial scholarly reaction to this phenomenon may have been too bleak. In the late sixties, welfare specialists talked about the unbreakable dependency generated by the system, leading to second and third-generation welfare families. More recently, they have focused on the apparent high turnover in the welfare caseload. According to the new interpretation, long-term cases are in the minority; most "clients" alternate between periods on the dole and periods at "dead-end" jobs.

Perhaps this new approach is exaggerated. In New York, it appears that many of these case closings can be attributed to paper shuffling, since the same families showed up on the rolls again a month later with no change in their condition. But the new mood among researchers reflects the changing pattern of the growth of welfare. The rolls levelled off at the end of the sixties largely because most of the eligible population had been signed up. More recent changes in size have reflected the changing condition of the economy. New welfare cases are frequently long-term unemployed who have exhausted their benefits. But the reverse of this situation is that these people are anxious to return to work as the economy improves.

The program that may reduce the worst evils of poverty and of the earlier government programs is economic growth. In the current circumstances, the debate over urban poverty should actually be a debate over the best means of obtaining and sustaining economic development. But that, as the poet has said, is another story. □

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Ernest van den Haag

Thomas Szasz and the "Myth" of Mental Illness

I am second to none in my admiration of Thomas Szasz. He has great merit in having drawn to our attention (in *The Myth of Mental Illness*) the scandal of forcible confinement of harmless, if eccentric, people who have been confined as mentally ill because they were a nuisance to their families, friends, or enemies, or to the community as a whole. Helped by the growing effectiveness of chemical means in the management of agitation and depression, Szasz has greatly contributed to liberating literally thousands of patients—who should never have been confined in the first place.

Everyone who wants treatment, including institutionalization, for the sake of changing or controlling his feelings or behavior should have a right to arrange for it; but (with one exception of which anon), no one should be forced to accept treatment or institutionalization against his will. Treatment need not depend on the presence of disease: Obstetricians or cosmetic surgeons treat conditions that are not diseases. Treatment should depend only on wishes and possibilities.

Szasz is quite right in insisting that psychiatry historically has confused clinical questions and judgments—dealing with the presence of pathology—with moral ones—dealing with the rightness, propriety, or acceptability of the behavior of the patient. Historically psychiatry attempted to separate the pathological, to be treated, from the immoral, to be condemned. But in practice, as Szasz points out so incessantly, moral judgments often were disguised as clinical diagnoses. They still are: In the past disease often was regarded as immorality; today immorality, including criminality, often is regarded as a disease. The separation of psychiatric and moral diagnoses still is far from complete. Often "treatment" has been worse than punishment—more painful, indefinite, and confining—while depriving "patients" of the elementary procedural safeguards and rights that even the worst criminals retain before and after they have been found guilty. Confusion in this area is not limited to psychiatrists. Thus, a federal judge recently decreed that involuntary confinement of the insane without treatment is unconstitutional as though (a) treatment existed for a great number of conditions for which it does not exist, apart from judicial hallucinations; (b) treatment somehow could justify, or make constitutional, involuntary confinement, which clearly, if it can be justified at all, cannot be justified by involuntary treatment. And how could treatment be voluntary if the confinement is not?

Thomas Szasz is right then. But he goes too far. Which is unfortunate for he risks discrediting a justified position for the sake of what seems to me a seductively simple but wrong view. From the true and lamentable fact that many diagnoses of mental disease are no more than disguised moral judgments of disapproval (and bad judgments at that, apart from being irrelevant) Szasz goes on to assert that there is no such thing as mental disease. This is cure by definition; it does not help either the patient or society.

Consider Freud's vivid and accurate description of obsession: "...the patient's mind is occupied with thoughts that do not really interest him, he feels impulses which seem alien to him, and he is impelled to perform actions which not only afford him no pleasure but from which he is powerless to desist...he is perfectly aware of his condition...only he cannot help himself." Clearly obsession neither starts nor stops with a conscious (and voluntary) act; it is not desired by the obsessed and hinders and defeats his activities and wishes. To be sure, such a patient, although he suffers from a mental disease, is "perfectly aware of his condition" and capable therefore of deciding on treatment himself. Only part of his psyche is affected by his ego-dystonic condition. But what affects the patient is a disease, or the symptom of a disease, and he and others, except Szasz, perceive it as such. Mental diseases differ from physical ones in many respects. But they can be as involuntary, harmful, and incapacitating.

Obsession certainly does not call for confinement. But mental diseases may go further and affect other parts of the personality. The patient may lose all conscious control over his behavior and become unable to grasp or respond to rational communications, to judge the nature and effects of his acts, to be able to intend or control them. Surely this is seen when there is brain damage. Or even when a person is functionally disabled, intoxicated by drink or drugs. (Though I should hold drunks responsible for their acts for they contracted drunkenness voluntarily.) Irrationality and lack of control are also found when the disorder is purely behavioral without a detectable physical or chemical cause.

The Romans spoke of a person *non compos mentis*, who temporarily or permanently did not possess the rational ability required to exercise his rights as a member of society. Not all such persons need to be institutionalized. To do so, I agree with Thomas Szasz, may be neither necessary nor useful. But surely such persons exist; and, by definition, they are not competent themselves to decide whether they are better off institutionalized. Hence they may be confined involuntarily, on a basis other than their own decision, for the sake of either their own welfare—which they are no more competent to judge than an infant might be—or for the welfare of the community. The confinement has nothing to do with whether we like the decisions confined persons make—suicide, homicide, or any other—but only with whether their decisions are made while *compos mentis*, capable of making rational decisions, decisions that are intended and likely to lead to the intended effects. If they do not have a reasonable capacity to make rational decisions and are a threat to themselves or others, such persons may be confined. (Thus, most suicides are temporarily deranged, but by no means all; suicide attempts do not suffice for a diagnosis of illness, but they invite scrutiny; most homicides are sane and do not by themselves justify even a suspicion of mental illness.)

Szasz would oppose the involuntary confinement of such persons, not only because he denies the existence of mental disease, but also because he feels that the disturbed person, like the sane, should be confined only for what he has done and not for what he may do. I don't share this view. In principle, disturbed persons may be confined *qua* disturbed, for the sake of their welfare, or that of the rest of us, since when they threaten to interfere with either, they cannot be said voluntarily, intentionally to do so; thus they are not responsible and cannot be punished *post facto*. But we are entitled, even obligated, to prevent what they cannot control. If we could know for certain what the psychotic will

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