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PHILOSOPHY RESEARCH REPORT:

A PHILOSOPHICAL EXAMINATION OF THOMAS SZASZ ON MENTAL ILLNESS AS A MYTH

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2024

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ABSTRACT

The field of psychiatry has encountered substantial scrutiny pertaining to its diagnostic and therapeutic modalities since the inception of the antipsychiatry movement in the 1960s. A prominent figure within this movement was Thomas Szasz, a Hungarian-American psychiatrist whose influence looms large. Szasz, inspired by the ideas of Michel Foucault, posited that psychiatry functions as a ‘locus of control’ designed to subjugate and pacify societal masses into compliance. His seminal work, *"The Myth of Mental Illness,"* expressed the argument that the medicalisation of mental illness is inherently problematic, constituting a category error of profound significance and resulting in harmful stigmatisation.

Szasz advocated for the extrication of mental illness, or as he preferred, 'problems in living,' from the view of the medical domain. Instead, he proposed a paradigm shift towards addressing these issues through social frameworks, particularly emphasizing psychotherapy or counselling as opposed to reliance on psychiatric medications.

Szasz's perspectives yielded both enthusiastic support and strong criticism, and contemporary theorists, such as Gabor Maté, persist in echoing his sentiments to this day. The objective of this report is to critically examine Szasz's theoretical position, as well as to present a concerted effort to substantiate its enduring relevance in the current intellectual milieu.

Key Words: **Mental Illness. Antipsychiatry. Thomas Szasz. Problems in Living.**

SECTION ONE: INTRODUCTION

The aim of this research report is to evaluate Thomas Szasz's anti-psychiatric claim that 'mental illness' as we have come to understand it today is a category error, or in Szasz's words, a myth. By the time he published *The Myth of Mental Illness* in 1960 Szasz was ready to articulate a comprehensive, controversial perspective that would define his career and influence the field for decades to come (Benning 2016, p. 292). He argues that we should eliminate the term 'mental illness' and refer to the issues it addresses as 'problems in living' instead. Szasz's reasoning behind this proposal is that referring to so-called mental illnesses as medical phenomena constitutes a serious conceptual mischaracterisation.[1] He believes that 'mental illness' is not a medical phenomenon at all despite it historically, and presently, being treated as one. His view challenges the medical model that psychiatry applies to such problems, and it suggests that psychiatry is a tool of social control rather than a therapeutic endeavour (Szasz T. , 2011).

In this report, I will examine Szasz's view, address the main criticisms of it, and defend Szasz's idea of mental illness as a myth, building on some of its implications. I begin by contextualising his thought and clarifying the concept of mental illness he believed so problematic.

[1] These phenomena will be referred to as 'mental illnesses' in this report despite the contested nature of this and similar terms, as it remains the most widely used and accepted term and therefore easiest to utilise for exposition.

1.1 THE CONTEXT OF SZASZ'S VIEWS

The Antipsychiatry Movement: Critique of the Basis of Psychiatry

Szasz's critique of the concept of mental illness and the way that it was treated in the psychiatry of his day needs to be understood in the context of a broader anti-psychiatric movement. Although he resisted the label, Szasz is one of the first names to be associated with 'antipsychiatry' and his views were influential within it. The movement gained momentum during the 1960s and 1970s, especially in the United States and United Kingdom, and included figures such as R.D. Laing and Michel Foucault (Oliver, 2006). Alongside Szasz, these influential figures questioned the validity of psychiatric practices, diagnoses, and treatments.

The concept of validity in terms of psychiatry, though rarely discussed in studies, can be traced back to the Latin word *Validus*, meaning strong and can be further defined as "well founded, applicable, sound, and to the point; against which no objection can be brought (Jablensky, 2016, p. 29). Validity refers to "the characteristic of an inference that must be true if all its premises are true" and although there is no universally agreed upon definition of validity in science, it is generally accepted as "the nature of reality" (Jablensky, 2016, p. 29). With regards to scientific concepts, such as psychiatry, the attribution of validity may be described as an ongoing and unending quest due to the fact that knowledge regarded as valid in the past is quickly being replaced by new theories thanks to new evidence (Jablensky, 2016, p. 29).

Similarly, diagnosis within psychiatry has always been controversial (Wykes & Callard, 2010, p. 301). Usually, diagnosis refers to a process which assists in indicating possible treatments, as well as deciding which individuals will receive aid from mental health and social services (Wykes & Callard, 2010, p. 301). Supporters of psychiatry argue that diagnosis can in itself be therapeutic in the sense that psychological symptoms can be explained and discussed. However, antipsychiatrists argue that there are negative consequences to diagnosis, such as

medicalising human behaviours and creating stigma against mental illness (Wykes & Callard, 2010, p. 301).

Psychiatric treatment needs to be distinguished from psychiatric diagnosis, as such, treatment is defined as any therapeutic approach used for individuals with emotional and behavioural disturbances and can be divided into *psychological therapies* and *physical therapies* (Graham, 1992, p. 237). The antipsychiatry movement was created in response to growing scepticism regarding the validity of psychiatry as a whole, as well as psychiatric treatments and diagnoses.

The term 'antipsychiatry' was originally coined by David Cooper in 1967,[2] and in time began to be used to describe the growing criticism of conventional psychiatry (Crossley, 1998, p. 887).

Psychiatry is a broad field and has faced many criticisms since its inception. What made the antipsychiatry movement's criticism unique was, first, its radicalism. In contrast to previous critiques of psychiatry, the movement's goal was not to question specific treatments or policies within psychiatry, nor simply to argue for a more humane approach in practice.[3] Instead, it "questioned the very basis of psychiatry", including its purpose, foundational concept of mental illness, and the distinction between sanity and insanity (Crossley, 1998, p. 878).

A second distinguishing factor of the movement was its "rootedness in a wider critique of society", with society being seen as oppressive and restrictive (Crossley, 1998, p. 878). The movement's wider societal focus linked it to other political movements advocating for freedoms at the time, with these conceptual links often being "consolidated through practical cooperation" (Crossley, 1998, p. 878). An example of such cooperation was the *Dialectics of Liberation* congress. Organised by Cooper, Laing, Joseph Berke, and Leon Redler, it addressed

[2] Cooper was a former colleague of Laing's.
[3] Although these were incidental goals of the antipsychiatry movement.

a range of political issues, including psychiatry's role and influence. These issues were addressed by "various radicals from divergent struggles".[4] This event was seen by many as one of the "major events of the late 1960s" and emphasises the larger influence of the antipsychiatry movement on society.

The Social Control Function of Psychiatry: Foucault and Szasz

Additionally, antipsychiatry targeted the 'social control function' of the institutions associated with psychiatry. Such a critique is in line with Foucault's critical depiction of welfare organisations being used to "regulate life and discipline society". Foucault was referring in this context to overtly coercive institutions such as prisons, asylums, and courts, but also argued that institutions which seem to facilitate everyday life, such as social security, healthcare, and education bureaus, were coercive at their core (Lacombe, 1996, p. 331).

Szasz and Foucault are both considered part of the antipsychiatry movement despite differences in their theories. Foucault's theory is more sociologically orientated—he referred to his work as 'archaeology', employing history as a tool for understanding how certain concepts and ideas came to be accepted as true (Bracken & Thomas, 2010, p. 223). While Foucault was aiming for society to change its engagement with mental illness, or madness, Szasz was presenting an entirely novel way of understanding mental illness, philosophically, as well as questioning its medical basis (Bracken & Thomas, 2010, p. 223). Szasz based his critique of psychiatry on 'binary oppositions', emphasising the drawing of clear boundaries around our concept of illness. For Szasz, the definition of illness should be limited to "problems with our bodily functions"; he argued that issues essentially predicated on thoughts, emotions, interpersonal

[4] Including Herbert Marcuse, Stokely Carmichael, Paul Goodman, and Paul Sweezy.

relationships, and behaviours—the actual issues germane to mental 'health'—were of a different category to those relevant to illness (Bracken & Thomas, 2010, p. 220). Szasz's argument regarding the distinction between physical and mental illness provided a theoretical foundation for many of the anti-psychiatry movement's critiques of psychiatric practice (Oliver, 2006).

The Antipsychiatry Movement: Criticism from within the Profession

At the dawn of the antipsychiatry movement, most critics of psychiatry were laypeople. However, during the second half of the twentieth century the balance of criticism came from members of the psychiatric field itself (Nasrallah, 2011, p. 6). The start of the 1960s was an important period for the movement as various forces including "internal contradictions within psychiatry, the rise of the patient's movement, and the development of alternative treatments for mental disorders" came together to place psychiatrists on the defensive (Nasrallah, 2011, pp. 4-5). Not only laypeople but numerous psychiatrists began to believe that contemporary psychiatry was responsible for many "misdeeds" (Nasrallah, 2011, p. 4). These misdeeds included the medicalisation of mental illness, the use of drastic measures to control those deemed severely mentally ill,[5] the severe side effects of many psychiatric medications, labelling homosexuality or the natural desire of slaves to escape their masters as illnesses, and the "arbitrariness of psychiatric diagnoses" which is based on committee-consensus rather than on biomarkers (Nasrallah, 2011, p. 4). Critics also censured the administration of psychiatric drugs to minors and the dubious safety of these drugs (Nasrallah, 2011, p. 5). These criticisms have all been echoed by Szasz.

[5] Such as the use of electroconvulsive therapy (ECT), performing lobotomies, or resecting various parts of the body.

Progressive Ideas and Legal Reform in Psychiatry

The start of the 20th century was the beginning of a more progressive approach to psychiatry (Truong, Maguire, & Maguire, 2020, p. 60). For example, Adolf Meyer—a well renowned psychiatrist at the turn of the century— "placed emphasis on psychobiology, the influence of the environment, and the influence of constitutional and developmental factors on mental health" (Truong, Maguire, & Maguire, 2020, p. 60). This approach was seen as more progressive because the influence of the individual's environment and development was considered, whereas previously psychiatry had focused mainly on symptoms rather than such causes. The shift in approach was a reaction to the perceived social control that psychiatry exerted and was greatly influenced by antipsychiatrists from the United States and United Kingdom.

In addition to this new approach to psychiatry, constitutions and laws began to be re-examined and amended, particularly in the United States. In 1966, the California Legislative Mental Health Subcommittee began hearings, in which it was found that psychiatric patients who had been involuntarily hospitalised had fewer rights than convicted felons (Truong, Maguire, & Maguire, 2020, p. 60). This was seen as problematic by many: laypeople, legal and medical professionals, members of the subcommittee, and of course, those sympathetic to the antipsychiatry movement. The combined pressure from these protesting forces led to the subcommittee's amendment of certain laws (Truong, Maguire, & Maguire, 2020, pp. 60-61). The subcommittee's findings on the rights of patients and the control exhibited by society directly supported Szasz's claims that what we understand as mental illnesses are often caused by external factors, such as an "inability to provide for one's own food, clothing, or shelter" rather than underlying psychobiological problems with the patients (Truong, Maguire, &

Maguire, 2020, p. 60). Based on these findings, in 1969, the Lanterman-Petris-Short (LPS) Act—described as revolutionary at the time—was passed. This act raised the criterion for commitment to a facility from "the need for treatment (in a professional's opinion)" to "behavioural evidence, such as dangerousness or grave disability" (Truong, Maguire, & Maguire, 2020, p. 60). The act also ended indefinite commitment in favour of short-term treatment and restored the civil rights of psychiatric patients. This short-term approach to treatment reduced social control over patients by creating less of a dependency on mental health staff in the pursuit of healthy living. It demonstrated that by favouring effective methods and treating 'mental illness' correctly, patients are more likely to show signs of improvement and less likely to be readmitted to a facility.

The new approach was brought about by the subcommittee's agreement that a treatment period of fourteen days for involuntarily committed patients was "sufficient and effective in the vast majority of cases" and that "conditions within state hospitals were responsible for much of the unnecessary crippling associated with severe mental illnesses" (Truong, Maguire, & Maguire, 2020, p. 60). The point about conditions in these facilities supports Szasz's idea that the environment plays a large role in individuals exhibiting 'mental illness'. By the end of the 1970s almost all states within the United States had put provisions of the LPS Act into place. Fifty years after it was first written, it remains essentially unchanged (Truong, Maguire, & Maguire, 2020, p. 61). Since the United States was home to many antipsychiatrists during this time,[6] as well as being the seat of the American Psychiatric Association (APA)—recognised worldwide as an authority on mental health—these laws and changes in the approach to psychiatry quickly began to spread outside of the country. The changes were in line with Szasz's essential aspiration to rebuild the foundations of psychiatric practice. In order to do so,

[6] Including Thomas Szasz, Timothy Leary, Theodore Lid and Silvano Arieti.

amendments to outdated laws were (and remain) vital. Although Szasz may not have directly inspired these changes on his own, it was still the antipsychiatry movement's rebellion, informed by Szasz's ideas, that brought them about.

1.2 THE CONTINUED INFLUENCE OF SZASZ'S VIEWS

Since the core of Szasz's works revolves around responsibility and liberty, power and language, coercion, and psychiatry and the law, he attracted attention from specialists in diverse fields (such as law, medicine, psychiatry, psychology, and philosophy) and his works have been regularly cited by critics and supporters alike. He published thirty-five books and hundreds of articles translated into numerous languages over the course of his life (Domaradzki, 2021, p. 853). Szasz's works remain the focus of many debates regarding psychiatry and reforms to its practice sixty years since he authored them.

Despite passing away in 2012, Thomas Szasz continues to have a lasting influence. Some theorists label him "the most important moral philosopher of psychiatry", even if his critics would "neglect his ideas and emphasise the negative impact that his theory had on psychiatry" (Domaradzki, 2021, p. 852). Modern theorists such as Gabor Maté continue to use Szasz's theories as a basis for their critique of psychiatry (Maté & Maté, 2022). British psychologist, Lucy Johnstone, also supports Szasz's critique of psychiatry by arguing that physical and mental illness can simply not be treated similarly (Maté & Maté, 2022, p. 241). Szasz's influence on academia has been deeply significant, and his ideas are highly relevant to our continued conversation around mental health.

Challenging the Power Psychiatry Holds over 'Patients'

When Szasz began studying psychiatry, he already had a plan in mind. His intention was to "launch an attack on psychiatry that would end, or at least significantly reduce the use of civil commitment and the insanity defence" (Breeding, 2014, p. 1). The protest against the power psychiatry holds over its 'patients' has always been a central theme in Szasz's works, and I have sketched the influence of this idea in the 20th century.

More recently, thinkers such as John Breeding have stated that psychiatric discourse as it still stands aims to spread the belief that "countless people suffer from mental illness, and treatment of it is an important beneficent branch of medicine" (Breeding, 2014, p. 4). However, he and Szasz agree that such rhetoric is essentially about control. Breeding stated in 1998 that he often counselled adults who were working on "recovering from the trauma suffered at the hands of the mental health system" (Breeding, 2014, p. 6). He also supports Szasz's stance of studying psychiatry not primarily to practice it but rather to expose the numerous problems which still exist in the field (Breeding, 2014, p. 6). Drawing on Szasz, Breeding points out that typically in medicine doctors will make use of pathologists to verify a disease or illness, while in psychiatry lawyers are typically consulted instead of, as one might expect, psychologists (Breeding, 2014, p. 6). Szasz and later antipsychiatrists argue that this is because psychologists cannot verify an illness that does not exist; lawyers are brought in to enforce social control and remove individuals perceived as mentally ill from mainstream society.

Henry Weihofen contends that if mental illness were truly a medical concept its definition would stem from the medical field rather than from legislators and judges (Weihofen, 1960, p. 1). He also points out that disagreement persists between legal and medical professionals over the definition of mental illness, noting that there are currently two distinct categories of insanity: 'legal insanity' and 'medical insanity' (Weihofen, 1960, p. 3). As Weihofen says, in the case of a broken bone, a medical professional would simply examine and treat the patient—

there would be no correspondence with any legal professional regarding the existence of the broken bone (Weihofen, 1960, p. 4).

The Fruitfulness of Szasz's Fundamental Concepts

Szasz's theories are particularly valuable because they address the "epistemological and ethical problems of modern psychiatry better than anyone else" (Domaradzki, 2021, p. 863). They offer a foundational "alternative to the dominant school [7]of thought (within psychiatry)" (Bamijoko-Okungbaye, 2022, p. 47). Their purpose was always to address the various conceptual problems in the mental health industry, as well as to suggest alternatives to current methods of diagnosis and treatment (Bamijoko-Okungbaye, 2022, p. 47).

A recent study on the antipsychiatry movement indicates that although there has been progress with regards to patient rights and psychiatric treatment, there is still much that can be amended and improved within the field (Oyebode, 2023, p. 4). Topics that require further discussion include the stigma surrounding mental health, coordinating efforts between mental and physical health professionals, a demand for justice with regards to mistreatment at the hands of psychiatric professionals, and education programmes around mental health (Oyebode, 2023, p. 4). These discussions require the kind of conceptual rigour that Szasz's concepts promote.

Despite amassing critics, numerous theorists and mental health professionals still claim that Szasz's conceptual clarification is an essential factor in proper mental health research (Bamijoko-Okungbaye, 2022, p. 47). Essentially, the conflict between the traditional medical view of psychiatry and Szasz's psycho-social-ethical-legal view is still very much alive.

[7] Referring to contemporary psychiatry

Critical Reception

Most of Szasz's critics argue that his central argument is built on too-narrow a foundation, placing too much emphasis on 'conventional psychiatry' as a criterion for illness. Others accuse his contemporary supporters of failing to acknowledge the progress that has been made in psychiatry since Szasz's time. Still others criticise Szasz for exhibiting a kind of hypocrisy, being outspoken against psychiatry while being a psychiatrist himself. These criticisms will be addressed in greater detail in Section Four.

1.3 WHAT IS MENTAL ILLNESS?

The Contemporary Definition and Understanding of Mental Illness

When studying the concept of mental illness today, we are typically presented with two main positions: first, the view of the DSM (the *Diagnostic and Statistical Manual of Mental Disorders*) and secondly, the view of the American Psychiatric Association (APA). It is, however, important to note that the DSM is published by the APA, making the true dominant position one-sided. Therefore, in this report, I will be examining and critiquing the APA's definition of mental illness as it appears in the DSM. The DSM best exemplifies our established and contemporary understanding of mental health issues.

According to the DSM-V (the most recent and influential edition, published in 2013) mental illness can be defined as "a behavioural or psychological syndrome or pattern occurring within an individual reflecting an underlying psychobiological dysfunction" (APA, 2013). An additional criterion for diagnosing mental illness is the idea that an individual must experience a clinically significant amount of distress or impairment as a result of their illness. Such

impairment or distress could affect one or more vital areas of everyday life or functioning, such as work, school, social scenarios, self-care, memory, interpersonal relationships, susceptibility to addictions or substance abuse, or any combination thereof (APA, 2013).

Problems with the DSM's Characterisation of Mental Illness

The DSM-V is not only used across the United States but plays an important role in categorising "supposedly pathological conditions" around the world (Thyer, 2015, p. 46). Despite its widespread influence, the DSM-V has not gone without criticism.

Bruce Thyer , for example, criticises the very definition of mental illness the DSM-V proposes. He mentions that the DSM-V is a "conceptually problematic set of diagnostic guidelines" due to its "pervasive errors in logical reasoning" (Thyer, 2015, p. 46). The DSM-V is ubiquitous in practice settings around the world, and Thyer therefore pleads for mental health practitioners to "understand the manual's limitations and not confuse its unsupported assertions with nature's reality" (Thyer, 2015, p. 46). Thyer argues that the DSM's definition is "tautological", guilty of defining its subject circularly. Thus, he claims that the definition is unsatisfactory from a scientific standpoint and notes that "claiming that a mental illness is caused by a disturbance in mental functioning" is akin to "calling a particular rock broken because it is brittle" (Thyer, 2015, p. 47).

Furthermore, the DSM-V's usage of the terms 'syndrome' and 'dysfunction' illustrate that individuals who suffer from mental illnesses are perceived by society as being at a disadvantage due to their diagnoses (Radden, 2019). Szasz disagreed with this (medical) connotation of mental 'illness', stating that these problems should be seen and treated as social phenomena instead. Through this lens, theorists such as Jennifer Radden have argued that the DSM-V does not consider that it may be an individual's environment, rather than the individual, that is

dysfunctional. Consider for example an individual who is being bullied at school. Naturally, the important life area of schooling will be affected by this harassment (among other important areas such as relationships with others, self-esteem, and anxiety). In such an environment, abnormal behaviour does not obviously mean that the bullied individual is *ill*. Their distress in this example emanates from an external factor (the bullying), which is the cause of the individual's display of 'mental illness'.

Furthermore, the DSM-V ignores the fact that what we may without further thought consider dysfunctional may be considered to be "normal, admired, or even useful" by others. These discrepancies happen between cultures, religions, and even individuals (Radden, 2019). I will return to this topic in relation to cultural differences when developing some of the implications of Szasz's thought in Section Three.

The Importance of Conceptual Clarity

Despite these problems, the DSM-V's definition of mental illness is currently still amongst the most accepted. It thus plays an important role in characterising mental health and promoting its correct treatment by mental health practitioners.

In the following sections of this research report, I will elaborate why I agree with Szasz's idea that the current understanding of mental illness is flawed and requires further examination. With this in mind, I will be challenging the idea of mental illness as a medical phenomenon and supporting Szasz's characterisation of it as a myth. In addition to exploring Szasz's claim, I will address important implications and concerns that may be relevant if we are to accept Szasz's view of 'mental illness' as, fundamentally, a category error.

SECTION TWO: SZASZ'S ATTACK ON THE IDEA OF MENTAL ILLNESS

2.1 WHY MENTAL ILLNESS IS NOT TRULY AN ILLNESS

Thomas Szasz argues that while we may claim to have a sufficient understanding of the concept of mental illness, there is still vast speculation and debate over the correct definition, appropriate treatment methods, and everyday perceptions of it. In *The Myth of Mental Illness,* his main argument is that "the assumptions, language, and idiom we use in medicine are not appropriate in the world of mental suffering" (Kelly, et al., 2010, p. 36). His goal is to emphasise that when dealing with problems relating to thoughts, feelings, emotions, relationships, or behaviours, we are dealing with "aspects of our worlds that are not at all like the problems of diseased tissues or organs" (Kelly, et al., 2010, p. 36).

Szasz's works have always been influential within the antipsychiatry movement which, as previously discussed, claims that unless we change our model, mental illness cannot be adequately defined, as the very idea of mental 'illness' is a category error. As a result, the ways in which we currently treat mental illness also require amendment.

What is a Category Error?

By accusing psychiatry of making a category error in characterising the problems we call 'mental health issues' as medical phenomena, Szasz means that it is impossible to compare mental and physical illnesses as "the notion of mental symptoms is inextricably tied to the social or ethical context in which it is made, in much the same way as the notion of bodily symptoms is tied to an anatomical or genetic context" (Szasz T. , 2013, p. 114). But what exactly is a category error?

Finding a concise and agreed upon definition of what constitutes a category error is surprisingly challenging. Numerous theorists have made use of the concept in an effort to point out that "some kind of error has been made" conceptually (Malik, 2018, p. 1). Gilbert Ryle was one of the first to use the term 'category mistake' in his critique of dualist and materialist concepts of the mind. Such errors or mistakes can, at the risk of oversimplification, be understood as a type of logical fallacy. Fallacies can be thought of as "1) false but popular beliefs", and "2) deceptively bad arguments" (Hansen, 2023). Malik draws on Gilbert Ryle to say that "category errors violate the principles and laws of logic and logical inference, and thus lead to absurdities" (Malik, 2018, p. 16). Ryle did not offer much in the way of a systematic definition in his paper, but we can go further.

We can at least distinguish category errors from lies, or obviously false statements. Luke Malik draws on Ofra Magidor's definition to narrow the concept down: a category error can briefly be defined as an "infelicitous" statement that is different to obviously false statements such as '2+2=5'. Examples include "the number two is green", or "the theory of relativity is eating breakfast" (Magidor, 2022). Here, something not false but clearly ill-conceived is occurring—a conceptual mischaracterisation. Category errors (not being obviously false or always immediately recognisable) have the potential to subliminally influence our understanding of certain, often complex, topics (Magidor, 2022). Obviously false statements, on the other hand, do not typically have such potentially negative or harmful consequences—they are more easily recognised for what they are, and their scope is therefore more limited.

The reason for the ease of disproving obviously false statements is that it is fairly simple to 'fact-check' or dispute them with evidence. For example, it is easy for us to prove beyond any reasonable doubt that 2+2=4, and not 5 or that the world is not flat. By contrast, category errors often arise in relation to more complex or nuanced topics, such as, in our context, mental illness. Finding an objective truth in such fields is far more challenging due to uncertainty about what

would constitute evidence. There is a lack agreement on the topic of mental illness regarding fundamental issues such as its very definition or appropriate treatment. In terms of our broader discussion, on Szasz's reasoning if we continue treating 'mental health issues' medically—making a category error in the process—we will never truly understand what these problems are, what they are caused by, or how to treat them adequately.

Mental Illness is Different to Physical Illness

One of Szasz's main arguments against the current conception of mental illness is that it cannot, and should not, be compared to bodily or physical illness. His reasoning for this is that the two concepts differ far too greatly to be in the same category of 'illness'. Szasz, and supporters of his position such as Awais Aftab, do not deny the existence of the problems psychiatrists currently label and treat as mental illness, nor do they deny the suffering experienced by individuals experiencing these problems (Aftab, 2014, p. 1). Instead, Szasz argues that these conditions should not be understood as *medical* phenomena, as these 'illnesses' are not physical 'objects or things' or caused by physical phenomena inside the individual's body. That is, there is no physical deviation from a norm of bodily health present in the case of mental illness, nor is there an identifiable organic or biological origin to it.

Szasz is influenced by the idea that any disease or illness must be "demonstrable through anatomical or physical lesions" to qualify as such (Aftab, 2014, p. 1). Aftab supports this perspective by introducing the idea that an illness properly conceived must be in some way an 'object or thing'. What does he mean by this? Physical illness is often something we can *see*, either from overt physical symptoms or through medical procedures such as CAT scans or X-rays. In other words, physical illnesses often manifest in physical symptoms with appropriate medical treatments assigned to them. These treatments are responsive to the physical,

observable problem, and range from medicine taken for the common cold to radiation or chemotherapy for cancer.

Both Szasz and Aftab argue that mental illness can only exist in a metaphorical sense. The rationale behind this is that unless it is the brain itself that is diseased, there is often no physical trace of a mental illness, which raises questions about the appropriateness of treating mental illness medically (Szasz T. , 1960, p. 113). Our minds—in contrast to our brains—are immaterial objects, incapable of displaying such lesions. Therefore, Szasz and his supporters argue that the mind cannot be diseased, while the brain can (Aftab, 2014, p. 1). This is an important point. It shows that Szasz is not denying the existence of brain diseases; he is merely drawing attention to the difference between medical illnesses, which are physical in nature, and mental 'illnesses', which are essentially social, being responses to problems we encounter in life.

This point is emphasised in *The Myth of Mental Illness* where Szasz claims that "a disease of the brain, analogous to a disease of the skin or bone, is a neurological defect, and not a problem in living" (Szasz T. , 1960, p. 113). He gives the example of an individual suffering from a defect in their vision and states that this defect can be explained by "correlating it with certain definite lesions in the nervous system". He goes on to argue that an individual's *belief* cannot be explained by such a defect or lesion in the nervous system (Szasz T. , 1960, p. 113).

To clarify what he means by an individual's 'belief', he offers the example of a person who believes that they are Napoleon. He states that this belief would only be seen as a mental symptom if an outside observer believed that the individual was *not* Napoleon. Szasz, in essence, is arguing that when we classify something as a mental illness we are rendering a judgement, which involves "a covert comparison of the patient's ideas, concepts, or beliefs with those of the observer and the society in which they live" (Szasz T. , 1960, p. 114).

Diagnosing a medical illness is wholly different: it is not dependent on a moral judgement, but rather on a clearly defined set of medical norms, and this is what gives it scientific respectability.

The Requirement of a Deviation from a Set Norm

For any illness to be accurately defined, Szasz claims, there needs to be a clear deviation from a set norm of physical health. He argues that in the case of physical illnesses this norm refers to the structural or functional integrity of our physical bodies. To be classified as physically healthy, one must conform to the norms of the physically un-deviated body (Szasz T. , 1960, p. 114). However, with regards to mental illnesses, the norm is not as easily defined, nor is it universally agreed upon. Szasz advises that instead of trying to define this norm medically, it should be stated in psychosocial, ethical, and legal terms, as such a reframing would draw out the correct context of 'mental illnesses' or, more accurately, 'problems in living' (Szasz T. , 1960, p. 114).

"Many people today take it for granted that living is an arduous process", explains Szasz, and most hardships facing us do not derive from "a struggle of biological survival" but rather from "the stresses and strains inherent in the social intercourse of complex human personalities" (Szasz T. , 1960, p. 114). The idea of mental illness is traditionally employed to "identify or describe some feature of an individual's personality" and symptoms of 'mental illness', Szasz claims, are essentially perceived deformities in personality (Szasz T. , 1960, p. 114). He states that the problem with this idea is that it presumes human interaction to be normally harmonious. Then mental illness can be seen as the cause of any disharmony. But this is "fallacious reasoning" because it "makes the abstraction 'mental illness' into a cause, even though this

abstraction was created to serve only as a shorthand expression for certain types of behaviour" i.e. as a description of social effects (Szasz T. , 1960, p. 114) .

2.2 IMMEDIATE PROBLEMS ARISING FROM THE CONFLATION OF IDEAS

The Problem with Psychiatry's Foundations

Szasz states that because medical treatments are designed specifically to treat medical illnesses, it would be "logically absurd" to assume that these means would be effective in the treatment of non-medical phenomenon. He places emphasis, specifically, on the absurdity of the administration of psychiatric medications (Szasz T. , 1960, p. 115). If we accept Szasz's argument that in using the term 'mental illness' we are involved in a category error, the manner in which we currently understand these problems, as well as our current treatment methods must be flawed. If Szasz is correct in his view, in other words, it would mean that the field of mental health care (particularly psychiatry) is built on a false foundation. This makes the defence of psychiatry rest on a pernicious argument, with negative real-world consequences for those experiencing mental illnesses (ranging from improper treatment to stigmatisation).

The Problem with Pathologizing Social Issues

Jennifer Radden argues in this regard that medicalising normal emotional states—which can be brought about by external events or influences at any time during our lives—is highly unethical and brings more harm than good to the individual in question. Sadness, anger, resentment, or soaring joy etc. are all appropriate and normal emotions we feel at points in our lives and should not be pathologized (Radden, 2019). Indeed, it is the absence of these feelings in certain cases that would be considered abnormal, rather than the feeling itself. For example:

it is normal for someone to grieve and feel depressed after the loss of a loved one, or to be brought to tears of joy after the birth of a child; it would be a fundamental mistake to pathologize these emotional states as ‘depression’ or ‘mania’. Furthermore, each individual will express different emotions and at different intensities in response to the vicissitudes of life, which makes it even more difficult to set a standard, universal norm against which we would have to measure whether or not someone was mentally ‘healthy’.

Radden and Szasz are not denying that emotions can become extreme, causing distress or functional impairment. In such cases, they advocate for the use of psychotherapeutic approaches, such as counselling (Radden, 2019) (Szasz T. , 2003, p. 78). The broader social context is important though: lessening the stigma surrounding mental illness by properly situating extremes of emotion and behaviour would encourage individuals to seek help more readily, and moving away from the medical model would promote a more informed, appropriate response to such distress.

2.3 SZASZ’S PROPOSED TERM: ‘PROBLEMS IN LIVING’

The Error of Using Medical Means to Treat a Social Problem

Keeping these considerations in mind, I will now explain why Szasz advocated to replace the term ‘mental illness’ with the term ‘problems in living’ and why he preferred a psychotherapeutic approach over traditional psychiatry. Szasz claims that traditional psychiatry is inherently medical. Because of this, he argues, psychiatry cannot adequately treat what are essentially social, i.e. non-medical, phenomena (Szasz T. , 1960, p. 113).

To support this notion, Szasz refers to Jean-Martin Charcot (1825-1893), a neurologist and neuropathologist. Charcot specialised in diseases of the nervous system. These diseases were often seen as incurable or terminal, both in Charcot’s and Szasz’s times (Szasz T. S., 1962, pp.

17-18). The problem with this was that individuals who were experiencing 'mental illnesses' were not diagnosed or treated adequately. These individuals were hospitalised instead because in fact they were "poor, unwanted, or disturbing to others" (Szasz T. S., 1962, p. 18). The idea that mental illnesses are akin to medical illnesses implies that they have a biological basis (Malla, Joober, & Garcia, 2015, p. 147). As I have suggested, we must question whether this assumption is correct.

Perhaps one could argue that the intention behind categorising mental illnesses as medical is (instead of being a claim to truth) an attempt to reduce the stigma surrounding these problems. Then we must critically examine whether this has actually been effective (Malla, Joober, & Garcia, 2015, p. 148).[8] By reframing mental illness as a problem in living, Szasz's fundamental drive is to place it into a social rather than a medical category, and he believes that this is more therapeutically effective than characterising it medically (apart from being more conceptually accurate). I agree with Szasz that one of the reasons for this is that in the case of a mental illness, often a change in the individual's social or individual environment will help resolve or alleviate such an 'illness'. (Of course, this would also mean that if a person experiencing problems in living were to stay in the same situation or surroundings, their symptoms would be unlikely to disappear—some sort of change is required.)

The Role of External Factors

Szasz explains that the medical view predominant in psychiatry makes it impossible for people to experience mental health problems as problems rooted in different needs, socio-economic statuses, opinions, social values, religions, cultures, or aspirations (Szasz T. , 1960, pp. 113-

[8] The stigma surrounding mental illness will be addressed in greater detail in Section Three.

114). Schmidt points out that “any number of circumstances can produce psychological stress” (Schmidt, 2007, p. 3). Someone who struggles financially might displays signs of depression, for example. Szasz wants us to consider that this depression has a specific external cause (i.e., a lack of funds leading to stress, anxiety, or hopelessness)—a cause that could be remedied or removed entirely. The remedying of the financial struggle in this example may effectively stop the feelings of depression. If this is plausible, then surely mental illnesses are vastly different to physical illnesses, which do not cease without medical treatment regardless of changes to environment or circumstance.

The Error of Symmetrical Dualism

How did this conflation of a social phenomenon with a medical illness arise? Szasz explains that the concept of mental illness initially received most of its support from ideas regarding “syphilis of the brain” or “delirious conditions” (Szasz T. , 1960, p. 113). These statements were used to refer to “people who manifest various peculiarities or disorders in thinking and behaviour” (Szasz T. , 1960, p. 113). Historically then, the peculiarities of behaviour we now call mental illnesses were associated with physical illnesses such as syphilis. But this medical classification is, for Szasz, “erroneous”—the conditions being referenced are, as discussed, diseases of the physiological brain, not of the mind. The reference Szasz makes to ‘physical lesions’, syphilis or ‘delirious conditions’ is indicative of his time. We use different terms now, but ones which remain medical and constitute the foundation of our understanding of mental illness.

For Szasz, we have erroneously ascribed a ‘symmetrical dualism’ to symptoms of the mind and symptoms of the body. By making the error of equating the mind with the brain, we have mislabelled mental illness as a type of brain disease. Szasz reiterates that mental symptoms are

tied to the social or ethical context in which they arise, but "the notion of bodily symptoms is tied to an anatomical and genetic context" (Szasz T. , 1960, p. 114). In essence one must see Szasz's argument as partially a positive claim and partially a negative one. His positive claim is about what mental illnesses are (properly understood as problems in living), and his negative claim is about what they are not (medical phenomena).

Understanding this allows us to better understand why Szasz's argument is so important. If we can define, treat, and understand mental illness more effectively, much of the artificial stigma surrounding it will fade, and individuals experiencing problems with their mental health will not be marginalised and discriminated against based on their diagnoses. This would hopefully lead to these individuals receiving the psychological (not psychiatric) help they require to work through their mental health issues (e.g., counselling).

SECTION THREE: SOME IMPLICATIONS OF SZASZ'S POSITION

Accepting Szasz's characterisation of mental illness as a myth has important implications for our understanding and treatment of these problems. In this section I draw out some of the ways in which the conception we adopt has affected our approach in the past and continues to do so.

3.1 THE EVER-WIDENING RANGE OF MENTAL ILLNESSES

Even one of Szasz's biggest critics, Robert Kendell, acknowledges that Szasz is correct in stating that psychiatry differs from other branches of medicine in that most mental illnesses are defined only by their symptoms and not by their causes. This is different to physical illness, where, at least in principle, clear medical understanding of the various causes of different illnesses and appropriate treatments exists. Eric Dammann argues that psychiatry does not fit in with any other branches of medicine because all mental illnesses were "invented" rather than being physiologically "discovered", as in conventional medicine (Dammann, 1997, p. 734).

Such an unscientific approach results in psychiatrists claiming to "recognise an ever-widening range of mental illnesses", which would leave them "vulnerable to accusations of unjustified medicalisation of deviant behaviour and the vicissitudes of daily life" (Kendell, 2004, p. 33). This is precisely what Radden argued for; she and Kendell both recognise that psychiatry has the potential to pathologize normal human states or emotions. This, in turn, could lead to an array of negative consequences ranging from social stigmatisation to discrimination or the removal of basic rights, granting psychiatrists far too much power.

Szasz anticipated an increase in the list of mental disorders by cautioning that "the idea of mental illness is being put to work to obscure certain difficulties in social intercourse" (Szasz

T. , 1960, p. 117). Employed this way, the idea of mental illness functions only as a disguise, ignoring conflicts between "human needs, aspirations, and values" in favour of labelling responses to these events as an ever-increasing list of illnesses (Szasz T. , 1960, p. 117).

Contemporary commentators such as Gabor Maté (in his book *The Myth of Normal)* discuss how this has manifested. Consider the sudden spike in childhood ADHD diagnoses (Maté & Maté, 2022, p. 242). Is it reasonable to medically treat a seven-year-old child who does not sit still for extended periods of time? Mate has stated that in his practice, he prefers to steer away from the formal diagnostic and treatment process, and instead, chooses to analyse the various factors contributing to these 'symptoms' (Maté & Maté, 2022, p. 245). With regards to 'prescriptions', he states that he is more interested in "promoting the healing of the psychic wounds the ongoing traumatic patterns represent" (Maté & Maté, 2022, p. 245). It is not only ADHD diagnoses that have spiked with regards to children, however. Maté and Maté also draw our attention to the DSM-V's definition of Oppositional Defiant Disorder ('ODD') (Maté & Maté, 2022, p. 243), namely, "frequent or persistent patterns of anger, irritability, arguing, defiance, or vindictiveness displayed by children or teenagers towards their primary caregivers" (Maté & Maté, 2022, p. 243).

Let us consider that for a moment: Can anyone truly name a child or adolescent who has not experienced mood swings or outbursts at parental figures? Conflict and disagreements are a normal part of everyday family life. Furthermore, it is not always only the child or teenager behaving poorly in these situations. Poor communication or conflict resolution practices within the family can worsen childhood tantrums or rebellions. We must ask ourselves seriously whether we want to medicalise these situations. Reasonable levels of questioning, rebellion, and moodiness are all things that children will experience and learn to deal with while growing up. The social issues being navigated in family life, I am arguing, are not best dealt with through the administration of drugs.

3.2 THE STIGMATISATION OF MENTAL ILLNESS AND THE IMPACT THEREOF

The Nature and Cause of Stigmatisation

With increasing numbers of people being diagnosed with mental illnesses, stigmatisation becomes a real concern. We can define such stigmatisation as "negative attitudes (prejudice) and/or negative behaviours (discrimination) toward individuals with mental illnesses" (Krendl & Pescosolido, 2020, p. 150). In our context, stigmatisation has been "related to the types of attributions that individuals make about the etiology of mental illness", for example, whether mental illness is seen as springing from disease or a sort of moral failing (Krendl & Pescosolido, 2020, p. 150).

Consider the example of an individual who has been diagnosed as mentally ill (e.g., diagnosed with bipolar disorder). There is a significant chance that this individual, based solely on their diagnosis, will come to face judgement and stigmatisation. This stigmatisation could come from their interpersonal circle (family, friends, colleagues etc), as well as from society in general (governments, legal professionals etc). Now, consider whether *any* illness—mental or physical—should be stigmatised in this manner. With the rise of numerous disability activists, we can already observe a wave of protest against the discrimination of those suffering from stigmatised physical illnesses.

Krendl and Pescosolido emphasise that the stigmatisation of mental illness, particularly in Eastern countries, prevents individuals from speaking out about their problems or seeking treatment (Krendl & Pescosolido, 2020, p. 150). The reason for this, they argue, is that having a mental illness often violates cultural norms (Krendl & Pescosolido, 2020, p. 150). So long as the problematic stigma towards mental illness exists, discrimination against those who suffer from it will continue and prevent effective communication, help-seeking, and treatment.

I believe that Szasz was attempting to highlight this stigmatisation of our problems in living. Removing the stigma would be a step towards promoting equality in the mental health field. One of the most important implications of his argument may be that if we recognise our mischaracterisation of mental health problems, we could gradually lessen the stigma surrounding mental illness and avert the harm to those suffering from it.

Overcoming Stigmatisation through Understanding

Patrick Corrigan theorises that society has two predominant ways of approaching those with mental illnesses. Please see Corrigan's diagrams below marked *Figure 1* and *Figure 2* which illustrate these encounters (Corrigan, et al., 2017, p. 294).

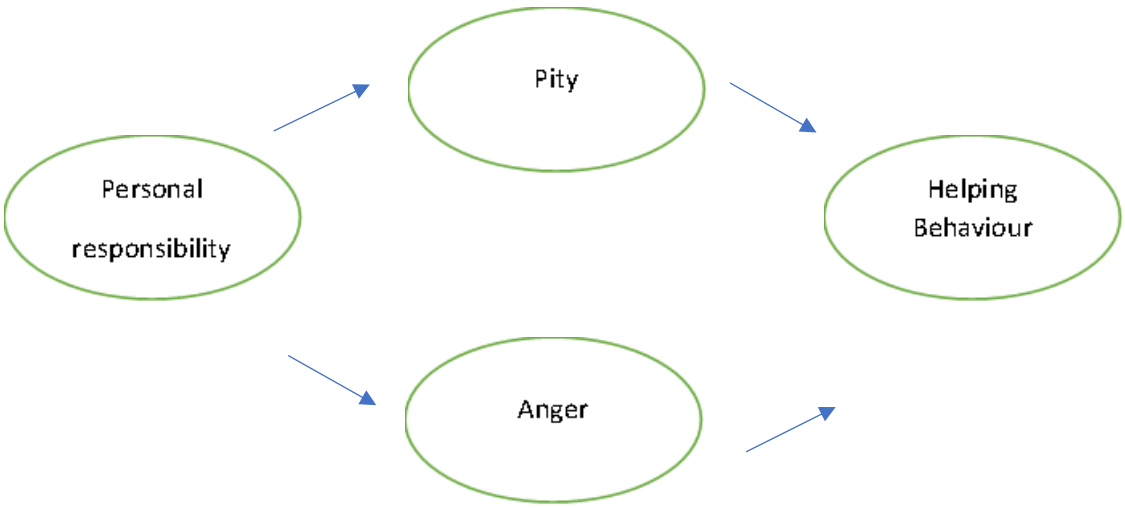


Figure 1: Corrigan's depiction of helping behaviour.

The first figure depicts that, when confronted with the mentally ill, we may feel a sense of responsibility arise in us. But we tend to react to the encounter with either pity or anger. Both of these feelings in the context of our sense of responsibility lead to a 'helping behaviour', but

in truth this behaviour is not designed to help the person who is mentally ill. Instead, it is designed to help the individual process their feelings towards that person.[9] 'Helping' then takes the form of institutionalisation or hospitalisation.



Figure 2: Corrigan's second illustration of how we may treat those with mental illnesses.

In this second figure, Corrigan is illustrating that we may perceive a mentally ill individual as dangerous, react with fear, and avoid them. These diagrams argue that a stigma surrounding mental illness still exists, as none of the diagrams contains an outcome in which both parties are equals. The mentally ill individual is either looked down upon, shunned, or resented. Corrigan's notion of personal responsibility entails a sense that we have a responsibility as individuals to familiarise ourselves with the terms used in mental health settings, so that we can more authentically understand the individuals experiencing what we call mental illness.

Corrigan's diagrams highlight Szasz's argument that psychiatry is not designed to help the individual, but rather to act as 'psychiatric enforcers' keeping individuals who behave abnormally hospitalised and away from the public. The argument that "coercion is in the best interest of the patient" diminishes the patient's autonomy and is unacceptable (Buchanan-Barker & Barker, 2009, p. 94). Szasz urges us to remedy our relationship to the mentally ill

[9] This "helping" behaviour is often not helpful to the individual themselves, but often serves to comfort those around them (i.e., make the individual less "unsettling").

when he states that "we the people have supported the construction of the myth of mental illness; and we the people continue to invest psychiatry with the power necessary to maintain its overarching authority over our lives" (Buchanan-Barker & Barker, 2009, p. 94). As in philosophy, we should strive to achieve as much knowledge as possible before claiming to understand a phenomenon. Fear of the unknown is a powerful force, but it is combatted by seeking to understand the things we fear, rather than by avoiding them.[10]

3.3 LACK OF CONSENSUS ON THE DEFINITION OF MENTAL ILLNESS

Cultural Discrepancies Regarding Mental Illness

Szasz also highlights cultural discrepancies that exist regarding the definition of mental illness. For example, there are vast discrepancies in view between Western, Eastern, and African medicine about what constitutes mental illness, which cannot be ignored if we seek to truly understand what mental illness is. Szasz offers the example of individuals who experiences hallucinations. Typically, in Western medicine, such individuals would be viewed as mentally ill (i.e., schizophrenic) and potentially be shunned by society on the basis of fear. However, in African medicine, such individuals might be seen as blessed and be revered in their community as *Sangomas* able to commune with the ancestors (Dammann, 1997, p. 734). Is it plausible to insist that one view is better than the other here? The attempt would be culturally insensitive, at least, but the point is deeper.

The idea of cultural discrepancies is vital to Szasz's argument—it helps clarify his positive claim that mental illness is not a medical but an external, social phenomenon. It could be argued

[10] This could be compared to Plato's Allegory of the Cave. While seeking the truth may be uncomfortable, it is the only way we can escape any illusions we may have.

that treatment methods differ across cultures for physical illnesses too (perhaps someone may seek out a homeopathic cure, for example) but individuals experiencing a physical illness will undoubtedly seek out *some* form of treatment. Physical illness is treated cross-culturally, albeit it by different means, what we understand as mental illness is not.

The importance of highlighting these cultural differences had been acknowledged in the DSM-IV (1994) by emphasising how "the manual is used in culturally diverse populations in the United States and internationally" (Bredstrom, 2019, p. 351). But despite the DSM-IV and DSM-V's efforts to be more culturally inclusive there are still many cross-cultural issues with regards to mental illness which need to be addressed (Bredstrom, 2019, p. 351). The field of cultural psychiatry arose precisely in an attempt to "merge anthropological methods and conceptualisations with traditional psychiatric and psychological approaches" (Bredstrom, 2019, p. 351). Its research presents psychiatric diagnosis with a real challenge. Not only do symptoms vary greatly cross-culturally but, as we have seen, differences in culture also affect how mental illness is understood, explained, and treated (Bredstrom, 2019, p. 352).

Practical Implications of a Lack of Agreed Definition

According to Manwell et al., the current lack of consensus over the definition of mental illness has serious implications for research, policy, and practice (Manwell, et al., 2015, p. 1). This lack of consensus is a "major obstacle for integrating mental health initiatives into global health programmes and primary healthcare services" (Manwell, et al., 2015, p. 1).

One of the issues with the current definition of mental health is that it places too much emphasis on interpersonal harmony and the ability to cope with life's stresses as qualifying criteria for mental health. This is problematic both because not all human interaction is harmonious (or even, arguably, *normally* harmonious) and because there are numerous situations where

controlled conflict is healthy. Furthermore, no two individuals will respond to the same stress in the same manner, making it difficult to define a norm for 'appropriate' coping behaviours. I argue that this emphasis on being able to cope with stress also promotes the stigmatisation of mental illness, as it essentially labels individuals who respond in emotional ways as abnormal or ill.

Manwell and his co-authors emphasise that the practical use of any definition of health will "be dependent on the epistemological and moral framework through which it was developed" (Manwell, et al., 2015, p. 10). This makes finding a consensus on the best definition of mental illness challenging, as mental and social frames of understanding are influenced differently from conceptions relying on the physical domain (Manwell, et al., 2015, p. 10). A medically orientated definition grounded in biology "may be more applicable across diverse populations", whereas a definition of mental illness encompassing social and mental domains would be more variable in its application (Manwell, et al., 2015, p. 10).

The current lack of consensus remains one of psychiatry's greatest problems, as without a solid foundation, we cannot claim to understand a phenomenon such as mental illness sufficiently.

3.4 THE MISDEEDS OF PSYCHIATRY

The Inherent, Inherited Problem: Coercion

The field of psychiatry has faced criticism since its inception, with Szasz stating that psychiatry is "the theory and practice of coercion, rationalised as the diagnosis of mental illness and justified as medical treatment" (Szasz T. , 2009, p. xi). He adds that this practice is not aimed at helping the patient in any way, but rather at "protect[ing] the patient from themselves, and society from them" (Szasz T. , 2009, p. xi).

One of Szasz's main criticisms of psychiatry is the medicalisation of children. He asks why coercing a child into a "painful but [allegedly] necessary medical intervention" is seen as virtuous. The issue here is one predominantly of coercion, arguably analogous, Szasz suggests, to coercing a child into "submitting to a sexual act" (Szasz T. , 2009, p. 1). In both cases "coercion could be seen as virtuous or wicked, prescribed, permitted, or prohibited by religion, law, society, and the actor's own conscience" (Szasz T. , 2009, p. 1).

His point is that in psychiatry, the societally approved-of medical intervention is based off of judgements rather than facts. Consider the example above: we would agree that coercing a child into a sexual act is immoral. However, why do we as a society allow the administration of psychiatric medication to children? Given our incomplete understanding of mental illness, this is particularly problematic.

Continuing to administer psychiatric medications to children, or to adults for that matter, reflects, for Szasz, one of psychiatry's greatest misdeeds. In psychiatry's early days, where many individuals experiencing mental illness were hospitalised and treated medically, the impetus behind the treatment was one of control: not necessarily because the administration of drugs would be helpful to those 'patients', but rather in an effort to make these individuals less "disturbing to others" (Szasz T. S., 1962, p. 18). Early psychiatric practices were often more harmful than beneficial to the individuals concerned. Ron Leifer states that "the most heartfelt and vocal criticism of psychiatry consists of the cry of those who have been abused, harmed, coerced, and drugged by medical-coercive psychiatry" (Leifer, 2007, p. 3). He goes on to raise the many areas of concern within psychiatry, including "involuntary confinement, forced drugging, electroshock [therapy], and the inhumane milieu of psychiatric hospitals" (Leifer, 2007, p. 3).

Leifer took Szasz's place at a conference in Berlin for antipsychiatry activists and survivors of medical-coercive psychiatry. There he argued that medical-coercive psychiatry makes the error of defining human problems medically and serves as nothing more than a covert social control agent, confining individuals against their will and "forcing upon them unwanted drugs and other invasions" (Leifer, 2007, p. 3). He states that as long as we continue to see mental illness through a medical lens, we are encouraging this social control function through the vehicle of psychiatry. Under the guise of medicine, these methods may seem justified, but seen in a moral-social context, he argues, they are not (Leifer, 2007, p. 7).

The Continuing Problem of Ineffective Treatment: A Case Study

We can see support for Szasz's argument in more contemporary sources. In Gabor and Daniel Maté's book *The Myth of Normal*, we are presented with a case study of a college student who was diagnosed with depression, paranoia, and psychosis (Maté & Maté, 2022, p. 235). This student was treated medically with a number of psychiatric drugs, including amitriptyline (antidepressant) and thioridazine (antipsychotic).[11] The student stated that his treatment consisted of "being evaluated by up to forty psychiatrists (who) labelled him with multiple diagnoses", including "depression, bipolar disorder, complex PTSD, and others which he could not even recall" (Maté & Maté, 2022, p. 235).

This is very concerning. First, the student was evaluated by close to forty different psychiatrists during his treatment. Why were so many different medical professionals required to treat an

[11] These are serious measures: amitriptyline is a schedule-4 drug, and thioridazine is a schedule-3 drug.

illness? Secondly, the student was unable to get a consensus on his diagnosis. He received multiple diagnoses from different psychiatrists, which only added to his distress. Lastly, the student was given high-schedule antidepressants and antipsychotics without his psychiatrists agreeing on what he needed. Is it viable to consider this an effective method of diagnosis and treatment?

Maté and Maté go on to state what Szasz has said before: this student's treatment was guided by "the same assumption that dominates medical thinking: such torments are caused by biological diseases of the brain" (Maté & Maté, 2022, p. 235). The student in the case study went on to admit that during his treatment he felt "increasingly lost, irritable, isolated, and despondent" (Maté & Maté, 2022, p. 236). His experience supports Szasz's view that it is ineffective to treat a social phenomenon by medical means. Instead of his condition getting better, it worsened.

Dr. Nabil Kotobi reportedly "changed that student's life" with only a few words. Dr. Kotobi told the student "I do not want you to call what you have a mental illness. You have been injured" (Maté & Maté, 2022, p. 236). Dr. Kotobi's words echo Szasz's sentiments. Mental illness is not some sort of "mysterious medical phenomenon". Mental illness comes from "somewhere very specific", somewhere external, which is often ignored in traditional psychiatry. According to the student in the case study, none of his forty psychiatrists ever asked about any potentially traumatic childhood experiences. Dr. Kotobi was the first of forty 'professionals' to do so, thereby uncovering the impact of the student's childhood environment as an explanation for his current behaviour (Maté & Maté, 2022, p. 236).

After bringing to light years of abuse at the hands of the student's mother, things began to turn around. This shows not only that Szasz's argument has merit, but also that recent studies are still presenting his ideas. Furthermore, the case study highlights that ineffective treatment

methods do more harm than good, and that traditional psychiatry has, in Szasz's words, "outlived whatever usefulness it might have had and now functions merely as a convenient myth" (Szasz T. , 1960, p. 113).

3.5 PSYCHOLOGY AS THE APPROPRIATE DISCIPLINE OF TREATMENT

This evidence for Szasz's view has the potential to make many uncomfortable. Maté and Maté state that "little in the training of doctors prepares them to wonder about their patients' lived experiences, much less to seek the sources of their malaises therein" (Maté & Maté, 2022, p. 238). This is true, as medical doctors train to treat physical illnesses by purely medical means. It is for this reason that Szasz, amongst others, advocate for a psychosocial approach when treating 'mental illness'. The psychologist, not psychiatrist, is trained to treat social problems, and possesses the knowledge and means to examine and treat patients accordingly, without the use of drugs.

Why does the psychiatric approach continue to be promoted then? Is it denial of the social dimension of these problems on the part of psychiatrists, or something more sinister such as laziness or convenience that drives them to pursue medical methods for 'mentally ill' patients? Perhaps the social control function of psychiatry is too alluring and convenient, with those supporting it being unwilling to acknowledge its faults. Perhaps the psychological process is seen as too difficult. According to Maté and Maté, it is often easier for the psychiatrists and for the patient to avoid looking too deeply into their lives. Neither party wants to think about getting involved in recovery, changing their way of life, or revisiting traumatic past events (Maté & Maté, 2022, p. 238).

I believe that psychology ought to take the place of traditional psychiatry. Mental illness is, as Szasz argues, a 'construct', which Maté and Maté define as "a particular frame we have developed to understand a phenomenon and explain what we observe" (Maté & Maté, 2022, p. 239). What is important to remember regarding the conception of mental illness as a medical phenomenon is that this view may be valid in some respects but is not in others. It is a view, a frame of understanding. However, it is never objective (Maté & Maté, 2022, p. 239). The danger is that it pretends to be, and that we do not question such claims. Maté and Maté caution that if left unchecked, this may become an "all-encompassing lens through which we perceive and interpret" (Maté & Maté, 2022, p. 239).

3.6 CONTEMPORARY SUPPORT FROM PSYCHIATRISTS AND PSYCHOLOGISTS

Bruce Perry on the Ethical Use of the DSM

It is not only the accusation of mistreatment by patients such as the student discussed above that is important here. The number of former mental health professionals or psychiatrists who have adopted Szasz's anti-psychiatric stance is also an important factor to consider. Author, psychiatrist, and leading trauma researcher, Dr. Bruce Perry, has come forth stating that "even playing the DSM game is completely wrong" before refusing to contribute to the manual's revisions (Maté & Maté, 2022, p. 244).

Dr. Perry believes that "in twenty-five years they are going to look back and won't believe that we thought about people that way" This, coming from a psychiatrist, is not to be taken lightly, and it is just one of many dissenting voices from within the profession.

Robert Whitaker on Chemical Imbalances

Journalist and author, Robert Whitaker had always been a firm believer in the traditional psychiatric belief that mental illness is the result of a brain imbalance. That is, until he was reporting for the Boston Globe, and asked a question regarding the source of the claim that depression is caused by serotonin imbalance, as is commonly believed, or that schizophrenia is due to a dopamine imbalance. When met with the response of (verbatim): "Well, we didn't really find that. It's a metaphor", Whitaker became disillusioned with traditional psychiatry (Maté & Maté, 2022, p. 241).

This confession from a disillusioned psychiatrist highlights that Szasz's argument has credibility. We have sufficient evidence to show that psychosocial approaches (i.e., psychology and counselling) prove to be significantly more effective against 'mental illnesses' than traditional psychiatry. Patients, as well as psychiatrists themselves, have seen the impact of a psychosocial approach to treatment: it is effective, it treats the cause and not the symptom, and it eliminates the prescription of brain-altering substances when treating social phenomena.

Lucy Johnstone on Confused Diagnoses

Lucy Johnstone, previously mentioned, highlights that there are no conclusive tests to confirm or deny the existence of a mental illness as there are with physical illnesses. She gives the example of an individual diagnosed with bipolar disorder, and echoes Bruce Thyer in pointing out the circular reasoning underpinning such diagnoses: "'Why does this person have mood swings?' 'Because they are bipolar.' 'Why are they bipolar?' 'Because they have mood swings'" (Maté & Maté, 2022, pp. 241-242). This method of diagnosis cannot be compared to the complex and well researched diagnostic procedures developed for physical illnesses.

Furthermore, we must examine the frequency and readiness with which psychiatrists prescribe high-schedule drugs to adults and children.

Johnstone emphasises that a new approach is needed. She states that traditional psychiatry lacks reliability and validity, excludes social contexts, and causes stigma (Johnstone, 2018, p. 30). She adds that the unwillingness for change from within psychiatry comes from the fact that "[medical] diagnosis is the Holy Grail of psychiatry and the key to its legitimation" (Johnstone, 2018, p. 30). She supports Szasz's line of reasoning that the imprecision inherent in psychiatric diagnoses shows that it is not truly a medical discipline, and adds that "a consistent theme of leading members of the survivor movement—people who have left psychiatry and now campaign for change—is abandoning diagnosis in order to take back authorship of their own stories" (Johnstone, 2018, p. 31).

Because of their ungroundedness and reliance on value judgements, Johnstone agrees with Szasz that psychiatry's allegedly medical diagnoses should be abandoned with regards to 'mental health', in favour of a "non-medical discourse that is primarily concerned with understanding people's distress within their life contexts" (Johnstone, 2018, p. 42), bringing us closer to reality.

3.7 SYNOPSIS

In summary, by agreeing with Szasz's views, I share the sentiment that the way we currently understand, define, and treat mental illness constitutes a category error, with dire implications. I agree with Radden that by medicalising normal human emotional states, we are granting psychiatrists powers that no healthcare provider should reasonably have. I believe that instead of treating mental illness, or rather, problems in living, medically, we should move from

traditional psychiatry to social treatment methods as outlined by Szasz, such as counselling, psychotherapy, socio-political change, or life-coaching, and I believe that psychiatry's history of resisting this reorientation has caused a great deal of harm. To conclude, I turn now to some criticisms of Szasz's position, arising in defence of the legitimacy of psychiatry, and consider how to meet them.

SECTION FOUR: SZASZ'S CRITICS AND DEFENCES AGAINST THEM

We have now established that according to Szasz's view, in order for something to be classed as a disease or illness, the thing in question must show some sort of "physical or anatomical lesions" or display a "deviation from the set norm of physical health". However, theorists such as Robert Kendell and Tony Benning, for example, argue that Szasz's concept of disease places too much emphasis on Virchow's notion of 'cellular pathology' as the criterion for illness or disease, which, according to them, may limit his overall argument (Benning, 2016, p. 293).

4.1 KENDELL: CONCEPTUAL NARROWNESS

'Lesions' an Outdated Concept

Rudolf Virchow stated that "cells are the ultimate active elements of the living body", meaning that cells are the base of all living things (Virchow, 1863, p. 27). He also saw the medicine of his time as marked solely by anatomical innovations regarding the structure of the body (Virchow, 1863, p. 27). Pathology then was conceived of as occurring at a cellular level. This view fits in with Szasz's idea of "physical or anatomical lesions" being the classifying factor for illnesses or diseases. But the view limits illnesses to the physical body, and if we accept the idea that the mind and brain are separate there can be no physical or anatomical lesions on the mind (except in a metaphorical sense).

The widespread evidence of illness being "accompanied by structural damage to the body, either at a gross or microscopic level" (i.e. accompanied by lesions) quickly led to the assumption that it was these lesions that constituted the illness, as well as that an illness always involves structural damage to the body (Kendell R. E., 1975, p. 4). However, one of Szasz's

most prominent critics, Robert Kendell, argues that by being predicated on this view the foundations of Szasz's argument are too narrow, and must thus be flawed or insufficient (Kendell R. , 2004, p. 31). He points out that as society's knowledge of biochemistry and physiology grew, the concept of 'lesions' had been updated to "include biochemical and physiological abnormalities without relinquishing the assumption that illness involves a demonstrable physical abnormality" (Kendell R. E., 1975, p. 4) There are many physical illnesses, Kendell argues, that are devoid of 'physical lesions'. For example, Down's Syndrome affects the chromosomes, but we are unable to see any lesions on the physical body (Kendell R. , 2004, p. 307).

But we should consider that although the term 'lesions' may lead us to assume that this is a question of observing actual lesions on the body, Szasz's use of the term was suggestive only of the search for a bodily cause, however it should manifest. He is not denying that the affected chromosomes in an individual with Down's Syndrome aren't an indication of illness, even if we cannot observe them without aid. Szasz's point is that any medical illness will exhibit some sort of 'lesion' or deviation from the norm of bodily health. With the aid of medical equipment and tests, we can see structural abnormalities in the body in cases of illness, such as affected chromosomes in an individual with Down's Syndrome, cancerous cells, tumours etc. Thus, even if this 'lesion' or 'deviation from the norm of health' is not visible to the naked eye, it does not mean that no visible evidence of a disease or disorder is present—the abnormality exists regardless of whether or not it has been seen.

Norms Need Not Be Unanimous

Kendell further suggests that we do not need an unambiguous norm to identify illness. He contends that the concept of disease is almost never unanimously agreed upon, even in the

medical field. This is because the definition of disease changes from generation to generation due to developments in medical technology as well as "assumptions about the nature of disease" (Kendell R. , 2004, p. 31). He states that usually the concept of disease serves as an explanatory concept for "suffering, incapacity, premature death, and obvious injury; with suffering and incapacity still being the main criteria" (Kendell R. , 2004, pp. 31-32). It is from these criteria that we diagnose illness, and these criteria exist in the case of mental illness.

It is true that suffering, incapacity, and death can be present in the case of mental illnesses. In Szasz's defence however, I must argue that in cases of death as a result of mental illness, the cause is rarely the "illness" itself, but rather the feelings of hopelessness, desperation, and shame due to the overly negative stigma surrounding mental illness (as well as the lack of effective treatment) that lead there. It is plausible to think that the suicide rate amongst individuals diagnosed as mentally ill would decrease significantly if the stigma surrounding their diagnoses were lessened, or ideally eliminated completely. Suffering and incapacity, I have argued, are normal parts of life and our reactions to its problems; Szasz would not accept these as "the main criteria" for diseases.

4.2 BENNING: NO CATEGORY ERROR

No Consensus on the Definition of 'Illness'

Tony Benning argues that Kendell's critiques could suggest that no category error is being made in the definition of mental health (Benning, 2016, p. 293). It is harder to come up with a sufficient definition of mental illness, he claims, than of physical illness because we as a society do not yet fully understand all the intricacies of our minds; and if the definition of physical illness is still evolving, obtaining a sufficient definition of an even more misunderstood

phenomenon seems unrealistic. Without a clear conception of illness, the claim that a category mistake is being made in relation to mental illness then seems problematic.

However, I believe that it is possible and necessary to adequately define both physical and mental illness. Illness in the physical sense can be defined as "a reasonably serious disease with incapacitating effects that makes it undesirable". This can be expanded on by adding that "illness requires treatment. It is a medical condition in terms of impairment, defect, or disability, and requires medical treatment" (Azmat & Razum, 2014, p. 29). If we are to accept Szasz's view that mental illness and physical illness are distinct phenomena, we can argue that just because the definition of physical illness is still evolving does not mean that we should abandon the idea of defining mental illness in a completely separate field and context.

Mental Illness Displays Deviation from Set Norms

Benning goes on to argue that Szasz is failing to acknowledge serious mental illnesses (i.e. schizophrenia) as a "devastating malfunction" with a clear deviation from normal behaviour (Benning, 2016, p. 294). Insisting that problems with thought, impulse control, drive, perception, cognition, and behaviour should be "exempt from the rubric of illness" is, he says, unjustified (Benning, 2016, p. 294). He states therefore that Szasz's rejection of the illness label is unwarranted, and that no category error is being made. (Although he acknowledges that the terminology of 'lesions' and 'cellular pathology' have little to do with psychiatry, Benning argues that mental illness still displays a clear deviation from a norm. Clinicians, he proposes, should "conceptualise mental illness in different ways from physical illness" rather than discarding the concept altogether (Benning, 2016, p. 294).)

There is an important distinction I must address: although Szasz argued that all mental illnesses were essentially myths, an alternative view may be that there are two categories of 'mental

illnesses': what we commonly call 'mental illness' (depression, anxiety) and what we could call 'serious mental illness' (schizophrenia). The 'mental illnesses' addressed in this report do not refer to extreme cases such as schizophrenia. Even Szasz acknowledges that in severe cases there are signs of brain abnormalities or deviations from the norm of physical health, and I would argue that these often *do* require medical intervention. Schizophrenia is "associated with structural and functional changes in the cortex and in the connections between cortical regions" (Karlsgodt, Sun, & Cannon, 2010, p. 1). The fact that an MRI scan—a medical test—can detect schizophrenia means that it can be seen as a medical problem requiring medical intervention. Furthermore, the clear deviation from the norm of brain functioning and health (reduced grey matter volume and disrupted white matter integrity) supports the idea that schizophrenia is a medical problem.

Beyond this though, Benning seems in his criticism to be trying to draw out a deviation from a norm other than that of bodily health in the case of schizophrenia, which is a separate issue. Szasz suggests that the term 'mental illness' is "widely used to describe something which is very different than a disease of the brain" by our society (Szasz T. , 1960, p. 114), and the term involves a value judgement. I have argued that different cultural interpretations of behaviour make it clear that what is normal (and whether an abnormality is considered a blessing or curse) depends on a (non-factual) judgement in those cases.

4.3 DISCOUNTING SUFFERING

Szasz has also been criticised for undermining the suffering experienced by the mentally ill, as critics claim that by denying the existence of mental illness, he is also denying the suffering of those experiencing it. Dr Henry Nasrallah was critical of Szasz when Szasz spoke at the University of Rochester and declared schizophrenia a myth. Dr Nasrallah "recalled

shuddering" at this statement, as he had "admitted three patients with severe, disabling psychosis earlier that day" (Nasrallah, 2011, p. 53).

Nasrallah also highlights Franco Basaglia's efforts in Italy to reform psychiatry (efforts Szasz would presumably have approved of). Basaglia was "outraged with the dilapidated and prison-like conditions of mental institutions that he convinced Italian Parliament to close all mental hospitals in Italy in 1978" (Nasrallah, 2011, p. 53). Instead of alleviating the patients' suffering, many of them ended up in prisons due to uncontrolled psychosis or mania. The conditions in these prisons were similar to or worse than those in the former mental hospitals and the prisons were poorly equipped to handle such cases. In extreme cases, patients died due to self-neglect or victimisation (Nasrallah, 2011, p. 53). All this example really shows though is that without intervention and proper treatment, individuals will suffer and be unable to live normal lives.

Szasz has answered the claim that he ignores suffering by stating explicitly that he does not deny that these individuals suffer in one way or another. But this is a change of subject: Szasz is not against treatment—his argument is one encouraging *effective* treatment. His concern is that placing mental illness in the same category as physical illness constitutes a category error, and that incorrect classification has severe consequences for those affected, such as stigmatisation and incorrect treatment of the actual situation they suffer from (Szasz T. S., 1962).

4.4 DUTY TO THE FIELD OF PSYCHIATRY

Many theorists criticise Szasz for adopting an 'anti-psychiatric' view whilst being a practicing psychiatrist himself (Kendell R. , 2004, p. xiv). Szasz, indeed, has stated that he first decided to study psychiatry not to practice it but to "expose the many issues within the psychiatric field"

(Szasz T. , 2004, p. 18). This admission shows that he had no intentions of supporting the discipline at all, but rather purely of gaining an understanding of it.

Szasz always rejected the 'anti-psychiatry' label and preferred the term 'anti-coercion'.[12] What he meant by this was that he did not support the involuntary treatment, nor the medicalisation of, mental 'illnesses'. He explained that instead of claiming to be a medical professional he assumed the role of a counsellor (a traditional psychotherapist), seeing and treating mental illness as a social phenomenon.

In short, Szasz was not against the treatment of what we currently call 'mental illnesses', nor denying the fact that the problems we label as such exist. In fact, he strongly advocated for a more effective way of treating mental illnesses. He argued that "the only legitimate professional response to states of madness and distress is autonomous psychotherapy" (Bracken & Thomas, 2010, p. 221). This, he explained, is a non-medical process, emphasising that it serves as "a special type of dialogue that has nothing to do with doctors" (Bracken & Thomas, 2010, p. 221).

As stated previously, one cannot possibly hope to treat a social phenomenon by medical means (just as one couldn't cure pneumonia with counselling). This is why Szasz's clarification of his 'anti-psychiatric' position is so important. He is not denying that problems in living exist, but merely suggesting that current methods of treatment are flawed and ineffective. If he had some duty to the field of psychiatry, it would presumably be to help those suffering from mental illnesses, which he strove to do as effectively as possible, i.e. by non-psychiatric means.

[12] This label also reiterates Szasz's concerns regarding autonomy.

CONCLUSION

In this report, I have explained Thomas Szasz's claim that mental illness is a myth or category error and defended his chosen term 'problems in living'. I have examined, and argued against, some of the criticisms of his view. Whilst I do believe that the manner in which we have been treating those seen as mentally ill is abhorrent, I also believe that it is never too late to change these ways for the better.

I support Szasz's idea of mental illnesses—of, much more informatively, 'problems in living'—being social, not medical, phenomena. I agree with Szasz that traditional psychiatry is not the way forward and that it has done more harm than good over the years it has been allowed to dominate mental health care. I believe that psychology or counselling can help not only the individual experiencing problems in living, but also serve as a means to better understand that human emotions, even when pronounced or enduring, are not 'wrong' or 'abnormal' but rather a part of life. There should be no shame, or stigma attached to seeking help from a psychologist when an individual requires support. People should feel comfortable communicating with their close circles (families, communities etc) rather than hiding in fear of judgement or involuntary treatment. This is most likely to be possible when problems in living are not seen as pathologies.

We are social and emotional beings, and our emotions range from the high to the low. Such normal fluctuations at different life stages and during intense moments should not be medicated away, but rather examined from a social perspective, and treated accordingly with counselling or another form of social aid provided if necessary. If we were to take pathology out of mental health care, I believe that society would benefit greatly, as more effective treatments based on more accurate conceptions of the problems being faced would yield better results. I echo the sentiments of Szasz and his supporters that we cannot, and should not attempt to, treat a social

problem medically, nor should we readily medicate children, adolescents, or adults deemed difficult to deal with into compliance. Doing so is not only archaic, but barbaric, and shows that psychiatry serves a social control function rather than a therapeutic one. Psychiatrists hold too much power under our current conception, and I have argued that this must change.

It is only when we achieve a greater understanding of something that we can begin to ponder how to tackle it. Problems in living are no different. Our current understanding of these problems is flawed, our treatments are ineffective and require new foundations. We should not be satisfied with convenient lies, and if the task to reform is arduous, we nonetheless have a moral duty to pursue it if what I have argued in this paper is true.

In conclusion, I believe that Szasz's anti-psychiatry movement warrants further study across the social sciences as well as in medicine and law. Szasz's original claim is still being examined by authors and researchers today, and ever more psychiatrists are becoming disillusioned with the field. For all of these reasons, I believe that Szasz's view is correct, and that it represents the best way for us to eliminate the ineffective treatment methods and harmful stigmas surrounding problems in living that we face today.

REFERENCES

Aftab, A. (2014). Mental Illness vs Brain Disorders: From Szasz to DSM-5. *Psychiatric Times, 31*(2), 1-5.

APA, A. P. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* Washington: American Psychiatric Association.

Azmat, J., & Razum, O. (2014). Health, Disease, and Illness as Conceptual Tools. *Medical Sociology in Africa*, 21-37.

Bamijoko-Okungbaye, A. (2022). Mental Disorder as an Illness: Szasz Revisited. *Logos Universality Mentality Education Novelty, 11*(2), 45-58.

Benning, T. B. (2016). No such thing as mental illness? Critical reflections on the major ideas and legacy of Thomas Szasz. *BJPsych Bulletin, 40*, 292-295.

Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the Role of Critical Psychiatry. *Philosophy, Psychiatry, & Psychology, 17*(3), 219-228.

Bredstrom, A. (2019). Culture and Context in Mental Health Diagnosing: Scrutinising the DSM-5 Revision. *Journal of Medical Humanities, 40*(3), 347-363.

Breeding, J. (2014). Practicing Szasz: a psychologist reports on Thomas Szasz's influence on his work. *Sage Open, 4*(4), no page(s).

Buchanan-Barker, P., & Barker, P. (2009). The Convenient Myth of Thomas Szasz. *Journal of Psychiatric and Mental Health Nursing, 16*, 87-95.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., . . . Kubiak, M. A. (2017). Challenging Two Mental Illness Stigmas: Personal Responsibility and Dangerousness. *Practice Innovations*, 293-309.

Crossley, N. (1998). R.D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis. *Social Science Medicine, 47*(7), 877-889.

Dammann, E. J. (1997). "The Myth of Mental Illness": Continuing Controversies and their Implications for Mental Health Professionals. *Clinical Psychology Review, 17*(7), 733-756.

Domaradzki, J. (2021). Thomas Szasz: The uncompromising rebel and critic of psychiatry. *Psychiatr Pol, 55*(4), 851-867.

Graham, P. J. (1992). Types of Psychiatric Treatment: Overview. *Archives of Disease in Childhood, 67*(2), 237-239.

Hansen, H. (2023). Fallacies. *The Stanford Encyclopedia of Philosophy*, no page.

Hoglund, P., Levander, S., Anckarstater, H., & Radovic, S. (2009). Accountability and Psychiatric Disorders: How do Forensic Psychiatric Professionals Think? *International Journal of Law and Psychiatry, 32*(6), 355-361.

Jablensky, A. (2016). Psychiatric Classifications: Validity and Utility. *World Psychiatry, 15*(1), 26-31.

Johnstone, L. (2018). Psychological Formulation as an Alternative to Psychiatric Diagnosis. *Journal of Humanistic Psychology, 58*(1), 30-46.

Karlsgodt, K., Sun, D., & Cannon, T. (2010). Structural and Functional Brain Abnormalities in Schizophrenia. *Current Directions in Psychological Science, 19*(4), 1-9.

Kelly, B. D., Bracken, P., Cavendish, H., Crumlish, N., MacSuibhine, S., Szasz, T., & Thornton, T. (2010). The Myth of Mental Illness: 50 Years After Publication: What does it mean today? *The Irish Journal of Psychological Medicine, 27*(1), 35-43.

Kendell, R. (2004). *Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics.* Illinois: Open Court Publishing.

Kendell, R. E. (1975). *The Concept of Disease and its Implications for Psychiatry.* Edingburgh: University of Edinburgh.

Krendl, A. C., & Pescosolido, B. A. (2020). Countries and Cultural Differences in the Stigma of Mental Illness: The East and West Divide. *Journal of Cross-Cultural Psychology, 51*(2), 149-167.

Lacombe, D. (1996). Reforming Foucault: A Critique of the Social Control Thesis. *British Journal of Sociology*, 331-352.

Leifer, R. (2007). *Critique of Medical-Coercive Psychiatry.*

Magidor, O. (2022). Category Mistakes. *The Stanford Encyclopedia of Philosophy*.

Malik, L. (2018). Category Mistakes: A Definition and Consideration of Their Meaningfulness. *Philosophia: OSAKA, 13*, 1-19.

Malla, A., Joober, R., & Garcia, A. (2015). Mental illness is like any other medical illness: a critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry and Neuroscience, 40*(3), 147-150.

Manwell, L. A., Barbic, S., Roberts, K., Durisko, Z., Lee, C., Ware, E., & McKenzie, K. (2015). What is Mental Health? Evidence Towards a New Definition from a Mixed Methods Multidisciplinary International Survey. *BMJ Open, 5*(6), 1-11.

Maté, G., & Maté, D. (2022). *The Myth of Normal.* London: Penguin Random House UK.

Nasrallah, H. (2011). The Antipsychiatry Movement: Who and Why? *Current Psychiatry*, 4-53.

Oliver, J. (2006). The Myth of Thomas Szasz. *The New Atlantis, 13*, 68-84.

Oyebode, F. (2023). Is Psychiatry Working? *Journal of Global Medicine*, 1-4.

Radden, J. (2019). Mental Disorder (Illness). *The Stanford Encyclopedia of Philosophy*.

Schmidt, C. W. (2007). Environmental Connections: A Deeper Look Into Mental Illness. *Environmental Connections*, 1-7.

Szasz, T. (1960). The Myth of Mental Illness. *American Psychologist, 15*, 113-118.

Szasz, T. (1998). What Counts as Disease? Rationales and Rationalizations for Treatment. *Complementary Medicine Research*, 40-46.

Szasz, T. (2003). *Pharmacy: Medicine and Politics in America.* Syracuse: Syracuse University Press.

Szasz, T. (2004). *An Autobiographical Sketch. Szasz Under Fire: The Psychiatric Abolitionist Faces His Critics.* Chicago: Chicago Open House.

Szasz, T. (2005). Idiots, Infants, and the Insane: Mental Illness and Legal . *Journal of Medical Ethics, 31*(2), 78-81.

Szasz, T. (2009). *Coercion as Cure: A Critical History of Psychiatry.* Transaction Publishers.

Szasz, T. (2011). The Myth of Mental Illness: 50 years later. *The Psychiatrist, 35*(5), 179-182.

Szasz, T. (2013). The Myth of Mental Illness. *Perspectives in Abnormal Behaviour*, 4-11.

Szasz, T. S. (1962). *The Myth of Mental Illness: Foundations of a theory of Personal Conduct.* Canada: Harper & Row.

Thyer, B. A. (2015). The DSM-5 Definition of Mental Disorder: Critique and Alternatives. *Critical Thinking in Clinical Assessment and Diagnosis*, 45-68.

Truong, A., Maguire, G., & Maguire, G. (2020). A history of psychiatry in the United States of America. *Taiwanese Journal of Psychiatry*, 59-66.

Virchow, R. (1863). *Cellular Pathology as Based Upon Physiological and Pathological Histology.* Ohio: J.B Lippincott.

Weihofen, H. (1960). The Definition of Mental Illness. *Ohio State Law Journal, 21*(1), 1-16.

Wykes, T., & Callard, F. (2010). Diagnosis, diagnosis, diagnosis: towards DSM-5. *Journal of Mental Health, 19*(4), 301-304.