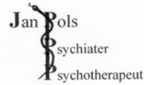

The Politics of Mental Illness:

Myth and Power in the Work of Thomas S. Szasz

by
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VAN THOMAS S. SZASZ
1984

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...A Word about this English Translation

It has been over twenty years since I undertook analysing and commenting on the writings of Thomas S. Szasz. In those days, there was a strong critical movement within and outside of psychiatry, in which Szasz played a prominent role. His attack on the concept of mental illness as designating a medical disorder, and his objection to the many forms of coercion prevalent in psychiatry at that time and still today, attracted the attention of a broad audience. His books became popular and widely read.

The result of my efforts was my thesis, an English translation of which forms the main body of this volume.

Antipsychiatry's heyday has receded into the past. Psychiatry chose to go down the road of science by way of empirical research, pushing issues of principle and scientific philosophy into the background. In fact, the dilemmas around which antipsychiatry rallied have not disappeared from the headlines due to having been satisfactorily resolved, but because attention has swung to other areas, and because society has increasingly accepted coercion as the solution for a plethora of social problems. One consequence is that since the 1994 inauguration of new commitment laws in the Netherlands, which were intended to better protect the position of involuntary psychiatric patients, there has been more than a 300% increase in involuntary commitments. This illustrates how much these issues warrant renewed discussion today.

My thesis about Thomas Szasz' work is as relevant now as it was in 1984 when it was originally published. His viewpoints, politics, and philosophies were already established by then and have not changed. On the contrary, over and over again since then as before he has responded to current events and developments by illuminating how his viewpoints and convictions apply to them. No fundamental or unexpected twists have surfaced in his prolific writings. His most important assertions, as elucidated in his many books and articles, have remained remarkably unchanged. Most of his books are still in print, and he continues to publish new books regularly.

Two chapters have been added to my original thesis: a preface in which I clarify the background to my own viewpoints; and an epilogue in which I describe the developments in the politics of mental illness since my 1984 publication. Hopefully this will contribute to reopening the debate.

November, 2005

▪▪Preface

Only at first glance is psychiatry an “ordinary” branch of medicine. Upon closer examination, we find that psychiatry is involved in various processes that shape the face of society:

- arranging it in a certain order;
- influencing its views on normality and abnormality, and on good and evil;
- setting values and determining reactions to violations of those values.

Psychiatry is not about mainstream society, normality, or political correctness. It is about the other side of society.

Every society maintains explicit and implicit ideals of the model citizen. Every society has its processes of exclusion and marginalization. Every society has its drop-outs, deviants, and outcasts. Who those will be is at least partially determined by social processes. In industrialized societies, the task of classifying and isolating individuals who do not meet social expectations falls to judges and psychiatrists. Precisely psychiatry exposes the shadow side of maintaining public order.

In our society, the psychiatric expert is the final arbiter in “identifying” someone as psychiatrically disordered. Therefore psychiatry warrants the interest of outsiders as well as insiders. Not only should the identification and definition (diagnosing) of society’s rejects command attention, but also and in particular how these people are subsequently treated. Yet there seems to be little of such concern. Perhaps the entire issue does not evoke interest as long as the institutions designated to deal with it do the job expected of them. Outsiders’ involvement is generally limited to stigmatizing the so-identified people.

Another reason for the apparent disinterest in psychiatry may be that it doubles as a professional-technical, applied, empirical science. This impedes outsiders from meaningful participation in psychiatric matters. Those outside parties who *are* interested tend to step aside and rule themselves unqualified regarding what is considered the professional domain of psychiatry. Such a position holds that legally, the only experts are the psychiatrists.

From time to time certain psychiatry-related issues rise to the headlines, for instance after a violent crime has been committed by a psychiatric patient. This sparks off an impassioned but temporary debate on psychiatry in the media. The public’s usual response is to demand closer supervision of psychiatric patients. But aside from such incidental discussions, interest in the processes psychiatry employs for handling the job assigned to it by society is scant.

This book solicits attention to precisely these processes by clarifying the dilemmas they pose and the daily realities of psychiatric practice. Two aspects in particular are discussed. The first is the question: What exactly are psychiatric disorders? How can they be defined? What are their parameters? The second aspect involves the actual functioning of these definitions in practice when treatment methods are applied, whether voluntarily or not; their influence on the exercise of power; the role of various conflicts of interest; and the fulfillment of the social role of psychiatry.

These are issues to which Szasz has addressed his almost entire professional life. My interest in his work was aroused by my own experiences as a physician in psychiatric institutions and as a psychiatrist. I will elaborate on these experiences first and afterwards turn to the reasons for writing this book as a commentary on Szasz's works.

...My Experiences in Psychiatry

....The first experience

I was channeled into psychiatry in 1961, early in my medical career, more or less by coincidence. It was not my own choice. As a conscientious objector, I was conscripted to work as a physician in an institution for the criminally insane in lieu of military service.

There was practically no treatment in the institution. It rather resembled a labor camp, with various different types of labor, such as landscaping, farming, metalworking, welding, and carpentry. The inmates, who were called patients, slept in cage beds made of mesh wiring. The atmosphere was grim. There was a great deal of inmate hostility. Many spent vast amounts of time in solitary confinement. After a certain period, depending in length on the seriousness of the committed crime, the institution would file a recommendation for conditional release at the Ministry of Justice.

The director of this particular institution was a woman, most unusual in those days, whereas almost all the other staff members and all the patients were men. She ruled with an iron hand, but occasionally and unexpectedly would grant privileges to a certain patient. This turned her into a distant goddess who performed miracles seemingly by whim or at random. To the staff she was a fickle, unpredictable woman who used her near-absolute power to intimidate and belittle the men over whom she wielded her scepter. Every once in a while a professor would arrive from the capital city, Amsterdam, to dispense advice on treatment. He was willing to discuss such only with the director. Often he would single out certain patients for observation at his clinic, which for these people meant months of waiting, then six weeks of observation, and afterwards again months of waiting for the report. The report would routinely recommend psychotherapy, which I later understood to be futile, as such therapies as a rule failed. Sometimes it was decided that sexual offenders should undergo castration, which was performed after obtaining the consent of the patient. One can wonder just what the value of such consent was: the alternative was reconciling with indefinite detention without hope of returning to society.

In those days professor Pieter Baan* was experimenting in the city of Utrecht with the treatment of detainees ruled criminally insane. I don't know how successful he was, only that when the treatment failed, the detainees were sent to us. When treatment had not succeeded detention could not be terminated.

---

* Today's Ministry of Justice's observation clinic in Utrecht is named after him. – translator

Sometimes the detainees had been held for experimental treatment for over six years before being transferred to us.

In those days this type of detention was also applied to people who had committed less serious crimes, such as repeated theft of bicycles,* small-scale fraud, swindling, and exhibitionism. In other words, there was often no reasonable relationship between the severity of their crime and the duration of their detention.

Many of the patients were eccentric and difficult to fathom. They had sometimes committed the strangest acts, and related bizarre stories about themselves. They were reclusive, odd people who often behaved inappropriately or in ways that defied comprehension. At the same time they evoked fascination. They found themselves in a grim world where the wielding of power was the key to events. They, and the way they were treated, led to my specializing in psychiatry. This book is the fruition of my experience with them.

....The Second Experience

I spent the subsequent years, from 1963 to 1968, as a resident psychiatrist. My first year of training was at the admission ward of a psychiatric hospital. All sorts of patients were mixed together there: recently admitted patients, chronic patients, patients with Alzheimer’s disease, and psychotics. Patients’ rights were hardly an issue in those days. Medical paternalism was rife, meaning that patients were at the mercy of whatever plans the psychiatrist or head nurse happened to consider suitable for them. The psychiatrist made his rounds twice a week, pointing out candidates for electroshock (ECT). On the mornings of his rounds the tension felt like it could be cut with a knife. In those days ECT was performed without anesthesia or muscle relaxants. Patients were not asked for their consent, and when necessary, were dragged to the “treatment” room by several nurses. This could do not harm, they said, as ECT cause amnesia for the events leading up to it. As agitated and chaotic patients in particular were prescribed ECT, rumor had it that ECT was not a treatment but a – terrible and dreaded -- punishment. Fear of it did not fail.

Some of the patients had been in that ward involuntarily for years, the commitment being continued by means of legally obligatory “monthly notes.” These notes amounted to: “April: patient hallucinates; May: still hallucinates; June: seems somewhat improved; July: hallucinating again,” etc. The notes were sent to the court, on grounds of which involuntary commitment was continued for another year. There could not be a bigger contrast between the simplicity of this administrative action and the consequences of it. Involuntary commitment implied that these people spent years locked up, incompetent, and deprived of their human rights, without any clear reason.

Solitary confinement was frequent. All the patients were administered psychoactive drugs, of which in those days two kinds were available: chlorpromazine for the treatment of psychosis, and imipramine for the treatment of depression. There was time for talking with patients only in exceptional cases.

* In the Netherlands this is the most common petty crime. – translator

The psychiatrist used the framework of psychoanalytic interpretation only for determining diagnoses.

The ward was kept clean by the female patients. As a home, the ward was not wholly unpleasant, as many chronic patients were assigned chores which they performed with pleasure. For instance, there was an elderly man who kept a pheasant sanctuary; another patient fetched meals on a three-wheeler; and many ladies embroidered or knitted. Everyone participated in work therapy. Sometimes they made beautiful wooden objects or furniture, but most of the patients only assembled clothes pins or bicycle-wheel spokes. Attempts at deinstitutionalization as was the vogue in the US at that time generally failed. Precisely the chronic patients considered the ward their home and did not want to leave. At the same time they were much needed as their departure would have thoroughly disrupted the daily routine.

The head nurse who lived on the ward was instrumental in determining its atmosphere. Her impossible job was warding off the always imminent and sometimes exploding bouts of aggression while keeping the climate somewhat bearable.

I remember once hearing one of the patients saying to the psychiatrist, “It’s just like a concentration camp here,” – which was interpreted as an expression of paranoia. The other patients echoed this sentiment far too often for it to be dismissed as utterly implausible.

In summary, the psychiatric institution was paternalistic. Involuntary commitment and coercive measures were standard, and not seen as problematic. The therapeutic orientation was biological and somatic.

....The Third Experience

After that followed an experience of a totally different nature at the university clinic in the city of Groningen. This was an interesting and exciting period, marked first of all by growing skepticism towards somatic therapies such as insulin coma and carbon dioxide inhalation. I just barely experienced the last of such treatments. Psychoactive drugs formed the basis and support of every treatment. Treatment itself stretched across a variety of methods, the most important of which was psychotherapy, in particular psychoanalysis. In addition, there were non-verbal therapies such as creative therapy and psychomotor therapy. Social-psychiatric interventions were considered an approach in its own right, to be practiced by specially trained social workers under the guidance of a psychiatrist.

The clinic was open to new developments. Client-directed therapy was received enthusiastically after several of Carl Rogers’s staff had informed us about it. We welcomed behavior therapy, although not without some reservations. It was a period of optimism about what was possible in psychiatry and what would become possible in the future.

In this climate of optimism, inspiration, and innovation, the first books by authors who would later be associated with antipsychiatry began appearing on the market. Those authors comprised a rather heterogeneous group: Goffman and Szasz in the US, Laing and Cooper in Great Britain, Mannoni in France, and later also Basaglia in Italy. Thomas Szasz actually does not belong in this list,

although he is often included by others. It is more correct to consider him a critical psychiatrist.

The Netherlands had its own antipsychiatrist, in the personage of Jan Foudraine. In addition to psychoanalysis he promoted the therapeutic community, and acrimoniously criticized the view that psychiatric disorders have somatic causes like other diseases. In those days Professor Kees Trimbos also had a certain reputation of being a critical psychiatrist.* He maintained that many of the causes of psychiatric disorders should be sought in the social context in which the affected people lived. He was a devoted educator regarding sexual problems in the Roman Catholic population. Prevention was to him a highly underrated and promising area of psychiatry. Trimbos was inclined toward antipsychiatry but did not identify with it.

Objections to the practices in institutional psychiatry as well as alternative views on the “true” nature of psychiatric disorders were passionately argued, in particular by us residents. We expected much to change and improve in psychiatry.

In short, academic psychiatry was marked by integrated views on psychiatric disorders, a wide palette of treatments emphasizing social and psychological approaches, and hermeneutical influences. Coercion was much less in the foreground of the academic milieu, although it certainly was not absent.

....The Fourth Experience

After this training, in 1968, I chose employment as a psychiatrist in an environment where the emphasis was truly on psychiatry as a helping profession: offering assistance to people who voluntarily sought it, with as broad a variety of treatment options as possible. The idea was that voluntary treatment in an early as possible stage would help prevent demotivation and the necessity of involuntary commitment at a later stage. In this way, psychiatry would become a healing and emancipating medical specialty.

I chose a kind of employment that until then barely existed in those days: in an outpatient clinic affiliated with a mental hospital. The expectation was that such clinics would develop into centers for multidisciplinary outpatient treatment on a voluntary basis. We would provide pre- and post-hospitalizational care to persons who would therefore not have to be hospitalized or re-hospitalized. We would also offer our services to people who had never had any contact with psychiatry yet, and for whom no hospitalization was being considered. In addition to psychiatrists, the team of helping professionals would consist of clinical psychologists, nurses specialized in social psychiatry, psychotherapists, psychomotor therapists and creative therapists. The treatments were to include foremost all forms of psychotherapy: individual psychoanalytical psychotherapy; client-centered and behavior therapy; group therapy, marriage counseling, and

* The Netherlands Institute of Mental Health and Addiction is named after him. – translator

family counseling. Secondly we would provide psychoactive drugs, supportive guidance, socio-psychiatric intervention, and non-verbal forms of therapy.

It was agreed that coercive measures would not be possible at the outpatient clinic. In my view these new treatment centers were to not frighten off people who would otherwise fear being subjected to involuntary commitment. Also, after my first two experiences, I did not wish to risk being in a position that I would be required to write medical statements for the purpose of effecting an involuntary commitment.

"My" outpatient clinic grew rapidly. Particularly family physicians were very much interested in the courses we gave on conversing with patients, as well as in our adequate and speedy reporting on the patients they referred to us. This provided doctors with a solution for their more problematic patients.

In no time we were faced with the necessity of expanding the staff to be able to continue treating the increasing numbers of patients. This expansion was hindered by all sorts of administrative, bureaucratic, financial, and political objections. Waiting lists were instated. The goal we had in mind retreated farther away. For years this was a constant source of tensions. We never succeeded in responding adequately to the waxing stream of patients. To complicate matters, suspicion was cast onto outpatient clinics by other institutions who resented what they felt was competition.

In those days the field of ambulatory psychiatric services was dominated almost totally by two parties:

- The Social-Psychiatric Services which provided pre- and post hospitalizational care; medical statements to effectuate involuntary commitments; and home visits; but could not prescribe drugs, and
- Private psychiatrists who were often affiliated with a general hospital.

Both of these parties perceived the new outpatient clinics as competition and felt threatened by them, which is astonishing, as they themselves were also overwhelmed by the growing demand for their services which they could not meet. Some politicians accused psychiatric hospitals of using the outpatient clinics to recruit patients to fill their beds. These allegations were all the more surprising in view of the outpatient clinics' policy which was clearly and explicitly aimed at preventing hospitalization. Also, admittance wards at psychiatric hospitals were always full. There was no need to recruit patients.

So the ideal – offering humane, effective, and early psychiatric intervention on a voluntary basis – turned out to be only partly realizable. It also became clear that hospitalization could not always be avoided, although thanks to intensive and motivation-enhancing guidance involuntary commitment was almost never necessary.

....The Fifth Experience

Five years later, in 1974, I was appointed as a trainer of psychiatrists. It was a position to which I had aspired, mainly because I had found the supervision of residents who were being trained in psychiatry extraordinarily inspiring. Thereby I became somewhat distanced from the care for patients, and found more

opportunity to delve into the theoretical setting of psychiatry and its policies. In this position I could supplement my practical experience by studying the backgrounds, premises, and social-political aspects of the profession.

...Two Quandaries

Two quandaries hallmark psychiatry as an independent discipline, social institution, profession, and applied empirical science in practice. These quandaries are the subject of this book. They impart to psychiatry its structural ambiguity.

The first quandary regards the extent of the psychiatric realm that must be considered relevant. Psychiatric disorders manifest themselves in behavior and feeling. History has seen the pendulum swing from an extremely narrow view on the realm of psychiatric disorders to an extremely broad one. In the narrow view psychiatric disorders require the presence of biological determinants. It is assumed that their causes and processes will eventually be unmasked by the neurosciences. The broad view holds that although biological deviation is a factor in psychiatric disorders, all sorts of psychological, social, interactional, and cultural conditions and conflicts affect them as well, independently from the biological factors. A person's development and experiences are also considered relevant. These two views alternate from time to time, but also exist alongside each other.

This quandary is echoed in daily practice in such practical questions as, "Does the massive flow of patients to institutions for voluntary psychiatric treatment reflect an upsurge in the number of psychiatric disorders in the population? Is it expedient to distinguish between people with psychiatric disorders and people with psychosocial problems?" etc. These are conceptual problems inherent to the view and conviction one has on the definition of psychiatric disorders.

The second quandary regards the social function of psychiatry. On the one hand psychiatry is a "normal" field of medicine dedicated to diagnosing and treating people with psychiatric disorders. On the other hand psychiatry as a social institution is vested with the task of assisting in the control of all sorts of disruptive influences in society. In this sense psychiatry can be described as a social institution that serves the social order in addition to the justice system. It is to protect society against the dangers evoked by the disturbing or dangerous behavior of people with psychiatric disorders. The application of coercion is unmedical. Medicine is hallmarked precisely by its being a service institution, that acts only at the patients' request. In addition, in medicine the interests of the patient as defined by himself are paramount. Inasmuch psychiatry is to serve this social role, it is unmedical in both of these aspects.

For the sake of argument the contrast between the patient's interests and that of society has been exaggerated here. To a certain extent such interests in reality run parallel in a macro model. This holds true on a micro level as well. When a psychiatric patient can be treated, he himself is benefited as well as his environment. Conversely, treatment which benefits the patient's environment benefits himself. Nonetheless refusal of psychiatric treatment frequently occurs.

This may be because the person does not want it, does not regard it necessary, or fears it. In the case of somatic illness the patient's wishes are generally respected, but not in psychiatry. Therefore the problem of coercion, in commitment as well as in treatment, returns to center stage.

Together with these two quandaries, the following question can more generally be posed: how can society best deal with people who…

- cannot manage on their own and require assistance to prevent their social ruination?
- pose a nuisance to others, disrupt normal social processes, or are otherwise troublesome though do not commit crimes?

Foucault vividly described how this social problem urgently required a solution during the seventeenth century, and which categories of people were affected. The solution arrived at for the various groups was initially incarceration. Later other solutions were found for all sorts of subgroups, or the problem was accorded less weight. Only the category of psychiatric patients was left, until through deinstitutionalization this group too was "socialized", only to partly return as homeless people, vagabonds, and asocial folk. Criticizing and rejecting the psychiatry as an institution that spreads its wing over this group raises the question whether we have or can imagine other social systems that could handle this job better.

In principle the quandaries are not insoluble. But making the choices necessary for such solutions appears to be impossible in practice due to a complicated network of ideological convictions, scientific and ethical considerations, and professional and social-political interests. Certain aspects of this problem can be clarified by empirical-scientific research. But as the choices are between concepts, and the goal is finding the best solution for social-political predicaments, which view is the right one cannot yet be *empirically* determined. What can be done is to weigh the different options, and clarify the advantages and disadvantages of the various choices.

...Thomas Szasz as a Source of Inspiration

The personage who has been involved more than any other in exposing these quandaries is Thomas Szasz. With his keen scrutiny, rooted in a clear social-political conviction, he identified psychiatry's quandaries conceptually as well as politically-strategically. Although at the time his views seemed to me to be extreme and highly controversial, I decided to explore his work more closely. A major part of his objection to psychiatry arises from his rejection of the coercion it entails, and the manner in which that coercion is justified. I found much truth in Szasz's writings. I often did not understood very well the furious but ill-founded manner in which his critics reacted to him, or I found their arguments not very convincing. Although Szasz appeared to be less interested than I in a psychiatry dedicated to helping people voluntarily, he never opposed it. His main focus was and is the coercion and abuse of power he saw and sees in institutional

psychiatry. To a certain point I shared his revulsion of the social power and repressiveness which could and still can emanate from psychiatry.

Conferring with my sponsor, Professor W.K. van Dijk*, I decided to write a thesis about Szasz's oeuvre. In the framework of this project I visited Szasz in June of 1982, together with my companion, friend, and colleague, psychiatrist Leo van Dijk. During an entire week we enjoyed the opportunity of discussing with Szasz a myriad of questions which his work had raised in our minds. He was a wonderful host. He stood squarely behind his writings, and was very much willing to expound on anything we asked. My dissertation appeared in May of 1984 in the Dutch language with the title "Myth and Power, Thomas Szasz's Critical Psychiatry." The responses in the Netherlands were mainly cautious-friendly, although the book was also fiercely attacked several times, among others by the Head Inspector of the Mental Health Service of the time during a symposium dedicated to the new Dutch commitment laws.[1]

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* Today a large foundation in the north of the country dedicated to drug abuse issues is named after him. – J.P.

▪▪Introduction

Thomas S. Szasz has been a conspicuous phenomenon in psychiatry during the last 25 years. In his up until today [1984] 18[*] books and more than 350 articles, he demands attention for the iniquity of current health care systems, psychiatry in particular. He points out psychiatry's unwholesome alliance with the state, a paternalistic system of services and rules that violates people's freedom and autonomy, and deprives them of responsibility for their own life and well-being.

Szasz is a psychiatrist and psychoanalyst. He criticizes his profession from within, much to the annoyance of many psychiatrists. He is in the unique position of being a member of the psychiatric establishment while constantly rebelling against it. Although this too arouses anger among his colleagues, he astutely understands that this status prevents others from waving his views away as unprofessional or irrelevant.

Szasz, with his often rigorous criticism of current psychiatric practice, is not comparable with any other psychiatrist, not even Laing and Cooper, the founders of antipsychiatry. His political philosophy is likewise far removed from Basaglia and Italian democratic psychiatry. As some of Szasz's recommendations resemble those of the Italians, he, along with them, is often considered an antipsychiatrist. He himself categorically rejects this title.

At least as noteworthy as his oeuvre itself are the reactions to his work. It has gained attention and elicited appreciation mostly beyond the psychiatric profession. Inside the profession the responses are two-fold. Initially, attempts are made to ignore him. Discussion is avoided. Professional journals are reluctant to publish his articles. When he cannot be ignored, most critics in psychiatry focus on the way he expresses himself. In 1973 Stone summed it up thus: "One intriguing aspect of the Dr. Szasz situation is the seeming helplessness of the psychiatric establishment in coping with his charges."

This challenge is my first motive for writing this book. My second motive is that in recent years we are increasingly experiencing, in the Netherlands as well, the state interventions in health care to which Szasz is so averse. These interventions are becoming increasingly intensive and invasive, while hardly any voices are being heard that oppose it, or even pose the question whether this is a desirable development. My third reason for writing this book is that if psychiatry is a branch of medicine, it is unclear why the social reality of this branch is so different from other branches of medicine. Why do precisely psychiatrists, who work with concepts that are so less well defined than those in other branches of medicine, have so much more social power, and are involved with so many non-medical questions? Lastly, contemplation about the fundamental concepts of psychiatry and psychiatric treatment is most advisable in these times, when the former chairman of the [Psychiatric] Clients' Union, representing the Dutch Patients' Movement, is sounding serious criticism of psychiatry. He concludes that it "has terrible shortcomings."[2]

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[*] At time of publication of this translation two decades later, Szasz has published 30 books. For titles, see the appendix. – translator

The motives mentioned above form the blueprint for this book. In Part I, a summary of Szasz's theories, assertions, and insights are presented (Chapter I). Afterwards is a sketch of several historical developments that are important for determining the position of Szasz's work (Chapter II), followed by a description of Szasz's personal, political, and moral philosophies (Chapter III). After Szasz having been described as well as possible with only minimal comment in these three chapters, Chapter IV will examine Szasz's use of language and his arguments.

Part II offers a commentary on Szasz's main themes in three chapters. Chapter V proposes a theoretical concept of illness and mental illness. In Chapter VI the theoretical concept of illness and mental illness is further examined in light of the way physicians, patients, and institutions approach it in practice. Finally, Chapter VII focuses on Szasz's central theme of psychiatry as a repressive institution: the involuntary commitment.

Obviously it is impossible to do justice to all aspects of Szasz's work in the confines of this book. In selecting issues, a certain amount of subjectivity is unavoidable. I have chosen to stress general principles and fundaments, as Szasz himself does, rather than going into the details of procedural problems and legal cases. Psychiatric hospitals and other psychiatric institutions are mentioned only incidentally. An examination of the different psychiatric institutions would require a separate study, all the more as there are rather large differences between for instance the state mental hospitals of the United States and psychiatric hospitals in the Netherlands. Also, I have minimized attention to matters that are major issues in the United States but scarcely at all in the Netherlands, such as a person's competence to stand trial.

Finally, some technical notes:

I have designated the word patient for a person who is being treated by a physician or psychiatrist, in accordance with medical tradition. The word patient is to be seen as defining a social role.

In accordance with linguistic tradition, I have used the male pronoun to designate both men and women. Also other nouns, such as those that represent professional or other status, are intended to include the female counterpart.

Cross references are made by referring to the chapters in Roman numerals, and the sections in Arabic numerals.

In referring to Szasz's books, only the title is given. A list of his books appears in the appendix.

■ Part I Thomas S. Szasz's Critical Psychiatry

▪▪Chapter I Szasz – the Man and his Work

...1. Some Biographical Notes

Thomas Szasz was born in Budapest, Hungary, in 1920. He grew up as the younger of two sons in a non-religious Jewish family. His brother George is two years older than he. His family was comfortably situated. The father was a successful lawyer and estate holder. The Szasz family valued intellectual and scientific pursuits. In their youth, sibling competition strongly stimulated both boys. Szasz describes his brother as a "Wunderkind" in those years. His brother George made a career in organic chemistry, and is now living in Zurich. The brothers are still in regular contact with each other, including regarding Thomas Szasz's work. In the acknowledgments section of his books, Szasz regularly credits George with having assisted.

Szasz studied at the "Gymnasium"* in Budapest. He enjoyed tennis and table tennis. He was the school champion in both these sports during all the eight years that he attended the school. This drive to be competitive is characteristic of him.

In those years, Szasz became impressed that jails and psychiatric institutions were two places that people went in, but never came out.

In 1938, at George's insistence, the Szasz family decided to emigrate. The threat of national socialism was an important motivation. In the Hungary of those days there was no discrimination of Jews, other than epithets. However, in the United States at the time it was extraordinarily difficult for Jews to gain admission to universities. Only after many vain attempts was Szasz accepted at the College of Liberal Arts at the University of Cincinnati, Ohio. His uncle, Otto Szasz, who arrived in the United States several years earlier, taught mathematics there. Szasz remained two years, and in 1941 was awarded a Bachelor of Arts with honors in physics. Afterwards he studied medicine. In those war years it was an intensive and condensed study. He completed the theoretical part in August, 1944, receiving the Stella Feiss Hofheimer prize for the highest achievement during the entire curriculum. Internships in Boston and Cincinnati followed. He obtained his MD in 1945.

In 1946 Szasz began specializing in psychiatry. Shortly before then he had begun psychoanalytic training at the Psychoanalytic Institute in Chicago. His psychiatric training was at the University Clinic in Chicago. He was the favorite student of his trainer, F. Alexander. By continuing his specialization at the Institute of Juvenile Research in Chicago, Szasz succeeded in avoiding the obligatory internship at a mental hospital. He wished to avoid such an internship at all costs in order to not be compelled to apply electroshock to involuntary patients. Already at that time he objected to such treatment on grounds of principle and for humanitarian reasons. In practice his entire training took place outside of institutions. He only experienced out-patients. He never accepted

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* In Europe this word refers to a middle and high school for superior students. – translator

employment in an in-patient clinic or mental hospital, so also as a psychiatrist he is experienced exclusively with patients who were not hospitalized.

Szasz held a clear position on the involuntary commitment and treatment of patients in mental hospitals already at the time he completed his analytic training in 1950 and his psychiatric training in 1951. Although he did not yet expound on his position at the time, pending the shaping of his professional identity as a psychiatrist and analyst, this position prevented him from gaining experience with hospitalized patients. It would be another ten years from this time that his first and best-known book critical of psychiatry, *The Myth of Mental Illness*, would appear.

Szasz's critical attitude to psychiatry is hardly inferable from his publications up to 1956. He was on the staff of the Chicago Institute for Psychoanalysis and was considered a young genius and future director [3]. However, he did not aspire to such a position, because he did not want the role of boss, nor did he want so many other people to be subservient to him.

In 1954 Szasz was conscripted. Two years later when discharged he was a Navy Commander. That same year he was appointed professor of psychiatry in Syracuse, a department of the University of New York State. He still holds this position[*]. In 1962 and 1968 he was "visiting professor" at the University of Wisconsin and Marquette University, also in Wisconsin. In the fifties Hollender also came to Syracuse. Hollender and Szasz were close friends.

Although Szasz was aware that *The Myth of Mental Illness* was controversial, he had not foreseen the tumultuous effect of this book. In Syracuse the Commissioner of the New York State Department of Mental Hygiene prohibited Szasz from teaching psychiatry to medical students at Syracuse Mental Hospital. The commissioner did not do so directly, but through Hollender, who at the time was chairman of the Department of Psychiatry and director of the mental hospital. Hollender tried to solve the problem diplomatically. However, Szasz could not reconcile himself to that, and demanded that the prohibition be rescinded in the name of academic freedom of speech. Grenander writes the following about it: "… New York State's Commissioner of Mental Hygiene tried to get Szasz fired for espousing and developing these radical ideas. The attempt was unsuccessful, and his case became a classic illustration of the principles of academic freedom. As the American Association of University Professors demonstrated, a faculty member holding tenure – and Dr. Szasz did – could not be dismissed simply because his ideas are heretical."[4]

The echoes of the conflict that ensued about this issue between Hollender and Szasz are still palpable among the staff of the university's psychiatric clinic in Syracuse. It ended when Hollender transferred to Vanderbilt University.

Szasz is a "fellow," an honorary title, and since 1983 a "life fellow" of the American Psychiatric Association. He is likewise a life member of the American Psychoanalytic Association since 1983, and "fellow" in the International Academy for Forensic Psychology. In 1971, together with Goffman and others, he founded the American Association for the Abolition of Involuntary Mental Hospitalization.[5]

[*] This refers to 1984 when this book was first published, in the Dutch language. Today Szasz is still professor emeritus at the same university. - translator

It was dissolved in 1979.[6] He was an advisor for the Institute for the Study of Drug Addiction.

Of the many honors he received, I will name as examples, the Ralph Karas Award from the Civil Liberties Union in 1967; the Annual Civil Liberties Carey lectureship from Cornell Law School in 1968; the Holmes-Munsterberg Award from the International Academy of Forensic Psychology in 1969; the C.P. Snow Lectureship from Ithaca College in 1970; and the Spiritual Freedom Award from the Church of Scientology. Further worthy of note are his appointment as honorary President of the International Committee for Human Rights in London in 1974; his honorary doctorate from Allegheny college, Pennsylvania, in 1975; the E.S. Meyer Memorial Lecture in Brisbane and Lambie-Dew Oration in Sydney, both in 1977.

Szasz married in 1951. He has two daughters, Margot Claire, who specializes in dermatology, and Susan Marie, who is a librarian. Since his divorce in 1970 and his daughters' leaving the family home to attend college, Szasz has been living alone in a bungalow on a hillside near Syracuse. He has regular contact with his daughters, and with his mother who lives [in 1984] in the area. Aside from his wanderings in the scenic environment and his swimming, Szasz lives for his work. As a "senior professor" he is pressed by few organizational and teaching duties. He spends his time mostly writing books and articles, and traveling to give lectures both in the United States and abroad. Although he sometimes sees patients, he has more or less retired from his psychiatric and psychotherapeutic practice.

In the sixties, Szasz was quite popular with students and trainee psychiatrists. Many came to Syracuse to study or to specialize specifically because Szasz taught there. Later, particularly in the second half of the seventies, his popularity hit a low point: the trainees did not expect much from him anymore, and he was no longer a magnet. In recent years [1984] however, trainee psychiatrists are demonstrating renewed interest in Szasz's views.

Szasz is a lively man. During discussions he may be contemplative, but also enthusiastic at moments that he is reaching the conclusions that are important to him. He is richly imaginative, and constantly tries to clarify his tenets with comparisons and analogies from history and daily life. In his enthusiasm, he tends to lapse into monologues, and is more concerned with elucidating his convictions than critically discussing them. Interrupting him is often difficult as he is so absorbed in the train of his own thoughts and associations. He is a very opinionated person, who leaves little room for doubt about his ideas. He is charming to associate with, friendly, warm, and hospitable. He treats little children thoughtfully and pleasantly. His relationship with his daughters is warm, deep, and respectful. He is of small and ecto-mesomorphic stature. His dress is conventional and inconspicuous. In his daily behavior, he is a model citizen who observes rules and laws.

In 1979 Szasz visited Hungary for the first time since his emigration. He was impressed by how psychiatry in this communist country functioned exactly as it did in the United States.

Recently [1984] he republished a series of essays under the title: *The Therapeutic State: Psychiatry in the Mirror of Current Events.* He is preparing a

book about politics regarding mental health and mental illness. He hopes to broaden the field of his research and write a book about political philosophy.

The sources for these biographical notes are, in addition to the forewords of his books: conversations with Dr. Lakovics and Dr. Kaplan, two of Szasz's contemporary colleagues at the University Mental Health Clinic; *Current Biography* 1975, pages 395-398; and in a significant portion, conversations with Szasz himself.

...2. Szasz as Author – Introductory Comments

Below I will describe Szasz's thoughts, views, and theories as they are expressed in his publications. Mainly of concern will be his critical-psychiatric theories. Although Szasz is often considered an antipsychiatrist,[7] he himself has always denied this and distanced himself from the term. Nonetheless, as he, like the antipsychiatrists, attacks the very foundation of psychiatry, he is included among them by others. He criticizes the very foundation of conventional psychiatric theory and practice, as well as the social role and significance of psychiatry as a science, an applied science, a profession, and an institution.

In addition to these critical reviews, Szasz has dedicated several publications to psychosomatic, psychoanalytic, and psychotherapeutic subjects. These will be discussed below only to the degree that they are necessary for understanding the complete oeuvre.

Szasz is a prolific author. Besides countless articles – until 1983 around 380 according to his own bibliography – he has written 18 books.[*] Some of them became bestsellers. Undeniably his work has attracted considerable attention both inside and outside his own profession. They appeal especially to people in the legal field and interested "laymen." Many of his books appeared in pocket versions, and were translated to other languages. Not only did Szasz publish in psychiatric and psychoanalytic journals, but also in legal and philosophical journals, as well as in general newspapers and magazines. He has written and continues to regularly write letters to editors in which he presents his views on current affairs. He published two[†] anthologies of aphorisms, in which he expresses himself on all sorts of social issues, not at all limiting himself to psychiatry. This reflects a certain shift in his work. Initially he directed his writing mostly to colleague professionals via professional journals. In time he began directing his writings more towards the public at large, for whose benefit the entire field of psychiatry with all its institutions is constructed. This shift is also reflected in his use of professional jargon, which over time gives way to language that is comprehensible to the general public. Probably this shift is due, at least in part, to the hostile responses Szasz received inside of psychiatry. Among other ways, this is demonstrated by the refusal of professional journals to publish his submissions.[8] He has enjoyed much more recognition and appreciation by non-psychiatrists. This is exemplified by the many awards he received, often from institutions concerned with civil rights, and the fact that he was chosen as

[*] See the appendix. – translator
[†] Now four. – translator

"humanist of the year" in 1972. It is notable that he continues to consider himself a psychiatrist, and keeps returning – no matter how critically – to what he considers his own professional territory. From a scientific point of view that is the part of psychiatry that deals with psychological and sociological methods, and in which man is seen as a social being who imparts meaning to life. From a practical point of view it is a helping service that is summoned at the patient's request.

Seen chronologically, in the beginning his publications were mainly about psychosomatic subjects, viewed from a psychoanalytic point of view. This seems to be linked to his training. His trainer, F. Alexander, was interested in psychosomatics from a psychoanalytical point of view. Szasz's publications from this early period are discussed in the next section.

Preceded by several articles leading up to it, that are discussed in section 4.1, he published *The Myth of Mental Illness* in 1961. This book can be considered his basic thesis that he has defended ever since. Some aspects of this basic thesis are discussed more thoroughly in *The Manufacture of Madness*, published in 1970. Together these two books provide a good and fairly complete insight into his views. They are discussed in section 4.2.

In several of his books and publications Szasz elaborates on his basic tenets and applies them. Particularly important for general psychiatry are his books regarding addiction (1974), schizophrenia (1976), and sexology (1980), as well as several articles. These elaborations on his main thesis are discussed in section 5.

The problems of justice and law regarding psychiatry form an important preoccupation for Szasz. This interest is expressed in several books, such as *Law, Liberty, and Psychiatry* (1963), *Psychiatric Justice* (1965), and *Psychiatric Slavery* (1977), as well as numerous articles. Mainly he discusses the problems of involuntary incarceration of psychiatric patients, their rights, and lack of them. He also discusses how psychiatry is used by judges. These views are summarized in section 6.

Szasz has always remained generally dedicated to the convictions he launched in 1961. Contrarily, his approach towards psychoanalytic theory and therapy changed rather fundamentally. In 1965 he published *The Ethics of Psychoanalysis*, in which he presented a detailed framework for psychoanalytic psychotherapy. The year 1978 saw the appearance of *The Myth of Psychotherapy*. His book about Karl Kraus (1976) is particularly interesting because of the position that Szasz develops in it on the function of Freud's psychoanalysis and other psychoanalysts in the first decades of the twentieth century. Section 7 elaborates on these aspects of Szasz's work. Although Szasz is active primarily as a critic – often most polemically and acrimoniously – he has occasionally suggested new theories. He has also suggested concrete changes to the mental health system. These are discussed in section 8.

Except for views on the significance of psychoanalysis, Szasz's work consists of elaboration on views of which the essential foundations were already committed to paper in 1961, rather than of the development of new ideas and theories. Therefore classifying his work chronologically is not particularly useful.
If we do so anyway, then we might do it as follows:

- The first period, up to 1956, is a time when Szasz publishes works on psychosomatic phenomena and "orthodox" psychoanalysis, in which there is as yet no hint of the controversial path he will follow later.
- The second period, from 1956 to 1961, is the period in which he is preparing *The Myth of Mental Illness* up to which he leads with a profuse amount of critical articles.
- The third period, from 1961 to 1970, culminates with publication of *The Manufacture of Madness*. This period is characterized mainly by further elaboration on the theme of *The Myth of Mental Illness*.
- The fourth period lasts from 1970 until today [1984]. Now Szasz can be described as a political philosopher. He seems to move away from psychiatry as a practical and applied science. Although he is still intensely dedicated to the subject of psychiatry, he increasingly views it from a political-philosophical point of view rather than from within. This period is also marked by a clear shift in the type of journal in which he publishes: less psychiatric and more general. Many of his letters to editors are published in this period. They are commentaries on all sorts of current events from a certain political-philosophical point of view. A symposium held in Albany, NY, in 1980, calls Szasz a "libertarian humanist" in its subtitle.

...3. Szasz and Psychosomatics (1947 – 1956)

During the period from 1947 to 1956 Szasz published articles that were fairly exclusively confined to psychosomatic subjects. He published research on patients who had undergone vagotomy for the treatment of peptic ulcers. His role was to find psychoanalytic explanations for the results in accordance with Alexander's theories.[9] In addition his articles dealt with hypersalivation,[10] constipation and diarrhea,[11] and balding.[12] These studies culminated in a summarizing article on psychoanalysis and the autonomic nervous system[13] and "The Psychosomatic Approach in Medicine" which he wrote with Alexander.[14]

After a brief moratorium, in 1955 and 1956 Szasz published several articles about pain, culminating in his first book, *Pain and Pleasure: A Study of Bodily Feelings* (1957). This book can be considered a psychoanalytic study of physical feelings, of which pain is the most important. Up to this point Szasz's writings reflect the tradition of the psychoanalytic research of the day. They include practically no hints of the way his theories will develop in the future. Perhaps an exception is a statement in *Pain and Pleasure*. Basing himself on Bertrand Russell and Woodger, and taking into consideration that medicine, to the extent that it concerns itself with the body as a physicochemical object, borrows methods from sociology and psychology, he states: "It seems to me, that from the point of view of scientific clarity it would help to restrict the scope of 'medicine' to those sciences and techniques that are based on and that use the physicochemical frame of reference. Other sciences, that study human experiences in different frames of reference (such as those of history, sociology, linguistics) would be subsumed under the label 'socio-psychology' and would complement 'medicine' in the study and change of man."

On the one hand, Szasz is advocating a sharper demarcation between the study of man in the two worlds of the physical and the psychical; on the other hand he rejects a practically applicable criterion for ascribing the phenomenon of pain to one world or the other, as he wishes to avoid discriminating. The explanation is as follows. Pain is essentially a psychological phenomenon. It is of interest to the somatic physician only insofar as it indicates a physical lesion. Whether there is a demonstrable lesion makes no difference to the experience of pain from the point of view of the person who is feeling it. That is why Szasz resists the usual division of "organic" and psychogenic" pain. After all, it is the examiner's judgment about the source of the pain that serves as the criterion in this division. "Organic" is used as a neurological, physical concept. "Psychogenic" is used "only" as a psychological phenomenon. Szasz considers this division senseless and discriminatory. By implication, "organic" pain would be understandable, clear, and justified. "Psychogenic" pain would not be understandable, but unjustified and suspicious. In "Language and Pain" he concludes that the physical concept of pain should be abandoned, and pain should be considered exclusively a psychological concept.[15]

To me this creates a dilemma. Whose point of view of pain is more valid, that of the person experiencing it or that of the professional examining it? The differentiation between organic and psychogenic is that of the professional, not of the person in pain. Making a choice between these two points of view implies choosing either the views of the professional and science or the views of the patient. Szasz chooses that of the patient. Much of his later work can be considered a criticism of the notion that the professional's point of view is the correct one. That is all the more interesting as several years later, when choosing a definition for bodily disease (see section 4.2), he supports the professional's point of view and not the patient's. It makes no difference to the patient's experience of illness whether the cause of it is bodily or psychical. Contrarily, to the professional, it does make a difference. The dilemma is the same whether applied to pain or illness. Szasz's positions on pain and illness are diametrically opposed. His position about sexual disorders concurs with his position on illness. It is therefore not surprising that in 1980 he writes, "The traditional distinction between organic and psychogenic sexual disorders remains of paramount importance," (*Sex by Prescription*, page 7). There will be more on this in Chapter V.

...4. Szasz as a Critical Psychiatrist

....*4.1* Leading up to *The Myth of Mental Illness* (1957 – 1961)

Szasz attempts to describe what psychiatry is actually about in several articles that appear before *The Myth of Mental Illness*. During this period, contrary to his later works, he repeatedly mitigates his criticism, for instance by commenting that his intention is not to attack psychiatry *per se*, but to suggest additional considerations and improvements. In these articles he rejects the traditional, institutional description of psychiatry as a branch of medicine that is concerned with studying and treating mental illness. He calls these descriptions, "…generally

comforting, and often useful, in a practical sense. It is inadequate, however, from the viewpoint of scientific accuracy."[16] Instead he chooses two instrumental premises. The first is the question of which methods and frameworks of reference serve psychiatry in theory. The second is the – operational – question of what psychiatrists do in practice. The first question leads, according to Szasz, to scientific theories; the second to a closer examination of the social circumstances in which psychiatrists work, and an analysis of psychiatrists' social roles. In answer to the question on methods and frameworks of reference, in "Language and Pain" Szasz describes psychiatry as that which the British call medical psychology: "…the science and practical application of those disciplines which use the psychological method and language (in a medical setting). Their object is man as a social being, his development, social identity, self-concept, and his relationship with his fellowmen. The idioms appropriate to such discourse are what Woodger aptly called the 'person language' and the 'community language."[17] The same is reflected in his description of psychiatry as "the science of human feeling, thought, and action."[18]

In an article in 1958 he explains that there are two kinds of psychiatrists. One kind uses physicochemical treatments such as electroshock, drugs, and psycho-surgery. They are to be considered physicians as they work within a physicochemical framework, but they are not psychiatrists. The other kind utilizes socio-psychological methods of research and treatment. This is the type he means when he refers to psychiatrists.

This means that that which he considers desirable in *Pain and Pleasure*, namely divorcing medicine that resorts to physicochemical methods of research and treatment from psychiatry that uses socio-psychological methods, has become a necessity, and even *de facto* reality. "Now, it is clear that medicine is concerned with the workings of the human (and animal) body as a physicochemical machine."[19] Thus a choice unavoidably has to be made. "We cannot have both or a combination of the two, either by simply wishing or by coining a word like "psychosomatic."[20]

This duality based on method used, frame of reference, and object, implies to me the drawing of a dividing line that runs straight down the middle of medicine and psychiatry as they are defined, organized, and practiced nowadays. The result of this division to him is that medicine is on one side of the line and psychiatry on the other. This duality is and remains essential for Szasz. For instance, when he discusses the family doctor in days of yore, he states that this figure "combined the social roles of physicochemical scientist vis-à-vis the body and psychotherapist vis-à-vis the person."[21] From the text we learn that Szasz means that the family doctor of the past maintained an ethic of caring about his fellow man. His goal was to provide humane care at least as much as medical treatment, which he was often powerless to provide. These two social roles reflect the duality that Szasz establishes in medicine and psychiatry.

Once this duality is established, it is apparently unimportant to Szasz to divide up the socio-psychological sciences any further. It is often quite difficult to find a clear difference between psychiatry, psychoanalysis, and psychology in his work. Repeatedly words like psychiatrist and psychotherapist are used interchangeably. His description of psychotherapy is so broad as to include psychological influence. (See Chapter II, 2.) The difference has become

unimportant to Szasz for two reasons. The first is that as he declares the concept of illness invalid in psychiatry[22] (see also 4.2), the most important reason for separating psychiatry from psychology is eliminated. The second is that also in this period Szasz ascribes an extraordinarily essential role to psychoanalysis for psychiatry as well as psychology. Regarding the latter, this is reflected best by his statement: "Various branches of modern psychology, such as physiological psychology, learning theory, experimental psychology, clinical psychology, psychometrics, social psychology, and so forth have no common denominator other than psychoanalytic theory. In so far as they do not lean on, nor borrow from psychoanalysis each of the foregoing disciplines remains relatively isolated from the others…"[23] About psychiatry he says, "Modern psychiatry is said to consist of a body of knowledge upon which there is more or less general agreement. This knowledge consists of, or is derived from, the theory and practice of psychoanalysis."[24]

An operational definition of psychiatry should not cover only frames of reference, method, and object. The social position and purpose should be included as well. Thus the question arises: in which social roles are psychiatrists cast? What do they do? These questions in turn beg the questions: What is the nature of the psychiatrist-patient relationship? What are the moral implications of that relationship? Finally, we can gain operational insight into psychiatrists' intentions when we examine their attitude towards various social developments. Szasz does so mainly regarding law and justice.

Psychiatrists have very differing roles. Szasz names some in an article in which he analyzes how they classify and diagnose patients:

- Psychiatrists in state mental hospitals decide whether the patient is psychotic. If so, an involuntary commitment and various, sometimes highly invasive therapies could be justified;
- Psychoanalysts use the term psychosis in a totally different way, namely as referring to certain mental mechanisms or relationship patterns. The word thus bears no reference to observable behavior or social judgment;
- Psychiatrists testifying in legal cases have to choose their diagnoses in a way that enables them to assign one of two classifications to the defendant: punishable or not punishable. I believe Szasz's use of the word "punishable" in this sense is erroneous. He means responsible. He discusses the role of the psychiatrist as expert witness further in other articles;[25]
- Psychiatrists in military service and child psychiatrists have other social roles with various corresponding preoccupations regarding the classification of their patients. Obviously, in each situation, the object of their intervention is different.

His conclusion is that absolute classifications of psychiatric disorders that are applicable in all these different situations are impossible.[26]

In another article Szasz describes the intense distress that parents experience when their baby cries. The need to help the infant is generated partly by the parents' feelings of guilt over his distress. Szasz concludes that parents find it difficult to tolerate their children's unhappiness.[27] He transposes this feeling to psychiatrists whose patients are threatening to commit suicide. Psychiatrists feel

distress and the need to act so that they will not have to continue bearing their patients' unhappiness, even when doing nothing would be better. Such "help" could be an involuntary hospitalization of the patient. However, that cannot be done without turning those patients into inarticulate children, to whom all sorts of things are done without consulting them. This is a dilemma: either patients are respected and nothing is done with them, or they are involuntarily hospitalized and thus are treated like children. This dilemma is repeatedly referred to in Szasz's work. So treating others as competent adults who are responsible for themselves precludes involuntary commitment and treatment, as such unavoidably infantilizes, dehumanizes, and devalues them. This dilemma remains, no matter how much those others express verbally or through their behavior that they no longer wish to be (or are incapable of being) responsible for themselves.

In various articles Szasz emphasizes the difference in the relationships between psychiatrists and their voluntary patients versus psychiatrists and their involuntarily committed patients.[28] In the former case, patients consider the psychiatrist as their ally and helper; in the latter, as their adversary, precisely because the patient role is imposed upon them against their will. Therefore involuntarily committed patients resemble someone suspected of a crime more than they resemble a sick person who wishes to be helped. However, when the position of involuntarily committed patients is compared to that of suspects in detention, the comparison is unfavorable to the patients. Suspects' rights are clearly defined: they are to be informed as to the nature of the accusation, who accuses them, and what their rights are. They are explicitly told that anything they say can be used against them. In the case of psychiatric patients, the fact that the psychiatrist is the accuser and the patient is the accused is camouflaged by the rhetoric of illness and treatment. That is why hospitalization, no matter how much the patient resists, is regarded as in his best interest. Therefore in 1960 Szasz advocated a "Bill of Rights for the Mentally Ill"[29] – not so much as a practical proposal, but in particular to draw attention to the loss of civil liberties and protection of the law of fellow citizens. That same year Szasz declared his rejection of any and all involuntary commitment.[30] (See also 6.1 and 6.2.)

Regarding both types of relationship – voluntary and involuntary – Szasz asks the question, whose interest do psychiatrists serve? In the case of the contractual relationship (see 4.2.2) psychiatrists clearly act in their patients' interest. Patients who do not think so (anymore) will discontinue the relationship. In the case of psychiatrists who write reports on the basis of which someone will be involuntarily committed, the situation is less clear. Aspects such as the interests of the family, environment, and public order come into play. An equally complex pattern of interests comes into play when the patient is a child, regardless whether that child is confined by court order. Szasz generalizes that in all cases of involuntary commitment the interests of others, society, and social order are served rather than those of the patient. He clarifies that not only by pointing out the dehumanizing and discriminating deprivation of civil liberties, but also by postulating a central connection between interpersonal conflict and mental illness (see 4.2.2).

So according to Szasz, psychiatrists who hospitalize patients against their will are categorically acting against what those patients regard as their interests.

Such psychiatrists set the interests of the environment as their priority, and identify with that environment, to the detriment of their patients. When they claim to be acting in their patients' best interest in such a situation, they are being deceitful. They can do that only on the basis of the authority and power invested in them, so their actions are characterized by "force and fraud."

One implication of this position, according to Szasz, is that psychiatrists serve the conservative forces in society. Any unrest or unusual behavior can be delegitimized by psychiatrists by calling that behavior a symptom of mental illness. Psychiatrists take on the role of "social tranquilizer."[31] This happens in particular when they are protecting certain social institutions, such as marriage, a profession, or the criminal justice system. They defend the illusion that these institutions are good and harmonious at the very moments that these institutions are cracking under their own weight or contributing to people's problems. To clarify this, two examples follow:

- Not infrequently involuntary hospitalization of patients is requested by a member of their family. That is not surprising, as deeply depressed housewives, paranoid psychotic men, and increasingly demented grandfathers can pose serious risks for the other members of their family. Aside from the misery and suffering that strikes the entire family in such situations, it can be stated that such patients fail to fulfill their necessary social function in the family. The family can keep requesting the patient to change his behavior, they can abandon him, or they can appeal for medical assistance. When such medical assistance consists of involuntary hospitalization, it can be concluded that the integrity of the family prevailed over the autonomy of the individual. Insofar as the involuntary commitment comprises a solution for an unbearable family situation, it can be concluded that the institution of family is being protected, even at the expense of the individual. The family is a social structure that is far from optimal, as unbearable stresses often occur in it. Involuntary hospitalization conceals that. Thus people are hindered from facing their social roles, and, by changing them, creating better and more satisfying social structures.[32]
- In the criminal justice system sentencing delinquents arouses judges' feelings of guilt and anger. In order to reduce these unpleasant feelings as much as possible, judges feel the need to know whether defendants can be held responsible for the crimes of which they are accused. Psychiatrists express their opinions about this in their expert evaluations, making it easier for judges to decide whether to sentence particular defendants. Thus by way of their expert-evaluations psychiatrists conceal a sore point that could lead to changes and improvements in the criminal justice system, forming an obstacle to improvements.[33] The result is that judges no longer make punishment fit the crime, but the person who committed it. In addition, "…the oracular pronouncements of eminent psychiatrists have taken the place of publicly verifiable fact (and of scientifically acceptable theories)."[34]

....4.2 The Fundamental Hypotheses of Szasz's Theory

.....4.2.1 The Myth of Mental Illness (1961)

This book first appeared in 1961, and a second edition appeared in 1974. The differences between the two editions are mostly editorial changes. In the second edition the phrasing has become noticeably more sharp and resolute. Nearly all mitigating phrases have been omitted, and the author seems to leave his readers less room for their own thoughts about his views. There is, however, no essential difference in content and meaning in the two editions.

The first part of *The Myth of Mental Illness* consists of an examination of the origins and foundations for current psychiatric theory and practice. The second part offers an alternative view on mental illness and how to speak about it meaningfully. In this second part, not only psychoanalytic points of view are presented, but also social-psychological, linguistic, and system theoretical points of view.

The book revolves around a number of premises. The first is that mental illness does not exist. The idea that there is such a thing as mental illness is a "myth," arising from a "category-error" as Ryle describes it.[35] According to Szasz, the concept of illness is applicable only to bodily aberrations that can be demonstrated by physical and chemical methods. "Strictly speaking, disease or illness can affect only the body." (p. 275) As there is no demonstrable aberration of the body in mental illness – when there is such, we should speak of an internal or neurological illness, whichever the case may be – the concept of illness is not applicable, therefore there can be no such thing as mental illness. When in certain aspects mental illness resembles physical illness, this does not mean that mental illness is a real disease. The word illness used in this way is a metaphor.

Until the middle of the nineteenth century and later, according to Szasz, illness was defined as a physical disorder. The disorder had to be physicochemically demonstrable in the form and structure of the body. Many new diseases that conformed to this criterion were discovered and described. Psychiatry could only enter the domain of medicine by changing this criterion for illness. Aside from the demonstrable change in body structure, a changed function of the body, discernible by studying behavior, was added as a criterion. Thus structural and functional aberrations were placed in the same category. I remark here that Szasz thus unified functional and behavioral criteria. The function of organs or organ systems are assigned to the same category as the behavior of an individual, and contrasted to physicochemical changes. This view seems incorrect to me.

Szasz presents hysteria as paradigmatic of this development. Hysterical patients who formerly were considered and treated as malingerers were introduced into the domain of medicine by Charcot, an operation that was completed by Freud. Thus malingerers were promoted to patients. For a commentary on this historical reconstruction see Chapter II, 2.

The hysterical conversion phenomena – somatic symptoms that cannot be ascribed to a physicochemical defect in the body – Szasz continues, confront the investigator with the difference between real and fake. A disorder is suggested and imitated that in reality does not exist. Hysteria is a fake disease. This leads to the conclusion that all mental illness is fake illness.

As mental illness does not exist, the entire body of medical terminology used in psychiatry is senseless. If there is no question of illness, there can also

be no question of diagnosis and treatment. Psychiatric interventions are forms of social, thus ultimately moral treatment, not medical interventions. It is therefore wrong to accept any psychiatric intervention whatsoever when the only ground for it is that it is considered a form of medical treatment.

The second premise is that a diagnosis is not only a physician's subjective judgment of what is going on, as the presence of disease can be proved by demonstrating the corresponding physicochemical disorder. However, in the case of mental illness, diagnoses cannot be verified. That means that a psychiatric diagnosis is nothing other than the unverifiable or incontestable judgment of one person, the psychiatrist, of another person, the patient. There is no objective criterion by which it is possible to prove that the psychiatrist is right. So if the psychiatrist and his patient disagree – for instance if the patient contends that he is not ill – the issue is settled by the difference in *power* between the two. That means that regarding psychiatric illness we cannot speak of *discovering* but rather *inventing* a new class of illnesses. In other words, mental illness does not exist in the natural world, but is a behavior that is declared an illness by the doctor.

As in Western culture medicine, including psychiatry, increasingly gains importance to man, more and more behavioral patterns are labeled mental illness. The importance of whether certain behaviors are ascribed to mental illness is equally growing. This entire development unfolded without any contextual justification, as the corresponding physical aberrations that have to be demonstrated in order to speak of illness were never found. Thus there must have been other, strategic motivations for continued psychiatrization. Szasz considers one of the reasons for this psychiatrists' gained prestige. By maintaining medical concepts, psychiatrists share the prestige of physicians.

The third premise is that the concept of illness itself has not only a contextual but also a strategic significance. This was already clarified by the transformation of the social role of hysterics from malingerers to patients. Thus relabeling simulation as mental illness means restoring social honor to people who are now cast into the patient role, as well as entitling them to the privileges and welfare payments of the sick. As sick people, patients are no longer responsible for their illness, but victims of it. They deserve sympathy rather than the scorn accorded to malingerers.

Although this improvement in social status with corresponding improvement in living conditions in itself is to be appreciated as advantageous to these people, at the end of the day the maneuver is to be valued negatively. The problem posed to themselves and others by people suffering from hysteria is not changed, in spite of the changed label. So the problem is not solved but rather concealed. That is why in spite of the changed semantics and social reclassification, the mentally ill have the same bad reputation as the malingerers of the nineteenth century. The label of mental illness is a stigma suggesting inferiority, causing people so labeled to be socially excluded. It is even a useful tool for the express purpose of social discrimination. The cure generates a new disease: instead of social rehabilitation, mental illness now means social discrimination.

At this point another important social implication comes to mind. Life is difficult, and people have always sought excuses for personal failure. By labeling all sorts of deviant patterns and behaviors as mental illness, personal failure turns

into being victimized by illness. That which is in fact human activity is turned into a process to which people are subjected and over which they are powerless. Concealing the true – in the revised edition, in essence, moral and political – significance of the phenomena and behaviors that are labeled mental illness, serves as a semantic tranquilizer. The problems in personal and social relationships that have been obscured and explained away by the label of mental illness have therefore become insoluble.

Although mental illness does not exist, the behavior that leads to such a label does, of course. In the second half of the book an alternative model explaining hysteria is designed. Szasz fairly exclusively limits himself to hysterical conversion phenomena in this model, although he states that the model is applicable to hysteria as such.

In his model, Szasz utilizes the concepts of role, rule, and game, in addition to psychoanalytic views. He bases them on the game model of human behavior as formulated by George Herbert Mead in 1934. Although the concepts of role, rule, and game are used metaphorically throughout the book, Szasz conspicuously never mentions that he is using metaphors. This is all the more peculiar as he repeatedly emphasizes the metaphoric nature of the concept of mental illness, which is the cornerstone of his argument.

Hysterical conversion, then, can be described as a certain type of communication that mainly utilizes iconic signs. An iconic sign is a symbol that outwardly resembles the object symbolized. For instance, a photograph of a person is an iconic sign of that person. This form of communication may emerge when direct verbal communication becomes difficult or impossible. Furthermore, conversions transmit incorrect information as the physical disorder does not really exist. Such information can also be characterized as indirect, like the manifest content of a dream is an indirect form of communication, in which the true message – the latent content of the dream – is both concealed and revealed.

Through the conversion people signal helplessness and so request help, as helplessness appeals to helpfulness. This connection can be explained as follows. First is the fact that children are helpless and powerless, and cannot survive without the support of adults. Children's helplessness evokes a strong urge to help in adults. A somewhat similar process occurs when adults present themselves as helpless and powerless, and as such behave more or less like children. Second is the influence of the most important western religions, Christianity in particular, which command a helpful attitude towards the weak, sick, and helpless. Thereby they in fact encourage rewarding an attitude of humiliation, poverty, dependence, and powerlessness.

When human behavior is considered like a game that follows certain rules and aims at a certain objective, it can be stated that through conversion a person plays the game of helplessness, the objective being to dominate others. The typical strategy is that the person with the conversion, by appearing weak and helpless, motivates or compels others to do all sorts of things.

Human behavior follows rules. These rules can be divined by studying the social context of behavior. Examining this further leads Szasz to the conclusion that the behavior of people with hysteria, like the behavior of "normal" people, follows strategic rules. This means that it is meaningful and aimed at reaching a

certain objective. But if so, then also from this point of view hysteria is not an illness. Illness, by definition, is a defect or blemish, and *not* intact, albeit unusual, functioning. Furthermore, viewing hysteria from the perspective of rule, role, and game implies that the methods by which meaningful information about hysteria can be collected have a lot in common with those of linguistics, sociology, and communication sciences. So they are not the methods of physics and chemistry, which can neither clarify human symbolic behavior nor explain it by somatic deviance found when examining the body. He generalizes this reasoning to all mental illness.

In short: mental illness does not exist. It is a socially reprehensible concept because it stigmatizes and discriminates against those labeled with it. It conceals the life problems and conflicts people have with each other, and by calling them illness, makes them insoluble.

.....4.2.2 The Manufacture of Madness (1970)

This book can be considered a sequel to and complement of *The Myth of Mental Illness.* In it Szasz expounds on his position that mental illness is an objectionable concept for social reasons. “In the present work, I shall try to show how and why the ethical convictions and social arrangements based on this concept constitute an immoral ideology of intolerance” (p. XV). Before setting himself to this task, he differentiates between two kinds of psychiatry, contractual and institutional. This differentiation has fundamental significance for understanding his entire oeuvre. His motivation was discussed in 4.1.

The term mental illness mystifies and conceals “man’s struggle with *the problem of how he should live.*” (Ideology and Insanity, p. 21, italics in the original) That which is called mental illness is in fact human conflict, which can be between individuals or between an individual and the group. In Szasz’s view psychiatrists deal in interpersonal conflict, thus they are comparable to practitioners of law. Like practitioners of law, they have three alternatives: they can side with their client (as do lawyers); they can side with the other party, who could be a spouse, the family, the employer, the neighborhood, or society (comparable to public prosecutors); or they can attempt to remain neutral and fulfill the role of mediator (as do judges).

Szasz describes the paradigm of the relationship between psychiatrists and patients in which the psychiatrist sides with the patient as follows. The patient volunteers himself for treatment, being fully informed about the possibilities, limitations, and risks. He pays the psychiatrist for his services, dedicates time and energy to the treatment, and swallows the humiliation of being unable to solve his problems by himself (at least, if that is how he perceives it). He does this explicitly in the expectation that the psychiatrist will serve him and help him solve his problems as he himself sees them. The psychiatrist offers his services and treats the patient in such a way as to serve the patient’s interests as that patient sees them, for as long as and to the extent that the psychiatrist is able to agree to them. Both are free to sever the relationship should the other not hold to the contract. In addition, the patient is free to discontinue treatment whenever he wishes. In this relationship the patient’s interests are the only ones, other than his

own, that the psychiatrist serves. As the psychiatrist is defending the interests of his patient, and thereby could possibly damage the interests of others, he must avoid a situation of conflicting loyalty. This means that he must be in private practice and receive his income directly from the patient. It also means that he cannot treat patients with conflicting interests at the same time. The psychiatrist-patient relationship is a contractual relationship in which both sides retain their autonomy. It emanated from psychoanalysis. Szasz calls this form of psychiatry contractual psychiatry.

The other type of psychiatry Szasz calls institutional psychiatry. In this type of psychiatry, patients do not seek the relationship with the psychiatrist, but it is imposed upon them in one way or another, for instance by an employer threatening the sack, or a spouse threatening divorce, or – typically – by a court order. This means that clients have little to no influence on their participation in the relationship with the professional. The epitome of institutional psychiatry is involuntary commitment to a mental hospital. The patient's situation is characterized by lack of freedom.

In institutional psychiatry psychiatrists assume the double role of therapists to their patient and defenders of the interests of other parties. Even though the interests of patients and their environments are not necessarily always conflicting, and even though it can sometimes be extremely complicated to determine to what extent psychiatrists' interventions are advantageous to which party, nonetheless we can assume, according to Szasz, that institutional psychiatrists are always agents of the community and defend the interests of the community. It is dangerous and deceptive to maintain that anyone is capable of defending conflicting interests, and that is even more dangerous when the client's adversary is a powerful group, society on the whole, or public order. In such cases the imbalance of power is extreme. In institutional psychiatry, psychiatric jargon serves to oppress patients. Conflicts are concealed, interpreted, and explained away as patients' illnesses. Thus patients are automatically blamed, even though the word illness implies that they cannot be held responsible for this blame. Influencing patients in such a way that they again fit into the social rut and behave as their adversaries wish is called treatment. This leads Szasz to call mental hospitals jails, and therapies such as involuntary drugging, electroshock, and lobotomy, oppression and torture. The purpose of the label of mental illness is treatment and recovery. The true aims "…include such penalties as personal degradation, loss of employment, loss of the right to drive a car, to vote, to make valid contracts, or to stand trial – and, last but not least, incarceration in a mental hospital, possibly for life." (p. XXVIII)

In *The Manufacture of Madness* Szasz compares institutional psychiatry to the Inquisition. He does so most expansively, comparing psychiatrists to inquisitors; patients to witches, heretics, and Jews; and the science of psychiatry to the Catholic faith. See also Chapter IV, 4.1.

His premise and conclusion is that a far-reaching structural similarity exists between both complex social phenomena, and that their social significance is identical. He views both social institutions as an expression of the fundamental human need to confirm one's self as good, innocent, and normal, by designating individuals or groups who deviate in any way as bad, sinful, or abnormal: the

“scapegoat” theory. (See 4.2.4) Everywhere that people live or lived in a community, this phenomenon emerges more or less clearly, according to Szasz. The community “purifies” itself, maintains its integrity and stability by seeking out scapegoats, shaming them, and sacrificing them. The scapegoat is the symbolic personification of guilt and sin; sacrificing the scapegoat absolves the others of sin. This is epitomized by the scapegoat in the Old Testament. The most honored scapegoat is Jesus, who took the sins of humanity upon himself and atoned for them by his death. Anthropologists and historians reveal similar scapegoat histories in various cultures. Szasz views the Inquisition as one example of the scapegoat phenomenon, and institutional psychiatry as another example. All forms of discrimination, whether based on race, skin color, different life styles, or other religions, are in essence variants of the same phenomenon. In this way all subjects of discrimination, whether on grounds of congenital attributes (such as race or skin color), acquired attributes (such as religion), or no attribute at all but only a quirk ascribed to them by others (such as witches and the mentally ill) are lumped together in one group, namely, that of scapegoats. So for Szasz institutional psychiatry is an age-old, integrally human phenomenon in a new costume. It emanates from a human trait that is so fundamental that he states, “Man’s refusal to sacrifice scapegoats – and his willingness to recognize and bear his own and his group’s situation and responsibility in the world – would be a major step in his moral development.” And, “In the rejection, or transcending, of the scapegoat principle lies the greatest moral challenge for modern man. On its resolution may hinge the fate of our species.” (p. 285)

In *The Manufacture of Madness*, several examples of the fabrication of insanity are given. One example is masturbation as a cause of insanity. In 1710 a book by an anonymous priest turned physician appeared: *Onania or the Heinous Sin of Self-Pollution*. This was the first time in history that attention was directed to masturbation as a medical problem. Apparently the book satisfied a demand, as by 1765 it reached its eightieth printing. In 1758 Tissot – a prominent Lausanne physician – gave his name to a book about onanism and its dangers. By the beginning of the nineteenth century belief in the danger of masturbation as a generator of all sorts of diseases was so widespread in medical practice that it can be considered a dogma, according to Szasz. Masturbation was in particular regarded as the cause of insanity in masturbaters themselves or their progeny. Practically everybody in the medical world believed in it, preceded by such famous men as Benjamin Rush in the United States, Esquirol in France, and Maudsley in England. Medical descriptions of those days were a mixture of psychiatric and moral views. This prompts Szasz to point out that there is no confusion, because moral and psychiatric views are identical. “Calling masturbation an ‘addiction’ is really no different than calling it a sinful or bad habit: the former is to condemn it in the language of medicine, the latter in that of morals.” (p. 195)

In the second half of the nineteenth century belief in the evil of masturbation began to wane. Freud blew new life into the declining belief in the pathogenic power of masturbation by suggesting a connection between masturbation and neuroses. In psychoanalysis, masturbation long retained its meaning as infantile sexual activity that ought to disappear during sexual maturity.

Gradually the picture changed, and physicians, initially still hesitantly, began to say that self-stimulation is perhaps not harmful. In *Sex by Prescription* (1980) Szasz adds the latest chapter until now on the history of the significance of masturbation to health. He describes the transformation of masturbation from originally evil and heretical, through a neutral transitory stage of harmlessness, to its current status as a laudable habit that is endorsed in sex education. Not only that, but it is recommended as therapy for people with sexual problems. The cycle is pretty much completed now that Masters and Johnson invented a new disease, "masturbatory orgasmic inadequacy." This is defined as when a woman (they say that it occurs only in women) is orgasmic during coitus but not during (mutual) masturbation.

The point, to Szasz, is that illness suggests an objective defect (to him, physicochemical), whereas in reality there exists only an unverifiable belief, originally, in the harm, and currently, in the healthfulness of masturbation. Every such belief, regardless whether religious or scientific, has the same credibility. It is impossible to objectively determine what is deviant, sick, or normal. This means that limiting the rights or freedom of others on the basis of such a belief is wrong. It also means that each person must decide for himself how he wishes to lead his life and what he wants to make of it. If others object, this doesn't mean that they have the right to label the undesired behavior (originally, masturbating, and now, not masturbating) sick, and even less to turn the said person into a scapegoat.

Finally, *The Manufacture of Madness* was translated into Dutch with the title *De waan van de waanzin* [*The delusion of madness*]. This translation of the title is not only incorrect, but is even an expression of that which in the book is so thoroughly contested. When the fabrication of madness is called a delusion, that fabrication itself is being declared a mental illness, as delusions are the most classic symptom of mental illness. So those who fabricate mental illness are turned into mentally ill people. Such psychiatrization is exactly what Szasz opposes so vigorously in this book. The word "manufacture" implies that something that does not really exist is fabricated. Szasz considers that wrong and worthy of rejection, but not sick. By the way, the English title also does not seem to me to do justice to the author's intention. Szasz is not concerned with the fabrication of madness, but with the fabrication of mental illness. Probably his choice of this title was influenced by his love of alliteration. (See Chapter IV, 2.)

.....4.2.3 Some Additional Remarks

In 1973 *The Age of Madness* appeared. This book can be considered further defense and expansion of the positions taken in *The Manufacture of Madness.* The book consists of several publications of literary, journalistic, and scientific character, collected by Szasz and provided with introductions. The contributions span more than two centuries. These contributions criticize institutional psychiatry, and in particular, involuntary incarceration and treatment. The earliest contribution is from 1728 by Daniel Defoe. It condemns men who put their respectable and virtuous wives away in psychiatric institutions in order to be at liberty to lead a lewd and lascivious life. John Conally (1830) writes among other

things about declaring men insane, "When men's interests depend upon an opinion, it is too much to expect that opinion always to be cautiously formed, or even in all cases honestly given…" (p. 10) In addition there are contributions about abusive circumstances in psychiatric institutions, about unjust declarations of insanity, about strange views on mental illness such as that the democratic persuasion is a new form of mental illness, and about the use of deceit in treatment.

Ideology and Insanity that appeared in 1970 is a collection of essays with dehumanization by (institutional) psychiatry as the common theme. All of these essays had been published previously, some ("The Myth of Mental Illness" and "The Rhetoric of Rejection") already before the publication of *The Myth of Mental Illness,* and others during 1961-70. Their themes are similar to those of *The Myth of Mental Illness* and *The Manufacture of Madness*, but certain aspects are examined more deeply. For example, the theme of representing two adversary parties at once is highlighted in the essay "Mental Health Services in the School." Szasz quotes several authors on this subject. It is clear that pupils' interests are different, and sometimes obviously opposed to the interests of the school. He demonstrates that psychiatrists – serving not their patients but the school – side with the school when pressured by the system. The last essay, "Whither Psychiatry," will be discussed in 8. This collection of essays conveniently presents Szasz's most important views.

The Theology of Medicine (1977) is a collection of essays similar to *Ideology and Insanity* that is subtitled: *The Political-Philosophical Foundations of Medical Ethics*. In the introduction Szasz attempts to clarify his political-philosophical premises from a different angle. He starts by positing that human life without suffering is unthinkable. People can only struggle to achieve things they want in life at the expense of other desired things. The things we as humans want exclude each other so we have to make choices. At the same time, different people often have very different desires. That means that people in similar situations suffer to different degrees, and that relief of suffering can have totally different meanings to different people.

When people aim to maximally relieve the suffering of humanity, conveniently assuming that all people suffer to the same degree and in the same circumstances, the result is more, not less, suffering. The greatest suffering was/is generated by political programs that claimed/claim to relieve suffering most radically – examples being Marxist communism and medical-scientific ideology.

Nowadays nobody would want to impose a religion on someone else, Szasz says. Why does such a thing happen to people who are labeled mentally ill? There are two reasons for succeeding. The first is that language has been deflected from reference to suffering and happiness to reference to illness and health. The second is the destruction of the ideals and institutions that are supposed to protect us against those who would help us.

Szasz uses the words theology and religion in an unconventional meaning. He means everything in which people believe and that provides sense and purpose to their lives. So religion encompasses both what is conveyed by the French word *foi* and the word *croyance*, and is about synonymous to what Stüttgen in 1972 calls ideology. In short, it encompasses everything in which a

person believes. (*Ceremonial Chemistry*, 1974, p. 2) In my opinion the use of the word religion this way is confusing and strictly speaking incorrect. The same holds for the title of the book, *The Theology of Medicine.* Nowhere in the book is there any reference to theology. The title is, I believe, intended to suggest that health has become a (false) god, the physician a priest, and medicine a theology. So the title is to be understood as a metaphor. The contents of the essays in this collection have already been discussed above.

.....4.2.4 Psychiatry as a Social Institution

Psychiatry can be described as a social institution as well as a humanity, an applied science, and a profession. Szasz uses this concept in the sense that Feibleman does. It means “stable patterns of group behavior, usually pertaining to the regulation of one or another of the functional prerequisites of society.” (*Law, Liberty, and Psychiatry*, p. 86)[36]

Institutional behavior, the objectives of the institution, and its rules can be contrasted to personal behavior, individual objectives, and less conventional rules.

Accordingly, an individual’s belief can be contrasted to organized religion with established public opinions and political power. Religion, education, family, and health care can all be considered and described as social institutions this way. So a social institution is not a thing or fact or organization, but an abstraction that is expressed in the behavior of individuals and groups. As institutions imply regular and thus predictable behavior, they form a part of a larger system of social control.

Psychiatry’s structure as a social institution includes the following components: psychiatrists and psychiatric patients; psychiatric hospitals and institutions; the state regulating agency; complex rules of conduct regarding what may and may not be done with psychiatric patients; parapsychiatric professions such as psychology and psychiatric nursing; and the psychiatrists’ professional organization.

The functions include testing and treating psychiatric patients, and removing some people from the community. The latter is, historically speaking, the oldest function. It is practiced in part by scientific and rational maneuvers, and in part by symbolic maneuvers. The term “mental illness” itself is in part a rational and in part a symbolic maneuver. So are psychiatric diagnoses. A diagnosis can be considered rational inasmuch as it describes a certain behavior. It is symbolic inasmuch as it evokes a certain feeling that in turn evokes a certain action. Examples of the latter are psychopathy and hysteria, and even more so the words psychopath and hysteric. The result of the symbolic meaning, if not the purpose, is uplifting the institution and its practitioners and dragging down the person so diagnosed. I notice that here Szasz apparently ascribes a certain rational significance to the diagnosis. In later works the diagnosis to him turns into an instrument the sole purpose of which is to discriminate and dehumanize the person diagnosed.

According to Szasz, psychiatry as an institution derives its authority from the fact that psychiatrists are physicians. This, too, is a symbol, because owing to this

authority, psychiatrists can define and redefine reality: anybody can declare somebody else to be crazy, but only when a psychiatrist does so – serious – social consequences follow.

The most important feelings that the institutional symbols of psychiatry evoke are feelings of aversion to psychiatric patients.

The purpose of psychiatry as a social institution, inasmuch as these are apparent from the way psychiatry works, are: in the first place, raising one's own status and power; and secondly, protecting the status quo and the principal established interests of the community at any given moment. In this sense, a concept like mental health works. It cannot be separated form other core values in society, such as the socialization of citizenry and the maintenance of internal order. Viewed as such, psychiatry presents itself as a social power that contradicts reason, personal responsibility, and human dignity. This can be illustrated by two important effects. The first is the psychiatrization of law, politics, and decency. Economic, religious, and social problems are converted to psychiatric problems, problems suggesting illness. The second effect is that psychiatry is elevated to a religion. Hence psychiatry has become an example of an institution that has changed and in fact destroyed its own purpose. It started out to help patients live as they wish. It turned into a servant of the community, and is willing to understand and assist the individual only to the extent that such assistance will contribute to greater glory and stability of the group.

Szasz opines that only in the twentieth century did psychiatry assume the character of a social institution, and as such is still in an early stage of development. He advocates that psychiatry as an institution seek a balance between serving the interests and needs of individuals and groups, being aware that these interests can – in fact, must – contradict. It is difficult to imagine how this is possible for Szasz. After all, to him, serving both the individual and the group is always to the individual's detriment. Probably his intention here is to create space for contractual psychiatry next to institutional psychiatry.

...5. Views on Certain Types of Mental Illness

Szasz elaborated on his insights into mental illness in several books and articles. On the one hand, these could be viewed as tests as to whether his most important theories apply to specific mental illnesses. On the other hand, they are an answer to the criticism that in *The Myth of Mental Illness* he chose hysteria, an example that seems to fit his theory exceptionally well. After all, hysteria, if it *is* a fake illness, is one that imitates somatic illness. Afterwards Szasz wrote in succession about addiction (5.1), schizophrenia (5.2), and sexual dysfunction (5.3).

Here we may pause to consider that the term mental illness is becoming obsolete in the Dutch language, including in Dutch professional jargon. Except for theoretical discussions about the concept of illness in psychiatry, the term is rarely used. The term suggests the existence of separate, clearly circumscribed entities that can be interpreted as illness or even as units of illness. It is noteworthy that Szasz fairly continually uses the nosological entity as focus of his views, while exactly that has been so criticized.[37] Neither the multi-conditional nor

the poly-interpretable character of the symptoms and syndromes that are encountered in psychiatry is adequately reflected in the study of nosological entities.[38] In my opinion it is preferable to speak of psychiatric disorders rather than mental illness. I will return to this issue in Chapter V, 2.4.

To Szasz the use of nosological entities seems to imply a certain distance between work in the field and dealing daily with patients. The writings discussed below contain general views on the implications of concepts such as addiction and schizophrenia. Szasz almost exclusively studies what other authors have written on the subject, and almost never refers to his own experiences with such patients.

One will search in vain for a preoccupation with what is wrong with the so-labeled patients. Symptomatology and phenomenology are completely absent as subject of further study. Specific cases are not even presented as illustrations. This prompted critics like Cancro and White to note that Szasz seems to be so far removed from actual practice that one wonders whether he knows what he is writing about.[39] Be that as it may, the books and articles discussed below are about psychiatry as a social institution and about psychiatrists, but hardly at all about patients.

....5.1 Ceremonial Chemistry (1974)

Ceremonial Chemistry is about drugs, drug users, addiction, and all the various psychiatric, legal, and criminal measures and problems that are generated by the drug problem.

Szasz begins by wondering what the concept of addiction actually means. In former times it referred to a strong, morally neutral tendency towards a certain behavior. Later it became a bad, morally objectionable habit. In 1934 the American Psychiatric Association adopted a resolution that “alcoholics are valid patients,” which marks the beginning of the official medicalization of addiction. At that moment addiction became a medical problem. The official *Standard Classified Nomenclature of Diseases* published by the American Psychiatric Association first listed “drug addiction” as a category of diagnosis in 1934. Nowadays the word refers to just about anything that is illegal, immoral, or undesirable regarding some (but not other) drugs.

Then Szasz explores in which conceptual framework and in which logical class of concepts the word addition belongs. He denounces the custom of ascribing addictive properties to certain drugs because that would evoke the illusion that the problem is pharmacological. Addiction is not about a pharmacological substance, but about a certain way people deal with it. As such the study of addiction belongs in the humanities, alongside anthropology, sociology, law, and ethics. Addiction belongs in a category of concepts that include ritual, ceremony, and religious and symbolic actions, rather than pharmacology’s scientific and technical category of concepts. A chapter on addiction in a manual of pharmacology is comparable to a chapter on prostitution in a manual of gynecology, a chapter on perversion in a manual of physiology, a chapter on the racial inferiority of Jews and Negroes in a manual of genetics, and a chapter on sun-worship in a manual of astronomy.

Inasmuch as drugs can help in dealing with life's difficulties and disappointments, drug dealers are comparable to the white witches of the middle ages. They, too, offered substances for the relief of pains and cares. They, too, were persecuted and severely punished.

The role of medicine in the drugs problem does not confine itself to the examination and treatment of ill people, but is strongly associated with controlling human behavior. Physicians have often served political regimes that requested their assistance. In the current war on drugs, physicians take the lead by denouncing the use of drugs and lobbying for their restriction and prohibition. Szasz describes how physicians are poised to become victims of their own opposition to drugs. He cites examples of doctors who were visited by agents of the "Bureau of Narcotics and Dangerous Drugs." These agents posed as patients with certain complaints. If the duped physicians prescribed "prohibited" medicines, the agents charged them. Noting that one reaps what one sows, Szasz concludes, "However, my adaptation, to the requirements of the contemporary drug scene, of a time-honored wisdom from the Gospels makes a fitting epitaph for the headstone of a Medicine devoted to curing the sick but murdered by a brother devoted to controlling the sinful." (p. 142)

To Szasz the essence of the drug problem is the notion that drugs form a temptation for man, one that he can or cannot resist through moderation or abstinence. These concepts used to be key concepts in our Christian culture. As religion gradually gives way to medicine as a religion, they are replaced with the more "scientific" terms impulse and satisfaction. In other words, whereas man used to be considered exposed to all sorts of temptations which he was supposed to resist through self-restraint, now he is seen as helpless in the face of impulses for which he seeks satisfaction, and from which he must be restrained by external controls. Man has been converted from a tempted individual to an organism in need of protection. This implies that external controls are gaining in emphasis. Any external controls will evoke resistance, so ironically, the use of illegal drugs is promoted by their prohibition.

External control means that the satisfaction of certain impulses is encouraged, for instance heterosexual impulses towards one's own spouse, masturbation, and the use of some drugs like tobacco and alcohol. Satisfaction of other impulses, such as homosexuality, pedophilia, and the use of other drugs, is made impossible by social controls. The extent to which man is viewed as a defenseless victim of his impulses is illustrated by the growing tendency to exonerate the user (the "victim"), and punish the tempter (the drug dealer, prostitute, and such). Szasz sees a similar development regarding jealousy. In former times, jealousy was a vice. Nowadays the person who gives the other reason to be jealous is denounced. Undoubtedly this shift places a premium on dependency, helplessness, and civil heteronomy.

By replacing self-restraint with external controls, by unleashing an attitude of lynch towards drugs and all that is related to them, and by constantly drawing attention to the problem, it is clear that "our present war on drug abuse encourages precisely the sort of behavior which its stupid or sadistic supporters claim they want to discourage." (p. 163) In this book, the "Therapeutic State" (see Chapter III, 2.4) is turned into a "Pharmacracy," a characteristic technical form in which we are ruled by the control of drugs.

Szasz's conclusion is that respect for citizens' autonomy requires that all drugs and medicines be freely available, at least to adults. Whoever cannot deal with that can ask for assistance if he wishes. It is not the government's job to determine what somebody may eat, drink, inhale, or inject.

....5.2 Schizophrenia (1976)

Szasz starts by recounting the history of schizophrenia. At the beginning of the twentieth century, dementia paralytica was discovered. That was a mental illness that turned out to be caused by syphilitic infection of the central nervous system. This discovery was all the more impressive as a large percentage (Szasz quotes examples of 20% to 30%) of the patients in psychiatric institutions during 1900-40 turned out to be suffering from dementia paralytica. (p. 7) To a certain point that justified the expectation that other psychoses would also turn out to be caused by somatic factors.

In spite of immensely comprehensive research on the matter, however, no criteria for diagnosing schizophrenia were ever found other than behavioral criteria. Kraepelin and Bleuler believed that an organic disorder would be discovered, but what is the value of such belief, considering that the people in whom such a "disease" was diagnosed were involuntarily incarcerated? Szasz posits that the conclusion that they suffered from an illness called schizophrenia actually had *only* strategic significance, namely, that it justified locking these people up against their will. Society, the medical establishment, and judges demanded such a point of view. If Kraepelin and Bleuler had published everything they *discovered* – namely that no consistent physical aberrations whatsoever could be found in these people – instead of what they *believed*, they would have compromised the prestige of the psychiatric profession and their own careers.

Contrasted to the syphilis model for schizophrenia, Szasz describes the model offered by the antipsychiatrists Laing and Cooper as the model of the "plundered mind." The schizophrenic is viewed as a victim of his environment. He has been squeezed and drained to the point that he has lost his own identity. Szasz condemns the duplicity of rejecting the concept of schizophrenia and denying its existence, whereas schizophrenia and the best way to treat it is constantly discussed, suggesting that it exists after all. In many ways Szasz views antipsychiatry as the mirror image of psychiatry. Their theories and explanations are diametrically opposed, yet formally very much resemble each other. It makes little difference whether a person has become schizophrenic because of a sick brain (the traditional psychiatric explanation), because of a weak ego or strong id (the psychoanalytic explanation), or because family and society have driven one crazy (the antipsychiatric explanation). Psychiatry treats psychotic patients as minus entities, who at most ought to be regarded as irresponsible children who must be guarded against themselves. Antipsychiatry treats them as plus entities. Both distinguish the schizophrenic from the rest of society. Both use a metaphor as though it were literal. Psychiatry claims that schizophrenia is an illness, whereas it but resembles illness. Antipsychiatry claims that schizophrenia is a journey through madness, whereas that, too, can be meant only metaphorically. Both psychiatry and antipsychiatry imply

idealization of people: psychiatry, by assuming that everybody could be well-adjusted and happy if only the brain were not affected by disease; antipsychiatry by assuming that everybody could be his own authentic self if only he were not plundered by others.

Szasz rejects the term antipsychiatry, calling it “imprecise, misleading, and cheaply self-aggrandizing.” (p. 48) He notes that the coining of the word is erroneously ascribed to Cooper, because Beyer already used it in 1912, meaning a publication that is critical of psychiatry. Approvingly, Szasz quotes some of Laing and Cooper’s critics, in particular Martin and Trilling. The former, according to Szasz, portrays Laing as “an angry prophet, an intolerant religious fanatic.” The latter analyzes the concept of authenticity as a meaningless concept, and both antipsychiatrists as people who value prophetic visions more highly than facts and reality.

Finally, Szasz criticizes Cooper’s Marxist-collectivist political premises that are formulated in Cooper’s ideas much more explicitly than in Laing’s. Szasz compares the elevation of the schizophrenic above ordinary people to the communists’ elevation of the poor above the wealthy.

Afterwards Szasz states that he wishes to examine what exactly is meant by schizophrenia, but – stating that its phenomenology is too vague, and that the term is often used to describe just about any behavior that the doctor rejects – examines several authors on schizophrenia instead. He labors from the premise that schizophrenia is an irrelevant concept and that its only purpose is the justification of involuntary commitment and force. The age-old practice of institutional psychiatry needs a scientific rationalization to justify itself. The word schizophrenia suggests the presence of an illness whereas in reality it is no more than a word. Statements by several authors are held up to this central hypothesis. When their statements do not conform to his hypothesis, they are condemned. It seems to me that this is faulty logic and procedure, because this way Szasz keeps repeating his own position instead of demonstrating it. (See also Chapter IV, 4.)

At the same time it becomes obvious that to Szasz the word schizophrenia is synonymous to psychosis, and more specifically means: any behavior for which somebody may be involuntarily hospitalized. Szasz seems only interested in that no clear and consistent physical defects have been found in the manifestation of schizophrenia, and that therefore it cannot be a disease.

....5.3 Sex by Prescription (1980)

In *Sex by Prescription* Szasz discusses two subjects. The first is that area of sexuality with which medicine concerns itself. The second is sex education as it used to be taught in religious circles, and now is taught at schools and universities. Not without sarcasm he notes that pastors and doctors both think that they and only they know how people should amuse themselves, in particular sexually. Pastors derive their authority from God and His laws. Doctors derive their authority by declaring that certain behaviors, of which they disapprove, are illnesses, whereas other behaviors, of which they approve, are healthy. Of course there are physical factors that can cause sexual dysfunction. This does not mean

that non-physical causes, which may cause for instance frigidity or impotence, also belong to the domain of medical competence. They are more likely to be solutions that people seek and find for certain problems and tasks in living, so can be understood as expressions of individual life styles.

Modern sexologists and sex educators have an animalistic view of sexuality. The person must be "filled" with stimuli by his partner, and subsequently produces an orgasm. Szasz compares it to the production of feces after receiving an enema. Further they encourage deprivatization of sexuality and sexual relations. They raise the expectation that if people "read the right sex manual, seek the counsel of the right sex therapist, or find the right partner, then they will enjoy unremitting sexual satisfaction, in a loving encounter with another, with integrity and dignity, day after day, year after year, for forty, fifty, of more years. The absurdity of this image is a measure of the absurdity of modern sex education and sex therapy." (p. 166-167)

Szasz concludes that not only does he oppose state sponsored and taxpayer financed sex education programs and sex therapy, but that he endorses an economic, legal, and political policy that leaves the individual a maximum of freedom to become acquainted with sex and be sexually active. His conclusion conforms with his earlier works. He further concludes, paraphrasing Voltaire (who posited that religion is to theology as food is to poison): "Sexology is to human sexuality what slavery is to freedom." (p. 157)

...6. Psychiatry, Justice, and Law

A preoccupation with the connection between psychiatry and the law permeates throughout Szasz's work. This applies to involuntary commitment laws and patients' rights as well as to the criminal justice system. His first article on this subject was published in 1956.[40] His first book that appeared after The *Myth of Mental Illness* was *Law, Liberty and Psychiatry*. It is an examination of and commentary on all intersections between justice and psychiatry, based on the premises developed in The *Myth of Mental Illness.* More recently this preoccupation is expressed in numerous letters he sends to editors, for instance regarding the criminal procedures against Sirhan (Robert Kennedy's murderer)[41] and Hinckley (who tried to assassinate Reagan in 1981).[42]

The most important axiom expressed in these writings is: in a free society, as a democracy purports to be, there should be only one system of social control and constraint, namely, the criminal justice system. Criminal law should stipulate clearly what is prohibited and how the violator will be punished. Justice should be applied without discrimination. This means that identical violations will lead to identical punishments, regardless of the perpetrators' personal traits or idiosyncrasies. This is the "Rule of Law." The same principle determines that a person who has not violated any law may not be punished and should remain free. Szasz categorically rejects psychiatric involuntary hospitalization, which he considers persecution and punishment for people who have not violated the law. Thus psychiatry is an oppressive social institution alongside the criminal justice system.

This does not mean that Szasz advocates that "everyone who has done something wrong should go to prison" as Matza claims in an interview with

Weis.[43] Szasz posits the mirror image of this statement: someone who has not violated the law should not be locked up. To a certain point, however, Matza's view can be considered as implied by Szasz's position. A person who has violated the law should be punished for the violation in accordance with legitimate law, and no other way. Trimbos's characterization of Szasz as a proponent of "law and order" is,[44] in view of the above, incomplete, to say the least. It is incorrect if the implication is that Szasz believes existing laws to be sacred. Szasz in fact vehemently criticizes various laws, or points out that they are incompatible with the United States Constitution. Nor can Szasz's heartfelt advocacy for recognition of the differences between individuals and the right to express those differences be construed as advocating "order." Szasz's position is that psychiatry inasmuch as it functions as an extralegal institution of social control and oppression should be abolished.

....6.1 Law, Liberty, and Psychiatry (1963)

In *Law, Liberty, and Psychiatry* Szasz examines the function of psychiatry as a social institution, particularly in connection with law and justice. A pivotal theme is the role of the concepts mental illness and mental health in denying certain rights and freedoms to citizens who did or did not violate the law. Szasz considers involuntary commitment the epitome of coercions and deprivations of liberty in psychiatry as a social institution. Involuntary commitment is perhaps the subject most frequently examined by Szasz, precisely because it so spectacularly exemplifies depriving of liberty a person who has not violated any law. The same principle applies when retroactively judging whether a person was "of sound mind" when writing a will or committing a criminal act.[45] Not only is mental illness a myth, but the concept is too vague to be a useful instrument in court procedures, and to form the basis of rulings that profoundly affect human lives. There is way too much room for error and arbitrariness. Psychiatrists are influenced by different parties each of which has a certain interest in the results of their examination. Quite often psychiatrists testifying on behalf of the state or public prosecutor reach different conclusions than psychiatrists testifying on behalf of the defense. The famous, or rather infamous, trial of Hinckley in 1982 is a spectacular example of this.[46] (See also Chapter II, 3.3.)

In the United States legal precedence strongly determines views on criminal responsibility. The oldest of these rulings, the McNaghten Rule of 1843, essentially stipulates: madness can only be a valid defense when it is proven that the defendant, while committing the crime, suffered from a defect of reason caused by mental illness, that caused him to either not know what he was doing, or if he did, to not know that it was wrong. (p. 128) The Durham Rule was formulated in 1954. (p. 132) Its most important stipulation is "that a defendant is not criminally responsible if his unlawful act was the product of mental disease or mental defect." Although Szasz seems to accept the McNaghten Rule, he vehemently opposes the Durham rule. Firstly, the Durham rule reifies the concept of mental illness, although in reality it is no more than a theory that can be useful in explaining something that has happened. Secondly, it views an action as an incident that can be explained by previous incidents. This would imply that man is

considered similar to a machine that functions according to natural laws of cause and effect, whereas humans actually have a certain freedom to choose their actions. Thirdly, genuine, scientific, causative theories – Szasz is referring here to theories borrowed from physics – can consider an object no other way than predetermined. Therefore such a consideration would always lead to exculpation, not because it is justified, but because this is how the theory is constructed. Fourthly, instead of people being held responsible for their actions as competent adults, their status is converted to that of incompetent psychiatric patients. "Accordingly, I submit that, except in cases of gross disability, adults should always be treated as if they were capable of fulfilling the contractual obligations they have assumed. If people are to remain responsible, contracting individuals, it is important to respond to their failure to fulfill obligations by punishing them, not by redefining them as inferior beings, unfit to enter into contracts." (p. 151)

In theory, according to the Durham Rule, when defendants are found not guilty on grounds of mental illness, they should be acquitted. Thus those people should go free and unpunished. Nothing could be less true. Suspects who are turned into psychiatric patients are worse off than those who are convicted of their crimes. They are incarcerated by court order without due trial, to be treated, implying that their detention in an institution is of indefinite duration rather than relative to the crime. Furthermore, the opportunities to appeal and reclaim one's honor are minimal compared to those of the convict.

Involuntary commitment for the purpose of treatment to Szasz is "disguised punishment," not only because such incarcerations replace detention in a penal institution, but also because of the inhumane aspects: mental hospitals are overcrowded; there is a tremendous shortage of professionals; in reality there is seldom if ever any treatment, even when such might be possible. This last argument is of a different order than the first two. It is not a matter of principle or theory, but one of practicality. Nonetheless it is quite important, because legally involuntary commitment and treatment are linked. This link constitutes fraud when there is no treatment.

Szasz notes that the problem of involuntary commitment is extremely important in the United States. He states that 90% of the people in State Mental Hospitals are there involuntarily, that 150,000 people are so committed every year, and that the total amount of people involuntarily hospitalized in the United States exceeds one million.

In a letter to the editor in 1967, Szasz criticizes a remark in *The Economist* claiming that in England and Wales 94% of the patients in psychiatric institutions are there voluntarily, and free to leave whenever they wish. Szasz points out that their stay is "voluntary" because they know that if they resist, they will be committed involuntarily. As long as there is a legal possibility of involuntary commitment, statistics about voluntary admittances are meaningless as well as misleading.[47]

Although there is no way of proving this speculation, or determining in which percentage of cases it applies, in my opinion it also renders the statistics regarding *in*voluntary commitment meaningless and misleading. They in no way reflect the patients' actual situation.

Although Szasz is an indefatigable advocate for abolition of laws making involuntary commitment to psychiatric institutions possible, he does list a few exceptions in *Law, Liberty, and Psychiatry.* He names two types of people for whom a legal accommodation is necessary. The first is the "passive, stuporous, uncommunicative patient." Szasz opines that this person should be treated the same as the person in a coma. To me this category appears to cover those people who do not understand what is going on (such as in advanced stages of Alzheimer's disease and oligophrenia), or who do not protest (such as in depression with serious inhibition, catatonic states, and the like), or whose answers are so confused, complicated, or paradoxical that it is impossible to determine whether they wish to be hospitalized (such as with incoherent psychotics, confused states, and manias). My intention here is to demonstrate that this category of patients might be much larger that Szasz suggests, depending on who is judging them. It can be expanded endlessly depending on how high the criterion for clarity in expressing protest is set.

The second type is the aggressive, paranoid person, who is threatening violence. This type, however, should be treated as a criminal, preferably being incarcerated not in prison itself but in a prison hospital, where he can receive medical and psychiatric assistance.

Szasz points out that such emergencies are rare and should remain exceptions. In any case they constitute only a small portion of the current involuntarily committed population. In addition, as such people usually (turn out to) "have" something physical, they should be hospitalized in general hospitals. Involuntary commitments should be revoked the moment that patients regain their ability to communicate their wishes.

....6.2 Psychiatric Justice (1965)

In this book Szasz examines a special – in the Netherlands in principle not impossible but in practice never used – procedure of psychiatrists testifying in trials. This refers to the question of whether a person is fit to stand trial, whereby both the person's ability to understand what it is about as his ability to assist in his own defense are important. Szasz writes about this procedure in a way that indicates that it has become quite customary in the United States in the fifties and sixties [of the twentieth century]. He does not quote any numerical statistics, but rather mentions that they are not available (yet?).

Szasz vehemently attacks this custom. Although ostensibly serving suspects' interests, in fact this measure turns against them, because the consequence is that they are removed to psychiatric institutions to be treated. If the treatment succeeds, the trial proceeds, so that the suspect is in fact locked up (punished) twice. If treatment fails, which is common, then the suspect remains detained in the Mental Hospital. Szasz quotes Hess and Thomas who studied the effect of this legal procedure in Michigan. They found that more than half of the suspects who were transferred to psychiatric institutions this way spent the rest of their lives in them.[48] Their study indicated a nearly complete role reversal between psychiatrists and judges, as well as confusion around the entire procedure. Often criminal responsibility for the crime and fitness to stand trial

were confused. The point of the hospitalization was often not understood in the psychiatric hospital. Repeatedly the paradox arose that such people were released on a trial basis for which the criteria were much higher than the criteria for being considered fit to stand trial. Hess and Thomas's conclusion is that suspects have been victimized by a measure ostensibly instated to protect their rights. Szasz opposes this procedure because in his opinion suspects have the right to a fair and public trial. When they are incarcerated in psychiatric institutions no judge has ruled on whether they actually committed the crime of which they stand accused. Szasz considers this a violation of the sixth amendment to the United States Constitution which grants everyone suspected of a crime a "speedy and public trial." Besides, the question of what qualifies people to be fit to stand trial remains unanswered. There is a huge difference between the minimal criterion that people should at least understand the charge against them, and the maximal criterion that they should be able to participate in the trial using all the skill and ingenuity that it takes to optimally play the trial game. In the latter case practically nobody besides attorneys can be considered competent. Accordingly, Hess and Thomas found that different courts use the measure in very different degrees, introducing a questionable inequality of legal procedures.

Several examples of such procedures are thoroughly discussed in *Psychiatric Justice*, with verbatim reports of the trials. A comparison of these cases leads Szasz to comment that wealthy, famous, and intelligent suspects are much more likely to successfully resist being ruled incompetent than poor, unknown ones. This way psychiatry contributes to privileging the higher classes and helps the state to oppress the poor and humble.

As there is no other appropriate place in this book, I wish here to make a few more comments about the fate of this procedure. In the ensuing years attempts were made to improve the situation. A ruling by the Supreme Court put a limit on the length of hospitalization for people who are ruled "incompetent." Uniform questionnaires were instated for examining suspects. Seminars and conferences were dedicated to the subject. In 1978 Geller and Lister, after studying the situation in Massachusetts, reported bafflingly little improvement.[49] They noted that the crimes involved were usually petty, and that 72% of the suspects whose trials were resumed after treatment were acquitted. Apparently, Hess and Thomas pointed out, the question of competence was raised with these suspects not so much because of their mental condition, but because no other sensible measure could be thought of. Stone underlines this by commenting that abuse should be blamed not so much on the law but on the chaos in the system of penal justice, and that reforms in the justice and penal systems are necessary.[50]

In conclusion, I quote Pendleton who reports on a treatment program for this category of people in a Mental Hospital. It consists – in addition to routine psychiatric treatment and occupational therapy – of a training program in which the participants learn the ins and outs of a trial and how a defense can be effectively conducted. The course even includes an examination and participation in a mock trial. With this program 90% of the patients ruled incompetent can be released as competent.[51] My comment on this is that it would be desirable that every suspect who so wishes can take such a training program. A different question all together is whether involuntary commitment to a State Mental

Hospital is really necessary for such a program, particularly considering that the average length of "treatment" was 104 days. One can also wonder what the point is of such a program, if more than 70% of these people are acquitted anyway, as Geller and Lister state.

....6.3 Psychiatric Slavery (1977)

Psychiatric Slavery is a commentary on the Donaldson court case. Donaldson tried to fight his involuntary commitment through the courts. The case reached the Supreme Court. The main problem around which this case turns is the linkage between commitment and treatment. This linkage was already discussed in the section above, particularly in relation to criminal behavior. The question of whether people who are involuntarily hospitalized have a right to treatment raises other questions. Is it justified to involuntarily commit people for the purpose of making such treatment possible? Can this treatment be so essential as to justify involuntary commitment even though the patient is not dangerous? And, if the explicit purpose of involuntary commitment is treatment, should the person be released when no treatment is possible or when the person refuses treatment?

Szasz comments on the case and answers these questions from his point of view that involuntary hospitalization in itself is an unjustifiable social, moral, and political evil. He considers the question of the victims' right to treatment illogical and misleading, because it disguises and protects the phenomenon of involuntary commitment.

The title of the book is a reference to Szasz's analogy between slavery and institutional psychiatry, an analogy that he formulated already in *The Manufacture of Madness*.

...7. Freud, Psychoanalysis, and Psychotherapy

....7.1 Introduction

Where there is no illness, there can be no therapy. According to Szasz, the question of the medical significance of treatment methods in psychiatry should be replaced with the question of their moral and social significance.[52]

Szasz has published little about physicochemical treatments in psychiatry. These treatments became possible only because of the same error of category that is the basis for the invention of the concept of mental illness. (*Schizophrenia*, pp. 90-92) Szasz's conclusion is predictable when considering that drugs, electroshock, insulin-induced coma, carbon dioxide inhalation, or any other in part obsolete physicochemical treatment method exists for the purpose of treating one of the parties to a conflict, which is what patients are. He considers psychoactive drugs chemical straitjackets.[53] Electroshock and psychosurgery are archetypal of patients' coercion, oppression, and dehumanization. Not only are they gruesome and violent methods, but they don't work. They harm patients. Psychosurgery in particular deprives them of their ability to complain and resist. Finally, it is noteworthy that Szasz traces the invention of electroshock to Cerletti, who

observed that in the slaughterhouse animals were stunned with electricity before slaughter.[54]

On the other hand, psychotherapy and psychoanalysis feature prominently in Szasz's work. Probably most interesting is the clear change in his views on these in the course of time, contrary to the premises of his critical-psychiatric theory, that remain unchanged. This change is most apparent in his views and appreciation for Freud (7.2), but it is also noticeable in his opinions and judgments about psychoanalysis as a theory and a therapy (7.3). Psychotherapy in general will be discussed separately in 7.4.

....7.2 Szasz on Freud

In his first professional years Szasz is an admirer of Freud. He conspicuously examines whether his positions correspond with Freud's in his earliest works.[55] When he quotes Freud in 1949, he adds praise, such as: "as Freud … so clearly describes…"; "this beautiful analogy of Freud's…"[56] In a 1955 article he stresses in a footnote that certain of his positions should not be taken as criticism of Freud's views.[57] When, fairly early in his career, Szasz criticizes aspects of psychoanalytic theory, he carefully avoids personal criticism of Freud.[58] By 1959 he openly attacks Freud about the ambiguity of using both biomedical-therapeutic and psychological-moral frames of reference.[59] Shortly afterwards Szasz states that Freud's motives for vacillating between stressing a medical approach to psychoanalysis and a psychological one were not scientific but of a social, professional, legal, and political nature.[60] Just how dangerous it was in those days to attack Freud becomes apparent in the ensuing discussion about Szasz.[61] Several of his opponents accuse him of shortchanging Freud and quoting him out of context, even though to varying degrees they concede to the criticism.

Szasz's criticism of Freud becomes clearer in *The Myth of Mental Illness*, but remains circuitous and is directed at Freud's theory, not at him personally. Two years later in an article entitled "Freud as a Leader" Szasz directly attacks Freud.[62] He describes him as a kind of industrialist who wished to patent psychoanalytic discoveries, who opposed anyone with ideas on psychoanalysis that differed from his own, and who wished to monopolize the determination of what is included in the concept of psychoanalysis and what is not. That is why, according to Szasz, Freud had endless confrontations with his disciples as soon as they tried to make their own contributions. Freud made psychoanalysis a movement rather than a science. Not only was he an autocratic leader – this had been claimed before – but he was also deceitful, pseudo-democratic, and pseudo-scientific. Szasz ascribes psychoanalysis's resemblance to a movement rather than a science to Freud's leadership. In 1913 Freud wrote to Ferenczi, "We possess the truth; I am as sure of it as 15 years ago." Szasz calls that an example of how leadership ought not be. On the side, I note that although Szasz has no ambition to form a movement comparable to psychoanalysis, it is ironic that he responded to Roth's criticism of his (Szasz's) views on schizophrenia[63] as follows: "I believe, therefore, that my influence is due … to the fact that I tell the truth …"[64]

Karl Kraus and the Soul Doctors is published in 1976. Karl Kraus was a Viennese journalist who published a magazine, *Die Fackel*, for decades at the beginning of the twentieth century. He wrote most of the articles himself. Szasz describes him as an individualist with integrity who opposed every form of collectivism and advocated human freedom and dignity, as well as purity of language. Thus Kraus is presented as a man who strives for the same ideals as Szasz. The book about Kraus is however as much about Freud, and opposes him as well as the psychoanalysts around him. Szasz scathingly criticizes Freud as a man whose "basic aims" were "to annex morals to medicine, to create a cryptoreligious ideology and be its leader." (p. 52)

Szasz posits that both Kraus and Freud were rhetoricians, describing rhetoric as the use of language with the intention of influencing others. He quotes Richard Weaver: there are three ways in which language can influence us. It can move us in the direction of good ("noble rhetoric"), it can move us in the direction of evil ("base rhetoric"), or, hypothetically, in no direction. Weaver states, "Base rhetoric is therefore always trying to keep its object from the support which personal courage, noble associations, and divine philosophy provide a man." (p. 53) Szasz considers Kraus a noble rhetorician, whereas Freud is a base rhetorician, someone who "uses language to increase his own power, to produce converts to his own cause, and to create loyal followers of his person." (pp. 53-54) Freud was also a "base rhetorician" because he aimed to mislead people by labeling their conflicts illnesses, and by humiliating his opponents, defaming them, and often even stigmatizing them as sick.

Szasz accuses the historians of psychoanalysis of falsifying history. They ascribe Kraus's opposition to psychoanalysis to his personality, as assessed by one of Freud's followers, Wittels, at a meeting of the Viennese Psychoanalytic Society in 1910. Such a procedure, "psychoanalysis" of a personage from the past or present in his absence and without his consent, was customary in the at the time still small circle of psychoanalysts. In fact, Freud himself did so in his writing on Leonardo Da Vinci,[65] about which Szasz says, "Where Freud is at his best as a base rhetorician, defaming one of the most revered artists the world has ever known." Szasz demonstrates that Kraus already rejected psychoanalysis in 1908, and that Wittels' view was "an exercise in psychoanalytic denigration and defamation for which no special knowledge of the victim's personality is required." (p. 27) This book will not be further discussed here. Szasz's condemnation of Freud as a person and as a practitioner of a pseudo-science has been sufficiently highlighted. Also Szasz's view on the role of Freud's Jewishness, which is discussed thoroughly in *The Myth of Psychotherapy* (1978), is omitted here for the sake of brevity.

****7.3 Psychoanalysis

Szasz completed his psychoanalytic training and worked many years as a psychoanalyst. His appreciation of psychoanalytic theory and therapy runs roughly parallel to his appreciation of Freud. He did criticize all sorts of aspects about psychoanalysis before he criticized Freud himself. The brief sketch below will touch only on some of the major issues.

a. The scientific status of psychoanalysis
Szasz rejects psychoanalysis's pretension of being a value-free study of human psychic functioning. This would mean that events in psychic lives are connected through the principle of causality, as in physics. The claim that people's current behavior can be thoroughly understood through their past makes psychoanalysis historistic, and implies that human behavior is completely predetermined. In that case free will, free choices, and thus responsibility would be fictions, even though the historistic theory is paradoxically balanced with an antihistoristic therapy. The concept of "cause" in physics has a different meaning than in the humanities. Besides, as physical laws are relative to mass, so psychological laws are relative to social circumstances. Psychological laws cannot be formulated independently from sociological laws. (*The Myth of Mental Illness*, pp. 23-24) In an article published in 1959 Szasz posits that the term "explanation" has three meanings in Freud's writings. Firstly, it is synonymous to etiology, the cause of illness. Secondly, it is synonymous to "translation." Something means something else and can be translated as such. Thirdly, it means the compilation of an instrumental theory about studied events, and the formulation of that into analytic ascription. In all three cases the concept of explanation has a different meaning.[66] In *Psychiatric Slavery* (1977) Szasz asserts that the difference between explanation and justification is that explanation refers to events and justification refers to actions. The question why someone does a certain thing can be answered in different ways. Each approach generates a claim, or guess, or view of the event. None can lead to an explanation in the scientific sense of the word. (pp. 2-3)

Szasz defends the view that psychoanalysis can be best understood as psychological theory. Terms such as erogenous zones, drives, and libido have dubious medical-scientific frameworks of reference. Obviously, for instance, sexual behavior is dependent on the body and its chemistry, just as it is obvious that thinking, feeling, and behavior are dependent on the structure and function of the brain. The sociopsychological frame of reference of such concepts is much clearer. Sexual behavior, for instance, is much more closely connected to social learning and social conventions within a culture than general medical matters are.[67] Using quotes from Freud, Szasz demonstrates that many pronouncements sound like medical-scientific explanations, but are in fact moral pronouncements, for instance regarding the question of which sexual behavior is healthy (good).

Szasz concludes that psychoanalysis cannot keep up the appearance of being a medical science. Psychoanalysis shares the status of the humanities, such as theology and ethics. Szasz isn't completely clear on this point. He speaks about "fake science" when discussing psychiatry and psychoanalysis, and posits that the relationship between psychoanalysis and physics is as the relationship between astrology and astronomy. Szasz told me that he considers only the physical sciences as true sciences. Psychiatry and psychoanalysis, like ethics, anthropology, and law, concern themselves not so much with the question of how people are, but with the question of how life should be lived. Thus they are molded in a moral frame, and derive their significance from that. Szasz mentions another difference: science produces facts. The role of scientific language is to formulate those facts. Psychoanalysis consists of an interplay of views on how life

should be lived. Psychoanalytic language seeks to influence, which explains the term rhetoric for this language. Szasz approvingly quotes Voegelin, who considers psychoanalysis a kind of gnosticism. Voegelin contrasts this term to philosophy. Philosophy is the love of knowledge and truth. Its purpose is personal salvation. Gnosticism is the claim to have knowledge or truth. Its purpose is not personal salvation, but domination of others. As a gnostic movement, psychoanalysis is comparable to positivism, Marxism, communism, and fascism. (*Karl Kraus and the Soul Doctors*, p. 77)

b. Psychoanalysis as a therapy

Rejecting psychoanalysis as a (physical) science on the one hand, and locating it beyond the realm of treatment for illness on the other, Szasz is led to develop a variation of psychoanalytic psychotherapy. He details it in *The Ethics of Psychoanalysis* (1965). Therein he credits Freud and psychoanalysis for the absence of coercion and deception in the therapeutic relationship. The contractual nature of this relationship became for Szasz the prototype of contractual psychiatry.

This therapeutic relationship forms the framework for *The Ethics of Psychoanalysis*. The aim of therapy, which Szasz calls autonomic psychotherapy, is that clients are assisted in becoming more free and in expanding their autonomy. This is achieved by reducing complaints and insoluble problems to what he considers their essence, namely the impediment of free choices. Thus psychotherapy is a kind of social action, aiming to broaden clients' freedom of choice by equipping them with more knowledge about themselves and others. This is done by analyzing communications, rules, roles, and games. He combines insights from psychoanalysis with insights detailed in *The Myth of Mental Illness*, and with his thoughts on contractual relationships and liberty as a core value in life. (See Chapter III, 2.2.)

Autonomic psychotherapy was awarded little attention in psychoanalytic circles as Szasz himself writes in 1974. He postulates that it jeopardized psychoanalytic dogmas too much, such as by rejecting psychoanalytical mythology and criticizing training-analysis.

c. Training-analysis

In three articles aside from in *The Ethics of Psychoanalysis* Szasz criticizes psychoanalytic training, and specifically the required analysis of the trainee.[68] In the epilogue to *The Ethics of Psychoanalysis* he asserts that a personal analysis is generally sensible, but that a required training-analysis is for the purpose of becoming a psychoanalyst rather than to be liberated from internal confines. Psychoanalysis independent of training is more useful. Also, "Having a 'good' analysis does not make one a good analyst, nor does knowing one's 'blind spots' ensure him against analytic ineptitude." And further, "The notion that the psychotherapist's personal analysis is bound to make him a better analyst than he would be without it is illogical and probably untrue." (p. 216)

Psychoanalysis is characterized by a voluntary relationship between therapists and clients, where the clients' goals are to learn more about themselves and others, and that way become more free. This situation is perverted in obligatory training-analyses. Both therapists and clients are tied to all

sorts of outside interests. The clients wish to complete their training. They have social and professional interests in a good, and preferably expeditious, analysis. The therapists have a double loyalty. They are a therapist to the client, but have a secondary loyalty as trainer to the training center and to the future clients of the trainee. In 1962 Szasz publishes a study using questionnaires that were distributed among psychoanalysts who analyze trainees.[69] He concludes that most psychoanalysts do not mind discussing the contents of the training-analysis with others, and in particular with the people in charge of the training, although some do mind. In the entire United States there was only one training center that did not involve training therapists in its assessment of candidates' suitability. This means that the basic rule of privacy, that generally applies to psychoanalysis, was frequently violated. Szasz considers this an inadmissible form of spying on the private lives and functioning of trainees. In a 1958 article Szasz sheds light on psychoanalytic training from the power angle. The more desirable the status of psychoanalyst became during the course of time, the more requirements were put to the trainee. Trainee analysis was introduced at a meeting in Budapest in 1917. Szasz considers it no coincidence that at that same meeting a growing demand for psychoanalysis was observed. An international training program was never developed. Each national association does that in its own way. Szasz quotes Balint, who opines that this is because of conflict between the generation of older analysts and younger ones.[70]

According to Szasz, the need to select candidates for analytical training raises a peculiar ambiguity about being neurotic or being disturbed. On the one hand, there is a tendency to refuse obviously disturbed or neurotic candidates. On the other hand it is emphasized that everybody has neurotic tendencies, and that they who deny that about themselves must have strong psychic defenses, meaning that they are too neurotic. Therefore, in order to make themselves acceptable to the training center, candidates must navigate between the Scylla of a neurotic presentation of themselves and the Charybdis of a non-neurotic presentation of themselves.

It is amazing that practically no attention is directed to the possibility that training-analysis could harm trainees. This is all the more surprising, Szasz notes, as the notion that parents or doctors can harm their children or patients respectively, as well as benefit them, is as old as psychoanalysis itself.

....7.4 The Myth of Psychotherapy (1978)

Szasz describes psychotherapy unusually broadly. Psychotherapy is what two or more people do with, for, and against each other using verbal and non-verbal messages. It implies a relationship that is comparable to friendship, marriage, education, etc. (p. 1) So his description encompasses all possible interactions except those that utilize a physical or chemical influence.

A different way of describing psychotherapy is: talking to people. It is: trying to convince people to view things differently, and trying to convince people of certain matters. In that sense it is rhetoric. It is also: talking about the value and purpose of life. In that sense it is, in Szasz's terminology, religion. The

conventional view of psychotherapists as benevolent helpers is idealized. Often therapists punish, confine, humiliate, or coerce.

This book is largely about the history of psychotherapy. Interestingly, it is more about personages than about therapies. Mesmer, Erb, Heinroth, Freud and Jung are discussed thoroughly. Szasz considers psychotherapy as having originated from religion (the "cure of souls") on the one hand, and traces its roots in Judaism, the classic Greek spiritual treatments, and Christianity. On the other hand it originated from rhetoric as it was described and practiced in ancient Greece. Accordingly, psychotherapy is closer to art than to science.

It is not so easy to answer the question what exactly is the myth of psychotherapy to Szasz. My impression is that in this book he means the same as in *The Myth of Mental Illness*. Psychotherapy is therapy only in a metaphoric sense, just as mental illness is illness only in a metaphoric sense. Furthermore, psychotherapy is actually a moral influence whereas it pretends to be a medical-scientific treatment. These claims were formulated by him previously, so in this sense the book offers few new ideas. It does, however, include fascinating information about several important personages in the history of psychiatry and psychotherapy.

...8. Which Changes does Szasz Advocate?

Szasz is, first of all, a critic who analyzes all sorts of existing situations inside and outside of psychiatry. He attempts to apply certain premises and ideologies to them, and judges and condemns them in that light. He demands accountability, and has taken it upon himself to serve as a kind of professional conscience of psychiatry. It seems to me that this is his strength, and that he is much less someone who leads down new paths or proposes concrete changes. Yet the changes and improvements that he advocates are not only implied in the sense that they can be deduced from his social criticism. Szasz has made them explicit in two ways: by outlining the principles of a new theory, and by proposing concrete changes.

Outlines of a new theory can be found in the second part of *The Myth of Mental Illness* and in *The Ethics of Psychoanalysis*. In Part II of *The Myth of Mental Illness* he develops the rudiments of a theory for personal behavior, in which he attempts to combine psychoanalytic insights, game theory, and the rule-following model of human behavior. Although this theory seems to be promising, he is satisfied with laying only the foundation. He illustrates it with only one example, the hysterical conversion phenomenon. Later he repeatedly refers to this theory, but does not develop it any further. The same can be said for the autonomic psychotherapy that is discussed in *The Ethics of Psychoanalysis*. They are theoretical underpinnings and several sketches of, in my opinion, a promising theory regarding psychotherapy, of which further development in practice is missing.

In *Law, Liberty, and Psychiatry* and in "Whither Psychiatry"[71] he proposes concrete changes and reforms in the mental health service.

His recommendations for change in *Law, Liberty, and Psychiatry* can be found in Chapter 19 of that book. They are preceded by three premises. The first

is that freedom as a core value should be a priority above health as a core value. The second is that as diagnosing mental illness has such horrible consequences, the same principle should apply as in criminal law: a person is innocent unless proven guilty. Accordingly, a person should be considered mentally healthy unless he is proven mentally ill. This is a reversal of the principle that is normally followed in somatic medicine, namely, suspecting that someone is ill until he is proven healthy. The third premise is that changing the way in which society deals with social problems must necessarily occur slowly and gradually.

The long-term goals he sets are:

1. Involuntary commitment to psychiatric institutions should be abolished. In particular it should be abolished regarding people who are threatening suicide and regarding people who are considered mentally ill by others, but themselves refuse hospitalization and treatment.
2. Hospitalized psychiatric patients should remain in possession of all their rights as persons and citizens. Psychiatric hospitals are to be converted to institutions where contractual treatment is possible for those who want it. These institutions have no role in protecting society, nor in protecting hospitalized people against themselves. Both the custodial and the medical aspects of these institutions should be abolished, so that they will begin to resemble some schools, hotels, or vacation camps.
3. Mental illness can no longer be used to exculpate criminals. Not only should it be abolished regarding criminal responsibility, but it should never be used to deny suspects a trial. The rule that people can be tried only if they understand the charge against them and can assist in their own defense should be maintained, but in the literal meaning. Psychiatrists may testify as expert witnesses but should confine themselves to facts and observations. Psychiatric considerations as such are irrelevant, as well as psychiatric views on criminal responsibility. This way, actually, there will hardly be anything left for psychiatrists to do in the courthouse. Postponement of trial would take place only in those extreme cases that even a lay person can see that the person in question is not capable of standing trial.

As short-term goals, he sets:

1. It should be publicly acknowledged that psychiatrists and their involuntary patients are adversaries. Committed patients should develop a feeling for freedom and even for sedition.
2. Patients' rights should be protected by a regulating agency.
3. Mental Hospitals should no longer be used to warehouse all people in society for whom a different solution cannot be thought of. There should be humane and reasonable alternatives that, temporarily, offer asylum to people who are socially troubled and have no other place to go.
4. Hospitalized patients should retain their rights as much as possible.
5. Involuntary commitment as a means of solving all sorts of problems should be discouraged.
6. People should be informed about the dangers of psychiatric hospitalization and about the differences between medical and psychiatric services. People should be informed about the risks and pitfalls, instead of being encouraged to seek help as much as possible.

In “Whither Psychiatry” (which was later included in *Ideology and Insanity*) Szasz stresses the need for clarifying the social role of psychiatrists. It should be clear when psychiatrists are benefiting patients and when they are benefiting society. He suggests splitting psychiatrists into two groups, as is the case with attorneys, namely, there are attorneys who represent clients and there are attorneys who represent the state. The difference with the current situation is not that psychiatrists will fulfill these roles, because they already do. The difference is that they will have to choose which of these roles they will consistently play, rather than playing both roles at the same time or alternating between them.[72]

D(efense) psychiatrists practice privately, have contractual relations with patients who seek their help, and exercise only contractual psychiatry. P(rosecution) psychiatrists practice institutional psychiatry but without the pretense of benevolence. Their role and goal is clear to all. This proposal consists of the classification of experts rather than the classification of illnesses. Szasz himself, however, seems to think such a proposal not realistic, as suggested by his remark that the role of P-psychiatrists “is often considered defamatory of psychiatrists and of the psychiatric profession.” (*Ideology and Insanity*, p. 232)

Furthermore, in this article he proposes a further demarcation between neurology and other somatic specialties on the one hand, and psychiatry on the other. Finally, he anticipates that the current trend in the direction of collectivist and scientistic psychiatry will continue in the near future, but in the long-run the pendulum may swing between individualism and collectivism, and between protecting citizens against the state, and protecting the state against citizens.

▪▪Chapter II The Historical Context of Szasz's Theories

...1. Introduction

The history of psychiatry is often recounted rather naively. Its course over the years is generally described as a line on a graph that only rises. Every new development is considered an improvement. Wrongs are considered things of the past and obsolete. The current state of affairs is a final destination, a climax.[73]

Other writers report a kind of cyclic movement. Ideas, views, and innovations are lost, only to resurface later.[74] Schoeneman states that in much historical writing, events of the past have been reinterpreted. Quoting Kirsch, he calls this the "whig interpretation" of history. Behavior that today is considered abnormal is retroactively labeled psychopathological. Ideas that do not correspond with current scientific thinking are ascribed to ignorance or maliciousness or both.[75] In this way the present state of knowledge and insight is presented as the pinnacle of psychiatry.

If taking into account the historic, social, and intellectual context when studying behavior in former times and the ideas people had about it in those days is desired, then relating history turns complicated. It is exactly this reason that Pearson[76] and Jones[77] object to the method Szasz uses in *The Manufacture of Madness*. In this book Szasz compares the Inquisition to modern psychiatry. (See Chapter I, 4.2.2.) Pearson calls it ahistorical, and Jones adds that Szasz has followed the Levi-Strauss method by lifting events and institutions from different eras out of their context for the sake of comparison.

A typical example of "whig interpretation" is found on page 47 of *The Myth of Mental Illness*. First Szasz quotes Charcot, who, at a party, remarked about a hysterical patient, "*Mais dans ces cas pareils c'est toujours la chose génitale, toujours … toujours.*" ["But in such cases it is always a sexual thing, always, always."] Then he states that this indicates that Charcot must have known that he was deceiving himself by assuming that hysteria is a disease of the nervous system. In my opinion this conclusion cannot be made from Charcot's statement. Observing that hysteria always involves sexual problems is not the same as declaring sex to be the prime problem, and thus arriving at the supposition that any organic-cerebral aberration is absent. Szasz is explaining Charcot's statement through his own ideas about hysteria.

Another example is pointed out by Stone. In *Law, Liberty, and Psychiatry* Szasz quotes Freud who commented on a test by Jung in 1906. The object of the test was to determine whether someone had committed a certain crime. Szasz accuses Freud of failing to emphasize the suspect's privilege to refrain from self-incrimination. Stone notes that in 1906 Freud was addressing students in Vienna, where, at that time, there was no such privilege.[78] So Szasz was accusing Freud of not defending modern American insights. Regrettably, Stone does not carry through this idea. Szasz continues by saying that Freud was opposed to

incorporating psychoanalytic insights about the defendant in a trial, and that is perhaps more important than what precedes.

Although Szasz is greatly preoccupied with the history of psychiatry, and he often compares past events to current ones, it is not my intention to comment on the historical-scientific merit of his work in this chapter.

My object in this chapter is twofold. First I wish to briefly examine whether, and if so, when, problematic behavior and feelings that nowadays we associate with mental illness in the past were also considered illness. Secondly, I wish to sketch an image of psychiatry as it must have been when Szasz began his career, and shortly thereafter, as this must no doubt have contributed to his critical stance. The risk inherent in such a brief sketch is that it is so incomplete as to falsify the image of the past rather than clarifying it. Two considerations are of significance here, because they help justify matters and place them in perspective. The first is that I am not concerned with history for its own sake, but rather as a backdrop to Szasz's work. The second is that Szasz himself has indicated in many places what it is in recent American psychiatry that appeals to him and what he thinks about all sorts of developments. On the one hand, placing his writings in historical perspective provides the opportunity to clarify certain aspects of his work. On the other hand, it provides a tool for comparison, as Szasz's historical placing can either be or not be supported by what to him was important or deserving of condemnation in the reality of the time.

...2. The Conceptualization of Problem Behavior as Mental Illness during the Course of History

Nowadays certain forms of feelings and behavior are considered an expression of mental illness, that is, conceptualized as belonging in the medical-psychiatric realm. Whoever opposes this, and who believes that a different context, for instance religious or sociological, is more appropriate, is challenged to choose a different name for such feelings and behavior. I will follow the custom of using the word madness. Thus madness here means such behavior and feelings, without any implication about how they should be conceptualized. I use the term here in a purely descriptive way, with no other connotations, as a *Stichwort* [key word].

Szasz maintains that only an aberration of the body that can be physicochemically established qualifies as a disease. (See Chapter I, 4.2.1.) A comparable definition was proposed by Virchow,[79] who asserted that all pathology is actually cell pathology. Such a definition could be formulated only after systematic postmortem research on the body became possible. In our culture that was scarcely possible before the nineteenth century. Thus Virchow's description of illness is the first that is empirically based.

Szasz asserts that conceptualizing madness as mental illness is only possible by expanding Virchow's description to include not only aberrations of the body's form and structure, but also aberrations of its functioning, and of behavior. This implies that according to Szasz, hysteria is considered a mental illness only since Charcot's time.

Was madness considered the same as mental illness? Szasz posits that going back in time to before the eighteenth century to answer this question is pointless. The reason is the validity of the question: before this time, there was no

concept of illness the way it is understood in modern (physical) science. There is little reason to fault such reasoning, insofar as everyone is free to be interested only in the modern scientific development of medicine and psychiatry. Ellenberger, too, is of the opinion that scientific psychiatry originated around the year 1800, although he traces precursors already several centuries earlier.[80] However, this form of reasoning has one important flaw: the concept of illness existed much longer than that. References to illness can be found in the earliest dawning of history. And even though in those days it could not be described in a way that meets modern scientific criteria, nevertheless certain forms of behavior and feeling were demarcated from other forms by this abstraction. In addition, the Corpus Hippocraticum, for example, contains elements of scientific methods.[81] Therefore the choice of a specific moment in history as the ostensible starting point of scientific medicine is inescapably arbitrary. This means that the developing modern physical science was not at liberty to define the concept, but was challenged to come up with as good a redefinition as possible. Virchow's redefinition was an induction. As it was demonstrated that illness coincided with bodily aberrations, the conclusion that such aberrations were imperative for illness to exist seemed justified. However, in the nineteenth century an additional hypothesis was necessary to prevent certain irrefutable illnesses from being excluded from this definition. That was the hypothesis that when bodily aberrations could not be found, they might as yet be determined in the future when improved research methods and techniques would become available.

Modern science, which is still developing, was and is still challenged with the task of redefining disease as it was understood in more primitive science, or if preferred, pre-science. (See also Chapter V, 2.2.) In continued attempts to redefine it, there is an exchange between scientific and pre-scientific (lay) concepts. It would be incorrect for modern science to assume a monopoly on the right to define illness. It would be even less correct to assume that that definition applied before the advent of modern science. An example would be the "Whig-interpretation" which I mentioned in the introduction when referring to Schoeneman.

This can be considered a problem of language, and also of authority. To whom do we attribute the power to determine the meanings of words? There is also a moral aspect, inasmuch as valuing one's own views so much more highly than those of yore that one does not consider it worth the bother to judge former views on their own merit, is a matter of hubris.

This leads me to the position that the conceptualization of certain behaviors as diseases in former times is not only historically valid, but also relevant to forming *current* ideas on the matter from a historical perspective.

Indeed, there is unanimity that madness, or certain forms of it, was considered a disease in various places as early as the fourth century before Christ, Hippocrates's era, and possibly earlier. Moreover, physicians considered it a legitimate object of their care and concern. However, this position warrants noting certain qualifications.

a. The current segregation of mental and physical illness exists by the grace of Cartesian dualism and the development of the sciences of the last few centuries.

b. This segregation requires the premise that it is legitimately possible to think of the body and the mind separately to the point that one can be considered “ill” while the other remains “healthy.” When the above manipulation is invalidated and the phenomenon of *being* ill is observed, this segregation becomes untenable. (See Chapter V, 2.) Szasz’s position – that the body can be ill without the mind, but the mind cannot likewise be ill without the body because the mind is a different kind of entity than the body, which in my opinion implies an asymmetric dualism – also seems to me untenable. Disregarding plants and animals, only a *person* can be ill, not a body or a mind. Szasz’s premise that disease is an aberration of the body compels him to make statements as, “Thus, although the desirability of physical health, as such, is an ethical value, what health is can be stated in anatomical and physiological terms.” (*Ideology and Insanity*, p. 15.) This, too, is an untenable position.
c. Before the eighteenth century, there was little knowledge about physical aberrations and their connection to disease.

These qualifications made insight into any difference between physical and psychiatric disorders incomparable to modern insights. For instance, for a long time the theory of the four body humors dominated medical thinking. When melancholy was associated with an excess of black bile,[82] that was done without too much worry over *how* the one phenomenon (melancholy) was related to or resulted from the other (excess of black bile). This does not diminish the fact that formerly several forms of madness were considered disease and treated as such.

History is rich in examples of madness medically conceptualized as illness. Ellenberger relates that in chapters on medicine in Greek and Roman literature psychiatric disorders were described among other illnesses.[83] There was no separate psychiatric system. Other classification systems were used according to whichever philosophy was maintained. The same holds true for Arabic and Persian medicine in the early Middle Ages. In the West views on madness during the Middle Ages were totally dominated by explanations and interpretations that were offered by the Church. Allderidge stated that in the early Middle Ages and after, the mad were often viewed and treated the same as other ill people, and presents several examples.[84] Beek and Neaman each dedicate a chapter of their respective books to the involvement of physicians with the mentally ill during the Middle Ages.[85] Somatic medicine flowered in the Renaissance. In that period, madness was increasingly associated with disorders of the nervous system and thus considered a disease. In the eighteenth century De Sauvages included psychiatric disorders in his classification of illnesses. These matters are of course described much more thoroughly in books about the history of psychiatry. This brief summary suffices here, because I merely wish to illustrate that the medical concept of madness was not at all new in the nineteenth century, and in fact was a repetition of an association that was made many times previously. Sarbin, who, like Szasz, opines that mental illness does not exist and is a myth, explains the medicalization of madness similarly to Szasz. However, he illustrates his point with a different historical event. In the sixteenth century Teresa of Avila was challenged with the task of saving a group of nuns, who, according to Sarbin, could be described as hysterical, from the clutches of the Inquisition. She did so by declaring that their behavior was generated by natural causes and should therefore be considered illness. This tactic was successful. According to Sarbin,

the metaphorical nature of the illness explanation of behavior became lost in the course of time, thus such behavior became “real” disease.[86] Sarbin and Szasz both regard strategic motives to be involved in medicalization: both Charcot and Teresa of Avila aspired to improving the fate of their respective wards. It seems exaggerated to me to attribute a conceptualization, of which Sarbin evidently does not approve, to one particular historical event. This is all the more so as the conceptualization of madness as mental illness is not an isolated incident, but recurs throughout history.

Equally conspicuous as the conceptualization of madness as illness is the fact that almost never was it the only, or even the most prominent conceptualization. First of all, there were the religious explanations. Van Dijk lists three views that recur throughout history, sometimes separately, sometimes running through each other, sometimes conflicting. They are the empirical-medical, the religious, and the humanitarian approaches.[87] Different explanations dominated in different time periods. In ours the scale has almost entirely tilted towards the medical-empirical explanation with its two variations: the physicochemical and the sociopsychological. Although demonological explanations have not disappeared completely in our culture, as for instance, occur in the Pentecostal and Christian Science communities, these are generally considered relicts rather than conceptualizations to be taken seriously. So the medical view has nearly become dogma, though in the eighties [of the twentieth century] perhaps slightly less. (See section 3.)

On the side, it is interesting to note in view of Van Dijk’s position, that Szasz up to a certain point can be characterized as a modern representative of the humanitarian view, that regards: “…the psychically disordered person primarily as a fellow human being, who has the right to be treated humanely, with as many rights and privileges as possible in common with those who have not been stricken by illness. The approach is to console, encourage, offer safety, motivate, and educate. Reduction to an object, contempt, humiliation, and brutality are rejected. The shared responsibility of the professional and the client is emphasized, and an appeal is made to all healthy powers that are still present.”[88] This quote can be applied to Szasz inasmuch as he advocates a humanitarian approach to these fellow human beings. And inasmuch as that is the case, Szasz can be considered the epitome of the humanitarian tradition that opposes the medical-psychiatric model. However there are also differences between Szasz’s views and Van Dijk’s sketch, which will be discussed in Chapter VI, 4.

An important implication of the above is that Szasz’s view that madness became mental illness by Charcot’s maneuver regarding hysteria, or more generally by expanding Virchow’s definition of disease to include functional disorders, is untenable. The historical development teaches us that it would be more correct to say that in Virchow’s redefinition of disease, influenced by nineteenth century positivism, psychiatric disorders would have largely fallen by the wayside.

It is therefore a toss-up whetherwe are speaking of a maneuver by Charcot to (re)absorb them into the concept of disease, or a maneuver by Virchow resulting in their exclusion therefrom. We are not dealing with facts that can be proved or disproved, but with different views regarding how a complex concept as illness should be (re)defined. There will be more on this in Chapter V.

In conclusion, madness, nowadays commonly conceptualized as a psychiatric disorder, was regularly regarded and treated as disease throughout history. Before the nineteenth century, this way of looking at it was one among many, often not the dominating one. In the twentieth century the scale tilted almost completely towards medical-psychiatric conceptualization.

...3. Some Comments About the Development of Psychiatry in the Twentieth Century, in Particular in the United States

In these sections I will discuss different trends in thinking about psychiatric disorders (3.1) and the most important institutions for treating psychiatric patients (3.2). After that, a brief history of the Mental Health movement and of the Psychoanalytic movement follows. It is noteworthy that the two most spectacular developments of twentieth century psychiatry in the United States resemble movements more than sciences (3.3 and 3.4). Finally, I will sketch the situation around 1961, that in more than one way can be considered a turning point in the developments (3.5).

*....*3.1 Developments in Ideas about Psychiatric Disorders

In the beginning of the twentieth century ideas on psychiatric disorders were largely dominated by the conviction that there must be a bodily cause for these diseases. The discovery of the syphilitic infection of the central nervous system as a cause for dementia paralytica powerfully reinforced this thinking. At the time dementia paralytica was a fairly common disease. It was assumed that it was just a matter of time before organic lesions and bodily causes for the other psychoses would be found. In the thirties, several therapies with a bodily angle were introduced, among them insulin shock in 1933, psychosurgery in 1935, and electroshock in 1938. It is notable that all of these treatments, whether intending to cause shock or whether intending to cause lesions in the nervous system, insofar as they have not been abandoned, are heavily criticized on humanitarian grounds, in particular by patients' movements.

The idea that mental illness could be explained by psychogenic causes gained ground after 1910. In this view psychiatric disorders were thought to originate from psychological factors rather than organic ones. In the United States the dominating psychogenic school of thought was psychoanalytical, although at the same time Adolf Meyer's psychobiology and Bleuler's work in Zurich should not be forgotten. In the forties and early fifties of the twentieth century this school of thought determined the face of psychiatry.

In the fifties, the pendulum swung back in the direction of organic psychiatry, mainly owing to the discovery and use of psychoactive drugs. These drugs deeply affected the treatment of psychiatric patients and conditions in the institutions. The institutions became less locked. The idea of the therapeutic community arrived from England (Maxwell Jones) and made a hit. It was the beginning of social psychiatry. In those days there was an atmosphere of hope and optimism. There is complex mutual influence among ideas on psychiatric

disorders, therapeutic discoveries, and social events, to which this brief sketch cannot do justice, but it should be mentioned.

It is worth noting that the benefits of practically every newly introduced psychiatric theory and therapy were heavily overestimated. Ridenour mentions as examples the focal infection, thought to cause psychoses, and the avitaminosis theory, which were extremely popular in the nineteen-twenties.[89] But great expectations were also pinned on shock therapy, psychoactive drugs, and psychotherapy when they were introduced, which later disappointed. It seems that there is a propaganda element in both schools of thought, prompting the pendulum to swing farther in the directions of both organic and psychosocial theories and therapies than could be justified by new facts and findings.

....3.2 The History of the Institutions for Intramural Psychiatric Involvement and Treatment

Throughout the centuries, care and treatment of the mad and the psychiatrically disordered resemble a nightmare, save a few humanitarian exceptions. Cruelty, torture, humiliation, and banning are but a few of the abominations inflicted on these people. In addition, they were regularly exposed to starvation, thirst, cold, and exhaustion.[90] Conditions in institutions in the United States at the beginning of the twentieth century were deplorable. Ridenour states that conditions were reminiscent of the worst abominations of the past: iron cages on stone floors, without heating, light, or furniture, and patients who were not let out of the cages even when they died.[91] Improvement in these conditions was but very gradual. At the time of World War II they still occurred. In the fifties, State Mental Hospitals in the United States were overcrowded. There was a great lack of trained therapists, and no more than *one* physician for every 200 patients. Only about one tenth of the patients were treated, “while the other nine-tenths vegetate, waiting to die.”[92] Some advancement was being made, mainly owing to psychoactive drugs, in changing direction from custodial care to environment therapy, and more intensive treatment of some patients. In 1956 the population of the State Mental Hospitals began to decline due to shorter periods of hospitalization. In these years, mental illness was increasingly becoming the most important health problem in the United States. Half of all hospital beds were occupied by psychiatric patients. One of every ten or twelve Americans spent some time in a Mental Hospital. In some states, more than a third of the total budget went to caring for the mentally ill.[93] The American Psychiatric Association stated that in the United States more than 75% of the hospitalizations were involuntary, compared to for instance England, where this percentage was less than 30.[94]

At the beginning of the twentieth century, besides “insane asylums,” institutions were erected that would later be called “psychopathic hospitals.” There, in addition to clinical observation and short-term treatment, also were out-patient clinics. Private clinics existed, and still do, in which conditions were and are generally much better. Institutions erected by the Veterans Administration after World War II enjoyed high quality as well, according to Ridenour,[95] although she does not explain that any further.

....3.3. The History of the Mental Health Movement

This summary is based on the book *Mental Health in the United States, a fifty-year history* (1961) by Nina Ridenour. Throughout the book there is an element of propaganda. In addition, throughout the entire described period there is a preoccupation with how to mobilize public opinion and how funds can be acquired to meet the stated goals. These interrelated elements are no doubt explainable by the fact that, particularly in the early years, the movement was largely dependent on private donations. Later funds were provided by the federal government. Such funding is determined by law, and is thus more a political matter than until recently in the Netherlands, where more cooperation between civil service and private organizations exists.[96] This means that it was and is essential for such a movement to mobilize public and political opinion. This is also why plans that are clear, demonstrably necessary, regulatable, and in particular, politically attractive, are preferred. Obviously, in such a system, there will be a temptation to "oversell."[97]

The history of the Mental Health movement begins in 1909 when the National Committee for Mental Hygiene was erected. The committee's goals were the preservation of mental health, prevention of psychiatric disorders, and improvement of care, among others. The initiative came from Clifford W. Beers, himself an ex-psychiatric patient who, after his release, crusaded to bring mental health and mental illness to the attention of his fellow citizens. The committee was, and later remained, an organization that was primarily concerned with society, not with the mentally ill individual. The committee's first activity was typical – a resolution to lobby congress for mandatory systematic psychiatric assessment of all immigrants, with the purpose of returning those who turned out to be psychiatric patients to their ports of departure. Ridenour defends this position by emphasizing that the fate of immigrated psychiatric patients was tragic. Not infrequently the contact between the patient and the family was lost once the patient was in an institution. I note that returning them can never have been in the best interest of the patients, as it would have unavoidably caused permanent separation from their families. Furthermore, it is not apparent how the mental health of these patients was served by refusing them entry. From a political point of view, such a measure cannot be considered anything but discrimination against psychiatric patients, as well as confirmation of the hypothesis that the Committee was not so much concerned with improving the fate of individuals, but rather primarily served the interests of society and the nation. Other activities as well were not intended, at least not primarily, to benefit individual patients, but society at large. Statistics about how many patients were in the hospitals began being compiled; summaries of existing laws were designed; the use of standard nomenclature was promoted; the public was informed; and government was mobilized. Apparently it was assumed that a psychiatric disorder is a given fact, and that someone who has one belongs in an institution to be treated.

The year 1921 marked the beginning of the "child guidance" movement. Its goal was to prevent juvenile delinquency through involvement of the Child Guidance clinics in youths' lives. These clinics, rooted in society, cooperated with juvenile judges, schools, and the like. This can be considered a medicalization of

asocial or antisocial behavior. This medicalization was further advanced when the American Orthopsychiatric Association was founded in 1924 at the initiative of Karl Menninger. Its aim was to promote the "medical view of crime," namely that criminals should be considered psychiatric patients. This implies that they are not evil but ill and should be treated accordingly, so without punishment. The question of whether someone should be incarcerated is deemed irrelevant to the question of whether he is guilty. The important question is whether he will commit (another) crime. In his last book, *The Crime of Punishment* (1968), Karl Menninger claims that punishing criminals is criminal. This opens the way for Szasz to score an easy point. "We are thus asked to believe that the illegal acts of criminals are the symptoms of mental illness, and the legal acts of law enforcers are crimes. If so, the punishers are themselves criminals, and hence they too are 'ill, not evil.' Here we catch the ideologist of insanity at his favorite activity – the manufacture of madness." (*Ideology and Insanity*, pp. 8-9). Ridenour states that the Orthopsychiatric Association was of great influence, particularly on clinical work. She does not elaborate on this.

The Mental Health movement had a significant role in the organization of mental health care provisions for the military during both World Wars. The American public was deeply impressed by the fact that during World War II 1,750,000 men were rejected for military service on psychiatric grounds, and another 750,000 were released from active duty for the same reasons. According to Ridenour this fact had an important educational impact on the nation because people began to better understand the nature and prevalence of psychiatric orders.

In 1946 William C. Menninger founded the "Group for the Advancement of Psychiatry." This group promoted the idea that psychiatry should not be concerned only with patients and their treatment, but first and foremost with normal people and social action. Politics were at the center of their activities. Thus mental health gradually began to form a problem for the entire nation and society. In 1947 the WHO defined health as follows: "A state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." Ridenour praised the WHO for a "lofty definition of health."[98] In my opinion this description of health is not only utterly idealized, but also expands the domain of research and involvement of health professionals to an almost extreme extent: from now on all of society is included.

At the time, optimism about psychiatry was rife. Mora quotes Alan Gregg, who in 1944 expressed this optimism as follows: "Psychiatry, along with other sciences, gives us a sort of oneness-with-others, a kind of exquisite communication with all humanity, past, present, and future … Psychiatry makes possible a kind of sincere humanity and naturalness…"[99]

The Mental Hygiene movement, which after 1947 became the Mental Health movement, has always promoted the idea that mental health is a government responsibility.[100] It lobbied for legislation regarding involuntary commitment of the mentally ill and special trial procedures for mentally ill criminals. Ridenour labels such legislation as laws for the *protection* of the mentally ill without a word about the moral problems posed by such legislation, or the question of patients' rights. Also noteworthy is her observation that psychiatrists are reluctant to testify in court, which she ascribes to their fear of the "battle of experts." This refers to the

conflicting reports sometimes submitted to courts by psychiatrists testifying for different parties. Her advice is, “No one will deny that the defendant must have the privilege of expert testimony, but psychiatrists can stay out of the trap and fulfill their moral obligations if they are wise enough to follow the principles of the Briggs law, and testify only on the request of the court, and with the court bearing costs.”[101] This comment, too, demonstrates that preoccupation with the justice system and with psychiatric esteem was greater than with the interests of the individual. According to Ridenour’s proposal, if a defendant feels that he has been judged unfairly and wishes to present a counter-expert witness, he will be denied the opportunity.

In the forties of the twentieth century, the change of expression from “Mental Hygiene” to “Mental Health” led to a change in focus of which Ridenour did not unambiguously approve. The emphasis on health meant increasing attention to prevention while the patient was forgotten. In addition, the concept of mental health is so complicated that confusion of concepts was inevitable.

In the fifties support was gained for the idea that government was responsible not only for the care of patients in institutions, but also for patients who remain free in society. Moreover, according to Ridenour, government is responsible for the mental health of the entire nation.[102]

Referring to the relationship between religion and psychiatry, Ridenour observes that spiritual leaders wish to learn from psychiatrists, but the possible contribution of religion to psychiatry is never discussed. Clergy take courses on emotional conflict and mental disorders. Some churches require their candidate clergy to have psychological examinations to rule out mental illness and to help candidates learn to know themselves. Apparently spiritual leaders are also expected to promote mental health.

The mentality of the Mental Health movement, as described by Ridenour, resembles that of the crusaders. There is constant preoccupation with the immensely important message, and the public that consistently refuses to listen. “Many of the professionals were messianic about their work.”[103] Accordingly, in 1938 Kingsley Davis, a sociologist, described the “mental hygiene” movement as a social movement which is considered a panacea by its supporters. He asserted that the generally accepted ethic is implicitly (he used the word “unconscious”) present in images of mental health and illness, and determines them. This makes the Mental Health movement one that promotes the established ethic in a psychologizing way, whereby moral and political backdrops are veiled by the terminology of illness and health, and whereby social factors insofar as they contribute to the causes of mental illness, are consistently not considered.

After World War II mental health professionals increasingly learned to deal better with the press and public relations, which benefited the intensity of their propaganda. All means justified the end. Ridenour underlines the propagandist value of a photograph taken in a Mental Hospital in 1946, showing “… half a dozen naked, emaciated men huddled against the peeling plaster wall, defeat, despair, degradation crying out from every line and shadow – stark human misery at its nadir.”[104] Was this anti-propaganda for further psychiatrization? On the contrary, it was a source for enormously much publicity and requests for more funds and facilities.

Directly out of the Mental Health movement grew community psychiatry. Funds became available for it, which led to the establishment of the National Institute for Mental Health (NIMH) in 1946. In 1955 funds were appropriated to a national study, which was finished in 1961, and titled Action for Mental Health. Mora calls this a milestone in American psychiatry.[105] In this study the plan to shift the care for psychiatric patients form the Mental Hospitals to the community unfolded. The Community Mental Health Centers (CMHCs), intended as centers for psychiatric assistance, consultation, and prevention, were supposed to provide services to as many people as possible from all walks of life. They were not only, and as it later it turned out, not primarily, meant for treating patients. These centers were intended for changing society on the whole and solving various social problems.

Controversy developed between those who wanted the CMHCs to have a curative approach, as, for instance, existed in many out-patient clinics, and those who advocated a more behavioral-scientific and collective approach.[106] This controversy had an ideological background. The out-patient clinics were about curing patients, whereas the CMHCs were intended for the community with a mixed program of curative, preventative, and public health service. On the side, I wish to mention that a remarkably similar controversy developed in the Netherlands in the early eighties of the twentieth century between the Regional Institutions for Mental Health (RIAGGs) that were being erected and psychiatric out-patient clinics. In the United States the out-patient clinics lost the contest in 1963 because President Kennedy chose the side of the NIMH and the CMHCs.

Szasz calls the Mental Health movement a typical social reform movement, its main thrust being disdain for the individual, in this case, the psychiatric patient.[107] The patient must be helped, but does not have to be respected. Szasz considers this movement a scion of a larger social-intellectual movement, which Hayek named “counter-revolution of science.”[108] The individual is turned into an object. The group is considered much more important than the individual. The purpose of the social sciences, in imitation of the physical sciences, is to predict human behavior and thus control it. Disdain for man as an autonomic individual, according to Szasz, is intrinsic to this approach. Also, this movement exposes the aspirations of the “scientific” elite to dominate the masses to whom they condescend. Beers opposed the idea that disturbed behavior could be meaningful and understandable. He preferred the view that mental illness is equally senseless as physical illness. In this respect Szasz considers psychopharmacology as another means to control human behavior. Psychiatric drugs are good for psychiatrists because they undergird their medical identity. Community psychiatry “complements and reinforces the posture of a drug-oriented, quasi-medical approach to human problems.”[109] The goals are collectivism and social order and tranquility. The individual only has a right to exist if he is well-adjusted and useful. If he is not, he has to be “treated” until he is. Szasz approvingly quotes Kingsley Davis: What is called healthy behavior is in fact behavior that conforms to the most established ethical and behavioral rules of the moment. The goal is not to prevent illness, but to prevent deviation.[110]

....3.4. The History of the Psychoanalytic Movement

The history of the Psychoanalytic movement in the United States began in 1909 when Freud gave a series of lectures at Clark's University in Worchester. The movement grew rapidly. Already in 1911 psychoanalytic associations were founded in New York and nationally. These were the first ones to be established after the one in Vienna.

The movement flourished and was successful in disseminating psychoanalytic views, especially in medical schools. The movement in the United States differed from that in Europe in that it valued what Szasz calls the "deterministic-mechanic superstructure" of the theory. This implied that psychoanalysis, although psychological in nature and practice, was to be considered belonging in medicine. A decision in the twenties of the twentieth century determined that psychoanalytic training was open only to physicians. After World War II this exclusive medical nature became increasingly difficult to sustain. Yet it was not until 1964 that the American Psychoanalytic Association decided to open its membership to certain, carefully selected non-physicians. The insistence of the psychoanalytic movement in the United States on a medical identity contributed to its great influence on psychiatry. Gross calls the movement's dominion in psychiatry "its greatest triumph in the world."[111] He estimates that in 1978 there were 4,500 psychoanalysts in the United States. Considering how few patients a psychoanalyst can treat at a given time, Gross's comment cannot refer to psychoanalysis as a therapy. The influence of psychoanalytic theory, the instruction of trainee psychiatrists in it, and the large numbers of them who submitted to training-analysis, explain the influence of psychoanalysis.

The formation of psychoanalytic associations and institutions gave the movement its organizational shape. These not only expanded psychoanalytic insights but also designed training programs, and thus engendered a certain amount of uniformity and continuity in psychoanalysis. The year 1933 saw the establishment of the psychoanalysis section inside the American Psychiatric Association, whereby the close association of psychoanalysis and psychiatry became an organizational fact as well.[112] In addition, the arrival of psychiatrists and psychoanalysts from Western Europe in the pre-World War II years fortified the psychoanalytic movement. They were fleeing from national-socialism which had outlawed psychoanalysis.[113] Mora adds that Freud felt rather ambivalent about the explosive growth of the movement in the United States, fearing it would jeopardize the movement's identity. As in Europe, there were stormy conflicts that led to the secession of, for instance, Karen Horney in 1941, and Clara Thomson, Eric Fromm, and Harry Stack Sullivan in 1943, and to the formation of new groups and organizations.

Szasz approves of the influence of psychoanalysis in the United States, stressing that it is by nature individualistic and "libertarian." The psychiatric patient is viewed as a fellow human being, someone to whom it is worth listening.[114] Furthermore, the relationship with the analyst is voluntary, shaped in part by the wishes of the analysand, who participates actively in his treatment. The goal of the treatment is freeing the individual of past experiences that impede his freedom. Szasz thus values psychoanalysis, regretting, however, the

exclusively medical identity of the movement, which he ascribes to psychoanalysts' ambition to share in physicians' prestige.

....3.5. The Turning Point: 1961

Ellenberger describes the development of psychiatry from 1920 as explosive.[115] Subspecialties such as child psychiatry and forensic psychiatry arose and became independent. New research territories were explored, such as genetics, biotypology, and psychiatric endocrinology. Social psychology, transcultural psychiatry, psychosomatics, and social psychiatry made their inroads. All sorts of treatments were invented. Psychiatry's expansion was limitless. Nor was there a limit to the areas of life in which psychiatry became involved.[116] Rome said, "Actually, no less than the entire world is a proper catchment area for present-day psychiatry, and psychiatry need not be appalled by the magnitude of this task."[117]

Towards the end of the fifties, an atmosphere of hope, optimism, and euphoria pervaded psychiatry. Ridenour notes with satisfaction that in those years – her book was published in 1961 – the public at large had generally accepted the most important Mental Health principles: the idea that all behavior has a cause, and that there are many of those causes; that feelings and unconscious drives are powerfully motivating forces; that the fulfillment of certain physical, psychological, and social needs are essential to health; and that events in early youth are important in determining later adjustment.[118]

There *was* a flip side: the Mental Hospitals were still enormous warehouses where treatment was the exception rather than the rule. One wondered whether these institutions did not have more disadvantages than advantages. On the other hand, as patients were being released sooner, the total amount of hospitalized patients declined, in spite of the upsurge in admissions. The "Action for Mental Health" from 1961 promised a revolution: care and treatment would be shifted to the patients' home environment. The enormous amounts of money that would be saved because psychiatric patients would no longer be hospitalized would be redirected to the entire community through Community Psychiatry.

Henri Ey, according to Ellenberger, warned that the endless expansion of psychiatry, which he called panpsychiatry, would not remain without repercussions.

1961 is the year in which the first book critical of psychiatry appeared, *The Myth of Mental Illness* by Thomas Szasz. 1961 is also the year that Goffman's *Asylums* appeared, and in England, Laing's *Self and Others*; as well as in France, Foucault's *Folie et déraison*, *Histoire de la folie à l'âge classique*. Szasz says, among other things, about the explosive development of psychiatry, "Indeed, it is no exaggeration to say that life itself is now viewed as an illness that begins with conception and ends with death, requiring at every step along the way, the skillful assistance of physicians and, especially, mental health professionals." (*Ideology and Insanity*, pp. 4-5.)

Twenty years later [when this book was originally written], we know what happened afterwards. We know the confusion that reigned because of the contributions of critical psychiatrists, antipsychiatrists, and sociologists. We know it from the profuse supply of new treatment forms, such as marital and family

therapy, behavioral therapy, and sex therapy. The theories on which these various treatments are founded are sometimes so contradictory that if the one is true, the other must be false. Social confusion resulted from the democratization movement and great social conflicts, such as the Vietnam war, the dissatisfaction of disaffected citizens which led to riots in the cities, and by rising feminism. We are familiar with the exodus of chronic patients from the State Mental Hospitals which is called deinstitutionalization. It was an exodus into a society in which nobody welcomed them and in which the promised care and treatment mostly never materialized. We are aware of the disappointment in the CMHCs that did not live up to expectations, and of the thousands of chronic patients who live in squalor, albeit not inside but outside the Mental Hospitals. This prompts Mora to conclude that "Psychiatry is now in a state of uncertainty and restlessness, unable to abandon the traditional theoretic models, and unprepared to face the challenge of the great issues at stake."[119]

Some signs indicate that the pendulum will again swing in the direction of a somatic explanation for the origin of mental illness, this time in the form of biological psychiatry.[120] [*] That would mean that complex insights into the multiple causes of psychiatric disorders would be avoided on behalf of the primacy of *one* orientation, and that history will repeat itself.

[*] This has since been dubbed biopsychiatry. The author's prediction can now be confirmed. – translator

▪▪Chapter III The Ideological Context of Szasz's Theories

...1. Introduction

Szasz's ideas, beliefs and personal philosophies, as related to his theories and expressed in his work, form the basis of this chapter. Such beliefs can be called premises. They form a background, a perspective, and a clarification of the theories themselves, facilitating critical consideration.

This chapter is partly descriptive, partly interpretive, and partly critical. It is descriptive particularly when discussing Szasz's views on humanity and freedom; autonomy and individualism; as well as his political convictions (2.1-2.4). The critical part is in particular my commentary on those (2.5). In the section afterwards it is part interpretive and part critical about (scientific) philosophy, physics, and the humanities (3.1), and about the problem of the relationship between body and mind (3.2). Finally, it is interpretive in particular when I attempt to characterize several aspects of Szasz's work (4).

Summarizing: it is my intention to reconstruct a general theme from Szasz's work, on which his theories regarding psychiatry are founded.

...2. Some of Szasz's personal philosophies

....2.1 Szasz as a Humanist

Szasz's personal belief system can be considered humanistic. Formally, this can be inferred from his being chosen as "Humanist of the Year" in 1973 by the American Humanist Association, and from the fact that he is or was a member of the Editorial Boards of different humanistic periodicals. He also published articles himself in humanistic magazines.

For Szasz, every belief system that alleges to extend sense and meaning to human existence is dangerous because people use such belief systems to gain power over other people. It makes no difference to him whether such a belief system is based on religion, science, morality, or other premise. Skepticism towards anyone who wishes to "convert" others to whichever belief system leads him to reject religion, but also movements such as socialism and Marxism.

Nonetheless certain themes regularly reappear in his views about humanity. One is the way he portrays life: "The simplest and most ancient of human truths … namely, that life is an arduous and tragic struggle; that what we call 'sanity' … has a great deal to do with competence, earned by struggling for excellence; with compassion, hard won by confronting conflict; and with modesty and patience, acquired through silence and suffering." (*Schizophrenia*, pp. 82-83.)

No matter how strong man's inclination to envision a future for himself that is better than his present, be it in the form of the Marxist utopia or in the form of a

religious ideal, Szasz rejects such visions as self-aggrandizing and unrealistic. Perhaps he expresses his own view on sense and senselessness in life most clearly in *Human Nature and Psychotherapy.* "The idea that life is meaningless is difficult, if not impossible, for people to accept. Perhaps this, too, is a matter of education. Because of the megalomanic significance that man has always attributed to his own conduct, most of us are unfit to approach this issue with equanimity. Although Shakespeare suggested, and the existentialists reiterate, that life 'is a tale told by an idiot, full of sound and fury, signifying nothing,' people must live as if this were not true. Indeed, for some people, the meaninglessness or futility of life may itself constitute a meaning – perhaps by the same kind of psychological reversal and reinterpretation that can turn submission into domination, humility into pride, and asceticism into sensuality. In any case, I accept Camus' thesis that hope is a destructive emotion, and that resignation without bitterness, without anger, and without inactivity is the optimal mood for modern man. This is an integral feature of the portrait of Moral Man."[121] Freedom and autonomy are core values to Szasz. (See 2.2.) In addition, he repeatedly stresses dignity, honesty, trustworthiness, respect for oneself and others, and similar virtues as prerequisites for human social intercourse. These values arise largely from his view of man as a free and autonomous being. They are also the premises on which he bases his beliefs about institutional psychiatry and about Laing's antipsychiatry. His values form criteria for assessing all the interpersonal phenomena and institutions he studies.

Szasz considers man to be motivated mainly by a craving for power. Power to Szasz is not abstract in the sense of influence or moral authority. He means the concrete possibility to impose one's will on another person, and to compel that other person to actions he does not want. Power is political power in the sense of obtaining that which is desired by threat of violence, and economic power in the sense of owning and obtaining money. It can be a determining factor for everything a person wishes to do and achieve. Power is the angle from which Szasz observes interhuman contacts and activities. It is an almost ever-present preoccupation.

The role of power as "ulterior motive" or, as Szasz calls it, strategic meaning of human action, is comparable to the role Freud attributed to sexuality. As according to Freud sexual intentions and wishes contribute to practically everything a person does or attempts, according to Szasz intentions and wishes for power contribute to practically everything a person does or attempts. I see here a structural correspondence between Freud and Szasz. Both identify a "dissociation" of reality. (See Chapter IV, 3.2, 10.) Things are not what they seem. Their true meaning can only be deduced when the particular point of view that each espouses is chosen. A difference may be Freud's view of the role of the unconscious. It causes a person to be driven by drives unknown to himself, of which he is in a way a victim. Szasz, on the other hand, seems to be of the opinion that people are completely aware of their struggle for power, and in consequence he accuses many people of abuse of power. I will return to this line of thought in Chapter IV, 3.

*....*2.2 Freedom and Autonomy

Individual freedom, understood as self-determination, is both the most important point of departure of Szasz's thinking about man, as well as his most important life value for himself.

In *The Ethics of Psychoanalysis* he asserts that the modern concept of freedom is complex and actually rather confusing, because it has two diametrically opposed meanings. In the Enlightenment a concept of freedom originated that has an individual and positive structure: freedom is the possibility for the individual to attain his own goals. The purpose of freedom is to become an "individuated person, an autonomous, authentic, self-responsible man." (p. 18) This is "freedom *to*." The second concept of freedom, originating in the eighteenth century, and carried out in the nineteenth century by "political revolutionists" such as Marx and Lincoln, is collectivist. It has a negative structure. It is formulated as freedom *from* something, such as: freedom from oppression, freedom from slavery, or freedom from abuse. In short, according to Szasz, this freedom is the freedom of a group to have the same privileges as all other groups. Szasz identifies "freedom *from*" with collective freedom. The individual has "freedom *to*." The group has "freedom *from.*" In my opinion this could be confusing because both concepts of freedom are actually closely related as becomes apparent from the statement about privileges. Having privileges implies both "freedom *from*" and "freedom *to.*"

Although Szasz considers both forms of freedom desirable and necessary, collective freedom is to him meaningful only as a condition for individual freedom. He opposes the view that individualism and autonomy are but excuses to take advantage of the weak. In western nations where dictatorship, oppression, and tyranny have disappeared, the basic conditions for collective freedom have been satisfied. A well-functioning democracy provides the cultural conditions that enables citizens to shape their own individual freedom to personal autonomy. That is why Szasz considers democracy the most desirable form of government. (*Psychiatric Justice*, p. 12) Moreover, he states that never before in history have so many people had the opportunity to develop themselves as in our time. So for Szasz, the concept of freedom has first and foremost a political-philosophical meaning. This also applies to the concept of autonomy. Autonomy is a very central concept in Szasz's thinking. He defines it as follows: "Autonomy is a positive concept. It is freedom to develop one's self – to increase one's knowledge, improve one's skills, and achieve responsibility for one's conduct. And it is freedom to lead one's own life, to choose among alternative courses of action so long as no injury to others results." (*The Ethics of Psychoanalysis*, p. 22)

Autonomy is not something that is given to a person. It can be attained only through effort. This is accomplished by developing oneself, by learning, but also by taking responsibility for what one does or causes. According to Szasz a person's biggest and most central duty is to become an autonomous person. Szasz uses this term as synonymous to "Moral Man."[122] He postulates that in our world incredibly much improvement would be achieved if everybody would take responsibility for that for which he is indeed responsible.

Subsequently Szasz reasons that as it is essential to have the freedom to develop oneself, actually utilizing that freedom is virtuous. When one person achieves more than another it is justifiable to esteem the achiever more highly. Szasz not only regards the freedom to choose as important, but also the nature of the choices made. Achieving is to him more worthwhile than not aspiring to achieve. There is a paradox in this. A person is free to the extent that he can realize his own choices regardless of the nature of the choices he makes.

The boundary of individual freedom coincides with the boundary of the other's personal freedom, namely where the freedom of one person restricts or violates the freedom of the other. Here a principle of reciprocity applies. It is not completely clear to me where exactly this boundary is in Szasz's opinion. However, he does state that the boundary is violated when a person compels another to do things he does not want, and when he causes the other direct harm. In his political views, which amount to maximization of individual freedom and minimization of state power (see 2.4) there are indications of this boundary. Furthermore it is clear that free competition with others is within the "territory of freedom." Obviously those who, for whatever reason, cannot keep up, will suffer in a society of free competition, unless this society instates measures to protect the weak. However there is little to be gained by punishing the good players for their success at the game. It is more useful to reward the bad players for their efforts at trying to play better.

Freedom is a core value in Szasz's work. Only in freedom does man become man. Other life values, such as happiness and health, are secondary in relation to freedom. This applies not only to one's own freedom but also to that of others. Freedom is so elementary that, even when there is only a little bit left, it is exactly that little bit of freedom that turns man into man, and therefore is more important than all other factors combined. "Following in the tradition of individualism and rationalism, I hold that a human being is a person to the extent that he makes free, uncoerced choices. Anything that increases his freedom, increases his manhood; anything that decreases his freedom, decreases his manhood. Progressive freedom, independence, and responsibility lead to being a man; progressive enslavement, dependence and irresponsibility, to being a thing. (*Ideology and Insanity*, p. 47) So it becomes an ethical premise that treating people as people means first and foremost: respecting their freedom.

When Szasz speaks about freedom, he usually means individual freedom. By describing it as "the ability to make uncoerced choices" (*Ideology and Insanity*, p. 1) he underscores that freedom is a value, but *also* a skill that can be developed or neglected. The measure of an individual's freedom is linked to and restricted by internal and external conditions. "His internal conditions, that is, his character, personality or 'mind' – comprising his aspirations and desires as well as his aversions and self-discipline – propel him towards, and restrain him from various actions. His external conditions, that is, his biological make-up and his physical and social environment – comprising the capabilities of his body, and the climate, culture, laws and technology of his society – stimulate him to act in some ways and inhibit him from acting in others." (*Ideology and Insanity*, p. 1)

The individual is challenged to attain freedom and autonomy through effort. To do so, he must first learn to control his desires and aspirations. Secondly, he must learn to control his tendency to exercise power over others. And thirdly, he

must learn to liberate himself from all sorts of external influences that interfere with his freedom and thwart him in developing his creativity. In so doing, the freedom of the individual is realized by striking a balance between defending one's interests and self-control; expanding oneself and restraining oneself; taking space and allowing others space; developing the self and controlling the self. Actually, where to draw the line between a person's autonomy and that of others is an ethical-moral problem. The moral character of this syllogism is exemplified in questions as, "Can man be held responsible for his conduct?" and "Where are the lines between his responsibility and the responsibility of others, and, as man is a social being, the responsibility of society?" Inasmuch as certain values shape the way people treat each other, the moral problem takes on the features of a political position.

Autonomous development is difficult and can be painful. It can be threatened, stagnate, and miscarry, in all sorts of ways, from within as well as from without.

A person's autonomy can be threatened from within because he succumbs to the temptation to exert pressure on another person without respect for the other's autonomy, or to exercise power at the expense of the other. His autonomy can also be threatened because he attempts to escape from a heavy responsibility, sometimes experienced as unbearable, by declaring himself dependent on the other, "handing over" his responsibility, or presenting himself as not responsible. Szasz's thoughts on this issue are related to those of Sartre and Camus, whom he quotes repeatedly with assent (for instance, in *The Manufacture of Madness* and *Psychiatric Justice*).

The most important threat to a person's autonomy from without is the power that others attempt to exercise over him. This power can present itself in all sorts of ways: the power of dictatorship, the power of tyranny, the power of authority, the power of the professional, the power of the state, the power of the church, and so forth.

So freedom and autonomy are values that are threatened from two sides. The person who wishes to dispose of his responsibility and the other person who agrees to accept it in exchange for an increase in his power, match each other in a complementary relationship. This construct reminds me strongly of the story of The Grand Inquisitor from Dostojewski's *The Brothers Karamazow.* In this story, the Church offers a translation and disguise for the problem of human responsibility in religious terms, and offers the escape route of religion in exchange for the autonomy of the faithful. That is exactly what Szasz means, and he refers repeatedly to this construct as the characteristic heteronomy of the time when religion controlled life, the "Age of Faith." But when Szasz describes this situation, he does so to provide an analogy with our time, characterized by him as the "Age of Science" or rather the "Age of Madness." "In short, whereas in the Age of Faith the ideology was Christian, the technology clerical, and the expert priestly, in the Age of Madness the ideology is medical, the technology clinical, and the expert psychiatric." (*Ideology and Insanity*, p. 5) He is suggesting that in modern times the healing arts, and psychiatry in particular, have replaced religion in this respect.

This threat to freedom from both sides has in our time led to the following construct among others:

1. One of the ways by which man tries to escape his moral responsibility is by mystifying and technicalizing problems as symptoms of illness. This is precisely what happens nowadays when someone displays certain phenomena that are labeled as mental illness. The person identified as mentally ill is no longer held responsible for his conduct. Illness provides him with an excuse.
2. Directly corresponding to this, psychiatrists and behavioral scientists have devised a system that Szasz calls "behavioral technology." It is a system of psychiatric illnesses and disorders that provides those who want it a legal and socially accepted opportunity to escape the unbearable burden of their responsibility by becoming ill. In other words, psychiatry has transformed the dilemma of accepting or fleeing responsibility to the dilemma of health and illness. At the same time, the fundamental moral and political character of this choice between autonomy or heteronomy is veiled by the images and the jargon of medicine, illness, and health.

"The lesson is," thus Szasz closes his arguments about the inquisition in *The Manufacture of Madness*, "that man must forever choose between liberty and such competing values as health, security, or welfare. And if he chooses liberty, he must be prepared to pay its price – not only in eternal vigilance against malevolent tyrants, bent on enslaving their subjects; in eternal skepticism of benevolent priests and psychiatrists, bent on curing souls and minds; but also in eternal opposition to enlightened majorities, bent on reforming misguided minorities." (p. 134)

....2.3 Individualism and Collectivism

Szasz is an individualist. This is his opinion about himself. His work also reflects it. Above (2.2) we saw that the concept of collective freedom is only meaningful when it functions as a foundation for individual freedom. The concept of autonomy only makes sense when applied to the development of the individual. It implies among other things that it is the duty of the individual to struggle to free himself from social frameworks and forces that seek to control him and restrict his freedom. Individual freedom as a core value implies individualism.

From a social-philosophical point of view Szasz sees the individual as a nucleus, the unit around which all of society revolves. He considers personal autonomy, historically, a relatively recent development in human existence. This development was made possible and advanced by a number of factors: the advancement of technology in the realm of food production and industry; the advancement of medicine; and the opportunities for education. The massive attainability of a certain measure of personal autonomy – that, for example, in the eighteenth century was achievable for only a happy few, the wealthy, who could have others care for their needs – has posed new and large problems. Life in fixed role patterns, following a group identity, is much simpler than having to constantly negotiate compromises and having to live with a large measure of pluralism and interpersonal diversity. Perhaps that is why in our modern society both socialization and desocialization processes occur.

On the one hand having more and more specialized skills makes man increasingly independent in the realm of his own specialty. This underscores his individuality so strongly that it can even lead to his alienation. On the other hand, the increasing specialization increases his dependence on others. According to Szasz, society curbs too much autonomy, for instance as expressed by sexual morality. Whoever travels the lone road more often than others will soon be considered deviant and pathological. However, it is “Moral Man's” duty to reflect skeptically on the value of all moral rules and principles, not to accept them uncritically. Here Szasz quotes Reichenbach, “The power of reason must be sought … in the ability to free ourselves from any kind of rules to which we have been conditioned through experience and tradition.”[123]

Szasz's emphasis on individualism causes him constant preoccupation with the question: for whom are psychiatry and psychotherapy designated (or ought they be) and at whom are they (or ought they be) aimed? To Szasz, psychiatry as a helping profession, like medicine in general, should be molded in the ethical context of voluntariness and should benefit the person seeking help. Szasz considers it the obligation of psychiatry to refuse to participate in pressuring an individual into allowing himself to be treated when he does not want to be. Where there is a conflict of interest between the person asking for help and the group (family, employer, society), the psychiatrist is duty-bound to let the interests of his client prevail.

As to his social-economic and social-political ideas, Szasz can be characterized as an individualist as well, as we shall see in the following section.

....2.4 Szasz's Political Views

Szasz's political views, inasmuch as they are about regulating relations among citizens, can be characterized as “libertarian,” at least, when this word is understood in the meaning that the word “liberal” had for the founders of the United States of America. Szasz often quotes these Founding Fathers approvingly, and he not infrequently refers to the United States Constitution in his arguments. In *Law, Liberty, and Psychiatry* he even dedicated a chapter to it, in which he notes which basic legal rights are unjustly denied psychiatric patients.

In addition, Szasz's political views are strongly influenced by Hayek.[124] Like Hayek, Szasz believes that the state functions most optimally when it interferes as little as possible in the lives of its citizens, and aims to ensure maximal individual freedom for them. “Legislative prescriptions, no matter how enlightened, will not create a good society. Our best chance for success still lies in a political system that is consistently noncoercive, limiting its power to the prevention and punishment of crime, and deploying its resources to providing relatively equal opportunities for various kinds of personal self-development.” (*Law, Liberty, and Psychiatry*, p. 222)

In an interview with professor Kuntz, published in *The Theology of Medicine* (1977, pp. 145-162) Szasz supplies some more details of his political views. The state is to limit its regulation of life as much as possible in order to not hinder the personal freedom of its citizens. Szasz considers certain social benefits necessary. He specifically names national defense, the police, and certain public

works such as the water supply and trash disposal. As far as health services are concerned, government should restrict itself to the above matters. The addition of certain substances to the water supply or bread goes too far for Szasz. “The state can’t protect people beyond a certain, very minimal point without denying them their freedom of choice.” (p. 155) When the state wishes to proceed beyond that minimum, the consequences are always serious. Szasz illustrates this with the government’s attitude towards drugs, which he considers ambiguous. Some drugs are forbidden and war is vigorously waged on them; other drugs provide income for the government through taxation. He points out that increasing governmental regulation is leading up to a totalitarian state. He considers freedom of speech the most important difference between communist and non-communist countries, but immediately adds that education and health care are completely regulated by the state in both systems. He wonders how it is that in the West, freedom of speech is considered essential, whereas citizens can buy almost no medicines without a prescription. Is penicillin, bought without a prescription, so much more dangerous than all the lies in the newspapers?

Medicine and health care have fused with the state, a type of state religion. The state exercises complete control over medical schools, both financially and in content, by way of subsidies and authorization. Physicians serve the state in various ways: by reporting birth and death, controlling deviant behavior, and so forth. The state grants “official” medicine a monopoly and guarantees a good income for physicians. Physicians in turn support and validate government in all sorts of ways. Szasz advocates complete separation of health care and state. State regulation of medical schools is to be abolished, and the schools must be self-supporting. State authorization of the medical profession, together with its monopoly, should be exchanged for free market competition by all who offer healing services. They can “validate” themselves by revealing their education and special skills. Medicines and drugs are to be freely available to all adults. Elementary medicine is to be taught in schools in order to instill in people the capacity to critically assess the best course of action when they are ill. On the side, note that Szasz unfortunately does not elaborate on the question who is to determine what people should learn about medicine in school, and whether for instance physicians or alternative healers are to provide these lessons. The question of how people can become more knowledgeable regarding their own health seems so important to me, that it is a pity that he did not further elaborate on these matters.

In the [former] USSR, the state aspires to make a better life for its people – definitely a paternalistic attitude. The citizen is considered as a child who cannot care for himself. In the United States and other democracies the relationship between state and citizen used to be comparable to the relationship between a father and his grown children, a relationship based on equality and mutual respect. In time, democracies have also started to show paternalistic tendencies, which led to our “collectivist welfare state.”

The most important implication of psychiatry as a social institution (see Chapter I, 4.2.4 and further) may be that it gave birth to the “Therapeutic State.” That is a state that considers it its duty to care for its citizens, and to shape and educate them according to what the state deems best. (*Law, Liberty, and Psychiatry*, pp. 212-222) As an example Szasz names the increasing habit – he

is writing this in 1963 – to punish sexual psychopaths with a sentence of unlimited duration. The purpose of the punishment is *treating* the offender. Aside from the fact that the concept of sexual psychopathology is not accurately defined, which risks arbitrariness, and aside from the fact that the provision of adequate treatment facilities has been neglected, this has been a fundamental change in the application of criminal law. The principle that the law is applied on equal terms and in equal measures to each citizen has been abandoned. It is no longer the crime that is punished, but the criminal. The punishment no longer fits the crime, but fits the assessment of the offender's personality by others. In addition, the principle that the state, when punishing an offender, is his adversary, is exchanged for the paternalistic attitude that the state considers it its duty not only to punish but also to educate and adjust the person through treatment. Criminal law should conform to the Rule of Law, as Hayek described it, among other places, in *The Road to Serfdom* (1944). All acts of government are bound to rules that are determined and publicized in advance, and that are equal for all citizens.

Literally, Szasz says that criminal law should satisfy a double objective. On the one hand it should protect the state against the citizen, and on the other hand it should protect the citizen against the state. (*The Theology of Medicine*, p. 157) In this description, too, Szasz reminds us that government can serve the individual, but government can also have a conflict with the individual. And as, in the latter case, government always has infinitely more power than the individual, there should be guarantees – paternalistic or not – that the individual will not be overrun.

As a second example of the development of the "therapeutic state" Szasz names the right to psychiatric treatment for the person who "needs it," regardless of whether he wants it. Both these problems appear to be psychiatric but are in reality political, and illustrate how government deals with deviant citizens.

....2.5 Some Comments

Szasz's concept of freedom is in some ways ambiguous. The first ambiguity is that freedom must be obtained by effort, yet is attainable only in an environment of uncoerced choices. Freedom is needed to learn to be free. The intention is not a "freedom *to*" which is superimposed on "freedom *from*" as the "freedom *to*" can only be learned in an environment which is "freedom *to*" as well. So apparently the concept "freedom" has two meanings: the process by which making choices in experiencing internal freedom is learned, and an environment around the person that guarantees that such choices can actually be made.

A second ambiguity is that sometimes he considers freedom the hallmark of man, that which makes a person human, and other times he considers it the epitome of man's duty. In the first case man's hallmark, and with that his mission, is a given fact, although it immediately raises the question who determined that mission. In the second case there is an essential difference between one imposing this duty upon oneself, or that one believes that this duty applies or should apply to others as well. Szasz states that his portrait of "Moral Man" is based on observation of human behavior in today's industrial society (for which he refers to, among others, Camus), and that at most he can lay claim upon the

identification of the – in fact already existing, albeit in embryonic form – "Moral Man."[125] But the painting of such a portrait is never a description only. It indicates a development deemed desirable by the painter as well.

A third ambiguity is that freedom on the one hand is expressed as uncoerced choices, yet on the other hand is restricted by Szasz in the sense that he opines about the nature of those choices. The concept of autonomy includes self-development and growth. Achievement and competence are important features of man's existence (2.1). That creates the paradox that man has freedom of choice, but his choice is free only if it meets certain criteria, for instance, that it is employed for self-development, whereby it is no longer a free choice. Apparently Szasz also sees this ambiguity. He proposes that every citizen declare by way of a psychiatric will whether in the future he wishes to be hospitalized and treated in the event of insanity.[126] I will not go into the logical and moral dilemma whether and to what degree a person can decide like this about the person he may later become, which raises the question whether such a declaration will ever be valid. The ambiguity that man is not free to do as he wishes, but *must* do as he wishes (or rather: what he once in the past wished) explicitly remains. The proposal above implies – and that is the point here – recognition that, if man is free, he should decide for himself how he wishes to live and what he wishes to choose.

The following example illustrates how these ambiguities can influence the train of thought. Much of Szasz's writings can be interpreted as an endorsement of freedom and rights for oppressed minorities such as Jews, psychiatric patients, and other scapegoats. Do these minorities want that? The answer can be yes or no – yes, inasmuch as these people wish to live in freedom and responsibility; no inasmuch as they wish to escape responsibility and not be confronted with it anew. It is confusing that extremely diverse groups are discussed as though they are similar. I certainly agree that it is our ethical duty to end racial discrimination as quickly and radically as possible. But in the case of psychiatric patients the situation is quite different, at least if I follow Szasz in his views about these people.

Psychiatrists' activities figure most prominently in Szasz's work. Yet it is obvious that people who display the phenomena that can be interpreted as psychiatric disorders, precisely by such a display, are attempting to escape their responsibilities. Thus, according to Szasz, those people are behaving heteronomically. In *The Myth of Mental Illness* he illustrates this at length regarding hysteria. In other places he does it regarding other psychiatric disorders. When psychiatric patients are treated as free, autonomous adults he expects them to reciprocate. That means that they (have to) give up their psychiatric disorders. Szasz words it thus: "I submit that in much the same way most of what now passes for 'medical ethics' is nothing but a set of paternalistic rules whose aim is to diminish the patient while aggrandizing the physician. Genuine improvement in medical, and especially psychiatric, care requires the liberation and full enfranchisement of the patient – a change that can be accomplished only at the cost of full commitment to the ethic of autonomy and reciprocity. This means that all persons – whether sick or wicked, bad or mad – must be treated with dignity and respect – and that they *must* also be responsible for their conduct." (*The Myth of Mental Illness.* Rev. Ed. pp. 176-177, my italics,

J.P.) Thereby he puts the patient in a paradoxical situation. He *must* take responsibility for his behavior. He *must* be free, whereas freedom (also for the patient) means that he makes his own choices. The paradox is illustrated in the continuation of this last quote, from which it becomes apparent that it is Szasz himself who determines what it means for the patient to take responsibility for his own behavior. "If such a change in medical perspective were instituted, what patients would gain in dignity and control over the medical situation, they would lose in no longer being able to use illness as an excuse." Szasz not only determines the most important value in life for himself and for others. He also determines which choice this value obligates one to make. When this value itself is precisely the making of uncoerced choices, the paradox is complete.

If I follow Szasz's habit of speaking in analogues (see Chapter IV, 3,2, 8), I can also clarify the dilemma of this ideology as follows. If I take the analogy of the "Age of Faith" and the "Age of Madness" seriously and apply it to the story of Dostojewski's Grand Inquisitor, then the psychiatrist represents the grand inquisitor, institutional psychiatry is the Church, the patients are the faithful, and Szasz is … Christ. But there is an essential difference between Christ in Dostojewski's story and Szasz. Christ remains silent whereas Szasz prescribes a way of living. In other words, a society of people who value individual freedom above all else can exist only by consensus, as was the case in the United States in the past. Such a society can be advocated. It cannot be imposed without throwing the principle of freedom overboard.

Finally I wish to add a comment about freedom as competence or learned skill. The problem that arises when asking who can assess this competence is the same one that arises when judging someone's competence to stand trial. (See Chapter I, 6.2.) If Szasz assumes that every citizen who is suspected of a crime has the right to be tried equally without consideration of who he is, the question of competence is restricted to the most elementary issues, such as whether the suspect is capable of understanding the accusation levied against him. Considering that a trial is an extremely complicated and ritualized game, the "fine details" of which are understood only by professionals, competence may require relevant and adequate schooling. Even so, if individual autonomy means a personal duty in life and at the same time an existential space to be respected for each person, then it follows that it is also an ethical duty to leave to each his own space. Competency should then be questioned only in the absence of the most basic elements of consciousness, such as in the case of coma, severe mental retardation, or an advanced state of Alzheimer's disease. However, Szasz sees autonomy as the skill to independently and creatively play the game of giving and taking space in our extremely complicated and pluralistic society. This way only a relatively small group of competent autonomous people remains. Szasz believes – in my opinion correctly – that all citizens have the right to an equal trial. It would be consistent to say that all citizens have the right to be treated with dignity. It would follow that they should not be compelled to accept the conditions of competency and responsibility as formulated for them by Szasz, or whomever, such as abandoning the argument of illness as an excuse for behavior. When Szasz requires that, he does precisely what he wishes to avoid. He creates different kinds of people. Thus he risks the application of contradictory policies in situations that assessment of someone's autonomy is at stake.

Personally, I believe that Szasz's sketch – fleeing from responsibility for life's problems → mystification of these problems into symptoms → being declared a psychiatric patient → not having to take responsibility anymore – has important and worthwhile elements, but that it strongly simplifies reality. The relationship between problems in living, responsibility, and psychiatric disorders seems to me so complicated, that this problem deserves more thorough discussion, that will take place in Chapter V, 3.4.

Speaking for myself, I fully endorse Szasz's premise that individual freedom is the core value of life, and that experiencing it is what makes one human. I also believe that not many people will dispute this premise by itself. The difficulties begin when the question is asked where the line is between my freedom and other people's. They increase when the question is asked what people can do for themselves and what they cannot. In the story about the Grand Inquisitor Dostojewski has Ivan express it as follows: "[The faithful] will come to the conclusion that they can never be free because of their weakness, their evil, their worthlessness, and their rebelliousness." Only those who hold paternalistic views one way or another have used this argument in one form or another, and in doing so justified their paternalism.

This the question whether professional help does not always imply weakening the person asking for help and strengthening the helper. I will return to this problem in Chapter VI.

In the history of our culture, according to Szasz, religion is the ruling ideology. It is perceived by him as: the totality of values and meanings in which a person believes that purports to be the only correct way of thinking, all-inclusive, and valid in all places at all times.[127] When, during the Enlightenment religion began losing its power, science's star started rising. Nowadays, according to Szasz, we live in the "Age of Science," or rather in the "Age of Madness." I object to characterizing our era as the age of madness, inasmuch as that this expression implies that psychiatry and insanity are so central to our present-day culture that they are a hallmark of it. Psychiatry fascinates many people because of the sticky dilemmas it poses regarding the best way to live life, and because the way society treats its "madmen" reflects the most important elementary values in society. Nonetheless in my opinion this can be viewed as an example or illustration, rather than as an all-encompassing essence. In 1980 about 4.6% of the population of the Netherlands became involved with some sort of psychiatric institution one way or another.[128] "Insanity" can have been involved only in a small portion of this 4.6%. Aside from this percentage it may be more important whether, and to what extent, the psychiatrist is considered the person who can provide solutions for problems in living. In Dutch society he seems to be *one* among many, and one who can be accessed only with difficulty. This leads me to conclude that psychiatry is insufficiently manifest in Dutch society to justify speaking of an "Age of Madness." American publications give the impression that psychiatry in the United States is considered much more important and prominent as a cultural phenomenon than in the Netherlands.[129]

Be that as it may, in the term "Age of Madness" Szasz suggests that medicine and psychiatry have replaced religion, and therefore have themselves become a religion. That is to say, that medicine is no longer an applied science or

an art dedicated to maintaining and restoring "clients'" health as well as possible, in order that they can seek purpose, direction, and sense in their lives. Medicine has become a goal in itself, and health, as described by medicine, has become a purpose in life.

We can distinguish two kinds of core values or purposes in life. The first kind consists of those values that describe a principle that determines relationships among people, for example, values as freedom and solidarity with the community. These core values are based on the assumption that the way people treat each other is the most important aspect of human existence. The other group consists of those core values that primarily disregard interpersonal relationships, such as health, happiness, and wealth. To this second group belongs an attached ethic that regulates relationships. It is necessary to determine to what extent, for instance, fraud and oppression as a means of achieving a certain goal, are justified in this ethic.

In other words, even if health becomes an important value in life, that does not determine the consequences this ideology has for human freedom and autonomy. The prime rule of medical ethics has always been, and still is, that medical assistance is extended only at the client's request, or at least consent. Linked to this is the physician's freedom to refuse to examine and treat the client. So also when freedom and autonomy are not seen as core values the rule that medical assistance can be freely accepted or rejected applies. Not until this prime rule of medical ethics is abandoned does it become possible to examine or treat people against their will. In somatic medicine this happens only when a very serious danger is posed to the community as in the case of diseases that by law must be reported. This is extremely rare. In psychiatric disorders this is done much more often and occurs regularly. (See Chapter VII, 3.)

Szasz maintains that it is the concept of madness as mental illness that justifies involuntary hospitalization and treatment. Or, put differently, the justification for undesired intervention in someone's functioning by way of forced treatment is derived from the element of (mental) illness. (*Schizophrenia*, p. 21)

Szasz's view on this is in my opinion debatable. There are several arguments in support of a diametrically opposed view. The medical-ethical rule in existence since Hippocrates that medical examination and treatment may occur only upon request and consent of the patient means that medicalizing madness should lead to the *elimination* of force and involuntary procedures. Since Hippocrates, and even earlier, physicians have been involved in the problem of madness and with madmen, albeit to a different extent and intensity. Nonetheless, during many centuries there was no systematic involuntary institutionalization of the insane anymore than there were other systematic coercions initiated by physicians. And when, in the middle of the seventeenth century, the institutionalization began, it certainly did not involve only mental illnesses, as, among others, Foucault thoroughly described in his *History of Madness.* The poor, the unemployed, beggars, madmen, and several other categories of citizens who distinguished themselves from others by the fact that they did not engage in productive labor were equally incarcerated. Foucault stresses that the first large institution for incarceration, the *Hôpital General* in Paris, that served as a prototype for other institutions, "showed no (demonstrable) relationship to any medical thinking, neither by way of functioning nor in aim."[130]

Szasz of course knows this as well. This is evident when he comments that *in spite of* the medical model on which psychiatry bases itself, the most characteristic political aspect of medicine, namely the mutual free choice of physician and patient, is absent from involuntary commitment (for example, in *Schizophrenia*, p. 157). Here is a clear contradiction in Szasz's work because he simultaneously maintains that the medicalization of madness only occurred in order to justify force and coercion regarding this group of people.

So the involuntary incarceration and manipulation of all sorts of non-criminal deviants were already long applied in society before the intervention of physicians in this social-political practice. And when physicians did become involved, it was initially more so because they were dependable personages and bigwigs than because their qualification was appraised so highly, according to Foucault. Foucault also states that the involvement of physicians was called on to confine the evil to institutions, rather than to examine and treat people. I cannot avoid the impression that Foucault's representation is somewhat askew. After all, he himself sketches all sorts of treatment activities by physicians outside, and later also inside, the institutions. Nonetheless, this historical development validates the hypothesis that, when clinical psychiatry began to emerge, it did so in a framework of social and political assumptions regarding the necessity of involuntary commitment and other coercions. Only much later did a significant movement from involuntary to voluntary measures gradually take place, albeit with ups and downs.

This does not contradict Szasz's postulation that institutional psychiatrists, in particular Kraepelin and Bleuler, declared the insane to be ill in order to justify their incarceration. They did that because they simply could not afford to call these people not-ill. Neither the medical, psychiatric, or legal professions, nor the public at large, would have accepted that. However, by doing what everybody expected of them, they validated a justification that did not exist at all.

The above implies that there was a historical development whereby the physician was transformed from uninvolved observer through sympathizer and accomplice to main agent in institutionalization. The physician did bring along medical insights, but also the time-honored social, political, and principally non-medical assumptions in which coerced institutionalization was rooted, and by which it became possible. But this is not all. The physician also submitted his medical knowledge to the service of denying the political nature of these assumptions. This is how he became an extension of that denial. Nowadays he is its main and most eloquent defender.

This view of the historical events may clarify how a link was laid between the world of health and illness on the one hand, and force and coercion on the other. The development was not at all unique. Physicians have colluded with all sorts of social and political developments, including those that sacrificed the prime medical-ethical rule of voluntariness in treatment. Szasz, too, has commented that there has been no dictatorship which was not also served by physicians as accomplices. Mitscherlich et al provide most bewildering examples.[131] Whenever the medical-ethical rule of voluntariness in examination and treatment is abandoned the consequences are disastrous, as physicians have no other ethical framework. They become powerless to resist the demands

that those who have political power make of them. In reaction they tend to identify with the powerful, making them even more powerful.

From the above we can conclude that in principle medical and psychiatric territory is confined by the prime medical-ethical rule that has always remained valid in our culture, namely that of consumers' freedom to allow or refuse examination and treatment. When this rule is abandoned not only has medicine become an ideology, but also an institution that has the power to impose this ideology (by way of involuntary commitment). Further discussion of this to Szasz essential problem, can be found in Chapter VII.

...3. Szasz and Dualism

....3.1 Philosophy of Science, Physical Science and the Humanities

I will briefly sketch some philosophical and scientific theories that have apparently influenced Szasz. These influences are demonstrated by his quotes, whether direct or indirect, and related ideas. Afterwards I will comment on the relationship between physical science and the humanities according to Szasz.

Szasz seems to have been influenced by Vaihinger, among others. Vaihinger, who was inspired by the theory of evolution, considered thinking a tool for survival – a weapon for conquest and defense. Therefore he considered thinking, and also science, less useful for seeking truth on an abstract level, or for uncovering the purpose of life. In accordance, thinking and science are composed of certain thought constructs that function both inside and outside of science. They are either incongruous with reality or even contradictory in themselves, but nonetheless useful and maintained. An example from mathematics is the concept of the infinitesimal. Vaihinger calls these constructs fictions. Because they reflect an unreality, he designates the conjunction "as if" to these fictions.[132]

In addition, Szasz's views on science seem to be influenced by logical positivism. He insists that arguments be based on facts and experiences, and judgments thereof which can be validated.

Science is but the prediction of future experiences. It is determined by its utility. Metaphysics cannot be reconciled with science. These premises, as well as a preoccupation with the use of language, are found extensively in Szasz's work. However, he seems to differ with Von Mises in where to place the dividing line between physical science and the humanities, which have fundamentally different methods of interpreting reality .[133]

Szasz was also influenced by Susanne Langer who speaks of "…the claim that symbolism is the recognized key to that mental life that is characteristically human and above the level of sheer animality."[134] This is reflected mainly in the theory about human mental and social functioning which Szasz developed in *The Myth of Mental Illness*. The person who attaches meaning to himself and his world through symbols is to a certain extent complementary to the person who attempts to gain cognition of his world through observation.

Karl Popper seems to be important to Szasz mostly for his social and political philosophy. Popper considers societies as temporary solutions to problems. Political liberty is the most important political value and essential condition for maximizing the potential for solutions. Popper, like Szasz, rejects every form of totalitarianism, but rather endorses parliamentary democracy. Popper rejects a system whereby government considers procuring the happiness of members of society among its tasks. On the contrary, the goal is eliminating unhappiness. Social reforms should not take place on a massive scale. He advocates "piecemeal social engineering," an idea that Szasz seems to have adopted from him. Finally there are Popper's views on historicism. Szasz quotes them concurrently in *The Myth of Mental Illness.* They prompt him to critically review the theory of psychoanalysis, which he characterizes as historicist doctrine.[135]

Bertrand Russell also influenced Szasz's thinking about the relationship between body and mind. Russell attempted to solve the problem that many important phenomena are but subjective experiences and cannot be related in an objective, scientific way. Yet these subjective factors, which can be experienced only through introspection, are so comprehensive and central, that it is not sensible to declare them categorically unavailable to scientific research. He found a solution by proposing that the reality that occupies science is the reality of "public data" – perceptible by everybody, and therefore constituting verifiable reality factors. However those reality factors that a person can know only through introspection cannot be related objectively. He calls them "private data." Psychology is the science dealing with private data, thus confirming that these private data are indeed available for scientific research and evaluation (*Pain and Pleasure*, pp. 14-20). The methods and the object of research are different in the physical sciences and in psychology. Woodger, according to Szasz, has suggested that physical science utilizes two languages: the exclusive language of physical objects, and the language of perception. These languages should be separated and distinguished from the two languages of psychology, namely the "personal language," about people, and the "community language," about groups.[136] That means that physical science and psychology differ because different languages are employed. In addition there are differences in the way information is systematized and classified.

Finally, Hayek should not be left out, because his views about the differences between physical and social sciences strongly remind one of Szasz's views.[137] Hayek lists three differences between physical and social sciences. Physical sciences are distinguishable firstly by historicism, noting that everything that is encountered can be explained from the past; secondly, by collectivism, noting that physical science is based on complex wholes which it analyses; and thirdly by objectivism, which holds that things should be judged on their own merit, so disregarding any introspection, and should be considered objectively. In contrast, the social sciences, according to Hayek, should be marked firstly by scant contribution of history in predicting events; secondly by individuals, noting that the opinions, beliefs, and actions of the individual are fundamental and that social events should be studied as a consequence of all that individuals think and do; and thirdly by subjectivism, noting that the meaning ascribed to things is fundamental. Hayek considers the adoption of elements of physical science by

social science, which he historically ascribes to Saint-Simon and Comte, wrong and dangerous.[138] Szasz defends Hayek's position on this.

Szasz believes that these two groups of sciences cannot be epistemologically linked. There will always be a gap of understanding between, for instance, the experience of an emotion, and the "organic substrate" of such an emotion. Even if it were possible to determine exactly what transpires at a molecular level in the brain of someone experiencing a certain emotion, scientifically we can but determine that these two phenomena appear simultaneously though the connection between them cannot be established.

Szasz stresses that all attempts at a holistic approach have been unable to close this gap. In discussing psychosomatic medicine, he states, "We recognize that in spite of all the empirical work in this area, we still face the mind-body problem."[139] The scientist will have to be content with studying *either* public data *or* private data. When it comes to studying humans, that means either examining the body as a physicochemical machine, *or* examining experience and behavior. He distances himself from the psychosomatic method that he practiced in the beginning of his career under the direction of Alexander. The most friendly statement he makes about it is, "Some workers, well aware of the methodological differences between medicine and psychiatry, still consider the 'psychosomatic approach' a useful one, understanding thereby a separate use of both methods and a combination, in the mind of the observer, of what has been learned. I do not see how anyone could object to this conception of psychosomatic medicine. At the same time, I think it should prove to be extremely difficult, if not impossible, for anyone to put this conception to actual use in a clinical situation."[140]

Distinguishing physical science from the humanities is so essential to Szasz that it forms the epistemological foundation for adhering to the biomedical concept of illness. Illness is a physicochemical disorder of the body. (See Chapter I, 4.2.1.) Psychiatry to him is social psychology. Psychiatry, inasmuch as it uses the methods of physical science, is called so erroneously. (See Chapter I, section 4.1.)

To Szasz the worlds of physical science and the humanities are separate. Different laws apply. The relationships between cause and effect are totally different. Regarding psychological phenomena, not the question "What caused it?" but the question "What is the person expressing by that?" is appropriate. Behavior has to be examined in a broader context before it makes sense to reach any conclusions.

Szasz warns of the danger of using pseudoscientific methods and constructs from physical science when speaking of phenomena in the humanities. For instance, examining the pharmacological properties of drugs is a matter for pharmacology, but chapters on drug addiction do not belong in pharmacological text books. (See Chapter I, 5.1.)

If science's goal is expanding knowledge and insight, it makes an essential difference to Szasz whether the object being studied is influenced by that study or its results. A major difference between physical science and the humanities is that in the latter case, the object of study is intimately involved with and affected by the outcome because the people or their institutions which are the object of the study will be changed by it. Szasz notes that the point of physical science is to expand control over objects and events. Unfortunately, in the humanities as

well the goal is to find ways to exercise more control over people. Morally, the goal should be to examine how people might be left more alone, in other words, to find ways of maximizing self-control.

Szasz proposes two ways in which human behavior can be controlled. Either the person does it himself through self-control, or it is done for him by coercion. The self-control system stresses values as free will, interpersonal variety, and self-determination of fate. The coercion system is about material values, scientific determinism, and conformity. Inasmuch as the humanities aim to control human behavior and experience, for instance by discovering the mechanisms that determine behavior, we can speak of a tendency to increased scientific determinism. However, the more scientists assert humans to be determined beings devoid of free will, the more those scientists can be asked whether they themselves are also devoid of free will, and if so, who or what determines or controls their choices. Possibly even more important, attempts to control people evoke their resistance. "Coercion stimulates resistance, prohibition engenders desire," and "It is mainly by resisting authority that the individual defines himself." (*Ceremonial Chemistry*, pp. 143-145).

Szasz points out another important circumstance that demonstrates the influence of humanistic research on the "object" of that research. As man is extremely dependent on his fellow man, and the human need for social contact is "second only to the organismic need for the satisfaction of the biological requirements for survival," (*Ceremonial Chemistry,* p. 35) and as man is a rule-following being, descriptions of human behavior soon assume a normative meaning. This applies particularly to descriptions of "normal" human behavior. Much of what psychiatrists do and describe has such an effect, even though the intention is to describe, not to set norms. What is called description easily turns into prescription. But also what is offered as a scientific description may well be a veiled morality. Szasz states that Freud and Marx "…have become celebrated and socially significant more because of the social impact of their prescriptive programs than because of their scientific discoveries" and that this applies to many others as well.[141]

Throughout Szasz's work we find the importance he accords to the categorical and unambiguous separation of physical science and the humanities this way. He tirelessly confronts the confusion engendered when concepts and methods from physical science are applied to the study of the humanities.

….3.2. The Relationship Between Body and Mind

Szasz, as Ryle, claims to be an opponent of dualism. However he seems to be much more interested in the principal difference between body and mind than in the fundamental unity of both.[142] Perhaps this is because to date research on the body and the mind remains separate. In Szasz's view it will always remain so. The body and the mind are separate concepts, referring to totally different types of phenomena, so the term "illness" cannot apply equally to both. The mind cannot be ill as the body can. Illness of the mind can only be metaphorical, a manner of speech. He has no choice but to reach this conclusion because without it he cannot support his view of illness as a physicochemical disorder.

However, by postulating that the mind cannot be ill but the body can, he brings about a breach between the two. Mind and body are not only separated as research objects, they become separate objects in general, obeying different rules, and responding totally differently to life's events.

In his study of the meaning of physical feelings, Szasz posits from a psychoanalytical point of view that the ego can view the body as an object. This way the body is accorded a status comparable to that of other people and objects with which the ego has a relationship. (*Pain and Pleasure*, Chapter V) While an anamnesis is being recorded, the mind functions as a road map that is to direct the physician to the lesion. "The patient reports on his affective experiences. His feelings function as pointers to his body-as-psychological-object."[143] Speaking about the conditions that influence and limit human freedom, Szasz counts the body and its properties as external conditions, contrary to the mind, which is an internal condition. (See 2.2.) The first of these positions can still be held to mean no more than that the ego is capable of being objective towards its own body. The second is reasoned not from the point of view of the ego, but from that of the observer of the facts. A person is not his body. He has it and has to take it into consideration. Repeatedly Szasz posits, for instance in discussing abortion, that man owns his body, it is his property. Here too he stresses the nature of the body as an object. (*Ideology and Insanity*, Chapter 7) Quite interesting is the analogy Szasz repeatedly makes to illustrate the difference between the body and the mind. As this analogy is found at different places in his work, we are justified in assuming that it expresses fairly exactly what Szasz means. (This analogy can be found in the preface to the 1975 revised edition of *Pain and Pleasure*, and in numerous other publications.[144]) "Mental diseases are metaphorical diseases, that stand in the same sort of relation to bodily or literal diseases as disliked or disapproved television programs stand to defective television-receivers." Let's analyze this analogy further, paying special attention to the nature of the relationship between a television program and a television set.

In the analogy, the mind is the program producer and the body is the television set.

1. The program is created independently of the set that relays it;
2. The program is not influenced by the set;
3. The program can be observed in other ways than through the set, such as at the studio where it is being filmed;
4. The program is broadcast regardless of whether the set is turned on;
5. If the set is out of order, it can be replaced and exactly the same program will still be received;
6. There is an unequivocal phenomenon that brings about the contact between the broadcast and the set. That is the electromagnetic wave, and as we know, it travels only in one direction, from program to set;
7. One broadcast reaches many sets identically.

It is obvious that the relationship between a television program and a television set in at least these seven ways is totally different than that between the body and the mind. The "program" of the human mind cannot be made independent of the body, but is most fundamentally influenced by it. On the other hand, the body's actions are strongly dependent on the mind's "program." The "program" of the psyche cannot be made visible or observable in any way, except

through the body and behavior. Apparently a separate studio where the mind makes its programs is lacking. In addition, we cannot envision a situation where the body is "turned off" while the mind continues to function. The opposite is impossible as well. A television set can be turned on even when no program is being broadcast, but there is no comparable situation compatible with life that the body functions without the mind. Nor is it imaginable that the body is "out of order" while the mind, totally independently of the body, continues to function. Finally, little is known about the "connection" between the body and the mind. In Ryle's terminology, it is not sensible to speak this way about the connection between the body and the mind, as they are locked in a meta-relationship. In conclusion, the analogy, which does not apply in at least seven essential ways, suggests that the body and the mind are much more loosely associated with each other than can be justified by reality. Furthermore, in this analogy, the body and the mind are presented as two different though connected entities. This is indeed a dualistic view of man.

The analogy suggests yet another implication. One may disagree with a program or find it disgusting. That is quite different from finding it fragmented, illogical, or unintelligible. This difference is admittedly problematic because opinions about a program's logic or comprehensibility can vary greatly. Szasz maintains that communication, also that of psychotic people, is meaningful, sensible, and purposeful. He is not the only one. A lot seems to depend on the attitude one has while watching the program. Does one try to identify the differences between programs that are unintelligible and those that are? Or does one look for similarities? Or does one try to understand the program by assigning it an interpretation of one's own? More will be said about this problem is in Chapter V, 3.4.3.

From the above we can draw the conclusion that although Szasz claims not to hold a dualistic view of humanity, in fact he does. He is led to that indirectly by the theoretical imperative to study physical and mental phenomena along different pathways.

...4. Szasz in Short

In completion of this chapter, I will describe two additional aspects of Szasz as expressed in his work.

....4.1. Szasz as a Heretic

Szasz is a heretic. He can be considered so because he contests many generally accepted assumptions regarding mental illness, mental health, and the implications of these concepts. He is also a heretic in the sense that he looks for controversial issues in contacts between people and between individuals and groups. He attempts to throw an extraordinary light on those contacts. Szasz sees himself as a heretic, named one of his books *Heresies*, and indeed he wants to be a heretic. "Heresy" is being right when the right thing to do is to be wrong." (*Heresies*, p. 1)

In *The Manufacture of Madness* he points out that an ideology such as that of mental illness and mental health, which is upheld both by psychiatrists and the general public, can hardly be criticized without the critic himself risking being called crazy. From a strategic standpoint it is wise for the critic to anticipate such by pointing out the risk. As far as I know, Szasz has never been called crazy. He *was* threatened with being fired after publishing *The Myth of Mental Illness* in 1961. (See Chapter I, 1) He was not fired. He has, however, been called incompetent, irritating, unscientific, obstinate, someone who undermines faith in medicine, and someone whose theories threaten the happiness of countless people. So he is also a heretic inasmuch as heresy can be inferred from the reactions to someone's behavior.

Szasz is a man who is constantly looking for morally objectionable elements in the attitudes and behavior of those people who have authority and power over others. "The fundamental conflicts are not between competing ideas, one 'true' and the other 'false' – but rather between those who hold power and use it to oppress others, and those who are oppressed by power and seek to free themselves of it." (*The Manufacture of Madness*, p. 63) Practically all of his publications, save several studies from before 1957, are controversial. Also his constant seeking of and involvement with issues that are both controversial and anchored in ideology mark Szasz as a heretic. On the one hand he is aware of the heretical, even revolutionary nature of his positions, as implied for instance by the following excerpt from the preface of the revised edition of *The Myth of Mental Illness*, in which he says about this book, "…a work which…must have seemed to fly in the face of nearly everything that was known about psychiatry and psychoanalysis." On the other hand, he says about heretics, "Their heresy all too often lies in their conservatism, that is, in their insistence on the validity of ideas and values long established and honored." (*The Manufacture of Madness*, p. 112) Considering his frequent references to the United States Constitution and his frequent quotations of the United States' Founding Fathers, this is a statement that is very much applicable to himself as well. Finally, Szasz compares himself to Martin Luther in several ways. (*The Myth of Psychotherapy*, pp. 34-38) This is not incidental, as Szasz interrupts his postulation to stress the similarity.

From the above we can assume that Szasz is confident and aware of himself. Other statements demonstrate this too, such as that the antipsychiatry movement was significantly influenced by *The Myth of Mental Illness.* (*Schizophrenia,* p. 48)[145]

In *The Myth of Psychotherapy* Szasz wonders what might have motivated Mesmer, literate and moneyed as he was, to choose the road that he followed, and that would bring him both fame and infamy. Szasz expresses Mesmer's choice thus, "He could embrace a life of gambling, hunting, womanizing, and the pursuit of similar tangible pleasures, or he could pursue the spiritual pleasures of trying to satisfy his thirst for knowledge – and fame." (p. 47) The same way one can wonder what motivated Szasz, a brilliant man who had a dazzling career as prominent psychoanalyst waiting for him, yet chose the controversial path that he took. My hypothesis is that Szasz, aside from his growing insight in the differences between what he and other people hold to be true and right, was enthralled by that which is controversial. This by no means is to suggest that Szasz holds his controversial positions "for the fun of it." It is apparent to anyone

who takes his books and other writings seriously that he wholeheartedly believes in the issues he raises and has a clear message. At the same time he is convinced that humanism means “the right to disagree and reject authority.” (*The Theology of Medicine*, p. 162) His language and the way he attacks the representatives of conventional psychiatry are provocatively polemic. He paints the contrasts as colorfully and sharply as at all possible, increasingly so as the years pass by. When discussing how the enormous power of the common ideology in society can be countered, Szasz opines that “the task of social criticism must remain forever in the hands of individuals.” (*The Manufacture of Madness*, p. 134) He has applied this statement to himself in his work, and has done so extremely evocatively.

....4.2. Szasz as Theoretician

Szasz is a theoretician. The domain in which he works is the philosophy on which medicine and psychiatry are based. He studies situations that determine the relationships between people and in particular between physician and patient. He examines the fundamental aspects of the physician-patient relationship, and especially the psychiatrist-patient relationship, more so than daily reality. He also examines psychiatry more in its theoretical premises and assumptions than in its daily practice. The fact that he seeks out operational definitions does not detract from that. His study of actual practice is limited to examining publications by colleagues and others. Only rarely did he collect data himself, using the questionnaire method.[146] That is revealing of his most important preoccupation. Not the patient but the person who does something to that patient is the center of his attention.

His interest in the practical aspects of problems concerning implementation and organization, if not totally absent, is scant. When he occasionally treads that area anyway his views are so general and simplistic as to be unconvincing. An example is his contention concerning “the right to health.” (*The Theology of Medicine*, Chapter 8) He claims that the government artificially creates a market of “demand,” ensuring high income for physicians and specialists by limiting the amount of people admitted to the practice of medicine.

His preoccupation with the theoretical rather than the practical and organizational sometimes detracts from what he aims and possibly could achieve through his points of view. For instance, in *Psychiatric Justice* he reports on a lawsuit in which he himself testified as a special witness. (pp. 85-144) However, his testimony was so confusing because of the many theoretical implications that the client whose interests he was defending lost his case. Something similar occurred in 1980 when Szasz testified at the Medical Ethics Board in Amsterdam. It was the only time that he raised his voice in the Netherlands in connection with such a matter. The complaint concerned a woman with a strong obsessive-compulsive disorder for which she was treated with LSD, and later with stereotactic surgery. Her condition did not improve.

By the way, in stereotactic surgery certain specifically localized connections are destroyed by electrocoagulation. It is, also internationally, a highly controversial treatment in psychiatry. For one thing, healthy brain tissue is

damaged, whereas it is not known whether an organic disorder is involved in the particular psychiatric disorder. Secondly, it is not clear whether the treatment actually has a specific influence on the complaints and symptoms, or whether the treatment alters the patient's personality in a way that renders him incapable of complaining, protesting, and resisting. As the treatment is reserved for extreme cases it is applied only to people who have pushed their environment, their doctors, and probably also themselves to utter despair. That is what makes it so difficult to be certain of the results of the treatment apart from the hopeless and desperate situation of all who are involved.

In the official report of the Medical Ethics Board's hearing, Szasz's testimony is summed up as follows. "Finally, it is noted, that the specialist, Szasz, who rejects the said treatment because of its possible mutilating effect, apparently assumes that it was wrong to deprive the patient of her compulsions because she needed them. He overlooks the fact that the patient and her environment seriously suffered from them, and longed for years to be freed from them."[147] The misunderstanding on the part of the Medical Ethics Board is so complicated that the translation of the theoretical concepts into practice seem to have led to an apparent contradiction. Anybody who is familiar with psychiatric practice appreciates that the request, "help me get rid of this complaint" can mean many different things. It is up to the diagnostician to determine what exactly this request means in each case. Besides, Szasz is not the only one who denies the existence of any psychiatric syndrome that justifies a mutilating treatment. In an article on Szasz following this case, it was mentioned that in the United States, psychosurgery is prohibited.[148] Article 24 of the *Mental Health Service Patients' Rights Manifest*, which was drawn up by the Dutch Psychiatric Patients' Movement in 1981, states: "Psychosurgery and radiation in the framework of psychiatric treatment is to be prohibited by law." The Vatican and the [former] USSR – in agreement for a change – have prohibited psychosurgery.

Szasz has said little about the exceptionally difficult terrain that lies between determining theoretically pure and morally correct premises, and the execution of a practical policy of mental health care in which these premises are actually carried out as they are intended.[149] An exception to this is his elaboration on autonomic psychotherapy in *The Ethics of Psychoanalysis*.

Although the Libertarian Party in the United States has adopted Szasz's views on psychiatry in its program, we cannot speak of extensive political support from political parties. This might be partially explained by the fact that his views are difficult to translate into direct, concrete policy. Another factor is his individualism which has precluded his forming a school of thought, although he does have some clear kindred spirits such as Leifer.[150] Additional factors are his constant endorsement of social pluralism and diversity, making it difficult to join forces with others for certain social goals,[151] and his skepticism, which he ascribes to "Moral Man," and that is applicable to himself.

▪▪Chapter IV Szasz's Argumentation and Rhetoric

...1. Introduction

When reading the works of Szasz's critics and commentators one is impressed by the enormous differences in appreciation for his use of language and style and for the quality of his arguments. Grenander mentions him in one breath with Socrates and Aristotle as a philosopher.[152] Foudraine, in the foreword to the Dutch translation of *The Manufacture of Madness*, characterizes Szasz as "Clear, businesslike, with a painfully accurate logic, seemingly without emotion but with the ardor of the revolutionary."[153] Contrarily, Weihofen calls his style, "luridly sensational" and the content unscientific in the following aspects: Szasz accuses without presenting proof (as, for instance, Weihofen quotes, "Psychiatrists have shown great alacrity in meting out life sentences…"); he intentionally misuses words (for example, "locked up" instead of "hospitalized" in a Mental Hospital); he insinuates that criticized practices are frequent without presenting statistics; he poses rhetorical questions, the answer to which is not in the least self-evident; he uses quotation marks frequently and insinuatingly, not to quote, but to suggest that the word used is incorrect; he fails to present arguments for and against; and he accuses psychiatrists and judges of intentionally unethical and illegal behavior.[154] Cohen states, "To assume that Szasz does not recognize these and other logical fallacies, semantic ploys, inappropriate analogies, and internal contradictions is not tenable. He perceives them as readily as his readers do." Cohen opines that Szasz seeks to compel us to reflect on generally accepted premises.[155] To me Cohen's comments leave unclear how it is possible that someone could compel us to reflection by emitting nonsense which is what Cohen is apparently suggesting.

The question rises, how should we judge the conclusions that Szasz draws in view of his presentation of the problems posed and his argumentation? The answer cannot tell us whether Szasz's conclusions are right or wrong. It can only tell us, to a limited degree, how these conclusions are formed and argued, and thus to which extent he has justified them.

I will attempt to clarify this question in several ways. First I will remark on Szasz's use of language and his characteristic writing style (2). Afterwards the argumentation will be discussed as a process in which several different elements, such as the manner in which the premises are formed, the nature and order of the arguments, the way of reasoning, and the formulation of the conclusions. His reasoning is thus artificially reduced to several constitutional building blocks, which makes it possible to examine each of these building blocks separately (3). Then, partly to illustrate the previous section, a chapter from one of Szasz's books will be analyzed regarding reasoning and argumentation (4). Finally, his reasoning and argumentation will be examined by comparing several examples from his different publications (5). The chapter will be closed with conclusions (6).

The word rhetoric will be used by me in about the same meaning that it had in classical works, which is also Szasz's preferred meaning. (See Chapter I, 7.2) I am following Perelman's explanation of rhetoric.[156] He describes how Aristotle distinguished between two kinds of reasoning: the analytic and the dialectic. Analytic reasoning has certain patterns by which the necessary and only possible conclusions from the given premises can be deduced. If the premises are true it is certain that the conclusion is true as well. If the premises are untrue so is the conclusion. Analytic reasoning is merely formal, that is to say, it is valid regardless of the content of the premises. It is irrefutable and impersonal. It forms the groundwork of what later will be called formal logic.

Aristotle calls reasoning dialectic or rhetoric when the premises are formed by generally accepted opinions. Its goal is to make other arguable propositions convincing. Dialectic reasoning does not produce valid or compelling conclusions but more or less persuasive ones. Aristotle uses the word dialectic in cases of discussion or debate with *one* conversational partner and the word rhetoric in cases of communication between someone delivering the reasoning and (a) listener(s). Perelman, on the other hand uses the word rhetoric for every type of discussion. His use of the word rhetoric includes both Aristotle's dialectic as well as his rhetoric. I will use the word rhetoric as Perelman does.

Sometimes Szasz uses analytical or logical reasoning, for instance, when he posits that "mental illness" is not an illness in the absence of a demonstrated physicochemical disorder. This reasoning is, however, not much more than a tautology because it cannot be other than true when the given premise, namely the definition of illness, is true. Usually, however, premises regard beliefs or (basic) values. The term rhetoric is applicable to exactly this reasoning. This means that in all of these cases there can be no proof but rather conclusions that are, according to the author, necessarily deduced from the premises, considering the reason and the power of the arguments.

So the domain of rhetoric is that of opinions which are supported by the power of reasonable arguments. An argumentation can never be evident. At most it can be persuasive. To Perelman, every argument that is not based on true or evident premises is rhetoric. As far as I can tell, this exegesis concurs with Szasz's. After all, when referring to the humanities he too emphasizes that there are only views, arguments, and conclusions that either are or are not convincing. Therefore I believe that I am not unjust towards Szasz when I consider a large part of his reasoning and argumentation of a rhetoric nature. (See also Chapter I, section 7.2.)

...2. The Use of Language

Szasz is a captivating writer. His style is clear and his imagery lively. He is greatly talented in expressing complicated problems in a fairly simple and comprehensible way. His often unexpected points of view and perspectives are compelling. Although he usually writes about complicated matters his books read like novels. At the same time, his style of writing and approaching the problem is somewhat overwhelming. As a reader, one sometimes feels protestingly swept away. His evocative remarks stimulate resistance and opposition – but by the

time these have taken shape he is already appealing for attention to something else. Not infrequently he evokes in me the feeling that something is not quite right though it is difficult to lay a finger on it, let alone come up with a compelling refutation. Perhaps this is partly caused by his erudition – Stone speaks of a façade of erudition[157] – and his use of many and different types of sources.

Grenander, who calls Szasz's aphorisms "audacious and startling, clever, charming and quotable,"[158] relates that *Ideology and Insanity* is used in college classes of sociology, psychology, and law, but also in English classes.[159] That is an exceptional compliment for someone who was introduced to the English language only at age 18.

Conspicuous in Szasz's writings are the heavy tone and frequent use of emotionally loaded words. When he is criticized for that he defends himself by stating that his intention is not personal but to describe social processes.[160] When he criticizes publications by others he asserts not to mean it personally as well. From the responses, however, it is clear that those criticized do take it personally. Stone writes, "He insults either by innuendo or directly nearly every important psychiatrist within recent history."[161] According to Guttmacher, Szasz enjoys running just about everybody into the ground, and he seems to see himself as the only American psychiatrist who cares about human dignity and freedom.[162] Interestingly, Szasz himself, after having explained that it is not his intention to be personal, adds, "To the liberal, what matters is not intentions, but power."[163]

That raises the question whether the violence in Szasz's language can serve the dissemination of his views. My hypothesis is that this is indeed the case. In addition to his insights and fire and brimstone style, the violence, accusations, and use of forceful terms, appeal to the readers' thirst for the sensational. By shocking he commands attention. His oppugning of well-known and respected peers resembles a storm of imagery and, I believe, is attractive to many people. It is nonetheless clear that Szasz chooses his objects carefully. Although in his view patients and psychiatrists have complementary roles – the former abdicate responsibility, the latter take over that responsibility – he attacks psychiatrists much more often and severely than patients. He also advocates patients' rights more frequently and clearly than the responsibilities which, according to him, they should shoulder.

It is therefore not surprising that Szasz's work has gained less recognition and appreciation inside psychiatry than outside it. After all, psychiatrists are Szasz's most important target.[164] They are variously described as jailers, brutes and torturers, frauds and charlatans, abusers of power, slave drivers and slave traders, and people who earn money by humiliating, demoting, and dehumanizing fellow human beings. We can safely say that there is more here than controversy – it is rather a declaration of war. Many of his critics also perceive it that way. At least as noticeable as the verbal violence in Szasz's writings is the verbal violence of his psychiatrist-opponents. Obviously many of them highly resent that Szasz writes what and how he writes.[165] Practically unavoidably, Guttmacher notes that "A bird that fouls its nest courts criticism."[166]

Szasz himself justifies his use of verbal violence by stating, "I simply call a spade a spade."[167] He says that he wishes to avoid what George Orwell in *1984* called "newspeak," concealing reality by using euphemisms and misplaced terms. As described above, Szasz frequently uses emotionally loaded words and

expressions and his style is at times polemic to the extreme. Rare in his writings are texts that are characterized by the distancing intrinsic of scientific objectiveness, pure logical reasoning, and controlled elucidation of proof. Therefore Szasz's works are perhaps comparable to political, literary, or polemic texts rather than scientific ones. The two anthologies of aphorisms also illustrate this.

It is exactly this emotional and polemic manner of expression, that imparts to Szasz his practically immediately recognizable style of writing. Although his use of language resembles that of the radical sociologists' jargon described by Jones,[168] which in my opinion is partly influenced by Szasz, there are several types of poeticisms, imagery, and allegory that would be expected in literary texts rather than scientific ones.

One poeticism that Szasz likes to use is alliteration.[169] For example, in *Ceremonial Chemistry* the titles of almost all the chapters are alliterations; and in *The Myth of Psychotherapy* he writes that many psychiatric ideas and interventions are characterized by "an insidious and pervasive combination of disease with deviance, illness with immorality, cure with control, treatment with torture." (p. XV)

In describing the roll of the psychoanalyst, Szasz provides us with an example of his poetic use of allegory. He writes, "His task, rather, is to illuminate and thus to help [the patient] to see the signs at the crossroads among which he got lost and confused in his march through life."[170] In other places the poetic allegory serves the argumentation by evoking a certain emotion, as in his discussion on combating drug abuse in *The Theology of Medicine*: "The government is now spending millions of dollars – the hard-earned wages of hard-working Americans – to support a vast and astronomically expensive bureaucracy..."(p. 36)

As well as the frequent use of quotation marks and alliteration Szasz typically uses neologisms which are usually derived from existing words. Bloch lists several: metaphorization, technicizing, therapeutizing, medicalize, jargonize.[171]

Szasz's writing is rich with imagery. He uses many metaphors and analogies. I am using the word metaphor as Perelman, following Aristotle, defines it: a poetic figure of speech whereby something is given the name of something else.[172] In contrast, analogy is symmetric, determining a commonality between the two contexts, according to Perelman.[173] Sometimes Szasz limits such imagery to *one* word or phrase, there being *one* point in common. For instance, he draws a parallel between the relation of science to society (religion) on the one hand, and the relation of parapsychology to science on the other.[174] As science presents new explanations, undesired by society, so parapsychology presents new claims towards which science is hostile. At times Szasz elaborates on an analogy, naming several commonalties between the object of discussion and the phenomenon to which it is being compared. For example, he compares the increasing requirements made by psychoanalysts of the training of new candidates with the requirements made of immigrants to the United States. The more desirable the aspired status becomes the greater the sacrifice which must be made to attain it.[175] Or, viewed from the perspective of power, the more valuable that which is on offer the higher the cost. His most elaborate analogy is

the commonality between the Inquisition and institutional psychiatry as described in *The Manufacture of Madness*. This analogy is spread over 134 pages.

Often the analogies are effective in clarifying his meaning. Sometimes, however, they are less convincing and there is reason to doubt their applicability. (See example in Chapter III, 3.2) In *Schizophrenia* he elaborates on an analogy which at the same time he presents as a model for the total social situation of the "schizophrenic patient." So there is a pretension that rises above the analogy, namely, that of the explicatory model. His analogy is the traditional marriage. The psychiatrist is the husband, the schizophrenic is his wife, and schizophrenia as a product is the child. His extraordinary talent and inventiveness in finding similar elements in these very differing social patterns are highlighted in his elaboration of the analogy which is spread over 43 pages. In how much Szasz is himself convinced that he has designed a valid theory explaining schizophrenia remains an open question for me. In other writings he scarcely returns to this theory. On page 161, after having triumphantly declared that "in many essential respects, hospital psychiatry … is a perfect replica of the 'happy' Victorian marriage," the next remark he makes is, "We must keep in mind, however – *and now I am quite serious* – …" (my italics, -*J.P.*) Then he notes that each of the two systems serves a totally different purpose. My interpretation of this last phrase is that Szasz was swept away by his own enthralling imagination and inventiveness but realizing that he had ventured too far from base, returned to it by pointing out a difference.

Finally, I bring an example of a virtuoso combination of two analogies that exclude each other, commanding rather much willingness on the part of the reader to accept them. In *The Myth of Mental Illness*, pages 82-83, Szasz compares the triangular relationship government-physician-patient in Russia to the nuclear, patriarchal family, strict father-mother-child. First the father is the tyrant who oppresses mother and child. The mother (physician) makes life bearable for the children and is thereby necessary for homeostasis in the entire system. Not a page later he turns the analogy around 180 degrees. Now the patriarchal and tyrannical father is the physician, and the mother is the always well-meaning government. In both analogies the citizen as patient bears the cost. Of course, comparing anything with familial relationships offers unlimited possibilities to find commonality as there are endless variations of relationship patterns to be found within families. One would think – though Szasz does not clearly state so – that the system in Russia to a certain degree resembles the one analogy, and to a certain degree the other, or sometimes the one and other times the other. Such a double analogy can also illustrate the contention that someone who is sufficiently resourceful and masterful can "prove" just about anything he wishes using analogies.

...3. The Argumentation

....3.3. Presentation and Thought Processes

Szasz often begins his argumentation with the conclusion. For example, in Chapter II of *Ideology and Insanity*,[176] after several introductory lines he posits,

“My aim in this essay is to ask if there is such a thing as mental illness, and to argue that there is not.” (p. 12) In itself there is nothing wrong with this, but with Szasz, something peculiar happens. The conclusion is constantly repeated in one form or another during the argumentation so that it turns into a premise. The reader is left uncertain whether the author considers his argumentation completed and has drawn the conclusion yet. It seems to me that his frequent repetition of the premise and conclusion encourage this confusion.

A second, most noticeable trait is repeating certain contentions time and time again. It seems as though Szasz wishes to hammer them into the reader. Sometimes the repetition seems almost like an incantation as though the ritual of repeating it will illuminate the truth. Verbeek, who, in a thin book about antipsychiatry, dedicates two chapters to Szasz, is apparently highly irritated by these repetitions because he calls him a “crashing bore.”[177] The repetition, however, is not only a matter of premises and conclusions. Reading Szasz’s entire oeuvre is mighty tiring as the same contentions and explanations repeatedly show up in different places, with minor variations. Possibly the large number of journals in the United States has something to do with this. In any case, repetition of contentions, statements of position, and argumentation is frequent and a feature of his style.

Another feature of Szasz’s style is what could be called the conditional pseudo-argumentation. By that I mean reasoning by the following structure: if A is true then B is true – where A is a contention that still has to be proved so B is also unproved. A variation on this is that B is a consequence that does not necessarily follow A. Normally A would be a contention that needs no confirmation because it is generally accepted or proved in the preceding text, so such a structure is suggestive.

An example of the first is: “Modern psychiatry, if dated from Charcot’s work on hysteria and hypnosis, is approximately one hundred years old.” (*The Myth of Mental Illness*, p. 25) Beginning modern psychiatry with Charcot is completely arbitrary. Probably nobody does that, not even Szasz himself. He dates the beginning of institutional psychiatry in the middle of the seventeenth century and the beginning of contractual psychiatry with Freud. (See Chapter I, 4.2.2.)

An example of the variation is that Szasz advocates, in my opinion correctly, absolute “privacy” in psychoanalysis.[178] In other words, the psychotherapist must strictly adhere to confidentiality, no matter what. Then Szasz continues, “If it is agreed that this model of analysis is indeed the correct or desirable one, do we not jeopardize the candidate’s image of analysis … by conducting his analysis in other than a private setting?” Statement A was certainly not “agreed” in the United States around 1960 when these words were written. (See Chapter I, 3.) Moreover, the correct conclusion would be to require the training analyst to adhere to strict confidentiality as should all other analysts as well. Szasz, however, reaches the conclusion of a private analysis, which can mean psychoanalysis unrelated to the training as well as psychoanalysis by an analyst in private practice. And although the latter is often advocated by Szasz (also regarding psychiatric treatment in general), it does not follow from statement A.

Another style typical of Szasz is that he uses ear-catching, plausible sounding “shorthand” descriptions for complex concepts. Describing mental

illness as “problems in living” or as “human conflict” are the most frequently occurring examples. Szasz’s gain by staying easily readable and not complicating matters seems to me often outweighed by loss when such shorthand is misunderstood and by the advantage that is so easily and so often taken of such handy pocket-definitions by his critics.

Finally, there is the “nothing-but” aspect. By that I mean that, after having demonstrated that a certain phenomenon or behavior has a certain meaning he takes the position that this is not only the real, but also the only meaning, without presenting further arguments. On page 29 of *The Myth of Mental Illness* is the following example: “The language of hysteria … is nothing other than the language of illness, employed either because another language has not been learned well enough, or because this language happens to be especially useful. There may occur, of course, various combinations of these two reasons for using this language.” Because Szasz defines hysteria as “communications by means of bodily signs and complaints,” hysteria has been presented here in a nutshell.

I list the above elements under *Presentation and Thought Processes* because they are not arguments on their own but more to be considered as stylistic techniques and thought processes. It seems to me however, that these elements not infrequently profoundly influence the argumentation, and in particular the power of persuasion.

....3.2. The Building Blocks of Argumentation

1. Facts as premises for argumentation.

Stone accuses Szasz of falsely representing facts.[179] An example is Szasz’s representation of Durham after whom the Durham rule was named. In *Psychiatric Justice* Szasz states that Durham was black. He uses this to support his position that the exculpation of defendants on grounds of insanity and then locking them up in mental institutions serves to oppress blacks in the United States, as proportionately many more blacks are tried than whites. Stone maintains that Durham was white and thus in Szasz’s terminology, belonged to the oppressors rather than the oppressed. Stone states that Szasz often does such things and that it is a pity, because they are not really essential to his argumentation. Stone does not present more examples which is unfortunate, particularly as the disputed passage about Durham does not appear in the revised edition of *Psychiatric Justice* (1978), nor, in fact, in the Collier edition of 1971. As Stone’s criticism was published in 1973, it came too late.

Guttmacher describes *Law, Liberty, and Psychiatry* as “a wealth of misinformation.”[180] He states that the situations in which Szasz presents him in this book are not described accurately. An example is Szasz’s comment that a certain wealthy patient had a better chance to be released from Mental Hospital because she could afford to pay for her own counter-expert. Guttmacher states that his report led to her release but that he was not paid by her. Szasz includes Guttmacher in a group of psychiatrists who believe that most delinquents are sick. Guttmacher denies ever having defended this position, and states that neither did Weihofen and Zilboorg, who also appear on Szasz’s list. This means that Szasz incorrectly quotes others and imputes assertions to them which he

subsequently opposes. Guttmacher lists a few more inaccuracies. Szasz states that when two psychiatrists disagree as to whether a person is mentally healthy, the reason is that they each maintain a different concept of mental illness, which Guttmacher disputes. Szasz states that differences of opinion among expert witnesses occur only if they are psychiatrists. Nonsense, says Guttmacher, extreme differences of opinion occur daily, also when the experts are orthopedic surgeons, radiologists, mining engineers, etc. These last two factors seem meaningful to me because Szasz seems to idealize the accuracy of somatic specialists and physical scientists whereas he excessively controverts that of psychiatrists. I will return to this more in detail in 3.3. Finally, Guttmacher denies Szasz's explanation for why only very few involuntarily hospitalized patients escape from Mental Hospitals. Szasz states that this is "because a person's sense of identity – that is, his self-esteem and his confidence in his ability to appraise reality and to plan his actions – is more radically undermined by mental hospitalization than by imprisonment." Guttmacher wonders how often Szasz has been in prisons, "places that utterly violate the dignity and crush the spirit of a man," according to Guttmacher. I note, however, that this is no longer about facts, but about their explanation.

2. *Definitions as premises for argumentation*.
Once in a while Szasz chooses definitions as premises for argumentation. Clare mentions as an example a definition of disease in Gould's *Medical Dictionary* which is used by Szasz in *The Second Sin* on page 109.[181] In this dictionary the word disease is defined as Szasz defines it. Clare calls this "semantic gymnastics" and quotes a different dictionary with a different definition. In my opinion Clare is in this unjust towards Szasz: the struggle for a correct definition of disease is contended in *The Myth of Mental Illness*. *The Second Sin*, a collection of aphorisms, is intended for a broad audience and not as a publication in which theories are construed. Szasz did not use this definition in *The Myth of Mental Illness*. If he had the criticism would have been justified.

In a 1971 paper Szasz uses a definition for addiction from *Webster's Third New International Dictionary*.[182] In response Cohen accuses him of using an insecure definition and that it would have been more fair to use the WHO's definition.[183] In an article with the same title Szasz picks up this challenge and uses the WHO's definition.[184] It certainly does not make his argumentation any less convincing.

I have not found clear examples of Szasz misusing this method of basing his arguments on generally accepted meanings of concepts. However, he does sometimes confuse the issue by defining concepts in an unusual way, such as his definition of the concept of religion, and by sometimes ascribing different meanings to concepts in different places. I have already mentioned the different meanings of the concept of freedom. (Chapter III, 2.5) Another example is the concept "explanation." In *The Manufacture of Madness* (p. XXI in particular) the concept refers to events as well as behavior; in *Psychiatric Slavery* (pp. 3-4) only to events and not to behavior. The reason, Szasz says there, is that events can be explained but the word "explanation" is not applicable to what people do. Only words like justification, assumption, and contention are.

3. *The* ad hominem *argument*.
The *ad hominem* argument is a pseudo-argument attacking not a certain opinion but a person's integrity.[185] Szasz has protested vehemently against *ad hominem* arguments which he claims are not infrequently used by psychoanalysts. One of his examples is Wittel's criticism of Kraus, the tireless critic of psychoanalysis. Wittel claimed that Kraus's criticism was motivated by an unresolved Oedipus complex.[186] (*Karl Kraus and the Soul Doctors,* p. 32-35) I am of the opinion that Szasz, too, has been guilty of *ad hominem* arguments, in particular regarding Freud. (See Chapter I, 7.2.) The ninth chapter of *The Myth of Psychotherapy* is titled, "Sigmund Freud, the Jewish Avenger" even though the book is not intended as a personal description of Freud but as an "unmythologization" of psychotherapy. The chapter so titled begins with the sentence, "Because I regard psychotherapy as a moral rather than a medical enterprise, it is reasonable to inquire into the religious origin, development, and self-identification of the founder of psychoanalysis." I would like to counter that regardless whether psychotherapy is moral or scientific, it should be judged on its own merit. Whatever is thought of Freud's religion, development, and self-identification, his ideas should be judged on their own merit.

4. *Simplifications*.
Simplifications can be found in Szasz's writings. I already mentioned the "shorthand" descriptions for mental illness in the paragraph on presentation. Another simplification is that disease is something that happens to a person whereas a psychiatric disorder is something that one does and is. The one comes falling out of the sky, the other one makes oneself.[187] In this form the description is untenable, even misleading. That is relevant because such descriptions are presented as correct in the argumentation and form the foundation of conclusions. I will return to this in the next chapter.

5. *Generalizations*.
Sometimes generalizations creep into the argumentation without in themselves being argued. In *The Myth of Mental Illness* Szasz generalizes that what applies to hysteria applies to all psychiatric disorders, *mutatis mutandis*. On pages 25-26 of *Ceremonial Chemistry* he generalizes the scapegoat theory, (see Chapter I, 4.2) which is so broad that everyone becomes a scapegoat and whoever rejects this role often does it by becoming a scapegoater. But dividing up practically the entire human race into oppressors and the oppressed deprives the scapegoat theory – which tries to clarify a typical human trait and phenomenon – of its specific, unique character, and with that a large part of its value. In a 1971 article on addiction Szasz generalizes that as most medicines are not freely available, but must be prescribed by a physician, self-medication is the same as medication-abuse.[188] This generalization makes a parallel possible: that which is autonomous is called abuse, and from this standpoint he advocates "freedom of self-medication as a fundamental right."

6. *Circular reasoning*.
Circular reasoning is common in Szasz's argumentation. Sometimes it is pure circular reasoning, with that which is to be demonstrated returning in the

argumentation. More often, however, it is a repetition of that which is to be demonstrated in the form of a contention. (See 3, 3.1.) Some examples will be given in 4.2 below.

7. *Contradiction by contrast*.
Sometimes Szasz tries to demonstrate a contradiction by showing that people react differently to similar behaviors. For example, why are some drugs prohibited whereas others are freely available? Alcohol and tobacco are no less addictive than some drugs that are everywhere illegal. The one group richly contributes to the national treasury, the other is prohibited by the government. Another example is: if the suspicion that someone may be dangerous to himself is a reason for involuntary hospitalization, then why not also commit motor racers, trapeze artists, and stunt men? Such a way of reasoning constitutes quite a simplification of a complex reality. People or things that resemble each other in certain aspects are assumed to resemble each other in other aspects as well. A convincing counter-argument is harder to find regarding drugs than regarding involuntary commitment. In the latter case the crux is the grounds on which some people are dangerous for themselves. Why are some people who have a proclivity to be dangerous for themselves approached differently than other people with such a proclivity? Because they differ in other aspects than this one. Lettuce and foxglove are both plants with green leaves. Why do we eat one and not the other? The answer is because one is not toxic and the other is. In short, they are spectacular arguments with a very varied degree of applicability.

8. *Analogies*.
Analogies were already mentioned in the paragraph on presentation. When an analogy is used it is to declare the implication of a phenomenon applicable regarding a different phenomenon, on grounds that both phenomena resemble each other in one or more important aspects. This form of reasoning can be risky. A certain commonality in a particular aspect can never lead to the conclusion that this commonality exists in other aspects as well. An analogy can never determine the identity of different phenomena. And that is exactly what Szasz means to do. He invites us to concede to the identicalness, from a socio-political point of view, of complex phenomena as the Inquisition, slavery, racial discrimination, and institutional psychiatry, whereas he shows only that they are comparable in a limited number of aspects. The object of this equation is to make the amorality of the first three applicable to the fourth. From a purely argumentative point of view it remains to be proven that the analogy applies in that aspect as well. Instead, by calling these phenomena identical, Szasz concludes that institutional psychiatry is amoral.

Moreover, when stating something about the sense and applicability of an analogy is wished, not only must that which is in common be taken into consideration, but also the differences among the compared phenomena. Usually when Szasz discusses analogies he does not include a systematic evaluation of the differences. They may be mentioned incidentally but not systematically. For instance, Szasz compares psychoanalysis to a game of chess listing seven aspects in common, but never mentions whether there are also differences.[189] The same holds true for his analogy of the mind/body to a television

program/television set. (See Chapter III, 3.2.) In *The Manufacture of Madness* there is no systematic examination of the *differences* between the Inquisition and institutional psychiatry.

9. *The dichotomy game*.
Glaser sees an anti-synthetic inclination in the structure of Szasz's dialectic reasoning, an emphasis on contrasts.[190] The dialectic of individual freedom and social responsibility is turned into that of psychiatry and law. Just as Szasz does not seek a possible synthesis between mind and body but rather whets the antithesis, so he seeks no possible synthesis between psychiatry and law. Glaser calls this "the dichotomy game."

Together with the tendency to overemphasize commonality, as discussed in 8 above, the overemphasis of differences leads to a reality sketched in black and white, lacking subtlety. Such a style, although risky, is not unacceptable as long as contrast is not turned into contradiction and analogy is not turned into identicalness.

Stone calls "the dichotomy game" Szasz's "principle conceptual device."[191] I suspect that he is ascribing to this term a wider significance than Glaser. It is not uncommon that in his argumentation Szasz posits that a certain phenomenon A is part of one of the two mutually exclusive classifications X and Y. He then does not leave room for the possibility that A is part of neither, or both, or a third classification that has not been mentioned. Also the classification descriptions may appear incomplete or incorrect, or the classifications are not mutually exclusive after all. Stone mentions the example of the "lie-mistake" argumentation in *The Myth of Mental Illness.* (pp. 135-136) There Szasz states that "lies" and "mistakes" are two kinds of misinformation. The difference is that the lie aims at an effect whereas the mistake is indifferent regarding consequence. This dichotomy is not correct according to Stone. There are mistakes that are indifferent and mistakes that are not. The category of not-indifferent mistakes encompasses both lies and mistakes made in good faith the consequence of which is not indifferent. Szasz applies this dichotomy to hysteria. That the application is only relevant in case of agreement with Szasz that hysteria is no more than a form of communication of an untrue message is but implied. If after that Szasz is joined in his opinion that hysterical behavior follows rules and aims at a goal – only then – is Szasz's conclusion inescapable: "It is more accurate to regard hysteria as a lie than as a mistake."

Stone's description of the dichotomy game encompasses more than Glaser's because Glaser only notes that Szasz stresses antitheses. Stone, on the other hand, presents an image of Szasz's argumentation leading the reader to a fork in the road and then allowing only one choice, either right or left, whereas other choices or refraining from choice are equally possible. In other words, Szasz presents dilemmas, the choice being possible only after accepting the premises.

As such dilemmas occur regularly in Szasz's work this can be considered an important element of his argumentation.[192] Brody, in his commentary on a 1977 article by Szasz, mentions an example when wondering why Szasz makes a categorical distinction between descriptive and prescriptive concepts.[193] Concepts may have both descriptive and prescriptive implications, and are more

likely to be complementary than mutually exclusive.[194] *Psychiatric Slavery* presents us another example. In it Szasz, speaking about the inclination to reify mental illness as the cause of crime, asserts, “Either we accept this psychiatric idolatry – in which case we regard the principles and practices of modern forensic psychiatry as progressive and scientific, or we reject it – in which case we regard psychiatric pronouncements on the human mind, especially when offered in courts of law, as agnostics regard theological pronouncements on God.” (p. 5) There are many other examples, among them *The Myth of Mental Illness*, pages 94-95, page 271, and in the revised edition page 87; *The Manufacture of Madness*, page 241; a 1958 paper on psychoanalytic training,[195] and a 1974 article entitled “The Myth of Mental Illness: Three Addenda.”[196] For the sake of brevity I will not discuss all of these.

10. *Arguments on the grounds of dissociation of concepts*.
In order to clarify some other elements of Szasz’s argumentation I must interrupt this list to present an explanation and a theoretical framework from which these elements can be viewed, as several very important building blocks in Szasz’s argumentation are based on what Perelman calls the dissociation of concepts.[197] He explains this dissociation as the pair of concepts semblance/reality. Semblance is reality as it presents itself to the immediate experience, reality at first glance. Semblance may correspond with reality. Semblance may also be irreconcilable with reality, for instance when a straight stick in water looks broken. So semblance has two sides: sometimes it reflects reality and sometimes it is a source of illusion and error. Inconsistencies and contradictions in the immediate experience of reality, which Perelman calls “Term I,” therefore lead to seeking a second reality, which Perelman calls “Term II,” behind the first semblance of reality. Term II offers a criterion, a standard, by which legitimate and illegitimate aspects of Term I can be distinguished. At the same time Term II’s design becomes a construction that determines reality. Term II is normative as well as explanatory, and distinguishes between semblance that deceives and semblance that reflects reality.

History has judged the relationship between Term I and Term II quite divergently. To Plato, the world of ideas was the “true reality,” which he valued more highly than perceivable reality. Throughout history, however, the value attributed to these terms varied from regarding Term I practically worthless and ascribing essence to term II, to practically eliminating Term II. Kuiper says about this, “It is an expectable idea that a different reality hides behind the one that is immediately experienced, one which determines our culture, religion, art, and science. We cannot do without the distinction between that which is immediately visible and experienced, and that which is at first concealed. It is of utmost importance to our thought and existence, as people are constantly pursuing the deeper insight that imparts sense and happiness to life, a pursuit that also presents itself in science.”[198]

Aside from enthusiasm for the all but limitless possibilities of the semblance/reality approach, I counsel skepticism. Kuiper himself warns that people in power are benefited by an ideology that presents the reality of the physical sciences as the “real” reality, because physical science enables the control of reality. It seems to me that in every ideology, like in Term II, there is an

inherent danger that it will serve as justification for oppressing others or committing violence against them. The history of our culture has already amply proved that this is the case in matters of religion. The same holds true for national socialism, communism, and Marxism, except maybe for those who believe in such an ideology. My point is not whether one ideology is more beneficial than the other, but the danger inherent in every ideology. It is exactly the pretense of Term II that it describes and determines reality as it actually is which poses this danger.

Szasz's most important criticism of psychoanalysis is that Term II is speculative and scientifically unprovable, yet masquerades as truth. As examples I suggest the following quotes from Fromm: "Freud realized that most of what is our reality is not conscious, and that most of what is conscious is not reality. Freud's relentless search for the internal reality opened a new dimension of truth;"[199] "Man, who is so proud of his freedom to think and choose, is actually a puppet that is animated by strings behind and above him, and these strings are in turn moved by forces that are unknown to his conscience."[200] Fromm's choice of words indicates that he does not consider psychoanalytic insights views but rather that to him they are the revelation of authentic truth. When it is considered that psychoanalytic theory reveals the true nature of the forces that move the puppet strings, my conclusion that the psychoanalyst knows this truth about man, and is therefore in Fromm's view at a higher level than normal mortals as the high priest with his understanding and insight into the mysteries and secrets of godliness is at a higher level than the "normal" faithful, is inescapable.

These remarks regarding psychoanalytic theory as Term II are intended to be an elucidation of the significance of Term I and Term II. The point here is how Szasz uses Term I and Term II in his argumentation, and the consequences thereof. Now I will return to the list.

10A. *The contextual meaning and the strategic significance of a concept*. Szasz uses concepts both ways: contextually and strategically. The contextual meaning is the one that is given in the definition of the concept and corresponds to Term I; the strategic significance is an implication of the concept and is related to the (social) consequence of applying the concept. Thus illness can be described contextually as, for example, a physicochemical disorder, and strategically as adoption of the "sick role." (See Chapter V, 2.1.) Szasz tends to regard the strategic significance essential when the contextual meaning cannot be forged into a physical-scientific framework.[201] He considers the concept of schizophrenia as exclusively strategic. It serves to justify locking up people who have been so-labeled. The balancing of contextual and strategic aspects depends on which view of the phenomenon being considered is held. Such a view can be argued and therefore be made more or less probable, but from a scientific angle it remains a view or opinion.

10B. *The purpose and consequence of behavior.* This regards a maneuver in the argumentation that Szasz not uncommonly uses, in particular, when there is a discrepancy between declared intention and actual consequence. The intention a person claims to have does not always correspond to the way he behaves or the results of his behavior.[202] Szasz opines that human behavior should not be

judged by declared intentions but by the behavior itself and its consequences. This is why he is inclined to formulate operational definitions such as that of psychiatry. (See Chapter I, 4.1.) Another example is his definition of psychotherapy as "just talking." This emphasis on actions and their consequences causes that which people (say they) *mean* to lose significance. Whether they are well-meaning or malevolent, hypocritical or naive, loses importance. Being responsible for one's own actions and their consequences raises the question whether such responsibility also covers not reasonably foreseeable consequences, and whether there can be such a thing as an unexpected effect.(See Chapter V, 3.4.3.)

10C. *Consequence of behavior as an intention of it*. Often Szasz goes even further and posits that the consequences of an action are also its intention. This ploy assumes the nature of an accusation in those cases that the consequence is in some aspects worthy of condemnation.

In psychoanalysis, the discrepancy between intention and consequence is typically resolved using the concept of the unconscious. The intention is considered a conscious motivation for an action but the consequence is unconsciously desired. The effect is two-fold: as the true motivation is unconscious, the person cannot be blamed for it, but at the same time, the person cannot be regarded as responsible for the consequences of his actions. Thus the concept of the unconscious exculpates and infantilizes in one and the same maneuver. Szasz prefers a different route: the person is responsible for his actions as well as their consequences, which, when the consequence could not have been reasonably foreseen, leads to accusation. As such a structure occurs frequently in Szasz's writings, I list two examples here:

1. "This search for the physical causation of so-called psychopathological phenomena is motivated more by a need for prestige on the part of the investigators than by a quest for scientific clarity." (*The Myth of Mental Illness*, p. 92) "The quest for clarity" corresponds to Term I, contextual meaning, and in Szasz's opinion is a claimed motive; "a need for prestige" corresponds to Term II, strategic significance, and in Szasz's opinion is the true motive.
2. Which factor determines whether an act is to be considered a crime or a (product of) mental illness? "The answer is simple: first we decide how we want to deal with the problem or person. If we want to spirit the culprit away and pull a curtain of secrecy and silence around the issues involved and the social conflicts which may be mobilized by inquiry into them, then we decide that the person responsible is mentally ill. Conversely if there is no objection to free inquiry into the problem opened up by the socially deviant act – or, even more, if the act can be used to influence particular social issues in certain desired directions – then no recourse to mental illness is taken and the great public drama of a trial follows."[203] Here Term I, the contextual aspect of mental illness, has disappeared entirely, and Term II, the strategic implication, is presented as the only relevant reality. In comparable cases (*Law, Liberty, and Psychiatry*, pp. 154-159, and from p. 193) Szasz at least states that unusual motives and unconventional behavior, or more generally, the question, "How is all this possible?" evoke the idea of a psychiatric disorder.

There are many arguments of this type: *Ceremonial Chemistry*, page 4; *The Myth of Psychotherapy*, pages 128 and 137; *Law Liberty, and Psychiatry*, page 194.

10D. *Szasz's Term II as an alternative*. Sometimes the dissociation of concepts expresses itself as a way of explaining a certain reality which is presented as an alternative, for instance, the "official" explanation, or the psychoanalytic one. Here are some examples:

1. How can the origin of depression be explained? Is it the result of a series of events (so considered [pseudo-]causative), or is it the expression of a person's view of himself and his world? To Szasz, the former implies that depression is a disease, the latter is but an ethical judgment.[204] This is another example where contrast is turned into contradiction, as alternative explanations are presented as contradictions.
2. In the review of a book on Robert Kennedy's assassination Szasz suggests an alternative explanation for the assassin's motives, which rather contrasts the "official" psychiatric explanation.[205]
3. A similar structure is to be found in *Law, Liberty, and Psychiatry*, pages 154-159. Szasz's explanations are more existential-phenomenological than psychoanalytic.

The most important reason for Szasz to offer these alternatives is probably that he, by presenting a different view, demonstrates the fragility of psychoanalytic explanations, that after all are no more than opinions, and in particular opinions on Term II.

...4. The Structure of Argumentation as revealed by Text Analysis

Now a method will be followed that is more or less the opposite of the one in the previous section. Insight into an argumentation will be derived by analyzing it more closely. Elements will be considered in their context rather than a variety of building blocks being presented. For this text analysis I chose Chapter II of *The Manufacture of Madness* (pp. 28-41), a relatively short excerpt from one of Szasz's most well-known writings, which deals with a more-or-less completed subject in itself. It originated in around the middle of the productive critical-psychiatric period until 1984. It is one of the eight chapters in which institutional psychiatry is compared to the Inquisition. It is titled "The Malefactor Identified" and is meant to describe how witches were identified and how psychiatric patients are diagnosed. The purpose of the chapter is to show how much these two procedures resemble one another.

*....*4.1. Introductory Comments

Most notable is that inquisitors and psychiatrists are discussed at least as much as their alleged victims, respectively, witches and patients. That is highly characteristic of Szasz, who prefers to comment on relationships and their

meanings rather than viewing phenomena on their own. Equally characteristic is that when he discusses the couples psychiatrist-patient and inquisitor-witch, the emphasis is on the psychiatrists and the inquisitors, rather than on the patients and the witches. The interest that witch-hunters and psychiatrists have in locating respectively witches and patients is noted, but the patients' interest in their psychiatrists is not considered. The suggestion is that both inquisitors and psychiatrists gain importance as the number of, respectively, witches and patients increase. Therefore their number continually increases. After all, witches do not really exist, but are "fabricated" by declaring people to be witches, etc. So the chapter is not only about occurrences, but also about why they occur. Finally, the statement that inquisitors and psychiatrists are and do the same is repeated thirteen times on these pages. On the side: on page 75 Szasz states about Zilboorg, "…and seeks to establish the validity of his interpretation by constantly repeating it."

****....****4.2 Following the Thought Process in Detail

(Page 28) Witches were identified in three ways: confession, witch marks, and the water test. Each way is considered separately and compared to psychiatric identification methods.

Witchcraft was considered proven when the accused woman confessed. The way in which the confession was extracted, such as by torture, and the fact that such torture was so cruel and sadistic as to uniformly lead to confession, were not relevant. (Page 29) The psychiatric parallel is the psychiatric forensic evaluation, by way of which the psychiatrist "demonstrates" that a criminal is mentally ill based on what the defendant said or was purported to have said. In my opinion these phenomena are incomparable except inasmuch as witches through their confessions and defendants through their expressions incriminate(d) themselves. Finding symptoms could possibly be compared to finding witch marks, but a parallel between the self-accusation of being a witch and whatever psychiatric procedure is not to be found. On the contrary, it makes no veritable difference to the diagnoses whether the person being diagnosed considers himself ill or normal and healthy.

"When reading accounts of 'the confessions' of witches and of the 'symptoms' of mental patients, we must always keep in mind that we are presented with documents written by victimizers purporting to describe their victims." This statement holds true for witch-hunters, but for psychiatrists it is pure circular reasoning. (See 3.2 paragraph 6.) It remains to be proven that psychiatrists are "victimizers" whereas the book was written to prove exactly that! There is another instance of circular reasoning in the same paragraph. "The records of the witch-hunts were kept by the inquisitors, not the witches … similarly, the records of psychiatric examinations are kept by the physicians, not the patients; the psychiatrist thus controls the language of clinical description, which is *but a rhetoric for invalidating a person as a normal individual and defining him as mental patient.*" (my italics -*J.P.*) This, too, is exactly what Szasz is supposed to be proving. (Page 30) Szasz concludes: "This is why the inquisitor was, and the institutional psychiatrist is, free to interpret any behavior as a sign of

witchcraft or mental illness." Here Szasz refers to two important themes, namely, the poor description and demarcation of psychiatric disorders and the nearly endless expansion of what is considered included in the concept of psychiatric disorder. However these problems have little to do with the witch's "confession." Szasz implies that the commonality between these two situations is that the accuser is infallible and the accused always winds up holding the shortest straw. (Here, too, the reasoning is circular). (Page 31) Here Szasz elaborates.

(Page 32) The inquisitors intimidated and isolated their victims and generally confused them. The secret police in the modern, totalitarian state also do so, but institutional psychiatry has refined the system. Psychiatrists pose as friends and therapists whereas they are in fact adversaries. Why? Szasz repeats, regardless of whether you concede, you are mentally ill, but does not elucidate his contention, making it yet another instance of circular reasoning.

Next witch marks are compared with hysterical stigmata and with the results of projection tests. Instead of the latter, it would be more correct to compare witch marks ("symptoms") exclusively with symptoms of mental illness, such as delusions or conversion phenomena. A test is a kind of experiment, and thus not comparable with an attribute but with an experiment, such as the water test. (Page 33) Szasz returns to a comparison of inquisitors and psychiatrists in terminology which suggests that the latter are not only accused but already convicted, so without a trial. A report on the blood-curdlingly cruel pricking of witches ensues.

The next paragraph begins with "The fundamental similarity, then, between the methods of witchfinders and psychopathologists is that each perpetrates a cruel hoax on his victim and deceives his audience." But no information that could justify this "similarity" precedes it. So here again the reasoning is circular.

(Page 34) The water test is compared with modern psychodiagnostic methods, such as the projection test. According to Szasz the projection test always "incriminates" whereas the water test gave the witch a tiny chance: if she sank, she was not a witch, but usually drowned. (Page 35) Szasz contends that he has never experienced that the result of the projection test was that the person is normal and mentally healthy. As far as I know, a projection test can never render such a result because its construction does not allow that. Peculiarities in the person's associations can be observed that signify something (or nothing), no more and no less. However, the water test rendered a definite "proof," and that is a major difference.

(Page 36) Szasz discusses economic aspects. Not only was the property of an identified witch transferred to the witch-hunters and their institutions, mostly the Church, but the witch-hunter also earned a premium for every witch he found. Psychiatrists, too are benefited by the frequent occurrence of mental illness, but they do their utmost to socially suppress that idea. However, Szasz does not clarify what "Social suppression" is, how it is done, and according to what can be observed that psychiatrists do this. Therefore in my opinion this accusation does not have a leg to stand on.

(Page 37) After Szasz makes another parallel – the inquisitors have assistants, and so do the psychiatrists – which seems to me to clarify little, he returns to the economy. Psychiatrists are not paid by their patients but by the community. Then he returns to the assistants, and posits that psychiatrists and

psychologists rival each other in diagnosing mental illness. But in 1965, five years earlier, the behavioral faction in psychology had already clearly distanced itself from the "medical model."[206] The publication in which, according to Szasz, behavioral therapists factually maintain a medical model, even if they themselves deny it, has yet to appear.[207] Certainly the psychologist-behavioral therapist of that day presented himself more as the psychiatrist's competitor than as his "accomplice" by vehemently opposing the conceptualization of delusions as mental illness.

(Page 38) Szasz dedicates *one* paragraph to the fact that not only the deceivers should be faulted. Witch hunters and psychiatrists could/can do what they do because the majority of people believe(d) in, respectively, witchcraft and mental illness. Then Szasz discusses William Menninger's work during World War II. Menninger developed a new system of classification for psychiatric disorders resulting in more citizens being declared unfit for military service, more soldiers being declared ill, and more veterans receiving a pension and being treated for psychiatric reasons than ever before. (Pages 39 and 40) Here Szasz elaborates on this.

(Page 41) Unrelated to the preceding text Szasz comments: "But, whether physicians like it or not, the stubborn fact remains that psychiatric training is, above all else, a ritualized indoctrination into the theory and practice of psychiatric violence." Up to this point in the book not a single word about psychiatric training was mentioned and this position is not defended in any way. Yet this "fact" does have a consequence: in the United States, the percentage of suicide is higher among psychiatrists than any other sector of the population whatsoever. The reason, according to Szasz, is that same psychiatric violence. But no effort is made to convince the reader, argumentation is not presented in any way, and it has nothing to do with finding and identifying witches and psychiatric patients.

....4.3. Postscript

The above demonstrates that it is nearly impossible to determine the state of argumentation at any given moment. In itself, it could be posited that the parallels between the identification of witches and the mentally ill could produce arguments for the effective identicalness of both processes – albeit that these arguments would in my opinion not be very convincing. The constant repetition of the contention that psychiatrists resemble inquisitors is but constantly repeated circular reasoning, unless this contention is meant to be a conclusion. But if the conclusion has been attained, why continue arguing?

Szasz has the reader constantly skipping back and forth between the era of witch hunts and the twentieth century. It happens so flashingly fast, that after a while one loses sight of the fact that the socio-cultural events being discussed take place in two totally different socio-cultural contexts.

At the same time the impression cannot be escaped that the premises which Szasz seeks to bring to our attention – namely that the concept of mental illness being poorly defined and poorly demarcated, the increasing areas of life to which this concept is considered to apply, and the imbalance of power between

psychiatrists and patients – are extraordinarily important, even though there is doubt whether his argumentation adequately supports these premises.

...5. Comparisons Between Different Presentations of Argumentation

In addition to that which was discussed in sections 3 and 4, I will now attempt to compare different presentations of argumentation using examples from various publications. Such an approach can provide insight into the consistency of certain arguments and their use. It can also provide an impression of opportunistic and speculative reasoning, depending on which conclusions one wishes to draw. I wish to make the comparisons from two points of view.

1*. The first point of view*. Here I base myself on Szasz's classification which he makes on page XXI of *The Manufacture of Madness*. He states that if we wish to view matters clearly, and not conform to "popular beliefs" or participate in the justification of common practices, we mush sharply distinguish between three classes of phenomena, even though they are undeniably also interrelated. They are firstly, the facts (events and observable behavior); secondly the way we interpret or explain them; and thirdly the measures for social control which are justified by that explanation. I agree with Szasz that distinguishing these different classes of phenomena is indeed important. Let us see how he does so.

Example 1. In "Legal and Moral Aspects of Homosexuality" Szasz calls homosexuality an immaturity, and perhaps an illness, because there are signs that it may be determined by heredity.[208] In itself it is rather interesting that Szasz, the indefatigable opponent of declaring behavioral patterns to be diseases, here makes an exception, and that of all things for a category that American psychiatrists would shortly afterwards remove from their list of diseases.[209] Even more interesting is his own commentary on that. "The issue, in fact, is not so much whether or not, as psychiatric theoreticians, we conceptualize homosexuality as a type of disease. The issue is what we *do* on the basis of our concepts." One might rub his eyes. Would this author, who has written so many books condemning the concept of mental illness as a falsification and more, and has attempted to demonstrate that position, in this spot resort to a concept of illness for the sake of a most uncertain consideration, and then even posit that that conceptualization is not so important? It cannot be coincidence because also in *The Manufacture of Madness* he writes about homosexuality. "Clearly, the question that is really posed for us, is not whether a given person manifests deviation from an anatomical and physiological norm, but what moral and social significance society attaches to his behavior." (p. 168) Another such comment is to be found on page 176. These passages are of utmost importance regarding Szasz's basic premises. The relationship here between conceptualizing behavior as illness and the consequences of such may illuminate a very important point, namely, that the conceptualizing of illness need not automatically be connected with certain measures of social control. (See Chapter III, 2.5.)

Example 2. On page 26 of *The Manufacture of Madness* Szasz states that the inquisitors were truly convinced that their beliefs about witchcraft were correct, and that they may not be accused both of believing the wrong things *and*

acting according to their beliefs. Thus explanation and social control remain united. I wonder whether this is correct. The concept of "witchcraft" does not necessarily imply the necessity to torture and burn. In Spain there was almost no burning of witches although their existence was not denied (footnote on page 71 of *The Manufacture of Madness*). More important is Szasz's following remark about institutional psychiatry. "Insofar as a psychiatrist truly believes in the myth of mental illness" (that is ambiguous, in what does he believe, in mental illness or in a myth?) "he is compelled, by the inner logic of this construct, to treat, with benevolent therapeutic intent, those who suffer from this malady even though his 'patients' cannot help but experience the treatment as a form of persecution." (p. 26) Is that true? Does the assumption of illness imply a justification for forced treatment? It is precisely characteristic of medicine that such never happens, except in psychiatry. Szasz seems unjustified in not maintaining a distinction which he himself claims to consider of utmost importance, namely between interpretation and social control. Besides, that last quote contradicts the quotes in the first example regarding homosexuality.

Example 3. In "What Psychiatry Can and Cannot Do" (*Ideology and Insanity*, from p. 81) Szasz posits that "psychiatry has accepted the job of warehousing society's undesirables." One of his examples is a man with what today is called Alzheimer's disease. But Alzheimer is a condition that is generally linked to an organic disorder, and thus according to Szasz's views should be called a neurological illness (see for instance *Ideology and Insanity*, p. 13), and thus is beyond the scope of an article on psychiatry. The problems of social control are not affected by whether the disorder is considered psychiatric or neurological. In other words, here Szasz does not consider the existence of an organic disorder relevant regarding the issue of social control. The interpretation, however, is very different. In one case Szasz speaks of "disease," in the other of "problems in living"! So here the interpretation is omitted. Behavior and social control are linked together without further explanation. Yet in "Schizophrenia – a Category Error" he states that "If an objective, biomedical definition of, and test for, schizophrenia existed, then its diagnosis and treatment would of necessity conform to the diagnosis and treatment of other (real) diseases."[210] From the context we can derive that that would in any case rule out involuntary interventions. How, then, would a schizophrenic patient be treated, one may wonder. Similarly to someone with pneumonia? Or as the man with Alzheimer in *Ideology and Insanity*? The interpretation of the facts are again considered central to determining the social control.

Conclusion: Szasz sometimes does not keep to his own distinctions between behavior, interpretation, and control, but combines two of the three here and omits one of the three there. This produces a certain inconsistency in the argumentation.

2*. The second point of view.* In Szasz's work ambiguity can be found regarding whether he is a revolutionary who seeks radical changes or an evolutionary who seeks gradual changes and is willing to be satisfied with gradual developments in the desired direction. Many of his writings request revolutionary changes: the abolition of the concept of mental illness, the cessation of involuntary commitment and forced treatment in psychiatry, etc. These are fundamental, not gradual

changes. He categorically rejects the idea that involuntary hospitalization would be illegitimate when a patient is not treated, implying that it would be legitimate if treatment were offered. "… [I]n a society such as ours is and aspires to be, involuntary mental hospitalization is an unjustifiable moral and legal wrong. Hence, attempts to illegitimize it on the grounds that psychiatrists fail to treat involuntary mental patients is as faulty logically and as unworthy morally as are attempts to legitimize it on the grounds that psychiatrists protect society from madmen or madmen from themselves. Because each of these justifications is premised on the legitimacy of depriving innocent persons of their liberty under psychiatric auspices, supporting such justifications validates, implicitly, but therefore all the more powerfully, the legitimacy of psychiatric coercion." (*Psychiatric Slavery*, p. 9)

On the other hand, he says that he opposes sudden changes. "… I agree with Popper that 'piecemeal social engineering' is the most desirable method for effecting social change." (*Law, Liberty, and Psychiatry*, p. 225) It must be a very special kind of gradual change, because it has to lead to a very far-away destination that has already now been determined. This is quite different from Popper's "trial-and-error" method of gradual change, in which the search and learning from experience are more important than the utopic destination. Thus is engendered the ambiguity about the changes that Stone observes, partly as a result of Szasz's influence – such as limiting the criteria for involuntary commitment, the implicit right to suicide, and improved legal protections during trial.[211] On the one hand, in personal interviews, Szasz concedes that these are valuable improvements towards a development which he supports. On the other hand, compared to the changes he advocates, they are hardly worth mentioning. The deinstitutionalization movement in the United States, that seems to have been partly inspired by Szasz's work, prompted him to comment that first patients were involuntarily hospitalized, and now they are tossed out on the street against their own wishes, so that essentially nothing has changed.[212] This illustrates the problems that Szasz's theories can pose for us. (See Chapter III, 4.2.)

...6 Conclusions

It was noted already in the introduction to this chapter that studying the argumentation can only lead to statements about that argumentation itself, and not to the correctness or truth of the argued views. We can certainly conclude that Szasz is an imaginative and often captivating writer who employs all sorts of rhetorical tools to convince and motivate us.[213] Equally we can say that he sometimes minimizes differences, or on the contrary, exaggerates contrasts, creating rather charged and colorful portrayals of reality. His lines of thought sometimes reveal flaws or gaps. The tone of his writing, attacking and defending, has won him many friends but also not a few enemies, and has probably contributed to his fame. Finally, his argumentation is sometimes unclear and confusing. Worthy thoughts and positions risk being deluged by the violence of his words, images, and accusations. That his rhetoric and argumentation contribute to what he wishes to achieve and of which he wishes to convince his readers cannot be unequivocally confirmed.

My conclusion is that he is a good defender of his own thoughts and theories, considering his absorbing style of narrative, his evocative imagination, and his rhetorical devices, but that he is a poor defender from the point of view of his argumentation. Much of what he considers worthwhile and important in his premises is argued in a way that is more accusatory than convincing, casts more suspicion than clarity, and moralizes more than providing insight. Finally, there are some clear discrepancies between the seriousness of his accusations on the one hand, and the power of his arguments on the other.

■ Part II The Myth and the Power: a commentary

▪▪Chapter V Is Mental Illness a Myth?

...1. Introduction

Szasz's entire oeuvre can be considered to revolve around two premises. The first is that mental illness does not exist; the second that mental illness is a socially damaging concept that leads to stigmatization, dehumanization, and the application of all sorts of coercions. In this chapter I will comment on the first premise from a theoretical and conceptual point of view. In chapter VI some of the consequences of that conceptualization will be considered from a practical point of view. The second premise insofar as involuntary intervention and coercive measures are concerned, will be discussed in Chapter VII.

Szasz's opinion that there is no such thing as mental illness was discussed in Chapter I, 4.2. He reaches this conclusion by defining illness as a process that affects the body in a way that makes the physical aberrations that ensue demonstrable by physicochemical methods. I will call this the biomedical concept of illness, in which I distinguish between two variations:

a. *The materialistic biomedical concept of illness*. In this concept man is a physicochemical machine. The methods of investigation are physical and chemical. Disease is present only when bodily aberration can be demonstrated by these methods.
b. *The biomedical concept of illness in a broader sense*. Man is not seen only as a physicochemical machine, but also as a biological entity, involving biology in addition to physics and chemistry.

It is not entirely clear which of these two variations is chosen by Szasz as his premise. Usually he mentions only physics and chemistry as prime sciences which implies that he chooses a materialistic biomedical concept of illness. Occasionally, however, his descriptions include biological references. Therefore I will consider the concept of illness used by Szasz as biomedical unless there is a special reason to add the word materialistic.

It is not surprising that using this premise Szasz arrives at the proposition that the majority of psychiatric disorders cannot involve disease. To date no organic aberrations have been demonstrated for many psychiatric disorders. The question is, what are the arguments Szasz uses for the biomedical concept of illness? This position is not obvious. The literature on this subject contains several different concepts. Not only is there no consensus but ideas on this subject vary greatly. That was already the case before Szasz's publications kindled animated discussion about this subject.

Szasz's most important arguments for his choice can be summarized as follows:

1. Health can be defined in anatomical and physiological terms, illness in physicochemical terms. Thus the definition of disease is objective, value-free, ontologically anchored, valid in all places and at all times.
2. The development and differentiation in the sciences, and the organization and structure of our knowledge and insight, are thus that only the biomedical

concept of illness meets the requirements of scientific and methodological purity.
3. Man's ideas about disease have always throughout history been linked to the presentation of organic aberrations.

So Szasz's first reason is the value-free nature of the biomedical concept of illness. The tenability of this position is debatable. Even though physicochemical aberrations are objective findings which can be described as facts or processes, not these aberrations in themselves are of primary importance but their significance in the context of a human being experiencing suffering and disability, and feeling menaced. In other words, from all possible formal aberrations, only those that are significant in connection with illness are selected. Abnormalities that are not connected to illness are not considered. The word disorder, as indeed the word aberration, in itself implies a value judgment of that which can be objectively determined. In this sense illness – and health – is not only an explicatory concept but also one that imparts significance.[214] Probably this implicit value judgment does not attract attention because of the fairly general consensus regarding these values. It goes without saying. Pain, suffering, and the specter of death are so universally experienced as negative that these values assume the nature of universal values.[215] The values involved in psychiatric disorders are more controversial and thus more obvious.

Szasz' second argument will be discussed further in 2.4. The third was discussed in Chapter II, 3.1.

Significantly, in his chosen definition as well as in his argumentation, Szasz, as a matter of principle, approaches and defines the concept of illness from the viewpoint of the professional, the man of science, the physician. He does not explain this choice even though it is for him a rather peculiar choice to make for two reasons. The first is that in his book *Pain and Pleasure* he sides *against* the professional's viewpoint in favor of that of the patient (p. 23). Secondly, for Szasz, human liberty and dignity are top priority even when a person is ill. Choosing the professional's viewpoint is risky considering the ethical and moral context in which medicine develops and justifies its existence. Professionals are mainly interested in the factual aspects of disease, taking the ethical context for granted.

The person who is ill, suffering, and seeking assistance is the center of every form of medicine, whether it is defined as a science, helping profession, or social institution. Therefore being ill is the most obvious starting point for developing ideas about illness. It is up to medical science to design concepts that produce workable strategies by conceptualizing the problems of ill people in a certain way, the more pragmatic the better. However, this conceptualization, this redefinition, risks emphasizing certain elements more and others less, or even omitting them altogether. By using the professional concept as his point of departure Szasz hazards not or insufficiently recognizing these shifts of emphasis. Below I will argue that indeed he did not escape this hazard.

As in my opinion Szasz has chosen an unfortunate point of departure for his ideas on illness and mental illness, this and the following chapters will not be a direct commentary on his views. First I will detail my own ideas on this subject. Then I will compare my considerations and conclusions to Szasz's. I will describe the phenomenon of "being ill" more closely as a descriptive, and in combination with the concept of health, classifying concept (2.1). Then illness will be

described as a conceptualization, a theory about being ill, and thus an explicatory concept (2.2). After that the relationship between disease and organic aberration will be discussed (2.3). Next I will discuss the concept of mental illness (2.4) and finally, the connection between mental illness and organic aberration (2.5). My intention is to provide a general view of the meaning of the concept of illness, particularly in psychiatry.

Precisely by starting with being ill and with the ill person rather than the professional, the concept of being ill is revealed to have two poles: it is a value concept and an ontological concept. It is a value concept because a negative value judgment is always involved in illness. Being ill is ominous, frightening, disabling, etc. It is an ontological concept because it involves changes in reality, be that in material reality or be it in the reality of events, behaviors, and experiences.

Due to the enormous expansion of somatic medicine illness as an ontological concept has increasingly attracted attention. It is generally viewed as an objectively given fact or event. But this representation is incorrect. Demonstrated bodily aberrations are objective facts and processes. Illness is an abstraction of that, a concept which imparts meaning, a theory about the facts. The facts have been selected for their significance in connection with being ill. Viewed from a purely utilitarian angle it could for instance be argued that an infection proceeds most "advantageously" when the "participants" – the host who is ill *and* the bacteria causing the illness – fair well. At the same time this view is nonsensical because in medicine the point is that the host recovers and the pathogenic bacteria are killed. The value judgment remains implicit and goes without saying.

My argumentation will lead to choosing a different concept of illness than the Szaszian one, namely the biopsychosocial concept of illness. This integrated concept of illness accommodates both the value element and psychical and social factors relevant to illness in addition to physical ones. Szasz's point of departure is the professional; mine is the ill person. From these two different vantage points different concepts of illness are derived.

Although medical science is based on the concept of illness as a theory about being ill, the value of every concept of illness is determined by its utility. That means that when evaluating concepts for medicine, and for psychiatry in particular, a kind of ledger of gains and losses should be compiled. In addition to considerations of the conceptualization itself, considerations about its implications should be included. The second part of this chapter will be about these. I will discuss the connection between the concept of illness and views about the human condition ("*la condition humaine*") (3.1), the competition among different possible explanations for being ill (3.2), validation in medicine and in psychiatry in particular (3.3), and finally the significance of symptoms and disorders in psychiatry as well as in general medicine (3.4). It will become obvious that in a biomedical concept of illness the principle of causality applies to organic aberrations. In a biopsychosocial concept of illness for which no organic aberration can be demonstrated, loss of freedom and autonomy determine being ill. In the next chapter the balance of loss and gain will be expanded by discussing the roles of the physician, the patient, and their relationship, as well as the social institutions of medicine and psychiatry.

Finally, two comments: The first is that in viewing the problem of being ill and illness from the ill person's perspective, the environment's view cannot be ignored, and thus should be included in the argumentation. The second is that the expression "medical model" – so often used in debates about the utility and applicability of the concept of illness in psychiatry – has countless unexplained meanings, as Begelman,[216] Bremer,[217] Leenen,[218] Fischer,[219] and others posited, and will therefore be avoided as much as possible.

2. The Problem of Conceptualization

....2.1. "Being ill'

Below I intend to describe "being ill" in more detail. Not the professional definition concerns me, but a description of the experiences, behaviors, and signs which identify the ill person to himself and to non-professionals around him. I am aiming here at a sociocultural concept of illness,[220] and at what Baron means when he says "an intuitively based humanly grounded ontology of illness."[221] "Ill" and "healthy" are concepts that in a polar sense are inseparable because each derives its meaning from the other. Therefore the problem posed above can also be formulated thus: by which criteria can ill and healthy be distinguished? In this question ill and healthy are classifying concepts which require making a short detour and discussing classification. Then a closer look at the hallmarks of being ill and their significance as criteria for ill-healthy will be taken. Finally there will be references to several criteria found in literature.

The paired concepts of "ill" and "healthy" are probably as old as humanity itself. These concepts are/were used by people in all sorts of cultures today and in the past. Many different theories explaining illness have been proposed. It might be redefined as, for instance, a religious or a medical concept. My intention is not to redefine illness itself but to focus on what *being* ill means.

Being ill is not synonymous to "having an illness." That would imply inverted reasoning, namely that the "being ill" is derived from the concept "illness." A consequence of my reasoning is that someone can have an illness without being ill. An example would be the *lues latens*, and what Taylor, quoting Feinstein, called "lanthanic" illness, such as a physical aberration which is discovered by coincidence, for instance during a medical check-up.[222] Usually such aberrations are minor, which are interpreted as illness due to the predicted prognosis.

When accepting such a definition is not wished, but only being ill in its common meaning, the problem that it is difficult determining whether this concept means more or less the same for everybody in every era and culture is encountered. Nonetheless the experiences, behaviors, and signs by which being ill is recognized in our culture seem to be fairly universal.

"Being ill" can be limited in four ways:

- Only living things can become ill. Here we will consider only humans.
- Only individuals are ill. Solely as a metaphor can the concept “ill” be applied to groups, such as the family, Church, and society, or to abstractions, such as mutual relations, the economy, the world.
- “Being ill” refers to a certain, in principle temporary, change in the ontological condition and existential quality, so a process. Where there is not to some degree a process, the person is not called ill. For instance, someone who is blind or deaf is not considered ill, even though such a disability may have been caused by illness.
- Being ill is valued in a negative way.[*] All facts and signs associated with being ill derive their significance from this negative value judgment which is fairly intrinsically connected to it.[223]

Before exploring the hallmarks of being ill in more detail it must be pointed out that it always denotes a special, aberrant event as opposed to the “normality” that is identified as health. “Ill” and “healthy” are two contrasting, in principle mutually exclusive concepts, although they cannot be clearly demarcated from each other. Van Dijk uses Moser’s term, *Schwerpunktsbegriffsbildung*. In this so-called core concept, concern is with the heart of, for instance, a certain characteristic, process, or state of affairs. The lines between one core concept and another cannot be clearly drawn.[224] So “ill” and “healthy” are considered a polar pair of core concepts.

This implies that the characteristic differences between ill and healthy are at the same time criteria by which we can divide the universal class of living people into two classes: people who are ill and people who are healthy. As the attributes of illness also count as classifying criteria for the ill-healthy distinction, I interrupt my argumentation for some comments about classification.

When dividing a class of objects into two groups is desired according to a certain criterion, for instance, the presence or absence of a certain attribute, then, logically, that criterion must in the first place be unambiguous. In the second place, it must be possible to draw a clear line between the two groups. Thirdly, the entire class must be divisible into the two groups. Taylor posits that these logical conditions are generally not attainable when application of whatever type of classification to the sphere of living beings is attempted.[225] Two important limitations must be taken into consideration.

The first limitation is that no criteria for classification will be equally and unambiguously valid for all items in the class. In the biological sciences classification criteria are generally established by combining several different factors into a cluster. When the cluster is composed of factors which must all be present the criterion is called *conjunctive*. More often, however, the criterion is *disjunctive,* that is to say, there is a certain amount of leeway expressed by the and/or formula. This is because there are always organisms to which not all the criteria included in the cluster apply. The more of the cluster’s elements apply to the entity, the more certain that entity’s classification is. Taylor reported that Beckman formulated two rules for biological classifications:

1. The classification is formed by a cluster with a fairly large number of features.

[*] In English, the word “ill” also literally means bad, as in “ill manners” or “ill fortune.” – translator

2. Each entity inside the realm is required to show only a certain amount of these features.[226]

The second limitation is that the nature of the classifying criteria usually do not allow drawing clear lines between different classes. Taylor quotes Körner's work about this. Körner indicates that even when an empirical class is demarcated from another one by a conjunctive criterion, the lines between the classes remain blurred to a certain extent. Where the line is finally drawn is unavoidably to a certain degree arbitrary. The arbitrary choice is determined as much as possible in accordance with the division's factual state of affairs, and also by pragmatic considerations.

Clearly these limitations have to be accepted when seeking criteria for the ill/healthy classifications as well.

After these auxiliary remarks about classificatory aspects we can discuss the characteristic hallmarks of the "ill" concept. I will discuss these hallmarks from three points of view: the experiences; the behavior; and the attributes which distinguish the ill person from the healthy person. By consistently reasoning through each of these three angles, Fabrega developed three different concepts of illness.[227] I will not do that here. I will describe the aspects drawn from these different angles as phenomenological, behavioral, and biological aspects of illness.

Phenomenologically – and here I limit myself to that which is experienced – being ill means a discontinuity in someone's life. Feelings of being unhealthy impose themselves on ill people with an experiential quality that surrounds them and changes their lives, whether they wish it or not. Other experiences can join this general, imposed feeling of indisposition, such as pain or shortness of breath. Ill people feel powerless, their role is passive – it is happening *to* them. They experience being unfree, unable to do what they wish, having lost their autonomy.[228] Ill people lose interest in more distant or abstract matters which normally engross them. Their mental horizon narrows.[229] In serious illness the change in the way the world is experienced can be intense and far-reaching, so that it is massively restricted, even to the point of reduced consciousness or coma. In addition, being ill is ominous. The situation could worsen. There is always the possibility of an unfortunate outcome. The specter of approaching death, or of permanent disability, always hovers around people who are severely ill. Being ill can also evoke all sorts of other feelings, in ill people themselves as well as those around them. Ill people may feel worry and a need for care, but sometimes also guilt (being ill is sometimes associated with sin), anxiety, suspicion, anger, rebellion, resignation. The people around an ill person may feel a need to help, to comfort, to nurse, and to treat. But there can also be fear, for instance of contagion, hesitance, trivialization, accusation, or resentment.

In summary, this entire complex of experiential changes with negative value judgments can be called suffering, this word being used as a key word denoting the entire complex. In general, it can be said that being ill brings suffering. So suffering is a necessary condition for being ill. Someone can also suffer from, for instance, dismal social or economic conditions, or political pressure. Suffering alone is not a sufficient condition for being ill.

From the angle of *behavior and behavioral change* being ill means a discontinuity in people's behavior and functioning. Typically, people who are ill will remain in bed, abandoning their normal activities and responsibilities. In general the change of behavior is such that all sorts of normal and habitual behaviors and functions are performed less well or do not succeed at all anymore. Achievement levels drop. There is an inclination to withdraw from social contacts, etc.

I will call this decline in behavior and functioning as compared with being healthy dysfunction. Although being ill does not always result in poorer functioning, it can be posited that in general a certain degree of dysfunction is a necessary condition for illness. Conversely, dysfunction as seen in ill people can also occur in healthy people, for instance, in the case of overwhelming fatigue or conditions of loss of liberty. So dysfunction alone is not sufficient for being ill.

Szasz does not consider this behavioral criterion significant for being ill in itself but only for the voluntary acceptance of the social role of illness, the "sick role." Indeed the behavior of ill people is not determined by being ill only, but also by social, cultural, and personality factors. The point at which an ill person decides to stop working and remain in bed is illustrative of this. Drawing a clear line between the social role of the ill person and the behavioral criterion for being ill is practically speaking very difficult. Yet it can be concluded that the nature and severity of being ill on the one hand, and social, cultural, and personality factors on the other, can be considered two complementary series of factors which together determine the manifest behavior. Szasz also here chooses dichotomy (see Chapter IV, 3): the social role of illness is chosen voluntarily, while illness is a biological condition, which happens to a person.[230] This applies more or less to the "heavy cold" which he chooses as an example, but had he chosen a more serious illness as his example, such as a stomach perforation, then his assertion would not have applied anymore.

Being ill from a *biological* angle means biological discontinuity in living. In this perspective the word illness denotes an abnormality of form, structure, and/or function of some part, process or system of the individual. All sorts of phenomena may occur that ill people or others consider abnormal – compared to how those people used to be when they were still healthy; compared to others who are healthy; and sometimes also compared to ideal conditions. Health is sometimes typified as a static-normal and other times as an ideal-normal condition. Being ill is never normal. The converse is also true: when for instance in a different culture something is considered normal, then in that culture it does not count as an illness. Abnormality of structure or function is a necessary condition for calling somebody ill. On the other hand, many matters are considered abnormal without being dubbed ill. So abnormality alone is not a sufficient condition for being ill.

Three factors are given for being ill, namely suffering, dysfunction, and abnormality. In addition, to qualify as illness, they must be present in a certain severity. These three factors are independent of each other and their scientific investigation, as sketched above, is carried out in different ways: those of phenomenology, behavioral science, and biological and physical science.

It has been attempted to find other factors besides these three. The way people react to their own being ill, and the way the people around them react, is in different aspects typical. In our culture the social role of the ill person is marked by Parson's four postulations:

1. Ill people have both the right and the obligation to be free of some or all of their usual social role responsibilities according to the nature and severity of their illness. People who do not take their being ill seriously enough may be told that they should stay in bed or that a physician will be summoned more or less against their will. So being ill can be validated by others, which has the social function of guarding against simulation.
2. Ill people are not regarded as responsible for their illness, nor for their possible lack of recovery.
3. Being ill is undesirable. Ill people are expected to want to become "better."
4. Ill people are expected, depending, of course, on the gravity of their condition, to seek competent assistance, normally from a physician, and they are expected to cooperate with him in order to recover.[231]

Taylor considers "therapeutic concern" the most characteristic of all these factors, and proposes making this a conjunctive classification criterion.[232] The evocation of ill people's need for treatment, and the need of those around them for such treatment, is fairly consistent in our culture. In other eras and cultures the response to being ill could be very different, for instance banishment of ill people (leprosy, mental retardation), causing the criterion of "therapeutic concern" to decline in value. The use of this feature as a criterion would provide society and physicians with excessive opportunity to call all sorts of deviants ill.[233] It would also unavoidably lead to the following circular reasoning: Why does someone evoke in me a need for treatment? Because he is ill. But why is he ill? Because he evokes in me a need for treatment. Finally, if investigatigation is desired regarding to what extent the judgment of physicians and psychiatrists declaring people to be ill is valid, then this judgment itself as a valid criterion for being ill cannot be accepted.

Redlich proposes a similar definition. He defines psychiatric patients as people who need help.[234] Even more than Taylor's, Redlich's definition raises the question on what moral ground it is based, particularly when he follows that this help is sometimes voluntary and sometimes involuntary. Who decides that help is necessary? And who extends that help? If the answer to these questions is: the physician (or: the psychiatrist), then what distinguishes this physician from a paternalistic despot who by definition is always right?

De Jonghe mentions the criterion of maladjustment as a conjunctive criterion for the existence of disease.[235] The broad definition which he assigns to this word encompasses not only the dysfunction factor but also abnormality. In my opinion this criterion should be supplemented with suffering, as this experiential complex with a negative value judgment is not necessarily maladjustment. Besides, the technical meaning of the word risks its being applied to that which is in fact deviant.

Kendell proposes a conjunctive criterion for being ill which he adopts from Scadding as follows: an individual is ill when he has an abnormality which constitutes a "biological disadvantage."[236] According to Kendell a biological disadvantage is present when there is an increased risk of death or a decreased

chance of procreation. He posits that for example sufferers of schizophrenia and manic-depressive psychosis are at increased risk of death.[237] However, for a large part this increased risk of death was caused by what was done to these people: being locked up in institutions where in those days a frequent cause of death was tuberculosis possibly influenced mortality more than the schizophrenia itself. The same holds true for the drastically reduced chance of offspring among psychotic people. Their stay in institutions, and not primarily their disease, reduced their opportunity for producing progeny. Moreover, in my opinion it is unsatisfactory that according to this criterion homosexuality would be a rather spectacular example of illness while in our culture it is nowadays generally denied that homosexuality is a disease. To maintain his criterion, Kendell has to bend over backwards. He posits that we should omit consideration of pure social and cultural factors insofar as they influence a person's chance to die. The increased risk of death has to be present even when others do not notice the abnormality and treat the person as they would treat anybody. I note that this would actually mean that (abnormal) behavior as a criterion for illness has to be abandoned as others respond to abnormal behavior, which would conceal judgment of the existence of a "real" biological disadvantage. Even so, omitting consideration of behavior in psychiatric disorders is usually equal to making reality imaginary as the diagnosis is usually determined mainly on the basis of behavior. Who would dare diagnose a fellow citizen schizophrenic when his behavior in no way strikes others as abnormal, and who therefore is treated like everybody else? As far as psychiatry goes, this criterion puts us back where we started. Furthermore, omitting consideration of cultural and social factors means that the omission of evaluation of certain cultural phenomena is wished. That is unsatisfactory because cultural influences on what is called ill and healthy are so abundantly evident. It seems to me that every attempt to describe ill and healthy as facts must fail because the value judgment, which is so wished to be reasoned away, is precisely essential. I will return to this in 2.2.

Interestingly, Szasz's response to this publication by Kendell is limited to noting with satisfaction that Kendell admits that psychiatrists have claimed too wide a territory for themselves. (*Schizophrenia*, pp. 94-95) However, Szasz misses the point of Kendell's proposal when he concludes that Kendell wishes also to exclude homosexuality from the realm of illness.

Possibly other criteria could be established in addition to these. It is interesting that such a generally occurring complex of phenomena as being ill is so difficult to describe unambiguously and satisfactorily. No doubt one reason is that being ill is subdivided in categories of illness, so that the general, all-encompassing concept "ill" draws less attention than the notion that a certain disease should be treated in a certain way (see also 2.2). Another possible explanation may be that we are dealing not only with observable and describable phenomena but also with value judgments. That explains why the realm of being ill has/had different limits in different places and in different times.

Above three different criteria were found for being ill: suffering, dysfunction, and abnormality. Although it can be posited that these criteria are necessary conditions for being ill – in spite of the exceptions which exist for each – none of

the three was in itself a sufficient criterion for being ill. Now the question is whether these three together can count as a usable cluster for the classification of disease and health.

If these criteria are generally necessary conditions for being ill then it must be logically concluded that being ill in the absence of these criteria is not possible. The complementary position, i.e. that these criteria also suffice for demarcating the domain of being ill from other unpleasant and ominous processes can be falsified only by circumstances or processes that meet these criteria and yet can evidently not be called illness. All sorts of dysfunctions and forms of suffering which result from externally imposed limitations on liberty can cause someone to become ill. They cannot in themselves be called illness because they do not occur spontaneously but are imposed. Impending natural disasters, lack of food or finances, and social crises can impede people in all sorts of ways but here the circumstances are abnormal, not the people themselves, while that is what is meant by "ill." A process of mourning or deep sorrow does not meet the criteria of being ill because, although someone going through it may feel "ill," it is not abnormal to mourn as a reaction to serious loss. Trimbos notes that mourning is definitely not a circumstance of illness although according to him it would be considered illness in terms of Van Dijk's "The medical model in social context."[238]

The conclusion is that the three proposed criteria together form a cluster which is useful as a classification that distinguishes ill from healthy. As all three factors must be present to some degree the cluster is conjunctive.

....2.2. The "Disease" Concept

When humans address their own being ill or that of others in an effort to understand or influence it, their attitude to being ill changes. In addition to initially passively allowing the peril of being ill happen to them, an active, investigating attitude emerges as an attempt to regain control of the situation. In so doing the need arises for a language, a framework of concepts, and a conceptualization. The concept which epitomizes access to reflection and scientific thought about being ill is "disease." Thus the ill person is transformed from somebody who has a defect to somebody who has gained an attribute, namely, the disease.[239] The concept of illness initially derived its significance in particular from the fact that all sorts of signs of illness could be registered and related to each other using this concept. In the large realm of being ill it became possible to isolate diseases which apparently differed from each other. Historically the description and discovery of different diseases preceded the formation of a comprehensive scientific concept of disease. The realization that there were different diseases led to the distinction of increasingly more of them.

Disease is a concept. This implies that disease is not the same as an observed phenomenon of illness or clinical symptom. The concept of disease is an abstraction of that which is reported and observed. An attempt is made to discover structure, relationships, and patterns in the facts. This has the benefit that the same pattern can be found in other ill people, giving rise to the insight that they are suffering from the same disease, or perhaps a disease that

resembles it but is also different in some way. The disease concept allows the phenomena to be arranged in a pattern or at least allows such a pattern to be found, and in addition allows important and unimportant factors to be separated.

The disease concept also implies, as was elaborated on regarding being ill, that there is a process. Illness originates quickly, slowly, or creepingly. It progresses in a certain way towards a final phase which may be full recovery, a new equilibrium due to permanent impairment, or death. By conceptualizing these complex events the possibility is created to study them. This is done from three angles: a. investigation of the image and progress of the disease; b. asking what causes the disease, where does it come from, and of what significance it is; c. determining whether or not the process can be influenced. So the disease concept provides a thought model, the disease model, that makes the formerly vague and ominous events of being ill available for investigation and attempts at influencing it.

Thus, the disease concept encompasses a theory about being ill. It is not only a description of what is happening, but also a perspective and interpretation, and therefore an explanation of the phenomena, imparting significance to them. This theory can differ rather much in degree of abstraction and complexity in respect of different illnesses. The more insight is gained into the relationship between etiologic and pathogenic factors on the one hand, and form of occurrence, prognosis, final phase, and measure of possible intervention through treatment on the other, the more the complexity of a particular disease concept increases. If, on the contrary, only a symptom or syndrome of a disease is known, the degree of abstraction is relatively minor. The degree of abstraction of the disease concept itself is larger than the degree of abstraction of different illnesses as a concept. The relationship between the disease concept in general and the different individual illnesses can be considered a meta-relationship.

One result is that certain diseases seem to be not much more than observed phenomena whereas others represent a highly complex concept. Particularly regarding those illnesses that can be relatively simply conceptualized there is a tendency to reify the disease concept.

If illness is a theory about being ill, was this theory shaped in different ways, and are there different disease concepts? This question can be answered affirmatively. For instance, since the competing medical schools of Cos en Cnidus in the fourth century before Christ there are two different disease concepts which, with their variations, continue turning up throughout the history of medicine to this day.[240]

The Cnidus disease concept consists of the idea that illnesses can be viewed as separate entities. The illness-entity is an independent entity that is so-to-speak planted into people. The phenomena and progress are entirely dependent on the nature of this “implanted parasite.” The disease leads a more or less independent existence in people’s lives and possesses them. In this sense, disease is comparable to a demon that landed in the person. This concept of illness, which is called the ontological or empirical disease concept, is used when speaking of the “classic image” of a certain disease or of “pathognomonic phenomena” as phenomena that render assurance about the existence of a certain illness.

This disease concept in its pure form has been abandoned, among other reasons, because the idea that there are specific explanations for all forms of illness appeared untenable.[241] However, if science is considered not only a matter of object and method of research, but also the way the obtained knowledge is arranged, then it can be said that the typical patterns of phenomena and events of disease form the bases of arranging them in medical textbooks and manuals. Not the ill people but the illness forms the point of departure in the assumption that disease can be isolated from its "host."

Contrarily, the Cos disease concept considers illness as an aberration from that which is normal. Health is viewed as a harmonious equilibrium and disease as a disturbance thereof. In 1847 Virchow formulated it this way: "…*dasz Krankheiten nichts für sich Bestehendes, in sich Abgeschlossenes, keine autonomischen Organismen, keine in den Körper eingedrungene Wesen, noch auf ihm wurzelnde Parasiten sind, sondern dasz sie nur den Ablauf der Lebenserscheinungen unter veränderten Bedingungen darstellen*…"[242] […diseases are not isolated phenomena, not autonomic organisms, not beings that have penetrated into the body, nor are they invading parasites, but they are a certain way in which living beings react to changed circumstances..…] Gradually this model, later called the physiological disease concept, was expanded. Cohen puts it this way: "a. Disease indicates deviations from the normal – these are its symptoms and signs; b. symptoms and signs are commonly found to recur in constant patterns; these are "syndromes" or 'symptom-complexes'; c. these syndromes always indicate one or more of three aspects of disease, 1. its site 2. associated function disturbances 3. causative factors in terms of (1) morbid anatomy, physiology and psychology (2) ætiology".[243] He adds, "It is this concept which should dominate our teaching and our approach to medicine."

The existence of different concepts of disease illustrates that illness is not a fact or empirical factor but an interpretation of facts and factors. So the question whether illness exists is also not a question about empirical factors but about the reality value and/or validity of a concept. This is particularly important because a frequently used concept easily turns into a thing or fact. Reification of the concept of disease has not a few consequences. I will return to this later, among other places, in 2.4.

Every conceptualization influences the way in which the related phenomena are viewed.[244] The question is, does the disease concept also influence the way an illness and being ill is viewed by those who maintain the particular concept? An answer can be found by comparing the description of being ill in 2.1 and Cohen's description – a description which is generally accepted nowadays.

In 2.1 being ill was among other ways described as undesirable and ominous; healthy as desirable and good. The concepts disease and health clearly constitute a value judgment that cannot be found in Cohen's description. Transcultural differences illustrate that this value judgment is instrumental in interpreting certain phenomena as abnormal or ill. King mentions the example of women in the higher classes in China whose feet were tied in such a way as to cause pain, dysfunction, and malformation. Yet they were not considered to be

suffering from a disease.[245] Likewise in China of yore adiposity was a symbol of affluence while in today's western culture we consider it an illness. All sorts of examples could be added such as cosmetic interventions that we would consider disfiguring, female genital alterations that are considered essential in certain African tribes, and more.[246] When somewhere else, or in former times, a phenomenon which we would consider a disease is considered desirable, then there or at that time it is/was not considered a disease.[247] No doubt the converse is true of us to people from other cultures. For King this is a reason to include value judgments prevalent in a particular culture in his description of illness in addition to criteria as pain, dysfunction, and abnormality.

A second noteworthy difference is that subjective indisposition, for which the word suffering was used, does not occur in Cohen's description. Thus to the afflicted person the most important criterion of illness is lacking from his definition of disease.

These two differences indicate that there has been a shift in attention among those who concern themselves with disease from the subjective experience of illness to discernible clinical symptoms and pathological manifestations. Advances in scientific research and rational thought diverted attention from the irrational and emotional aspect of being ill. Medicine as an applied science and form of assistance can only exist in the context of the positive value that man ascribes to health and the negative value of being ill.

Due to the absence of this element of value and subjective suffering in the description of disease, that with which the physician concerns himself, namely disease, loses its connection with the patient's experience when he is ill. Therefore a shadow is cast on the ethical foundation of medical treatment. A certain estrangement has come into the relationship. The physician takes it for granted that someone who has a disease wishes to rid himself of it at whatever cost. By that I mean that the value judgment "illness is bad" is turned into a law: "Illness must be eradicated wherever it is found." Physicians often cannot imagine that someone may differ on that and allow their patients little opportunity for their own thoughts and decisions. Many physicians cannot imagine that a patient might wish to refuse a certain treatment or operation and therefore they forget to ask. The result may be misunderstanding, dissatisfaction, and suffering. When reading *Der Zauberberg* by Thomas Mann one will be impressed by the ease with which physicians in the first years of the twentieth century accepted that their patients made different decisions than those recommended by their doctors, and how self-evident it was in those days that people must determine their own destiny. This realization seems largely lost today.

There are other conceptualizations of disease in addition to the above. Some conform more readily to the "ill" concept as described in 2.1 than to the biomedical concept of illness.

There is, for instance, the holistic disease concept with its variations, in which man is viewed as more than the sum total of his parts. The entire person in his entire environment should be investigated. Man should not be reduced to bodily, mental, or social factors without taking into account the significance of these factors for the totality.[248]

Related to this is the ecological concept of illness,which views life as based on maintenance of a dynamic equilibrium with the environment at all sorts of levels, which can be particularly significant for prevention.[249]

A relatively recent, and I believe promising, development in the conceptualization of disease is arising from general system theory.[250] It was elaborated upon in the United States by Engel[251] and Lipowski[252] among others, and in the Netherlands discussed regarding psychiatry by Lit,[253] Milders,[254] and Van Tilburg.[255] According to Neill this theory was already anticipated by Adolf Meyer's psychobiology in the first half of the twentieth century .[256] Scheflen applies its principles to schizophrenia.[257]

Although a thorough discussion of these concepts is beyond the scope of this book, I would like to briefly expand on this last concept, which is called the biopsychosocial disease concept, because I wish to use it shortly.

In General Systems Theory (GST), "system" is a core concept. When a system is defined as an organized collection of interrelated components that form a totality, then systems can be found everywhere in nature among inanimate as well as among living things. These systems appear to be arranged hierarchically, that is to say, that each system in turn consists of smaller systems, and constitutes a part of more encompassing systems. One of the most important properties of all these systems is their isomorphism. All these systems have a number of structural properties in common. An example of such in life is the openness of the system. That is the property of interaction between the system and the environment. Also, open systems are self-maintaining, which means a dynamic equilibrium with the surroundings ("steady state"). In addition to this "adaptive stability" there is an "adaptive self-organization," which is the capacity to adapt to changes in the environment by changing the own structure or function. This can be described as well as: the capacity to accumulate information, organization, and complexity.

When it is assumed that an individual person is such a system then it can be posited that this system is composed of several decreasingly complex subsystems, for example: organ systems ⊃ organs ⊃ cells. However, man also constitutes part of higher, more complex systems, such as the family, a profession, and society. Reality can be viewed in its entirety as one huge system. Each system is more than the sum total of its compositional parts.

Due to isomorphism systems differ from each other only in the complexity of their organization, which creates the possibility of relating findings at a certain level with findings at other levels.

In the framework of GST, illness can now be described as a shortcoming in one or more of an individual's system properties. This shortcoming can be described at different levels. Scheflen describes schizophrenia at eight different levels. As to man the biological, including the physicochemical, the psychical, and the social levels are most relevant in respect of illness, we speak of the biopsychosocial concept of illness. This biopsychosocial disease concept is clearly related to holism.

The biopsychosocial disease concept and its systematic arrangement, its isomorphism, and its possibilities for systematic description of the complex events of being ill at different levels, may be the most promising disease concept at this

time. Therefore below I will compare it to the biomedical disease concept that Szasz uses as a basis for his theory.

By now it is clear that if the term “ill” is described as in 2.1, the biomedical disease concept cannot be applied to it without great effort. Of the three described phenomena, only bodily abnormality can by accommodated by this concept of illness. Suffering and dysfunction do not fit in.

The materialistic, biomedical concept of illness actually recognizes only *one* element in the network of relationships that is meant by the word illness, namely physical aberration. One could even go as far as to posit that the biomedical disease concept cannot literally be a concept of illness because in it the conceptualization as it is formed by the word illness is short-circuited. It is limited to the notion that bodily aberrations exist which have causes and can be treated. That would mean not only that mental illness does not exist, but also that illness on the whole does not exist, or in any case has become superfluous as a concept. To me it seems more correct to speak of a disease concept characterized by its strong reduction with heavy emphasis on things and facts.

The biomedical disease concept fails to include the significance of what ill people themselves and those around them experience. However, we can use the biopsychosocial disease concept without any problem as it is a comprehensive concept. It accommodates humans as experiential and behavioral beings at the center of their social network and as co-carriers of their culture, as well as biological organisms and physicochemical “machines.” In other words, the biopsychosocial disease concept can be meaningful to professionals as well as to “lay” people.

....2.3. Disease and Organic Aberration

The pair of concepts “ill - healthy” is initially descriptive and classifying, not explanatory. The disease concept clears the path for ideas about the causes and explanations of the phenomena of illness which man has sought and found in the course of history. Only afterwards a different distinction becomes relevant to explaining illness, a distinction which man has made in the course of history in order to understand himself and others better. This is the distinction between mind and body.

In Chapter II, 2, we saw that before the eighteenth century the presence or absence of bodily aberrations could hardly form a criterion for disease because way too little was known about normal and aberrant structures and functions of the body and its parts. Historically speaking, the disease concept could only fairly recently be associated with the existence of physical aberrations.

Although Szasz’s assertion that until the nineteenth century all diseases were considered physical diseases (for instance, in *The Myth of Mental Illness*, revised edition, p. 36) is untenable, it is conceivable that the development of medicine in the second half of the eighteenth and in the nineteenth century led to reconsideration of the issue of the role of organic aberration in illness. By that time the organic causes of so many illnesses had been identified that the

inductive question could be and was asked whether perhaps organic aberration is involved in all illnesses, and whether this could be a criterion in classifying ill and healthy.

Not only historically, but also logically the classification ill-healthy precedes the distinction mind-body, at least if being ill is viewed as described in 2.1. Only after the classification ill-healthy and the conceptualization of illness had occurred, after dualism was developed in man's thinking about himself, could the question be posed whether the aberrations and abnormalities that are encountered in the realm of being ill are of a bodily or a mental nature. This question presupposes dualism in the view of man: body and mind must be unlinked using a scientific abstraction so that one can think and act as though he is concerned only with the body or only with the mind.

It is surely not coincidental that postmortem research was the first step towards developing a medicine oriented to physical science (Morgagni, Bichat, and others). After all, the body after death is the only situation in which the body can be perceived as purely a body. During life the body can be viewed as exclusively a body only by pretending that the mind does not exist and ignoring it. For this to be possible body and mind have to be separable from each other in principle in thought.

In speech dualism was not limited to seeking and finding physical and mental aberrations and abnormalities. Our speech has expressions which distinguish bodily illness from mental illness. These expressions imply that the body and mind can be ill without participation of the "other part" of the person. Literally, not only factually but also theoretically, that is untenable.

Boyle et al suggest that the view that illness can be purely physical conceals a reified metaphor.[258] That metaphor originated with Descartes when he posited that the body can be described *as though* it were a machine. In the expression "physical illness" the "as though" has vanished, the metaphor is reified, and therefore has become a myth, according to Boyle. So when Szasz states that mental illness can only be illness metaphorically, exactly the same can be claimed for physical illness. Taken literally, neither mental illness nor physical illness exist. Both are myths. The only way these concepts can be maintained is by determining that physical illness involves illness which is mainly manifested by physical disorders and aberrations; and mental illness involves illness which is mainly manifested by disorders and aberrations of psychological and social functioning. Both concepts will be used this way below.

Using the existence of bodily aberrations as a conjunctive classifying criterion for being ill raises the question whether medicine is adequately advanced to be able to identify all existing and possible organic aberrations. It must be possible to demonstrate with sufficiently reasonable certainty that physical aberrations can be fully and dependably found during medical examination before assuming that when such have not been found, they do not factually exist. If this ideal is for now unreachable, categorizing in three groups can provide a recourse. Group 1 includes diseases with proven physical aberrations; group 2 includes conditions for which no physical aberration can be found but that make a strong impression of being illnesses for which the physical aberrations will some day be discovered;

and group 3 includes conditions that make the impression that probably no physical aberration will ever be found although one can never be sure.[259]

Thus the criterion for classification in group 2 or 3 becomes expectation based on subjective conviction. That is not only scientifically undesirable but also a chaotic state of affairs as illustrated by the ardent and rather fruitless controversy about whether or not physical aberration is probable in, for instance, schizophrenia.

Of course nobody can predict how many new physical aberrations will be discovered in the future. The vastness of research in this area indicates that expectations are high, for instance with regard to the spectacular developments in genetics. Other arguments can also be named. Firstly, sometimes in the initial phases of illness, for instance some malignancies, no physical aberration can be demonstrated yet, although in retrospect once the aberrations have become apparent it must be assumed that physical aberration was already present in the initial stages. Secondly, changing living conditions give rise to new diseases. Whether, and if so, which, physical aberrations are involved becomes apparent only after a period of time. Until such time they would have to be accommodated in the dubious group 2. Thirdly, all diseases that are known only as symptoms or syndromes, for instance pruritus senilis, trigeminus neuralgy, and dystonia musculorum deformans, would have to be categorized in group 2 or 3.

Therefore a modification has to be added to the criterion: not the existence of a physical aberration is a valid criterion but the existence of a *demonstrable* physical aberration. This implies that a part of what conforms to the criteria of being ill – for now, anyway – is not a disease according to this definition. Thus is rendered insoluble the problem of where in practice to draw the line between disease and non-disease.

The next question is whether every demonstrated physical aberration indicates the presence of disease. The following comments can be made:

a) Bodily aberrations can vary from extraordinarily severe to trivial. Further – arbitrary – lines will have to be drawn to distinguish trivial from significant. A blurring of lines is inherent in the realm of classification in the biological sciences, as explained in 2.1, and can therefore not count as a decisive objection.
b) The considerations about the connection between bodily aberrations and illness imply that aberrations found have a relevant relationship to the phenomena of the illness. In order to impart meaning to the concept of relevance, the possible kinds of relationships that can exist between physical aberration on the one hand, and the phenomena of illness on the other, must be investigated. The physical aberration can be: 1. the cause of the phenomena of disease as is the case, for instance, regarding cirrhosis of the liver; 2. an accompanying phenomenon as for instance the exanthem in measles or rubella. 3; a consequence of illness such as the contractures of leprosy or decubitus ulcers in the bedridden; 4. efforts of the body to repair itself or to ward off the miasmatic factor such as fever and leukocytosis in pneumonia; and 5. possibly have little or nothing to do with the phenomena of illness such as an in itself unimportant aberration, or someone may have multiple, unrelated illnesses. So physical aberration can have several different meanings in the pattern of illness. Add to this that many physical illnesses are

not derived from physical aberrations. Examples are infectious diseases, intoxication, and avitaminosis, the cause of each initially being outside of the body. The concepts of etiology and pathogenesis should be remembered here. Etiology means the cause of disease. Pathogenesis means the totality of processes that occur between the onset of the cause and the appearance of the disease, so the way the factor causing the disease works. If, for instance, a pathogenic microorganism damages the liver, thereby causing jaundice, then the microorganism is the etiologic factor, and the damage to the liver the most important pathogenic factor that gives rise to the jaundice.

c) Physical variations, when present, are not always signals or indicators of disease being or having been present. There are several statistical variations that have a positive or neutral value judgment so are not considered aberrant. Examples are abnormal tallness, abnormally high vital capacity, abnormally sharp vision, and abnormal strength. The fact that these variations exist underpin the judgmental quality of the words “disorder” and “aberration.” This means that the biggest advantage of describing disease as a physicochemical disorder, namely the objective, value-free nature of the description, is but a deceptive advantage. The value judgment is already implicit in the description.

Finally, note that several aberrant *bodily functions*, which are generally considered disease can be described as a physicochemical disorder but not as an aberration in the shape or structure of the body. Essential hypertension and genuine epilepsy are the best-known examples and in this sense functional diseases. (See Chapter I, 4.2.)

In conclusion, physical aberration can only be a criterion for classification when it complies with three limiting conditions: the aberration has to be demonstrable, relevant, and have the nature of a process. Exactly these limitations, however, mean that the bodily aberration cannot count as a necessary criterion for being ill. In other words, the conjunctive cluster for the classification of ill-healthy (see 2.1) cannot be replaced by the conjunctive criterion of physical aberration. In addition, the most important reason for maintaining the physical aberration as a criterion of classification, namely its objective, value-free nature, is invalid, because this criterion in itself implies a value judgment.

....2.4. The Concept of “Mental Illness”

In 2.3 mental illness, taken literally, was considered an untenable concept. It can be made tenable by indicating that it means illness, the manifestations of which are seen as disorders and aberrations in psychical and social functioning. In common usage the term mental illness is applicable to psychoses and more or less synonymous to madness. In English-speaking countries the term seems used more broadly and is more a part of everyday language than in the Netherlands. Therefore perhaps it would be better to avoid the term. The most pragmatic solution would be to replace it with “psychiatric disorder” which indeed has been done as much as possible in this book. The term psychiatric disorder is

synonymous with “mental illness,” and more importantly, with the term “mental disorder” used by the DSM-III*.

The risk inherent in the term psychiatric disorder is that it will be perceived as all with which psychiatrists concern themselves. That would legitimize every expansion of psychiatry *a priori*. One should be aware of this risk precisely because it is the reason the problem of defining mental illness is posed in the first place. (See Chapter II, 3.5.)

Using the term psychiatric disorder has additional advantages. In the first place, it does not reflect a dualistic view of man, as does the term mental illness. Secondly, the word disorder suggests that the diseases so categorized are not identical to bodily diseases but rather differ from them in important aspects. Thirdly, it reflects that the subdivision of diseases among the various branches of medicine in fact does not meet logically and methodologically consistent criteria, no matter how much one would wish it to. Van Nieuwenhuizen, who was many years chairman of the Central Committee for the Training of Medical Specialists in the Netherlands, and therefore particularly expert in this field, during his retirement speech stated among other things: “The subdivision of specialties is one of the most irrational in the world.”[260]

The term psychiatric disorder includes several very different disorders, also in comparison to each other. A large part of them, in particular the neuroses, are fairly generally presumed to correspond to no clear physical aberrations.[261] In a different part, such as the symptomatic and organic psychoses, the dementias, and deliriums, the relevance of an organic disorder is incontrovertible. Regarding yet another part, as the many psychoses and in particular schizophrenia, the issue of the existence of underlying organic disorders is the subject of hot debate. So the three groups listed in 2.3 are all amply represented.[262]

When a relevant and demonstrable organic aberration is present in a psychiatric disorder whether such a disease belongs in psychiatry can at most be doubted, and it can be posited, as does Szasz, that it should be included in neurology. There is no conflict about the disease status of such disorders. The reason that such disorders are included in psychiatry seems to be related to the way in which care and treatment are organized rather than to the illness itself. For instance, when someone with psychiatric problems is discovered to have a cerebral tumor, the primary treatment will be neurological or neurosurgical. Remaining behavioral disorders after completion of such treatment will be referred to psychiatry even though they initially resulted from the tumor and its treatment. So psychiatric disorders are those that express themselves mainly in experience and behavior regardless of their causes. Psychiatry scarcely utilizes the techniques and methods of somatic specialties, respective of medical examination as well as treatment. The boundaries are indistinct and determined more by daily practice, experience, and sometimes local conditions, in short, by pragmatic arguments rather than principles. The significance of the link between psychiatric disorders and organic aberration will be further discussed in 2.5.

* The DSM-III was the current edition at the time this book was written. At the time of the translation, the current edition is the DSM-IV-TR, which still uses the term “mental disorder.” - translator

The controversy about whether or not psychiatric disorders constitute diseases regards those disorders for which no relevant organic aberration can be demonstrated. An important consideration is that people with such disorders can be called ill due to the factors of suffering, dysfunction, and abnormality. That third factor, abnormality, cannot be determined other than in terms of experience and behavior. This means that the real basis of these disorders can be determined much less objectively, in any case to the extent that a degree of objectivity as required by the physical sciences cannot be found here. Although physicochemical events are in principle no more real than events, circumstances, and human actions in general, psychiatry in fact does not base itself on those actions and events in themselves, but on psychologically understood complexes which include the action as well as its context and its quality. The entire framework in which the action takes place, or, in any case, in which the action is significant, is important. An example borrowed from Kraus's textbook is a respectable housewife who steps totally nude out of the window of her ground floor bedroom to buy strawberries from a passing vendor. Such an act would be considered a disorder of judgment, unless, for instance, she were an actress being filmed for a movie.[263] This example illustrates a difference from when a bodily aberration has been found, albeit a gradual, not principal difference. A bodily aberration provides us with enough information in itself without knowledge of the context (see also 3.3). This difference is related to the structure and organization of our knowledge and familiarity with reality.

Jaspers noted already in 1923 that the idea of illness is always linked to a value judgment (*Wertbegriff*) in addition to a principle of normality (*Durchschnittsbegriff*).[264] Positing that the physician "*um gar nichts klüger(ist), wenn es im Allgemeinen heisst, irgend etwas sei krank*," ["is generally no wiser than that someone is ill"] he continues that physicians have sought and concerned themselves with "*eine Fülle von Seins- und Geschehensbegriffen*" ["an abundance of concepts about symptoms and processes of illness"]: "*Weil die Fragestellung ursprünglich aus dem allgemeinen Wertbegriff kam und fortdauernd durch die therapeutischen Aufgaben des mediziners mit ihm verknüpft bleibt, nennt er alle diese von ihm geschaffenen Seinsbegriffe, aus denen die Wertung so gut wie ausgeschaltet is, doch Krankheiten.*" ["While the original issue was whether the general value judgment is not that, through continued therapeutic treatments, the physician remains in contact with the patient, calls all matters he encounters signs of illness, and so automatically considers everyone who comes to him as ill"]. Hereby Jaspers notes the negative value judgment as essential while the process of redefining illness as an ontological process is of lesser concern.[265] When redefining, the value judgment was increasingly forgotten and that which was describable as a fact and a process increasingly became the focus of attention. It seems to me that now, sixty years later, this process has progressed yet further.[266] The description of illness has been removed even farther from the *Wertbegriff* which it originally was and factually still is. Therefore disease seems to be increasingly considered a fact, a factor in reality, rather than a concept that is intended to conceptualize certain ominous, unwanted events in life.

Two trends have been notable for some time. One is that disease as a *Wertbegriff* began to regain interest. Occasionally this happened indirectly,

namely by describing health as a *Wertbegriff* (for instance, in the WHO definition, see Chapter II, 3.3). The consequence was that health became more than the absence of disease because disease remained defined as a fact. Another expression of this trend in the Netherlands was Querido's noting that when medicine concerns itself only with the factuality of illness, in many ways it falls short in practice.[267] Since then, the attitude and role of the physician, particularly that of the family doctor, has been a constant subject of debate. Those aspects of being ill that were removed from the definition of illness in the biomedical disease concept came under scrutiny. The other trend was to remove value judgments farther and more consistently from the disease concept in an effort to achieve value-free, objective medicine. Szasz's description of illness as a physicochemical disorder fits into this trend. Psychiatric disorders, as disorders that fit poorly or not at all into a biomedical disease concept, led to a great deal of controversy in this trend as to whether the disease concept was applicable to them at all. Therefore other conceptualizations were sought in which the facts could be accommodated more satisfactorily than in the biomedical disease concept. The point is that gradually it is becoming clearer that several diseases can have no more than a controversial status inside the biomedical disease concept because the expected organic aberrations cannot be demonstrated. So we are faced with a choice: either declaring these uncertain illnesses to be non-illnesses, or realizing that illness originally was and in fact still is a "Wertberiff," with the consequence that a disease concept must be found which accommodates this value concept.

Medicine that is focused on physical science can deal with facts and processes but shuns values. For a while there was a euphoric belief not only in value-free science but also in value-free medicine, and even in value-free psychiatry. Gradually it became clear that this illusion could be upheld only when certain values are reified and considered solid laws, as *a priori*s instead of values. Bichat expressed it thus at the beginning of the nineteenth century, "La vie est l'ensemble des forces, qui résistent à la mort." [Life is the collection of powers that resist death.] This dictum was often a practical hypothesis quite reconcilable with the wishes of patients. It turned into a law that required medicine to postpone death as long as possible at every cost. Therefore expressing doubt about whether this dictum was always everywhere the right course became nearly taboo even when the enormously expanded development of medical-technical equipment led to a demand for quality of survival.[268] The value and significance of death were denied as well as the value and significance of being ill.[269] Put differently, because death was viewed as ominous and living longer as valuable, this value judgment was turned into an unquestionable law. It seems to me that part of the lack of understanding for and the tremendous resistance against abortion, euthanasia, and suicide, precisely among physicians, must be understood this way. To physicians, who prolong life at every cost, it is incomprehensible that the patient does not always want that.

In the case of psychiatric disorders, not only this central problem of illness as a value-judgment as opposed to illness as a concept of being arises. Also some other aspects of psychiatric disorders, conceptualized as illnesses, pose problems that are important in this respect:

- When certain forms of behavior and experience are viewed as disease it is fairly impossible to not implicitly or explicitly reflect social norms.[270] In this matter the point is not the line between illness and non-illness, but that in the realm of illness, the manifestations of psychiatric disorders can be described as facts but are in fact not uncommonly violations of social norms or normative behavior. To quote Szasz, "Whenever we try to give a definition of what mental health is, we simply state our preference for a certain type of cultural, social, and ethical order."[271]
- It is impossible to draw clear lines between what is considered a manifestation of illness and what is not. This problem might be partly solved by drawing pragmatic lines between normal and pathological. Partly the problem goes deeper, because the lines change when different models are maintained. Precisely in psychiatry there is a rather large number of models in which these lines are drawn differently as well as models in which no lines can be discerned. They conflict with models in which the concepts of health and disease figure prominently.[272]
- A problem which is closely associated with the one above is the near impossibility of defining normality.[273]
- In somatic medicine, seeking the causes of disease has been quite fruitful. Contrarily, in psychiatry, such a way of looking at disease must be supplemented at least with the *motives* which are relevant to the experience and behavior which are interpreted as a syndrome. Furthermore, a look might be taken at what the person is trying to express by his syndrome, in other words, the *communicative meaning* that the syndrome might have. And finally, the *purpose* (Aristotle's "final cause" according to Grenander[274]) which the syndrome might have for the person might be examined.
- In the humanities, and so also in psychiatry, account must be taken of the influence exerted by the examiner, his methods, and his instruments, on the object of examination.

These five problems underline the dilemma that was already posed by the conceptualization of disease as "*Wertbegriff*" being inescapable in psychiatric disorders. The dilemma itself can be solved only by making a choice. This choice can be expressed thus: either disease is again conceptualized as a value judgment, which amounts to a biopsychosocial disease concept or something similar, or the attempts that have already been made to define disease as anchored in objective reality according to the biomedical disease concept are followed. If the latter is chosen, it must be accepted that all sorts of situations and processes that were considered part of the realm of disease will be excluded from that realm in order to make the definition applicable. It will be necessary to pretend that illness is objectively present in reality and ignore that "the medical enterprise is from its inception value-loaded."[275]

The consequences of this choice are extensive. Below they will be examined by systematically comparing the biomedical and the biopsychosocial disease concepts. Although the significance of such conceptualizations for the future of medicine must not be exaggerated, the choice between these two concepts *will* be of influence. Its influence will be limited firstly because all sorts of factors will remain excluded from the conceptualization, and secondly, because the biomedical concept of disease in the various somatic branches of medicine

has proved highly efficacious and will remain so, and so will remain, in that context, a quite tenable (sub-) concept. Briefly summarizing, the direction in which this influence will take medicine could be sketched as follows:

- In the case of the biomedical model medicine will continue to develop technologically, limited only by the boundaries of physical science and the budget available for expansion. Human bodies will continue to be manipulated in increasingly more perfect technical ways. The prolongation of life at all costs will be countered only by ever more iatrogenic causes of death. Disease, as a fact, will increasingly influence the social decisions that are made about people. The people making those decisions will be the ones exclusively qualified to assess disease: physicians.
- In the case of the biopsychosocial model, technological development will be limited not only by budgets but also by what people wish to have happen to them when they are ill. In this case the person will be treated not as a body but as a person which may reduce the so-called heroics, but also iatrogenic complications. Significantly fewer social decisions will be made about people regarding their medical conditions. Individuals themselves and only they will have final authority over their lives.

Szasz clearly chooses the biomedical disease concept and thus the first alternative. It seems to me that the biomedical disease concept may to a certain extent be appropriate for the body and (bodily) disease, but that the true task of medicine is to offer people help when they are ill, not necessarily with maximal technical perfection, but in a humane way. This leads me to choose disease as a "Wertbegriff" and a biopsychosocial disease concept.

I wish to point out that in this aspect Szasz's choice leads to an effect which is diametrically opposed what he himself advocates. Respect for man and his dignity and freedom in my opinion require us to choose a biopsychosocial disease concept, and in his opinion a biomedical concept. Regarding Szasz's views on who psychiatric patients are from a biomedical point of view, I will show in chapter VI, section 4, that Szasz's position is untenable.

....2.5. Psychiatric disorders and organic aberration

Whoever considers organic aberration a criterion for illness, as does Szasz, removes most psychiatric disorders from the realm of illness. The structure and organization of our knowledge is such that those sciences that deal with experience and behavior employ different methods of investigation and language than the physical sciences. This complicates the search for a link between psychiatric disorders and bodily aberrations. It equally renders difficult any conclusion about the relevance of such a link. This is what led Szasz to suggest in *Pain and Pleasure* that psychiatry should be considered sociopsychology and entirely separate from medicine.

Let us examine more closely some physical aberrations seen in connection with psychiatric disorders. A reduction of psychic and bodily functioning often accompanies what the DSM-III calls "major depression with melancholia." This reduction is recognizable by diminished secretion of perspiration, constipation, and a dry mouth, among other things. These are observable, physical

aberrations, as are the increased levels of corticosteroids.[276] Heavy anxiety is accompanied by an increase in pulse rate, secretion of perspiration, and adrenaline levels. In anorexia nervosa we see loss of body weight and amenorrhea.

All these bodily aberrations are the accompanying phenomena of some people's psychic functioning. After all, people also respond to all sorts of sociopsychological influences in a bodily way. This, however does not constitute an argument for supposing an organic disorder.[277] In other words, these physical aberrations are not considered relevant. Which criterion for relevance is posed here? There are also many physical illnesses in which the bodily aberration is not the cause of the disease. (See 2.4.) We are in fact treading on extremely complex ground where, it seems to me, the dualistic view poses insoluble problems. Only when we assume that man is composed of two very different kinds of being, body and mind, can there be a "relationship" between these two beings. Then the question can be asked: what is primary – the physical or the psychical manifestations of anxiety? Or do they run parallel? Much has been done to "unveil" these extraordinarily difficult relationships.[278] It would be convenient if this discussion could be postponed until such time as we have a better theory about human functioning than dualism. However, the need to determine whether psychiatric disorders must be viewed as diseases is contemporary. It cannot be deferred to some (distant) future. The significance of the physical aberration that occurs in some psychiatric disorders is of course extremely important in everyday practice.

The most important aspect of the theoretic foundations of the link between bodily aberrations and psychiatric disorders is that virtually nothing is known about the true nature of such a relationship. Therefore equally little is known about the relevance of these organic aberrations. This means that the existence of a relevant link between physical aberrations and psychiatric phenomena as a criterion for the disease/health classification poses indomitable problems. To date, we have no choice but to reject this criterion as unusable.

The word organic here has an additional meaning. As psychical experience and functioning can be perceived only through human contact, and as such contact always involves the body as well, we can know the expressions and functioning of the mind only indirectly, namely through others' and our own physicality. No psychical or social functioning is perceivable without our bodies, or as Van Dijk says, our "biotic substrate."[279] Szasz assumes the same: "Let me make clear that I do not contend that human relations, or mental events, take place in a neurophysiological vacuum. It is more than likely that if a person, say an Englishman, decides to study French, certain chemical (or other) changes will occur in his brain as he learns the language. Nevertheless, I think it would be a mistake to infer from this assumption that the most significant or useful statements about this learning process must be expressed in the language of physics." (*The Myth of Mental Illness*, pp. 102-103)

I would like to take this thought one step farther. Suppose that in a certain, not French-speaking population, someone has learned French, and that the corresponding phenomena of the biotic substrate are demonstrable. In that case, this French-speaking person will be found to have a brain function (or structure)

that deviates from the statistical norm. It is not, however, pathological, but rather should be considered as a superior variation (of course this is a value judgment). Reasoning the same way, the phenomena of a developing phobia in the biotic substrate would in principle have to be demonstrable. These, too, would deviate from the statistical norm but the complex of phenomena of psychical functioning and the biotic substrate together would be harmful and undesirable, bringing suffering and dysfunction. Therefore, it would not only satisfy the criteria of the biopsychosocial disease concept, but also of the biomedical one. It may well be that these phenomena in the biotic substrate should be marked as relevant physical aberrations.

This reasoning is admittedly exceedingly speculative. To be able to claim validity it should be stated thus: if normal behavior and psychical functioning are unthinkable without a biotic substrate, then abnormal or pathological behavior and psychical functioning is equally unthinkable with a biotic substrate. Because in the psychical realm, much more even than in the bodily realm, that which is considered normal is tied to social and cultural norms and value judgments, one must wonder whether that biotic substrate can be called aberrant. This is probably what led Van Dijk to posit, "It is theoretically not refutable, yes, even very likely, that a psychical disorder occurs on the basis of a normal, undisturbed somatic substrate."[280]

However, let us not be inhibited from our line of reasoning by this. It went like this: if, in a certain culture, normal behavior X has a biotic substrate, then behavior Y does too. If in a given culture or social milieu Y is considered abnormal behavior, and it can be shown that the somatic representation of that behavior is different from the somatic representation of behavior X, then formally, logically, there is no longer anything preventing behavior Y from being declared also an organic aberration. The somatic representation of Y need in itself only deviate from the statistical and/or individual norm. The corresponding undesirable and abnormal phenomenon is behavior Y and as a cluster satisfies the criterion of a biomedical concept of disease. If that is not accepted – for instance by Murphy, who uses the example of vegetarianism for what here is called behavior Y[281] – then this can only mean that the value judgment as decisive in determining what is disease and what is not has been set. This is exactly what Szasz wishes to avoid at all costs. Reasoning on yet another step, it can be posited that such organic "disorders" and their corresponding behavior may be influenced by physicochemical means. If that were so, then a specific, relatively perfected effect, compared to current psychoactive drugs, would be possible, rendering this somatic representation to be of the highest practical relevance.

Some remarks are necessary regarding this line of reasoning. It is easier to postulate a somatic representation than to form an image of its specific nature. Our current state of knowledge and understanding does not allow insight into how the epistemological gap between body and mind might be bridged by a specific somatic representation of psychical events. On the other hand, constantly considering psychical processes and events as a totally different entity from somatic events, as does Szasz, risks that body and mind will be viewed as two different kinds of entities, linked to each other only in function, like a television station and a television set, but otherwise mutually foreign. And if psychical and

bodily functioning are indeed inseparably linked, then a representation of the one in the other is the most obvious way to imagine that inseparability.

These speculations beg some questions. Suppose it were possible to define some patterns of behavior or psychiatric disorders inside a biomedical disease concept this way. Would that mean that all psychological and social theories regarding these disorders have become irrelevant and that the influencing or treatment should happen only through biomedical techniques? These questions should be answered in the negative. The search for the significance of certain experience and behavior remains relevant, whether the disorder is considered rooted in a biomedical or in a different disease concept. This applies to the understanding of the disordered behavior as well as to the treatment of it.

If it is assumed that experience and behavior do not take place in a neurophysiological vacuum then it must be concluded that demonstrating neurophysiological aberrations corresponding with abnormal behavior does not in fact change the category of that abnormal behavior. That is in spite of the fact that formally a relevant physicochemical disorder has been demonstrated. This means that Szasz's contrast between disease in the biomedical sense as something that happens to somebody, and of which a value-free description is possible, on the one hand, and on the other, "mental illness" as something that someone is or does, and which is always in a moral category, is in principle a pseudo-contrast regarding psychiatric disorders in the above sense.

In conclusion, it can be posited that in our current state of knowledge and insight, the presence of demonstrable bodily aberrations can be neither a necessary nor a sufficient condition for the existence of disease, also regarding psychiatric disorders. Precisely because of the epistemological gap between the sciences that deal with somatic substrates and those that deal with psychical and social functioning dependence on finding empirical connections remains. Therefore the application of the conjunctive cluster mentioned in 2.1, namely suffering, dysfunction, and abnormality as a classifying criterion for ill/healthy remains decisive, also regarding psychiatric disorders.

....2.6. Summary and Conclusion

Szasz bases his premise that mental illness is a myth on the biomedical disease concept. He chooses an apparently value-free concept, and the professional concept. I, on the other hand, base myself on concepts of being ill and healthy using the meanings that those terms have for ill people themselves and the non-professionals around them. By characterizing the typical phenomena of being ill from a phenomenological, behavioral, and biological point of view, I reach the conclusion that ill can be distinguished from healthy by means of a conjunctive cluster of three factors, i.e. suffering, dysfunction, and abnormality.

In consequence, illness is considered a conceptualization, a theory about being ill, the purpose of which is to understand what is happening to someone who is ill. This conceptualization in medical science leads to a pattern of assumed links between etiology, pathogenesis, appearance, progress, end state, and therapy. In different diseases this pattern is more or less completely present.

The position that disease is a concept is supported by the fact that, also inside medicine, different concepts of disease exist. These concepts influence the way being ill is viewed. In the nineteenth and twentieth centuries there was a strong tendency to emphasize the factual, and in particular physicochemical aspects of illness, culminating in the biomedical disease concept. However, when the ill person's point of view is taken, suffering and the negative value judgment in respect of being ill are found to be lacking in this biomedical disease concept. For inclusion of these aspects of being ill in the conceptualization the holistic or biopsychosocial disease concept is preferable.

Further examination of the significance of a physicochemical disorder to the pattern of disease reveals three limitations when this classifying criterion is used. The disorder must be demonstrable, relevant in respect of the phenomena of illness, and have the nature of a process. These limitations render the physicochemical disorder as a classifying criterion unsuitable and lead to classification in three groups: the group of "real" diseases (demonstrated and relevant physicochemical disorder), the group of "probable" diseases (physicochemical disorder not yet demonstrated, but the expectation is that it will be found), and the group of "probably not" diseases (physicochemical disorder not demonstrated, and not expected to be found). At the same time it became apparent that even when a physicochemical disorder is an objectively demonstrable fact, the word "disorder" and similar terms imply a negative value judgment. Thus the main advantage of the biomedical disease concept – that it is value-free – is lost.

The disease status of many psychiatric disorders is doubtful in a biomedical disease concept. This raises the question whether the conditions and processes in which physicochemical disorders were expected to be found, but which to date proved not demonstrable, must be regarded as not diseases, or whether a change in the definition of disease is necessary. Disease is not only an ontological concept. It is also a value concept. The latter is expressed all the more clearly in the absence of a demonstrated physicochemical disorder. A consequence of the fact that illness is a concept is that this dilemma cannot be solved by research but only by making a choice.

Next some problems which arise when psychiatric disorders are conceptualized as illnesses were discussed. Examples are the normative element implied by many psychiatric symptoms and syndromes; the imprecise lines between normality and illness; the definition of normality; the need to maintain supplemental considerations such as motivation, the meaning of symbols, the purpose of complaints and phenomena; and the influence which the examiner and his examination may exert on the examined psychiatric disorder. Although these problems occur (much) less in respect of physical illnesses, they nevertheless occur.

Closer examination of the connection between psychiatric disorders and physicochemical aberrations renders first of all the difficulty of determining the significance of physicochemical aberrations. Next, assuming that behavior and experience do not take place in a neurophysiological and neurochemical vacuum, it should in principle be possible to identify the corresponding neurophysical and neurochemical processes. Were that realized, then certain behaviors would be describable as linked to certain processes in the brain. When such a behavior is

labeled abnormal, a cluster of abnormal behavior plus the corresponding neurophysiological changes is formed. This cluster complies with the criteria of the biomedical disease concept, without changing the category of the behavior, and without disqualifying sociopsychological theories. In other words, the significance of behavior remains the same whether or not the corresponding neurophysiological process is known. In a biomedical sense, however, the behavior would change categories, namely, it would be considered a disease.

The conclusion drawn is that the biomedical disease concept no longer suffices as a general medical paradigm, that illness as a value-judgment cannot be further eliminated without greatly damaging the patient and medicine, and that there is an immense need for an all-encompassing concept of disease which accommodates both the value aspects and the existential aspects of being ill and illness. The holistic, and even more, the biopsychosocial disease concepts satisfy this need.

...3. Biomedical or Biopsychosocial? Implications of Conceptualization

....3.1 The Biomedical Disease Concept and the Dualistic Concept of Man

The biomedical disease concept presupposes a dualistic concept of man. Dualism here divides a human being into two compartments which are viewed and described separately. Therefore this concept condemns us to recognizing the compartmentalized, dualistic concept of man, and will continue to do so. My point is not to discredit knowledge gained about the body and mind as separate compartments. Scientific reductions are useful, necessary, and often even desirable. In medicine the search for the existence of organic aberrations is quite important. The practitioners of different branches of medicine whose job it is to determine the existence of these aberrations benefit from the biomedical concept as a reductionist concept. This could be called a sub-concept: *one* of various, alternative sub-concepts possible inside an all-encompassing concept. This is acceptable as long as the reduction is abandoned where and when it is no longer relevant or when the aberrations found in the sub-concept no longer adequately and satisfactorily explain a person's being ill. When the biomedical disease concept is not used as a reductionist sub-concept but as a definition of disease this definition will constantly compel us to view man as consisting of two separate, co-existing compartments.

The distinction of ill-healthy precedes the distinction of mind-body (see 2.3). The latter can serve only as a temporary reduction. It is useful in limiting the area of examination and in directing the examination. When the reduction is not canceled but used as a basis for defining disease, then an apparently objective basis for the definition is gained, but the realization is lost that man consists of solely his body only in death. In an effort to achieve objectivity the baby is thrown out with the bath water. Disease disappears from the picture. Lost is man as a biopsychosocial entity, as an entity which can be structured, but in which there is no longer a point to the structuring if it goes beyond the distinction of different levels of organization and integration.

The biopsychosocial disease concept restores the ill person to his existential unity. This advantage is gained at the price of objectivity in the physical scientific sense of the word. Fabrega describes the wondering attitude of the Ladinos in Mexico, who themselves have an integrative view of being ill and illness, towards official medicine and its biomedical disease concept. This difference in views is the source of estrangement, broken contacts, and dissatisfaction with the official medical services.[282] It seems to me that much of the criticism of established medicine in our own society is rooted in this same dissatisfaction. The ill person is not a duality, and clashes with a medicine that tries to turn him into one.

....3.2. The Unfalsifiable Thesis of Organogenesis

The biomedical disease concept causes a dilemma regarding illness-like conditions for which no physical aberrations can be found. The root of the dilemma is that it is in practice very difficult, and theoretically even impossible, to prove the absence of any bodily aberration. This has very important consequences which occur in particular in psychiatry. Anyone who wishes to can insist that "schizophrenia" is basically a brain disease for which the nature of the organic disorder has not yet been definitely demonstrated, and that all psychoses are organic disorders as will become apparent at some future time. As the absence of physical aberrations is in principle not provable, a core theoretical and scientific stalemate is reached in which each is free to believe in either the biological cause or psychogenesis and/or sociogenesis, as well as a combination of these two, or yet a different cause.

There is only one way out of this predicament, namely, by demonstrating a physical aberration. The organogenicists are in the comfortable, though nonetheless in the scientifically not unequivocally enviable circumstance, that there is always a chance that they will be proved right, and no chance that they will be proved wrong. Research into possible organic aberrations in schizophrenia has been extraordinarily expansive and expensive. The argument that it turned up no convincing evidence and that a different kind of research would probably turn up more relevant information[283] contradicts the established order and is therefore powerless. We have long been caught in the trap into which the biomedical disease concept has lured us.

As disease is the object of medicine, and so that with which physicians (should) concern themselves, proof that certain complaints or symptoms indeed are caused by bodily aberrations attains strong, but overrated, appreciation in the biomedical disease concept. Whoever "discovers" a new disease or can demonstrate a new organic aberration is admitted to medicine's Hall of Fame.[284] Whoever can demonstrate the biomedical cause of schizophrenia makes his mark as a *real* doctor. That is why the search for, and as long as next to nothing has been found, the claim for an organic cause of schizophrenia has status from a medical perspective. If what Szasz posits is true, namely that psychiatry and psychoanalysis "…have acquired their social power and prestige largely through a deceptive association with the principles and practice of medicine" (*Ideology and Insanity*, pp 166-67) then this would be a strong motivation for physicians

and psychiatrists to continue looking for organic causes of schizophrenia into the distant future.

Finally, the definition of disease as an organic aberration poses a problem for psychiatrists who feel that they are physicians: at some time the presumed organic aberrations will have to be proved in order to justify the status of psychiatry as a branch of medicine, and the status of the psychiatric patient as a real patient. So researchers are unduly motivated to find an organic aberration in schizophrenia rather than a different kind of cause which falls outside of the scope of the biomedical disease concept. Szasz was right in emphasizing this dilemma which may be why criticism of his work is often so acrimonious.

The insolubility of the dilemma can also be clarified as follows. The difference in the physical sciences and humanities, as Szasz experiences and describes them, renders both realms in which the mind and body of man are studied separate fields. As these two groups of sciences employ different languages their pronouncements are presumed irreconcilable. On that ground Szasz defends his biomedical disease concept. At the same time this means that no matter how convincing the theories on psychogenesis and sociogenesis of certain psychiatric disorders, these theories can never be valid as a counter-argument to those who view disease as necessarily linked to organic aberration. The physician who embraces this disease concept can do nothing but continue following the same track without ever finding what he is looking for. Sociopsychological theories are left behind because they no longer have anything to do with illness and being ill.

This serious situation has the character of a dilemma, a dilemma which can only be solved when one is prepared to revise the definition of disease which led to it.

....3.3. The Problem of Validation

A physician investigating a patient's complaint will try to form an image of the problem by conversing with him. This is the anamnesis. Next he forms a hypothesis, the possible diagnosis. After that he will attempt to verify or rule out his hypothesis by further examination. This process of verifying or ruling out a diagnosis is called validation. The word validation will be used here in this meaning. In addition, the concepts of reliability and predictive validity will be used, as does Kendell, as statistical-scientific concepts.[285] The reliability with which for example a certain diagnosis can be determined is the measure in which one can be sure that that diagnosis is indeed correct. Predictive validity is the measure in which the determination of the diagnosis allows prediction of future events such as for instance the determination of a prognosis and how it may be influenced by treatment. Predictive validity is crucial in diagnostics. Its accuracy depends on the reliability of the diagnosis. So high reliability of the diagnosis is a necessary condition for a good predictive validity. But predictive validity is not determined by the diagnosis alone, so in itself not a sufficient condition for it.

One of Szasz's arguments in support of his view that mental illness does not exist is the problem of validation. When a physician suspects an organic aberration he has all sorts of physicochemical methods at his disposal by which

to demonstrate this aberration objectively. In contrast, the psychiatrist has only his subjective judgment to pose along with or opposite the patient's. No objective criterion for proof is possible. When the psychiatrist's and the patient's opinions differ, the psychiatrist's is decisive, not because he is right – that cannot be proved – but because power is on his side. So here there is no scientific examination of the nature of things, but a – moral – confirmation of power of the one over the other, which has no relation to disease, according to Szasz.

In order to judge the value of this argument it is necessary to examine it more closely and compare the validation process in somatic medicine and psychiatry. One immediately noticeable difference is that physicochemical methods of validation are not applicable when, as in the majority of psychiatric disorders, no organic aberrations are known. Advocates of a materialistic biomedical disease concept who value only physicochemical findings are justified in positing that validation regarding most psychiatric disorders is not possible. However, those who do not maintain such an absolute contrast between physical scientific insight on the one hand and every other insight on the other can ask how validation in psychiatry works, and compare this with validation in somatic medicine.

Below I will first examine the process of validation in somatic medicine more closely. Afterwards I will do the same for psychiatry. Finally I will compare the two.

3.3.1. Validation in Somatic Medicine

Let us choose as our point of departure someone who, for instance, complains of headaches to his family doctor. The number of physical aberrations that can be "responsible" for this complaint is huge. The physician will try to orient himself, apply a simple diagnoses, and attempt to influence the complaint with simple treatment. He will almost never consider validating an extremely rare disease of which headache is a symptom, for instance echinococcosis of the central nervous system, during the patient's first visit. That would require a thorough, deep, expensive and not risk-free examination. He will consider looking for and validating rare disorders only when multiple attempts to find simple explanations have failed. He must constantly contemplate which diagnosis is relevant to the complaint. When during an influenza epidemic someone displays the symptoms of influenza, the physician as a rule will assume that this patient also has influenza. Judgment is based on the assessment of different likelihoods. Conversation with the patient is of utmost importance because based on it the doctor can decide whether further validation is necessary. Are the complaints typical of something specific or vague? Do they seem relatively mild or do they indicate something serious?

Even when the physician conducts a number of examinations which he uses to validate his hypothesis about the patient's complaints, even when he remains on the side of caution by performing or ordering more examinations than he considers strictly necessary (most physicians would rather examine too much than miss a diagnosis) he will only very rarely wish or be able to do all of the examinations possible regarding a certain complaint. If he tried that the

examinations would soon be worse than the affliction. In addition to the risks and complications of the diagnostic measures themselves, the patient would be led to believe that there is really something seriously wrong with him, and perhaps become fixated on his complaints. In addition, it would make health care exorbitantly expensive. This means that the physician is constantly in a process of assessment. How far must he go in examining the complaint? Which risks must he rule out? Which risks can he take?[286]

If he decides to continuing examining by physicochemical means in order to confirm his suspicions or rule out risks, such means can provide him with either correct or incorrect information. All possible forms of examination render a certain percentage of correct results and a certain percentage of false positives and false negatives. The percentage is different for every method of examination. Besides, the normal values of for instance many laboratory findings range broadly, and clear lines between normal and abnormal can seldom be drawn. Also, in any examination, mistakes can be made. Further, it is inherent to every physicochemical examination that the results must be interpreted. This can be extraordinarily difficult and require a high degree of training and acuity, for instance interpreting x-rays and EEGs, and thus be a source of inaccuracy, error, and misunderstanding.

Cochrane et al reported that experienced radiologists, when evaluating a series of photos of the thorax, overlooked 30% of the aberrations shown by the photos, while observing aberrations in 2% of the photos that had none.[287] Davies presented 100 ECGs to nine experienced physicians and one less experienced physician for assessment. There was unanimity on 30% of the ECGs, some difference of opinion on 50%, and gravely differing opinions on 20%.[288] Several weeks later, all the physicians assessed one in eight ECGs differently than they had done the first time. The experienced evaluators succeeded much better than the inexperienced evaluator. Garland lists a large number of examinations, including the following: some laboratory examinations revealed serious errors in 10% to 28% of the results. Erythrocyte counts varied by 16% to 28%.[289] He recommends having x-ray photographs assessed either by two experts or by the same one at two different occasions.

So for a somewhat reliable assessment it is necessary to conduct a large number of examinations, preferably at different times. When a large number of factors deviate in the same direction a certain aberration, or diagnosis, becomes more likely. The more finely the criteria for a certain diagnosis are defined, the less often that diagnosis will occur. Engle et al. state, “Thus, inherent in every diagnosis is a factor of uncertainty, greater in some and less in others. The uncertainties are partially related to our imperfections of knowledge concerning health and disease with all of their manifestations, and also to the most useful way of thinking about classifying and naming them.”[290] A diagnosis is an evaluation of probability. The probability is sometimes high, sometimes lower, and rarely approaches 100%. “Demonstrating” the accuracy of a diagnosis, delivering the “proof” that a certain disorder exists, is in fact: making assumable that the disorder is likely.[291]

From the above we can infer that the used methods are of a physicochemical nature, yet the assessment of the result of such examination must be done by human perception, not only in the sense of taking readings from

instruments, but also in interpreting quite complicated patterns. This means that the objectivity of these methods is limited by the possibilities and boundaries of human perception.

Only a physicochemical disorder of the body can be demonstrated, and validated, by a physicochemical method. The patient's complaint, for instance, his subjective experience of pain, can strictly speaking not be validated this way, nor can the diagnosis.[292]

Whether such physicochemical examination is the most effective and least harmful way of validating is not so easy to determine. Reiser posits that the value ascribed to clinical dialogue in the nineteenth and twentieth centuries fluctuated a great deal. Today, impersonal, "objective" methods are valued most. He explains this as partly due to the fact that research as to the value of anamneses has lagged behind research as to the value of "objective" examination methods, and that also during training the anamnesis is neglected.[293] Engel agrees.[294]

Feinstein states the same regarding clinical observance: there is a classification of diseases and physical aberrations but not of clinical pictures. The preoccupation with "objective" findings led to the dehumanization of medicine which in turn led to "bad therapy and bad science." He advocates a renewed interest in clinical symptoms and clinical phenomena "to restore the patient, rather than the disease, to his proper place as the center of the universe of clinical science."[295]

So it turns out that a value judgment is partly the basis of the preference for "objective" validation. The idea that physicochemical results provide better information than careful anamneses and careful clinical examination is a premise that is probably derived from this value judgment. It is tempting to relate this premise to the biomedical concept of disease. When the existence of disease is believed to be linked to the presence of physicochemical aberrations, finding such aberrations is of utmost importance.

Finally we come to the postmortem examination by autopsy. This examination provides general information about organic aberrations that are found after death. It is thus a test of diagnoses made during life. Steffelaar found that in a series of 163 postmortem examinations 69 cases (42%) had unexpected aberrations. In 40 cases (24.5%) either the main diagnosis was wrong or an unexpected complication which contributed to the death was found. He found that 25% of malignant tumors were not diagnosed during life. This margin of error was found in a modern hospital which had access to all the usual validation methods.[296] Prutting mentions more of such research in the United States and France, with similar results.[297] So too does Sanders.[298]

3.3.2. Validation in Psychiatry

In psychiatry the situation is different, at least in those cases that no validation by physicochemical means is possible. There are several possibilities for confirming a hypothesis about the diagnosis: expansion of the anamnesis, heteroanamnesis, conversation with the patient and those who are close to him together, and psychological testing. In addition, much research has been done as to the reliability of the diagnosis by comparing diagnoses made by different psychiatrists

regarding the same patient ("observer agreement"), by comparing the frequency of certain diagnoses in comparable patient populations ("frequency agreement"), and by comparing diagnoses in the same patient at different times ("consistency").[299] It was found that factors such as whether or not symptoms and diagnoses were precisely defined, the psychiatrists' school of theory, and the setting in which the examination transpired, were very important, alongside other variables. Kendell mentions research by Beck in 1962 regarding an out-patient population in which four psychiatrists reached "observer agreement" in 54% of the specific diagnoses, and 82% when the alternative diagnoses were included.[300] Kreitman et al found "observer agreement" of 63% in similar research.[301] Improvement in the results can be expected when examination instruments are utilized such as questionnaires for patients to complete themselves, questionnaires for the examiner to complete, behavioral scales, and structured interviews.[302] Improvement can also be expected from better classification systems: the DSM-III seems to offer such. It is not my intention to elaborate on the efforts to increase the reliability of psychiatric diagnoses.

When reading these research reports the impression constantly made is that it is more difficult to "extract" as it were, psychiatric disorders from a person, than is the case in physical illness. After all, determining a diagnosis is an effort to abstractly separate the person and his disease. In psychiatry, who someone is – or was, before his illness – constantly influences the phenomena of being ill. A psychiatric disorder is something one "has" and at the same time something one "does."[303] Furthermore, in my opinion the influence that the diagnosis itself can have on the diagnosed person and his environment, which in turn influences the predictive value, should also be constantly considered.

Assessment of reliability and predictive validity in psychiatry can be summarized as follows. Rooymans researched the literature as part of his dissertation about judgment and prejudice in psychiatric diagnoses. He mentions an "observer agreement" percentage which at the level of the main categories is usually between 60 and 70%, and at the level of specific diagnoses between 40 and 55%. The highest percentages are to be found in the main category of the organic disorders, the lowest in the category of neuroses. His conclusion is that the reliability of diagnoses is usually disappointingly low and that also the predictive validity is low.[304] Kendell concludes regarding research on reliability done since 1950 that "reliability is often very low, and generally lower for neuroses and personality disorders than for psychoses and organic states."[305] Furthermore Kendell states that there is a certain predictive validity but that it is smaller than in most other branches of medicine.[306]

Bakker's dissertation can provide us with an example of research on the value of psychiatrists' prognostic assessment. He requested the treatment teams of clinically treated patients who were about to be released to predict a number of matters regarding the first half year after release. Among the matters to be predicted were general conditions, progress, rehospitalization, suicide, and employment. These predictions were compared to the actual situations. A value of 0.12 to 0.27 was found for the ordinary kappa*, meaning that these predictions

* This is a statistical measure in which, in addition to the observed correspondence, the coincidental correspondence is also figured, as well

scarcely materialized, if at all. Although Bakker admonishes us to not generalize the results of his research too much, he did reasonably demonstrate that psychiatrists' prognostic judgment based on their findings is far from dependable. Excessively optimistic predictions were made in particular when the patient was young, when his condition at the time of release was reasonable or good, and when the physician-patient relationship was judged to be "usual" or "better than usual." Excessively pessimistic predictions were made in particular when the patient was 45 years or older, if he was not recovered at the time of release, and when the physician-patient relationship was judged to be "less well than usual." In addition, it was shown that there was more pessimism than optimism.[307]

In summary, there is little to applaud in psychiatry regarding reliability, predictive validity of diagnoses, and the making of prognoses. It should not be overlooked that this problem is significant in psychiatry only since the sixties of the twentieth century. Since then there have been concerted efforts to improve classification, to design evaluation instruments, and to achieve operational, well explainable concept definitions.[308] There can be no other conclusion than that the reliability and predictive validity of psychiatric diagnoses are meager. On the other hand it has become clear that psychiatric validation is possible to a certain extent, and that the results are better than random. This means that psychiatric diagnoses are not, as Szasz asserts, purely subjective and random, but that they rise above that to a certain degree.

3.3.3. A Comparison of Validation in Somatic Medicine and in Psychiatry

There are at least three important differences between the validation methods in somatic medicine and psychiatry:

- In somatic medicine validation is done by physicochemical means. So validation takes place at a different system level and utilizes a different language than that in which the problem is posed. In psychiatry both the posing of the problem and the attempt to verify the hypothesis about it are in terms of behavior and experience, so not different in quality from each other.
- In somatic medicine validation is very carefully and routinely done in research and daily practice. Due to its importance and predictive validity, its valuable role has become essential in the diagnostic process. In psychiatry, in contrast, the above mentioned methods are used mostly for research. In daily practice they are scarcely used although there is a clearly increasing tendency to apply more of such aids in practice. This nonetheless means that until now in daily practice psychiatric diagnoses consist almost entirely of anamneses and psychiatric evaluations, in some cases supplemented by physical exams and the collection of information about the patients' important relations.
- The number and nature of the methods of validation in somatic medicine are large and varied. There are usually multiple possibilities for further examination and verification of the hypothesis. Reliability can be increased by repeating examinations or involving multiple examiners. In comparison, both the number

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as the nature of and relationship between the variables. The value is set between 1 = perfect correspondence and 0 = no correspondence. – J.P.

and nature of instruments of examination available in psychiatry are quite limited.
– Knowledge of the context in which examinations transpire is much more significant in psychiatry than in somatic medicine. I wish to elaborate on this extraordinarily important point.

Physicochemical validation methods reflect processes and events in the body as a physicochemical machine. In these methods, the same values count as "normal" for everybody, independent of the social or cultural context in which the person lives. Therefore this validation is much more "objective" and less personal than is possible in psychiatry. People in different cultures and different social circumstances differ from each other much more than their bodies. It is for instance possible to interpret the results of biochemical examinations of body fluids in the same way around the world regardless of racial differences and other variations.

However some limitations must be taken into account. Firstly, the objective laboratory values can have different meanings in different cultural contexts. Fabrega pointed out that all sorts of physical diseases are considered as such in some cultures and not in others.[309] Such "cultural masking" occurs regarding certain avitaminoses, chronic bronchitis, light to medium anemia, trichuriasis, and other diseases. Even when the same validation methods are used, the line between health and disease, and with that the meaning of the objective values found, differ across cultures.[310] A second significant factor is that knowledge of certain contextual facts is decisive in the assessment of certain validation results. For instance, the presence of acetone in urine can mean that someone has diabetes, or, in the absence of an adequate amount of carbohydrates, that he is starving and therefore his body fat is disintegrating. Whether or not this has pathological significance will have to be derived from the context. The same problem occurs with people who have Munchausen syndrome.[311] These are people who, feigning a serious physical disease, have themselves hospitalized and sometimes even manage to undergo operations or other invasive treatments. Apparently the context of this type of simulation is so extraordinary that the usual validation methods are inadequate for detecting it. Consider also Kety's example, quoted by Spitzer, "If I were to drink a quart of blood and, concealing what I had done, come to the emergency room of any hospital vomiting blood, the behavior of the staff would be quite predictable…"[312] Finally, there is a classic report by Bakwin about research at the American Child Health Association.[313] 610 of 1000 schoolchildren had undergone tonsillectomy. Physicians who examined the others recommended tonsillectomies in 45% of the children. The remainder were examined by different physicians, who recommended tonsillectomy in 46%. This last group was again examined by other physicians, who recommended tonsillectomies. At the end there remained 65 children who were not further examined because no more physicians were available. There did not seem to be any correlation between the different physicians' conclusions. It seems to me that in this research, the context had an important role. If the physicians had known that the children had been selected in advance their own selections would have been different.

The objection that validation methods are adversely affected when the context in which the examination took place is manipulated, or when

circumstances are artificial, for instance for the sake of research, is even more valid in psychiatry than in somatic medicine, although the phenomena are in principle comparable. Best known in this respect is research by Rosenhan which revealed that healthy people who applied for hospitalization claiming to suffer from hallucinations were unfailingly diagnosed as mentally ill and admitted.[314] Temerlin describes an experiment in which 25 psychiatrists, 25 psychologists, and 45 psychology students were played an audio tape of a psychiatric anamnesis. The interviewee on the tape was in reality an actor who had been instructed by the researchers to impersonate a “normal person.” Before the tape was played the test professionals and students were told by an eminent colleague that the interesting thing about this interviewee was that he “seemed neurotic, but was in fact totally psychotic.” Although the task was to make a diagnosis on the basis of phenomena that were heard or reported, 15 psychiatrists judged the interviewee to be psychotic, 10 thought he was neurotic, and nobody thought he was healthy. The psychologists were in the middle: 7 thought him psychotic, 15 neurotic, and 3 healthy. Among the students, 5 judged him psychotic, 35 neurotic, and 5 healthy. A different group was told beforehand that the person was healthy. They unanimously judged the interviewee healthy. Out of a group of 21 test persons who were told nothing in advance about the interviewee, 9 judged him neurotic, and 12 healthy.[315]

In such situations the paucity of possibilities for validation in psychiatry and lesser objectivity compared to physicochemical methods strikes home. When the circumstances in which the psychiatrist meets his patients are manipulated, the vulnerability and imperfection of the usual assessment methods in psychiatry are exposed.

The most important implication of the fact that the reliability of psychiatric diagnoses is considerably contingent on the context, is that the context in which the examination has taken place and what may be the influence thereof on the diagnostic evaluation must be constantly queried. The majority of diagnostic experiences involves the situation in which the purpose of the diagnose is to determine a treatment, so a situation in which the assessment is in the interest of the patient, who will cooperate. If even in this situation reliability is low, how will it be in a situation where it is in the patient’s interest to present a certain image of himself, or if the patient resists assessment? In such circumstances, research on reliability can be expected to yield differening results. It seems fair to hypothesize that reliability diminishes along with the patient’s willingness to cooperate. Whether the reliability of diagnostic assessment under such circumstances is sufficient to warrant basing decisions on it that may deeply affect the person’s life – which in practice happens regularly – seems dubious to me. I will return to this problem more than once below.

This vulnerability of psychiatric evaluation methods is augmented by the fact that in psychiatry there are many different, in part mutually exclusive frames of reference. The way patients are approached and the way examination results are interpreted differ in respect to the different frames of reference.

Kendell tried to explain the proliferation of the diagnosis schizophrenia in the United States compared to England through the different historical development of psychiatry in these two countries. In the United States psychiatrists attempted to constantly expand the concept of schizophrenia while in England they

attempted to circumscribe and define it as narrowly as possible. The period of reduced scientific communication before and during World War II was sufficient to cause the conceptualization to grow apart, according to Kendell. He opines that for the two conceptualizations to grow back towards each other either new treatment possibilities or the finding of physicochemical validation methods will be necessary.[316] In 1982 Spitzer conducted a workshop about the DSM-III in which he related his opinion that the large differences in frequency of the schizophrenia diagnosis have since disappeared. He ascribed the disappearance to the impression which the many publications about this difference made on American psychiatrists and to criticism of the significance of Schneider's so-called first-rank symptoms, which had been justified by research.[317] Kendell's prediction was thus discredited…

In summary: Validation is possible to a certain extent in psychiatry, but the possibilities are limited. In principle the methods of validation resemble anamnesis and psychiatric examination. In addition, validation methods are scarcely used in daily practice. The reliability of diagnostic assessment in psychiatry is extraordinarily susceptible to influence by the context.

The conclusion is that reliability and thus also predictive value in psychiatry are meager. At the same time it is shown that validation in psychiatry is not only possible, but too good to conclude that it is purely subjective, as does Szasz. On the other hand validation in psychiatry is too insecure to be considered satisfactory from a scientific viewpoint, and as a rule supplies too little ground for having invasive measures or treatments based on it.

The statement that psychiatric symptoms and disorders can be validated does not imply a statement about the way these phenomena should be understood and interpreted, nor about the significance which should be ascribed to them. These matters will be discussed next.

....3.4. The Meaning of Psychiatric Disorders

Mental illness, according to Szasz, does not exist. Of course the experiences and behaviors that are labeled mental illness do exist. Their conceptualization as mental illness, however, is misleading and conceals the real issues. If that is so, how must these experiences and behaviors be understood?

According to Szasz they are problems in living and interpersonal conflict which are inherent to human life. Psychiatry strips these problems of their essentially moral and political character. Psychiatrists absolve people of responsibility for these problems. As responsibility can be a difficult and heavy burden, psychiatrists and patients serve each others' interests by creating this mystification, at least in this respect. This way Szasz explains the upsurge in behaviors that are called psychiatric. More and more people are being absolved of their responsibilities. The sacrifice that patients must make for this is losing their autonomy and being turned into unassertive children who are not responsible for their own behavior.

This reasoning rests on three premises which I will regard more closely below:

a) Experiences and behaviors that are labeled mental illness are nothing other than problems in living and conflicts.
b) There is an essential difference between bodily illnesses and psychiatric disorders. “Physical illness is usually something that happens to us, whereas mental illness is something we do (or feel or think).” (*Law, Liberty, and Psychiatry*, p. 17)
c) As illness is something for which a person cannot be held responsible, the essential, implicated manipulation of the conceptualization of these problems and conflicts as “mental illness” is to absolve people of responsibility for behavior for which they are in fact responsible.

Below I will first discuss the connection between problems in living and psychiatric disorders (3.4.1). Next the problem of causality versus responsibility will be discussed, first regarding physical disease (3.4.2) and then regarding psychiatric disorders (3.4.3).

3.4.1. The Connection Between Problems in Living and Psychiatric Disorders

It is obvious that psychiatric disorders and problems in living are somehow related. The connection between the two can be approached from both sides. From the side of problems in living can something be said about these problems which is psychiatrically relevant? From the side of psychiatric disorders what role do problems in living play in psychiatric disorders? After attempting to answer these questions a third question will be considered. How does Szasz defend his statement that psychiatric disorders are problems in living?

So first of all, is there something we can say about problems in living that is relevant to psychiatric disorders? In general what can be said about problems in living is that they can be soluble or insoluble. In the latter case the insolubility can have originated due to changes in the environment. For instance, the fulfillment of the wish to return to one’s birthplace may prove impossible because a highway has been built there. The longing to return to life the way it was before the death of a spouse is equally unrealizable. The insolubility may also be caused by the fact that, although in principle a solution would be possible, that solution would pose demands that for example exceed one’s inventiveness or creativity. Thus this is an interim situation between solubility and insolubility, namely, the problem is in principle soluble, but in practice the person is unable to solve it. Below these will be called relatively insoluble problems. On the side, note that the word problem here also means constellations of problems which can be highly complicated and interlocked.

Two other interrelated aspects of problems in living are significant here: the content of the problem and the way it manifests itself in a particular individual, i.e. the form of expression. The content can regard all sorts of areas in life: contacts, employment, leisure, housing, etc. Sometimes the content of problems is very important, sometimes less. In accordance a person will dedicate from relatively little, through sometimes fairly much, to just about all of his available time to the problem. A problem is always a difficulty, a burden. Serious problems influence the way in which a person behaves. The person may be preoccupied with the

problem. His mood may become sullen. He may be stressed, partially withdraw from his contacts, or ask attention from others for his problem. It can grow worse. The person may become depressed. He may despair. The continuity of his life may be temporarily or permanently broken by the problem. In this last case, we can speak of a person who is "broken" by life.

In general it can be posited that the problems that are relevant to psychiatric disorders are characterized by 1. the difficulty identifying them; 2. the difficulty solving them; 3. the way they are expressed.

1. The problem involved in a psychiatric disorder is not completely or completely not clear to the person who has the problem. It may be, for instance, that a person is painfully aware of feeling unfree and inhibited in his contacts with other people without understanding why. It can also be that the original problem has become unrecognizable to the person. This can be taken a step further, positing that the functional significance of a symptom or syndrome is precisely that it causes the problem to become unrecognizable. Psychiatric phenomena cause "interference" which renders the problem incapable of being understood. The reason for this lack of clarity seems in particular to lie in the unbearableness of it for the person who has it. These insights, which were developed by Freud and many others in the framework of psychoanalytic theory, are well-known, and need no further explanation.

One can conceivably wonder whether serious and complicated problems in living do not always harbor unrecognized, unclear components. Freud said that in everybody problems are concealed to a certain degree. This consideration, however, does not diminish the significance of this criterion for problems that involve psychiatric disorders. It can be posited that here again it is a matter of *Schwerpunktsbegriff*. Although the line between problems of which the structure is totally clear to the person who has the problem and problems for which that is not (totally) the case can be drawn only arbitrarily, there is a clear difference between clear and unclear content or structure of problems.

2. A second hallmark of problems relevant to psychiatric disorders is that the person himself cannot solve it. This precisely becomes apparent by the appearance of symptoms. The psychiatric disorder can be described as a compromise which expresses on the one hand the insolubility of the problem, and on the other, the relative impossibility of living with the problem. This criterion is not completely independent from the first because the insolubility nearly consistently originates in part due to lack of recognition of the problem. Psychotherapy is an attempt to identify the problem. By doing so it can often be solved. But even when the problem is not soluble and part of the tragedy in life, its character changes when it comes into focus. Problems in living which are recognized and experienced as such and are insoluble due to originating from circumstances over which the person has no control, no matter how oppressive and tragic they may be, do not belong to psychiatry, unless the way they are expressed constitutes secondary problems relevant to psychiatry.

In other words, the psychiatric syndrome is the best possible solution to the problem which due to its unbearableness is recognized only partially, while the incomplete recognition contributes to the insolubility. So the psychiatric disorder

is the result of both the problem and the person's response to the problem. An obvious analogy would be a physical illness consisting of both a process which is disrupting homeostasis and the body's response to that.

3. In the third place, problems relevant to psychiatry are distinguished from other problems in living by their expression. By definition, psychiatric disorders are expressed through experiences and behaviors which satisfy the criteria formulated in 2.1, namely suffering, dysfunction, and abnormality. It is this form in which the problem appears that is typical of psychiatric disorders. Rümke emphasized this aspect of the form of psychiatric disorders.[318] As with bodily disease, the manifestation of the illness in the form of the syndrome significantly determines the disease concept.

When the role of problems in living is viewed from the perspective of the psychiatric disorder it is immediately obvious that the concept of psychiatric disorder is more complicated than the above description of the connections between problems and the expression thereof implies. As yet no or only partial explanations have been provided as to why a certain problem is so unclear to the person who has it, why it is so insoluble, and why it becomes a symptom or syndrome.

In psychiatry a symptom or syndrome is determined by multiple conditions. That means that not *one* cause (for instance, the problem) is considered to adequately explain it but that such explanation is sought in a network of causes and conditions that are related to heredity, the body, the circumstances in which the person grew up, the way in which he experiences and conducts himself, his network of [social] relationships, the way in which he communicates, other social factors, and finally, cultural factors. In this network of conditions problems in living can significantly contribute to the origin of a syndrome in different ways: as the most important condition or as an auxiliary condition.

In other words, certain problems in living in certain situations within a certain constellation of circumstances requiring further description can cause or have a relevant connection to psychiatric syndromes. Two comments must be made. The first is that the image projected here is too static. It insufficiently emphasizes that we are dealing with processes and not stationary facts. Szasz was right to point out the dangers of such in his introduction to *The Myth of Mental Illness*. The second comment is that this way of describing other people's problems is too abstract to elucidate what is essential to them.

These comments are important because precisely in psychiatry there is a risk of considering certain experiences or behaviors phenomena of illness, calling them symptoms, and thereby robbing them of the sense that they may have for the person. The attempt to understand such sense is one of psychiatry's tasks. Certain phenomena can be both sensible and sick. In other words, a certain phenomenon which is interpreted as illness can at the same time be loaded with significance for the person.[319] The same holds true *mutatis mutandis* for physical symptoms. Leukocytosis can be considered a symptom of the existence of an infection, and at the same time it is the body's meaningful response to that infection.[320] "*Mutatis mutandis*" means here that there is an essential difference of

category between the meaning of "meaningful" regarding physical and regarding psychiatric disorders.

How, in view of the above, can Szasz conclude that that which is called mental illness is in reality only problems in living?

Above it was already noted that in psychoanalytic theory, both the unclarity as well as the related insolubility of problems are not directly viewed as part of the ill-healthy polarity. Such problems can be considered neurotic. They occur to a greater or lesser degree in everybody. Whether or not treatment is necessary depends more on the wishes and motivation of the person concerned than on whether there is illness. In this sense the line between healthy and ill is extremely blurry in psychoanalytic theory.[321] A neurotic problem can actually only be counted as belonging to illness when the concept of health is understood as: ideal (2.1). From that point of view it is understandable that Szasz, as a psychoanalyst, does not see a reason to distinguish between illness and health.

Let us look more closely at the experiences and behaviors which can be considered to constitute psychiatric symptoms. Szasz, notably, rarely mentions this formal aspect of psychiatric disorders.[322] Perhaps this is due to his psychoanalytical inclination. In psychoanalytic theory intrapsychic conflict is highlighted rather than its formal forms of expression as symptoms or syndromes. This does not seem to be the only factor. In his criticism of multinational, transcultural research performed by the WHO,[323] Szasz minimizes the significance of symptoms. Repeatedly he contends that so-called symptoms are in fact an interpretation by the person in power who utilizes this interpretation to justify his power over the powerless patient (*Schizophrenia*, from page 87). The point is that Szasz seems to be so certain that mental illness is but rhetoric intended to conceal conflicts, that considering symptomology would only interfere with his much more important purpose. That purpose is to show that mental illness is not an attribute that belongs to a person but an attribute that is imposed on him by his adversaries.

The third chapter of *Schizophrenia* is entitled: "Schizophrenia: Psychiatric Syndrome or Scientific Scandal?" Szasz kicks it off with a remark about the meaning of the word syndrome – just about the only one which I was able to find in Szasz's work – "…And what is a syndrome? According to Webster, it is 'a group of signs and symptoms that occur together and characterize a disease.' In short, it is yet another psychosemantic trick to affirm that a 'disease' without a demonstrable histopathological lesion or pathophysiological abnormality is nevertheless a disease." So it is from the vantage of the biomedical disease concept that he criticizes calling schizophrenia a disease. Szasz justifies the existence of symptoms and syndromes only when there is a proven physicochemical disorder which grants disease status to the entire pattern of problems.

My impression is that Szasz mentions the symptoms of mental illness more often in his earlier writings. Interestingly, in his article "The Myth of Mental Illness" he writes about the position that all psychiatric disorders originate from aberrations of the nervous system, "This position implies that people cannot have troubles – *expressed in what are now called "mental illnesses"* – because of differences in personal needs, opinions, social aspirations, values, and so on."[324]

In the republication of this article in *Ideology and Insanity*, the modifying phrase in the middle is omitted. Instead, the following sentence is added, "These difficulties – *which I think we may simply call problems in living* – are thus attributed to physicochemical processes…" (p. 13, my italics). The line of reasoning is entirely dependent on his premise, the biomedical disease concept.

Finally, it is likely that Szasz accords as little attention as possible to the signs and symptoms of psychiatric disorders because in his opinion such would deflect attention from what in his view is the main issue: the stigmatization and dehumanization of powerless people by psychiatrists who hold all the trump cards. This viewpoint of his is regrettable as precisely the abnormal experiences and behaviors that are interpreted as symptoms and syndromes form the strongest argument for speaking of illness to those who maintain a non-biomedical disease concept.

In conclusion, the position that all psychiatric disorders are only problems in living is an untenable simplification.

3.4.2. Causality and Responsibility Regarding Physical Illness

Before taking a closer look at causality and responsibility regarding physical illness, some comments about causality and responsibility are in order. Although causality is a controversial concept,[325] what I mean here is the relationship of cause-effect which in modern physics is often called statistical causality, a relationship which is not influenced by man. When the cause-effect relationship *can* be influenced by man then it is responsibility.[326] So causality and responsibility are mutually exclusive explanations for things that happen. They can also be complementary, namely when a certain event can be influenced to a certain extent by human actions or will.

In determining responsibility for human actions it is necessary to differentiate between the responsibility a person has for what he does or neglects to do and his responsibility for an effectively endless series of events which are secondary or an indirect effect of his (in)actions. For instance, by participating in traffic Jones takes a certain risk for which he is responsible (1). An accident occurs for which Jones is neither morally nor legally responsible. For example, a motorist runs into him from the rear while he is waiting for a red light (2). Is Jones responsible for the accident (2) due to the responsibility (1) which he accepted? On the one hand, no, as although the accident involved Jones, he could neither foresee nor forestall it. On the other hand, yes, because if Jones had not been there the accident would not have happened. Here is another example. Jones runs through a red light (1) and causes a collision (2). The motorist behind the other car cannot brake on time resulting in a chain collision (3). A passenger in one of the damaged cars is at risk of being fired from his job due to repeated tardiness. Due to the collision he will now again arrive late and thus be fired (4). This chain of events can be continued indefinitely. Each new link adds another element that was unknown and unforeseeable.

Obviously the word responsibility takes on a different meaning for each link. I show the difference using the terms direct responsibility (1), secondary, indirect responsibility (2), responsibility of the third order (3), etc.

In addition, when contemplating the concept of responsibility, distinctions must be made between being responsible, feeling responsible, and holding another person responsible.

After these introductory remarks we can say the following about causality and responsibility regarding physical illness. According to the biomedical disease concept illness is something that happens to a person. It is an event with natural causes of which he is a victim and for which he is not responsible. In other words, it is an event regarding which the concept of responsibility is irrelevant because it is not in the conceptual framework of this disease concept. Accordingly, Parsons describes not being held responsible for the illness as one of the elements of "the sick role."[327] Siegler et al describe this aspect as of utmost importance and unique to the medical model in psychiatry. All other explicatory models place responsibility as well as blame partly or wholly on the person who displays the experience and behavior being considered.[328] In order to examine this premise further some examples will be given.

Example 1. Jones is hospitalized with a broken leg after having been involved in a traffic accident. If we assume that he caused the accident, he would be directly responsible for it, and indirectly responsible for his broken leg. If we assume that the accident's cause cannot be clearly determined or someone else is to blame, then Jones is indirectly responsible for his broken leg all the same. Is the accident itself something that happened to Jones and for which he therefore cannot be responsible other than the general responsibility that each participant in traffic has? Research indicates that some people are often involved in accidents and many others seldom or never. "Accident proneness" seems to be related to personality factors such as depression, preoccupation, and feelings of inferiority.[329] Apparently accidents do not occur completely at random although it may be unclear in specific cases whether the person was aware of his "accident proneness."

Example 2: Jones is discovered to have been intoxicated. Again there seems to be indirect responsibility as he drank knowing that he would be driving. He was directly responsible for the drinking and indirectly responsible for the accident.

Example 3: A man becomes infected with venereal disease when visiting a prostitute. Here again there is indirect responsibility. He was responsible for his visit with the prostitute and knew that there is a certain risk in that, but he could not know that he would become infected with venereal disease. In Roman Catholicism it would indeed have been considered a punishment for sin.[330]

Example 4: A person is a heavy smoker for 30 years and develops lung carcinoma. Here again there is a certain indirect responsibility as he knew that smoking is hazardous to health. He is to be considered responsible for his smoking but only indirectly responsible for the fact that the risk he took led to this particular disease.

The number of examples could easily be expanded. One form or other of indirect responsibility is involved in a number of diseases, such as the so-called occupational diseases, diabetes mellitus in the obese, etc. De Jonghe calls these illnesses behavioral diseases.[331] In general it can be posited that when the cause of a certain illness is known and can be influenced this implies indirect

responsibility for contracting the illness. The heavy smoker from the fourth example would not have been indirectly responsible for his illness before the link between smoking and lung carcinoma was discovered.

What about feeling responsible for illness? Zola relates a small-scale research project involving subjects aged 17 and 18. They were asked how they would describe a five-year-old's most recent illness to him. All of the subjects employed moral terms. Illness and being ill were called bad; being healthy was called good. Zola concluded, "In short, despite hopes to the contrary, the rhetoric of illness by itself seems to provide no absolution from individual responsibility, accountability, and moral judgment."[332] The constant connection between sickness and sin in religion deserves mention here too. Trimbos stated, "Everything that is objectionable can be called sick."[333] That way sick becomes synonymous to sinister. Trimbos laments that this synonym is also often found in medical and psychiatric judgments.

In conclusion, a person is not held responsible for physical illness even though a usually indirect responsibility is often indicated. There are, however, indications that people tend to feel guilty, and thus responsible, for their being ill.

3.4.3. Causality and Responsibility Regarding Psychiatric Disorders

Szasz posits that in the absence of organic aberrations there is no objective ground for not holding people responsible for their actions. Below I will begin by discussing two ways of looking at psychiatric disorders, unreason (A) and unfreedom (B). After that I will illustrate, using some psychiatric disorders as examples how this way of looking at them seems to the psychiatrist and the patient (C). Next I will examine whether the criterion is reliable and valid by looking for signs that psychiatrists are prejudiced (D). Finally, I will examine in which situations it can be sensible to maintain the criterion (E).

A. *Psychiatric Disorders as Irrationality*

The former view that psychiatric disorders mean that the person so disposed is incapable of acting as a rational being has recently found an advocate, namely Moore.[334] As Moore's position contradicts Szasz's that hysterical patients are acting rationally and purposefully it is worthwhile to examine it more closely.

Moore defines the concept of rationality broadly.[335] He reasons as follows. For a certain behavior to be considered rational there must be a motive. Secondly there must be goal. Thirdly there must be a number of beliefs such as that a certain intervention in a certain situation will achieve the desired goal. Fourthly there must be a view and interpretation of the circumstances. Fifthly this chain must not be broken by other motives that might lead to different actions. Behavior is rational only when with all five of these components comply with the criterion of rationality. Edwards even distinguishes seven components. By that he poses such high requirements for the criterion of rationality that he is compelled to admit that most people are not very rational.[336] Moore's premise is that a person's rationality is a function of the rationality of his actions. The less rational the behavior the less rational is the person who displays it. When someone's capacity for rational behavior declines it means that that person himself is irrational, which is the same as saying that the person is psychiatrically disordered, and cannot be

considered responsible for his behavior. Moore concludes, “In this, the mentally ill join (to a decreasing degree) infants, wild beasts, plants, and stones,” which prompts Szasz to remark that Moore’s concept of mental illness is indeed dehumanizing (*Psychiatric Slavery*, p. 7).

It is worthwhile to follow Moore’s reasoning more closely, in particular the first four steps which he considers as leading to irrational behavior.

In the first place, there is the action’s *motive and the purpose related to it*. Moore posits that the conscious motive must be considered first. When that is not done the motive must be elicited from the action itself. It is all too easy, according to Moore, to find a motive for whatever behavior and assume that the consequences of that behavior are the goal. (See Chapter IV, 3.2.) That way every behavior can be considered rational but in a thoroughly speculative sense.

In my opinion Moore’s position implies that anything which is not directly comprehensible must be labeled unintelligible. Moore is actually saying that every dissociation from reality, every “Term II” according to Perelman (see Chapter IV, 3.2), is not only necessarily speculative but also should not change our views on the rationality of behavior. Moore’s requirement implies that only immediate reality may count as a basis for our assessment about others’ behavior. Highly speculative and unlikely theories explaining human behavior have been posited. This does not have to mean that every explanation is out of bounds. Speculations about “Term II” can after all not be verified as true or untrue, but they can be evaluated for their utility. Freud’s concept of the unconscious, for instance, as a “Term II” concept, has greatly expanded our insights into behaviors that are at first glance unintelligible. The motives and goals can thus be made understandable. This does not mean that they are also rational. It would be impossible to prove that all human motives are rational. Man is a rational being but he is much more than that. Many of his motives are not rational, although comprehensible, and as in the phenomenological approach, we can identify with them. Moore does not claim that man is a rational being, only that a person with a psychiatric disorder is less rational than other people.

It does not seem particularly reasonable to me to follow Moore and reject a plausible explanation of human behavior that provides insight into primary motives and goals and which in addition proves effective in treatment, as soon as such behavior must be judged rational or irrational. Such an explanation does not make irrational behavior more rational, but it also does not make it less rational. In other words, it can be understood in a way that is comparable to the way rational behavior is understood.[337]

Weinberg et al, attempting to defend Szasz’s position on Moore, employ yet another argument. Using the conscious motive as a premise necessarily implies that the claimed motive is indeed the true motive. They assert that Szasz impugns that someone’s claims may or may not reflect his true motives and that therefore in principle the motive can never be determined with certainty.[338] Although this reasoning undoubtedly has relevant and sensible elements, to me it seems to imply that someone’s claim must never be accepted as a valid motive for his actions and thus that the person in principle must never be believed. Instead only the effects of his actions should be considered (as already discussed in Chapter IV, 3.2.10c). The ultimate consequence of such a viewpoint is that just about any verbal communication is rendered senseless.

Moore's arguments regarding presumptions and beliefs that contribute to behavior seem valid. The epitome of a belief with a subjective reality value that can lead to irrational actions is the delusion. In typical cases the content of such a delusion may be patently absurd and at the same time the person is immovably convinced of its validity, thus making the impression of being extremely irrational. The problem here is that many people have ideas and convictions that are irrational. For example, the multiplicity of religious convictions and ideas is irrational when the rational premise that at most *one* of these can be true is chosen. The same holds true for the various political convictions. Kuiper mentions the example of a general who speculates on the consequences of an atomic war and who considers millions of deaths acceptable in such an event. Kuiper asks whether this involves a case of rational or delusional judgment.[339] The convictions held in Nazi Germany regarding Jews and the superiority of the Arian race can also be considered examples of absurd, irrational convictions. This means that whoever wishes to maintain the criterion of rationality as opposed to delusion must point out its individual, subjective nature. It is a belief that someone has but shares with no one. Even then the clarity is more apparent than real. The *folie à deux* is an intermediate form. Furthermore, due to delusions' formal features – their place in the totality of experiences and the relatively stereotypical and unchangeable content, including over time – they could exist alongside a similar reality. For instance the infidelity delusion (the immovable belief that the spouse is unfaithful) can also exist when the spouse is in fact unfaithful. If this is true then not the actual content of the delusion is most important but the form in which it manifests itself. In addition, certain convictions, for instance that the earth is round and rotates around the sun, were at certain times considered not only dangerous but also irrational, while at other times were considered perfectly rational. So a social-cultural factor is always involved in the assessment of a delusion. Finally, it is true of delusion as well that seeking its purpose reveals viewpoints, for instance in a psychoanalytical context, that can shed light on how to understand the contents of the delusion making it seem less irrational.

Two kinds of rational behavior can be distinguished here. Behavior can be rational given a certain conviction (such as a delusion or an opinion). At the same time this same behavior can be futile depending on the rationality of the conviction itself, or irrational, if no reasonably rational person shares the conviction. Mullane defends the view that neurotic behavior is irrational because the motives are unconscious and because the process of the motives becoming unconscious is "automatic," that is, transpires independently from the person's conscious volition.[340] His view implies that a causal-analytical explanation is applicable. It seems to me, however, that a motive becoming unconscious can be seen as something that happens to a person but also as something that he does or causes. There is no point in ascribing irrationality to neurotic behavior as Mullane does anymore that there is a point in ascribing rationality or irrationality to the growth of a plant or the growth of a tumor. Mullane seems not in fact to speak about whether neurotic behavior is rational or irrational but about the freedom of choice regarding neurotic behavior. This is a different way of looking at psychiatric disorders which will be discussed shortly.

As to the *visualization and interpretation of the situation* in which one finds himself – the context in which a certain behavior can lead to a certain goal –

many internal and external factors that have no relation whatsoever to reason may influence such circumstances. The emotional state, previous experiences under similar circumstances, physical state (the thirsty will look everywhere for a drink), and the strangeness or familiarity of the situation can, when considered, suddenly clarify that which at first seemed irrational. Many mistakes in evaluating reality have nothing to do with (ir)rationality, such as those caused by disabilities of the senses or hallucinations. “Reality testing,” the skill to distinguish between stimuli from the environment and stimuli from within, is extraordinarily complicated and vulnerable, (ir)rationality having little to do with it. The significance of “beliefs” has already been discussed.

It is peculiar that Moore does not explicitly address the disorders of thought that can occur in psychiatric disorders. Such disorders may cause conclusions to be drawn that do not rationally follow the premises. After all, irrationality is essentially a disorder of reason or of cognizance. It might be expected that disorders of thought would be the primary and central focus. However, here too closer examination reveals that there are all kinds of possible explanations that can clarify and furnish insight into such incorrect conclusions.

Moore’s statement that people with psychiatric disorders are less rational than other people compels us to make a comparison and thus to determine a base rationality in a social and cultural context.[341] Obviously, it is impossible for anyone to exit this context, which would be required in order to assess it objectively. This limits the criterion. Even though in theory it might be value-free it can at no time be practiced value-free in society. In other words, Moore cannot escape basing the test for rationality on his own motives, goals, beliefs, convictions, and interpretations. The less similar to Moore’s thoughts the other person’s are, the less rational (more ill) the other is. A value system is concealed in the apparently value-free terminology of (ir)rationality. It is this value system which is decisive for considering a person irrational. In my opinion, it is inadmissible that Moore links this irrationality to the conclusion that the mentally ill are less human than other people, and resemble children or wild animals (!) more than they.

Two examples demonstrate that irrationality can also be a factor in medicine and psychiatry. The first is Rooymans’ remark that clinical judgment is not rational.[342] The other is Van Nieuwenhuizen’s contention that the subdivision of diseases among the various branches of medicine is not rational.[343]

My commentary on Moore’s reasoning is not intended to deny that psychiatric disorders can involve irrationality. I only wish to point out that developments in psychology, sociology, and psychiatry have generated so much information, and explanatory theories have shed so much new light on the “method in madness” as well as on the irrationality of normal people, that irrationality as a criterion for psychiatric disorder is untenable. It is a fruitful point of view in curative psychiatry and has stimulated the formulation of all sorts of theories. But it is in no way a criterion that has sufficient reality value to serve as an ontological base for the concept of psychiatric disorder.

Moreover, human behavior and experience have a very important symbolic significance in addition to literal meaning. “Except for the immediate satisfaction of biological needs, man lives in a world not of things but of symbols.”[344] Both in psychiatry and everywhere else it is important to realize that language and

behavior have symbolic meanings to an important degree. This implies that what a person says or does has a communicative meaning that is sometimes quite clear and other times difficult to unravel. Symbolization is not only about what words and things are but even more about what they mean. Psychotic people often use unusual symbols and are therefore difficult to understand. It can be considered a communicative disability which can be described as a disorder, and therefore becomes treatable. One's attempts at communication not being understood by others is a source of great suffering. Considering such behavior irrational in the sense that people who behave like that are actually essentially different from other people is like saying that a stick in water is broken because it looks that way. (See Chapter IV, 3.2, 10). It cannot be a justification for viewing people with psychiatric disorders as different than other people and as people to whom all sorts of things should be done that would be inadmissible for everybody else.

B. *Psychiatric Disorders as an Obstacle to Freedom*

Foucault writes that in the seventeenth and eighteenth centuries the essence of madness was considered unreason, and today, unfreedom.[345] This view of psychiatric disorders, namely, that they are disorders because they limit and impair people's freedom, seems fairly generally held nowadays. Kubie states, "Freedom to change is the essential tribute of healthy life … the process of mental illness is initiated when anything freezes behavior into forms that can no longer change."[346] Furlong quotes Whitaker as saying, "Wellness is perceived as fundamentally the increasing capacity to choose. Shorn of all its frills, sickness is perceived as any hindrance to free choice."[347] Szasz tells us, "What distinguishes the varied phenomena that may be classed as psychiatric symptoms? All entail an essential restriction of the patient's freedom to engage in conduct available to others similarly situated in this society." (*The Ethics of Psychoanalysis*, p. 14). Keeping in mind the description in 2.1, being psychiatrically ill would have to be described as: a process in which the freedom to make choices and creative adaptations inside the potential range in which the person might be capable of doing so is restricted in such a way as to engender suffering, dysfunction, and abnormality. The person behaves as he does because he is not capable of behaving differently. Freedom has been replaced by determination.

When unfreedom, rigidity, incapacity to grow and change, and incapacity to creatively adapt (creative meaning adjusted to the unique constellation of actual circumstances) are viewed as the common denominator of psychiatric disorders, established psychiatric theories generally explain them very well. Psychoanalytic, humanistic, psychological, and social theories, as well as integration, family interaction, and Janet's theories each explain psychiatric symptoms and behavior differently, but all share the notion that a person is disordered only when he behaves in a certain way because he cannot behave in any other way.

The restriction on freedom, and obviously also the measure to which a person can be held responsible for his behavior, are considered to correspond to the unfreedom generated by organic aberrations in physical disease.[348] Logically speaking, assuming restriction on freedom is inescapable. If symptoms are chosen purposefully then such behavior, even when it is aberrant or

unconventional, cannot be considered ill. Therefore I will below assume that psychiatric disorders are restrictions or impairments of a person's freedom and autonomy as a practical hypothesis for the purpose of examining to what degree this definition is useful and sensible. In Chapter VI I will discuss dealing with this basic notion in practice.

C. *Examination of Restriction of Freedom in Various Psychiatric Disorders*

How is freedom restricted in psychiatric disorders? I will illustrate this using examples in order of increasing levels of restriction of freedom.

In what the DSM-III calls "major depression with melancholia" patients may feel overwhelmed by severely depressed mood and inhibition which deprive them of all happiness, initiative, and activity. Their lives are a torment for reasons totally obscure to them and the people around them. They are helpless to overcome the situation. The same holds true for psychotic disintegration, in particular when there is no discernible relation between behavior and intention. Perhaps the prototype of psychical inflexibility is the delusion that occupies a person's attention for years without the least change. Some psychotic people complain that their thoughts are manipulated or that they are compelled to obey voices. These are explicit cases of (the experience of) unfreedom. However, when someone is thoroughly convinced of experiences which others call crazy and the psychiatrist calls psychotic while not experiencing unfreedom, the situation becomes more difficult. How, then, do we determine whether that person is free or not? We can do so by comparing pre-disease functioning with current functioning. An example is the querulous delusion in which a person for years fills his life with attempts to obtain redress and revenge for an imaginary injustice done to him, or perhaps a real but trivial injustice. His behavior is rigid and stereotypical.

Compulsive thoughts and actions are less problematic in this aspect. Patients complain that they are compelled to constantly and endlessly repeat certain thoughts or actions. This is accompanied by an oppressive feeling of unfreedom and senselessness.

Paraphilia, which used to be called perversion, includes several sexual activities such as pedophilia, exhibitionism, and voyeurism. Such behavior is unusual and from a moral viewpoint is certainly not admirable. But does it have anything to do with a limitation of freedom? And if so, then how? It can be stated unequivocally that such behaviors are deviant but if the person who displays them feels that he freely chooses them, why call them psychiatric disorders? It is noteworthy in this regard that in the DSM-III and fairly generally in practice, homosexuality is no longer considered a psychiatric disorder unless it is ego-dystonic. Is homosexuality the first in a row of falling dominoes? Can we expect the other paraphilias will soon also be counted as psychiatric disorders only when they are ego-dystonic?

How, then, should we consider disorders such as pyromania and kleptomania? People who have this behavior express being incapable of resisting the urge to perform certain acts. But they perform them with complete awareness of what they are doing, knowing that their actions are illegal. They do so with planning and care. How can we objectively assess their actions if they claim to be unfree in this aspect?

Then there are the disorders which in the DSM-III are called “factitious disorders.” Examples are Ganser syndrome of which it is still not clear whether the person is performing an act or behaving unfreely, and Munchausen syndrome. In its commentary the DSM-III notes, “The production of psychological symptoms is apparently under the indiviual’s voluntary control.” Apparently these people, through their syndrome are expressing a desire for the sick role though the reason remains unclear. They are willing to sacrifice a great deal for their goal and choose unusual ways. But is there really unfreedom in this?

Finally, there is simulation. This is not considered a psychiatric disorder. The faker has to have a clearly recognizable and demonstrable goal such as rejection for military duty. The difficulty here is the criterion of the recognizable and demonstrable goal. How should a behavioral pattern of claiming physical illness in the absence of physical aberration be considered when the goal served is not recognizable or scarcely demonstrable, for instance when it is trivial?

For this criterion of will or capacity it is essential to ask who is doing the assessment. Is it the patient himself, the people around him, or the psychiatrist? From the perspective of people with psychiatric disorders a feeling of unfreedom, of not being able to do what they want, and being compelled to do things they do not want, of being determined by all sorts of factors that are not authentically their own, is quite consistent. The experience of unfreedom repeatedly appears in psychiatric descriptions of these disorders although it must be noted that this unfreedom is sometimes extremely obvious, sometimes only slight, and sometimes not at all noticeable. So it is not always possible to be objective about this criterion. Psychiatrists’ assessments necessarily contain an element of intersubjectivity. They pass judgment on others’ behavior and on the degree to which those people chose that behavior or were driven to it. There is a large measure of agreement between patients and psychiatrists regarding the measure of unfreedom in behavior that can be labeled a psychiatric disorder. A clear exception to this is when patients experience themselves as not ill and their behavior as authentic while their psychiatrist is of the opinion that they have a psychiatric disorder.

D. *Freedom, a Psychiatric Fiction*

Are psychiatrists’ opinions impartial and unprejudiced or are there factors that color their views and thus detract from their validity?

Bakker’s research (3.3.2) revealed that psychiatrists are consistently more pessimistic about the their patients’ prognoses than is justified by reality. This would mean that they view their patients as more ill, that is, less free, than they actually are. Bakker mentions that little research has been done regarding the making of psychiatric prognoses. He cites research by Van Bork, Van De Jonghe, and Van Beenen, which all seem to support his own findings, or at least, not contradict them.

Townsend contends that psychiatrists expand the borders of psychiatric illness broader than other people do. He describes the reluctance to recognize psychiatric disorders in other people as fairly high. Once such recognition has been made psychiatrists nearly always confirm it.[349] I would like to add that in psychiatric practice there is generally little attention for the question of *whether* there is a psychiatric disorder, only *which* psychiatric disorder. Not infrequently

people who are regarded as disordered by others are with great effort urged to go to a psychiatrist, sometimes almost literally being pushed through the clinic door. In such circumstances there is great pressure on psychiatrists to come up with something that can be done for the patient. When viewed from such a perspectiv, there is much less preoccupation with the question of whether there is a psychiatric disorder at all. In such cases the most important function of the diagnosis may be to justify the assistance offered.

There also seems to be a rule in psychiatry, that overlooking a diagnosis is a more serious mistake than making an unjustified diagnosis. The inclination to assume a person is ill unless it is demonstrated that he is not exists throughout medicine, including psychiatry. In psychiatry this means that there is an inclination to assume a person is unfree unless it is demonstrated that he is not. Admittedly, this bias is much more difficult to correct in psychiatry, as, contrary to somatic medicine, there are no more or less objective methods to be used in daily practice that might have a corrective influence (see 3.3.2).

My hypothesis is that one of the reasons that psychiatrists tend to be more pessimistic about their patients, assessing them to be less free and more determined by their illness than they really are, is because most of the explanatory theories at their service are basically deterministic. Immergluck stated, “It would be inconceivable to think of a science of behavior without a systematic deterministic position.”[350]

As to psychoanalytic theory, Furlong notes that although there is not complete consensus on this, the theory leaves no room for true internal freedom. He quotes Holt who says, “There is no tenable alternative to determinism for science. The behavior of the ‘free’ person can be predicted from a knowledge of his past, his structure, need, and presenting situation because it follows lawful regularities just like any other behavior.”[351] Furlong concludes that psychodynamic theory could not explain the contradiction between experienced and obvious freedom, and determinism. He mentions Pavlov and Skinner in particular regarding behavioral science and learning theory. He states, “Absolute determinism is a concept so deeply engrained in the theories, that it is difficult at times to recognize the hidden assumption for what it is.”[352] Those who believe in a social model view the individual’s behavior as the result of a complicated but determined social power game.

I wish to note that obviously whoever wishes to approach experience and behavior scientifically *must* seek cause-effect relationships and rules. He cannot escape homing in on precisely those forms of experience and behavior that fit the rule or (seem to) confirm it. So that which is determined, or can be assumed to be determined, draws more attention than that which is free, and thus difficult to grasp. If there is such a thing as free will then it cannot manifest itself any other way than in that nebulous realm where rigid rules do not apply.

The forming of psychiatric theories about unfreedom presents itself here as a paradox. On the one hand psychiatric disorders are explained as restrictions on freedom. On the other, established psychiatric theories tend to deny human freedom in general. The more we know about people, the more predictable their behavior is. But if man is in essence not free there is no point in calling the restriction on his freedom disease. This paradox is partly a contradiction and partly not. Undeniably humans do perform a number of acts with a feeling and

awareness of freedom and choice while they perform other acts without this experiential feature being clear, or with an obstructive and oppressive absence of any feeling of acting freely.

It is not so important for the enormous significance that this experience of free choice, of doing what one wishes, has for man whether or not it is ultimately based on a scientific fiction. It is, however, a serious drawback of the theory that it can construct no other explanation for human freedom than that it is fictional. In other words, it is a reason to correct the theory rather than allowing it to condemn man to slavery and heteronomy.

A different important consideration is that theories explaining psychiatric disorders as restrictions of freedom are not about being free or unfree but about functioning with a greater or smaller degree of freedom.

Finally, no psychiatric theory has even remotely succeeded in predicting human behavior in all its complexity. The notion that man is determined does not arise from any proof based on this theory but rather from an extrapolation of that which has become known. A number of behaviors can be predicted, for instance, from previous behaviors. The more is known of previous behaviors the better future behavior can be predicted. The inference is that if all previous behaviors are known all future behaviors can be predicted. In theory this situation is unattainable because the prediction itself becomes an experience which contributes to determining behavior, and because the evaluator doing the predictions introduces a complicated network of new experiences.

E. *The Contextual Constriction of the Freedom Criterion*

In psychoanalytic theory the unfreedom of a person who has a psychiatric disorder is elucidated using the concept of the unconscious. This concept is one of the most basic concepts in today's psychiatry. It means that all sorts of important feelings and thoughts that people have are partly or wholly unclear to themselves. They cannot access them, so cannot take them into account, but are nonetheless influenced by them. These mental factors remain concealed because they are frightening or unbearable. People can begin to realize what is going on inside of themselves, and unconscious contexts can become conscious, only when an atmosphere of safety and acceptance is achieved.

Psychoanalysis as a therapy is the epitome of a situation in which this atmosphere is achieved. People who submit themselves to psychoanalysis do so because they are burdened by their complaints and problems and because they believe that this treatment can help them. A contractual relationship exists between analysts and analysands by which the analysands regard their analysts as their allies. Confidentiality guarantees that analysts will not use anything analysands say against them. In short, the relationship is ideal for patients to be as candid as possible about themselves. The significance of the unconscious nature of mental factors and processes must be seen in the context of this treatment situation. Also in this situation we discover how extraordinarily difficult it often is for patients to express what is going on inside of them. Obviously, in every other situation this will be even more difficult. This is particularly true when patients' interests are served or jeopardized by the outcome of the evaluation such as in matters of eligibility, involuntary commitment, or a trial, and they do not know exactly what psychiatrists will do with the information they provide. In such

situations it is difficult to extract reliable information about what is conscious and what is unconscious. A person could be presenting a polished image of what is going on inside of him. He could remain silent on some things, twist, or change them. In that case no reliable methods are known for determining to what extent the person's problems are clear to him and how accurate the picture he presented of his own experience is.

Psychiatrists in general assume that people will inform them as well as possible as that is in their interest. It is however not at all certain that the people themselves always see it that way too. Obviously there is a need to be cautious in assessing what people actually experience, and what is unclear or unconscious, particularly in non-treatment situations. Symptoms and syndromes are important in such situations because the are observable. In conclusion, a reasonably reliable pronouncement on what is going on inside of a patient can be made only when there is unambiguous cooperation between the patient and the examiner. Any other circumstance is in this respect dubious.

From the above the following conclusions can be drawn. In psychiatry people are not considered responsible for their psychiatric disorders in the same way that people are not considered responsible for their illnesses in somatic medicine. The former conviction that people with psychiatric disorders are incapable of acting as reasonable beings is no longer tenable. Nowadays patients are not held responsible for their psychiatric disorders because it is assumed that they are subjected to them involuntarily and are not free to act any differently than they do. Patients themselves often clearly experience unfreedom except in those cases that they do not consider themselves ill or aberrant nor their behaviors strange.

Psychiatrists for their part seem to perceive the realm of psychiatric disorders to be broader than other people perceive it. This inclination may be partly caused by the assumption that patients are to be considered ill unless the contrary is "proven."

Theories explaining psychiatric disorders tend to view man as determined. Accordingly, the decisive criterion for psychiatric disorders, namely restriction of freedom, risks becoming a fiction in a scientific sense.

An ideal insight into what is going on inside of a person and how much that person is free to shape his own life is possible only when there is optimal cooperation between the patient and the psychiatrist. When cooperation is less than ideal, restriction of freedom can be determined less reliably, even though a certain pronouncement on the matter can be done on the basis of symptoms and syndromes.

....3.5. Closing Remarks and Conclusions

Two theoretical disadvantages of the biomedical disease concept were discussed. The first is that not only is the biomedical disease concept based on a dualistic view of humanity but it also compels us to maintain this dualistic view, promoting it to (scientific) reality. The second disadvantage is that physicochemical explanations for, for instance, psychiatric disorders, gain undue preference over hermeneutical explanations because only the physicochemical

explanation can bestow the disorder with disease status. As hermeneutical explanations are out of bounds in the biomedical disease concept organogenicists can only be proved right. In this disease concept they can never be proved wrong.

Afterwards the validation of psychiatric disorders and how this compares with validation in somatic medicine was examined. It was found that validation of findings is possible in psychiatry. There are clear differences with the validation of organic aberrations. The results of validation in psychiatry reveal that diagnoses are reliable beyond coincidence but less reliable than in somatic medicine. Predictive validity is scant in psychiatry. Although Szasz's position that validation is purely subjective in psychiatry has been refuted the scant reliability and predictive validity in psychiatry do cast doubt on the sufficiency of diagnostic evaluation as a basis for invasive decisions, in particular when they are made against patients' wishes.

Then Szasz's assertion that that which the term psychiatric disorder denotes is none other that problems in living was examined in two ways. First the hallmarks of problems that are encountered in psychiatry were reviewed. It was found that such problems are characterized by relative vagueness, insolubility, and the fact that they manifest themselves in experience and behavior that can be described and recognized as symptoms and syndromes. Then the role of problems in living in psychiatry were investigated. It was concluded that these roles can differ greatly varying from vague to paramount, and secondly, that certain problems in living in certain circumstances within a constellation of conditions to be described, in addition to all sorts of other factors, bear a relevant connection to psychiatric syndromes.

Next the degree of responsibility that a person can be considered to have for his own psychiatric disorder was discussed. A comparison was made between responsibility for somatic disease and responsibility for psychiatric disorder. Szasz here posits a contradiction. Physical illness happens to a person. "Mental illness" is something somebody does. The person is not responsible for the former, but *is* responsible for the latter. We investigated whether and to what degree a person can or cannot influence events in both cases, whether these events can be described as having causal relationships, and whether they are events that man can influence with his free will and for which he thus bears (partial) responsibility. The question in itself presumes a non-biomedical disease concept. A biomedical disease concept would mean that the question of responsibility for the disease, whether the patient's or someone else's, would become irrelevant. In the absence of physicochemical aberration the question could not be asked because there would be no disease. When assuming a biopsychosocial disease concept the questions can be answered as follows:

- People are not held responsible for their physical illnesses even when their behavior was a clear, albeit indirect, causative factor.
- People are not held responsible for their psychiatric disorders because it is assumed that they are subjected to those illness involuntarily – at least to the extent that their experience and behavior can be called "disordered" – and are no longer free to experience and act differently from the way they do.

With this restrictions of freedom and autonomy are shown to be the main hallmark of both bodily diseases and psychiatric disorders. In psychiatry patients'

own experiences of unfreedom regarding their symptoms and disordered behavior are a fairly consistent factor. Exceptions are those people who claim to experience themselves as free and totally healthy while their behavior justifies diagnosing a psychiatric disorder. The degree to which unfreedom is experienced can vary greatly. In some psychiatric disorders the loss of freedom and autonomy is spectacular. In others it is much less clear. In some it is dubious. Patients are not considered responsible for their disorders even when there is a more or less clear, though usually indirect, responsibility (however see Chapter VI, 3.2).

So there is obvious commonality between physical disease and psychiatric disorders which is: a. physicians' basic attitude of exculpation; b. the degree to which co-responsibility, usually indirect, is traceable; and c. the degree to which patients feel responsible.

In bodily disease the measure of unfreedom and loss of autonomy is due to the (objectively demonstrable) physicochemical disorder even though the degree of loss of liberty can usually be only estimated, not accurately assessed. Unfreedom and loss of liberty in psychiatric disorders cannot be objectively measured. On the contrary, the most established psychiatric theories of explanation, due to their deterministic nature, are more likely to play down the significance of restriction of freedom. Nonetheless:

a. Loss of freedom in the sense of creative hermeneutical adjustment can be determined;
b. It is not plausible to posit that psychiatric patients are faking their disordered experiences and behavior, particularly when these supposedly faked experiences follow a recognizable pattern that could not have been known to the patients;
c. Even when following Szasz's reasoning (see Chapter IV, 3.2) that people's intentions can be deduced from their behavior, psychiatric disorders also occur in situations where there cannot possibly be any benefit to the disordered person, only loss. At the same time Szasz's position cannot be refuted as a motive for behavior can always be inferred from its effect. There can be no other conclusion than that Szasz proves that this view about the true meaning of human behavior and experience, when maintained with sufficient consistency, cannot be objectively invalidated. This however can be posited about any established view of motivation and meaning of behavior.

Finally, Szasz asserts that invading people's lives against their wishes can at the end of the day never be ethically justified. The above argumentation regarding the implications of the conceptualization of disease clearly reveals that his assertion not only remains valid but two arguments were found to support it:
Only when there is obvious cooperation between patients and physicians can truly reliable insight be gained into people's motivations and with that the hermeneutical pattern of their disorders;
In those cases that patients do not experience either a psychiatric disorder or restriction of freedom as applying to them, no confirmation of restriction of freedom as a main hallmark of psychiatric disorder can be obtained from them.

▪▪Chapter VI Physicians, Patients, and Disease: The Consequences of Conceptualization

...1. Introduction

In the previous chapter whether mental illness is a myth was discussed from a theoretical and conceptual perspective. The conclusion was that psychiatric disorders can be considered diseases but that their status as such is different from that of physical diseases mainly in the way they are validated and explained.

This chapter will include a continuation of the comparison between the biomedical and biopsychosocial disease concepts, this time, however, focusing on the *dramatis personae*: physicians, patients, and others. The effects of these disease concepts in practice will be central to the discussion. That is a relevant matter regarding the conceptualization, as a concept, like a theory, exists by the grace of its applicability, utility, and efficacy.

In psychiatry, roughly speaking, two types of explanation are common: the causal-analytic explanation and the sense-analytic or hermeneutical explanation. In the former the explanation of phenomena is sought in cause-effect relationships as in somatic medicine. This type of explanation is applied in particular when organic aberrations, heredity, or constitution are involved in the disorder. Hermeneutical explanations seek to explain the significance of being ill. The motive for being ill, what it expresses, and the purpose of the illness are investigated. The sense of experience and behavior are examined. In the causal-analytical domain laws of cause and effect limit human freedom. In the hermeneutical domain freedom, responsibility, and their restriction by non-causal factors are relevant concepts. The line between these two domains has been a matter for philosophical, moral and political strife for centuries. I do not intend to join this strife. My point is that in psychiatry, causal-analytical and hermeneutical explanations are two complementary ways of viewing being ill. As causal-analytical explanations suit the biomedical disease concept, and are in fact identical to the way illness is viewed in the biomedical disease concept, I can leave that part of psychiatry out here, and discuss it under the header of the biomedical disease concept. This is not a choice based on principle or a proposal for reclassification, as Szasz proposes, but rather a practical measure intended only to simplify the argumentation by avoiding the necessity of constantly repeating, "In psychiatry, inasmuch as causal-analytical explanations are applicable, the same holds true as in somatic medicine." So this chapter will deal only with the part of psychiatry in which hermeneutical explanations for being ill are considered valid.

Perhaps it is a good idea to briefly summarize the relevant differences between the biomedical and biopsychosocial disease concepts here:

1. The biomedical disease concept is more narrowly defined than the biopsychosocial disease concept. It assumes that illness is an event that affects the body. It is based on physics, chemistry, and biology. The biopsychosocial disease concept is broader. It is based on the premise that

man is a system composed of several subsystems and is a part of several super-systems. It is based on psychology and sociology in addition to chemistry, physics, and biology.
2. The biomedical disease concept uses causal-analytical explanations, mainly cause-effect relationships. The biopsychosocial disease concept also uses hermeneutical explanations.
3. In the biomedical disease concept behavior is viewed as an objective symptom or syndrome and explained as the effect of certain causes. In the biopsychosocial disease concept behavior is also viewed as actions with motives and intentions.
4. Within the biomedical disease concept therapy is the attempt to correct an aberrant physicochemical pattern. Within the biopsychosocial disease concept therapy is the attempt to correct system features at different levels.

Several problems can be expected when comparing both disease concepts in practice. The first problem is that the biomedical disease concept, after having been formulated in the nineteenth century, has extensively functioned as medical paradigm without being significantly challenged. Of late – Kendell states that as from 1960[353] – it has been increasingly criticized. It seems to me that there is confusion nowadays. Many people still maintain the biomedical disease concept. Many other people are seeking new conceptualizations because the old one does not suffice. Its deficiency has possibly become manifest partly because the biomedical disease concept increasingly shaped medical practice. Attention was monopolized more and more by the aspects of disease that can be approached and influenced through technologically. So much focus was directed at organic aberrations that illnesses and ill people themselves were pushed to the background. Seeking and designing new disease concepts can be considered a reaction to this development and to the realization that such a shift towards organic aberration is not possible regarding some diseases because it cannot be found. The current confusion may well be comparable to a conflict of paradigms as described by Kuhn in which the forces that would have us return to the older paradigm, of which Szasz is a powerful advocate, and the forces which due to the shortcomings of the older paradigm seek new concepts, together contribute to the current image.[354]

The second problem is that in psychiatry (and also in general and family medicine) a much broader disease concept than the biomedical one has been standard for a long time already. Yet this much wider view of what being ill is seems to disappear as soon as the disease concept itself becomes the subject of scrutiny in psychiatry. In other words, a different disease concept is claimed to be held than is actually held. An example is the statement that psychiatric disorders are diseases just like physical illnesses. If such a statement were taken seriously most psychiatric disorders, namely those in the hermeneutical domain, would go up in smoke. That is not happening. Something much more dangerous is happening, namely, that psychiatric disorders are being treated *as though* they were identical to diseases involving physical aberrations and thus *as though* causal-analytical theories of explanation were valid in the hermeneutical domain as well. There is no reason not to test causal-analytical theories in psychiatry but when they (and only they) are treated as valid without examining whether the premise on which they are based is valid, explanatory models in the physical

sciences may as well be declared valid in the humanities. Adhering to a biomedical disease concept invites us to do so because declaring a disease concept applicable is not a value-free theoretical-conceptual event but generates consequences for physicians, patients, and others. By that I mean that all sorts of people benefit from declaring something to be a disease. That is the subject of this chapter.

A third problem is that it is not only the conceptualization itself that determines events although its influence is far-reaching. Bockel et al researched the connection between illness behaviors and disease careers of an out-patient population and the influence exerted on them by family doctors. They conclude, "*Wesentlicher Einfluss auf die Krankengeschichte und das Krankenverhalten kommt dem Krankheitskonzept zu.*" ["Essentially behavior and the course of the disease is influenced by the disease concept."][355] However, although within a biomedical disease concept there can only be illness when there is a demonstrable physical aberration, there is plenty of room in the etiology and pathology of the disorder for psychical, social, and all other sorts of factors as well.[356] Not only that but there is a medical ethic – beyond this concept – which contributes to determining physicians' behavior. That is to say that the beside manner is not anchored in the concept yet remains significant. The difference is that in the biopsychosocial disease concept the bedside manner is considered part of the treatment and relevant to the disease itself, to its course, and to the (results of the) treatment. Engel provides us with a good example. A man is lying in a hospital attached to a monitor after a heart attack. Two physicians are trying to perform an arterial puncture, but fail. They are naturally dissatisfied with this. The patient is becoming continually more anxious and after several minutes he has ventricle fibrillation. The physicians exclaim how fortunate he is that the fibrillation did not start until after the patient was attached to the monitor, overlooking the fact that the fibrillation may have been (in part) caused by the tension created by the physicians' failed puncture.[357]

This can be formulated another way. A humane, understanding bedside manner is not essential for the course of illness and recovery in the biomedical disease concept. That does not mean that it is totally unimportant. It certainly counts in an interpersonal way. It is comparable to the service at a restaurant: it is important but has nothing to do with the quality of the food served. At the same time everybody knows that even the most delicious food will be less tasty if served in a brutish manner. If this is true, the implication is that the food itself together with the way it is served, and possibly additional factors, determine its flavor. This last way of reasoning, employing all sorts of factors, is precisely the hallmark of the biopsychosocial disease concept. Here is a recent example with regard to health care in the Netherlands. No so long ago it was announced that a certain fixed length of stay in the hospital was determined for various operations. Such a measure can only be conceived within a biomedical disease concept. Disease is a bodily aberration. The operation is a technical matter which takes a fixed amount of time and is thus directly comparable with the reparation of a machine. Duistermaat, in an excellent article, states, "And yet it must be possible to give the patient responsibility as well in the hospital. After all, he is the expert on his own body. The question, 'Do you feel up to being operated in the morning?' compels a person to focus on his own body and gives him a say in

it."[358] That is not only a different type of bedside manner. It is also utilizing a different disease concept.

Below I will continue the comparison between the biomedical and biopsychosocial disease concepts firstly by considering the biomedical concept a territorial concept, meaning that it marks a territory and its boundaries, namely, physicians' (2). After that I will focus on the physician and his functioning, specifically, on his different roles. Although at times I will discuss physicians in general, my intention is to shed light on psychiatrists and their professional activities (3). Next I will discuss how Szasz views the psychiatric patient, who, according to him, should not be a patient, so the psychiatric patient and the biomedical disease concept (4). Then the psychiatrist-patient relationship will be examined (5). The chapter will be closed with the formulation of several conclusions (6).

...2. The Biomedical Disease Concept as a Territorial Concept

By its nature the biomedical disease concept is a concept that can be understood and applied exclusively by experts. Due to the strong technological development in medicine an enormous package of knowledge and skills is now essential within this disease concept. This package is only understandable and available to insiders who are trained in it and have learned to understand the "secret language." The epitome of the insider is the physician. This can be formulated in two ways. Physicians' domain is disease, but also, physicians own the domain of disease. The term domain suggests that not only is this a matter of effective conceptualization in a scientific and practical sense but also that there are territorial claims. The disease concept has also become a territorial concept. The point is not even whether doctors (or other professionals) have certain capabilities but whether it *ipso facto* means that others do not belong in that territory and must be refused. For instance, in "Mental Illness is a Myth" Szasz states that a large part of human behavior has been psychiatrized and "in so doing, the study of a large part of human behavior is subtly transferred from ethics to psychiatry, from the free marketplace of ideas to the closed wards of the mental hospital."[359]

This territorial claim cannot be wholly explained by the specific expertise required. Formerly magicians, medicine men, and priests had territorial claims as well though they were not based on science or qualification, but rather on being initiated into mystical secrets and supernatural powers. Mostly, though, their claims were based on the position of power which they had attained.

In modern times such a territorial claim rises from a combination of having a specific qualification and a certain monopolistic position indicated by the term professionalization. Disease is the domain of the medical vocation. Obviously this leads to a totally different description of the biomedical disease concept than used until now. Aside from a theoretical and scientific concept it is now also describable as a social institution that has led to professionalization in a certain vocation, has become this profession's territory, and partly shaped the institutions and services for tracing, diagnosing, and treating diseases.

This position wants further explanation. It cannot necessarily be taken for granted that professionalization of a certain vocation is linked to the development of a concept. Blaney emphasizes that the professional implications of the "medical model" are completely independent of its utility as a conceptual instrument. "The confounding of these two issues reaches a high level of folly when the statement 'mental disorder is disease' is used as a euphemism for 'mental disorders are the province of persons with an M.D.' Whether or not either of these statements is true, they do not imply each other."[360]

It is worthwhile to investigate whether Blaney's postulation is tenable in practice. I will attempt to do so first by examining the influence of the biomedical disease concept on the relationship between physicians and patients and on "lay people" in general, and afterwards whether and to what extent the relationship between the medical profession and other vocations is determined by this territorial aspect.

When physicians employ the biomedical disease concept they consider illness an event describable in physicochemical terms. The causes, course, and treatment are formulated in terms of physicochemical influences. Patients can talk about their illnesses almost exclusively in terms of experience (pain, anxiety, dizziness, etc.) and behavior. Exaggerating somewhat we can put it this way: Physicians ask patients about their complaints in order to gain a general idea of the direction in which they should be thinking. Which aberrations might there be and where? Afterwards they and their patients part ways. The physicians continue their inquiries into the patients' body (parts). Results of the physicians' examinations are expressed by prescriptions or other treatments or by additional examinations, the purpose and significance of which are often difficult to explain. Patients may try to understand when matters are explained to them in simplified terms. They can scarcely or not at all participate in the discussion. Only physicians are knowledgeable in the domain of disease, only they speak the language, nobody else. Other professionals do not, other people involved with patients do not, and last but not least, patients do not.

Even though from a theoretical and scientific aspect the biomedical disease concept is valuable, it has serious drawbacks as a concept in treating patients. Illness and being ill are realities in everybody's life. So knowledge and insight are also important to everybody, not only for *preventing* illness and identifying it on time, but also and especially to be able to understand what is happening, what the dangers, risks, and possibilities are in a certain situation. Disease, when understood as a physicochemical concept, makes it possible only to inform patients in technical jargon which is hardly comprehensible to lay people, let alone manageable. Information, dialogue with patients, and the method of discussion themselves are strictly speaking outside the domain of what is considered relevant regarding disease. Disease is defined precisely in terms that eliminate those aspects that would make it possible for patients to comprehend and manage what is wrong with them. (See chapter V, 2.2.)

This attitude on the part of physicians has several implications of which I will mention the following:

– Physicians consider their patients' diseases as a matter of and for the professional. Reporting back to patients what is going on and what must be

done is of secondary importance. Although most physicians are convinced of the will to live, recuperate, and thus cooperate, these notions are not included in the biomedical disease concept because they cannot be translated into physicochemical terms. This can contribute to patients' feelings of anxiety and insecurity. Patients may feel like a number, like their doctor does not give them the time of day. That is only partly true. Patients' bodies have physicians' full attention. Only they as people are not or scarcely noticed.

- Physicians consider the results and documentation of examinations as their own property or that of the clinic in which they are employed. The idea that someone might want to obtain x-ray photographs of his own organs not too long ago stirred up surprise and consternation in the Netherlands.
- Physicians consider the facts that they collect, the stories from and about their patients, as their property, or the clinic's. They save it not for their patients but for their patients' benefit. The information contained in them is incomprehensible to the patients anyway and probably harmful to them. On the other hand, when patients return for treatment previously collected information can be significantly useful to their doctors.
- The relationship between physicians and patients is basically determined by the positions of professionals and lay people, the positions of helpers and the helpless. The inescapable conclusion is that patients are dependent on their physicians.
- Mahler points out that it is medical technology itself that determines on what the funds available for health care will be spent. All technically possible treatments must be available. He adds that this may have consequences that do not go without saying from a moral perspective. "In some places where it has been examined it has been identified as an increasing expenditure upon persons in the final months or years before death. It appears that this expenditure does not measurably increase life expectancy or make humanly tolerable the closing episodes of the lives of elderly people."[361]

These implications and in particular the protests against them have become especially significant in recent decades. The protest reflects dissatisfaction among people who are and were being medically treated with physicians' paternalistic behavior and inadequate dialogue between physicians and patients. Querido's proposal made in 1955 can be considered a reaction to the much too narrow and therefore ineffective boundaries of the biomedical disease concept. He advocated employing professionals such as medically trained psychologists or psychologically trained medics or others, in addition to organ specialists, in order to integrate the somatic, psychological, and social factors. His conclusion that we need a new type of family doctor who should integrate the somatic, psychical, and social factors, has been reflected in family medicine.[362] So the new type of family doctor also no longer bases his practice solely on the biomedical concept.

I pause here to point out a most peculiar and interesting position that Szasz takes in this respect. Szasz declares mental illness to be a myth among other reasons because the concept of mental illness conceals people's true problems in living and makes them unrecognizable. (See Chapter I, 4.2.) Patients are turned into victims of illness who are dependent on experts, namely psychiatrists, for solutions to their problems. This process of dependence on physicians however

began much earlier and has become much broader and deeper due to the nature of the biomedical disease concept which creates this dependency. Szasz, considering his preoccupation with autonomy, could be expected to be hostile precisely to this biomedical disease concept. Yet he but asserts that the development of our culture has made extensive specialization inescapable.[363] Querido agrees with this, although he sought a solution for the dilemma by linking the above-mentioned (super) specialists as "generalists" to the new type of family doctor.[364]

Zola posits regarding this that the process of "medicalization," that is the process by which concepts of sick and well are considered relevant to increasingly many matters, must not be blamed so much, and certainly not in the first place, on psychiatry. He ascribes this process to "our increasingly complex technological and bureaucratic system – a system which has led us down the path of the reluctant reliance on the expert."[365] Zola does admit that psychiatry and preventive medicine in particular have spectacularly contributed to medicalization. Illich extensively and passionately points out how the biomedical disease concept causes dependence and the dangers thereof.[366]

My conclusion is that Szasz sees the "smaller" evil, namely the threat to autonomy caused by medicalizing behavior, but that he scarcely notices the "larger" evil of the medical disease concept causing dependence on medicine in general.

Now I continue the thread of my argumentation. Blaney's postulation which is that disease concepts and professionalization are unrelated was examined in view of the influences of the biomedical disease concept on the relationship between physicians and "lay" people. It was found that in the biomedical disease concept illness becomes physicians' territory, and nobody else's. Now I will investigate to what extent professional relationships between physicians and other helping professionals are determined by territorial aspects.

First I present some quotes directed at psychiatry. To illustrate the assertion that "the domain of disease is physicians' property" I will mention Kendell. He states, "By all means, let us [psychiatrists] insist that schizophrenia is an illness, and that we are better equipped to understand and treat it than anyone else."[367] To illustrate the assertion that "physicians' domain is disease" I offer the statement by Wolffers, quoted by Grauenkamp that "hyperventilating patients do not belong to physicians' work domain because these *patients* are not sick."[368] (my italics – J.P.)

Ribner wonders why psychiatrists are so reluctant to work in Community Mental Health Centers. He quotes Du Mas, a clinical psychologist, who says "Generally speaking, M.D.s certified in psychiatry are the people most competent to treat mental illness. By law and training, they are the only ones qualified to treat the whole person: with drugs, organically, surgically, psychologically, and socially."[369]

Next Ribner paraphrases Fink. "Fink goes on to answer his own questions by maintaining the superiority of psychiatric training and the value of the medical model. He acknowledges that a problem may exist around who should be team leader. But he concludes that the psychiatrist alone possesses the 'depth of

understanding' and the 'capacity for a broad overview of the entire process of illness and care' to make clinical judgments."

Glasscote is the third to be mentioned by Ribner. "To those positive attributes of the medical model, Glasscote adds two not usually considered – thoroughness of care and conservatism. It is, he says, the psychiatrist who will contribute these qualities, implying that no one else can offer the first and no one else wants to offer the second."

Afterwards Ribner quotes Zusman and Lamb, "Psychiatrists must become more involved in community mental health and should reassert their leadership. As the group of mental health professionals with both the broadest and most intense training in relevant areas, they have an unmatched over-all perspective."

Ribner quotes the official position of the American Psychiatric Association. "The medical, including psychiatric, treatment program offered by a Community Mental Health Center must be the responsibility of a physician, preferably a psychiatrist, and should be directed by him. The Center's total program, however, may be under the administrative direction of any health professional who has adequate training in administration and experience in mental health."

In contrast, Ribner quotes Eisenthal and Bloom who posit that psychiatrists keep to the medical model for the sake of safety, and not because of conviction. "The physician is defending a model in which his superiority is secure." This rounds up Ribners quotes.[370]

Roman defines medicalization as a social process with two elements. The first is that a certain complex of behaviors fits into a medical model. The second is that the accompanying intervention is to be carried out under medical supervision.[371] Berlin et al agree.[372]

In addition to these statements it should be noted that certain areas in medicine such as surgery, the prescription of most drugs, and physical examinations, is permitted only to physicians in most states. The legal rules and regulations may be considered a stamp of approval on the territorial claims and convert them to an exclusive right.

On the basis of the above I conclude that Blaney's postulation, namely that the disease concept and professionalization are unrelated, is untenable. The biomedical disease concept has double significance. It is both a theoretical and scientific concept that aims to examine and influence disease phenomena as well as a social institution that led to physicians' professionalization. So all literature about disease as a biomedical concept should be read in two ways: first as studies on the conceptualization of disease as a theoretical problem and secondly as studies on physicians' domain. Each implies the other.

In the same way the process of medicalization constantly raises the question whether new relevant associations are being made or whether the medical profession is engaging in expanding its territory. The advancement of ideas about disease as a medical paradigm is complicated by all sorts of professional interests contributing to the discussion from the background. Here is another quote to illustrate this. Sarason et al quote Albee (a psychologist), as follows. "We must abandon the illness model and develop a viable alternative model. Clinical psychology cannot be *both* an independent profession *and* a health profession. So long as we acquiesce to the fiction that people with neurotic

and psychotic behavioral disturbances are sick, our field will keep itself in bondage."[373]

Compared to the biomedical disease concept the biopsychosocial disease concept seems to have very important advantages. Not only do physicochemical and biological categories fit into this disease concept, but so do intrapsychical, relational, social, and cultural categories as well. This fact alone already implies that territorial claims within the disease concept are extremely difficult to maintain. Nonetheless applying a reduced concept in certain situations remains relevant as well as posing territorial requirements regarding training and qualification of those who, for instance, perform operations. In other situations this concept will invite, and even compel, cooperation between different disciplines. Not only that, it replaces exclusive explanations within the biomedical concept with various explanations and explanatory models which are in principle of equal value.

In family medicine and psychiatry, which involve all of these categories, such a development has been going on for decades in the Netherlands and elsewhere. Exactly because physicians cannot maintain that they are experts in so many fields respect for other professionals is facilitated, as well as recognition of their superior expertise in some of these fields.

Finally, the biopsychosocial disease concept has the essential difference that patients comprehend and so can and must also participate in discussing prime aspects of illness and being ill. The significance of "switching" from a biomedical to a biopsychosocial disease concept to psychiatrists is stepping back from a position in which they were lord and master in their "domain," and sharing this domain with various others. This changed situation generates tensions for psychiatrists as well as for others which are not easily solved. For instance, the question of what exactly of all the issues raised in team discussions should be considered medical remains confusing and controversial, not in the least because it remains totally unclear which disease concept is being maintained.

To date there is no consensus about the ideal position of psychiatrists in multi-disciplinary treatment teams. Psychiatrists often emphasize their distinction from other team members by the breadth of their expertise rather than by its depth.[374] That would be an argument for viewing psychiatrists as coordinators and ultimately responsible for the team as also suggested in some of the above quotes. Their broad expertise makes them suitable for supervision and coordinating interventions. Their leadership skills seem, however, to depend in particular on their personal qualities, qualities that are not identical to psychiatric qualification.

...3. Physicians and the Biomedical Disease Concept

....3.1. Physicians as Professionals

According to Freidson the medical profession developed as such in the nineteenth century.[375] That is the same century in which Virchow and others defined the biomedical disease concept. So historically as well it is likely that the

professionalization of physicians and the formulation of the biomedical disease concept are connected.

What is meant by profession? Briefly, this is how Freidson puts it. Professions are based on two pillars. The first pillar is a qualification in the sense of having special knowledge and ability which are considered superior to that which others in the same field know or are able to do. The other pillar is a state legislated and upheld position of monopoly in that field. So there is a combination of expertise and power. The features of a profession are:

- the profession itself determines what must be regarded as the correct qualifications;
- the profession has the liberty to regulate itself but also to regulate other "adjacent" vocations;
- education and training are determined by the profession itself;
- the profession determines with which clients it works and manages them itself.

There is a broad variation of fields in which a profession can be autonomous. At the one extreme the state allows itself more or less to be led by the profession and uses its power to support the profession's values, protect it from competition, and control its employees. At the other extreme the profession is allowed autonomy in knowledge and skills but the state reserves the right to determine its social and economic circumstances, and the way in which the work is socially organized. In this respect, the United States is not too far from the former extreme, and the [former] USSR is not too far from the latter. On the side, note that in the Netherlands the medical profession is shifting from a position similar to that of the United States to one similar to that of the [former] USSR.

So the profession is in a privileged position which features autonomy and monopoly. It is the medical profession which has the right and power to define what illness is. "Medicine may be said to be engaged in *the creation of illness as a social state which a human being may assume.*"[376] Note the distinction between its demonstrable scientific accomplishments and its demarcation of territory. The latter is much larger than the former. Physicians are made into "moral entrepreneurs" who see illness where lay people see something else and who label as serious what lay people do not take so seriously.

Professional autonomy restricts the autonomy of individual citizens as they are no longer autonomous in the profession's special field. That is why the value of citizens' autonomy should prevail over that of the profession, and the profession's autonomy should be kept as restricted as possible when determining the general good of society, so Freidson points out.

Surely nobody will deny that the biomedical disease concept was the basis for spectacular discoveries regarding illness and its treatment, from a statistical lowering of mortality to the blossoming of medicine. However, in the last decades the public has increasingly criticized the way medicine is practiced and at the same time analysis of the costs versus the benefits is increasingly unfavorable.[377]

Szasz points out that there has been a clear shift in physicians' functioning during the last century. He describes family doctors of yore as wise, preferably older men, who albeit could not do very much, but intensely sympathized with sick people.[378] Present-day physicians more resemble scientists and experts. They are more often distanced than friendly and more likely to be younger than older. They are efficient and express little sympathy. According to Szasz,

dissatisfaction with this "scientific doctor" is much greater than used to be with the "humane doctor."

Eisenberg as well ascribes the increasing dissatisfaction with medicine to its technicalization. "The professionalization of medicine has resulted in enormous advances. But it has exacted a considerable price in the divorce of what the physician sees as his job from what the patient seeks of him. Professional and lay views of the meaning of health and sickness have drawn too far apart." He advocates including social and psychological treatments, performed by physicians or others in health services.[379]

Szasz and Eisenberg apparently agree that the expansive development of medicine in our century has the side-effect of a certain estrangement between physicians and patients. However, their reactions to this state of affairs are diametrically opposed.

Van Es et al state that "numerous investigations revealed that the patient wants good, dependable assistance that is humane," and emphasize the "increasing insight into the relationship between living conditions and the origin and/or course of illnesses and being ill."[380] If that is so, the conclusion must be that the biomedical disease concept falls short of satisfying patients' wishes and of providing the scientific frameworks that would make further research in this direction possible.

....3.2. The Psychiatrist as Helping Professional

Assuming that psychiatric disorders imply restrictions of freedom and autonomy (see Chapter V, 3.4.3), how do psychiatrists approach their patients from this basic notion? The main question is, who or what is considered responsible for the origin of a psychiatric disorder? In other words, if it is not patients' fault and responsibility that they have come to this, then whose is it? There are, as is well-known, many kinds of hermeneutical explanations. In each of these responsibility for psychiatric disorders is laid elsewhere.

In intrapsychical theories of explanation, the most important of which is the psychoanalytic, explanations are sought in people's early experiences, particularly in early childhood. People are not or hardly held responsible for their early experiences. During treatment their parents are considered responsible for what they did with the child. So the person himself is exculpated and the parents are in a sense incriminated. Certain factors in the child could be relevant. Alice Miller mentions giftedness in children as a possible source of neuroses although the child is not at all held responsible of course.[381]

Client-centered psychotherapy (Rogers) is based on the axiom that if the therapist can accomplish a number of basic conditions in his relationship with patients the latter will develop themselves further and expand their autonomy. These basic conditions involve general human values such as warmth, genuineness, unconditional positive regard, and acceptance. This axiom implies that people who can so recover have in the past not been given adequate opportunities by their fellow humans to develop themselves. Otherwise these special conditions of psychotherapy would not be necessary. So the explanation,

if not the blame, and with that, the responsibility for the patients' disorders is placed on the environment.

Family interaction theories differ. The Laingian view leaves no doubt about the blame: the origin of psychoses is to be found in the destructive terror of the family. Other theories also put responsibility with the family. The "schizophrenic mother" is a more concrete condemnation. In some theories of family interaction the idea of the existence of a patient is considered wrong. The family system is to be viewed as the patient while the patient who applied for treatment has only been "labeled" as such. Yet other theories emphasize not so much families' *responsibility* for the origin of the disorder as their capacity to deal with or solve it.

Sometimes society as a whole is blamed, especially by Marxist psychiatrists .[382] Perhaps Szasz, although certainly not a Marxist, also belongs in this group, as to an important degree he holds the paternalistic tendencies of states as partly responsible for the existence of psychiatric disorders.

I could name more examples but these suffice to make the point. Every theory of explanation exculpates the patient one way or another except for *one*, namely, that the disorder is the person's own fault. As far as I know no one in psychiatry holds this theory any longer. This way of thinking in history is probably most clearly represented by Heinroth. He ascribed mental illness to sin and guilt, and willing submission to evil.[383] Other representatives of this position in distant history are to be found in religion rather than medicine. Perhaps Szasz, too, to a certain extent, belongs in this peculiar group because he asserts that people abscond from responsibility by displaying psychiatric disorders. (See 4 below.)

Exculpating theories of explanation also affect the subjects to whom the theories are applied. Exculpation can be seen as an authentic explanation of events, but also, just as well, as a maneuver aimed at releasing a particular patient of his stifling guilt feelings, freeing up space for development and change. Szasz points out that exculpation is at the same time infantilization. This element becomes even more clear when viewing therapeutic statements in different theories of explanation.

In general psychiatry poses a paradox for patients, by which is meant a seeming irreconcilability. "You are not responsible for the fact that you are ill (as is obvious, among other things, by your behavior), but you *are* responsible for your actions."[384] This is especially obvious in forced measures applied to psychiatric patients for restlessness, hyperactivity, or aggressiveness. Psychotherapy features the paradox, "The disorder makes you unfree and thus incompetent; to recover you are offered a relationship in which you are considered free, responsible, and competent, so that you can become free again."

In principle there are only two possibilities. The first is an offer of care, an offer in which helping professionals acknowledge and accept patients' powerlessness and inability to be different, choose their side, and offer guidance. This offer changes patients' situations so they themselves can change. But if they do not change that is all right too. The point is not changing them but accepting them as they are. The other possibility is an offer of treatment with the inherent purpose and desirability of change. But in psychiatry that is not only a change in the current situation. It is also a change in people's functioning, the patients themselves must change. For psychoanalysis this treatment offer implies a

paradox which Szasz expresses thus: psychoanalysis is a historistical theory, and at the same time, an antihistoristical therapy. More generally, the paradox can be formulated as this: the patient has become ill due to no fault of his own, but healing himself is within his capacity, albeit with the assistance of the person who offers this paradox. In psychotherapy, again the offer of the paradox is paradoxical: although no advice, medication, and so forth are offered as the patient must himself lead the way to recovery, yet in the offer of psychotherapy itself a prescription is given, and the way to recovery pointed out.[385]

Finally, in practice, one is confronted daily with two sides of the view that people with psychiatric disorders cannot be held responsible for them. One side is that patients are not necessarily burdened by guilt about their failures. The other side is that they may be passive about their recovery and leave whatever is to happen to them up to the helping professional. Sometimes, for instance, in the case of disorders that respond well to medication, the passive attitude is not so disadvantageous. Often, however, patients shortchange themselves by being passive, and in so doing reduce their chances of recovery. Helping professionals are challenged with the task of attempting to clarify to them that their own actions and efforts are important for their own future prospects. This means that a disease concept which absolves them of all responsibility for their being ill can actually only make them sicker. The realization that one is not totally powerless but primarily responsible for what one makes of one's own life is a highly important realization in psychiatry. This is so not only in the sense of accepting the disorder, comparable to accepting a somatic disorder, but particularly in the sense of the opportunity for changing the disorder itself that this realization can bring about. Furlong concludes, "Empirically, a sense of inner determination, freedom, and choice appears to be a mark of mental health."[386] This means that when psychiatrists succeed in clarifying to patients that they are not powerless but rather remain themselves responsible for what they make of their lives, not only has the probably most important condition for recovery been created, but at the same time the process of recovery is in fact already occurring. This means nothing more or less than that patients are not held responsible for the conditions in which they find themselves yet by taking responsibility for their recovery upon themselves they are already recovering.

The main problem in practice in psychiatric treatment is where to draw the line between accepting patients' helplessness and powerlessness, and confronting them with their responsibility for their own lives. When someone is about to drown it is not helpful telling him about the different ways he might learn to swim. Helping professionals are first of all to pull the person back onto dry land. In such circumstances pointing out responsibility is heartless as obviously the person is not able to come out of the water on his own. Yet helping professionals who repeatedly pull such a person out of the water and then let him fall back in are not only lacking, they are also making the person prone to drowning dependent on them, in addition to all of his other problems. This line is partly drawn by the helping professionals' intuition, experience, personal qualities, courage, and special skills, so that patients' treatment is hardly transferable or objective.

A special difficulty is that as a rule patients cannot know how their psychiatrists will approach them and to which explanatory theory they subscribe.

It means that "informed consent" which includes psychiatrists' explanations of their views is extremely important. On the other hand, the theory of explanation could lose its power when told. That is the case in a modification of psychoanalytic theory proposed by Taylor. He suggests using the tactics that most efficiently evoke behavioral changes regardless of the contextual correctness. So a contention would not have to be true, as long as it stimulates change.[387] Possibly a part of directive therapy, namely, the paradoxical approach, would also lose its efficacy if patients were told exactly (so: not paradoxically) what the treatment entails. This raises the question to what extent such treatments are morally justifiable. For the sake of brevity this will not be discussed here.

....3.3. Psychiatrists as Social Arbitrators

Until now psychiatrists have been discussed in their role as helping professionals and therapists. However, physicians have multiple social roles. Mechanic lists the roles of scientific practitioner, helper, and bureaucrat, which are usually tied together.[388] I would like to skip the role of scientific practitioner now and focus on the role of bureaucrat, a function that is related to medicine's function of social control. I will examine more closely two of these bureaucratic roles: A. physicians or psychiatrists who determine whether or not someone is ill; and B. physicians or psychiatrists who determine whether someone is entitled to certain social privileges due to illness.

A. In a biological disease concept only physicians are experts on disease. Patients may feel sick but the presence of disease must be verified – legalized – by a physician. An additional need for expert verification arises from the advantages and privileges associated with the sick role. (See Parsons' four postulations in Chapter V, 2.1.) These privileges are written into law. Today in the Netherlands recognized patients are in a considerably better position than other people who become unemployed due to circumstances beyond their control. The law entitles them to a pension equal to their previous incomes for the duration of their illness. Employers are prohibited from firing a sick employee. Laws regarding disability benefits guarantee pensions for people who have been sick for at least two years. Employers for their part do not have to worry too much about the fate of their sick employees who after a certain amount of time are pronounced permanently disabled. Their employees are assured of a living from the disability benefits. The disadvantages of this system in view of the enormous inflation of the numbers of people proclaimed to be disabled has become the focus of political debate. In my argumentation the point is that the privileges of the sick role necessitate using experts to guard the entrance gates to the coveted domain of the sick. Both the implications of the biomedical disease concept and the social advantages of being sick entail engaging expert arbitrators. Perhaps this is the reason that this situation draws relatively little criticism. In actuality citizens' autonomy has been drastically restricted. Officially they cannot pronounce themselves ill. That has to be done by others, physicians. There is a contradiction here. On the one hand being ill is an undesirable, feared condition.

Social rules assure sick people access to measures deemed optimal for recovery, and protection in their powerless, helpless state. On the other hand, the sick role is apparently so coveted that measures must be taken to prevent too many people from enjoying its benefits. Obviously certain people in certain circumstances prefer the sick role to their usual social roles. Equally obviously other people in other circumstances prefer their usual social roles to the sick role. The solution for this contradiction was found in engaging social arbitrators who decide whether people's claims to the sick role are justified. This role of social arbitrator is performed by physicians.[389] Physicians can determine whether a person is sick or well with certainty only when there are reasons for the pronouncement that the person is ill. After all, even in the biomedical disease concept illness can never be definitely excluded. The question of eligibility for certain social privileges on the grounds of illness may be answered by one of the following:

1. There is an illness on grounds of which said person is eligible (for instance, for benefits);
2. There is an illness but it is not grounds for eligibility;
3. No illness is demonstrable nor is there any reason to suppose the existence of illness. Said person is ineligible.
4. No illness is demonstrable but the expert nonetheless suspects the existence of illness so regards said person eligible.
5. No illness is demonstrable but as the expert suspects that said person will react to such a pronouncement by managing to procure the benefit anyway the expert considers him ineligible but permits him to receive it;
6. No illness is demonstrable nor does the expert suspect the existence of illness. The expert suspects said person of malingering and thus he is ineligible.

We now arrive at the question whether the system of physician arbitrators guarding the domain of the sick works well. Within a biomedical disease concept physicians can in certain cases determine the existence of aberrations and pronounce patients sick on that ground. In such cases, however, clarity is more apparent that real. Of how many and which social obligations should the physician exempt his patient? Is the patient still capable of working, and if so, how much and which work can he still do? In spite of extensive research into such matters, decisions remain literally arbitrary except for the most severe and unambiguous cases. Decisions become even more difficult when no physical aberrations are found. In addition to the obvious benefit to patients that any existing aberrations be found, such findings also entail social rehabilitation for those who claim to be ill and entitlement to the privileges of the sick role. This is likely to stimulate over-consumption of medical examination. Huygen states, "Adherence to 'objective' standards is in those cases much scantier than for which [the family physician] was trained. These standards as a rule assume that there is always a risk that complaints indicate a life-threatening disease that must be traced or excluded as soon as possible. He was dramatically cautioned how he might fail at this if he does not continue investigating everything. In order to safeguard himself from this risk of overlooking physical aberration the family physician refers many people to specialists every day. His motto is often, 'One can never be sure.'"[390]

This would mean that physicians cannot be good arbitrators simply because there are way too many uncertainties. Their uncertainty moves them to examining too much, too intensively, too long, which contributes to the duration of the illness. “Health workers consider that the ‘best’ health care is one where everything known to medicine is applied to every individual, by the highest trained medical scientist, in the most specialized institution.”[391]

In addition, the specter of being excluded from employment is not one that “in a cool discussion leads to the conclusion that the social status of being sick has preferable aspects. No, such an invasive event makes many people ill: sleeping problems, headaches, depression, stress symptoms.”[392] It must be said that this last consideration does not fit into the biomedical disease concept but is based on a biopsychosocial disease concept.

In the Netherlands the rights of people who have become ill and can therefore not work are established in law. Grond et al states about that, “Both in and outside of the circle of insurance physicians many physicians worry about the paradoxical situation created by social insurance. Laws intended to compensate sickness and disability as much as possible are found to an important extent to encourage absence from work and disability, and discourage recovery.”[393]

A picture ensues of all sorts of specialists, physicians, employment experts, legislators, and judges, who think of and enforce all sorts of rules for patients’ control and protection, but not participation. Patients meanwhile become increasingly insecure. The many rules often create the very situations they were intended to prevent or remedy. The entire system was called into being in order to slam the brakes on unjustified use of the privileges of the sick role. To that effect physicians were engaged as arbitrators. The result is that all sorts of people are made ill. In compliance with existing laws a life-long sick role is imposed on them even though it is not strictly necessary.

Moreover, Grond et all assert: “Physicians only create conditions for healing. Abandonment of sick behavior and relinquishment of social privileges related to illness must be done by the patient.”[394] This is an interesting assertion because in effect it means that patients themselves must pronounce themselves healthy and that no one else can do it, especially not social arbitrators, who were engaged to do precisely that. If physicians’ pronouncing people ill has so many converse effects and complications for so many people that many more people become ill *from* this process than would be the case without it, then the following conclusion is inescapable: The only one who can rightfully pronounce a person either sick or healthy is that person *himself*. All measures of medical control and arbitration have more disadvantages than advantages. All restrictions on individual freedom for the purpose of preventing abuse are ineffective and sometimes destructive. Although it is a problematic and complicated situation, it appears that the situation in which the patient pronounces himself to be sick or well in fact already exists, but lacks official recognition. Grond et al, for instance, distinguish between objective disability to work (that is to say that the physician and the patient agree about the disability to work) and subjective disability to work (the physician and patient disagree. The patient says that he cannot work. The physician finds no symptoms of illness. Note that nonetheless there is a reference here to disability to work, albeit subjective.) The image of the inspecting physician who chased the malingerer out of bed and to work is a thing of the distant past.

The resumption of work has become, like so many things, a matter of negotiation between patients and inspecting physicians on the one hand, and patients and treating physicians on the other. When conflicts escalate to the point that disability benefits are forfeited, appeals can always be made to other social laws, for instance, welfare. In other words, not only do the arbitrators lack expertise but they lack power as well, which in turn means that the display of power does not have a leg to stand on. It is more a complicated mystification than a reflection of real functions.

From the above I conclude that the autonomy of people in our society should be reinstated in this respect. They should regain the right, not only *de facto*, but also officially, to pronounce themselves ill or healthy. The complicated and illness-generating system of controls should be abolished. Instead laws should be formulated that grant the individual this right and protect it. That way their own responsibility, and in some cases, blame, will be returned to citizens/patients. Not being able to work due to illness would be directly comparable to not being able to work for any other reason. There would also no longer be any reason for the difference in the level of benefits for these two classifications. This difference could be abolished.

It is clear, however, that these positions are tenable only when a different disease concept from the biomedical one is chosen as a premise. The secret jargon of the territorial biomedical disease concept is to be exchanged for the much more accessible jargon of the biopsychosocial disease concept. Only then will disease again be a concept that patients themselves can participate in discussing, and on which patients themselves are experts as well.

The above is of course not intended to imply that patients must make such decisions unassisted. Physicians can support them with their expertise – but not from a basic attitude of suspicion, as in “You claim to be ill now, but we will have to prove it first.” Rather, there should be a basic attitude of acceptance from which expert advice and assistance are possible without the unrealizable pretense of arbitration and judgment/condemnation.

Further elaboration on these positions would go beyond argumentation on the consequences of the conceptualization of disease, and exceed my expertise. The point is that the biomedical disease concept imposes on patients the role of powerless consumer of health care. It has rendered patients’ liberation and promotion to physicians’ colleagues impossible. It has turned health care into a fortress of revered expertise. The biopsychosocial disease concept offers a way out of these dilemmas that were in part created by the biomedical disease concept.

Finally, a third description of illness can be added to that of illness as a scientific and theoretical concept and that of illness as a social institution with territorial claims by physicians. Disease is an institution to which belongs a role pattern of illness which features advantageous as well as detrimental aspects for the sick person. The concept of illness has gained two side-definitions in addition to its “main” definition which should constantly be included in argumentation on illness and being ill.

B. As an example of psychiatrists who must judge eligibility for certain services on grounds of illness I propose psychiatrists who participate in so-called abortion

councils. In the not too distant past these abortion councils functioned as committees that were burdened with judging whether pregnant women's requests for abortion were to be granted or denied. The formation of these committees was based on the idea that abortion was permissible when carrying out the pregnancy entailed grave risks for the woman. My participation in such a council revealed to me how extraordinarily difficult it is for physicians to slowly convert a holy "no" into a conditional "yes." The problem was not only, perhaps not even mainly, the woman's. It was also very much the physicians' moral problem. Regardless of how sincerely it was attempted to pass objective judgments there always seemed to be a pitfall. Is the council a scientific forum or a kind of examination committee authorized to mete out an important social privilege? On the one hand there was the issue of responsibility: to what extent could a psychiatric disorder have contributed to the pregnancy? On the other hand there was the issue of the consequences that an abortion or continuation of the pregnancy would have. Such matters could be evaluated only on the basis of intuition as there was scarcely anything known about the nature and size of the risks involved. What was the influence on the decision when a woman made her request calmly and deliberately? Or if she was in a panic? What difference did it make in a situation experienced as hopeless whether or not the woman was neurotic? What sort of principle of "fair share of misery" was applied when abortion was granted to a woman of meager means and denied a moneyed woman, arguing that life for the former was "already so difficult"? Which should be "rewarded," someone's continual struggle in circumstances of extreme squalor or retreat into the sick role? In retrospect it is difficult to deny that a complicated process of changing norms was occurring that was moral and political but not medical or psychiatric.

Szasz dubbed this meted distribution of social privileges which are not accorded to everybody "bootlegging" (see *Ideology and Insanity*, Chapter 7): smuggling human and social values under a smoke screen of medical expertise. Although he condemns it, it seems to me that such a process can be sensible, and even inescapable, in a changing society with changing values, in order to make transitions possible and guide them. Apparently there is a strong inclination in these processes for which wise people are needed to seek (medical) experts, as apparently in our society we have no other way of judging who is wise. When the specific qualifications of psychiatrists in such a council are investigated it becomes evident that they are much less important than the social and political power that the expert takes upon himself or is dealt. The course of such a council would be quite different if the participating psychiatrist thought abortion ethically unjustifiable under all circumstances. Here, the profession is, as Freidson says, "a vehicle for society's values."[395] There is only *one* correct conclusion: women must decide themselves.

Here I will limit myself to these two examples. In Chapter VII a third example will be discussed: psychiatrists' role in involuntary commitment.

About psychiatrists' role as social arbitrators remains to be said that they are not trained for that nor experts in it. Generally complicated social problems are involved. Psychiatrists as a rule have insight into only into certain aspects of them. Psychiatric diagnoses and systems are directed at the question, "What is wrong?" in respect of the question, "What can I do about it?" Classifications are

designed for certain situations and with certain goals.[396] Situations in which sometimes very specific questions must be answered require a different system of classification and a different kind of diagnostics. However there are no separate classifications to which psychiatrist-arbitrators can resort. When important decisions are involved it is desirable to weigh the facts. Disease is not a fact, it is a concept. Matters of social arbitration seem to be based on the premise that disease must be established as a fact on which a decision must be based. Organic aberrations can at least be presented as facts, although this is dangerous, as the fact of the organic aberration acquires its significance only in the pattern of the disease.

In psychiatry the situation is even more difficult because there usually are no organic aberrations which can objectively confirm the findings. Considering the scant reliability and predictive validity in psychiatry it is already difficult to make diagnoses in a way that leads to meaningful treatment opportunities in the ordinary situation where the psychiatrist is a therapist. (See Chapter V, 3.3.3.) In addition, arbitration almost always is about making a comparison with "normal" people. Such a comparison can actually never be made because psychiatrists have not studied and do not know "normal" people. The matter of normality in psychiatry has only recently become a subject of research.[397] In psychiatry it is extremely difficult to diagnose somebody "normal" because there are no clear criteria for normality.[398]

Psychiatrists' task should be viewed in regard to their expertise. This expertise is recognizing somatic, psychical, social, and other possible factors that tie in to psychiatric disorders. Psychiatrists are trained to derive information from contacts with people and to translate that information into a number of theoretical frameworks. All of these frameworks are designed and intended to offer therapeutic opportunities. Finally, they are familiar with a number of these therapies and trained to apply some themselves. The problems arising from this expertise are great. Psychiatrists hands are full enough already.

Inasmuch as psychiatrists present themselves as social arbitrators they are extrapolating their skills, theoretical knowledge, and views regarding therapeutic possibilities and expectations on the parties to arbitration. This means that psychiatrists have to go beyond their own expertise and apply their theories outside of the framework for which they were designed and intended.[399] This does not mean that as social arbitrators they can contribute no wisdom. It means that it is impossible to judge the value of their views outside of the context of a relationship which has the goal of advice and treatment. Psychiatrists can only evaluate matters from a therapeutic perspective. This perspective can shed light on one aspect or multiple aspects of a problem, perhaps not even the most important aspect. Psychiatrists can pronounce opinions. Such opinions do have significance but not enough to base a well-considered decision on them. Whoever thinks he has received an expert evaluation is deceived. He has only received an opinion, a guess, or a viewpoint, nothing less and nothing more.

...4. Psychiatric Patients and the Biomedical Disease Concept

Although Szasz prefers to discuss people in their relationships with each other, he much more frequently discusses psychiatrists and what they do and pretend than their partners, and according to Szasz, victims, psychiatric patients. Nonetheless it is important to know what Szasz thinks of what other psychiatrists call psychiatric patients. The label psychiatric disorder dehumanizes and humiliates people according to Szasz. What would be thought of these people if the label were abolished?

Who are psychiatric patients when they are not called psychiatric patients? Szasz prefers to answer that they are normal people. There is no point in calling them sick. There is nothing special about them that would justify a separate classification. Szasz has never denied that the behaviors that lead to psychiatric labeling do exist. He only opposes their conceptualization as psychiatric disorders. As he as well observes features by which these people are distinguishable from others, his view of these people can be inferred.

In *The Myth of Mental Illness* Szasz asserts that people who were called hysterical by Charcot and Freud were before then considered impostors, malingerers, and frauds. In a 1961 article he calls this process "renaming," which he condemns as a semantic maneuver. Such a maneuver is pointless because it is only a matter of time before the stigma returns.[400] This article suggests that Szasz considers hysterical patients impostors and frauds.

In his discussions on responsibility and liberty the psychiatric patients are the ones absconding from their responsibilities and choosing the dependence of the patient role. In *Ideology and Insanity* he writes, "Psychiatry has accepted the job of warehousing society's undesirables." (p 82) Szasz does not state directly that he regards these people undesirable, only that they are considered undesirable, and that that is the reason they are labeled as psychiatric patients. In *The Theology of Medicine* he states, "The renaming and reclassifying as sick of a whole host of behaviors formerly considered sinful or criminal is the very foundation upon which modern psychiatry rests," (p. 69) and in a 1969 article, "Commitment shields the non-hospitalized members of society from having to accommodate to the annoying or idiosyncratic demands of persons who have not violated any criminal statures.[401] In *Schizophrenia* he asserts, "The facts are, that in the main, so-called mad-men … are not so much disturbed as they are disturbing; it is not so much that they themselves suffer (although they may), but that they make others suffer." (p. 36)

More quotes can easily be added to the above. Taking them all together the following description emerges: Psychiatric patients are non-criminal deviants who misbehave, who are often troublesome, irritating, or peculiar, and dangerous in the sense that they threaten the fabric of society because their deviance may be a response to social wrongs. They are impostors, so unreliable, and exploiters because they fraudulently use the sick role. They do not know how to live properly. They sabotage their responsibilities. On the other hand they are people who should be held responsible for what they do and say like everyone else and whose judgment (for instance, regarding the desirability of psychiatric hospitalization) should be respected.

So the image of the psychiatric patient as it emerges from Szasz's writings is quite negative and unpleasant. This image consistently recurs in his work. Szasz poses a moral criterion for judging behavior rather than a medical-

psychiatric criterion which for him generates a very negative picture. At the same time this means that psychiatric patients can have little hope that the image of them, which is negative due to stigmatization as psychiatric patients, will improve when they are no longer considered psychiatric patients and their aberrant behavior is no longer conceptualized as disease – at least, in Szasz's view. It may be true that "renaming" has in the long run not improved the image of psychiatric patients.[402] In view of the above, they do not seem to be any worse off either, at least not as far as stigmas go.

There has been not a little research done about the image of psychiatric patients among "normal" people as well as among psychiatric patients themselves. This image is rather strongly negative.[403] Aside from the features listed above psychiatric patients are not uncommonly associated with violence and danger. O'Mahony concluded that in Dublin psychiatric patients were viewed as unhappy, confused, withdrawn, and (by a minority of people) dangerous.[404]

Another question examined is whether the stigma that seems to adhere to these patients results from psychiatric treatment or psychiatric hospitalization rather than from their disorders themselves. Bagheri et al noted that of 103 referrals by other physicians to psychiatrists, 68% of these patients were not informed of the referral by the physician, apparently because the physicians expected the patients to respond in a negative way. Unjustified, Bagheri et al posit, as two-thirds of the patients either were positive about the referral or accepting.[405] Bockel, too, found that patients not uncommonly themselves suggest to their family doctors that they be referred to a psychiatrist.[406] Bockel also lists several other research projects which reveal that, although patients generally tend to await their family doctors' advice, 30 to 40% of them initiate the referral to a psychiatrist themselves.

Phillips investigated 300 white women. They were given five stories, four of which were about psychiatric patients, and the fifth about a "normal" person. The women's judgment became more negative as the people in the stories were described to have a mental counselor, a physician, a psychiatrist, or visited a Mental Hospital.[407] This suggests that the stigma was not so much formed on the basis of the disorder itself but rather on the basis of the type of assistance provided. Goudsmit, too, pointed this out regarding psychotherapy, and protested against it.[408] Gove possibly offers an explanation for Phillips's findings by suggesting that in the general public there is great reluctance to recognize psychiatric disorders in people.[409] Apparently treatment is used as a tool that legitimizes recognition of psychiatric disorders. Gove further emphasizes that according to several investigations people as a rule are hospitalized as psychiatric patients only when their behavior has become unbearable, but that the stigma often later disappears again when the ex-psychiatric patient achieves a reasonable measure of adjustment.

In accordance with the above Schwartz concludes that the image family members of psychiatric patients have is based more on the current level of adjustment than on the fact of having been treated.[410] Clausen, who researched psychiatric patients and their families, reaches a similar conclusion, namely, that ex-psychiatric patients' feelings of being stigmatized are particularly engendered by self-doubt and (remaining) symptoms of the psychiatric disorder.[411]

Finally I note Weinstein's comprehensive study of a large number of research projects regarding patients' attitudes about psychiatric hospitalization. He concludes that 78.9% of patients' attitudes are positive. In general patients considered their hospitalization helpful. The facilities were experienced as good. They generally did not feel restricted. The main reasons for hospitalization had been care and protection, and escape from daily stresses and conflicts with other people. The patients were not disappointed. Most interesting is also Weinstein's finding that neither social class nor level of education made any difference to this positive evaluation.[412] "The evidence indicates that the defenders of mental hospitals have more accurately portrayed the patients' point of view than the critics'."[413] I doubt that it is fair to draw this conclusion from the findings. The subjects of the research were people who had a psychiatric hospitalization in their past. They were dealing with the challenge of accepting what had happened after the fact and making the best of it, which may well have greatly influenced their judgment. Yet Weinstein's survey does clearly suggest that ex-psychiatric patients have a positive image of psychiatric hospitalization. It permits me to reach the important conclusion that it is a good thing that most of the people who have had such an experience can deal with it this way.

In summary, Szasz's viewpoint that psychiatrists are the ones who stigmatize their patients and that the Mental Hospitals are but prisons is remarkable. The image of psychiatric patients, held by themselves as well as by others, seems to be formed in a rather complicated way. It can be assumed that five factors in particular in varying degrees determine that image. Those factors are: becoming a psychiatric patient and the way in which it happens; being treated; the nature of the institution; the achieved level of (re)integration into society; and the presence of remaining symptoms of psychiatric disorder.

We can conclude from Szasz's work that not calling psychiatric disorders diseases provides little prospect for improving psychiatric patients' image. His position that psychiatric patients lose out at being treated, according to him, as inferior beings remains valid. He bases this on the fact that different laws have been legislated for them, that certain laws applying to everyone else no longer apply to them, that they can be detained even when (usually) not having committed any crime, that they are declared incompetent, and that they may lose their driver's license, their right to vote, and other civil rights. This problem will be discussed in Chapter VII as well.

....5. The Psychiatrist-Patient Relationship

Now the relationship between psychiatrists and patients in the framework of examination and treatment will be discussed. Here psychiatrists are in their primary role, primary in the sense that this role is the oldest, the main role, and the most important one. The roles of scientist and social arbitrator are spin-offs.

Szasz distinguishes the contractual psychiatric-patient relationship from the institutional one. I will discuss the former form first and afterwards some other aspects of relationships in psychiatry, keeping in mind the perspective of power and powerlessness. The institutional relationship will be discussed in Chapter VII.

Usually quite a bit has transpired before a person turns to a psychiatrist for help. First of all, the person has noticed that all sorts of things in life are no longer the way he would like them to be, that he is no longer able to do things that he is used to being able to do, and that all sorts of thoughts and feelings plague and impair him. He has sought explanations inside himself and possibly found some, but this did not bring about the hoped for relief. He has probably discussed it with other people but this too, did not help enough. He no longer succeeds at the things that he used to. Although there are all sorts of variations in this it usually takes a long time for a person to come to the decision to consult a psychiatrist, whether or not others have advised him to do so. Resistance against such a decision is high[414] although probably less today than in the past. As a rule such a person has already tried all sorts of things on his own. His unsuccessful attempts have repeatedly caused him feelings of powerlessness, helplessness, and inferiority.

This helplessness makes patients weak and psychiatrists, as people who may be able to achieve what patients could not, strong. When patients have more or less resisted contact with the psychiatrist and were finally pressured into it by others their position is possibly even weaker. Not only can those patients not solve their problems but they cannot even see them in focus or are afraid to see them and try to shelter themselves against them. The feeling of helplessness will be even stronger in a culture that values competence, self-reliance, and responsibility. Furthermore, there is the problem of saving face.

So the relationship with the helping professional begins with an inequality of power. Psychiatrists, as experts, are strong. Patients, helpless, are weak. In addition, patients need psychiatrists because they are in usually serious difficulties, and feel dependent on the psychiatrist for their solution. Psychiatrists need patients too, of course, as that is how they make their livings. But this need carries much less weight because every psychiatrist has many patients and his dependence on them is spread across this whole group. Additional reasons will be mentioned below. When psychiatrists are many and patients are few, psychiatrists' needs for patients are much more obvious.

So already at the beginning of the contact between psychiatrists and patients there is as a rule a clear imbalance. The former are independent while the latter are dependent on the other. The former are competent and the latter incompetent. It is not realistic to presume, as does Szasz, that these are two voluntary partners who agree on a contract in a symmetric relationship. In a more formal way, also, the relationship is asymmetric because psychiatrists can, for instance, prescribe medicines that patients cannot buy on their own, or can block access to certain services or treatments.[415]

Furthermore, a number of clear rules apply to the patient-psychiatrist relationship. For instance, patients have the right to discontinue the relationship any moment they wish whereas psychiatrists, once having accepted a patient, are obligated to carry out the pledged treatment. Psychiatrists are obligated to assist their patients as well as they can and know how while patients are obliged to see to it that the fees are paid. Finally, last but not least, there are rules that psychiatrists may not compel patients to do anything they do not want to (except for when the relationship is not voluntary which will be discussed in Chapter VII)

and they are obliged to observe confidentiality. In summary, the psychiatric relationship is asymmetrical with contractual aspects based on patients' hope and trust that their psychiatrist will offer the desired help.

Oddly, precisely this role of professional helper much more than the role of social arbitrator has become the subject of discussion and criticism. The problem posed in the criticism is patients' powerlessness and inability to judge whether they are receiving the best possible help. That is a call for inspection and regulation of psychiatry. In itself that is a fine thing. If such can be realized mistakes and bad decisions can be corrected which benefits both psychiatrists and patients.

All sorts of such regulatory measures have been invented and carried out. My position is that nearly all of these measures and developments *in this aspect* have a contrary effect and only make patients more powerless. I will list them briefly here, dividing them into the measures taken by psychiatrists themselves (1a-d), medical insurance providers (2), and the state (3).

1a. In an effort to improve treatments multi-disciplinary teams were formed. This development is to be applauded from the point of view that it is necessary to combine types of expertise. But it led and still leads to confusion about who is responsible and who should be addressed. "Democratization" of the multi-disciplinary team, so desired by the different members, puts patients under the care of a group instead of an individual. When a patient has a complaint it is he against a group instead of one on one. Leenen asserts that "the increase in the number of teams of professional helpers in health care fosters paternalism."[416] This risk is certainly present and reflects a shift in power to patients' detriment.

1b. This risk is especially present when a committee is charged with deciding on someone's suitability for a particular therapy. Although motivated to make a careful decision such a committee becomes an anonymous power that makes decisions about patients in their absence. Protesting such a decision becomes less possible the more experts participate in it.

1c. Another type of quality control is intervision. This is when colleagues discuss psychotherapies among themselves. This, too, is a double-edged sword. On the one hand there is the irrefutable advantage that psychotherapists can correct each other and point out matters that have escaped attention. On the other hand such a team serves as a backing for the psychotherapist, confirming his unquestionable authority.

1d. A similar situation occurs with intercollegiate examination. Here the risk is that it may cause an event to be incompletely reported and thus the examination may have to go much farther than strictly necessary for basing a decision. This risk is perhaps even more imminent in psychiatry than in somatic medicine. Furthermore, it is unclear how the person whose deficient treatment strategy has come to light will deal with such an experience. Among the possible responses are increased insecurity about his own functioning, feeling insulted, and anger. In itself that is not so terrible but in psychiatry, there is always the risk that tension or insecurity on the part of the therapist adversely affects treatment. This holds true as well for conflicts in the treatment teams. Perhaps it is advisable to caution that the effect of such conflicts is a reduction in the quality of care. The assumption that this *should* not occur is correct, but, I fear, unrealistic. Finally, intercollegiate examination may result in fewer risks being taken, a preference for trodden paths

rather than sticking out one's neck, and choosing routine procedures when a different one may be more risky but also potentially more effective. In psychiatry, due to the legal possibilities for involuntary measures, this can be especially risky and detrimental to the patient. Halleck poses that intercollegiate examination serves the interests of the profession at least as much as patients' interests.[417]

2. In the Netherlands providers of medical insurance are increasingly regulating treatments. The institutions that foot the bill wish to substantiate the necessity of in particular the more expensive treatments such as psychotherapy, and their quality. Therefore such treatments have to be requested separately by the therapist. The institution doing the regulating has to be supplied with information in order consider the request. One might wonder whether this does not excessively violate patients' privacy in spite of all parties' oath of confidentiality, so that here again patients' interests are jeopardized by regulation.[418] In addition, when the application is rejected, that is done by an institution which is anonymous to the patient without hearing his point of view.

It is doubtful that this measure affords protection for patients. Providers of medical insurance are preoccupied with financial aspects. Their involvement should be viewed in the context of spending the premiums paid by the insurers as responsibly as possible. This perspective inescapably influences their decisions. That is in fact as it should be. Mixing this aspect with regulation of providers of treatment (physicians, therapists, etc.) is, at least partly, inappropriate and detrimental to the interests of all parties.

Probably more important than the above is the development that providers of medical insurance and providers of treatment have become negotiating parties. The funding of treatment is done almost totally without patients' involvement. Patients often do not have the faintest inkling as to the cost of their treatment. This can cause a misplaced atmosphere of benevolence to exist in the therapeutic relationship as therapists offer treatment seemingly for free.

3. In the Netherlands the state increasingly intervenes in the physician-patient relationship. It does this, among other ways, by determining the social organization of the profession's work. It also does so by direct intervention in the content of matters such as the meaning, value, and restrictions of psychotherapy. Precisely psychotherapy is individualistic in the sense that more than any other type of psychiatric treatment it takes place in the privacy of the contact between the patient and his psychotherapist. It is difficult to avoid the impression that precisely this exclusive and private nature of therapy, in addition to its unfathomability for outsiders, is the provocation for violating the psychotherapeutic relationship and its premise of privacy. The inclination to regulate may well shake the pillars on which psychotherapy is built, bringing about its downfall, or compelling modifications which defeat the very purpose for which it came about[*]. For the sake of brevity I will not carry this further.

The state, too, tends to present itself as the patients' spokesperson and advocate. Again one must seriously wonder whether the state is capable of taking

[*] Two decades after the author wrote these words we know his prediction to be correct. – translator

on the role of patients' guardian without conflicts of interest in view of the state's other roles such as regulating the socio-economic aspects of helping professions and maintaining public order. Many people brush with psychiatry (partly) because the structure and order of our society poses problems for them. Precisely psychiatry, therefore, is in a certain opposition with the state which is ultimately responsible for this order. Szasz has correctly pointed this out time and again.

State policy aims among other things to create an efficient pattern of services. It achieves that at the expense of competition among psychiatrists and institutions due to their monopolistic positions. This lack of competition is disadvantageous in particular for patients who are rendered powerless by these monopolies. Any kind of conflict between patient and institution is likely to compel the patient to have to return to that same institution "tail between legs." These monopolistic positions are augmented even more by regionalization, another goal of state policy. Patients have less of a chance to use the facilities of regions other than where they happen to live.

The significance of the above comes into focus when it is realized that the number of different kinds of treatment within one institution is usually limited. Patients as a rule are treated with one of the methods that the particular institution happens to have on offer. It should be possible for patients who don't find any of the treatments on offer suitable to have the opportunity to seek a different psychiatrist or institution.

Another disadvantage of monopolization is that the mechanism of direct feedback on the quality of facilities' functioning is lost. As with everything the opinions of friends and acquaintances, or the experiences of the family doctor, help shape how patients feel about institutions. Monopolies of functions in the mental health service destroy this feedback. At the same time it drastically reduces patients' influence on the system.

Furthermore, by merging institutions, huge impersonal, anonymous, bureaucratic units are formed that leave dissatisfied patients with the "You can't fight city hall" feeling.

If in psychiatry diseases could be treated as though they are concrete facts, if psychiatrists had a large body of concrete knowledge making it possible to state directly and clearly what would be the right treatment, then this whole development would not be as dangerous as it is. But that is not what psychiatry is like in reality. Psychiatry desperately needs that feedback from patients. It can flourish only on a human scale. It is realized in interpersonal contacts in which an atmosphere of frankness, transparency, and trust are essential. The increasing power of psychiatry and increasing powerlessness of patients are alarming for both patients and psychiatry.

I wish to point out a special aspect of state intervention. The state aims to create a comprehensive system of services. That means that it must be accessible to everybody and offer solutions to all kinds of psychiatric problems. Everyone should have the right to be treated for every disorder. My position is that this is a dangerous illusion and that this political goal might lead to diametrically opposed results which would constitute a danger to people's health.

My arguments for this position are as follows. The state's goal, being a bureaucratic ideal described in detail, namely a closed circuit of facilities, is linked to a human and therefore fallible industry, namely the practice of psychiatry. This

is comparable to building a network of motor highways with the intention of having it traveled by horse-drawn covered wagons and expecting that the wagons will match the speed, comfort, and efficiency with which we associate highways. In other words, psychiatry as an applied science and helping profession is simply not developed enough to provide a satisfactory solution to every problem.

The role of helping professionals is to solve problems. That is what they expect and demand from themselves. Therefore the pressure to *do* something is always already greater than the pressure to do nothing in doubtful cases. This inclination will be even stronger when the helping professional is employed in an expensive chain of facilities which was erected apparently in the expectation that things have to happen. The former adage “When in doubt leave it out” has long been replaced with the attitude that it must be assumed that someone is ill and needs treatment unless the opposite has been proved.

Frances et at point out, “In actual practice, therapists tend to recommend treatment almost automatically and without a careful consideration of its necessity or possibly harmful effects.”[419] They note that little research has been done regarding disorders that do not respond to treatment, worsen when treated, or disappear without treatment. They recommend in difficult cases, “particularly in response to what is often a desperate or chaotic situation,” having the decision to refrain from treatment made by two psychiatrists. So deciding to refrain from treatment is as difficult as deciding on an invasive and risky therapy for which the same ethical code applies.

The closed system has the purpose of relieving need and thus must do that, for better or for worse. The highest authority must intervene when others know no solution. There is no place left in the system for doubt, powerlessness, or not knowing what to do. Doing nothing is impossible even when doing nothing would be preferable. The price paid for order is thus becoming very high.

As described above, all sorts of people and institutions present themselves as (uninvited) patient advocates and defenders of patients’ interests. Such a system raises the question, who regulates the regulators? This can set off the formation of another layer of “advocate” people and institutions. It was argued that this in fact only makes the patient more powerless. All these measures aimed at increasing patients’ power may achieve some reduction in the power imbalance. Although a thorough discussion of this would go beyond the scope of this book, I would like to make a few comments about it, disregarding legal aspects.

First of all, the imbalance of power can be limited by being aware of it. By this I mean that it is better to realize that this imbalance of power exists than to try to instill all sorts of manipulations in the hope of being able to eliminate the imbalance. Acknowledging the imbalance of power is a first step towards dealing with it.

Secondly, the imbalance of power can be limited by the nature of the helping professions themselves. In our pluriform society with its highly developed specializations it is not realistic to assume that anything a person cannot do for himself makes him less autonomous. Quite the contrary, using the abilities of another person to make headway in a problem experienced as insoluble may attest to responsibility. This does not mean that psychiatrists’ main role is solving their patients’ problems but that they should endeavor to increase their patients’

ability to solve their own problems. This can be done by teaching them skills or by finding and recognizing the obstacles that make people powerless in certain situations. Ruddick sketches the therapeutic relationship as that between a worker (psychiatrist) and a colleague (patient). In this case the latter can insist on thorough information and discussion of alternative possibilities with all their limitations so that they are sharing not only the decisions but also their implementation.[420] Ruddick's model fits well into a biopsychosocial disease concept and provides opportunities for helping professions that attempt to minimize patients' powerlessness.

Thirdly, patients' dependence and powerlessness can be diminished by enlarging their competence, and that in turn can be done by increasing their knowledge. Although a great deal of lip service has been given to health education, dealing with illness and health is so important that it is worth considering granting it more attention as a subject taught in schools. Everybody will be faced with illness sooner or later so it is important for everybody to know more about it. Once a person has accepted the sick role, thorough information, not only about what is wrong and what is likely to happen, but also about his rights and responsibilities, is very important. Here too, however, one must wonder how much formalizing rules about so-called "informed consent" will actually benefit patients.[421]

Fourthly, it seems of utmost importance to me that the psychiatrist-patient relationship remains as transparent as possible to the latter in the sense that the therapist's task must be clear and unambiguous. By that I mean that it is essential that the therapist does not take conflicting roles upon himself. In the Netherlands medicine is featured in this way by the happy circumstance that treatment and regulation are separate. That has recently been confirmed by the Royal Dutch Society for the Advancement of Medicine.[422] This means that psychiatrists can concentrate on treatment and do not have to be preoccupied with all sorts of interests that are not directly related to it. It also means that they cannot be authorities in addition to their therapeutic activities, with the power to grant or refuse all sorts of matters except as are directly related to the therapy. The interests of therapy and therapeutic relationships come first. Within psychiatry a splitting of tasks can be wise as well. An example is psychotherapy. Patients are asked to reveal their thoughts with as little censure as possible. To render the situation as safe as possible, psychotherapists specifically accept an obligation of confidentiality. For patients to be as independent as possible no advice, declarations, or medicines are provided. Limitation of the realm of what is to be done makes it possible to concentrate on the psychotherapy. If at a certain point it becomes necessary to prescribe medication after all, a different therapist can be involved for that. By limiting the role of both therapists, maximal transparency in both relationships becomes possible.

Fifthly, both psychiatrists and patients should realize that every person has an intrinsic and unalienable responsibility for his own life; that no other person can take on this responsibility; and that it is up to the person himself what will become of his life. This is not an appeal for some kind of hyper-individualism. It is an observation that people cannot relinquish responsibility for their own lives without drastic consequences for their future prospects. No matter how sincerely ideologies, systems, and religions promise people happiness and so forth when

they place their trust in them, no matter how heavy a burden responsibility for one's own life is (see Chapter III, 2.5), every alternative is worse.

Sixthly, there is an important role to be played by patients' organizations, helping those people who cannot hold their own in the system of helping professions, and letting the helping professions know when they make people more powerless than necessary.

Finally, in his contractual relations with patients, Szasz limits himself to "just talking." He rejects all sorts of methods that in his opinion violate personal dignity. He never prescribes psychiatric drugs.[423] Seidenburg reveals that Szasz condemns group therapy, marriage counseling, and the use of tape recorders, videos recorders, and one-way mirrors.[424] These means and methods do not strike me as violating a contractual relationship nor interfering with cooperation between psychiatrists and patients as long as they are not used against patients' wishes. On the contrary, group therapy and marriage or family counseling can be extremely successful forms of therapy. As to psychiatric drugs, when someone is so anxious that he can hardly think about himself and his problems, and if I know that he will be much better able to do so if he temporarily uses an anxiolytic, I do not see how it could be humiliating or insulting if I point this possibility out to him. This would be applying a mixed, causal and hermeneutical approach.[425] Moreover, in case of a person with a manic-depressive psychosis I would consider it negligent of the psychiatrist not to point out the possibility of using lithium preparations to his patient. It is impossible to place these medicines in a hermeneutical framework. They can be applied only in a causal-analytical framework, whereas Szasz disputes the validity of a causal-analytical framework in psychiatry.

Tape recorders, video recorders, and one-way mirrors are aids that are employed in certain therapies. They can be useful. They should never be used without patients' specific knowledge and consent. I do not see any reason not to use them as long as the patient has given his "informed consent."

In summary, the therapeutic relationship between psychiatrists and patients is an asymmetric contractual relationship based on, and existing only due to, patients' hope and trust that their psychiatrists can provide the help they want. It is of utmost importance to recognize and acknowledge the imbalance of power in this relationship, to not make it any larger than it already is, and to reduce it as much as possible.

It has been argued that in this aspect current developments in mental health care in the Netherlands forebode worse to come. External measures for regulating therapists have effects diametrically opposed to their purpose. Therefore I propose finding ways of making patients more expert and powerful.

Finally, the boundaries of what is possible and admissible in therapeutic contractual relationships can and must be taken more broadly than does Szasz, and should be determined by that with which patients, having been informed, can voluntarily cooperate.

...6. Closing Remarks

When they are "brought to life" by looking at what they are like in practice for patients, psychiatrists, and other therapists, comparing biomedical and biopsychosocial disease concepts in psychiatry results in the following image.

Due to the enormous development of expertise and skills the biomedical disease concept has become a territorial disease concept. In this territory only physicians understand the secret jargon and only they are qualified and skilled. This conceptualization has led to large medical successes. Physicians became professionals. The territorial features of this disease concept and the professionalization of physicians augmented each other until physicians became the exclusive experts on disease. Disease became so synonymous to organic aberration that the concept became more and more reified.

Psychiatrists' main dilemma as helping professionals is whether they should assume that disorders are things that their patients have and are beyond their own control, or that patients can influence their disorders by changing or actively accepting the challenge to change. The idea that people cannot be held responsible for their illnesses, and so also not for their psychiatric disorders, liberates them from responsibility and thus also from blame. It also tempts them to assume a passive attitude towards the helping professional.

In general it can be said that taking responsibility for what one makes of his life and thus also for the hermeneutical aspects of a psychiatric disorder is essential for self-realization. Therefore confronting patients with the fact that they are the one and only person responsible for what they make of their lives is essential to psychiatric therapy. Only when patients' powerlessness and helplessness is so obvious that their therapist shares their conviction that they are really not capable of changing the situation is acceptance of this helplessness inescapable and proper. In these situations, too, the challenge to confront people with their co-responsibility for the future remains.

Several rights and obligations of sick people have developed in the sick role: the privilege of not having to fulfill daily duties and responsibilities in addition to the moral obligation of calling in medical assistance and behaving according to the physician's advice. Dependence on the physician is more or less a clear factor in the sick role too. The attractive perspectives of the sick role necessitate limiting citizens' self-determination in this aspect. Physicians took the role of referee upon themselves. Who else would do it? After all, are not they the only ones who have the expertise? So in addition to their role as therapists, physicians took the role of social arbitrator upon themselves. This role gradually became more important as the question of illness became increasingly central to social developments and decisions. I offered the example of granting or refusing abortion. Other examples are granting declarations of urgency for dwellings[*] and psychiatric evaluations for trials. Further reification of the disease concept was unavoidable for these purposes.

Other recent developments are increasing state intervention with the organization of health care. On the one hand this has regulated, and so limited

[*] In the Netherlands the allocation of "affordable" housing is strictly regulated by state and local government. – translator

the power of the medical industry. On the other hand, that which the state supports can count on its backing. Mega-institutions, regionalization, uniformity, and bureaucratization have made their inroads. Competition and direct feedback on the functioning of facilities are suppressed. Augmented stated influence has made physicians' loyalty to the state an existential necessity, even when such loyalty conflicts with felt loyalty to patients. Psychotherapists hardly seem to object to obligatory evaluative reports that crack open the absolute confidentiality of psychotherapy. By threatening to withhold payment it is possible to compel psychiatrists and other therapists to reveal information about their patients, which compromises the oath of confidentiality. This is one reason that the state, the institutions that pay, and physicians are involved in increasingly intensive negotiations. Patients are scarcely a party to these negotiations.

Psychiatrists' loyalty has become increasingly divided. In addition to the primary loyalty to the patient there are loyalties to other members of the therapeutic team, the institution of employment, medical insurance, and the state. This has happened without consideration of what would happen when these loyalties conflict.

In addition to describing disease as a theoretical and scientific concept these developments make it necessary to consider three adjacent definitions of illness:

- a form of human misery arising from physicians' professionalization;
- a form of human misery imparting a social role entailing privileges and obligations;
- a from of human misery that gave rise to the social institution of health care which can be characterized as a medical-industrial complex, a definition derived from the fact that health care has developed into a powerful social institution.

This entire development is based on the idea that disease is an existential fact which can be clearly and concretely demonstrated and demarcated, in short, a scientific fact. This premise on which health care is founded is, however, not solid. While the developments sketched above demanded "harder" definitions of being sick, the biomedical disease concept was found to present so many objections, and to correspond so poorly to the reality of being ill, that it became necessary to seek alternative concepts. The biomedical concept can be fruitfully applied as a sub-concept in specialist somatic medicine. Its absoluteness is untenable in family medicine and psychiatry. Although the entire system of health care as set up and regulated by the state is based on the biomedical disease concept, in practice in family medicine and psychiatryit has been largely abandoned already.

In the development sketched above psychiatrists' role as therapists, made difficult as it is by the problems that being psychiatrically ill poses, is sketched as an authentic medical role, even though there are all kinds of gradual differences from other branches of medicine. The role of social arbitrator poses concern because moral and political considerations are unavoidable. Psychiatrists' conceptualization of illness cannot be made to fit the standard of large-scale, bureaucratic health care.

The biopsychosocial disease concept is broader and can therefore be less easily reified as a disease concept. It is irreconcilable with an exclusive territory

for physicians. It assigns a place for patients as experts on their own health. It returns to disease its just nature as a value concept. It offers the opportunity of a health care which is humane in addition to technologically developed. It reflects reality better than the biomedical disease concept. But it is not possible to accept this disease concept and at the same time act as though diseases are proven facts in the sense of the biomedical disease concept.

This is all the more significant in psychiatry because psychiatry has social functions in addition to therapeutic functions. The seriousness and admissibility of decisions as opposed to the scant accurate formulation of the grounds on which those decisions are made – namely the conceptualization of what psychiatric disorders are – is perhaps most noticeable when carrying out laws that are based on psychiatric insights. This problem will be discussed in Chapter VII.

■■Chapter VII Psychiatry and Coercion

...1. Introduction

In Chapter VI a number of elements related to stigmatization were mentioned as well as rendering people in the role of psychiatric patient powerless, whether they accepted that role voluntarily or had it imposed upon them. This chapter is about coercion and psychiatry, about laws that can cause people to be compelled to things they do not want, and that formally revoke civil rights on the basis of psychiatric justification.

Szasz takes a fundamental and deontological stand: as freedom and autonomy are values that are to be regarded more highly than health, intervening in someone's life against his wishes or deciding about the person without consulting him on grounds of a medical-psychiatric argument, is never admissible or justifiable. In this chapter I intend to discuss this position at a theoretical as well as practical level and to examine the problems that arise more closely.

In this discussion I will limit myself to what for Szasz is the epitome of coercion in psychiatry, the involuntary commitment to a psychiatric hospital (3).

First, however, I will discuss some considerations of principle regarding the concept of psychiatric disorders and their relation to competency as these are consequential for the relationship between psychiatric disorders and legal measures (2).

...2. Some General Premises

....2.1 Law and the Concept of Psychiatric Disorder

When the presence of a psychiatric disorder is the reason for applying the law differently to a particular person or applying different laws it must be assumed that the concept of psychiatric disorder warrants such. This assumption is justified only when two conditions are met. The first condition is that the nature and seriousness of the psychiatric disorder can be reliably determined, including a reliable prognosis. The second condition is that the theories and explanations which impart meaning to the psychiatric disorder can provide reasonably definite answers to questions that are asked in a legal framework.

Regarding the first condition, in Chapter V psychiatric disorders were found to be empirically anchored in disorders in which the range of behaviors and experiences is limited and stereotypical. However, determining the presence, nature, and prognosis of such disorders is barely reliable. It is in itself difficult to indicate just how much certainty is minimally necessary for the purpose of a legal hearing. If the degree of certainty required for proving that a crime has been committed – and that would seem reasonable in cases where the presence or

absence of a psychiatric disorder has a decisive influence on the ruling – is the standard, then it can be affirmed that such is not attainable in psychiatric diagnostics.[426] Evaluations by different, impartial experts could augment certainty in those cases that their opinions are unanimous, but if they differ, they will only augment uncertainty. Experience in the United States suggests that the latter will often be the case. That alone is enough reason to advocate evaluations by two psychiatrists independently from each other in cases that involve important legal decisions.

The question of the reliability of psychiatric diagnoses and prognoses at the level of practical arguments consistently returns in this chapter. At a theoretical level that reliability, except for in the most blatant of cases, cannot be considered adequate for this purpose. Not only is predictive validity scant in psychiatry but the reliability of the information which the person involved transmits to the psychiatrist is extremely difficult to assess when there is not full cooperation between the person and the psychiatrist, as was observed in chapter V, 3.4.3. This affects the reliability of conclusions drawn from such findings as well.

As to the second condition, in chapter VI the basic theory to which a particular therapist subscribes was found to heavily influence his notion of the restriction of freedom and autonomy. Based on views of varied fecundity the emphasis in some cases is put on circumstances that exculpate the patient while in other cases it is put on the justification of providing opportunities for the patient (and others). How these explanatory theories compare with the truth can after all not be scientifically solved. In therapy this question is ultimately less important than the fecundity of the views: utility, purpose, and fecundity determine their legitimacy.

So in treating psychiatric disorders the ultimate question is not whether these theories are true in an ontological sense nor whether liberty and autonomy are truly restricted in an existential sense. The point is whether it is true in a practical, operational sense, and in what way the patient can be held responsible so as to provide him with an optimal opportunity to recover from his illness. This does not mean that I advocate the view that explanatory theories are exclusively opportunistic. Every such theory attempts to reconstruct reality as well as possible. This holds true for legal explanatory theories as well as psychiatric ones. A theory is meaningful when it provides understanding of events and thus a basis for an effective approach.

The converse can be asked as well. Does the fact that a certain therapy is effective prove that the theory on which the therapy is based conveys reality? There are at least two possible answers. A particular treatment may succeed because it renders a part of the reality of a person's problems and existence visible and unveiling that reality heals. But a treatment may also succeed for instance because it is effective in stimulating the person to change, because it poses a challenge which the person cannot (or does not want to) resist. In that case the explanatory theory would be functioning as a "stimulation strategy." The treatment works "finally" and not "causally." So-called paradoxical therapies even base themselves on this principle. Furlong contends that Gestalt therapy, transactional analysis, and Janov's "primal scream" therapy work because they offer patients handy frameworks of explanation for their disorders. By providing insight into matters feelings of helplessness are converted to comprehension,

returning patients' power over the situation.[427] In an essay about psychoanalytic theory Haley claims that this therapy works by placing the patient "one down."[428] Many more such examples could be listed. The point is that the enigma of whether explanatory theories in psychiatry, inasmuch as they are applicable to therapy, are effective because they are correct and reflect man as he really is, or whether their value is determined by the insight they make possible and their utility as forms of treatment, is unsolved and in principle insoluble.

In itself this may be a relatively academic question. It turns into a most pressing question as soon as such a theory is lifted out of the context in which it was developed and in which it is useful and valid. Psychiatric theories are intended for and usable in the context of diagnoses and treatments. This means that psychiatrists' ideas about psychiatric disorders are determined and directed by this context. The value these theories have outside this context is unclear. It also means that using psychiatric theories of explanation in a legal context is not legitimate unless such "transposition" has been found to be admissible. In Chapter VI, 5 it was argued that the therapeutic relationship between psychiatrists and patients is marked by patients' voluntariness, cooperation, and trust in their psychiatrist, making it an asymmetric contractual relationship. This moral context is essential for fairly all hermeneutical explanatory theories in psychiatry. At the same time it is essentially different from the moral context in legal matters in which there generally is neither voluntariness nor a contractual relationship between the judge and the person appearing before him. Szasz's insistence on this is an important accomplishment. He has demonstrated that "transposing" psychiatric explanatory theories to a legal context is in principle inadmissible.

....2.2. Law, Psychiatric Disorders, and Free Will

There is a second fundamental problem with basing the ethic of coercion on the existence of a psychiatric disorder. The premise that makes social organization possible and is cardinal to every social structure is that every person is responsible for his actions. Without this principle no transaction, no agreement, no obligation would be possible. To what extent this principle can be based on the liberty and responsibility that are intrinsic to human existence in an ontological sense remains arguable. However, it is not necessarily pertinent. Accountability for actions and inactions is a social contract that applies equally to every citizen. Empirically it enables society to function.

There are a number of situations in which a person is alive but does not act. These situations such as coma or sleep exculpate a person for things at which he was present and which he could have influenced or prevented had he been conscious, as it is accepted that in such a state he is unable to act. Should the behavior of a person who is considered psychiatrically disordered be classified with coma or with behavior for which a person is responsible? His behavior apparently has commonality with both. Yet the distinction between willed behavior and behavior that is beyond one's control is extremely important. The line between these two is fundamental but not clearly identifiable. The position that a

person in coma is incapable of action is not an absolute but an empirical certainty.

In a scientific-theoretical sense it can never be *certain* whether someone fails to perform a certain action of which he is potentially capable because he does not want to or because he cannot. Only an empirical certainty is operative here. Sometimes it is large. More often it is little.

This basic inability, in a scientific-theoretical sense, to distinguish lack of will from lack of power is a troublesome problem in psychiatry as a helping profession. But it is not insurmountable as long as the patient has voluntarily entered into the contact with the psychiatrist. When someone wants to be helped the therapist can generally depend on the patient's relating his feelings and experiences to the best of his ability. If the patient does not he is mainly harming himself. A much more difficult situation arises when the patient's contact with the psychiatrist is aimed at seeking certain advantages such as gaining the status of the sick role. Very difficult indeed is the situation that the patient explicitly expresses the desire to have no contact with the psychiatrist and wishes no treatment or other intervention. But even in this last situation a pronouncement may not be impossible as long as the patient's behavior can be observed, although certainty declines, the risk of error rises, and the pronouncement can be only indirectly substantiated. Finally, most uncertain is an evaluation that has to be made on the basis of information from a third party. Yet even then the pronouncement is not impossible and in the odd case even possible with a certain confidence.

In other words, even when the constriction and stereotypy of a person's repertoire of behavior makes loss of autonomy highly likely there is never absolute certainty but a varying degree of empirical certainty that it is related to the person's inability or lack of desire to act differently.

One not infrequent suggestion in psychiatry is that patients refrain from certain behaviors because of anxiety. Although in the practice of daily life this is generally a useful supposition it could be pointed out that human freedom manifests itself precisely in "rowing against the current," by doing what one does not dare do, rather than by obeying the general rule that people refrain from doing what they do not dare do. When, after involuntary hospitalization, an ex-psychiatric patient proclaims to feel much better and be grateful in retrospect for the intervention this can be considered an indication, but not valid proof, of the patient's earlier powerlessness. Abductions and concentration camps have shown that even during a brief isolation with and by an aggressor the seized person may develop a strong inclination to identify with that aggressor and adopt the aggressor's opinions. I do not mean to imply a correlation between the way people are treated in psychiatric hospitals and the way they are treated in concentration camps or when they are taken hostage. I mean that from the moment patients are hospitalized they are surrounded by people who are *all* convinced of the patients' being ill and their lack of insight into that illness, and who all consider normal what to patients is incomprehensible and vice versa.[429]

There are patients, a clear example being those who are involuntarily committed with a bipolar disorder, who are treated with lithium, and after release continue to take the prescribed medication loyally. In short, they appear quite pleased with the course of the treatment. In contrast there are patients who were

psychotic when involuntarily committed and whose behavior was normalized with psychiatric drugs, yet upon release they stop taking them. Apparently these people prefer being psychotic to being adjusted with medication. These people live unenviable, often quite horrible lives. Yet they behave as though they prefer that to the adjusted existence which is so much more attractive to others. Is that truly a choice or an inability to choose? No ontologically objective answer to that question is possible.

In summary, in psychiatry, it is ontologically impossible to know for sure whether a person does not want to or cannot do something. The notion of restriction of freedom and autonomy in a theoretical-scientific and conceptual way can be included in the definition of psychiatric disorders without objection provided the application of this notion is confined to an area not requiring certainty about whether the observed unfreedom is "chosen" or "compelled." That area is voluntary therapy. When "patients" experience themselves as not ill and insist that they behave as they do of their own free will, determining a psychiatric disorder is typologically possible though with less certainty. However, the matter of restriction of freedom and autonomy cannot really be determined because when the person does not experience it or claims not to, the possibility of a certain freedom of choice existing in the displayed behavior can never be ruled out. It is precisely in situations that feature this dilemma that coercion and legal measures are pertinent. At this point the question of freedom and unfreedom unavoidably assumes a decisive significance. At the same time it is a question that psychiatry can answer typologically but not in principle.

...3. Involuntary Commitment to a Psychiatric Hospital

Involuntary commitment to a psychiatric hospital is a legal and psychiatric measure intended to prevent a person with a psychiatric disorder from endangering himself or others or disturbing public order and safety. It is a consistently occurring theme in Szasz's work. Not only does he condemn the event in itself, but to him it is the paradigmatic example of coercion and deprivation of liberty in psychiatry. Szasz categorically objects to every involuntary commitment. To him there is only *one* valid reason to deprive a person of liberty, namely, having committed a crime for which the person was sentenced to a prison term.

So Szasz opposes the virtually world-wide custom of committing psychiatrically disordered people against their wishes. Curran and Harding relate that formalized legal proceedings do not exist everywhere and that there are many different criteria for involuntary commitment.[430] Accordingly the percentage of voluntary admittances ranges between the extremes of 0 and 100%. However, such statistics should be interpreted with great caution as the ways the facts are collected and the ways voluntariness is defined vary enormously. A few premises regarding involuntary commitment are fairly generally endorsed according to Curran and Harding. Firstly, there is a desire for as much parity as possible with other psychiatric patients in order to avoid stigmatization. Secondly, the involuntary commitment is viewed as a last resort or emergency which is considered only when all other solutions have proven impossible.

In medicine the presence of illness on its own is hardly ever a reason for taking legal measures. This is possibly the most suitable fact on which to base a discussion on involuntary commitment. The legal measures that are taken regarding some illnesses are linked to the fact that those illnesses present risks to the health of the community. These risks justify isolating the sufferers of such diseases that are dangerous for others as well.

In the Netherlands there is an obligation to immediately report some infectious diseases, the so-called A diseases, to the authorities as soon as they are suspected. The most well-known of these is typhoid fever of which an average of 36 cases per year were reported in the period 1970 - 1979. Immediate action such as quarantine for the purpose of guarding the health of the community can be taken only regarding A diseases.[431]

Psychiatric disorders are comparable in the sense that involuntary commitment is a last-ditch measure when the psychiatric disorder manifests itself as behaviors that are risky to the patient and others. Current law in the Netherlands has two procedures for that called court power of attorney and guard order. A court power of attorney can be issued when “definite placing of an insane person in a psychiatric institution whether in the interest of public order or the sufferer himself is required.” A guard order is applied “when there is serious suspicion that a person presents such an immediate threat to himself, to others, or to the public order due to insanity, that placing the person in a psychiatric institution cannot be postponed until there is court ruling.”

In 1980 there were 21,254 patients in psychiatric hospitals in the Netherlands. Of those, 11,434 were women and 9,820 were men. Of these 88% were voluntary patients. The other 12%, that is 2,550 people, were in the hospitals involuntarily. The number of *admittances* in 1980 were 20,163; 10,581 women and 9,582 men. Of these, 15.5%, that is 3,125 people, were committed involuntarily. The number of guard orders (emergency hospitalizations) was about double the number of court powers of attorney in 1980. The numbers were similar in 1977 and 1978.[432]

In 1970 the number of involuntary commitments involved 2,781 people which was 25% of the total. The *number* of involuntary commitments remained fairly stable between 1970 and 1980, around 2,800 to 3,000 per year. The *percentage* of involuntary commitments dropped to circa 15% in that period. This decline is to be ascribed to the rise in voluntary admittances. It is noteworthy that in 1974 nearly 75% of the people committed with a guard order continued to remain in the psychiatric hospital voluntarily for some time after the guard order had expired.[433] The percentage of involuntary commitments in the United States was consistently somewhat higher. For instance in 1974 it was 42% of all admittances to Mental Hospitals.[434] In England and Wales it was lower, for instance in 1979 it was 10% of all admittances.[435]

There are clear differences between laws regarding involuntary commitment of people with physical and psychiatric disorders. The first is that the risk of infectious disease has to be very high and must pose a danger to large numbers of people before involuntary commitment can be considered. In psychiatric disorders posing a danger to *one* person suffices, and even that is not essential

because the danger to public order and safety is not necessarily a danger for one or more persons. A second difference is that in infectious diseases the danger is posed by the germ. In psychiatric disorders it is the patient himself. The terminology is sometimes confusing however. After all, disordered behavior that is dangerous is a manifestation, a symptom of a disorder which can often be described only as a disorder of behavior. Often the dangerous behavior is considered the result, or even the product, of a psychiatric disorder, as in the Durham Rule in the United States. (See Chapter I, 6.1.) That is not logical. Something cannot be its own cause.

In accordance with these differences involuntary commitment of sufferers of A diseases is extremely rare. Another reason is that the sufferer will usually be happy to cooperate. In contrast the involuntary commitment of people with psychiatric disorders is a commonplace event in our society.

Involuntary commitment is an invasive social event for the person involved that must be ethically justified.[436] Szasz adopts a deontological viewpoint regarding this justification: there is no ethical justification whatsoever for depriving of liberty a person who has not violated the law.[437] Furthermore, in general, the risk that a crime may be committed is not a justification for removing a person from society. If this last postulation is correct then it is also not justified when risky behavior can be conceptualized as a psychiatric disorder. This concept is so vague that the only result of such a procedure can be unsurveyable arbitrariness and legal inequality, according to Szasz. With this Szasz has posed a serious dilemma. When one does not follow Szasz in his views that psychiatric disorders are not diseases the dilemma becomes even greater. It can be formulated like this: How, in a society that considers preventive detention categorically inadmissible, can detention of people who display ominous behaviors that can be interpreted as psychiatric disorders be ethically justified? This question is the point of departure in the argumentation below.

....3.1. Justification of Involuntary Psychiatric Commitment

Traditionally, involuntary commitment is a type of social intervention involving both psychiatrists and judges. The combination of these two areas of expertise has been rather variable. At one extreme was a fairly exclusive involvement of psychiatrists, perhaps combined with judicial rulings that routinely underwrote psychiatric opinion and empowered psychiatrists to act accordingly. At the other extreme were fairly exclusive legal procedures to which psychiatrists contributed only elements on which to base rulings.

Jones compared psychiatric and judicial attitudes. Generally speaking she found several typical differences. Judges want concrete and clear answers to questions as: Does the person have a psychiatric disorder? Is the person competent? Is he dangerous? If so what is that danger and how large is the risk? Psychiatrists can answer only vaguely and with restrictions. “Almost anybody is capable of almost anything.” Law is normative, setting rules as clearly as possible. Mental health more closely resembles an undefinable ideal than a norm. Judges’ thinking is routine, psychiatrists’ individualistic. Judges aim to pronounce

a judgment, psychiatrists to comprehend. The legal model is optimistic in the sense that it presupposes that everybody can, with a little luck, comply with the law. The psychiatric model is pessimistic because mental health is an ideal that is difficult to realize.[438] It seems to me that one of the prime differences is that psychiatric theory was not designed to judge competency or responsibility but to form a basis for decisions on treatment. “Treatment” in psychiatry is totally different from “treatment” in law.

Jones further notes that judges and psychiatrists share a high regard for human liberty and dignity. However these are “ideals which the legal system and the mental health system do not greatly support in our prisons and mental hospitals.”

Finally, Jones posits that psychiatrists and judges are inclined to stereotype and denounce each other’s professions, which was amply proven by the tumultuous discussion that followed her speech in Oxford, from which above I have taken some excerpts.

How is involuntary commitment justified from psychiatric and legal perspectives?

From a *psychiatric perspective*, involuntary commitment is usually justified because it is considered to be in patients’ interest. The idea is that precisely due to patients’ disorders they cannot effectively evaluate their own situations nor view their own realities. An example is the man with the delusion of sin who refuses hospitalization because he considers himself too evil to be worth anyone going to any trouble for him. Another argument is that certain patients are socially destroying themselves and in no-time are estranging themselves from all of their acquaintances. This may occur expecially among manic patients. Sometimes patients’ inability to care for themselves is emphasized or their inability to defend their own interests. Psychotics are not infrequently presumed incapable of asking for help although they presumably could if they wanted to.[439] Threatening suicide or violence against others is also sometimes considered a valid reason. Generally: there is disease. Due to this disease either the ability to see reality as it is, the ability to correctly evaluate one’s own situation, or the ability to choose is afflicted. The degree of affliction is so grave as to oblige others to assume responsibility in order to protect the ill person against himself. So involuntary commitment becomes a measure for protecting patients meant to ease their suffering and protect them against themselves. A further goal is to enlarge their ability to evaluate their own situation and restore their ability to make free choices. On the side, note the paradox. People must be detained, thus lose their liberty, because they have already lost their liberty according to those who detain them. To regain their liberty they must be subjected to involuntary treatment, thus unfreedom. This paradox is in principle not insoluble because the liberty granted or denied patients by others is always a different type of liberty than their own existential freedom. The latter can be granted to them by no one. Only patients themselves can master such freedom, often with difficulty, when others do not hinder them. Not only is the goal of involuntary commitment to provide treatment, involuntarily if necessary, but that is its moral obligation.[440] There are of course all kinds of nuances in this point of view which Van de Klippe calls “the best interests viewpoint.”[441] The basic idea is that people risk serious harm because that part of

them which could protect them from that harm is damaged. Also extremely significant is the idea that treatment can prevent a great deal of suffering.[442]

In contrast, from a *legal perspective* the emphasis for justification is on the danger posed by said people. This can be a danger posed to the public order or safety or to the life of the person himself or others. Society rather than the individual is the main focus of concern. Involuntary commitment can be considered a certain kind of preventive detention.[443] The environment must be protected from these dangerous people and perhaps they must be protected from themselves. This "danger" criterion evokes the need to detain such people and prevent them from remaining dangerous. But they should be deprived of liberty only the necessary minimum. So they should be able to decide themselves whether or not they wish to be treated.[444] In practice, in the Netherlands, a line is drawn here. The Dutch supreme court ruled that physical measures, including coerced medication, to involuntarily committed patients are admissible only when there is no other possibility to stem serious dangers, in particular towards other patients, arising from a disorder of the mental faculties.[445] In reality in such cases there is (medical) influencing of danger rather than medical treatment. A commission on psychiatric patients' rights recommended permitting involuntary treatment only in patients who due to their psychological situation pose an immediate danger for their own lives or those of others, or of disabling themselves or others, or to prevent their regression when they have a serious psychiatric disorder that could cause severe disability or death.[446] What should happen to people who are involuntarily committed, refuse treatment, and therefore do not belong in a psychiatric hospital, which is a treatment center?[447] As far as I know this question has never been answered. Schultz described how the right to refuse medication led to patients' clinical regression, increased aggressiveness, increased need to isolate those patients, and the quitting of staff who could not bear to see the regression of untreated patients.[448] The dilemma of the right to treatment and the right to refuse treatment reflects the respective psychiatric and legal perspectives.[449]

The danger criterion is in itself not enough. The danger must be related to the existence of a psychiatric disorder.[450] After all, considering someone dangerous when he has not (yet) committed a crime is in general insufficient reason for preventive detention. Also here it is essential that both a psychiatric disorder be present and the likelihood that that psychiatric disorder and the dangerousness are linked.

There is an obvious incongruity between these two perspectives. The best-interests viewpoint focuses on patients' interests as defined by psychiatrists. The dangerousness viewpoint focuses on the rights of individuals and the community[451] and the interests of society. Although the polarity of both types of interests as Szasz maintains seems to me to inadequately accommodate the area where the interests of individuals and society parallel each other, equating them insufficiently accommodates the area where they conflict each other. Furthermore, the best-interests viewpoint aims to prevent human misery, which means that in particular those people who have something that "overwhelms" them and that jeopardizes their relationships, their social position, and their future prospects, must be guarded against themselves. I would like to mention the

manic syndrome as archetypal of such a hazard. The dangerousness viewpoint aims to reduce harm to others. This means that those people for whom the best-interests viewpoint dictates swift intervention such intervention can take place only at a very late stage, when the harm to them is already far advanced. The justification for speedy intervention increases as treatment methods improve. An example is manic syndrome which can be influenced with medication. The improvement of treatment methods is much less relevant to the dangerousness viewpoint. If something should be "treated" that something is the dangerousness, not the disorder, as such people should be released as soon as the dangerousness has passed.

The dangerousness viewpoint is ambiguous. If potentially dangerous people are divided into two groups, those who are psychiatrically disordered and those who are normal, then according to the dangerousness viewpoint involuntary commitment is admissible only for the group that is psychiatrically disordered. The premise is that psychiatric disorders can turn people into beings who cannot be held responsible for their behavior because the ability to evaluate their own situation and make choices among alternatives is disordered. But if that is so it is not rational to respect such people's "free will" as to whether or not treatment is administered for that disorder. Furthermore, if indeed that is the meaning of psychiatric disorder why wait for dangerousness? Is it not an ethical and moral obligation to help these people as one would reach out to a drowning person who cannot swim? If the premises regarding psychiatric disorders and non-responsibility are correct what is the justification for not intervening as soon as a person with such a psychiatric disorder is encountered? It seems to me that this ambiguity again illustrates the dilemma that the concept of psychiatric disorders does not include a pronouncement about (non-)responsibility. (See 2.1.) The dangerousness viewpoint is inconsistent in that it holds people not responsible when dictating repressive consequences but responsible regarding therapeutic consequences. Or vice versa: if the concept of psychiatric disorder is too limited to be a basis for deciding that someone cannot be held responsible as a social reality then the group of dangerous people with psychiatric disorders should be treated the same as the group of people without psychiatric disorders.

....3.2. Predicting Danger

3.2.1. Predicting Danger to Others

In psychiatry danger means that a psychiatric disorder can cause risks and complications and that people can get into trouble because of their impulsive decisions or actions. Such a danger can be, for instance, that someone resigns from his job without due consideration and without having arranged alternative income. So it does not have to be a danger in the legal sense of the word. The concept of danger in psychiatry is more vague and less narrowly demarcated. Judges approach it differently. They want to know exactly which danger is posed, how serious it is, how likely, how imminent, how acute the hazard is, and how likely it is to recur.[452] Below I will examine more closely this legal view of danger as the problems that arise in predicting it are extraordinarily large.

A first problem, pointed out by Stone who was quoting Livermore, is statistical. The lower the incidence of a certain event in a certain population the less accurately can the cases in which it will occur be predicted. Livermore offers the following figures: when the method of prediction has a 95% accuracy rate, and, say, among 100,000 people 100 can be found to be dangerous, then 95 of these 100 people can be correctly identified and 5 will be incorrectly identified as dangerous. Of the remaining 99,900 people, however, another 5%, that is 4,995, will be wrongly identified as dangerous. This means that in order to lock up 95 dangerous people 4,995 people who are not dangerous will have to be locked up as well.[453] In reality the situation is much more serious as dangerousness is not predictable with reasonable reliability and the error margins are probably much higher. Stone for instance also refers to research by Kozel et al regarding 31 perpetrators of sex crimes who were released against the advice of psychiatrists. Twelve of them (38%) repeated the offense. That means that the other nineteen (62%) were unjustly considered dangerous. The same research by Kozel et al reports that of 304 people released from an institution 26 (8.6%) repeated the offense. So prediction has a statistical value but no value in correctly identifying individuals. The number of “non-dangerous” people who repeat the offense is double the number of “dangerous” people who repeat it.[454] Cocozza and Steadman who proposed some refinements in predicting dangerousness nonetheless conclude that statistically the best strategy is to assume that nobody is dangerous. Such a prediction, although not correct, is closer to correct than any other prediction, regardless on what it is based.

A second problem is that psychiatrists who have concerned themselves a great deal with prediction, particularly regarding criminals, usually posit that dangerousness can be predicted only intuitively.[455] The only meaningful factor seems to be that the behavior has occurred several times in the past. The more often people have done something, the more likely they are to do it again. That makes predictions regarding first offenders highly speculative.

A third problem is that dangerous behavior does not come “falling out of the sky,” but as every other behavior, is determined by an unpredictable series of circumstances. These relate both to people’s personalities as their existential situations and all other sorts of factors. The examination necessary to predict danger could be one of those factors. The social context of people’s lives is so totally changed by involuntary commitment that subsequent behavior bears almost no relation to the problems and predictions which preceded the commitment.[456] It could well be that people who would never have become violent “outside” respond with violence to involuntary hospitalization, or conversely, that people who during their incarceration are not violent would have been so if not incarcerated. Yesavage et al found that in a group of people committed involuntarily due to the threat of danger there was no more violent behavior than in a comparable group who were involuntarily committed for other reasons.[457] This could mean that *a*. there is in fact no difference in the two groups in respect of the chances of presenting dangerous behavior; *b*. the contextual factors are primarily determinate; *c*. the procedure that is followed is of decisive influence; or *d*. treatment was so effective that the feared behavior did not present itself. Rofman et al conducted similar research, this time with a control group of nearly all voluntary patients. They found that during the first 10 days

there was significantly more aggressive behavior among involuntary patients committed for dangerousness.[458] Here too it is unclear what exactly is being measured. Circumstances in society and on the mental hospital ward are extremely different. Besides, violence could have been induced by the involuntary commitment itself.

A fourth problem is that it is fairly impossible to ascertain whether the prediction is valid. When people are committed on grounds of a prediction their behavior changes so drastically that it is doubtful that subsequently displayed behavior has any value as feedback for the predictor. However, when people who are not committed subsequently display the feared behavior, the presumption is that the evaluator was wrong. This implies that an evaluator cannot be found wrong when involuntarily committing someone. If the committed person later displays aggressive behavior that is (possibly wrongly) viewed as a confirmation that the evaluation was correct. If the person does not display such behavior the change of environment or efficacy of treatment is credited. However when that person is not committed and later displays dangerous behavior such is counted as a failure on the part of the evaluator. In particular when the events take on a dramatic form and become front page news, the evaluator is faced with a most difficult confrontation with his own apparent failure. This state of affairs naturaly evokes a constant urge to "play it safe," to not take risks, and therefore involuntarily commit more people than necessary.[459] High reliability can never be expected from predictive procedures for which there is no feedback.

A fifth problem is that psychiatrists have developed their concepts for the purpose of intervening with treatment. When a psychiatrist is asked to predict someone's dangerousness he cannot do so without observing the person's psychological condition and the presence of psychiatric problems. Rubin considers the notion that certain psychiatric disorders are associated with danger incorrect. According to him psychiatric diagnoses have no predictive value in respect of dangerous behavior.[460] Psychiatrists are preoccupied with treatment. No doubt they allow their conclusions regarding dangerousness to be influenced by their opinion on the desirability of treating the patient.

A sixth problem related to this is that psychiatric examinations and the "clinical eye" are inefficient ways of approaching the prediction of danger. Psychiatric examination neither was developed for that purpose nor is it suited to it. In a follow-up examination of 17 people who were considered insane while committing major crimes Rubin found that repetition of offenses was mainly connected to social factors. He calls the notion that psychiatric evaluation of individuals can reliably predict danger a myth and points out that it is wrong to consider impulses and actions interchangeable. He considers it a mistake to assume that certain psychiatric disorders are in themselves dangerous.[461] Here a problem discussed in 1.4.1 returns. The classification of psychiatric disorders, intended for indicating treatment, is unsuitable for serving as a prediction of danger.

The fate of the so-called Baxstrom patients is illustrative of these problems. In 1966 The United States Supreme Court ruled that 650 people incarcerated in "maximum security" clinics for the criminally insane were to be transferred to "ordinary" psychiatric hospitals. All 650 had remained in detention after expiration of their sentence as they were considered too dangerous to be released. After

four years only 20% of these people were reported to have displayed aggressive behavior, whether inside a psychiatric hospital or outside of it.[462] This implies that 80% no longer displayed dangerous behavior.

Additional conclusions can be derived from the above and from research referred to by Stone[463] and Robitscher.[464]

The matter of how high the risk is that someone will in the future display dangerous behavior is so complex that a reasonably accurate evaluation is fairly impossible. Inasmuch as it is possible to research the likelihood of dangerous behavior psychiatrists have been found to be no better at predicting it than others. In fact, neither psychiatrists nor other professionals can do so reliably. For each correct prediction there are always several incorrect ones. In short, future dangerous behavior is not predictable.[465] Even regarding repeat criminal offenders prediction is inaccurate. An even remotely accurate prediction is impossible regarding psychiatric patients who have never violated any law nor proven to be dangerous.

In "normal" criminal justice cases great care and accuracy is taken to determine whether people have actually performed the acts of which they are accused. Psychiatric patients are routinely locked up because of an off chance that they might in the future become dangerous. The discrepancy between the aspired levels of certainty for these two types of detention is so bewilderingly great as to evoke the impression that from a legal viewpoint having a psychiatric disorder renders a person fair game. Ellis[466] and Robitscher[467] among others have pointed out the dire social consequences of involuntary commitment to people so committed. The grounds on which such decisions are made, inasmuch as can be investigated, are strictly inadequate for making such an invasive decision.

Possibly the presumed dangerousness ascribed to psychiatric patients by many authors contributes to that. Snowdon reveals that dangerousness is much more common among non-psychotics than among psychotics. He voices the fear that the criterion of dangerousness makes involuntary commitment for psychotics impossible.[468] Melick et al note that several reviews of frequency of arrests of ex-psychiatric patients before 1965 led to the conclusion that arrests among this population were less frequent than in the general population.[469] Reviews after 1965 reveal a gradual increase in arrests. This difference is explained by assuming that criminal behavior was gradually becoming more "medicalized" causing more people with criminal behaviors to wind up in psychiatry. This would mean not that psychiatric patients are more dangerous than other people but the opposite, that in the last decades dangerous people are ever more being considered psychiatric patients. I might add that I consider the conclusion by Melick et al reversible. A diametrically opposite interpretation is possible as well. It could be that the small number of arrests before 1965 was due to ex-psychiatric patients being recommitted instead of arrested. The rise in arrests could then be explained by the "criminalization" of psychiatric disorders after 1965. This could be related to the large-scale closure and reduction of the Mental Hospitals in the United States after 1965, and the inadequacy of alternative facilities. Furthermore, experience in the United States shows that when involuntary commitment is made more difficult psychiatric disorders are proportionately "criminalized." People are then no longer eligible for commitment so when

arrested for minor infringements they wind up in jail.[470] Be that as it may, it is clear that both people with psychiatric disorders are to be found in jails and people with criminal behavior are to be found in psychiatric hospitals.

The Dutch law is aimed at making involuntary commitment a legal matter. Accordingly psychiatrists are expected to estimate future dangerousness. Psychiatrists, however, cannot predict that, unless threatening behavior is already concretely, directly, and immediately manifest, such as when someone is angrily swinging an ax and shouting that he will murder his wife. Yet even then a concrete prediction of what will happen remains difficult.

De Winter's view that every psychotic patient can be considered dangerous to himself, others, and the public order[471] seems to me not only factually wrong but also dangerous in the sense that the legislator may labor under the illusion of having made an efficient law when in fact that is not the case. De Winter's proposal would be an example of incorrectly enforcing a law. Asking about future dangerousness is not only pointless, as there can be no answer, but also poses an important ethical dilemma for psychiatrists. That dilemma is whether judging possible risks to third parties can and may be counted as one of their duties and whether such judgments may be used against their patients. Citizens' safety and maintaining public order in the community belongs in the realm of the police and the courts. Is it justified to expect psychiatrists to take this task upon themselves? It seems to me a 180º turn in their actual obligation: helping as well as possible people who ask for help because of an illness. Even when psychiatrists function not as therapists but solely as evaluators it remains to me questionable whether it is justifiable that they are asked not only about psychiatric diagnoses but also, more or less based on those diagnoses, whether they regard the patient as dangerous. Not only are psychiatrists incapable of such judgments, other than statistically, but they are compelled to become the adversaries of the people being judged and "accomplices" of the judicial system. If psychiatrists must be accomplices let them be the patients' accomplices also in their evaluating role. It is up to judges to make pronouncements about danger and its seriousness. Peszke pointed out the altogether unmedical nature of the job imposed on psychiatrists.[472] Stone[473] and later Robitscher[474] supported him in this view.

Likewise Cohen Stuart pointed out psychiatrists' conflict of interest evoked by the Dutch commitment laws. The problem is not only that psychiatrists are expected to perform the impossible task of determining danger. The law also expects the treating psychiatrists to signify the point at which the danger has abated to the point that patients may be given their freedom even though their psychiatric disorders remain. Cohen Stuart is right in pointing out that both roles, that of therapist and that of evaluator of danger, cannot be fulfilled by one and the same person. In the one role the psychiatrist is the patient's adversary, while in the other, his ally. After all, psychiatrists and patients are expected to set up the treatment plan together.[475] In Chapter VI, 5, I mentioned that the separation of treatment and regulation in the Netherlands is a valuable tradition. The combination of therapist and evaluator of danger is even less admissible. Psychiatrists are thus compelled to make decisions from the judge's point of view, determining whether freeing the patient serves the interests of society. When psychiatrists accept this dual role, which from a medical-ethical viewpoint is utterly inadmissible, they become officers of social control, which not only

corrupts their role as therapists but also will confront them with constant failure in both of these mutually exclusive roles.

The law has attempted to avoid the problem of unpredictability regarding danger by posing that the danger must already be manifest in the person's actions. The question is whether the solution is not worse than the problem.

In the first place is the insoluble problem that it is unknown what must be regarded as the manifestation of danger. Is it an argument? Making threats? A slap? Or must actual harm be done? How is behavior deriving from psychiatric disorders to be distinguished from that which is not? After all, "No psychiatric disorder exists which autonomously and predictably leads to direct danger."[476]

Secondly, if the respective manifestation poses immediate danger, then as a rule a crime will have been committed. Threatening violence or putting others in danger is a criminal act. Criminal law does not wait for the harm to have actually transpired.[477] That would mean that criminal behavior is "psychiatrized." Stone pointed out the shifting roles of the massive institutions of psychiatry, justice, and welfare. "What has happened in the last two decades is that in the name of reform, the professionals within each of these social institutions have taken on the roles, functions, and goals of each other."[478] Luckey and Berman wrote about a change in the law regarding danger in Nebraska stipulating that certain people who used to be tried according to criminal law would now be involuntarily committed.[479] This would mean that certain forms of criminal behavior would cause a person to be involuntarily committed while severely disabling psychiatric disorders, in particular many psychoses in which there is not a clear threat of danger, would not meet the criteria for involuntary commitment.

Thirdly, it seems to me justifiable to fear that soon we will no longer be able to distinguish between a criminal act of posing danger and the manifestation of a psychiatric disorder. This distinction depends on the decision which interpretation of events is more valid. The choice will sometimes be in one direction and sometimes in the other. As what happens to people once they are channeled into psychiatry seems to be very much determined by legal procedures and rulings anyway, psychiatry will be "criminalized." This risk is confirmed by Cocozza and Steadman's findings that identical behaviors led to some ex-psychiatric patients being recommitted while others were arrested.[480] Neither civil rights nor psychiatric clarity will be served when people displaying manifestations of danger are shifted arbitrarily whether in the direction of the criminal justice system or in the direction of psychiatry.

In summary, it is extraordinarily difficult to predict danger. Such predictions cannot or almost not be extrapolated from actual behavior. No criteria are known by which dangerous behavior can be predicted other than that such behavior has already been repeatedly displayed. Predicting danger with reasonable reliability is impossible.

3.2.2. Predicting Danger to Themselves

The problems of self-mutilation, threat of suicide, suicide attempts, and suicide itself are extremely complex.[481] Here I will limit myself to some comments about

the grounds for justifying involuntary commitment regarding suicidal threats and suicidal behavior.

The first problem arising from suicidal threats is that it is generally accepted that these may be but are not necessarily related to a psychiatric disorder. There are people who, being quite capable of doing so and aware of their responsibilities, assess their own situation and arrive at the conclusion that their future prospects are unacceptable to them.[482] This type of "rational" suicide does not qualify for involuntary commitment. In 1982 a court in the Netherlands refused to order commitment of a man who seriously neglected himself and lived in a way which was hazardous to his life, as "the patient not only realized very well what he wished, but also was sufficiently capable of freely determining his will in this regard."[483] The problem here is how can the professional judge whether people's assessments of their future prospects are more or less correct? The extent of this problem is illustrated by a poll conducted by Giel and Bloemsma regarding an actual case of suicide threat. Of the 160 helping professionals polled (mostly psychiatrists and other physicians, but also nurses, psychologists, and social workers) 54% considered the patient in question "psychiatrically ill" and 35% would have wanted to have her involuntarily committed. Among the physicians (the only profession that can request involuntary commitment) 68% judged the patient to be "psychiatrically ill" and 65% wished to have her involuntarily committed. "These facts richly illustrate the confusion regarding the background of suicidal behavior, as well as the contradictory feelings helping professionals have about the how far one must go in intervening."[484] A similar investigation by Peszke et al revealed that psychiatrists were fairly unanimous about involuntary commitment of people who are both psychotic *and* suicidal. There was equal unanimity about not committing people who were neither. However regarding people who were psychotic but not suicidal, or suicidal but not psychotic, there were major differences of opinion.[485] As such an invasive measure should be based on more than one subjective assessment anyway, as is the case with Peszke's two subgroups, involuntary commitment could be considered when the intention to commit suicide is explained in totally absurd terms that most obviously contradict all reason as in a manifest psychosis. This would imply that a judge and anyone else who bothers to talk to such a person could reach the same conclusion.[486]

Opinions differ about the ratio of "rational" suicides to "sick" suicides. People's views on this are probably strongly influenced by their philosophical, ethical, and religious convictions.[487] Diekstra found that the public's view of suicide is quite negative ("objectionable, shameful, crazy") and dominating psychiatric and psychological views are equally negative.

According to Diekstra there is no direct empirical relationship between (attempted) suicide on the one hand and the existence of psychiatric disorders on the other. He states that suicidal behavior is quite frequent among people who display no psychiatric symptomatology. He quotes Stengel and Cook, who estimate suicides by the psychiatrically disordered to be about one third of the total of suicides.[488]

In a later publication Diekstra quotes comparable research by Robins in 1959 and by Barraclough in 1968. They investigated cases of suicide (the former 134, the latter 100) for signs of psychiatric disorder by interviewing the relatives.

Barraclough compared his findings with 150 cases of people who died some other way and presented the findings to an independent panel of three psychiatrists. They concluded that in 94% of the cases (93% for Robins) psychiatric disorders were obviously present.[489] Diekstra concludes that psychiatric disorders are much more common in people who commit suicide than in the general population. He cautions, however, that one cannot conclude from this that such disorders are responsible for the suicidal behavior, and presents several arguments for that.[490] Furthermore, it seems to me that in the investigations by Robins and Barraclough the surviving relatives' judgment of whether or not the person who committed suicide was psychiatrically disordered could have been influenced by the suicide itself.

In general a distinction should be made between those people who truly wish to end their lives and those who by attempting suicide are signaling despair and a wish to be helped. In the latter case the entreaty has a strongly dependent nature. It is an appeal to others to assume responsibility. An involuntary commitment would seem to confirm the patient's negative opinion of himself as incompetent, dependent, and not responsible. As every treatment should be aimed at mitigating this irrational dependency, involuntary commitment is in most cases not only unnecessary but also undesirable.[491]

Also in cases of suicidal behavior prediction of repetition can be highly unreliable due to the large number of false positives when predicting behavior that is statistically speaking unlikely. Rosen has demonstrated this mathematically already as long ago as 1954.[492]

Schudel relates that in the years 1975 and 1976 only one out of every 40 people who attempted suicide in the municipality of The Hague were involuntarily committed. Of the remainder, 1154 cases in total, only 20 later committed suicide, ten of whom did so during psychiatric hospitalization. Furthermore, of the 99 people who actually committed suicide in The Hague in 1975 and 1976 only 20 had been known to have attempted it earlier. (Schudel does not reveal whether the other 79 were known to the social services because of other problems.)[493] This means that most suicides transpire without advance signals that reach helping professionals. This also indicates the dubiousness of preventing suicide by involuntary commitment, both because it is apparently not discernible which people who have attempted suicide remain at risk and because the involuntary commitment apparently offers no protection against suicide. De Graaf provides statistics that show that the number of suicides in psychiatric hospitals between 1970 and 1977 rose much more rapidly than outside of them. The cases of suicide in the hospital were doubled whereas in the general population the rise was only 4%. In numbers, in 1970, 1092 people in the Netherlands committed suicide of which 66 did so while staying in a psychiatric hospital. In 1977, 1252 people committed suicide of which 132 did so while staying in psychiatric hospital. In 1977 the risk of suicide in a psychiatric hospital was 26 times the risk outside of it.[494]

Diekstra posits that the custodial approach to the hospitalized suicidal patient has serious drawbacks. By constantly guarding patients to prevent their committing suicide they increasingly develop a suicidal identity which augments the risk. On the other hand following a more permissive policy, meaning less guarding, more freedom, and a larger supply of conversational contacts, can

provide the opportunity for suicide to someone who really does need to be protected against himself.[495]

It remains unclear whether the high frequency of suicide in psychiatric hospitals is caused only by a less custodial climate than formerly or whether the (involuntary) hospitalization itself or all sorts of events occurring during hospitalization are a factor. Van Ree suggests that there may be some relationship with (planned) changes of ward.[496]

The possibility that some suicidal patients who commit suicide during involuntary commitment might not have done so if they were free cannot be ruled out. This is an alarming possibility when one realizes that the only justification for involuntary commitment is the elimination of this danger. De Graaf concludes that suicides in psychiatric hospitals occur most frequently during involuntary commitments which last longer than 3 but shorter than 12 months although this cannot be inferred from her data. The longer the stay, the lower the rate of suicide.[497] Copas & Robin found the suicide risk to be highest during the first week of hospitalization.[498]

Stone relates that California law sets a maximum of 31 days for involuntary commitment of suicidal patients. An investigation of 335 patients revealed that after six months not one had committed suicide.[499] Caution must be exercised in interpreting such figures. As suicide is a rare event only very large numbers should be considered representative.

Pokorny's comprehensive and thorough research confirms the inability to predict a future suicide. He assessed 4,800 hospitalized patients using a number of tests in order to determine whether in the long-term suicide would appear predictable. Five years later he followed up on what had happened to these people. Based on his research he posits, "The conclusion is inescapable that we do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide."

Pokorny points out that his research relates to long-term predictions and that the situation is different regarding people in the midst of a suicidal crisis. He posits that in such a situation the suicide risk is essentially not researchable "as it would not be ethical to withhold taking appropriate emergency steps to ensure safety."[500] Here Pokorny is touching on an extremely complicated problem about which I will make some comments.

In the first place, there is a contrast between the ethical inadmissibility of refraining from involuntary hospitalization and the ethical relative inadmissibility of the involuntary hospitalization itself, which can be justified only as a last resort. In those cases, as here, where one is confronted with an ethical dilemma, it is important to deal with that dilemma, and seek either to augment our knowledge of such situations or offer alternatives. In my opinion Pokorny's position is valid only when every other possibility of approaching the problem is barred.

Secondly, several treatment methods and strategies exist for such situations. In fact, as Schudel's limited research revealed, the overwhelming majority of people are not involuntarily committed after attempting suicide.[501] An involuntary hospitalization is evoked only when that seems to be the last resort.

This shows that further research as to treatment methods can not only change the ethical dilemma but is very much necessary.

Thirdly, Diekstra repeatedly notes that crisis services for suicide prevention are often not an acceptable option to people who are about to commit suicide precisely because they are so focused on suicide *prevention.*[502] It is quite conceivable that people who wish to talk about their plan to commit suicide do not want to do so with others who may be their adversaries, let alone who will foil their plans by forcing them into hospitalization. It is not impossible that helping professionals make themselves inaccessible to certain people in a suicidal crisis by expressly opposing suicide.

Fourthly, the severity of the emergency is not uncommonly partly determined by the therapists' circumstances: how much time they have available, their personal stress in such situations, the degree to which they dare take risks, and the services that happen to be available in particular regions. These factors, too, are in principle mutable.

Fifthly, in such emergency situations, involuntary hospitalization provides therapists with a feeling of safety and security and of having successfully dealt with an urgent matter. Considering the many suicides in psychiatric hospitals one wonders whether this is not an illusion, comfortable for therapists but no real help to patients.

It is altogether uncertain whether suicide prevention by involuntary commitment produces the sought effect. Diekstra stated, "In conclusion, for now we can state that the preventive effect of forced commitment is unclear."[503] Most successful suicides appear to be committed before contact with mental health services has established suicidality. Only a very small amount of suicide attempts are followed by involuntary commitment. The subsequent suicides are not only unpredictable but it also seems there is no convincing evidence that the involuntary hospitalization provides any protection whatsoever. Finally, whoever wishes to make the fewest mistakes statistically should never involuntarily commit someone on the bases of suicidality or suicide attempt.

....3.3. Involuntary Commitment as an Intervention

Let us define certain concepts more precisely. Voluntary hospitalization is hospitalization to which the patient consents and with which he cooperates, being thoroughly informed and capable of understanding what is going on and the consequences. Involuntary or compulsory hospitalization means that commitment is ordered by a court in spite of the patient's clear and explicit refusal to be hospitalized.

When the concepts are defined thus, a more or less clearly demarcated interim area remains. This concerns patients who do not or cannot make their wishes known clearly; who are confused and disoriented, apparently not understanding what is going on; who refuse to speak; and who say no to whatever is said (no to going to the hospital and no to not going to the hospital). Jongmans calls these cases virtually voluntary hospitalization.[504] Van der Esch adopts the term "non-opposing" patients from English language literature .[505] Sipsma points out the danger of such hospitalizations regarding the elderly, which

are arranged more or less without involvement of the person in question. He posits that hundreds of hospitalizations are arranged for elderly people this way every year in psychiatric hospitals and nursing homes for the psychiatrically disordered elderly.[506] This is all the more serious as in this category of patients the process is usually irreversible as hospitalization itself quickly leads to permanent changes in condition. This is less so for totally confused, stuporous, or negativistic patients. My impression is that the inclination to request involuntary commitment for the latter category of patients is stronger than for the elderly. So for the powerless, extremely vulnerable elderly, legal procedures are considered unnecessary, while they are in fact very much necessary for the protection of these elderly people. The legal procedures *are* invoked for "non-opposing" adults even though the consequences for this group may be less serious.

It is most important to realize that every involuntary commitment involves a conflict between the person involved and the authorities who effectuate the involuntary commitment: the psychiatrist or physician who signs the medical statement, the judge who rules, and the state that actualizes the hospitalization. The reason this is so important is that the conviction that hospitalization serves people's best interests can create the illusion that the parties are acting benevolently to the exclusion of all other motives. This is not so. Coercion is being used to compel people to do things they do not want to do. Recognizing this conflict can safeguard against carelessness regarding the law and human rights. Furthermore, there should be awareness of the extreme difference in power between the authorities ordering involuntary commitment and the person involved. Not only are committed people forced to comply but to a certain point they are denied pronouncing an assessment of themselves and their situation, as though they were dangerous and disordered. They are feared and avoided by their fellow citizens.

In general, involuntary commitment should be considered a serious intervention in people's lives. De Smit describes involuntary hospitalization as a sudden, more or less unpredictable event which drastically disrupts people's social networks. Social reality is reconstructed in the direction of the stigmatizing stereotype of potential danger, that is to say, behaviorally unpredictable, destructive mental illness. De Smit concludes that involuntary hospitalization is always a more negative than positive experience.[507] Stone mentions "considerable harms" and lists stigmatization, collapse of self-regard, separation of the patient from his family and community, loss of employment, grave restriction of prospects for future employment, and – considering current treatment of patients in Mental Hospitals – a not trivial risk of being brutalized or physically harmed.[508] Such a commitment adheres to a person for a very long time as a handicap when applying for a driver's license or other privileges. In the Netherlands it is only since 1979 that people who are hospitalized by court order do not automatically become legally incompetent (European Council ruling in the Winterwerp case). Ellis and Robitscher also underline the serious impact of involuntary commitment on people's lives.[509]

A peculiar and at the same time alarming aspect of involuntary commitment is that when, for instance, a mistake has been made, restoration is not really possible. Someone who is accused of a crime may be acquitted and thus his status of innocence restored. In current Dutch commitment laws there need only

be *suspicion* that there is a disorder of mental functioning. But if this disorder should turn out not to exist, or not to be relevant to the dangerous behavior, the court order is simply terminated. As far as I know descriptions of unjustified involuntary commitment are extremely rare. When they do occur it is not uncommonly thanks to intervention by the media. Yet, in addition to judgmental mistakes made in good faith, incorrect information based on prejudice, or even malicious attempts of the family to remove another family member from society and have him declared incompetent, cannot be ruled out. Ellis relates that groups dedicated to assisting ex-mental patients claim that many Americans have been derailed this way. He quotes a publication by Redlich et al in which appears the statement, "In some cases, there is evidence that psychiatrists and other involved persons are motivated, in part, by counter-aggression toward very provocative patients."

In addition it is generally impossible for those who advise and order involuntary commitment to receive meaningful feedback. The first reason for that is the complexity of the issue. It has at least three aspects. First: is a psychiatric disorder present, and if so, how severe is it? Secondly: if there is danger, what constitutes it and how serious is the threat? Thirdly: Is there a relationship between the psychiatric disorder and the danger? If so, what is it? The first aspect was thoroughly discussed in Chapter V, 3.3. Some people have proposed dropping the concept of psychiatric disorder as a legal term because what is meant by it is too vague for legal procedures, can have too many meanings, and generates too many misunderstandings.[510] The second aspect was discussed in 3.2. The third aspect (see 3.2.1) is also problematic. Offerhaus describes the position of the psychiatrist who must advise about involuntary hospitalization as follows: "He makes his choice on the axis from 'safety' to 'freedom' first and foremost on the basis of personal insight and experience which is scarcely supported by scientifically obtained knowledge. He thereby finds himself in a situation that in no way satisfies the requirements of a careful and responsible decision process."[511]

Secondly, meaningful feedback is usually impossible for the reasons mentioned in 3.2.1: when during hospitalization the patient does well, the involuntary commitment is credited, if he does poorly it is seen as confirmation of the necessity for involuntary commitment. This state of affairs predisposes to an augmentation of the number of involuntary commitments as well as Scheff's medical decisional rule quoted by Giel, that "when no clear choice is possible, the physician considers the patient more benefited by presuming illness than denying it and risking having overlooked a disorder."[512]

Thirdly, meaningful feedback is very difficult because the dilemma of psychiatrists advising involuntary commitment cannot be formulated by the question "is it permissible to involuntarily commit this patient?" but by the question "is it permissible to allow this patient to continue on his own?" This is generated by the nature of involuntary hospitalization as an ultimate refuge. It means that psychiatrists feel morally responsible not for the serious intervention that they advocate but for all the things that might go wrong if they do not commit the patient. It has been amply demonstrated in different places and under different political regimes that such procedures are easily politically abused and form an

urgent, grave problem, as a motion against such practices in the [former] USSR by the World Psychiatric Association in 1977 attests.

When feedback on decisions is not meaningfully possible there is no opportunity to learn from experience, correct policy according to newly gained insights, and develop better procedures accordingly. This means that as involuntary commitment as a social intervention exists several centuries already, a process of self-confirming experience has led to such a deeply rooted tradition that we can no longer imagine what to do without such intervention. But it also means that the moral judgment of the necessity of involuntary commitment is still largely devoid of empirical support. And it means that the enormous social changes since the eighteenth century do reflect the number and percentage of involuntary commitments, but hardly any fundamental discussion of this intervention, while the improvement and intensification of the network of helping professionals since then should have given rise to this discussion.

We can conclude from the above that unless consistently discouraged involuntary commitments will continue to proliferate and the rate will even rise. Without it we fear that all sorts of people who neglect themselves, who apparently cannot care for themselves, who take to a life of vagrancy and squalor, or who cause themselves serious suffering, will be left to their own devices and succumb. Compassion seems to dictate intervention even against people's wishes. This also holds true for people who harm themselves or others due to voices they hear or who harm themselves when in a deep depression. Increasingly we fear disruption of society by psychiatrically disordered people who cannot be held accountable for their behaviors. Time and again the dilemma is whether such people can be left alone and whether it is admissible for society to deprive itself of the power to intervene. Here I should add that strictly speaking, the danger criterion does not justify involuntary commitment for most of the people in need mentioned in this paragraph, so they cannot be protected by the existence of involuntary commitment laws.

Robitscher quotes two relevant investigations in this respect, both carried out in the United States after a change in local law. Hiday determined in her research that in 20% of involuntary commitments the legal criteria for involuntary commitment were not met. Lelos found that of 109 hearings 58% of involuntarily committed people met the criteria and 42% did not.[513] We would be justified in suspecting that judges either at the instigation of psychiatric reports order more people to be committed than the law strictly speaking permits, or have to drastically change the target population of commitment laws. Neither the systematic violation of the laws nor the inability to apply them to those who need them most are a pleasant prospect.

In summary, the decision to involuntarily commit someone is a decision with serious risks and disadvantages for that person. Any advantages should be weighed against these disadvantages. The consideration that the person is ill and must be hospitalized for his own benefit should be strongly questioned in light of these other considerations. Good intentions often eclipse the serious consequences for the person's social future.

Thought on this problem is rendered more difficult by the moral burden. The near impossibility of meaningful feedback on decisions taken impairs learning

from experience. Due to the long historical tradition involuntary commitment is deeply rooted in our culture which also renders a critical view and the search for alternatives difficult. This alone makes the abolition of involuntary commitment unlikely. Moreover, even after the most stringent selection, there will always be people left who are either so deeply demented, oligophrenic, or floridly psychotic that it would be inhumane to abandon them to their own devices. From this point of view I will examine the prospects of abolishing involuntary commitment.

....3.4. Abolition of Involuntary Commitment?

From the above no other conclusion can be drawn than that usually no good, operational, and ascertainable criteria exist on which to base a decision of involuntary commitment. In the current situation, when both in the Netherlands and outside it, particularly in the United States, there is an inclination to anchor the whole procedure more in law, the prediction of danger is the cornerstone on which this procedure rests. Treatment of so committed patients becomes uncertain as it is unlikely that it would encompass more than intervention during emergencies. Furthermore, it will become impossible to commit patients who are in serious trouble but not dangerous. Involuntary commitment seems to be becoming a speculative as well as ineffective intervention.

In criminal law it would be unthinkable that people would be sentenced to detention on grounds of “evidence” as flimsy as the arguments usually presented for involuntary commitment. If that would happen it would mean fairly the end of the rights on which our state prides itself. Furthermore, except for a very few instances, preventive detention of potentially dangerous people violates what in democratic countries is felt to be human rights.

When involuntary commitment is a social intervention that is morally justified by claiming benefit either for the patient or for society; when feedback on this measure is hardly possible; when we realize that involuntary commitment means drastic intervention in people’s lives; when there are no tangible and ascertainable operational criteria for it; and when, finally, the feared dangers cannot be accurately predicted, and in addition the efficacy of commitment in preventing these dangers remains unclear, then the inescapable conclusion is that involuntary commitment should indeed be abolished.

So regarding involuntary commitment I reach the same conclusion as does Szasz, albeit partly through a different line of reasoning, namely a teleological one. To Szasz, freedom is a core value that takes precedence to health and depriving people of freedom to benefit their health is never admissible. In addition, it is a prime medical-ethical rule (see Chapter III, 2.5) that examination and treatment of illness can transpire only upon patients’ consent (barring conditions such as coma). In fact the conceptualization of “madness” as mental illness should have already made an end to involuntary commitment. Here the principle consideration leads to a conclusion comparable to the argumentation, deontology to a conclusion comparable to teleology.

It could be that abolition of involuntary commitment would totally change the climate of psychiatry,[514] as voluntary hospitalization and treatment also transpire on a background of the option for involuntary commitment. This happens not infrequently. Of all the people involuntarily hospitalized in 1974, 321, which was about one-ninth, were originally hospitalized voluntarily.[515] It is difficult to interpret such a figure. It could mean a praiseworthy attempt to first try voluntary admission as well as a blameworthy inclination to hold people, once they are hospitalized, longer than they themselves wish. The number is large enough to assume that in clinical therapy there is preoccupation with the idea of converting voluntary hospitalization into involuntary hospitalization as soon as the going gets rough. In any case it means a turnabout in the relationship between the psychiatrist and the patient. The way of seeking solutions together seems blocked and the way of exercising coercion over the patient is chosen. Cooperation is replaced by the conflict so tirelessly emphasized by Szasz and also mentioned by De Smit.[516] Presumably, when the option of coercion is no longer within reach, therapists' attitudes will change. Their dual loyalty, serving the patient as well as possible but also resolving the conflict with force when necessary, will be replaced by the obligation to treat the patient to the best of their knowledge and ability as is customary in medicine.

The attitudes of family and environment who by exerting immense pressure sometimes make involuntary commitment unavoidable, will also have to change, which will not always be to patients' detriment. There may come a place for alternatives to hospitalization.[517]

In cases when someone wishes to terminate hospitalization, for instance because of a disagreement with the therapists, power will shift towards that person, possibly expanding his options for hospitalization somewhere else.

Abolition of involuntary commitment leaves us with the group of "non-opposing" patients[518] in addition to voluntary admission. Many of these people such as the elderly are already considered voluntary patients, which necessitates protection of rights.[519] A desirable procedure regarding the hospitalization of people over age 65 in psychiatric hospitals or nursing homes could be requiring the additional consent of an impartial patient advocate who has discussed this with the person in advance.

This would not be the introduction of a new form of involuntary commitment through the back door. The measure would serve only to provide extra assurance of rights for a very vulnerable group of "non-opposing" patients, and would not be applicable to patients who refuse hospitalization. There could, however, be an overlapping area of people who are so confused, and formulate their refusal so absurdly, that one can hardly take that refusal seriously anymore than their consent. My point is to design procedures for this category of patients. I wish to suggest some lines of thinking. I wish for better protection of the rights of people who are hospitalized "without due process" because they do not resist, sometimes to their detriment.

Abolition of involuntary commitment would not only stimulate the creativity of helping professionals.

In the first place it would victimize some people. This cannot be an argument to continue current practices as there is no way to measure how many

people are victimized by involuntary commitment. It does mean, however, that it would be an unwise and irresponsible strategy to abolish it before there has been an opportunity to design alternatives. After all it is an institution deeply rooted in our history and tradition.

Secondly, the Patients' Movement in the Netherlands does not reach the conclusion that involuntary commitment should be abolished entirely. A publication by this movement posits that involuntary commitment is admissible for people who are demonstrably in crisis due to which they are dangerous for themselves or others when no acceptable alternative is available.[520] Therapists' impartiality is stressed as well as protection of people's rights and termination of the involuntary commitment as soon as the acute danger has waned or the person indicates that he is willing to remain voluntarily.

In the third place, Toews et al approached a number of involuntarily committed patients after their release. It appeared that in retrospect there was less resistance to the involuntary commitment than they had expected. The average assessment of the 61 responders was neutral (however, 18 refused to cooperate, and an estimated 11 responders had difficulties understanding the questions). Most of the ex-patients were of the opinion that their physicians should be able to arrange an involuntary commitment if those physicians considered it necessary. Toews et al further noted, as did Gordon et al, that the opinions of ex-patients about their hospitalization and treatment are rarely investigated.[521] The problem with this type of research, as well as Weinstein's[522] (see Chapter VI, 4) is the same as discussed in 2.2, namely that identification with the aggressor leading to adoption of the therapists' point of view by the patients cannot be ruled out. Besides, afterwards the suffering has become a *fait accompli* with which one is challenged to learn to live, and "make the best of it." This too may have influenced research results.

The Patients' Movement does not endorse unconditional abolition of involuntary commitment. In very rare cases it would be risky to not involuntarily commit someone. Only for those rare cases should the law continue to provide the means for involuntary commitment. One must consider, however, that in recent history many countries vacillated back and forth between rules with psychiatric design and those with legal design regarding involuntary commitment.[523] Neither design was able to satisfy the need.[524] Therefore it would not seem prudent to expect any serious improvement from new commitment laws. In my opinion we can expect the best results from an interim provision which would serve as a transitional period leading toward total abolition of involuntary commitment. During this transitional period alternatives can be sought and experience with those alternatives can be accrued. These experiences can then be a guide for designing further policy. In the next section I will discuss some proposals for this interim period.

....3.5. A Design for an Interim Provision to Bridge the Actual Situation and Future Abolition of Involuntary Commitment

Below are several proposals for an interim provision which might last, for instance, ten years. Its purpose is to create alternatives and to gradually become

accustomed to a new situation in which involuntary commitment is no longer an option. As far as I know such an attempt to gradually reduce involuntary commitment while sustaining voluntary hospitalization has never been made anywhere. Democratic psychiatry in Italy, for instance, proposed abolishing voluntary admissions along with involuntary commitment. The interim provision I propose may be able to prevent the drawbacks of a revolutionary transformation with the accompanying polarization of political positions. The project would have to be properly evaluated so that in addition to opinions there would be research results on which to base further policy.

The *first proposal* is to discourage involuntary commitment. This can be accomplished by posing stricter criteria for both diagnoses of psychiatric disorders and the formulation of the nature of the danger. Involuntary commitment should become less and less the culmination of measures aimed at resolving an existing situation. By that I mean a change in attitude. The current assumption is that an emergency should always be short-circuited, by coercion if necessary, in order to end it. It should be realized that it is sometimes better to not intervene.

Several elements from Stone's five-step plan[525] could serve as a guide here too although this plan was not received enthusiastically in the United States, in particular by lawyers.[526] One such element is that the psychiatric condition must be described in a way that the judge can use certain standard criteria, using a coding system especially developed for the purpose[*]. This would compel the psychiatrist to formulate explicitly and precisely what is wrong with the patient (first step). The second step is asking to what extent the patient is suffering from his condition. The third step is determining whether there are effective treatments for this disorder, what they are, how long it can be expected to take for an effect to be noticeable, and what the nature of that effect will be. This all makes it possible for the judge to form an idea about the balance of advantages and disadvantages in each case that involuntary commitment is requested. In addition, the judge should be able to evaluate whether the nature and gravity of the danger posed make a criminal procedure more acceptable than a civil procedure.[527] How much the person would benefit from the involuntary commitment should be explicitly considered. Van Eck notes that very little is known about the effects of involuntary commitment while this information is essential for properly evaluating it.[528] Instead of Stone's fourth and fifth steps, the person requesting the involuntary commitment could be asked why in this case alternatives to involuntary commitment would not suffice. Of course in acute emergencies it will as a rule not always be possible to ask all these questions. But every patient should have the opportunity of addressing the judge a few days after commencement of the involuntary commitment. These steps should then serve as a guide to the judge's decision.

A *second proposal* is introducing a 24-hour delay between the moment of onset of the emergency and the inception of the involuntary commitment.[529] This proposal is intended to prevent involuntary commitment from being used to intervene in emergencies. After all, such intervention implies that the emergency

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[*] In his book Stone provides a few examples which would have to be altered somewhat to make them suitable for the Netherlands. – J.P.

is caused by *one* person, or in any case that that person is blamed for it, as that is the individual who is chosen to be committed. The point is making clear that the object of involuntary commitment is removing from society people who are at risk due to a psychiatric disorder . The object should not be to resolve social emergencies. Involuntary commitment should not be usable for that purpose. The 24-hour delay can serve to clarify that emergencies should be resolved some other way. It can also serve to form the basis of an intensive therapeutic relationship, whether in an out-patient setting, or, if the patient wishes, in clinical crisis intervention. The developing so-called 7 x 24 hours available services could be adapted for this. This measure could be introduced in phases as not yet all districts in the Netherlands have the facilities sketched here.

A *third proposal* is to further research the notable phenomenon that involuntary commitment is quite often continued on a voluntary basis[*].[530] Kane et al in their research on changing attitudes regarding involuntary commitment also note the deficit of relevant statistics.[531] Gaining insight into this apparent paradox will no doubt produce strategies that can be used to avoid involuntary commitment.

A *fourth proposal* is that those who are caring for and treating patients should be strictly separated from those who are participating in the process of attaining involuntary commitment. This is mainly to ensure that therapists will devote all their attention to the treatment and to prevent preoccupations that hinder treatment or even impair it. Backing up the patient, the therapist must be free to offer a variety of assistance and treatment courses without their acceptance or rejection having consequences for the hospitalization. Separation of treatment and regulation (Chapter VI, 5) is logically followed by separation of treatment and involuntary commitment procedures. The reasoning is the same, *mutatis mutandis*. Patients are in an extraordinarily difficult position. It is in principle wrong that therapists are the same people as the ones detaining them. The law's requiring therapists to assess patients' dangerousness puts them in a position of double preoccupation even without the enormous problems of assessing "possible serious danger." It furthermore requires therapists to combine two incompatible roles. On the side, I consider separation of treatment and involuntary commitment procedures essential in general and not only for this proposal. Finally, an important argument is that this separation prevents the accumulation of power in *one* person (or team). The Patients' Movement of the Netherlands in its *Manifest* has also stressed the need for impartiality regarding those professionals who advise judges on the desirability or necessity of involuntary commitment. Rubin advocates this as well,[532] and Stone comments, "Legal reform has consistently undermined the therapeutic role and forced the psychiatrist into the role of policeman."[533]

Nieboer's proposal to employ special experts who are not involved with treatment, so-called imputation psychopathologists,[534] deserves special attention in this respect. Although Nieboer was seeking a solution to a different problem, namely providing information to a judge regarding a committed crime, his reasoning applies to involuntary commitment as well, as also in this case the

[*] In 1974 there were 1464 short-term involuntary commitments of which 1080 were continued voluntarily! –J.P.

psychiatric expert submits a report to a judge. Nieboer posits that such reporting has its own ethics. In the first place, the question being asked must be clear. Secondly, the report should provide only information about subjects that are clearly related to the questions asked. Thirdly, making the person into an object must be avoided. Fourthly, the relationship with the reporting professional should be explicitly structured in spite of the disadvantage of a less than ideal relationship, rather than accepting the development of a relationship of trust based on presumed professional confidentiality which the reporting professional will subsequently violate.

Imputation psychopathologists are not only experts on reporting. Due to their close working relationship with judges they are suited to "translate" psychiatric frames of reference to legal ones, thus minimizing misunderstandings. Nieboer's proposal has such important advantages, both in principle and pragmatically, that it is surprising that official policy has not (yet) adopted it.

A *fifth proposal* is attempting to describe as exactly and operationally as possible what is meant by danger in respect of involuntary commitment laws. Certain criteria should be more thoroughly described such as must the danger be posed to persons? How great must the danger be? How immediate is it? Exactly what type of danger is meant? How does the person's behavior reflect this danger? This would prevent vague and general notions from sufficing as the basis of a decision. The judge would have several clear criteria on which to base his judgment. There would be more uniformity in the decisions.

A *sixth proposal* is dropping the criterion of danger to property. When a crime has been committed the proper channel is criminal law, not civil law. When there has been no crime there is insufficient reason for involuntary commitment.

A *seventh proposal* is treating so-called non-opposing patients, those who are mutistic, confused, stuporous, or otherwise incapable of indicating whether or not they consent to treatment -– excepting the elderly (see 3.3) – the same as those who are unconscious. There is unanimity about the desirability of transporting people in such states to the hospital to be treated unit they can make their wishes known. At the same time the rights of these non-opposing patients should be guaranteed.

An *eighth proposal* is dedicating a portion of the Mental Health Service's budget for prevention to researching methods that can prevent involuntary commitment. A fact which can be observed in practice is that when the psychiatrist on duty has plenty of time to talk to the patient involuntary commitment often turns out to be unnecessary. Measures and agreements in the out-patient setting or voluntary admittance suffice. Parallel to that, it is strongly advisable to make admittance wards of psychiatric hospitals units that can offer intensive care in the sense of extremely intensive guidance. Experience has demonstrated that with such intensive guidance coercion is rarely necessary.

A *ninth proposal* is to start a program of research around the involuntary commitment procedure so that the accompanying events can be evaluated. One point of evaluation would be whether, in retrospect, the criterion of danger is maintained in the way intended by involuntary commitment laws. This would not be so much to point out mistakes but rather to dispel the illusion that the law is a good law while in reality improvisations are constantly being made. A further point worth investigating is whether the result of this interim provision will be fewer

involuntary commitments and at the same time proportionately more criminal procedures as was experienced in the United States. An important indication of such a shift would be that many psychiatric patients are winding up in prisons for trivial crimes.

This way it will be possible not only to determine further policy on the basis of all sorts of ethical, psychiatric, legal, and political theories at the end of the trial period, but also on the basis of fact about the actual effects of the measures.[535]

A *tenth proposal* is that involuntary commitment upon the person's own request must remain possible, albeit maintained as a legal measure enabling a person to become eligible for a treatment which is difficult to access. I am referring here in particular to treatments that can be obtained only under very special circumstances or which are too risky on a voluntary basis. For instance, intensive individual treatments as provided in clinics for criminal psychiatry are accessible only to people who were sentenced to such a clinic after having committed a crime. Such treatments are not available anywhere else in the Netherlands. Involuntary commitment at the patient's request should provide the opportunity for someone who was not sentenced for such a crime to access the same treatment. Obviously, there would have to be guarantees that the person truly needs such a treatment and that the involuntary commitment is linked to that specific treatment plan. This possibility should remain after termination of the period of interim provision. These ten proposals should make it possible within the space of the suggested ten years to reduce the incidence of involuntary commitment to a fraction of what it is today.

At the end of this period the reasons making involuntary commitment necessary in the remaining cases should be investigated. On the basis of such investigation measures can be designed making it possible to gradually abolish involuntary commitment entirely. Whether or not special procedures for exceptional circumstances would still be necessary could be considered.

...4. Summary and Conclusions

Justifying the application of coercion on a legal basis on the grounds of a psychiatric disorder is in principle a violation of the prime ethical rule of medicine, namely, that involvement and treatment may take place only at patients' request and consent. This is partly the reason that the presence of disease and/or psychiatric disorder in itself never suffices for applying coercion. There should always also be a risk or danger caused by the disorder.

In somatic medicine the application of coercion is negligible. In psychiatry it is frequent. In these cases the asymmetrical contract relationship between psychiatrists and patients is replaced by a relationship of conflict. This change in the moral context of the relationship requires reexamination of the hermeneutical theories of explanation in psychiatry which are almost all based on contractual relations, and possibly not valid in non-contractual relations. In addition, while typologically restriction of freedom can be inferred from the presence of a psychiatric disorder, in principle it is not possible to confirm this restriction of freedom with certainty when patients experience themselves as free and deny the existence of a psychiatric disorder.

There was discussion of involuntary commitment to a psychiatric hospital as the archetypal intervention against patients' wishes based on law. It was argued that this type of social intervention against patients' wishes which exists several centuries already is deeply rooted in our society. Questioning its justification is difficult due to the moral implications, namely, the feeling that it would be unethical not to involuntarily treat certain people in certain situations. The opportunity for relevant feedback is almost totally absent as the situation after commitment is incomparable to that before commitment. There is an inclination to prejudice in the sense that not committing patients involuntarily is considered risky and dubious, while involuntary commitment is a safe course of action. Behavior after such a decision is generally interpreted only one way. When patients turn out to be dangerous for themselves or others, that is perceived to be proof that involuntary hospitalization was justified. When they turn out not to be dangerous, that is perceived to be due to the benefit of the change of environment and/or treatment. However, when people who were not involuntarily committed later display dangerous behavior, the involved psychiatrist is considered to have made an error of judgment.

This state of affairs facilitates deciding to involuntarily commit people. In addition, the necessity of involuntary commitment becomes like a self-fulfilling prophecy with almost no opportunity for judges and psychiatrists to learn from experience. Ethically this is inadmissible. It makes it nearly impossible to question the necessity of the procedure and the inadvisability of its abolition other than on emotional grounds.

From a medical-psychiatric point of view involuntary hospitalization is justified mainly as serving patients' benefit. The assumption is that patients' behaviors are affected by pervasive disorders that can improve with treatment. From a legal point of view involuntary hospitalization is justified as a form of preventive detention, for the sake of preventing danger to others or self.

It has been demonstrated by research that danger, whether to self or others, is almost not predictable. Statistically speaking, certain groups of people can be identified as being at greater risk of posing danger to others or self, but in individual cases prediction is unreliable and frequently incorrect. The inescapable conclusion is that involuntary commitment on the grounds of such prediction is unjustifiable.

This led us to the conclusion that involuntary commitment should be abolished.

In order to prepare a responsible course for abolition of involuntary commitment an interim provisional plan was designed. During this period involuntary commitment would be systematically discouraged, greatly reducing its incidence. Afterwards the remaining cases would be reviewed in an effort to achieve services that would make total abolition of involuntary commitment possible.

The conclusions reached in this chapter largely confer with Szasz's, although they are partly based on different arguments.

Szasz posits that mental illness is a concept that can be socially damaging as it can and does lead to all sorts of legal coercion and to violation of people's

rights. His position, as far as involuntary commitment is concerned, is for the greater part supported by this book, albeit for different reasons.

However, whereas Szasz posits that psychiatric disorders are not illnesses, basing his reasoning on the value of freedom prevailing always and everywhere above the value of health, I conclude that psychiatric disorders can indeed be considered diseases. Precisely this is the reason that the prime medical-ethical rule of voluntariness in contacts between patients and psychiatrists applies. Basing justification of involuntary commitment on the concept of psychiatric disorder constitutes its improper use.

▪ Epilogue: Recent developments

More than twenty years have passed since the main body of this book was written. During these years, many, sometimes surprising, developments occurred both inside and outside of psychiatry. How relevant today are the problems of two decades ago? In this epilogue I will show that the issues raised in my book are presently as current as they ever were.

Developments in psychiatry as a branch of medicine are closely linked to developments in medicine as a whole, and to developments in mental health care. Psychiatry as a social institution develops along the lines of processes in society as a whole.

In this epilogue I will first discuss the development of ideological aspects in psychiatry. Here the first quandary mentioned in the preface will return: the extent of the psychiatric realm that must be considered relevant. These processes are mirrored to an important degree in the way the state deals with health care, for instance through legislation. I will discuss these, using developments in the Netherlands as an example. Next I will discuss the current state of affairs regarding coercion in psychiatry, as the foregoing aspects are reflected and come together in the subject of coercion. Here the second quandary mentioned in the preface will return: the social function of psychiatry. Finally, returning to the question asked in the preface, whether there can be alternatives for today's social and psychiatric practices, I will suggest some possible alternatives to coercion.

This epilogue is different from the previous chapters in two ways. Firstly, in it I describe developments rather than states of affairs. Secondly, I will be more concerned in gaining insight into these developments than making a thorough analysis.

These aspects will be discussed also in light of developments in Szasz's writings.

... The Concept of Illness in Psychiatry

....The DSM system

In retrospect it can be said that this book was originally published in Dutch during the decline of critical psychiatry and antipsychiatry. Interest in the philosophy of psychiatry was waning. Criticism aimed at improving matters of principle and practice in what was considered a hard and repressive system, began losing its voice. Reflection on the significance of concepts and theories gave way to scientific, and in particular empirical orientation. That road was paved to a significant extent by the system of classification in the American *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Its third edition, called in short the DSM III, appeared in 1980, and the DSM IV, in 1994.[536] This

system was so crucial to the further development of psychiatry, that we must take a look at it.

The DSM III and IV are rooted in the idea that for many psychiatric disorders only the symptoms are known, which present in constant or changing combinations. Classification therefore has to be based on sorting these symptoms. The cause is only mentioned when a disorder clearly emanates from a bodily deviation, such as is the case in Alzheimer's disease or the consequences substance abuse. For the rest, description of the disorders is limited almost entirely to description of the symptoms. In the service of empirical research, criteria are set for the number and gravity of the symptoms. These are necessary for determining a diagnosis. Enabling empirical research is one of the explicit goals of the DSM system.

It uses the term "mental disorders," not illness or disease. By this, functional problems are stressed rather than structural changes. The concept of mental disorder is defined as follows: "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a beloved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (i.e. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above."[537]

The concept of distress is directly comparable to the concept of suffering I described in Chapter V, and the concept of disability with the concept of dysfunction. The term "abnormality" which I used is described differently, but is very much associated with what I called a biological discontinuity. An important difference is that in Chapter V, I propose that suffering, dysfunction, and abnormality are a conjunctive cluster, while the DSM is satisfied with a disjunctive cluster: either one *or* the other is sufficient to determine the existence of a disorder – expanding the "universe" of psychiatric disorders beyond my own description.

The DSM system does not meet Szasz's criterion for disease, namely the presence of a physicochemical deviation of the body. Szasz has always adhered to this description.[538] In contrast, the DSM-system clearly rejects the biomedical concept of illness in favor of a biopsychosocial concept.

The DSM's definition is so broad, that it requires the additional condition that the identified syndrome or pattern must be clinically relevant. But as "clinically relevant" is not further explained, it remains more or less a *carte blanche* for the psychiatric diagnostician. This can be illustrated with a simple example. Suppose someone has serious ophidiophobia (fear of snakes). If such a person lives in an area where there are no snakes, there can hardly be any clinical relevance to speak of: the chance of a confrontation with a snake would be limited to a nature

program on television or a visit to the zoo. However, if the same person lived in an area rich with snakes, the disorder could have clinical relevance.

The condition that the syndrome “must not be merely an expectable and culturally sanctioned response to a particular event” is questionable. This changes the focus from the description of symptoms to their significance. The archetype is the occurrence of the symptoms of a depressive disorder after the loss of a loved one. In this case, the reaction is to be considered normal. One wonders whether the appearance of such symptoms after the loss of a job or prospect for the future (for instance, due to a disabling somatic illness) could not be considered normal reactions as well. This is highly relevant, as by far the majority of first depressions appear after such an important setback or crisis.[539]

By formulating explicit criteria for different disorders, the DSM system immensely stimulated empirical research, as well as contributing greatly to a more uniform use of symptoms, disorders, and diagnoses. The reliability of psychiatric diagnoses worldwide is greatly enhanced since the introduction and use of the DSM-system. The system has also contributed much to a uniform use of terminology throughout the world. It would not be exaggerating to state that the system has completely changed daily practice and protocol in psychiatry, particularly as in the past dynamic and especially, psychoanalytical views dominated.

However, the validity of the different categories remains an open question. What exactly is a mental disorder? Do mental disorders exist in the real world, or are they but manmade patterns that are imposed on reality? Which factors, in addition to clinical relevance, determine that a certain cluster of symptoms is established as a disorder? Kleinman suggested in 1988 that psychiatric diagnoses derive from categories. These “categories are the outcomes of historical development, cultural influences, and political negotiation.”[540] So doing, Kleinman exposed the difficult formation of the mental disorder concept, as well as the untenability of a biomedical disease concept in psychiatry.

The DSM system is not a diagnostic one, but one of classification. For the difference between the two, see my remarks in Chapter V, section 2.1. So the DSM system does not pretend to offer tools for treatment per category. It is usable for recognizing groups of different symptoms as disorders in people all over the world. This makes it clinically reproducible and usable, even though additional factors about the manifestations and specifics in the individual case are necessary in order to design a treatment plan.

The system is not suitable as a basis for important decisions in a legal context, such as establishing the necessity of involuntary commitment, criminal responsibility, eligibility for a disability pension, or the state of someone’s driving skills. These determinations involve a different dimension of reality, necessitating additional information, as clearly stated in the introduction to the DSM Manual. In daily psychiatric practice the diagnostic system is used for these matters, even though it is neither designed nor suitable for such.

Parallel to the DSM system's great interest in empirical research, a development emerged in medicine as a whole in the eighties and nineties of the twentieth century. It is the movement initiated by Sackett and others called Evidence Based Medicine (EBM).[541] This movement, which in a short time is strongly gaining influence, presumes that nowadays it is possible to determine links between medical interventions and their effects on the basis of research. Research methodology is so advanced nowadays, that results provide reasonable certainty. This makes it possible to decide which intervention for a certain illness is most effective, and at the same time the least expensive. Later, consideration of the motivation and goals of the patient is added as an objective. In EBM different methods of research are compared, and a hierarchy is established. At the top are the methods rendering the "hardest" evidence, below them the less certain methods. At the bottom is clinical experience.

In medicine this research is of a pronounced biomedical neopositivistic character. After all, the effect of all sorts of treatments on bodily deviations can be determined with quantitative methods borrowed from the physical sciences. Psychiatry appears to be following the same path and is also taking a neopositivistic turn. Using questionnaires and structured interviews, qualitative criteria are "translated" into quantitative data. This is how empirical research into the effects of all kinds of pharmaceutical and other interventions can be done in psychiatry just as it is done in somatic medicine. One of the developments stimulating this course in a neopositivistic direction is the spectacular progress in the field of genetics. Research into disorders that occur in certain families and research into identical and non-identical twins has been able to demonstrate the great significance of hereditary factors in many disorders. The Human Genome Project has further inspired and added to this research. In this light vast optimism is growing about future research and therapeutic possibilities.

In addition, these years saw spectacular developments in neurobiology. Increasingly, elements of the function of the Central Nervous System (CNS) are mapped. Gradually we are beginning to understand the nature of interneuronal connections, the synapses. More and more pieces of the puzzle are falling into place. This fascinating development, too, evokes enthusiasm. Imaging techniques, such as PET and MRI scans, provide us with a stream of information about the function of the CNS.

Spectacular discoveries in these areas of research are regularly reported in professional publications and the general media, receiving widespread attention. However, the great expectations, perhaps more than the actual achievements, have a darker side. They tend to narrow the ideological horizon, because attention is focused on the body and the CNS.[542] Some neuroscientists express the expectation that some day neuroscience will explain all psychiatric disorders. This can go so far as to cause all of humanity to be considered materialistically and monistically. That way the concept of "mind" is regarded superfluous. To determine who a person is, we need only examine his CNS. In *The Meaning of Mind (1996)* Szasz keenly criticizes this reductionistic attitude, as it makes man

as social, political, and above all, moral, responsible being, extraneous. Szasz attacks these neuroscientists with mordant irony in this laudable book.

By the way, Szasz notes that these developments are leading to increasingly more coercion in psychiatry. In the past the realms of voluntary and involuntary treatment were plainly demarcated. This demarcation has been erased now that biological psychiatry presents itself as a new, value-free science. He states, "Coercive psychiatric practices are now more common, affect more persons, and are believed to be better justified than they have ever been." (*Liberation by Oppression*, 2002, p.8).

The view that scientific proof for the existence of underlying neurological mechanisms of psychiatric disorders would justify coercion is based on a complicated misunderstanding. Somatic medicine deals with objective, demonstrable bodily deviations. Coercion, in somatic medicine, is a rare exception. From a medical point of view, finding objective, demonstrable deviations in connection with psychiatric disorders does not justify coercion. Yet the argument is used. The motto "Those people *really* have something wrong with them" conflates facts with ethics.

Nonetheless, these developments could have another perspective. For instance, nowadays, the treatment of schizophrenia is possible, but still only in a very limited way. Treatment cannot turn the tide of the schizophrenic process. At most it can slow it down somewhat. Ongoing intervention by mental health workers remains required. Only the symptoms are treated. This treatment has serious side effects, and may, in the long run, be more harmful than refraining from treatment.[543] Suppose, hypothetically speaking, that an effective medical treatment for schizophrenia were found. I doubt it will ever happen considering the extremely complicated problems involved, but it is tempting to fantasize about it. Such a therapy could put coercion for schizophrenia out of business. In this way, neuroscience would contribute to the reduction of coercion. Unfortunately, this time has not arrived yet. But there is a historical parallel, the history of the treatment of epilepsy, as recounted by Szasz in *Cruel Compassion* (1994): "When the treatment of epilepsy was nonexistent or rudimentary, psychiatrists used the epileptic's alleged need for treatment as a pretext for confining him. Subsequently, as the physician's *pharmacological* power to treat epilepsy increased, his political power to deprive him of liberty, in the name of therapy, diminished and quickly disappeared." (p.62)

So, in summary, there are reasons for vesting high hopes in the neopositivistic direction of psychiatry: the development of new research methods and the development of genetics, neuroscience, and imaging techniques. This direction largely dominates modern scientific discourse. This has two important implications. One affects views on the nature of psychiatric disorders. The other affects psychiatry as a medical specialty.

Regarding the former, the view that psychiatric disorders are basically defined by physical deviation is held much more strongly today than two decades ago. The expectation that the physical or biological determinants for all kinds of psychiatric disorders will someday be discovered, as discussed in Chapter V, 3.2, is greater than ever. Ideologically speaking, the old hypothesis that psychiatric

disorders exist only in connection with biological abnormality is again gaining terrain.

The other implication is that we can observe psychiatry moving toward medicine on the whole. The theme of the 2004 annual convention of Dutch Psychiatrists was: "The psychiatrist as a medical specialist under the sign of Asclepius." This slogan implies two positions, as the chairperson of the Association for Psychiatry declared at this convention. One is that psychiatrists are medical specialists, the other that psychiatric disorders are "real" (i.e. biomedical) disorders. The first is indisputable. The second is open to debate, as Szasz's work and also this book testifies. In itself, the fact that this slogan nonetheless can be launched like this in 2004 illustrates how far the ideological pendulum has swung in the direction of biological abnormality. Aside from the significance for understanding disorders, this move of psychiatry towards medicine also has strategic significance. Szasz has frequently observed (as early as in *The Myth of Mental Illness* in 1961) that psychiatry has always endeavored to be recognized as a medical specialty in order to share in medicine's prestige. In a moral sense, psychiatrists often were and are considered substandard specialists by their somatic colleagues. They are tolerated, but not as equals. Indeed, the point of this strategic approach is mainly gaining recognition for psychiatry in the eyes of somatic colleagues, the state, and medical insurance companies. In the seventies and eighties of the twentieth century this recognition was considered less important than psychiatry's independent status, but nowadays psychiatry clamors for status inside medicine.

On the one hand, the DSM's classification system has conquered the "market." With this the fundament of categorizing and treating psychiatric disorders is explicitly the biopsychosocial concept of illness. On the other hand, the biomedical view has gained the upper hand, in particular in scientific discourse. This ambiguous attitude can be characterized as "biomedical in principle but biopsychosocial in practice." The dilemma sketched in Chapters V and VI looms greater today than ever.

....Rationality and Relation

Practical medicine as well as psychiatry as a craft have always been based on two cornerstones. The rational cornerstone is the hallmark of a medicine that aspires to be scientific. This cornerstone has produced spectacular, partly specific therapies (the so-called magic bullets, pharmaceutical or other interventions which specifically attack a disease or its cause, such as antibiotics). It became the foundation of scientific medicine and scientific psychiatry.

The other cornerstone is the relational. I will briefly expound on this one, as it is extraordinarily significant in psychiatry. In the first place, to determine symptoms, the psychiatrist is almost totally dependent on the patient's willingness to talk about his symptoms. So the quality of the relationship has a direct influence on the diagnosis and therapy. Secondly, thanks to this relationship, the psychiatrist can perform useful work even when no (effective) therapies are available. Further, through this relationship the psychiatrist can support his patient, offer a prospect, and evoke a feeling of cooperation and identification.

Other relational elements are offering dependable information, providing insight into the disorder, discussing possible courses of action, and helping to weigh the advantages and disadvantages of various itineraries. In addition, during therapy, mutual trust, discussion on how things are going along, and the possible desirability of a change in itinerary are important for optimal cooperation. Such cooperation increases the effectiveness of the treatment. A satisfactory relationship with the patient is paramount to the healing process. It can shorten the stay in the hospital, boost motivation, and optimalize the patient's cooperation. Many psychiatric disorders are chronic or tend to keep returning, making a maximally cooperative relationship even more important. In short, the relational cornerstone is of great significance in psychiatry. Of course this applies to medicine in general as well. The significance of the relational element has not abated now that the nature and number of treatments have augmented.

The neopositivistic direction may, in this respect, have some damaging side-effects. Physicians have become technical experts who are poorly accessible to their patients.* Patients complain a great deal more about today's technologically perfected medicine than they complained about the powerless physicians of former times.

Illness does not strike only, nor in the first place, the body, but the entire person. "Doctoring" is much more than applying medicines or conducting operations. In practice, in somatic medicine as well, the biomedical disease concept is too reductionistic, too simplistic.

...Professional Ethics

Today, enormous value is attached to the partly dysfunctional physicochemical aspects of illness and being ill, so of illness as an ontological concept. At the same time, a different, integral aspect of medicine is retreating from focus these last decades. This aspect is medical ethics. Medical ethics deals with matters

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* In 2002 a national commission on mental health instituted by the ministry of health published its report in the Hague. One of its conclusions is that family physicians, the pillar around which the Dutch health care system revolves, are less willing than in the past to discuss all sorts of problems related to health care that can occur in the daily lives of their patients with them. Cardiologists often do not take the time to discuss the importance of not smoking with their patients after they have had a heart attack. Specialists report lacking the time to discuss organ donation with the family following the brain death of a patient. The suspicion is raised that they may lack the motivation and the skills to conduct a discussion with the family in such emotionally difficult circumstances. The report suggests hiring special hospital doctors, whose job will be to facilitate communication between the specialists and the patients, "relieving" the specialists of this load. Nurses are to assist family physicians in cases which require extra communication, such as chronic or terminal illness. These are only some examples of how inaccessible physicians have become to their patients.
It seems to me not unlikely that the growing popularity of alternative medicine may be related to this. – J.P.

such as confidentiality, privacy, loyalty to the patient, and respecting that which the patient considers to be in his own interest. In other words, ethics are losing attention because physicians are interested in studying physical, "objective" phenomena.

The state has expressly reserved a place for itself in the field of medical ethics by means of legislation. I will say more about this in the next section.

Many outside parties have become interested in and want to know more about what is discussed confidentially in the doctor's office or during a medical consultation. The state is interested due to its constant preoccupation with keeping down the costs of health care, and making it controllable. Employers, too, want to know what is going on, and where they stand with their ill employee. Large firms employ in-house physicians and controlling medical services through which employers seek medical information about their employees. Of course medical insurance companies have a financial interest in this information. In the United States this development has been experienced extensively through managed care.

The physician is bound to professional confidentiality since antiquity. This prohibits him from passing information about the nature of his patient's disorders to third parties. However, the physician's adherence to this confidentiality is becoming increasingly unacceptable to outside parties. The growing tendency to water down patient confidentiality seems nowhere near culmination.

Decades ago a book containing medical-ethical rules, published and regularly revised by the Dutch Alliance for the Art of Medicine (Nederlandse Maatschappij ter Bevordering der Geneeskunst), turned into a loose-leaf publication. By now it has been out of print for years. There is relatively little about medical ethics on the Internet.

The relative disinterest of physicians in medical-ethical matters is also expressed in the increasingly more prominent actions of professional ethicists in the field of health care. In itself there is no objection to this. Medical advancement engenders a number of serious and difficult to solve dilemmas. The scrutiny of professional ethicists in these matters is commendable. Yet closer contact between physicians and ethicists is desirable, to keep the ethicist abreast of the practical circumstances and catch-22s that physicians face. Such close contact, however, hardly seems to materialize.

Fulford attempted to bring medical ethics back into focus by proposing Value Based Medicine (VBM) in addition to EBM.[544] VBM is a system of values and ethical foundations that determines the relationship between physician and patient in addition to diagnostics. In this way he attempts to place ethics alongside positivistic science and draw attention to it. The need to do this illustrates how undervalued ethics have become in daily practice. The same holds true for the ethical dilemmas concerning involuntary commitment, which will be discussed below.

Note that interest in medical ethical matters has not waned evenly across the different branches of medicine. Obvious exceptions are the ethics involved in more recent, controversial developments, e.g. abortion, euthanasia, and highly technologized fertility treatments.

Szasz has repeatedly addressed ethical problems such as patient confidentiality and voluntariness. He continues to do so, recently in particular in

Liberation by Oppression. His position on these medical ethical matters is conservative, meaning that he advocates preserving old, received values. He condemns new developments quite critically. Inasmuch as medical ethics are rapidly becoming marginalized, his views deserve every support.

...State Intervention

In the past years, the state of the Netherlands has massively intervened in mental health care as well as health care in general. This involvement is so far-reaching, that it cannot be ignored. I am using the Netherlands as an example, although similar state intervention has been on the upsurge in many countries in recent years.

The purpose of state intervention is control. The state is strongly preoccupied with financing health care and dealing with the rising costs. It does so first of all by managing a social medical insurance system regarding heavy medical risks, such as long-term or permanent hospitalization. Furthermore, the Ministry of Health determines the fees for various medical treatments, and it determines hospital budgets. The single most important issue in health care policy during the past two decades has been keeping costs down.

These attempts at controlling costs have led to a number of successive financing systems, which were all sooner or later replaced because they didn't work well. Understanding and implementing these systems requires medical institutions to develop increasing specific economic expertise. At one time a psychiatric institution was managed by a psychiatrist-director. Through the years it became necessary to add a financial director. This financial director became continually more important and powerful. The emphasis on the organization of care and the demand for more efficiency gave rise to the development of a professional management, which increasingly determines work protocols and the organization of treatment. At the same time, there is a great deal of reorganizing, and in particular merging of various institutions. A common complaint that was and still is heard, is that mental health care is fragmented and a confusing jungle. Mergers are supposed to provide more clarity. These mergers generated regional, practically monopolistic institutions. Health care has been heavily bureaucratized..

The state's influence is not limited to determining financial/economic and organizational frameworks. Legislation has affected the practice of medicine in several major ways. Examples are standards of quality which stipulate which conditions institutions must meet to be eligible for state licensing and funding. Another law stipulates specific quality criteria for various medical professionals.

Even more intrusive is the law regulating physician-patient relations. The state considers this relationship contractual, yet determines most of the conditions of the contract. One of those conditions is that physicians must inform patients about what is wrong with them, which different types of treatment are available, and the advantages and disadvantages of each treatment. The final decision is made by the patient.

This law was a nail in the coffin of the medical profession's so valued principle of paternalism, which dictates that the doctor determines what is good for the patient. The law's influence on the physician-patient relationship is far-

reaching. Although physicians find it difficult to break the habit of a paternalistic attitude, and increasingly raise their voices to call for reinstating the honor of traditional paternalism, gradually a lot is changing in this aspect. Patients have become more assertive, or as we call it in Dutch, "mouthy." They play an active role in determining aspects of their treatment. Consequences for the therapy are far-reaching. In recent years many more complaints are heard about this law than the initial enthusiasm would have led one to expect. It seems that the law does not reduce costs as was expected, because the patient often chooses the more costly therapy, even when the physician does not consider it necessary. Terminal patients often choose a last-hope treatment, even when the side-effects are so serious, that one would wish to spare the patient from them. The use of placebos has become virtually impossible, as it violates the information obligation. Nonetheless this law has clearly improved the position of patients in the sense that their wishes are taken more seriously than before.

State intervention has resulted in little being left of physician-patient confidentiality. Psychiatrists are more and more turning into civil servants whose work is greatly influenced and determined by a large number of regulators: the state, medical insurers, complaint arbiters, and local government. All of these regulators claim to represent the interests of patients. This means that on the one hand, the power of individual psychiatrists regarding their patients has been drastically reduced, and on the other hand, all sorts of institutions are increasingly bearing responsibility for people's mental health care.

Szasz's views on this are unambiguous. They are described in Chapter III. He has continued to write about them during the last two decades as well. He holds the libertarian view that the state should limit its intervention to defense and criminal justice.[545] In books as *Our Right to Drugs* (1992) and *Pharmacracy* (2001) he discusses the problem that the state has in his view gained much too much influence over daily health care, and has through legislation imposed prohibitions, for instance, regarding the use of medical as well as recreational drugs. In *Cruel Compassion* (1994) Szasz sketches a lively image of the consequences of in his view undesirable state intervention in the lives of all sorts of helpless and powerless people. He condemns all state assistance to the weak, because this will weaken them even more.

I cannot share this view, as too many obviously powerless people would become victims of this ideology. This raises the question where the line should be drawn, and how far the state should go in this. An illustration of this problem, which was also discussed in Chapter VI, is the law providing attractive benefits for people who are declared unemployable due to illness. In recent years the benefits had to be constantly made less attractive, as such massive advantage was being taken of the law that a million people (on a population of 16 million) were receiving benefits under this law. The challenge is to find the mean between the Scylla of unjustly abandoning the needy and the Charybdis of excessively attractive benefits for people who cannot hold their own in society.

Indirectly, state influence on the conceptualizing of psychiatric disorders is expressed in many ways. For instance, dealing with addicted people used to be a function of the criminal justice system, but was later assigned to health care. In the past, the psychopathological nature of disorders related to substance abuse were considered less important than the criminogenic effects such use often has.

A similar problem is the question of what should be counted a psychiatric disorder, and what as a psychosocial problem, so what belongs in health care and what belongs in welfare. This is not the place to suggest an answer to these questions, only to point out how they influence work in the field in all sorts of ways.

As posited above the state also exercises far-reaching and determinate influence on medical ethical issues through legislation. The law regulating physician-patient relations has far-reaching consequences for daily contacts between doctors and their patients. Laws regarding areas as abortion and euthanasia compels physicians to act according to legal directives. Massive state intervention regarding coercion in psychiatry will be discussed in the next section.

I wish to limit my discussion to this survey of examples of state intervention in health care, which are only a fraction of the total. The examples mentioned are the ones which are relevant to the theme of this book.

...Coercion in Psychiatry

....The Law in the Netherlands and Other Countries

Discussion regarding legally sanctioned coercion in psychiatry has in the Netherlands been almost totally dominated by the drafting, ratification, and implementation of a new law regarding involuntary commitment. A long period of preparation preceded it. The first steps were taken already shortly after WWII. At that time an atmosphere of distaste hovered over anything coercive. During the war, many fine and honorable citizens were incarcerated for a period in jails and concentration camps, experiencing in the flesh how terrible it is to be detained. In the ensuing years, views about how such a law should look changed rather radically. Several drafts were made.

The most important elements of the new law, called “Special Admissions to Psychiatric Hospitals,” can be summarized as follows. As illness in itself cannot justify coercion, a condition is made that there is a danger present to others, the self, or public order. This puts safeguarding society at the center of concern. Psychiatry is assigned a place adjacent to the social institution of justice, as an instrument of social control, and for the purpose of enforcing social order. This was also the case in the previous law, but an important difference is that involuntary commitment on grounds of the person’s best interests is no longer possible. The only exception to this, is that danger to oneself is included. What is meant is suicide, auto-mutilation, self-starvation, and such. These types of dangers could also be deemed best interests. That is not unimportant, as the majority of involuntary commitments are effectuated on grounds of danger to self. (See Chapter VII, 3.2.2).

The new law greatly improves the legal position of the involuntarily committed person, partly under the influence of the patients’ movement, which is gaining power. For instance, it is specifically stipulated that the final arbiter is the judge, every patient is assigned a lawyer to represent him, etc. An important aspect is that a principal distinction is made between involuntary commitment and involuntary treatment. As the decisive factor regarding involuntary commitment is

danger, and involuntary treatment is looked upon as a more serious human rights issue than involuntary commitment in itself, the committed persons retains the right to refuse treatment.*

High hopes were hinged on the new law.[546] The number of involuntary commitments were expected to drastically decline, thanks to, on the one hand, stricter criteria, and other the other, legal guarantees for the patients. Alas, this turned out not to be the case. In the past ten years, the number of involuntary commitments has tripled, from about 2000 to 6000 per year, on a population of 16 million. This increase is partly ascribable to the concept of "danger" gradually being interpreted more broadly, and partly to several additions to the law. At this moment psychiatrists are lobbying to have the law fundamentally changed, so that involuntary treatments will again be automatically included with involuntary commitments.

The law also stipulates that involuntary patients are committed ahead of voluntary patients. While the number of involuntary commitments is rising, the number of available beds is declining due to deinstitutionalization. When the cutting of funds for voluntary treatments is figured in, it becomes obvious that psychiatry is inclining more and more towards coercion, as it was a century ago in this country. So a century of emancipating interventions is gradually going down the drain. This has not happened completely yet, but it obviously will.

A recently published study investigates the contribution of various experts involved in the procedures. One conclusion is that the state has almost totally retired from the procedure, and that psychiatrists have filled the void. This indicates that psychiatry heavily endorses both involuntary commitment and involuntary treatment, no matter how unmedical the content and circumstances.

No doubt the more repressive atmosphere in society as a whole has contributed to the rise in the number of involuntary commitments during recent years. We are moving away from tolerance, towards "law and order." Recent laws criminalize increasingly many behaviors, making them punishable. The penalties are becoming more severe. Every year the clamor mounts for building more cells and jails. Feelings of insecurity are on the increase, apparently fueled in particular

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*Regarding the regulations about involuntary treatment, these are quite complicated. In short, the idea is that immediately upon involuntary commitment, the psychiatrist is required to set up a treatment plan and present it to the patient. If the patient refuses, there remain two possibilities. If he is competent, that is to say, is capable of protecting his own interests in this respect, the treatment plan remains invalid. If he is incompetent, the person who represents his interests can consent to the treatment plan in the patient's stead. However, active resistance by an incompetent patient can still invalidate the treatment plan.

In addition, if the patient refuses treatment, and also inside the hospital forms a danger to himself or others (such as staff or other patients) , involuntary measures may be administered for maximally one week. These may be forced medication, forced feeding, and solitary confinement in an isolation cell. These involuntary measures are to be registered.

Psychiatrists object to these stipulations, as they are said to "paralyze" treatment. It is unclear to what extent actual practice conforms to the stipulations of the law. – J.P.

by 9/11 and other terrorist attacks. Governments and the media powerfully stimulate these feelings by evoking an atmosphere of fear.

Another factor in advancing the case for involuntary commitment are several incidents in which a violent crime was committed by a psychiatrically disordered person. One such incident, which has come to be called the "the madman on Vrolik Street" involved a psychiatric patient who fatally struck a neighborhood child outside of his home in Amsterdam. Afterwards, an upsurge in involuntary commitments was observed. (See also Chapter VII). Also in England such incidents have prompted calls for more involuntary commitments. There the government refers to "a crisis in mental health law."[547]

Every country has some kind of provision for involuntary commitment, although these provisions differ very much from each other.[548] In Germany, for instance, correct and careful legal procedures with little influence from psychiatrists and other professions are much emphasized.[549] In contrast, in England much more emphasis is placed on the opinions of professionals and kin. In England the assumption is that experts and family have the interests of the patient at heart, whereas in Germany the experiences of WWII have given rise to great caution in these matters.[*] France occupies an intermediate position.[550] In most countries, one or more of the following criteria have to be met:

- serious psychiatric disorder;
- some form of danger;
- the need for treatment.

The last criterion is least constant and shows the most variation.

There are extreme differences from country to country in the percentage of involuntary commitments as compared to admissions in general, as well as in the absolute number of involuntary commitments per 100,000 residents. However, these numbers are in reality difficult to compare, and there are insufficient reliable studies that could make accurate comparisons possible.[551]

....Coercion and Science

Conspicuous by their absence are studies comparing voluntary and involuntary patients. It would not be exaggerated to say that fairly nothing is known about the similarities and differences. This is all the more surprising, as well as alarming,

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[*] Before and during WWII German physicians and psychiatrists actively participated in the "euthanasia" programs. These entailed the murder and gassing of thousands of psychiatric patients on grounds of a completely out of hand, absurd theory about degeneration and "inferior" life. This development later also included the mass murders of the Jews and other groups labeled "inferior" such as Gypsies. Although not all psychiatrists participated, in today's Germany there is reluctance to grant power to such professionals. For more information, see Mitscherlich A, & Mielke F., *Medizin ohne Menschlichkeit*, Frankfurt: Fischer Buecherei, 1960; Mueller-Hill B., *Toedliche Wissenschaft*. Reinbek: Rowohlt, 1984; or Shorter E., *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, New York: John Wiley, 1997. – J.P.

considering that specifically the issue of whether involuntary commitment and treatment are ethically admissible, desirable, or even necessary, has generated much theoretical discourse, but until now is still not anchored in empirical research. There is a huge discrepancy between the emphasis on the beneficial effects on the patients, and the almost total absence of any empirical confirmation of such effects. According to Hiday (1996): "Given the controversy that coercive treatment has generated in psychiatry and law, it is surprising that there is not a wealth of data on the extent and outcomes of coercion."[552] Possibly one of the reasons for this is the uncertainty whether research on coercion should focus on formal aspects (involuntary versus voluntary patients) or on contextual aspects. If the latter, the question rises, is the hospitalization experienced as coercive? Voluntary patients are also exposed to all kinds of coercion. Contrarily, occasionally a person committed by court order may not experience his hospitalization as coercive, or not realize that he is being coerced.[553] A Finnish study revealed that only half of the voluntary patients and about a third of the involuntary patients were capable of correctly identifying the legal status of their hospitalization.[554] There is no reason to believe this would be much different anywhere else. One factor in this is the policy generally followed in institutions of not distinguishing between the treatment of voluntary and involuntary patients. No matter how important this policy is, unfortunately, it renders insight into the consequences of formal involuntary commitment, including on treatment and outcomes, unachievable. Of the few studies comparing patients who agree to treatment with those who refuse, I will mention here that of Kasper et al.[555] Forty-one patients who refused antipsychotic medication while hospitalized were compared with forty-one patients who accepted medication. All of the patients who refused were administered medication by force. The refusers appeared to be more seriously disordered according to the Brief Psychiatric Rating Scale. In addition, their attitude towards the hospitalization was more negative, the hospitalization lasted longer, they resisted more, and they were more often placed in solitary confinement or otherwise constrained. Oddly, the authors did not reveal whether the need for constraint arose from the conflict with the medical staff about their treatment, or was to be ascribed to their mental disorder. Even though it may not be conclusively determinable, this distinction should not be overlooked. Psychiatrists typically ascribe behavior of which they disapprove to either the severity of the disorder or lack of disease insight, rather than to the manifest conflict in which these people find themselves.

Ramsay et al compared the outcome of 81 voluntary anorexia nervosa patients with 81 such involuntary patients.[556] Although both groups gained the same amount of weight during hospitalization, which is supported by other research as well,[557] five years later ten of the patients from the involuntary group had died, as opposed to only two from the voluntary group. Here, too, the question rises to what extent conflicts with therapists have complicated the course of the illness. No conclusions can be drawn from this study about which treatment is advisable for best long-term results. It can be neither proved nor disproved that the involuntary group was more severely disordered. Yet it seems likely that coerced treatment produces poorer results than voluntary treatment, a rather obvious conclusion. It would be wise to give the possibility of escalating conflict between therapist and patient serious consideration. The tendency to

ascribe refusal of treatment to the severity of the patient's psychopathology does not do justice to the disparity in motivation that simply exists among people.

Altogether, the conclusions of research comparing voluntary to involuntary therapy are neither representative nor consistent. But it does seem possible, through such research, to learn more about situations and disorders regarding which forced treatment can be productive of the contrary. In that case decisions about whether to resort to coercion could be better justified.

...Incompetence and Disease Insight as Basic Elements

Some of the elements that play a key role in the problematic issue of involuntary commitment and treatment have been thoroughly discussed already in Chapter VII.

Two such elements have become more prominent than twenty years ago:

- Incompetence, or the question of to what extent a person can be held responsible for his behavior and decisions regarding his treatment; and
- Insight into illness.

Therefore I will discuss these two elements below.

(*In*)*competence* refers to a person's ability to freely determine his own volition and defend his own interests regarding treatment in case of illness or a psychiatric disorder. As such, it has a key role in every kind of coercion. When a person is competent and has the ability to make choices the same as "normal" people do, involuntary commitment and treatment are never an option. When such a person displays dangerous behavior or commits a crime, he is responsible, and should be channeled into the criminal justice system. This is clearly expressed in the phrase "danger due to mental illness." When the illness is what generates the danger, this is beyond the patient's control. He then becomes a powerless victim of his illness.

The concept of incompetence was launched into the center of the controversy from the moment that medical paternalism was buried. Now that the doctor is not in a better position to judge, because he is wiser, it has become the patients' turn to decide whether or not he wishes to be treated. When disagreement arises between the physician and the patient, the patient's ability to make such a decision is called into question, and with that the issue of competence comes into center stage.

Objections to using the concept of incompetence were discussed in Chapter V. To this the following can be added.

Sometimes incompetence is obvious, in which case legal measures such as guardianship may be taken. This happens, for instance, in severe oligophrenia or the last stages of Alzheimer's disease. Usually such a self-evident state is not involved when involuntary commitment is being considered. The competence in question is in a large gray area. People's choices lie on a continuum somewhere between making the conscious choices that most people would, and being

powerlessly driven. In any case it seems that sometimes there is more free choice than other times.

Science endeavors to make the area in which man can be free, and can make free choices at his own responsibility, continuously smaller. This is not the aim, but it happens indirectly when more and more facts and physical laws are mapped. When human behavior is based on immutable laws, human freedom disappears. It is difficult to determine which differences exist among people in this respect, because the concept of "mental health" and the related free volition are so difficult to describe.[558] (See Chapter V)

From a *social* point of view, a totally different image emerges. Our society is founded on the axiom that every person is free, and therefore responsible for his actions, so can also be held responsible. A society not founded on this axiom is unimaginable. All of the conditions in our society are based on the assumption that people can and should be responsible. This social viewpoint is evident in legal judgments about *force majeure* and intention. The point of departure is individual responsibility for one's actions. Yet in addition to this principle, is the experience that in exceptional circumstances a person may be less, even very much less, capable of being responsible. In order to do justice, not absolute definitions are sought, but comparisons. .

So we find ourselves in a field of contradictions. Science seeks determinations, and therefore can persuade us to believe that freedom is an illusion that can only exist because of the enormous complexity of human life. Society and law dictate to us that we must acknowledge social reality, and that we can only judge people by comparing them to a kind of average person. It is a legal consideration rather than a psychiatric one. Yet, in recent discussions on the concept of incompetence, this concept is regarded as a key element in dealing with the problems pertaining to involuntary commitment and treatment.[559] The concept is often used in a reified form and applied to people as a group: the incompetents. Glass draws the following conclusion from her research, "…there is still no agreement on either the exact criteria or the methods of assessing mental competency."[560]

Here, too, the formulation of theories has received a great deal more attention than empirical research. One example of research into this area is by Grisso and Appelbaum.[561] Comparing psychiatric patients, heart patients, and healthy people, they concluded, "Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions." Tan et al concluded that in the case of anorexia nervosa, the frequent dilemmas regarding involuntary commitment and treatment cannot be solved by declaring these patients incompetent, because they simply are not incompetent.[562] So empirical support for the key position regarding the concept of incompetence can scarcely be found, if at all. Wishing nevertheless to apply this concept is pseudoscientific and unjust.

Disease insight is another key concept used to justify involuntary interventions. In essence the idea is that "those agreeing with their treating psychiatrist have insight, those who disagree have not."[563]. This author, Høyer, expresses surprise that the concept of disease insight is accepted at face value in the literature. The degree to which disease insight is absent is seldom considered, nor to which

extent a lack in disease insight effects the ability to make decisions or influences the relevant competency. One might add that in psychiatry's turn toward neopositivism, the lack of disease insight is sometimes short-circuited as a manifestation of a dysfunction in the brain's pre-frontal lobe. This unproven and therefore unscientific explanation suggests that the patient's choice is limited by a brain disorder. Needless to say that this assumption is a clear example of the 'scientific' tendency to explain away human capacity for choice. As psychiatrists' criteria for an intact disease insight tend to vary considerably, Saravanan et al propose to assume the presence of insight, "if a person could acknowledge some kind of non-visible change in his or her body or mind that affects the ability to function socially, and if he or she feels the need for restitution."[564] The problem with this is that although patients with schizophrenia can have very different ideas about what is wrong with them, they cannot be expected to adopt the evolving views that psychiatry develops in the course of time about themselves and their disorders. In addition, there does not seem to be a consistent relationship between that which people express in words and their decision to cooperate or not with treatment. Finally, the involuntarily committed patient remains in a state of conflict with the psychiatrist. Precisely this can influence what he can or wants to reveal about of the thoughts he has about himself.

...Alternatives

A symposium at the World Congress for Psychiatry in Athens in 1989 was dedicated to the desirability of treating psychotic homeless people with depot-neuroleptics. These are psychoactive drugs that can retard psychotic manifestations. They are injected, and remain effective for two to four weeks. After discussion about the pros and cons, one psychiatrist rose and related to have done much work with the homeless, including psychotic homeless. He asserted that what this group of people needs, in the very first place, are shelter, beds, and food. This contradiction in views is characteristic for psychiatry,

In 1984 Kimble elaborately described what he called the two cultures of psychology.[565] This view seems to me applicable to psychiatry as well. He calls one of the cultures scientific, and the other humanistic. He names five dimensions in which these cultures differ. They are: determinism versus indeterminism; observation as the prime source of knowledge versus intuition; knowledge collection (in laboratories in particular) versus in the field or through case studies; nomothetic versus ideographic rules; and analytic versus synthetic thinking. Using questionnaires, he researched these dimensions in colleagues. According to Kimble, these two different orientations on reality have existed for millennia, and psychologists have also adopted them. The same can be said about psychiatrists. Perhaps these two orientations can explain in part why psychiatry's history is alternately dominated by one or the other. Clearly, today the scientific, analytical, deterministic view dominates, as it did in Athens. The humanistic view is marginalized, and mainly espoused by psychiatrists practicing in the field. Scientific approaches have the upper hand.

It is tempting to juxtapose these two orientations to the two most important disease concepts of the moment: the biomedical and the biopsychosocial. In a

period of domination by the biomedical concept, relatively little attention is paid to the humanitarian-social aspect, as is illustrated by psychiatrists' relative disinterest in the circumstances of the treatment and the environment in which it has to occur. Contrarily, nowadays there is a great deal of preoccupation with the more technical-therapeutic side of the profession: disease as an ontological concept, rather than as a value concept. This generates exaggerated optimism, but sometimes also underestimation, about what is achievable. The exaggerated optimism these last decades is especially as to the possibilities and prospects of therapies involving biological intervention. Psychological influencing and the humanitarian aspects are underestimated.

Furthermore, most psychiatrists have practically a blind spot for the aspect of their work that relates to power. They surrendered paternalism for lack of choice under the new law. At the same time, these past years they raise their voices continuously more loudly in demand of the reinstatement of paternalism.

Perhaps concrete and immediate improvement could be achieved if the balance between empirical-scientific and humanistic aspects could be restored. In that case, more attention would be directed at:

- Reinstating the asylum function of psychiatry, by creating safe havens, where people who apparently cannot hold their own in society can be provided shelter and protection;
- Providing for the primary needs of the homeless, in the sense of places to sleep and eat which are sufficiently comfortable, also in quantity, with an opportunity for permanent shelter if so desired, without the threat of the often so feared treatment;
- Further development of possibilities for intervention[566] and other forms of persuasion[567] on a voluntary basis.

On the one hand, these "solutions" are too attractive, as Szasz tried to show in *Cruel Compassion* (1994). The worry is that there will be too much demand for such provisions, which will massively draw candidates. That would of course mean that the need for such provisions is quite great, probably greater than the need for today's provisions which are preoccupied with treatment and therapy. At the same time, precisely because they refrain from the ideology of treatment and therapy, they are too modest to appeal to politicians.

Apparently, restriction and pretence tempt the state to choose solutions within the framework of psychiatry, with its inaccessibility, its stigmatization, and for many its unwelcome therapeutic ideologies. The restriction that a psychiatric disorder must be present prevents excessive demand for assisted living. The pretense that treatment truly cures makes funding more acceptable.

In my opinion, coercion as practiced by psychiatry has much more complex roots than psychiatrists' thirst for power and status. Apparently, society – the state, the legal system, and the public at large -- has a need to remove from its midst the feelings of being threatened and the fear of the unknown that psychiatric patients can evoke. It seems that this need for protection cannot be satisfied by the legal system with its precise rules and legal guarantees because of the impossibility of determining the exact nature and size of the threat.

This, I believe, is the complex reason that a more informal system of social control developed alongside the system of justice. Perhaps this clarifies why

every protest or criticism of this system is met with recoil, whether shouted in fire and brimstone by heretics like Szasz, or whether levelly evaluated, weighing the pros and cons, the way I have done in this book.

▪▪*Appendix: Books by Thomas Szasz*

Books published up to the time of publication of Myth and Power by Jan Pols:

Pain and Pleasure: A Study of Bodily Feelings, New York, Basic Books, 1957

The Myth of Mental Illness: Foundations of a Theory of Personal Conduct, New York, Paul B. Hoeber, 1961

Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices, New York, Macmillan, 1963

The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy, New York, Basic Books, 1965

Psychiatric Justice, New York, Macmillan, 1965

Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man, Garden City, NY: Doubleday, 1970

The Manufacture of Madness: A Comparitive Study of the Inquisition and the Mental Health Movement, New York: Harper Row, 1970

The Second Sin, Garden City, NY: Doubleday, 1973

The Age of Madness: The History of Involuntary Mental Hospitalization Presented in Selected Texts, Garden City, NY, Doubleday Anchor, 1973

The Myth of Mental Illness: foundations of a Theory of Personal Conduct, Revised Edition, New York: Harper Row, 1974

Ceremonial Chemistry: the Ritual persecution of Drugs, Addicts, and Pushers, Garden City, NY: Doubleday, 1974

Heresies, Garden City, NY: Doubleday Anchor, 1976

Schizophrenia: The Sacred Symbol of Psychiatry, New York: Basic Books, 1976

Karl Kraus and the Soul-Doctors: A Pioneer and His Criticism of Psychiatry and Psychoanalysis, Baton Rouge, Louisiana: Louisiana State University Press, 1976

Psychiatric Slavery: When confinement and Coercion Masquerade as Cure, New York: the Free Press: 1977

The Theology of Medicine: The Political-Philosophical Foundations of Medical Ethics, Baton Rouge: Louisiana: Louisiana State University Press, 1977, New York: Harper Row Colophon, 1977

The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric, and Repression, Garden City, NY: Doubleday Anchor, 1978

Sex by Prescription, Garden City, NY: Doubleday Anchor, 1980

Books published after publication of Myth and Power by Jan Pols:

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