The Psychiatrist
FORMERLY THE PSYCHIATRIC BULLETIN

The myth of mental illness: 50 years later

Thomas Szasz

The Psychiatrist 2011 35: 179-182
Access the most recent version at doi:10.1192/pb.bp.110.031310

The myth of mental illness: 50 years later†

Thomas Szasz[1]

The Psychiatrist (2011), **35**, 179–182, doi: 10.1192/pb.bp.110.031310

[1]State University of New York Upstate Medical University, USA

Correspondence to Thomas Szasz (tszasz@aol.com)

First received 16 Jun 2010, accepted 16 Nov 2010

Summary Fifty years ago I noted that modern psychiatry rests on a basic conceptual error – the systematic misinterpretation of unwanted behaviours as the diagnoses of mental illnesses pointing to underlying neurological diseases susceptible to pharmacological treatments. I proposed instead that we view persons called 'mental patients' as active players in real life dramas, not passive victims of pathophysiological processes outside their control. In this essay, I briefly review the recent history of this culturally validated medicalisation of (mis)behaviours and its social consequences.

Declaration of interest None.

In my essay 'The myth of mental illness', published in 1960, and in my book of the same title which appeared a year later, I stated my aim forthrightly: to challenge the medical character of the concept of mental illness and to reject the moral legitimacy of the involuntary psychiatric interventions it justifies.[1,2] I proposed that we view the phenomena formerly called 'psychoses' and 'neuroses', now simply called 'mental illnesses', as behaviours that disturb or disorient others or the self; reject the image of the patients as the helpless victims of pathobiological events outside their control; and withdraw from participating in coercive psychiatric practices as incompatible with the foundational moral ideals of free societies.

Fifty years of change in US mental healthcare

In the 1950s, when I wrote *The Myth of Mental Illness*, the notion that it is the responsibility of the federal government to provide healthcare to the American people had not yet entered national consciousness. Most persons called 'mental patients' were considered incurable and were confined in state mental hospitals. The physicians who cared for them were employees of the state governments. Non-psychiatric physicians in the private sector treated voluntary patients and were paid by their clients or the clients' families.

Since that time, the formerly sharp distinctions between medical hospitals and mental hospitals, voluntary and involuntary patients, private and public psychiatry have blurred into non-existence. Virtually all mental healthcare is now the responsibility of the government and it is regulated and paid for by public moneys. Few, if any, psychiatrists make a living from fees collected directly from patients and none is free to contract directly with his patients about the terms of the therapeutic contract governing their relationship. Everyone defined as a mental health professional is now legally responsible for preventing his patient from being 'dangerous to himself or others'.[3] In short, psychiatry is thoroughly medicalised and politicised. The opinion of official American psychiatry – embodied in the official documents of the American Psychiatric Association and exemplified by its diagnostic and statistical manuals of mental disorders – bears the imprimatur of the federal and state governments. There is no legally valid non-medical approach to mental illness, just as there is no legally valid non-medical approach to measles or melanoma.

Mental illness – a medical or legal concept?

Fifty years ago, it made sense to assert that mental illnesses are not diseases. It makes no sense to do so today. Debate about what counts as mental illness has been replaced by political–judicial decrees and economic criteria: old diseases such as homosexuality disappear, whereas new diseases such as attention-deficit hyperactivity disorder appear.

Fifty years ago, the question 'What is mental illness?' was of interest to physicians, philosophers, sociologists as well as the general public. This is no longer the case. The question has been settled by the holders of political power: they have decreed that mental illness is a disease like any other. In 1999, the US president Bill Clinton declared: 'Mental illness can be accurately diagnosed, successfully treated, just as physical illness'.[4] Surgeon general, David Satcher, agreed: 'Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain'.[5] Thus has political power and professional self-interest united in turning a false belief into a 'lying fact'.[6]

The claim that mental illnesses are diagnosable disorders of the brain is not based on scientific research; it is an error, or a deception, or a naive revival of the somatic premise of the long-discredited humoral theory of disease. My claim that mental illnesses are fictitious illnesses is also not based on scientific research; rather, it rests on the pathologist's materialist–scientific definition of illness as the structural or functional alteration of cells, tissues and

†This paper was delivered as a plenary address at the International Congress of the Royal College of Psychiatrists in Edinburgh, 24 June 2010. See also commentary, pp. 183–184, this issue.

organs. If we accept this definition of disease, then it follows that mental illness is a metaphor – asserting that view is stating an analytic truth, not subject to empirical falsification.

The Myth of Mental Illness offended many psychiatrists and many mental health patients as well. My offense – if it be so deemed – was calling public attention to the linguistic pretensions of psychiatry and its pre-emptive rhetoric. Who can be against 'helping suffering patients' or 'providing patients with life-saving treatment'? Rejecting that jargon, I insisted that mental hospitals are like prisons not hospitals, that involuntary mental hospitalisation is a type of imprisonment not medical care, and that coercive psychiatrists function as judges and jailers not physicians and healers. I suggested that we discard the traditional psychiatric perspective and instead interpret mental illnesses and psychiatric responses to them as matters of morals, law and rhetoric, not matters of medicine, treatment or science.

'Mental illness' is a metaphor

The proposition that mental illness is not a medical problem runs counter to public opinion and psychiatric dogma. When a person hears me say that there is no such thing as mental illness, he is likely to reply: 'But I know so-and-so who was diagnosed as mentally ill and turned out to have a brain tumour. In due time, with refinements in medical technology, psychiatrists will be able to show that all mental illnesses are bodily diseases'. This contingency does not falsify my contention that mental illness is a metaphor. It verifies it. The physician who concludes that a person diagnosed with a mental illness suffers from a brain disease discovers that the person was misdiagnosed: he did not have a mental illness, he had an undiagnosed bodily illness. The physician's erroneous diagnosis is not proof that the term mental illness refers to a class of brain diseases.

Such a process of biological discovery has, in fact, characterised some of the history of medicine, one form of 'madness' after another being identified as the manifestation of one or another somatic disease, such as beriberi or neurosyphilis. The result of such discoveries is that the illness ceases to be a form of psychopathology and is classified and treated as a form of neuropathology. If all the conditions now called mental illnesses proved to be brain diseases, there would be no need for the notion of mental illness and the term would become devoid of meaning. However, because the term refers to the judgements of some persons about the (bad) behaviours of other persons, what actually happens is precisely the opposite. The history of psychiatry is the history of an ever-expanding list of mental disorders.

Changing perspectives on human life (and illness)

The thesis I had put forward in *The Myth of Mental Illness* was not a fresh insight, much less a new discovery. It only seemed that way, and seems that way even more so today, because we have replaced the old religious–humanistic perspective on the tragic nature of life with a modern, dehumanised, pseudomedical one.

The secularisation of everyday life – and, with it, the medicalisation of the soul and of personal suffering intrinsic to life – begins in late 16th-century England. Shakespeare's *Macbeth* is a harbinger. Overcome by guilt for her murderous deeds, Lady Macbeth 'goes mad': she feels agitated, is anxious, unable to eat, rest or sleep. Her behaviour disturbs Macbeth, who sends for a doctor to cure his wife. The doctor arrives, quickly recognises the source of Lady Macbeth's problem and tries to reject Macbeth's effort to medicalise his wife's disturbance:

> This disease is beyond my practice . . . unnatural deeds
> Do breed unnatural troubles: infected minds
> To their deaf pillows will discharge their secrets:
> More needs she the divine than the physician.
> (Act V, Scene 1)[7]

Macbeth rejects this diagnosis and demands that the doctor cure his wife. Shakespeare then has the doctor utter these immortal words, exactly the opposite of what psychiatrists and the public are now taught to say and think:

> Macbeth. How does your patient, doctor?
>
> Doctor. Not so sick, my lord,
> As she is troubled with thick coming fancies,
> That keep her from her rest.
>
> Macbeth. Cure her of that.
> Canst thou not minister to a mind diseased,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain
> And with some sweet oblivious antidote
> Cleanse the stuffed bosom of that perilous stuff
> Which weighs upon her heart?
>
> Doctor. Therein the patient
> Must minister to himself. (Act V, Scene 3)[7]

Shakespeare's insight that the mad person must minister to himself is at once profound and obvious. Profound because witnessing suffering calls forth in us the impulse to help, to do something for or to the sufferer. Yet also obvious because understanding Lady Macbeth's suffering as a consequence of internal rhetoric (imagination, hallucination, the voice of conscience), the remedy must also be internal rhetoric (self-conversation, 'internal ministry').

Perhaps a brief comment about internal rhetoric is in order here. In my book *The Meaning of Mind*,[8] I suggest that we view thinking as self-conversation, as Plato had proposed. Asked by Theaetetus to describe the process of thinking, Socrates replies: 'As a discourse that the mind carries out about any subject it is considering . . . when the mind is thinking, it is simply talking to itself'.[8] (This is a modern translation. The ancient Greeks had no word 'mind' as a noun.)

By the end of the 19th century, the medical conquest of the soul is secure. Only philosophers and writers are left to discern and denounce the tragic error. Søren Kierkegaard warned:

> 'In our time . . . it is the physician who exercises the cure of souls . . . And he knows what to do: [Dr.]: "You must travel to a watering-place, and then must keep a riding-horse . . . and then diversion, diversion, plenty of diversion . . ." – [Patient]: "To relieve an anxious conscience?" – [Dr.]: "Bosh! Get out with that stuff! An anxious conscience! No such thing exists any more" ' (p. 57).[9]

Today, the role of the physician as curer of the soul is uncontested.[10] There are no more bad people in the world, there are only mentally ill people. The 'insanity defence'

annuls misbehaviour, the sin of yielding to temptation and tragedy. Lady Macbeth is human not because she is, like all of us, a 'fallen being'; she is human because she is a mentally ill patient who, like other humans, is inherently healthy/good unless mental illness makes her sick/ill-behaved: 'The current trend of critical opinion is toward an upward reevaluation of Lady Macbeth, who is said to be rehumanized by her insanity and her suicide' (http://act.arlington.ma.us/shows/index.html#mbeth).[9]

Mental illness is in the eye of the beholder

Everything I read, observed and learnt supported my adolescent impression that the behaviours we call mental illnesses and to which we attach the legions of derogatory labels in our lexicon of lunacy are not medical diseases. They are the products of the medicalisation of disturbing or disturbed behaviours – that is, the observer's construction and definition of the behaviour of the persons he observes as medically disabled individuals needing medical treatment. This cultural transformation is driven mainly by the modern therapeutic ideology that has replaced the old theological world view and the political and professional interests it sets in motion.

In principle, medical practice has always rested on patient consent, even if in fact that rule was sometimes violated. The corollary of that principle is that bodily illness does not justify depriving the patient of liberty, only legal incompetence does (and, sometimes, demonstrable dangerousness to others attributable to a contagious disease). Thus, I concluded that not only are most persons categorised as mentally ill not sick, but depriving them of liberty and responsibility on the grounds of disease – literal or metaphorical – is a grave violation of their basic human rights.

In medical school, I began to understand that my interpretation was correct – that mental illness is a myth and that it is therefore foolish to look for the causes and cures of such fictitious ailments. This understanding further intensified my moral revulsion against the power psychiatrists wielded over their patients.

Diseases of the body have causes, such as infectious agents or nutritional deficiencies, and often can be prevented or cured by dealing with these causes. Persons said to have mental diseases, on the other hand, have reasons for their actions that must be understood. They cannot be treated or cured by drugs or other medical interventions, but may be benefited by persons who respect them, understand their predicament and help them to help themselves overcome the obstacles they face.

The pathologist uses the term disease as a predicate of physical objects – cells, tissues, organs and bodies. Textbooks of pathology describe disorders of the body, living or dead, not disorders of the person, mind or behaviour. René Leriche, the founder of modern vascular surgery, aptly observed: 'If one wants to define disease it must be dehumanized… In disease, when all is said and done, the least important thing is man'.[11]

For the practice of pathology and for disease as a scientific concept, the person as potential sufferer is unimportant. In contrast, for the practice of medicine as a human service and for the legal order of society, the person as patient is supremely important. Why? Because the practice of Western medicine is informed by the ethical injunction, *primum non nocere*, and rests on the premise that the patient is free to seek, accept or reject medical diagnosis and treatment. Psychiatric practice, in contrast, is informed by the premise that the mental health patient may be dangerous to himself or others and that the moral and professional duty of the psychiatrist is to protect the patient from himself and society from the patient.[3]

According to pathological–scientific criteria, disease is a material phenomenon, a verifiable characteristic of the body, in the same sense as, say, temperature is a verifiable characteristic of it. In contrast, the diagnosis of a patient's illness is the judgement of a licensed physician, in the same sense as the estimated value of a work of art is the judgement of a certified appraiser. Having a disease is not the same as occupying the patient role: not all sick persons are patients and not all patients are sick. Nevertheless, physicians, politicians, the press and the public conflate and confuse the two categories.[12]

Revisiting *The Myth of Mental Illness*

In the preface to *The Myth of Mental Illness* I explicitly state that the book is not a contribution to psychiatry: 'This is not a book on psychiatry… It is a book about psychiatry – inquiring, as it does, into what people, but particularly psychiatrists and patients, have done with and to one another' (p. xi).[2]

Nevertheless, many critics misread, and continue to misread, the book, overlooking that it is a radical effort to recast mental illness from a medical problem into a linguistic–rhetorical phenomenon. Not surprisingly, the most sympathetic appraisals of my work have come from non-psychiatrists who felt unthreatened by my re-visioning of psychiatry and allied occupations.[13,14] One of the most perceptive such evaluations is the essay, 'The rhetorical paradigm in psychiatric history: Thomas Szasz and the myth of mental illness', by professor of communication Richard E. Vatz and law professor Lee S. Weinberg. They wrote:

> 'In his rhetorical attack on the medical paradigm of psychiatry, Szasz was not only arguing for an alternative paradigm, but was explicitly saying that psychiatry was a "pseudoscience", comparable to astrology… accommodation to the rhetorical paradigm is quite unlikely inasmuch as the rhetorical paradigm represents so drastic a change – indeed a repudiation of psychiatry as scientific enterprise – that the vocabularies of the two paradigms are completely different and incompatible… Just as Szasz insists that psychiatric patients are moral agents, he similarly sees psychiatrists as moral agents… In the rhetorical paradigm the psychiatrist who deprives people of their autonomy would be seen as a consciously imprisoning agent, not merely a doctor providing "therapy", language which insulates psychiatrists from the moral responsibility for their acts… The rhetorical paradigm represents a significant threat to institutional psychiatry, for… without the medical model for protection, psychiatry becomes little more than a vehicle for social control – and a primary violator of individual freedom and autonomy – made acceptable by the medical cloak.'[15]

The late Roy Porter, the noted medical historian, summarised my thesis as follows:

> 'All expectations of finding the aetiology of mental illness in body or mind – not to mention some Freudian underworld – is, in Szasz's view, a category mistake or sheer bad faith . . . standard psychiatric approaches to insanity and its history are vitiated by hosts of illicit assumptions and *questions mal posés*'.[16]

Having an illness does not make an individual into a patient

One of the most illicit assumptions inherent in the standard psychiatric approach to insanity is treating persons called mentally ill as sick patients needing psychiatric treatment, regardless of whether they seek or reject such help. This accounts for an obvious but often overlooked difficulty peculiar to psychiatry, namely that the term refers to two radically different kinds of practices: curing/healing souls by conversation and coercing/controlling persons by force, authorised and mandated by the state. Critics of psychiatry, journalists and the public alike regularly fail to distinguish between counselling voluntary clients and coercing-and-excusing captives of the psychiatric system.

Formerly, when church and state were allied, people accepted theological justifications for state-sanctioned coercion. Today, when medicine and the state are allied, people accept therapeutic justifications for state-sanctioned coercion. This is how, some 200 years ago, psychiatry became an arm of the coercive apparatus of the state. And this is why today all of medicine threatens to become transformed from personal care into political control.

The issues discussed in this article are not new. Ninety-nine years ago, Eugen Bleuler concluded his magnum opus, *Dementia Praecox*, with this reflection:

> 'The most serious of all schizophrenic symptoms is the suicidal drive. I am even taking this opportunity to state clearly that our present-day social system demands a great, and entirely inappropriate cruelty from the psychiatrist in this respect. People are being forced to continue to live a life that has become unbearable for them for valid reasons . . . Most of our worst restraining measures would be unnecessary, if we were not duty-bound to preserve the patients' lives which, for them as well as for others, are only of negative value. If all this would, at least, serve some purpose! . . . At the present time, we psychiatrists are burdened with the tragic responsibility of obeying the cruel views of society; but it is our responsibility to do our utmost to bring about a change in these views in the near future.'[17]

I want to note here that it would be a serious mistake to interpret this passage as endorsing the view that we – psychiatrists – define and devalue individuals diagnosed with schizophrenia as having lives not worth living. To the contrary, Bleuler – an exceptionally fine person and compassionate physician – was pleading for the recognition of the rights of 'schizophrenics' to define and control their own lives and that psychiatrists not deprive them of their liberty to take their own lives.

Notwithstanding Bleuler's vast, worldwide influence on psychiatry, psychiatrists ignored his plea to resist 'obeying the cruel views of society'. Ironically, the opposite happened: Bleuler's invention of schizophrenia lent impetus to the medicalisation of the longing for non-existence, led to the creation of the pseudoscience of 'suicidology' and contributed to landing psychiatry in the moral morass in which it now finds itself.

About the author

Thomas Szasz is professor of psychiatry emeritus, State University of New York Upstate Medical University, Department of Psychiatry, Syracuse, New York, USA.

References

1 Szasz T. The myth of mental illness. *Am Psychol* 1960; **15**: 113–8.

2 Szasz T. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. Hoeber-Harper, 1961; rev. ed. HarperCollins 1974, 2000.

3 Szasz T. Psychiatry and the control of dangerousness: on the apostrophic function of the term 'mental illness'. *J Med Ethics* 2003; **29**: 227–30.

4 Clinton WJ. *Remarks at the White House Conference on Mental Health, June 7, 1999*. Public Papers of the Presidents of the United States: William J. Clinton, 1999, Book 1, January 1 to June 30, 1999: 895. U.S. Government Printing Office, National Archives and Records Administration, Office of the Federal Register, 2000.

5 Satcher D. Satcher discusses MH issues hurting black community. *Psychiatr News* 1999; **34**: 6.

6 Szasz T. *Psychiatry: The Science of Lies*. Syracuse University Press, 2008.

7 Shakespeare W. *Macbeth* (ed A Harbarge): 100–1. Penguin Classics.

8 Szasz T. *The Meaning of Mind: Language, Morality, and Neuroscience*: 1–2. Syracuse University Press, 2002.

9 Kierkegaard S. A visit to the doctor: can medicine abolish the anxious conscience? In *Parables of Kierkegaard* (ed TC Oden): 57. Princeton University Press, 1978.

10 Hawthorne N. (1850) *The Scarlet Letter*: 124–5. Bantam Dell, 2003.

11 Canguilhem G. *On the Normal and the Pathological*: 46. D Reidel, 1978.

12 Szasz T. Diagnoses are not diseases. *Lancet* 1991; **338**: 1574–6.

13 Grenander ME (ed) *Asclepius at Syracuse: Thomas Szasz, Libertarian Humanist*. State University of New York, Mimeographed, 1980.

14 Hoeller K. Thomas Szasz: moral philosopher of psychiatry. *Rev Existent Psychol Psychiatry* 1997; **23**: 1–301.

15 Vatz RE, Weinberg LS. The rhetorical paradigm in psychiatric history: Thomas Szasz and the myth of mental illness. In *Discovering the History of Psychiatry* (eds MS Micale, R Porter): 311–30. Oxford University Press, 1994.

16 Porter R. *Madness: A Brief History*: 1–3. Oxford University Press, 2002.

17 Bleuler E. *Dementia Praecox or the Group of Schizophrenias* (transl J Zinkin): 488–9. International Universities Press, 1911.