In 1961, a psychiatrist by the name of Thomas S.Szasz initiated a one-man insurgency against his own profession. After years of being a practicing psychiatrist, he became an outspoken dissident, hell-bent on dynamiting the foundations of psychiatry.

"The law, social expectation, and psychiatric tradition and practice point to coercion as the profession's paradigmatic characteristic. Accordingly, I define psychiatry as the theory and practice of coercion, rationalized as the diagnosis of mental illness and justified as medical treatment aimed at protecting the patient from himself and society from the patient." -Defining Psychiatry

"For centuries the theocratic State exercised authority and used force in the name of God. The Founders sought to protect the American people from the religious tyranny of the State. They did not anticipate, and could not have anticipated, that one day medicine would become a religion and that the alliance between medicine and the State would then threaten personal liberty and responsibility exactly as they had been threatened by the alliance between church and State." -Chemical Straitjackets for Children

"Mental illness, of course, is not literally a "thing" -- or physical object -- and hence it can "exist" only in the same sort of way in which other theoretical concepts exist. Yet, familiar theories are in the habit of posing, sooner or later -- at least to those who come to believe in them -- as "objective truths" (or "facts"). During certain historical periods, explanatory conceptions such as deities, witches, and microorganisms appeared not only as theories but as self-evident causes of a vast number of events. I submit that today mental illness is widely regarded in a somewhat similar fashion, that is, as the cause of innumerable diverse happenings. As an antidote to the complacent use of the notion of mental illness -- whether as a self-evident phenomenon, theory, or cause--let us ask this question: What is meant when it is asserted that someone is mentally ill?" -The Myth of Mental Illness

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QUESTIONING
the authority of
PSYCHIATRY

3 Essays by Thomas S. Szasz, M.D.

SZASZ, T. S. The problem of psychiatric nosology: A contribution to a situational analysis of psychiatric operations. *Amer, J. Psychiat,* 1957, **114**, 405-413. (b)
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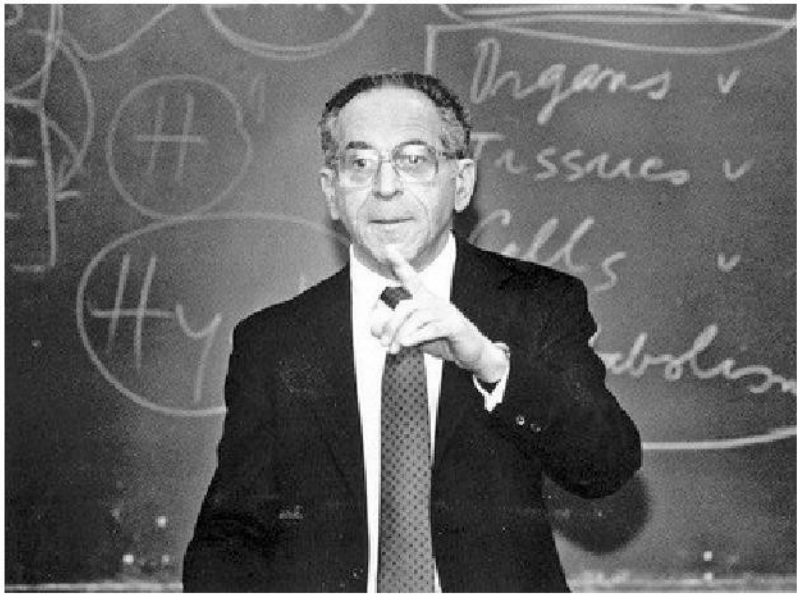
Footnote

[1] Freud went so far as to say that: "I consider ethics to be taken for granted. Actually I have never done a mean thing" (Jones, 1957, p. 247). This surely is a strange thing to say for someone who has studied man as a social being as closely as did Freud. I mention it here to show how the notion of "illness" (in the case of psychoanalysis, "psychopathology", or "mental illness") was used by Freud – and by most of his followers – as a means for classifying certain forms of human behavior as falling within the scope of medicine, and hence (by *fiat*) outside that of ethics!

[*] *Classics Editor's note:* In the original *American Psychologist* text the word "not" appears at this point. Dr. Szasz has informed me, however, that it "was a typo, which [he] corrected when [he] reprinted the piece, e.g. in *Ideology and Insanity"* (personal communication, 2002).



Dr. Thomas Szasz April 15, 1920 - September 8, 2012

"Why is self-control, autonomy, such a threat to authority? Because the person who controls himself, who is his own master, has no need for an authority to be his master. This, then, renders authority unemployed. What is he to do if he cannot control others? To be sure, he could mind his own business. But this is a fatuous answer, for those who are satisfied to mind their own business do not aspire to become authorities." -Thomas S. Szasz, M.D.

"Defining Psychiatry" by Thomas Szasz

In the United States today everyone considers himself an expert on psychiatry, especially in the aftermath of a mass murder by a "deranged madman". Yet, academically and legally qualified experts in the field keep telling us that they cannot even define psychiatry.

In 1886, Emil Kraepelin, the undisputed founder of modern psychiatry as a medical specialty and science, declared: "Our science has not arrived at a consensus on even its most fundamental principles, let alone on appropriate ends or even on the means to those ends." Eighty years later, the encyclopedic American Handbook of Psychiatry opened with this statement: "Perhaps no other field of human endeavor is so…..difficult to define as that of psychiatry." Andrew Lakoff, a professor of sociology at the University of California in San Diego, airily opines: "Two centuries after its invention, psychiatry's illnesses have neither known causes nor definitive treatments." This did not prevent him from writing a book about the diagnosis and treatment of a particular mental disease, "bipolar illness," in a particular country, Argentina.

Perhaps even more dramatic is the recent comment by Nancy Andreasen, professor of psychiatry at the University of Iowa and a former editor of the American Journal of Psychiatry, about American psychiatry's sacred symbol, schizophrenia.

Concerns about the American Psychiatric Associations "Diagnostic and Statistical Manual of Mental Disorders (DSM)," she writes, "led the author to write several editorials for the American Journal of Psychiatry about the current problems that have been created by DSM…. Europeans can save American science by helping us figure out who really has schizophrenia or what schizophrenia really is." One wonders how Andreasen reconciles her uncertainty about "who really has schizophrenia" or "what schizophrenia really is" with the standard legal-psychiatric practice of using the diagnosis to deprive innocent persons of liberty and excuse guilty persons of crimes, and deprive them, too, of liberty, often for a much longer period than they would have had been sentenced to prison.

Actually, it is easy to define psychiatry. The problem is that doing so – acknowledging its self-evident ends and the means used to achieve them – is socially unacceptable and professional suicidal. The law, social expectation, and psychiatric tradition and practice point to coercion as the profession's paradigmatic characteristic. Accordingly, I define psychiatry as the theory and practice of coercion, rationalized as the diagnosis of mental illness and justified as medical treatment aimed at protecting the patient from himself and society from the patient. It is impolite and impolitic to take this truism and its consequences seriously.

Non-acknowledgment of the fact that coercion is a characteristic and potentially ever-present element of so-called psychiatric treatments is intrinsic to the standard dictionary definitions of psychiatry. According to the Unabridged Webster's, psychiatry is "a branch of medicine that deals with the science and practice of treating mental, emotional, and behavioral disorders."

Plainly, voluntary psychiatric relations differ from involuntary psychiatric interventions the same way as, say, sexual relations between consenting adults differ from the sexual assaults we call "rape." Sometimes, to be sure, psychiatrists deal with voluntary patients. As I have shown elsewhere, it is necessary therefore not merely to distinguish between coerced and consensual psychiatric relations, but to contrast them. The term "psychiatry" ought to be applied to one or the other, but not both. As long as psychiatrists and society refuse to recognize this, there can be no real psychiatric historiography nor any popular understanding of the varied practiced called "psychiatric treatments."

Consider the parallels between coercive psychiatry and missionary Christianity. The heathen savage does not suffer from lack of insight into the divinity of Jesus, does not lack theological help, and does not seek the services of missionaries. Similarly, the psychotic does not suffer from lack of insight into being mentally ill, does not lack psychiatric treatment, and does not seek the services of psychiatrists. This is why the missionary tends to have contempt for the heathen, why the psychiatrist tends to have contempt for the psychotic, and why both conceal their true sentiments behind a facade of caring and compassion. Each meddler believes he is in possession of the "truth", each harbors a passionate desire to improve the life of the Other, each feels a deep sense of entitlement to intrude into the life of the Other, and each bitterly resents those who dismiss his precious insights and benevolent interventions as worthless and harmful.

The writings of historians, physicians, journalists, and others addressing the history of psychiatry rest on three erroneous premises: that so-called mental diseases exist, that they are diseases of the brain, and that the incarceration of "dangerous" mental patients is medically rational and morally just. The

conceived as the absence of mental illness, automatically insures the making of right and safe choices in one's conduct of life. But the facts are all the other way. It is the making of good choices in life that others regard, retrospectively, as good mental health!

The myth of mental illness encourages us, moreover, to believe in its logical corollary: that social intercourse would be harmonious, satisfying, and the secure basis of a "good life" were it not for the disrupting influences of mental illness or "psychopathology." The potentiality for universal human happiness, in this form at least, seems to me but another example of the I-wish-it-were-true type of fantasy. I do [*] believe that human happiness or well-being on a hitherto unimaginably large scale, and not just for a select few, is possible. This goal could be achieved, however, only at the cost of many men, and not just a few being willing and able to tackle their personal, social, and ethical conflicts. This means having the courage and integrity to forego waging battles on false fronts, finding solutions for substitute problems – for instance, fighting the battle of stomach acid and chronic fatigue instead of facing up to a marital conflict.

Our adversaries are not demons, witches, fate, or mental illness. We have no enemy whom we can fight, exorcise, or dispel by "cure." What we do have are *problems in living* – whether these be biologic, economic, political, or sociopsychological. In this essay I was concerned only with problems belonging to the last mentioned category, and within this group mainly with those pertaining to moral values. The field to which modern psychiatry addresses itself is vast, and I made no effort to encompass it all. My argument was limited to the proposition that mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations.

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I do not intend to offer a new conception of "psychiatric illness" nor a new form of "therapy". My aim is more modest and yet also more ambitious. It is to suggest that the phenomena now called mental illness be looked at afresh and more simple, that they be removed from the category of illness, and that they be regarded as the expressions of man's struggle with the problem of *how* he should live. The last mentioned problem is obviously a vast one, its enormity reflecting not only man's inability to cope with his environment, but even more his increasing self-reflectiveness.

By problems in living, then, I refer to that truly explosive chain reaction which began with man's fall from divine grace by partaking of the fruit of the tree of knowledge. Man's awareness of himself and of the world about him seems to be a steadily expanding one, bringing in its wake an ever large; *burden of understanding* (an expression borrowed from Susanne Langer, 1953). *This burden,* then, *is to be expected and must not be misinterpreted.* Our only *rational* means for lightening it is *more understanding*, and appropriate *action* based on such understanding. The main alternative lies in acting as though the burden were not what in fact we perceive it to be and taking refuge in an outmoded theological view of man. In the latter view, man does not fashion his life and much of his world about him, but merely lives out his fate in a world created by superior beings. This may logically lead to pleading nonresponsibility in the face of seemingly unfathomable problems and difficulties. Yet, if man fails to take increasing responsibility for his [p. 118] actions, individually as well as collectively, it seems unlikely that some higher power or being would assume this task and carry this burden for him. Moreover, this seems hardly the proper time in human history for obscuring the issue of man's responsibility for his actions by hiding it behind the skirt of an all-explaining conception of mental illness.

Conclusions

I have tried to show that the notion of mental illness has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth. As such, it is a true heir to religious myths in general, and to the belief in witchcraft in particular; the role of all these belief-system's was to act as *social tranquilizers*, thus encouraging the hope that mastery of certain specific problems may be achieved by means of substitutive (symbolic-magical) operations. The notion of mental illness thus serves mainly to obscure the everyday fact that life for most people is a continuous struggle, not for biological survival, but for a "place in the sun," or some other human value. For man aware of himself and of the world about him, once the needs for preserving the body (and perhaps the race) are more or less satisfied, the problem arises as to what he should do with himself. Sustained adherence to the myth of mental illness allows people to avoid facing this problem, believing that mental health,

problems so created are them compounded by failure – purposeful or inadvertent – to distinguish between two radically different kinds of psychiatric practices, consensual and coerced, voluntarily sought and forcibly imposed.

In free societies, ordinary social relations between adults are consensual. Such relations – in business, medicine, religion, and psychiatry – pose no special legal or political problems. By contrast, coercive relations – one person authorized by the state to forcibly compel another person to do or abstain from actions of his choice – are inherently political in nature and are always morally problematic.

Mental disease is fictitious disease. Psychiatric diagnosis is disguised disdain. Psychiatric treatment is coercion concealed as care, typically carried out in prisons called "hospitals." Formerly, the social function of psychiatry was more apparent than it is now. The asylum inmate was incarcerated against his will. Insanity was synonymous with unfitness for liberty. Toward the end of the nineteenth century, a new type of psychiatric relationship entered the medical scene: persons experiencing so-called "nervous symptoms" began to seek medical help, typically from the family physician or a specialist in "nervous disorders." This led psychiatrists to distinguish between to kinds of mental diseases, neuroses and psychoses. Persons who complained of their own behavior were classified as neurotic, whereas persons about whose behavior others complained were classified as psychotic. The legal, medical, psychiatric, and social denial of this simple distinction and its far-reaching implications undergirds the house of cards that is modern psychiatry.

Fashionable Cliches

Psychiatry and society face a paradox. The more progress scientific psychiatry allegedly makes, the more intolerable becomes the idea that mental illness is a myth and the effort to treat it a will-o'-the-wisp. The more progress scientific medicine actually makes, the more undeniable it becomes that "chemical imbalances" and "hard wiring" are fashionable cliches, not evidence that problems in living are medical diseases justifiably "treated" without patient consent. And the more often psychiatrists play the roles of juries, judges, and prison guards, the more uncomfortable they feel about being in fact pseudomedical coercers – society's well-paid patsies. The whole conundrum is too horrible to face. Better to continue calling unwanted behaviors "diseases" and disturbing persons "sick," and compel them to submit to psychiatric "care."
It is easy to see, then, why the right-thinking person considers it inconceivable that there might be no such thing as mental health or mental illness. Where would that leave the history of psychiatry portrayed as the drama of heroic physicians combating horrible diseases? Where would it leave psychiatrists, the law, and the public that depend on the myriad social institutions that rest on the mendacious premises that the phenomena we call "mental illnesses" are illnesses, and that "mental illnesses are like other illnesses"?

“Chemical Straitjackets for Children” by Thomas S. Szasz, M.D.

In February, a group of physicians writing in the Journal of the American Medical Association reported that the use of “psychotropic medications prescribed for preschoolers increased dramatically between 1991 and 1995.” About twice as many children between the ages of 2 and 4 were given Ritalin, Prozac, and other so-called psychotropic drugs at the end of that period as at the beginning of it. In a front page story, the New York Times cited experts calling the finding “very surprising.” It is about as surprising as finding the proverbial fox feasting on chickens. In a paper published in January 1957 – at the dawn of the “new psychiatric revolution” – I stated that psychiatric drugs are “chemical straitjackets” that control – not cure – the persons self-servingly called “patients.”

In my last column (May), I commented about the nineteenth-century epidemic of mental illness called “masturbatory insanity.” In this column, I comment about our present-day epidemic of mental illness called “attention deficit hyperactivity disorder (ADHD).”

To grasp the enormity of the stupidity that informs these so-called diagnoses, we must be clear about the difference between a diagnosis and a disease.
Diagnoses Are Not Diseases

Webster’s Dictionary defines diagnosis as “The art or act of identifying a disease from its signs and symptoms.” According to The Oxford English Dictionary (OED), it is the “determination of the nature of a diseased condition; … also, the opinion (formally stated) resulting from such investigation.”

The concept of diagnosis is contingent on the concept of disease. Diagnosis is the name of a disease, just as, say, violet is the name of a flower. For example, the term “diabetes” names a type of abnormal glucose metabolism. The disease qua somatic pathology – literal disease – is the abnormal metabolism; the diagnosis, “diabetes,” is its name. Somatic pathology is diagnosed by finding abnormalities (lesions) in bodies or body parts. Disease qua somatic pathology may be asymptomatic and changing the nosology (classification of disease) can change the name but not the reality of somatic pathology as disease. Unless we keep in mind that diseases are facts of nature, whereas diagnoses are artifacts constructed by human beings, and that the core meaning of the term “disease” is lesion, we forfeit the possibility of understanding the uses and abuses of the term “diagnosis.”

Manipulating things is difficult, sometimes impossible. Manipulating names is easy; we do it all the time. Violet might be the name of a flower, or a color, or a

practiced as though it entailed nothing other than restoring the patient from a state of mental illness has something to do with man’s social (that is, of ethics) do not [p. 117] arise in this process. [1] Yet, in one sense, much of psychotherapy may revolve around nothing other than the elucidation and weighing of goals and values – many of which may be mutually contradictory – and the means whereby they might best be harmonized, realized, or relinquished.

The diversity of human values and the methods by means of which they may be realized is so vast, and many of them remain so unacknowledged, that they cannot fail but lead to conflicts in human relations. Indeed, to say that human relations at all levels – from mother to child, through husband and wife, to nation and nation – are fraught with stress, strain, and disharmony is, once again, making the obvious explicit. Yet, what may be obvious may be also poorly understood. This I think is the case here. For it seems to me that – at least in our scientific theories of behavior – we have failed to *accept* the simple fact that human relations are inherently fraught with difficulties and that to make them even relatively harmonious requires much patience and hard work. I submit that the idea of mental illness is now being put to work to obscure certain difficulties which at present may be inherent – not that they need be unmodifiable – in the social intercourse of persons. If this is true, the concept functions as a disguise; for instead of calling attention to conflicting human needs, aspirations, and values, the notion of mental illness provides an amoral and impersonal “thing” (an “illness”) as an explanation for *problems in living* (Szasz, 1959). We may recall in this connection that not so long ago it was devils and witches who were held responsible for men’s problems in social living. The belief in mental illness, as something other than man’s trouble in getting along with his fellow man, is the proper heir to the belief in demonology and witchcraft. Mental illness exists or is “real” in exactly the same sense in which witches existed or were “real”.

Choice, Responsibility, and Psychiatry

While I have argued that mental illnesses do not exist, I obviously did not imply that the social and psychological occurrences to which this label is currently being attached also do not exist. Like the personal and social troubles which people had in the Middle Ages, they are real enough. It is the labels we give them that concerns us and, having labeled them, what we do about them. While I cannot go into the ramified implications of this problem here, it is worth noting that a demonologic conception of problems in living gave ride to therapy along theological lines. Today, a belief in mental illness implied – nay, requires – therapy along medical or psychotherapeutic lines.

What is implied in the line of thought set forth here is something quite different.

work? If they do make a difference, what are we to infer from it? Does it not seem reasonable that we ought to have different psychiatric therapies – each, expressively recognized for the ethical positions which they embody – for, say, Catholics and Jews, religious persons and agnostics, democrats and communists, white supremacists and Negros, and so on? Indeed, if we look at how psychiatry is actually practiced today (especially in the United States), we find that people do seek psychiatric help in accordance with their social status and ethical beliefs (Hollingshead & Redlich, 1958). This should really not surprise us more than being told that practicing Catholics rarely frequent birth control clinics.

The foregoing position which holds that con- temporary psychotherapists deal with problems in living, rather than with mental illnesses and their cures, stands in opposition to a currently prevalent claim, according to which mental illness is just as "real" and "objective" as bodily illness. This is a confusing claim since it is never known exactly what is meant by such words as "real" and "objective". I suspect, however, that what us untended by the proponents of this view is to create the idea in the popular mind that mental illness is some sort of disease entity, like an infection or a malignancy. If this were true, one could *catch* or get a "mental illness", one might *have* or *harbor* it, one might *transmit* it to others, and finally one could get *rid* of it. In my opinion, there is not a shred of evidence to support this idea. To the contrary, all the evidence is the other way and supports the view that what people now call mental illnesses are for the most part *communications* expressing unacceptable ideas, often framed, moreover, in an unusual idiom. The scope of this essay allows me to do no more than mention this alternative theoretical approach to this problem (Szasz, 1957c).

This is no the place to consider in detail the similarities and differences between bodily and mental illnesses. It shall suffice for us here to emphasize only one important differences between them: namely, that whereas bodily disease refers to public, physicochemical occurrences, the notions of mental illness is used to codify relatively more private, sociopsychological happenings of which the observer (diagnostician) forms a part. In other words, the psychiatrist does not stand *apart* from what he observes, but is, in Harry Stack Sullivan's apt words, a "participant observer." This means that he is *committed* to some picture of what he considers reality – and to what he thinks society considers reality – and he observes and judges the patient's behavior in the light of these considerations. This touches on our earlier observation that the notion of mental symptom itself implies a comparison between observer and observed, psychiatrist and patient. This is so obvious that I may be charged with belaboring trivialities. Let me therefore say once more that my aim in presenting this argument was expressly to criticize and counter a prevailing contemporary tendency to deny the moral aspects of psychiatry (and psychotherapy) and to substitute for them allegedly value-free medical considerations. Psychotherapy, for example, is being widely

woman, or a street. Similarly, a disease-sounding term may be the name of a bodily malfunction, or the malfunction of a car, a computer, an economic system, or the behavior of an individual or group. We cannot distinguish between the literal and metaphorical used of the term "disease"" unless we identify its root meaning, agree that it is is the literal meaning of the word, and treat all other uses of it as figures of speech. In conformity with traditional medical practice, I take the root meaning of disease to be a *bodily lesion*, understood to include not only structural malfunctions but also deviations from normal physiology, such as elevated blood pressure or depressed red blood cell count. If we accept this definition, then the term "diagnosis", used *literally*, refers to and is the name of a disease, and used *metaphorically*, refers to and is the name of a non-disease.

By identifying diagnosis as an *opinion*, the *OED* recognizes that it refers to a judgment. Typically, the process of diagnosing disease begins with the patient himself: he has aches or pains, feels feverish or fatigued, and judges that he is ill. If he complains about his body, then – in a medical context – his complain constitutes a *symptom*, a medical-sounding word that implies that the patient's experience is a manifestation of a disease. The point to keep in mind is that a symptom may or may not indicate the presence of a (real) disease. Whether a symptom is or is not a manifestation of disease depends on its confirmation or non-confirmation by objective data based, for example, on laboratory tests or the examination of a biopsy specimen. In contrast to the so-called "clinical diagnosis", the "pathological diagnosis" is based entirely on objective – histological, morphological, chemical, serological, radiological, and other physical-chemical – evidence. Historically, scientific medicine (as opposed to clinical medicine) is based on the post-mortem examination of the body; in modern medicine, it is increasingly based on ante-mortem scientific measures of abnormal bodily functionings.

Diagnosing Disease: Cui Bono?

Unlike bodily illnesses, mental illnesses are diagnosed by finding unwanted behaviors in persons or by attributing such behaviors to them. Bodily illnesses – say, cancer or diabetes – are located in bodies; mental illnesses – say, kleptomania or schizophrenia – are located in social contexts. Robinson Crusoe could suffer from cancer, but not from kleptomania.

The diagnosis of a mental illnesses validates its own disease statues. Disease qua psychopathy cannot be asymptomatic and changing the nosology can change disease into non-disease and vice avers (for example, homosexuality into civil right and smoking into substance abuse). Mental diseases are diagnoses, not diseases. Conversely, psychiatric diagnoses (however constructed) are, by *definition,* mental diseases (or "disorders", to use the mental health

professional's preferred weasel word).

To understand the tactical rather than descriptive uses of terms such as "ill" and "patient", we must – following Cicero (106-43 BC) – ask: *Cui bono?* Cicero explained the importance of posing this question, primarily to oneself, as follows: "When trying a case [the famous Judge] L. Cassius never failed to inquire, "'Who gained by it?' Man's character is such that no man undertakes crimes without hope of gain."

Mutatis mutandis, no man asserts that he or someone else has an illness without hope of gain. The goods that a person gains from asserting such a claim range from securing medical help for himself to justifying controlling the Other by defining coercion as cure. Consider the evidence:

-The disease of masturbation affected mainly children; so does the disease of hyperactivity.

-The disease of masturbation pained parents, teachers, and other adults, not the denominated patients; the disease of hyperactivity pains and does not pain the same persons, respectively.

-The disease of masturbation was treated with physical restraints forcibly imposed on the bodies of children; the disease of hyperactivity is treated with chemical restraints forcibly introduced into the bodies of children.

-The disease of masturbation was the favorite diagnosis of doctors and parents dealing with troublesome children in the nineteenth century; attention deficit hyperactivity disorder is the favorite diagnosis of doctors and parents dealing with troublesome children today.

Belief in masturbatory insanity was, as I emphasized, not an innocent error. Neither is belief in ADHD. Each belief is a manifestation of the adults' annoyance by certain ordinary childhood activities, their efforts to control or eliminate the activities to allay their own discomfort, and the medical profession's willingness to diagnose disturbing childhood behaviors, thus medicalizing and justifying the domestication of children by drugs defined as therapeutic.

Formerly, quacks had fake cures for real diseases; now, they claim to have real cures for fake diseases.

"The Myth of Mental Illness" by Thomas S. Szasz (1960)
First published in American Psychologist, 15, 113-118.

to the present use of tranquilizers and, more generally, to what might be expected of drugs of whatever type in regard to the amelioration or solution of problems in human living.

The Role of Ethics in Psychiatry

Anything that people *do* – in contrast to things that *happen* to them (Peters, 1958) – takes place in a context of value. In this broad sense, no human activity is devoid of ethical implications. When the values underlying certain activities are widely shared, those who participate in their pursuit may lose sight of them altogether. The discipline of medicine, both as a pure science (for example, research) and as a technology (for example, therapy), contains many ethical considerations and judgments. Unfortunately, these are often denied, minimized, or merely kept out of focus; for the ideal of the medical profession as well as of the people whom it serves seems to be having a system of medicine (allegedly) free of ethical value. This sentimental notion is expressed by such things as the doctor's willingness to treat and help patients irrespective of their religious of political beliefs, whether they are rich or poor, etc. While there may be some grounds for this belief – albeit it is a view that is not impressively true even in these regards – the fact remains that ethical considerations encompass a vast range of human affairs. By making the practice of medicine neutral in regard to some specific issues of value need not, and cannot, mean that it can be kept free from all such values. The practice of medicine is intimately tied to ethics; and the first thing that we must do, it seems to me, is to try to make this clear and explicit. I shall [p.116] let this matter rest here, for it does not concern us specifically in this essay. Lest there be any vagueness, however, about how or where ethics and medicine meet, let me remind the reader of such issues as birth control, abortion, suicide, and euthanasia as only a few of the major areas of current ethicomedical controversy.

Psychiatry, I submit, is very much more intimately tied to problems of ethics than is medicine. I use the word "psychiatry" here to refer to that contemporary discipline which is concerned with *problems in living* (and not with diseases of the brain, which are problems for neurology). Problems in human relations can be analyzed, interpreted, and given meaning only within given social and ethical contexts. Accordingly, it *does* make a difference – arguments to the contrary notwithstanding – what the psychiatrist's socioethical orientations happen to be; for these will influence his ideas on what is wrong with the patient, what deserves comment or interpretation, in what possible directions change might be desirable, and so forth. Even in medicine proper, these factors play a role, as for instance, in the divergent orientations which physicians, depending on their religious affiliations, have toward such things as birth control and therapeutic abortion. Can anyone really believe that a psychotherapist's ideas concerning religious belief, slavery, or other similar issues play no role in his practical

mental illness, we will now turn to the question: "Who defines the norms and hence the deviation?" Two basic answers may be offered: *(a)* It may by the person himself (that is, the patient) who decides that he deviates from a norm. For example, an artist may believe that he suffers from a work inhibition; and he may implement this conclusion by seeking help *for* himself from a psychotherapist. *(b)* It may be someone other than the patient who decides that the latter is deviant (for example, relatives, physicians, legal authorities, society generally, etc.). In such a case a psychiatrist may be hired by others to do something *to* the patient in order to correct the deviation.

These considerations underscore the importance of asking the question "Whose agent is the psychiatrist?" and of giving a candid answer to it (Szasz, 1956, 1958). The psychiatrist (psychologist or nonmedical psychotherapist), it now develops, may be the agent of the patient, of the relatives, of the school, of the military services, of a business organization, of a court of law, and so forth. In speaking of the psychiatrist as the agent of these persons or organizations, it is not implied that his values concerning norms, or his ideas and aims concerning the proper nature of remedial action, need to coincide exactly with those of his employer. For example, a patient in individual psychotherapy may believe that his salvation lies in a new marriage; his psychotherapist need not share this hypothesis. As the patient's agent, however, he must abstain from bringing social or legal force to bear on the patient which would prevent him from putting his beliefs into action. If his *contract* is with the patient, the psychiatrist (psychotherapist) may disagree with him or stop his treatment; but he cannot engage others to obstruct the patient's aspirations. Similarly, if a psychiatrist is engaged by a court to determine the sanity of a criminal, he need not fully share the legal authorities' values and intentions in regard to the criminal and the means available for dealing with him. But the psychiatrist is expressly barred from stating, for example, that it is not the criminal who is "insane" but the men who wrote the law on the basis of which the very actions that are being judged are regarded as "criminal." Such an opinion could be voiced, of course, but not in a courtroom, and not by a psychiatrist who makes it his practice to assist the court in performing its daily work.

To recapitulate: In actual contemporary social usage, the finding of a mental illness is made by establishing a deviance in behavior from certain psychosocial, ethical, or legal norms. The judgment may be made, as in medicine, by the patient, the physician (psychiatrist), or others. Remedial action, finally, tends to be sought in a therapeutic – or covertly medical – framework, thus creating a situation in which *psychosocial, ethical,* and/or *legal deviations* are claimed to be correctible by (so-called) *medical action.* Since medical action is designed to correct only medical deviations, it seems logically absurd to expect that it will help solve problems whose very existence had been defined and established on nonmedical grounds. I think that these considerations may be fruitfully applied

My aim in this essay is to raise the question "Is there such a thing as mental illness?" and to argue that there is not. Since the notion of mental illness is extremely widely used nowadays, inquiry into the ways in which this term is employed would seem to be especially indicated. Mental illness, of course, is not literally a "thing" – or physical object – and hence it can "exist" only in the same sort of way in which other theoretical concepts exist. Yet, familiar theories are in the habit of posing, sooner or later – at least to those who come to believe in them – as "objective truths" (or "facts"). During certain historical periods, explanatory conceptions such as deities, witches, and microorganisms appeared not only as theories but as self-evident *causes* of a vast number of events. I submit that today mental illness is widely regarded in a somewhat similar fashion, that is, as the cause of innumerable diverse happenings. As an antidote to the complacent use of the notion of mental illness – whether as a self-evident phenomenon, theory, or cause – let us ask this question: what is meant when it is asserted that someone is mentally ill?

In what follows I shall describe briefly the main uses to which the concept of mental illness has been put. I shall argue that this notion has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth.

Mental Illness as a Sign of Brain Disease

The notion of mental illness derives its main support from such phenomena as syphilis of the brain or delirious conditions – intoxication, for instance – in which persons are known to manifest various peculiarities or disorders of thinking and behavior. Correctly speaking, however, these are diseases of the brain, not of the mind. According to one school of thought, *all* so-called mental illness is of this type. The assumption is made that some neurological defect, perhaps a very subtle one, will ultimately be found for all the disorders of thinking and behavior. Many contemporary psychiatrists, physicians, and other scientists hold this view. 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. *All problems in living* are attributed to physiochemical processes which in due time will be discovered by medical research.

"Mental illnesses" are thus regarded as basically no different than all over diseases (that is, of the body). The only difference, in this view, between mental and bodily diseases is that the former, affecting the brain, manifest themselves by means of mental symptoms; whereas the latter, affecting other organ systems (for example, the skin, liver, etc.), manifest themselves by means of symptoms referable to those parts of the body. This view rests on and expresses what are, in my opinion, two fundamental errors.

In the first place, what central nervous system symptoms would correspond to a skin eruption or a fracture? It would *not* be some emotion or complex bit of behavior. Rather, it would be blindness or a paralysis of some part of the body. The crux of the matter is that a disease of the brain, analogous to a disease of skin or bone, is a neurological defect, and not a problem in living. For example, a *defect* in a person's visual field may be satisfactorily explained by correlating it with certain definite lesions in the *nervous* system. On the other hand, a person's *belief* – whether this be a belief in Christianity, in Communism, or in the *idea* that his internal organs are "rotting" and that his body is, in fact, already "dead" – cannot be explained by a defect or disease of the nervous system. Explanations of this sort of occurrence – assuming that one is interested in the belief itself and does not regard it simply as a "symptom" or expression of something else that is *more interesting* – must be sought along different lines.

The second error in regarding complex psycho-social behavior, consisting of communications about ourselves and the world about us, as mere symptoms [p. 114] of neurological functioning is *epistemological*. In other words, it is an error pertaining not to any mistakes in observation or reasoning, as such, but rather to the way in which we organize and express our knowledge. In the present case, the error lies in making a symmetrical dualism between mental and physical (or bodily) symptoms, a dualism which is merely a habit of speech and to which no known observations can be found to correspond. Let us see if this is so. In medical practice, when we speak of physical disturbances, we mean either signs (for example, a fever) or symptoms (for example, pain). We speak of mental symptoms, on the other hand, when we refer to a patient's *communications about himself, others, and the world about him.* He might state that he is Napoleon or that he is being persecuted by the Communists. These would be considered mental symptoms *only* if the observer believed that the patient was *not* Napoleon or that he was *not* being persecuted[*sic*] by the Communists. This makes it apparent that the statement that "*X* is a mental symptom" involves rendering of a judgment. The judgment entails, moreover, a covert comparison or matching of the patient's ideas, concepts, or beliefs with those of the observer and the society in which they live. The notion of mental symptoms is therefore inextricably tied to the *social* (including *ethical*) *context* in which it is made in much the same way as the notion of bodily symptom is tied to an *anatomical* and *genetic context* (Szasz, 1957a 1957b).

To sum up what has been said thus far: I have tried to show that for those who regard mental symptoms as signs of brain disease, the concept of mental illness is unnecessary and misleading. For what they mean is that people so labeled suffer from diseases of the brain, and, if that is what they mean, it would seem better for the sake of clarity to say that and not something else.

Mental Illness as a Name for Problems in Living

The term "mental illness" is widely used to describe something which is very different than a disease of the brain. Many people today take it for granted that living is an arduous process. Its hardship for modern man, moreover, derives not so much from a struggle for biological survival as from the stresses and strains inherent in the social intercourse of complex human personalities. In this context, the notion of mental illness is used to identify or describe some feature of an individual's so-called personality. Mental illness – as a deformity of the personality, so to speak – is then regarded as the *cause* of the human disharmony. It is implicit in this view that social intercourse between people is regarded as something *inherently harmonious*, its disturbance being due solely to the presence of "mental illness" in many people. This is obviously fallacious reasoning, for it makes the abstraction "mental illness" into a *cause,* even though this abstraction was created in the first place to serve only as a shorthand expression for certain types of human behavior. It now becomes necessary to ask: "What kinds of behavior are regarded as indicative of mental illness, and by whom?"

The concept of illness, whether bodily or mental, implies *deviation from some* clearly *defined norm.* In case of physical illness, the norm is the structural and functional integrity of the human body. Thus, although the desirability of physical health, as such, is an ethical value, what health *is* can be stated in anatomical and physiological terms. What is the norm deviation from which is regarded as mental illness? This question cannot be easily answered. But whatever this norm might be, we can be certain of only one thing: namely, that it is a norm that must be stated in terms of *psycho-social, ethical,* and *legal* concepts. For example, notions such as "excessive repression" or "acting out an unconscious impulse" illustrate the use of psychological concepts for judging (so-called) mental health and illness. The idea that chronic hostility, vengefulness, or divorce are indicative of mental illness would be illustrations of the use of ethical norms (that is, the desirability of love, kindness, and a stable marriage relationship). Finally, the widespread psychiatric opinion that only a mentally ill person would commit homicide illustrates the use of a legal concept as a norm of mental health. The norm from which a deviation is measured whenever one speaks of a mental illness is a *psycho-social and ethical one.* Yet, the remedy is sought in terms of *medical* measures which – it is hoped and assumed – are free from wide differences of ethical value. The definition of the disorder and the terms in which its remedy are sought are therefore at serious odds with one another. The practical significance of this covert conflict between the alleged nature of the defect and the remedy can hardly be exaggerated.

Having identified the norms used to measure [p. 115] deviations in cases of