

University of Groningen

Mythe en macht. Over de kritische psychiatrie van Thomas S. Szasz

Pols, Jan

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version

Publisher's PDF, also known as Version of record

Publication date:

1984

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Pols, J. (1984). *Mythe en macht. Over de kritische psychiatrie van Thomas S. Szasz*. s.n.

Copyright

Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

The publication may also be distributed here under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license. More information can be found on the University of Groningen website: <https://www.rug.nl/library/open-access/self-archiving-pure/taverne-amendment>.

Take-down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): <http://www.rug.nl/research/portal>. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Myth and Power: about the critical psychiatry of Thomas S. Szasz

SUMMARY

The aim of this study is to present a review and a critical evaluation of the work of Thomas S. Szasz.

First of all the extensive work of Szasz has been studied, resulting in a resumé of his views regarding psychiatry, mental illness, and psychiatrists and their patients. The work of Szasz is to be regarded as centered around two main theses. The first thesis is theoretic and conceptual: illness being a process affecting the body, mental illness as a rule doesn't fit this definition. That is why both medical language and medical interventions are not applicable. The second thesis is that, psychiatry lacking a medical-scientific basis, psychiatric opinions and statements are, in fact, of a sociopolitical nature: psychiatry provides a system to rule out social deviants by calling them patients. Moreover, as these patients are discriminated, stigmatized and dehumanized, the renaming of deviancy as mental illness is to be considered as socially harmful.

Next an attempt is made to locate Szasz' work in historical perspective. Since the twenties of this century there has been a continuous and forceful expansion of psychiatry in several ways: there was a continuous enlargement of the territory of psychiatric illness; there was a growing number of frames of reference with regard to psychiatric illness; there was a growing popularity of psychiatric and psychoanalytic interpretations of behavior also in the general public; and psychiatrization also comprised a growing interference with the judicial system. In the sixties there is a turning point. Criticism is coming into existence; antipsychiatry is developing; there is a critical sociology concerning itself with psychiatry and psychiatric practices; psychologists object to the 'medical model' in psychiatry; juridical supervision of involuntary psychiatric procedures and interventions is insisted upon. Szasz is an important exponent of this critical counter-current.

After this an attempt is made to clarify the conception of life from which Szasz' critical-psychiatric considerations proceed. The basic values for Szasz are freedom and autonomy. He is to be regarded as an individualist and a libertarian. Being preoccupied with the differences between natural science on the one hand and the humanities on the other, he advocates a categorical

separation of the somatic and psychic aspects of man, in this way reinforcing a dualistic vision. Lastly he is to be characterized as a theorist and as a heretic.

Following these viewpoints the way in which he presents his views and the structure of his arguments are considered. The study of these aspects leads to different conclusions. On the one hand: in the development of his argument, in the construction of his train of thought and in the presentation of his views he shows himself as an able rhetorician and an exciting writer. On the other hand: an analysis of his argumentation brings forth a number of elements being detrimental to the convincing power: for instance his frequent begging the question; the statement that mutual exclusive choices are necessary when in fact this does not apply; the sketching of outlines in sharp black and white contrasts by means of generalizations, simplifications, by minimizing or annihilating minor differences and maximizing more important differences as contrasts; and the use of handy but incorrect slogans meant as 'pocket-definitions' of complex conceptions. The conclusion is, that in many cases his argumentation weakens rather than strengthens his conclusions.

In the next chapter a lengthy discussion follows about Szasz' first thesis, namely that mental illness is a myth. It is argued a. that the distinction ill/healthy is historically and logically prior to the distinction mind/body, b. that any definition of illness should consider from the beginning how the word 'ill' is defined by the ill person and his non-professional surroundings rather than take the definition of the expert for granted, c. that 'being ill' has been conceptualized in a number of different ways in history and nowadays, and d. that illness and 'being ill' have as their implication value judgments which are presumably absent in the 'technical' Szaszian definition, although the disappearance of them has serious consequences for both medicine and psychiatry and for the patient. Therefore an alternative view is developed, the concept of 'being ill' being defined as a conjunctive cluster of three constituent factors: suffering, dysfunction and abnormality. This reasoning is leading the way to a conceptualization that is different from the Szaszian one, namely to the biopsychosocial concept of illness. Physicochemical abnormalities have no sense as criteria for the existence of disease unless they are demonstrable, relevant and processual. Notably those processes and conditions, deemed as illnesses, without demonstrable physicochemical disturbances, and among them many mental disorders, underline the fundamental idea that illness is not only an ontological concept but also a value-loaded concept. The problem is posed whether or not it is desirable to take account of these aspects of value in the definition of illness.

Psychiatric disorders, conceptualized as diseases, are problematic in several ways. Many psychiatric symptoms have as implication a normative meaning, as they denote undesirable behavior. It is very difficult to give an operational definition of normality. Sharp distinctions between ill and normal are

impossible. C
tives and me
question of t
investigation

Presumin
gical vacuum
that occur a
such process
be qualified
behavior and
context of a
ever the valid
That is to say
of another ca
accompanyin

After that
medical conc
presuppositi
in the contex
are overvalu
exposed, and
Validation in
relatively sm
ty is low. Af
tric disorder
bility as con
psychiatric
This last vic
Some probl
regarded.

With res
ness has ter
domain of t
inapt to ter

Two prc
role of soci
zed by an c
change (th
himself) or
disorder ju
offers on th
held respo
dered. It is

impossible. Complementary views are necessary, such as the question of motives and motivation, the communicative significance of behavior, and the question of the final cause. The influence of the investigator on his object of investigation should explicitly be taken into consideration.

Presuming that psychic occurrences do not take place in a neurophysiological vacuum, it becomes possible in principle to identify cerebral processes that occur at the same time as definite forms of experience or behavior. If such processes could be identified, and if the accompanying behavior could be qualified as abnormal, it would be possible to qualify the cluster of this behavior and the accompanying neurophysiological process as illness in the context of a Szaszian, biomedical concept of disease. At the same time however the validity of the sociopsychological points of view remains unaltered. That is to say that there is no valid reason to declare this behavior as behavior of another category (i.e. illness vs. non-illness) in case the identification of the accompanying neurophysiologic process is successful.

After that, some implications of the disease-concept are studied. The biomedical concept of disease not only has a dualistic view of man as a necessary presupposition, this concept also imposes that view. Further it appears, that in the context of a biomedical disease-concept physicochemical explanations are overvalued. Next the problem of the validation of psychiatric disorders is exposed, and compared to the problem of validation in general medicine. Validation in psychiatry is difficult, the reliability of psychiatric diagnoses is relatively small and moreover very context-dependent, and predictive validity is low. After that the connection between problems-in-living and psychiatric disorders is studied, and the connection between causality and responsibility as contributing factors. Two viewpoints are considered in this respect: psychiatric illness as irrationality, and psychiatric illness as loss of freedom. This last viewpoint is accepted as a necessary and sufficient interpretation. Some problems that arise when applying this principle of explanation are regarded.

With respect to physicians, it appears that the biomedical concept of illness has territorial properties as disease in this concept can be described as the domain of the physician. The biopsychosocial illness-concept is comparably inapt to territorial claims by its complexity and its extensiveness.

Two professional roles of the psychiatrist, i.e. the role of therapist and the role of social arbiter are considered next. The role of therapist is characterized by an offer either of a therapy emphasizing the goal and desirability of change (that is to say a change of the disorder and a change of the patient himself) or of an attendance emphasizing the acceptance of the patient and his disorder just as they are. The relations between these two basic different offers on the one hand, and the question as to what degree the patient is to be held responsible for his disorder or misconduct on the other hand, are considered. It is argued that, as a basic notion, nobody can leave to any other the

responsibility for his own life without a grave risk of serious and essential disadvantage for himself. The being held non-responsible for a psychiatric disorder has as an advantage in that it frees the patient from feelings of guilt, but as a disadvantage in as much as it seduces him to an attitude of passive expectation and dependency with respect to what ought to be done. This is seen as the central dilemma of psychiatric assistance.

The role of the psychiatrist as a social arbiter is being clarified by way of two performances of this role. The first is the role of judge with regard to the question whether illness exists, and whether the existence of this illness entitles the patient to certain privileges. It is argued that, although the prerogatives of the sick role lead to the institution of the arbitration, it appears that there are too many insecurities, too many undesirable side-effects and too grave disabling effects; and that, in the end, it is nevertheless the patient, in most cases, who, be it unofficially, takes the decision. Therefore it is preferable to restore the autonomy of people by giving them back the right to claim that they are ill, and also that they are healthy again. In that case there is no reason left for a prerogative of the sick role over the role of people who can't work for other reasons beyond their control.

The second role is the role of the psychiatrist as a member of so-called 'abortion-teams' as an example of a role that is to be characterized as 'boot-legging' of societal prerogatives.

Given the biomedical concept of illness, the image of the psychiatric patient, as is to be derived from Szasz' statements on the subject, is not too promising. Data from the literature regarding the negative image of the psychiatric patient don't seem to confirm fully Szasz' opinions in this respect, nor the negative image of psychiatric treatment and hospitalization.

The therapeutic relationship between patient and psychiatrist is described as an asymmetrical, contractual relationship based on trust. Recent developments menacing this relationship are described. First of all there is more and more a splitting of the loyalty of the psychiatrist versus his patient: in the beginning he had only to regard the interests of his patients, of his own self, and the rules of his craft. More recently loyalties were added toward the other members of the multidisciplinary team, toward the institution that employs him, toward the insurance companies, toward the Government. Secondly, an increasing number of agencies interfere with the therapeutic relationship, often presenting themselves as – uncalled for – protectors of the patient. It is argued that these developments, at least insofar as they are meant to enlarge the power of the patient in the therapeutic relationship, are to be regarded as failures, by making the patient increasingly powerless.

In everyday life it appears that the biomedical illness-concept has been relinquished for the most part in the work of general practitioners and psychiatrists, and that in daily practice different concepts of illness are mixed up in an opportunistic way rather than that one concept is consistently used.

This often le

Alongside account three of physicians giving rise to giving rise to patients; third medical com tions is, that that is said ar about illness groups of pe

In case th and interven borderline is being that exa and co-oper somatic disea regularly. W consequence ned for and relationships changed, aga posed. Apart free and tha illness is lack tonomy. The from the ma med from th

Involunta being consid chiatry. Com in about 15⁶ about 3,000 The main jus that it is for person is po on Involunt point of dan was studied. ness are ext research tha inaccurate, a

This often leads to confusion

Alongside the conceptual-theoretical definition there are to be taken into account three ancillary definitions of illness emerging from the functioning of physicians, patients and others: first of all illness is a form of human misery giving rise to the profession of doctors; second it is a form of human misery giving rise to the sick role with its obligations and prerogatives for the patients; third it is a form of human misery that gave birth to an industrial-medical complex. The most important aspect of these three ancillary definitions is, that they point to three groups that have a direct interest in anything that is said and written about illness and conversely, that in all considerations about illness these ancillary definitions, and the consequences for these three groups of people, need be taken into account.

In case the concept of illness is used to give a justification of procedures and interventions that occur against the expressed wishes of the patient, a borderline is being trespassed: the medical-ethical fundamental law prescribing that examination, treatment and therapy are allowed only with consent and co-operation of the patient in that case is violated. In the presence of somatic disease that seldom occurs, in psychiatry on the contrary it happens regularly. With regard to the concept of psychiatric disorder this has some consequences: nearly all sociopsychological explanatory theories are designed for and validated within the medical-ethical boundaries of contractual relationships between psychiatrist and patient; this moral context being changed, again the question of the validity of the explanatory theory has to be posed. Apart from that, in those cases where the 'patient' is arguing that he is free and that his condition is chosen for, an essential aspect of psychiatric illness is lacking, namely the manifest restriction of personal liberty and autonomy. The restriction of freedom in these cases is to be inferred indirectly from the manifestations of the psychiatric disorder, but is not to be confirmed from the experience of the patient.

Involuntary commitment in a mental hospital by juridical means is next being considered as the by Szasz most commented upon intervention in psychiatry. Commitment in mental hospitals in the Netherlands is involuntary in about 15% of all cases, the number of involuntary commitments being about 3.000 annually. In the USA the percentage is higher, in the UK lower. The main justification of this intervention from a psychiatric point of view is, that it is for the good of the patient; from a juridical point of view, that a person is potentially dangerous for himself or for others. As in the new Law on Involuntary Commitment in the Netherlands (de wet BOPZ) the viewpoint of dangerousness has been introduced, the usefulness of this criterion was studied. The problems that rise in the use of the criterion of dangerousness are extremely complex; on theoretical grounds and on reviewing the research that has been done the conclusion emerges, that predictions are very inaccurate, and are – as a rule – incorrect in the great majority of cases. The

meaning of this is, that prediction of dangerousness is correct only in a relatively small proportion of involuntarily committed patients, therefore in all other cases there appears to be no justification for involuntary commitment. Additional insecurity originates from the notion that it is hardly possible to learn from experience as on the one hand the commitment changes someone's circumstances in such a way as to make any valuable feedback on the decision virtually impossible, and as on the other hand moral pressure has the influence of promoting civil commitment. Notwithstanding these factors, involuntary commitment ought to be considered as a grave intervention, and as an intervention with grave consequences for the person involved.

The striking of the balance, as far as is possible with regard to the knowledge that is currently available, leads to the conclusion, that involuntary commitment ought to be abolished.

In order to diminish the risks, a transition period of five years is proposed. In that period, alternative strategies can be created, and the structure of mental health care adapted. Proposals are made to realize these goals.