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# The convenient myth of Thomas Szasz

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Thomas Szasz's original critique of the concept of 'mental illness' is almost 50 years old. Over that half century Szasz has maintained a consistent campaign against the 'Therapeutic State', challenging the paternalism of coercive psychiatry and defending liberty and autonomy. Despite his widespread celebrity Szasz continues to be misread and misrepresented. In this paper we review some of Szasz's key ideas, in the light of Clarke's recent critique, setting this within the context of 'mental health nursing' and the problems in living affecting persons worldwide.

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## Introduction

Thomas S Szasz is widely recognized as a key philosopher of psychiatry (Hoeller 1997). Despite repeated attempts to bury him or consign his work to the annals of history, Szasz continues to publish and speak. Szasz's ideas are now used liberally by other psychiatrists and physicians, especially in their conversations with the lay public (e.g. Dalrymple, 1998, McHugh 1999, Groopman 2000), whether or not he is actually cited. In that sense, Szasz continues to influence the mental health community and society at large.

1. In the 50 years since he first critiqued the concept of 'mental illness' (Szasz 1960), the American Psychiatric Association (APA) has largely abandoned any presumption of causation in the diagnosis of 'mental illness', in favour of a tendentious behavioural catalogue of 'disorders' (American Psychiatric Association 2005).
2. In many countries, the term 'mental illness' remains part of popular parlance, but lay people, politicians and professionals more frequently refer to 'mental health problems', acknowledging the problems in living Szasz talked about.
3. As a reaction to the burgeoning use of legal sanctions against 'mentally ill' persons, support has grown for 'advanced directives', which might afford people a degree of influence over their lives, should they fall into psychiatric hands. All such directives derive from Szasz's original 'psychiatric will', first written in the 1970s (Szasz 1982).
4. Finally, Szasz was the first psychiatrist to challenge the idea that homosexuality was a form of 'mental illness' or 'disease' (Szasz 1965). Although the APA eventually bowed to Gay Rights pressure, removing the homosexuality classification in 1973, Szasz's critique underpinned their crisis of confidence.

Szasz's influence may be limited in mental health nursing but some nurses appreciate both his arguments and their significance for the 21st century. Roberts wrote:

> Importantly, Szasz suggests that the 'transgression' of psychosocial, ethical and legal norms is not a consequence of 'illness', but of the attempt to confront and to tackle what he refers to as '*problems in living*' . . . (these) are not the consequence of some 'objective', intra-personal 'disease entity', the consequence of 'diseases of the brain' . . . but are instead 'the expressions of man's struggle with *the problem of how he should live*'. (Roberts 2007, p. 278; emphasis in original)

Roberts understood that:

> By claiming that mental illness is a myth, Szasz is not suggesting that the variegated phenomena that are currently identified as mental illnesses do not exist; rather, he is claiming that such phenomena is a consequence of the *attempt to confront* and to *tackle the problem of how to live*, and that to identify such phenomena as a 'disease' or an 'illness' is to *hide the very real problems in living that people face*. (Roberts 2007, p. 278; emphasis added)

Roberts also believed that Szasz's work held contemporary relevance, offering mental health nurses an opportunity to view mental health problems 'in the context of the shape and the direction of a person's life as a whole, and as a life embedded within, and therefore shaped by, the unique particularities of our historical epoch' (Roberts 2007, p. 281).

Arguably, Szasz's most significant contribution is his sustained examination of the ways that words, especially definitions, may be used to gain power over people, effectively enslaving them. Here, we explore some aspects of Szasz's work, in the light of the recent critique by Clarke (2007).

## Szasz: the man and his work

Clarke sought to question 'in a nuanced way' (Clarke 2007, p. 446) the views of Thomas Szasz 'on custodial psychiatry', ultimately finding the man, both 'fascinating and annoying' (Clarke 2007, p. 452). Was Clarke criticizing 'Szasz the man', or addressing Szasz's body of work? In this context, Elliot suggested that if authors abided by the 'two fundamental principles of scholarly activity, namely rigour and balance' they will avoid lapsing into personal attacks, which '*should not be tolerated in any writing, not least academic writing*' (Elliott 2006, p. 372; emphasis added). Readers must decide if Clarke's paper represented a personal (*ad hominem*) attack.

Here, we address some of the content of Clarke's critique, considering specifically the extent to which it was rigorous and balanced (**N.B.** We acknowledge Dr Clarke as an esteemed colleague and Dr Szasz as a colleague and personal friend, both of longstanding). In contrast to Clarke's 'nuanced' style, we avoid making any interpretations as to what might have been in Dr Clarke's mind when writing his critique, or to attribute any motives to him, in framing his conclusions.

## Fairness, civility and standards

Towards the end of his critique Clarke identifies an 'issue of civility', which 'Szasz violates . . . time and time again' (Clarke 2007, p. 452). Ironically, Clarke's critique did not appear to be 'fair': an old-fashioned view perhaps, but in the context of academic writing and 'civility', an important one. Fiennes (2004) noted how the reputations of 'heroic figures', like Captain Scott have been attacked and their achievements distorted. Although increasingly popular, such personal attacks have been around at least since Strachey (2003) published *Eminent Victorians* in 1918, which included a witty, but acerbic, summary of the life of Florence Nightingale.

Perhaps, Clarke assumed that Szasz would have grown used to *ad hominem* attacks. However, we believe that Clarke seriously misled readers of *Journal of Psychiatric and Mental Health Nursing* and his critique represents an example of diminishing standards in academic writing. That Clarke was able to publish so many unsubstantiated criticisms of Szasz's work and his person, may represent a failing on Clarke's part, but certainly suggests an editorial failure on the part of the academic journal, which approved their publication.

Clarke paper was unfair in three ways:

1. Clarke failed to acknowledge Szasz's body of work. He used only three books, one book chapter and one magazine article, as the basis of his critique (a fourth book was cited, but its content not addressed). Seven hundred publications are listed on Szasz's web site (http://www.szasz.com), including over 30 books. Did Clarke read all these works in preparing his critique, but felt it necessary to refer only to five of them? On what grounds did he believe that these five works represented 'Szasz's thinking'?
2. Clarke failed to acquaint the reader with Thomas Szasz the man before making, what appeared to be, unfair and discourteous personal comments. Szasz has received over 50 prestigious awards, at home and abroad. Among them are: the *Martin Buber Award* (1974), the *Humanist Laureate Award* (1984), the Great Lakes Association of Clinical Medicine *Patients' Rights Advocate Award* (1995) and the American Psychological Association, *Rollo May Award* (1998). These four particular awards represent appreciation, from various communities, of Szasz's 'human' qualities, which Clarke either attempted to diminish or deny existed.
3. Clarke encouraged readers to believe that Szasz is a marginal figure of no real relevance to the contemporary world of mental health 'care'. David Smail, the respected British psychologist, included Szasz among the six '*seminal (psychiatric) figures of the 20th Century*' (see: http://www.davidsmail.freeuk.com/psypsy. htm).

That Clarke devoted so much time and effort to 'critiquing' an anachronism, may illustrate the extent to which he values or fears Szasz's ideas.

## The myth of mental illness revisited

Clarke asserted that 'for 50 years he (Szasz) has berated "conventional" psychiatry, adamantly denying its claims that there really are such things as mental illnesses'. This assertion was unsupported by any citation. However, Szasz had written:

> While I maintain that mental illnesses do not exist, *I obviously do not imply or mean that the social and psychological occurrences to which this label is attached do not exist*. Like the personal and social troubles that people had in the Middle Ages, contemporary human problems are real enough. It is the labels we give them that concern me, and, having labelled them, what we do about them. The demonological concept of problems in living gave rise to therapy along theological lines. Today, a belief in mental illness implies – nay, requires – therapy along medical or psychotherapeutic lines. (Szasz 1974, p. 21; emphasis added)

Clarke continued:

> Indeed, he (Szasz) asserts, constructing illness categories in the absence of lesions amounts to downright lying. (p. 446)

Again, no citation was offered. However, Szasz had long ago made his position clear:

> To sum up: for those who regard mental symptoms as signs of brain disease, *the concept of mental illness is unnecessary and misleading*. If they mean that people so labelled suffer from diseases of the brain, it would seem better, for the sake of clarity, to say that and not something else. (Szasz 1974, p. 14; emphasis added)

Szasz's original argument concerning the 'myth of mental illness' (Szasz 1959, 1960) is summarized in his 'manifesto' (http://www.szasz.com). Mental illness is a metaphor. The mind can be 'sick' or 'diseased' only in the way that a joke can be described a 'sick' or the national economy can be seen as 'ailing'. 'Classifying thoughts, feelings and behaviours as diseases is a logical and semantic error, like classifying the whale as a fish.' [All attributions to Szasz are taken from the web site (http://www.szasz.com) unless otherwise stated].

Clarke noted (again without citation): 'Equally, is it fascinating to observe Szasz's reluctance to allow . . . the possibility that *some* physical correlates for schizophrenia might emerge' (Should the reader not be told where or when Szasz was 'observed' making this fascinating assertion?).

Clarke continued: 'Of course, if and when they do, he will straightforwardly re-assign schizophrenia to neurology . . . (p. 450)'. This implies that this might represent a new position for Szasz. Instead, this was the nub of Szasz's original thesis *viz*: if some demonstrable physical pathology is associated with some pattern of behaviour, then we have a manifestation of physical illness, not mental illness. Szasz has consistently argued that should a person be diagnosed with a 'brain disease' the 'patient' should be in the care of a neurologist. He has also discussed the many reasons why this is unlikely to happen (Szasz 2001).

Despite the alleged nuances of his argument, Clarke fails to grasp the concept of myth when applied to mental illness. In popular parlance Clarke, like many other such critics' just 'doesn't get it'.

We assume that Szasz chose the expression myth carefully. Myths are fictions with great symbolic power. On one level a myth is a falsehood that is patently not true. On another level, a myth expresses the ideology of a particular culture, explaining the world view of its members. People choose to believe the 'myth of mental illness', as this 'works' for them: giving some people comfort, relieving other people of responsibility or 'explaining' the 'inexplicable'. This myth also provides a growing army of 'mental health workers' with employment and a socially sanctioned rationale for some to forcibly 'treat' people 'suffering' from mythical 'illnesses'.

## Contracts and currency

Clarke wrote that:

> [For Szasz] psychiatry is defensible only when 'owned' by fee-paying patients: when delivered by state employees – for instance the British National Health Service – it is evil not just because it invokes legislation to compel acceptance of its treatments but more so because anything which violates capitalist-free enterprise is anathema. (p. 447)

Again, no citation is offered for this provocative claim. Recently, Szasz chose suicide as a context for the discussion of contracts:

> In liberal [free] societies, the law treats *persons* as contracting individuals, not as members of status groups (men/women, sane /insane) . . . Modern psychiatric ethics has declared war on this principle, as Marcia Goin's reaffirmation of the psychiatrist's unyielding commitment to coercion illustrates. She asserts that psychiatrists cannot makes contracts with the persons they call 'patients'. Builders, insurers, and car dealers make contracts with such persons. Why can't psychiatrists make contracts with them? Because contracting implies two (or more) legally equal parties, each putting his cards on the table. It implies mutual obligations. (Szasz 2004, p. 24)

Note here that Szasz addresses people as 'persons', not 'patients'. His considerable published work on 'contracts' emphasizes 'personhood' and 'mutual obligations', rather

than any singular emphasis on 'fee-paying'. Moreover, Szasz has repeatedly made it clear that he does not oppose the practice of psychiatry, except as practised on people involuntarily (e.g. Szasz 1984).

## Category errors

At several points Clarke challenges Szasz directly, as if in conversation. 'For example, on the question of whether psychotic people can give insightful consent, yes, Szasz dubiously asserts, if fee-paying: no, if treated by the state' (p. 447). Again, these comments carry no citation. If Clarke had, indeed, asked Szasz such a question, it seems unlikely that he would have received that particular answer, as it embraces the 'category error' which Szasz first discussed in The Myth of Mental Illness (Szasz 1961). Like Ryle (1949) Szasz argued that it would be a mistake to treat the mind as an object, like the body, and to apply the predicate disease to it. Szasz has noted, however, that Ryle's concept of the category error was 'grievously incomplete'.

> It ignores that treating the mind – mental symptoms, mental illness, psychopathology, the unconscious – as an object may be a strategy, not an error or mistake; that the 'error' is not innocent; that, depending on circumstances, it benefits some and harms others; that, today, there is fame, money, power, and escape from responsibility in the medicalization of everyday life, obloquy, marginalization, and worse in opposition to it. (Szasz 2007, p. xix)

As Vatz & Weinberg (1994) noted, critics who, in using the language of medicine, challenge Szasz to discriminate between 'psychotic' and 'normal' or 'insightful' people (as in Clarke's example), fail to appreciate Szasz's fundamental assertion that the very use of such language constitutes a category error.

## Brain pathology, rights and representation

In a related vein Clarke asserted that:

> Szasz's view, *of course*, is that (1) as there is no illness, there is no lack of insight and that (2) *offenders* must be dealt with in tandem with other *criminals*. (p. 447)

In this unsupported assertion Clarke either reads Szasz's mind or puts words in his mouth. Szasz's view is clear, as his Manifesto shows:

> Because being accused of mental illness is similar to being accused of crime, we ought to presume that psychiatric 'defendants' are mentally competent, just as we presume that criminal defendants are legally innocent. Individuals charged with criminal, civil, or interpersonal offences ought never to be treated as incompetent *solely on the basis of the opinion of mental health experts*. Incompetence ought to be a judicial determination and the 'accused' ought to have access to legal representation and a right to trial by jury.

Clarke worked hard to avoid grasping Szasz's distinction between 'social and psychological occurrences' and the labels applied to them. Instead, he played 'schizophrenia' as one of his 'ace cards':

> Its (schizophrenia) capacity to induce cyclical psychological misery – at rates of 1% in any population, worldwide – stood in stark contrast to Szasz's attempts to intellectualise it out of existence. (p. 448)

Clarke does not make clear what 'it' is, other than a diagnostic label, performing the sleight of hand that now passes for 'psychiatric fact': he endows an abstract noun with agency and at the same time asserts that the person diagnosed lacks agency. Clearly, an abstract noun cannot induce human misery, but Clarke talks as if it can and the person is a passive recipient.

Clarke illustrated 'contemporary discussions' about 'schizophrenia' and other 'mental illnesses' with reference to 'brain imaging techniques'. Given his previous reference to the 'worldwide' nature of 'schizophrenia', one might have expected him to cite the epidemiological work from the World Health Organization (WHO), which did describe the 1% rates mentioned, but not the cyclical misery – or at least not in every country. WHO reported recovery rates of 63% in 'developing countries' (i.e. poor and disadvantaged), whereas in developed nations (i.e. Western) the rate was only 39%. The most parsimonious explanation for this anomaly is that in developing countries, less than 16% of patients are maintained on neuroleptic drugs, compared with almost 60% in the West (Whitaker 2002). In short, there is more chance of recovering from 'schizophrenia' if one lives in a poor, underdeveloped country than if one lives in the USA or Europe, where the person has more chance of becoming a 'long term, chronic patient'. However, as Hegarty *et al.* (1994) have pointed out, outcomes for people diagnosed with 'schizophrenia' are worse now than before neuroleptic drugs were introduced (Hegarty *et al.* 1994).

These findings resonate with Szasz's original arguments. In the absence of 'high-tech' and highly fraudulent medical explanations for their problems in living, people in poor countries probably get personal and/or social help to deal with their problems, rather than forcibly injected with toxic chemicals or 'brainwashed' with 'psychoeducation' (Szasz 2001).

Alternatively, one might have expected Clarke to refer to the recent special issue of *Acta Psychiatrica Scandinavica* in which Morrison *et al.* (2005) edited a series of papers, which illuminated the personal and social factors, especially in early life, which appeared to be related to prob-

lems commonly diagnosed as 'psychosis', describing at least two-thirds of people with a 'psychotic' diagnosis (such as 'schizophrenia') having experienced physical or sexual abuse. They also reported that, in almost every country where surveys have been conducted, the public believes the causes of psychosis are more likely to be adverse psychosocial events and circumstances (like poverty, trauma and abuse) than bio-genetic factors. Clarke tried to convince the reader that 'schizophrenia' emanates from some ill-defined brain pathology, causing cyclical human misery worldwide. The available evidence suggests that some people have such led such an awful life that they develop 'strange' ways of relating to themselves and others, as a means of coping with life. For Morrison *et al.*, the picture was clear: 'psychotic experiences are essentially normal phenomena' (p. 327). These states may be 'strange' but they are not 'abnormal' and they certainly cannot be forms of illness.

Two concluding comments may be made here:

1. However uncertain the 'evidence' on the causal relationship between 'traumatic' and 'psychotic' experience, Morrison *et al.* extended further Szasz's original proposition that, rather than 'hide the very real problems in living that people face, we should help them to tackle the problem of how to live' (Roberts 2007, p. 278).
2. If some of the phenomena presently diagnosed as 'schizophrenia' are, as Clarke suggested, the result of some 'underlying brain pathology', then 'schizophrenia' would be a neurological condition, like Parkinson's disease. Is Clarke suggesting that neurologists should coerce their patients into receiving treatment for their brain pathology? If not, why not?

## Szasz, dialogue and critical gossip

Clarke observed that given Szasz's 'increasingly immoderate (language) . . . meaningful debate became impossible'. As 'an aside' Clarke noted that 'when Dr Jeffrey Schaler in 2001 attempted to float a (critical) book on Szasz, he was informed, by *Harvard Professor of Psychiatry*' Dr Thomas G. Gutheil, among others, noted that there was 'no reason whatever why Szasz deserves a book, even a mixed one with opposing views' (p. 448. [Gutheil is a forensic psychiatrist, and co-author of a handful of books, whose writing on 'coercion', 'seclusion and restraint' has been critiqued by Szasz (2002).]

In fact, when Jeffrey Schaler (2004) published *Szasz under Fire: The Psychiatric Abolitionist Faces his Critics*, a dozen international authorities on psychiatry, psychology, bioethics, social science and the law, paid the compliment of challenging Szasz, and receiving responses from him. What was Clarke's purpose in reporting this gossip, in the absence of any reference to the resultant, critically acclaimed book?

Gossip is one of the oldest means of impugning a person's character. Another popular tactic is the 'invention' of quotes or 'mind-reading', in which Clarke excelled. Szasz has noted how some critics used the views of distinguished figures to criticize him, deliberately omitting any mention that they had since changed their views. Karl Menninger was one, highly significant, example. In 1988, less than 2 years before his death, he wrote to Szasz:

> I am holding your new book, *Insanity: The idea and Its Consequences*, in my hands. I read parts of it yesterday and I have also read reviews of it. I think I know what it says but I did enjoy hearing it again. I think I understand better what has disturbed you these years and, in fact, it disturbs me, too, now. We don't like the situation that prevails whereby a fellow human being is put aside, outcast as it were, ignored, labelled, and said to be 'sick in his mind'. (Menninger, cited in Szasz 1994, pp. 201–202)

Menninger expressed his disgust at the horrendous practices perpetrated in the name of 'psychiatric treatment', concluding:

> Enough of these recollections of early days. You tried to get us to talk together and take another look at our material. I am sorry that you and I have gotten *apparently* so far apart all these years. *You* tried: you wanted me to come there, I remember. I demurred. *Mea culpa*. (cited in Szasz 1994, p. 202; emphasis in original)

Clarke claimed that increasingly 'meaningful debate (with Szasz) became impossible' (p. 451). He offered no support for this claim, other than some unfounded gossip. The documentary evidence shows that distinguished figures remain open to debate with Szasz and he with them. Other distinguished figures, like Menninger, are even persuaded by Szasz's arguments.

## Writing and responsibilities

Clarke described Szasz as 'a snappy writer: he is especially good at punchlines. His writing is *littered* with alliteration and his anecdotes . . . are unfailing, brilliantly, *cunningly* employed' (p. 451). However, Clarke detected many 'logical weaknesses' (p. 447) in his work. Many readers have, over the years, been impressed by both the content and the style of Szasz's writing. Karl Popper (1902–1994) was among them. The Professor of Logic and Scientific Method at the London School of Economics and Political Science, Popper, was the key philosophical influence on the development of contemporary 'scientific method'. In 1961, he wrote to Szasz:

> Thank you very much for sending me your truly admirable book, The 'Myth of Mental Illness'. Although my eyesight makes reading difficult, I found it so fascinating that I read it at one go. It is a most important book, and it marks a real revolution. Besides, *it is written in that only too rare spirit of a man who wants to be understood rather than to impress*. (cited in Schaler 2004, p. 134)

Popper, the pre-eminent logician, failed to find the 'logical weaknesses' Clarke detected, but did not elaborate upon.

Considering writing and responsibility, a contemporary philosopher noted:

> [Writers] have responsibilities to themselves and to the language they write in. They might not have a responsibility to entertain (although they are wise to), but at least they have a responsibility not to bore . . . not to obfuscate and that includes not writing in insolvable riddles in order to appear deep or clever. (A place will be reserved in the deepest circle of hell for academics on this score). (Grayling 2007, p. 139)

Szasz is renowned as a masterful writer, who steadfastly avoids jargon and other pretentious devices aimed at impressing, but bewildering, his audience. His arguments are clear, written in simple and precise language, and therein, may lie the danger. Almost anyone could read, and understand, Szasz's work. Those who do not 'get it', either have not read his work or, for some reason known only to themselves, refuse to 'get it'. Clarke did not grasp, or refused to grasp, the basic tenets of Szasz's writing. Or perhaps he was not really all that familiar with them. As Krauthammer observed: 'Szasz is the kind of author no one reads but everyone knows about' (Krauthammer 1985, p. 70).

## . . . and finally mental health nursing

Clarke noted: 'at least a dozen articles in this journal have referred directly to the psychiatry of Thomas Szasz, *even favourably on occasions*' (p. 446; emphasis added). Clarke too is a 'snappy writer', with a gift for subtle put-downs, if not punchlines. Who these authors were and why Clarke chose not to identify them was not made clear. Roberts (2007) might have been among them since he looked 'favourably' on some of Szasz's work, even suggesting that it might hold the key to the future of mental health nursing. Clarke noted that Szasz's work was 'relevant to nurses', but could not bring himself to say why or how.

A key question for anyone entertaining a career in any area of mental health might be:

1. Would this discipline allow me to dedicate my professional life to helping people, without being required to coerce or manipulate anyone who does not wish to be helped? (This seems such a simple question, we hesitate even to ask it.)
2. Who would ever oppose 'helping people' in ways agreeable to the helped?
3. What argument might be proposed in opposition to such 'contractual caring'?

As part of an ongoing study we asked nurses, at different levels of seniority, in different countries, this question. The answers were fairly unanimous. 'In principle' someone could practice as a nurse and refuse (on moral/ethical/philosophical) grounds to be party to 'coercive treatments'. However, such individuals would probably not gain employment; should they make these views known to the recruitment panel. However, although it is becoming increasingly difficult for psychiatrists, psychologists, psychotherapists and social workers can, if they wish, practice the kind of 'contractual psychiatry'. Szasz described: 'refusing to be involved in compulsory or coercive practices; declining to base their offer of help on any notion of 'mental illness'.

At both a philosophical and a practical level, we would ask: why should mental health nursing be a special case? We assume that mental health nursing is focussed on helping people 'grow and develop', as persons. Famously, Peplau (1994) stated, with an almost Szaszian emphasis:

> [Nurses] guide patients in the direction of understanding and resolving their human dilemmas. (p. 271)

Why cannot, at least some, nurses dedicate their lives, if they so wish, to helping people pursue this goal, freely, leaving others, with a preference for more coercive practices, to develop an alternative speciality (with a different name)?

## Psychiatric colonization

Ironically, many of the 'developments' in 'mental health nursing' (internationally) appear to have little to do with helping people 'understand and resolve their human dilemmas', but focus more upon promulgating the myth of 'mental illness', the medicalization of everyday life (Szasz 2007), and the further colonization of poor, or ravaged countries with Western concepts of 'mental illness' and its 'treatment'.

Recently, the World Health Organization (2007) and the International Council of Nurses reported that the number of skilled nurses was far too small to meet mental health service needs worldwide. Salvage (2007) noted that in all continents, except Europe, there are 'fewer than three nurses in MH settings per 100,000 people'. She cited the distinguished English Professor, Ian Norman, as saying: 'the evidence base for MH nursing interventions is at its

strongest for decades. Yet it is alarming that these interventions are not being delivered to patients in many parts of the globe because of inadequate training'. Professor Norman's examples of 'evidence-based interventions' included:

1. Prescription and collaborative medication management.
2. Education and training of service-users to manage their illness.
3. Family psychosocial education.
4. Assertive community treatment.
5. Integrated treatment for people with mental illness and co-occurring substance use disorders (Norman, personal communication).

There is no doubt that people in the so-called 'Third World', former eastern Bloc countries, and some South American and Asian countries, face great social problems, which may generate personal and interpersonal problems for some of their communities, families and individual members. Is the answer to these problems the wholesale 'exporting' of Western models of 'mental illness and treatment'? As noted already in relation to 'schizophrenia', Western countries (the USA in particular) have succeeded only in having poorer rates of recovery, than so-called 'developing nations', fostering the so-called 'enduringly mentally ill'.

Given the rampant psychiatric 'colonisation' of the 20th century, it would be regrettable if, in the 21st century, mental health nurses put their professional shoulder to the colonization wheel. Albee (1996) urged psychologists to:

> Join with persons who reject racism, sexism, colonialism, and exploitation and must find ways to redistribute social power and to increase social justice. (p. 1131)

Where 'evidence-based interventions' fit in to Albee's emancipatory scenario is unclear. People with the problems in living that are commonly diagnosed as 'mental illness', need something more like the social action that brought an end to slavery, opened the door to the emancipation of women, and guaranteed rights for 'people of colour' and gay and lesbian people in the 19th and 20th centuries.

We agree with Szasz, 'contemporary human problems are real enough'. Calling them 'mental illness' is 'unnecessary and misleading'. Sadly, an increasing number of human 'problems in living' are redefined as 'mental illness' both in the West and as part of psychiatric colonization, worldwide. Evidence of psychiatry's desire to territorialize virtually every conceivable corner of human life can be found in the latest edition of the APA diagnostic 'bible' the *DSM IV TR*, which states that:

> Where there is generally a combination of difficulties in the individual's ability to compose written texts evidenced by grammatical or punctuation errors within sentences, poor paragraph organisation, multiple spelling errors, and excessively poor handwriting' the diagnosis of '*Disorder of Written Expression*' may be given. (American Psychiatric Association 2005, p. 55)

Some academics and many of their students need beware! Alternatively, where the person is:

> uncertain about multiple issues relating to identity such as long term goals, career choice, friendship patters, sexual orientation and behaviour, moral values or group loyalties, the diagnosis of '*Identity Problem*' (318.82) may be given'. (American Psychiatric Association 2005, p. 741)

Finally, if the diagnostician cannot fit the 'patient' into any of the hundreds of other 'classifications', then 'Unspecified mental Disorder' may be applied (300.9). Ironically, more and more people seek the attribution of a psychiatric diagnosis to 'explain' their distress or that of some significant other. It is transparent that these labels carry no explanatory power. Doubtless, history will cast Szasz as the psychiatric equivalent of the child who pointed out that the Emperor had no clothes.

## The death of balanced critique?

However, our appeal that Szasz and his ideas should be treated 'fairly' may be 'old-fashioned'. Indeed, Clarke's critique may be an example of the so-called 'post-modern' critique.

Rolfe argued that:

> [Psychiatric and mental health nursing] should reject the traditional academic values of 'old critique' in favour of a post-structuralist, deconstructive meta-critique, in which the aim is not to enforce the existing rules of 'good scholarship', but rather to confront them head-on. (Rolfe 2006, p. 377)

Our appeal for 'fairness', 'rigour' and 'balance' seems stuffy and not 'playful' enough.

Offering a rationale, Rolfe noted:

> [T]he ideal of balanced critique is not itself a balanced view, but always meta-critique would entail a deconstruction of the notion that there are two sides to be balanced, in others it would attempt to show that the dominant discourse has no serious interest in achieving a balance, and in yet others it would attempt to *invert* the hierarchy, to tip the scales in the direction of the subordinate discourse. (Rolfe 2006, p. 377)

However, much earlier Marx (1930) had said:

> We must remember that art is art. Well on the other hand water is water, isn't it? And east is east and west is west. And if you take cranberries and stew them like applesauce, they taste much more like prunes than rhubarb does'. (From *Animal Crackers*)

Clarke's 'article' may be an example of Rolfe's 'new critique', dispensing with the need for 'fairness' and 'integ-

rity' of 'good scholarship'. We don't think so. Clarke's 'snappy', intelligible and entertaining writing guarantees that his readership is much wider than ivory-tower academics playing with 'deconstructive meta-critiques'. Like Rolfe, we are not averse to rule-breaking and iconoclasm, but in the absence of 'fairness', 'integrity' and 'good scholarship' who decides what merits publishing, on what grounds, according to which criteria? Groucho Marx's convoluted reasoning might not have passed as a 'deconstructive turn' but at least it was funny.

## Conclusion

Szasz's key arguments can be found in his considerable body of writing from the past 50 years. Like many other critics Clarke established his critique upon what he believed Szasz had said, or what he thought Szasz meant or intended, rather than upon actual cited work, revealing more about Clarke, his values and beliefs, than Szasz or his work.

In the final analysis, Szasz's position on the 'myth of mental illness' is unremarkable – at least to the philosopher or neurologist. Recently, he reminded us of the potential absurdity, of the metaphor of mental illness:

> If mental illnesses are diseases of the central nervous system (e.g. paresis), then they are diseases of the brain, not the mind; and if mental illnesses are the names of (mis)behavior (for example, fear and avoidance of narrow spaces, called 'claustrophobia') then they are behaviors, not diseases. A screwdriver may be a drink or an implement. No amount of research on orange juice and vodka can establish that it is a hitherto unrecognized form of a carpenter's tool. (Szasz 2007, p. 28)

If Clarke can demonstrate the physical basis of states called 'schizophrenia' (or any other diagnosable 'mental illness) then he – not Szasz – will 'straightforwardly reassign schizophrenia to neurology' (Clarke 2007, p. 450).

However, Szasz's position on 'coercive psychiatry' and especially the 'insanity defence' (Szasz 2002) poses more of challenge, especially for those in the 'mental health' field, not least 'mental health nurses', who invariably become the 'psychiatric enforcers', willingly or otherwise. In an era when 'freedom' has become the rallying cry for a disparate range of political ideologies, the paternalistic argument that coercion is 'in the best interests' of the person (patient) is no longer acceptable. The view of CS Lewis, from 60 years ago, remains relevant:

> Of all the tyrannies, a tyranny sincerely exercised for the good of the victims may be the most oppressive . . . To be 'cured' against one's will and cured of states which we may not even regard as disease is to be put on a level with those who have not yet reached the age of reason or those who never will; to be classed with infants, imbeciles, and domestic animals. (Lewis 1949, cited by Szasz 2002)

In defending the tyranny of coercive treatment of people with e.g. 'schizophrenia', Clarke avoided discussing the obvious fact that people with actual brain pathology – such as Parkinson's disease – are not coerced into receiving 'treatment'. More importantly persons who might represent an 'actual' threat to society – such as people with tuberculosis or AIDS – are not 'treated' against their wishes. What is the philosophical, ethical and practical basis for this distinction?

In his final analysis, Clarke believed that Szasz's 'anger' sustained him. This begs the question: why is Clarke not similarly incensed, especially given the history of his chosen discipline's complicity in the torture, invalidation, persecution and disablement of legions of persons defined, ubiquitously, as 'mentally ill' (see Whitaker 2002). Clarke (1999, 2001) is no mean 'radical' himself. Why, therefore, does he turn against the father of psychiatric radicalism, especially at such a precarious point in the history of human freedom, and the emergence of emancipatory psychiatry?

Edmundson (2007) believed that Freud, in his later work, anticipated the rise of tyranny and fundamentalism in the 20th and 21st centuries:

> Authoritarian religion and authoritarian politics are two sides of one debased coin. They feed off each other, borrow techniques, modes of persuasion, and inconography. They traffic in the same sorts of miracle, mystery and authority . . . Freud's work suggests that no one should ever think that fascism and fundamentalism are gone and done with . . . Through authoritarianism we attain assurance and happiness – though of a certain sort. It is only constant critical labor that keeps the worst political and religious possibilities from becoming fact. (Edmundson 2007, pp. 24–31)

As Szasz noted, Marx told only half the story when he declared that 'religion was the opiate of the people'. As 'religion is a product of our own minds, so too is psychiatry. In short, the mind is its own opiate. And its ultimate drug is the Word' (Szasz 2007, p. 29). We – the people – have supported the construction of the myth of mental illness; and we – the people – continue to invest psychiatry with the power necessary to maintain its overarching authority over our lives. This is the most vivid example of Sartre's (1956) concept of 'bad faith', wherein we deceive ourselves, for reasons known only to ourselves.

If the human community could seriously address the origins, meaning and significance of the problems in living variously diagnosed as 'mental illness', then it might begin to explore some serious alternatives to the history of obfuscation, colonialism and paternalism, associated with traditional psychiatry. We, the people, deserve such an

alternative. Szasz has, for over 50 years, signalled that alternative.

Clarke's views may be interesting, but we hope that readers would consult the primary sources (http://www.szasz.com) and make their own decisions as to the validity and value of Szasz's writing for contemporary society and their chosen discipline.

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