

## Psychiatry's Valid but Dishonest Reconsiderations

[Richard E Vatz](#), [Jeffrey A Schaler](#). [USA Today](#). Farmingdale: [Mar 2008](#). Vol. 136, Iss. 2754; pg. 58, 3 pgs

### Abstract (Summary)

Regarding the claim of more than 55% of Americans suffering from **mental** illness, Paul McHugh, former chief of psychiatry at Johns Hopkins Hospital, incredulously and famously stated, "Fifty percent of Americans mentally impaired-are you kidding me?" McHugh is one of the more skeptical psychiatrists whose writing reveals significant agreement with Szasz and yet, who, one may assume due to sociologically approved distaste for Szasz among **mental** health professionals, refuses to give him credit for his original skepticism and critiques of psychiatry. Here are some of those correct, but "borrowed," ideas: \* Normal, understandable suffering should not be diseased rhetorically. \* Normal sadness too often is medicalized . falsely. \* Coercive counseling and forced counseling neither are ethical nor effective. \* One of the dangers of misleading diagnosis in psychiatry is that the symptom does not point to the illness, but is the illness. \* The popularization of the notion of nonmedical, nonpsychiatric "problems-in-living" concept is pointed out in contradistinction to **mental** disorders. \* Just because drugs change behavior does not mean that a disease is being cured. \* Deficiencies or changes in brain chemistry could be the result, rather than the cause, of depression.

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"Much of the newest wave of psychiatric self-criticism is salutary and headed in the right direction; the problem is the field's unwillingness to credit the psychiatrist who paved the way."

MORE THAN HALF a century ago, Thomas Szasz shocked the world of psychiatry with his then, and still, electric book, *The Myth of Mental Illness*. Since that time, he has been unmasking the invalidity of psychiatric practice and its *raison d'être*: the diagnosing and treatment of mental illnesses. His reasoning through scores of major works and over 1,000 articles, reviews, and letters has been based on a simple, but profoundly true, insight-mental illness and mental health and their derivative concepts are metaphors, since the mind is not an organ.

From that concept, the entire mental health establishment intellectually has been reeling, while occupationally profiting for the same five decades. Psychiatrically-based rhetoric has used schizophrenia as the prototype mental illness because it represents-at least in the lay public's mind-the most bizarre and inexplicable behavior of the "mentally ill" and, most important, some people labeled "schizophrenic" may have genuine brain disease. This constitutes a tiny

percentage of those deemed "mentally ill," a population that psychiatry alleges has grown to more than a majority of the general population. Let there be no confusion about this claim of the discovery of brain disease, however. If persons called schizophrenic are discovered to have a lesion that correlates perfectly with their behavior, or clearly causes their behavior, a mental illness has not been discovered; rather, a new brain disease has been discovered.

Szaszian critics of psychiatric theory and practice tend to find the prototype mental illness to be in the "problems in living" category, first extensively discussed by Szasz. This would comprise the vast majority of the over 300 mental illnesses named in the current Diagnostic and Statistical Manual (DSM-IV-R) of the American Psychiatric Association. The National Institute of Mental Health, the primary sponsor of this finding-that more than 55% of the American population suffers from some mental illness over a lifetime-produced its

conclusion, according to a June 7, 2005, article in The [New York Times](#) entitled, "Most Will Be Mentally Ill at Some Point," at a time conducive to complementing its efforts to promote lucrative screening and treatment for mental illness among all ages. The study involved nonmedical interviews conducted by nonphysician personnel. What constitutes "mental illness" is that which is approved by the Board of Trustees of the American Psychiatric Association (APA) for the latest version of the Diagnostic and Statistical Manual (DSM), now set for revision by 2010.

Studies such as these can lead to changes in the manual, which often varies according to politics of the profession. In 1973, pursuant to protests by the gay community and others, homosexuality was removed as a mental disorder, but self-diagnosed involuntary homosexuality-called "ego-dystonic" homosexuality-remained until it, too, was removed. There were no scientific studies which adumbrated the change, only unfriendly sociological phenomena. Thus, homosexuality exited as a disease the same way it came in. Homosexuality was classified as a disease for political reasons-and it was declassified as a disease for political reasons. No other real disease has ceased being a disease. Its prevalence and incidence may have diminished-consider tuberculosis and small pox, for instance-but even if wiped off the face of the Earth, a disease remains a disease; it is not subject to political winds and changes.

Such studies and surveys are the nonscientific Rosetta stone of the mental health community. There is no limit to the percentage of the population which can be said to be "mentally ill," since, as a metaphor, there is no way to confirm or disconfirm diagnoses (or the number of people who are mentally ill). Moreover, there is no limit to the variety of behaviors that successfully can be labeled as "mental illness," since there is no measurable criterion that eliminates such labeling or name-calling.

One example from an inexhaustible list is a Dec. 10, 2005, [Washington Post](#) story, "Psychiatry Ponders Whether Extreme Bias Can Be [a Mental] Illness." Some prominent psychiatrists, such as Gary Belkin, deputy in chief of psychiatry at New York's Bellevue Hospital, were arguing for the APA to include extreme racism in the DSM's list of mental disorders-and thus inadvertently were conceding that psychiatrists falsely medicalize antisocial behavior as mental disorders. Belkin put forth this argument: "Psychiatrists who are uneasy with including something like this [extreme racism] in the Diagnostic and Statistical Manual need to get used to the fact that the whole manual reflects social context. . . . That is true of depression on down. Pathological bias is no more or less scientific than major depression."

Serious psychiatrists intuitively recoil from the worst fatuities of their field, of course. Several establishment mental health professionals publicly have disassociated themselves from the claims of such widespread incidence of mental illness and the limitless extending of its diagnosis. According to the same article on racial prejudice being an illness, the APA's director of research, Darrel A. Regier, asks, "Are you pathologizing all of life?" Still, he supports research into the matter.

Regarding the claim of more than 55% of Americans suffering from mental illness, Paul McHugh, former chief of psychiatry at Johns Hopkins Hospital, incredulously and famously stated, "Fifty percent of Americans mentally impaired-are you kidding me?" McHugh is one of the more skeptical psychiatrists whose writing reveals significant agreement with Szasz and yet, who, one may assume due to sociologically approved distaste for Szasz among mental health professionals, refuses to give him credit for his original skepticism and critiques of psychiatry. One finds in McHugh's impressive, if not original, treatise in Commentary ("How Psychiatry Lost Its Way," December 1999) many criticisms of psychiatry that first were made by Szasz, including the following:

- \* We are witnessing a proliferation of new, nonorganic, bogus psychiatric disorders.
- \* Psychiatry utilizes reliability of psychiatric disorders (testing to see if diagnosticians agree on what psychiatric disease patients suffer from) instead of focusing on the gold standard: the validity of psychiatric diagnosis or, in other words, whether it measures what it claims to measure.
- \* In psychiatry, as opposed to somatic medicine, the symptom is the disease, rather than a sign for the disease.
- \* There is collusion between some pharmaceutical companies and some psychiatric diagnosticians.

- \* The problematic DSM approach of "using experts and descriptive criteria in identifying psychiatric diseases has encouraged a productive industry."
- \* There is a profound consequence of self-fulfilling prophesy in the public positing of new psychiatric disorders.
- \* Positing "biological markers" for psychiatric disorders is unreliable and invalid.
- \* The changing of behaviors by psychotropic drugs ("Everyone is more attentive when on Ritalin . . . ") affects anyone who takes them and cannot be used validly as indicative of psychiatric disorders.

Actually, there is the one point for which McHugh does give Szasz credit: 'Exercises in mental cosmetics should be offensive to anyone who values the richness of human psychological diversity.'

From discussions long ago with McHugh, we know the personal distaste he has for Szasz, but this should not prevent him nor his psychiatric brethren from citing the lineage of these important and compelling points. There still are profound differences between Szasz and his psychiatric critics, including the vital component of free will claimed by Szasz in literally all alleged psychiatric disorders from "drug addiction" to "anorexia nervosa," but their differences are narrowing, and McHugh should have acknowledged that.

These points serve as continuing topoi for new skeptics in psychiatry. One now can find the objections to the overdiagnosis and overmedicating of children and, to a lesser extent, women and people in general in book after book. All of these criticisms are intellectually and academically indebted to Szasz's work.

The new self-skepticism in psychiatry has reached its current zenith with the publication of *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. The authors, Allan V. Horwitz and Jerome C. Wakefield, are not physicians, but professors of sociology and social work, respectively. They combine the in-house skepticism of psychiatric diagnosis-this time focusing on depressive disorder-with the ethically suspect ignoring of Szaszian ideational and evidentiary lineage. The book's main contention is that normal sadness has been "medicalized" or "pathologized" into "depressive disorder" due to the ignoring of the normalcy of sadness in many contexts, as well as the lack of use of exclusionary criteria, the proper utilization of which eliminate most instances of normal, situational depression's falsely being diagnosed as disordered depression. In addition, the arbitrariness of DSAPs duration criteria and its lack of confronting its own criteria of intensity and length of time of suffering add to the misdiagnoses. The book potentially is quite significant to the practice of psychiatry, because limiting diagnoses of disordered depression-often cited as resulting in the invalidating of up to 20% of psychiatric

diagnoses-would put quite a crimp into the patient numbers, prescription counts, and third-party coverage. The consequences of acceding to their recommendations are not addressed by Horwitz and Wakefield.

The Loss of Sadness includes the support of Robert Spitzer, the longtime overseer of the DSM. He wrote the Foreword and stated therein that the book is "relentless in its logic," and it "forces one to confront basic issues that cut to the heart of psychiatry." He calls the book a "brilliant tour de force." In return, the authors are extremely flattering to Spitzer, citing his "prodigious research efforts" for DSM-III and complimenting his "accomplishments" and his "greatest achievement... the shepherding of the creation of an entirely new psychiatric clinical diagnostic classification system" which, the authors claim, ensures reliability in the manual.

### Ignoring Szasz

At the same time, Sadness virtually ignores Szasz's contributions to the criticism of psychiatry that led to Horwitz and Wakefield's. (It should be noted that, in an earlier Horwitz book, *Creating Mental Illness*, there also is the lack of relevant and academically required footnoting of Szasz's voluminous works-Horwitz references him on a couple of pages essentially to say that Szasz calls mental illness a "myth," but ignores him on many points on which Szasz has declaimed over the years. Moreover, he asserts that Szasz is a libertarian.) Regarding the only two citations of Szasz, one is flat-out historically inaccurate: the citing of his support of the "antipsychiatry" movement which, in fact, he opposes. The other grotesquely oversimplifies and minimizes Szasz's extraordinary, unique, and comprehensive corpus by saying in a mere 10 words that he argues, "There are no mental disorders because disorders require physical lesions." This leads them to the unsurpassable non sequitur that Szasz (and others) "preclude the prospect of effectively critiquing overexpansive psychiatric definitions of disorder."

Sadness cribs many of the Szaszian insights that others in the mental health fields also have, but the list in this work is striking, and the many omissions of Szasz in the text and, particularly, in the endnotes are deeply disturbing. Here are some of those correct, but "borrowed," ideas:

- \* Normal, understandable suffering should not be diseased rhetorically.
- \* Normal sadness too often is medicalized . falsely.
- \* Coercive counseling and forced counseling neither are ethical nor effective.
- \* One of the dangers of misleading diagnosis in psychiatry is that the symptom does not point to the illness, but is the illness.

\* The popularization of the notion of nonmedical, nonpsychiatric "problems-in-living" concept is pointed out in contradistinction to mental disorders.

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The current retrenchment of psychiatry unembarrassingly takes much from Szasz, but there remain unbridgeable differences. Much of what has been examined insufficiently-that Szasz would argue deserves intense scrutiny-includes the psychological, social, and economic outrage of creating dependency, wherein people lose their autonomy and must be drugged and cared for.

The longstanding and ongoing use of Szasz's criticisms of psychiatry without sufficient-or any-attribution is, of course, indefensible. The motive simply may be resentment toward Szasz or it may be more complicated-such as the desire to affect psychiatric history by implying (falsely!) that psychiatric theory adapts through internal processes of thesis-antithesis-synthesis.

Irrespective of the expropriation of Szasz's insights over the past half-century, there remain some irreconcilable gaps. Szasz differs from psychiatry and conventional wisdom in the totality of his argument: that there is-or can be-no such thing as a mental disease or an empirically verifiable mental disorder. In addition, Szasz's contention that people must be held responsible for all of their behavior-particularly criminal behavior-is undercovered. Reflexes, palsy, and behavior emanating from authentic neurological diseases may not be chosen, but all purposive behavior is, he argues. Drugs may affect mood, but that does not mean that they are curing a disease. The metaphor of "mental illness" is an all-purpose explanation, as Szasz repeatedly has cautioned, that purports to explain everything but, in fact, explains and clarifies nothing.

Much of the newest wave of psychiatric self-criticism is salutary and headed in the right direction; the problem is the field's unwillingness to credit the psychiatrist who paved the way.

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