In my essay, “The Myth of Mental Illness,” published in 1960, and in my book with the same title which appeared a year later, I stated my aim forthrightly: to challenge the medical character of the concept of mental illness and to reject the moral legitimacy of the involuntary psychiatric interventions it justifies. 1,2 I proposed that we view the phenomena conventionally called “mental diseases” as behaviors that disturb or disorient others; that we reject the image of the patients as the helpless victims of patho-biological events outside their control; and that we critically scrutinize and reject participating in coercive psychiatric practices as incompatible with the foundational moral ideals of free societies.

In the 1950s, when I wrote The Myth of Mental Illness, the notion that it is the responsibility of the federal government to provide “health care” to the American people had not yet entered national consciousness. Most persons called mental patients were considered incurable and were confined in state mental hospitals. The physicians who cared for them were employees of the state governments. Non-psychiatric physicians in the private sector treated voluntary patients and were paid by their clients or the clients’s families. Since that time, the formerly sharp distinctions between medical hospitals and mental hospitals, voluntary and involuntary patients, private and public psychiatry have blurred into nonexistence. Virtually all mental health care is now the responsibility of the government and is regulated and paid for by public moneys. Few, if any, psychiatrists make a living from fees collected directly from patients, and none is free to contract directly with his patients about the terms of the “therapeutic contract” governing their relationship. Everyone defined as a “mental health professional” is now legally responsible for preventing his patient from being “dangerous to himself or others.” In short, psychiatry is thoroughly medicalized and politicized. The opinion of official American psychiatry – embodied in the official documents of the American Psychiatric Association exemplified by its Diagnostic and Statistical Manuals of Mental Disorders – bears the imprimatur of the federal and state governments. There is no legally valid non-medical approach to “mental illness,” just as there is no legally valid non-medical approach to measles or melanoma.

Fifty years ago, it made sense to assert that mental illnesses are not diseases. It makes no sense to do so today. Debate about what counts as mental illness has been replaced by political-judicial decrees and economic criteria: Old diseases such as homosexuality disappear, and new diseases such as attention deficit hyperactivity disorder(ADHD) appear. Fifty years ago, the question “What is mental illness?” was of interest to physicians, philosophers, sociologists as well as the general public. This is no longer the case. The question has been settled by the holders of political power: they have decreed that “mental illness is a disease like any other.” In 1999, President William J. Clinton declared: “Mental illness can be accurately diagnosed, successfully treated, just as physical illness.”3 Surgeon General David Satcher agreed: “Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain.”4 Thus has political power and professional self-interest united in turning a false belief into a “lying fact.”5

The claim that “mental illnesses are diagnosable disorders of the brain” is not based on scientific research; it is an error, or a deception, or a naive revival of the somatic premise of the long-discredited humoral theory of disease. My claim that mental illnesses are fictitious illnesses is also not based on scientific research; it rests on the pathologist’s materialist-scientific definition of illness as the structural or functional alteration of cells, tissues, and organs. If we accept this definition of disease, then it follows that mental illness is a metaphor, and asserting that view is stating an analytic truth, not subject to empirical falsification.

The Myth of Mental Illness offended many psychiatrists and many mental patients as well. My offense – if it be so deemed – was calling public attention to the linguistic pretensions of psychiatry and its preemptive rhetoric. Who can be against “helping suffering patients” or “providing patients with life-saving treatment”? Rejecting that jargon, I insisted that mental hospitals are like prisons not hospitals, that involuntary mental hospitalization is a type of
imprisonment not medical care, and that coercive psychiatrists function as judges and jailers not physicians and healers. I suggested that we discard the traditional psychiatric perspective and instead interpret “mental illnesses” and psychiatric responses to them as matters of morals, law, and rhetoric, not matters of medicine, treatment, or science. The proposition that mental illness is not a medical problem runs counter to public opinion and psychiatric dogma. When a person hears me say that there is no such thing as mental illness, he is likely to reply: “But I know so-and-so who was diagnosed as mentally ill and turned out to have a brain tumor. In due time, with refinements in medical technology, psychiatrists will be able to show that all mental illnesses are bodily diseases.” This contingency does not falsify my contention that mental illness is a metaphor. It verifies it: The physician who concludes that a person diagnosed as mentally ill suffers from a brain disease discovers that the patient was misdiagnosed: the patient did not have a mental illness, he had an undiagnosed bodily illness. The physician’s erroneous diagnosis is not proof that the term “mental illness” refers to a class of brain diseases.

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

The thesis I had put forward in The Myth of Mental Illness was not a fresh insight, much less a new discovery. It only seemed that way, and seems that way even more so today, because we have replaced the old religious-humanistic perspective on the tragic nature of life with a modern dehumanized pseudomedical perspective on it. The secularization of everyday life – and, with it, the medicalization of the soul and of personal suffering intrinsic to life – begins in late sixteenth century England. Shakespeare’s Macbeth (1611) is a harbinger. Overcome by guilt for her murderous deeds, Lady Macbeth “goes mad”: She feels agitated, is anxious, unable to eat, rest, or sleep. Her behavior disturbs Macbeth, who sends for a doctor to cure his wife. The doctor arrives, quickly recognizes the source of Lady Macbeth's problem, and tries to reject Macbeth's effort to medicalize his wife's disturbance; “This disease is beyond my practice. ... / Unnatural deeds / Do breed unnatural troubles. Infected minds / To their deaf pillows will discharge their secrets. / More needs she the divine than the physician.” Macbeth rejects this “diagnosis” and demands that the doctor “cure” his wife. Shakespeare then has the doctor utter these immortal words, exactly the opposite of what psychiatrists and the public are now taught to say and think:

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

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

By the end of the nineteenth century, the medical conquest of the soul is secure. Only philosophers and writers are left to discern and denounce the tragic error. Søren
Kierkegaard (1813-1855) warned: “In our time it is the physician who exercises the cure of souls. ... And he knows what to do. / [Doctor]: ‘You must travel to a watering-place, and then must keep riding a horse ... and then diversion, diversion, plenty of diversion...’ / [Patient]: ‘To relieve an anxious conscience?’ [Doctor]: ‘Bosh! Get out with that stuff! An anxious conscience! No such thing exists any more.’”

Today, the role of the physician as curer of the soul is uncontested. There are no more bad people in the world, there are only mentally ill people. The “insanity defense” annuls misbehavior, the sin of yielding to temptation, and tragedy. Lady Macbeth is human not because she is, like all of us, a “fallen being”; she is human because she is a mentally ill patient who, like humans, is inherently “healthy” / good unless mental illness makes her “sick” / ill-behaved: “The current trend of critical opinion is toward an upward reevaluation of Lady Macbeth, who is said to be rehumanized by her insanity and her suicide.”

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

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

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

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

The pathologist uses the term “disease” as a predicate of physical objects – cells, tissues, organs, and bodies. Textbooks of pathology describe disorders of the body, living or dead, not disorders of the person, mind, or behavior. René Leriche (1874-1955), the founder of modern vascular surgery, aptly observed: "If one wants to define disease it must be dehumanized. ... In disease, when all is said and done, the least important thing is man.”

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

According to pathological-scientific criteria, disease is a material phenomenon, a verifiable characteristic of the body, in the same sense as, say, temperature is a verifiable characteristic of it. In contrast, the diagnosis a patient’s Illness is the judgment of a licensed physician, in the same sense as the estimated value of a work of art is the judgment of a
certified appraiser. Having a disease is not the same as occupying the patient role: not all sick persons are patients, and not all patients are sick. Nevertheless, physicians, politicians, the press, and the public conflate and confuse the two categories.11

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In the Preface to The Myth of Mental Illness I explicitly state that the book is not a contribution to psychiatry: “This is not a book on psychiatry ... It is a book about psychiatry – inquiring, as it does, into what people, but particularly psychiatrists and patients, have done with and to one another.”12

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

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

The late Roy Porter, the noted medical historian, summarized my thesis as follows: “All expectations of finding the aetiology of mental illness in body or mind – not to mention some Freudian underworld – is, in Szasz’s view, a category mistake or sheer bad faith ... standard psychiatric approaches to insanity and its history are vitiated by hosts of illicit assumptions and questions mal posés.”16

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

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

The issues discussed in this lecture are not new. Ninety-nine years ago, Eugen Bleuler (1857-1939), concluded his magnum opus, Dementia Praecox, with this reflection: The most serious of all schizophrenic symptoms is the suicidal drive. I am even taking this opportunity to state clearly that our present-day social system demands a great, and entirely inappropriate cruelty from the psychiatrist in this respect. People are being forced to continue to live a life that has become unbearable for them for valid reasons. ... Most of our
worst restraining measures would be unnecessary, if we were not duty-bound to preserve the patients’ lives which, for them as well as for others, are only of negative value. If all this would, at least, serve some purpose! ... At the present time, we psychiatrists are burdened with the tragic responsibility of obeying the cruel views of society; but it is our responsibility to do our utmost to bring about a change in these views in the near future.17
This is not what happened. Notwithstanding Bleuler’s vast, worldwide influence on psychiatry, psychiatrists ignored his plea to resist “obeying the cruel views of society.” On the contrary, Bleuler’s invention of schizophrenia lent impetus to the medicalization of the longing for non-existence, lead to the creation of the pseudoscience of “suicidology,” and landed psychiatry in the moral morass in which it now finds itself.

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References