The Reality of Mental Illness

Responding to the criticisms of antipsychiatry.

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Psychiatry is unique among the medical specialties in the sense that it has a very active and vocal countermovement known loosely as antipsychiatry. What started in the 1960s with the writings of psychiatrists Thomas Szasz* and R.D. Laing, among others, has since broadened to include a whole host of ideas and philosophies subsumed under "antipsychiatry."

Individuals associated with antipsychiatry may oppose coercive practices in psychiatry; the use or overuse of psychiatric medication; electroconvulsive therapy; or the legitimacy of psychiatric diagnosis. Not all critics of psychiatry are necessarily "anti-psychiatry," and even some affiliated with the movement raise important ethical and philosophical questions for psychiatry. Unfortunately, others seem to harbor a visceral hatred for "all things psychiatry" (see Pies, 2012). One has to look no further than the

comments left by some on antipsychiatry websites calling for violence against psychiatrists and others in the field.

Both present authors have personal experience with antipsychiatry. One of us (R.P.) studied under Thomas Szasz during psychiatric residency training and has since written extensively on the logical errors in Szasz's work (see Pies, 1979; Pies, Thommi, & Ghaemi, 2011). The other (M.R.) identified for several years as a Szaszian psychoanalyst before more recently coming to disagree with Szasz's claim that mental illness is merely a "metaphor" (see Ruffalo, 2018a). Both authors have come under personal attack by those associated with antipsychiatry and the related, but more nuanced, "neurodiversity" movement.

Perhaps the most pervasive—and harmful—claim made by antipsychiatry is that mental illness doesn't really exist, and that the treatments for mental illness are merely concealed attempts to exert social control over the population. (A related claim is that all psychiatric medications "do more harm than good" and are driving an "epidemic" of mental illness. Paradoxically, the latter claim contradicts the notion that mental illness doesn't exist—see Pies, 2015).

Psychiatric symptoms, antipsychiatry alleges, are not products of disease or disorder; rather, they represent normal human differences; "problems in living" (to use Szasz's term); the result of social intolerance; or even special or advantageous qualities possessed by individuals. For these and other reasons, Szasz drew the conclusion that "mental illness" is illness only in the metaphorical sense, likening the statement, "Joe is mentally ill" to the assertion, "The economy is sick" (see below). The claims of antipsychiatry require careful philosophical investigation, since they have serious consequences for those we treat.

Here, we present six common claims made by antipsychiatry, along with our responses.

Myth #1: Mental illness is not real disease because no biological abnormality has ever been consistently demonstrated in supposedly mentally ill persons. The term "mental illness" is thus nothing more than a metaphor.

The idea that "mental illness" is a metaphor can be attributed to Szasz who began advancing his critique of psychiatry in the early 1960s. For Szasz (1998), "Mental illness is a metaphor (metaphorical disease). . . . Individuals with mental diseases (bad behaviors), like societies with economic diseases (bad fiscal policies), are metaphorically sick." Moreover, for Szasz (1987, p. 151), ". . . if I say that mental illness is a metaphorical illness, I am not saying that it is some other kind of illness; *I am saying that it is not an illness at all"* (italics added).

Szasz's conclusion regarding the metaphoricity of mental illness rests, in part, on his reading (in fact, his misreading) of the pioneering German pathologist, Rudolf Virchow.

Szasz frequently cited Virchow's emphasis on the cellular basis of specific diseases as evidence of the metaphorical nature of mental illness. To Szasz, since mental illness cannot be demonstrated at autopsy, it represents "fake disease" (Szasz, 1987). In addition, Szasz often repeated the misleading and incorrect claim that textbooks of pathology do not list mental disorders (see Pies, 2008; Pies at al., 2011).

In reality, Szasz and Virchow are in conflict on one major, and consequential, point. For Szasz (1974, p. 99), "Every 'ordinary' illness that persons have, cadavers also have." But for Virchow, illness or disease is always a condition of the *living person;* and whereas bodily lesions may persist for some time after death, *"the illness of the person is terminated"* (Pies, 1979). If, as Virchow insists, illness is an attribute of *living persons* and not of *cadavers,* then Szasz's claim is wrong. Indeed, an analysis of ordinary language renders the notion that cadavers can have illnesses risibly fallacious; for example, do we ever say, "That cadaver is seriously ill," or "That corpse is mildly ill"?

Furthermore, there is a broader, historical argument against Szasz's claim. The history of medicine tells us that the presence of an anatomical lesion or physiological abnormality—Szasz's "gold standard" for identifying disease—is merely one way to identify and conceptualize disease. Indeed, such findings are neither necessary nor sufficient to establish *clinically meaningful* disease or illness. A person may have an abnormally shaped ear lobe or an unusually high serum albumin level and not be "diseased" or "ill" in any clinically relevant sense. Historically, the concept of "disease" (dis-ease) is intimately linked with some combination of *suffering and incapacity*(Pies, 1979). The history of medicine is replete with examples of disease states whose pathophysiology was not understood for many decades after the disease had been characterized clinically; e.g., Parkinson's disease was recognized by its observable clinical manifestations (e.g., resting tremor) long before its pathophysiology was identified.

Even today, there exists a whole host of medical diseases—readily accepted as such—for which no single, specific physiological cause or mechanism has been identified. Migraine disorders, Kawasaki's disease, fibromyalgia, and amyotrophic lateral sclerosis (Lou Gehrig's disease) are but a few examples.

Moreover, the identification of *all* medical disease—like the identification of mental disease—rests on a subjective determination about what constitutes "abnormality" (Pies, 1979). It is misleading to claim that medical disease is diagnosed on the basis of "objective" biological findings and that mental disease is not (see Pies, 2007; Ruffalo, 2018a).

Nor is it accurate to assert that mental illness has not been associated with physiological abnormalities in the brain. On the contrary, there is abundant and growing evidence that serious psychiatric illnesses like schizophrenia, major depressive

disorder, and bipolar disorder are associated with specific structural and functional abnormalities in the brain—and that these abnormalities may be seen even in "drug-naïve" (never medicated) patients (Karkal et al., 2018; Ren et al., 2013; Cui et al., 2018; Machado-Vieira et al., 2017).

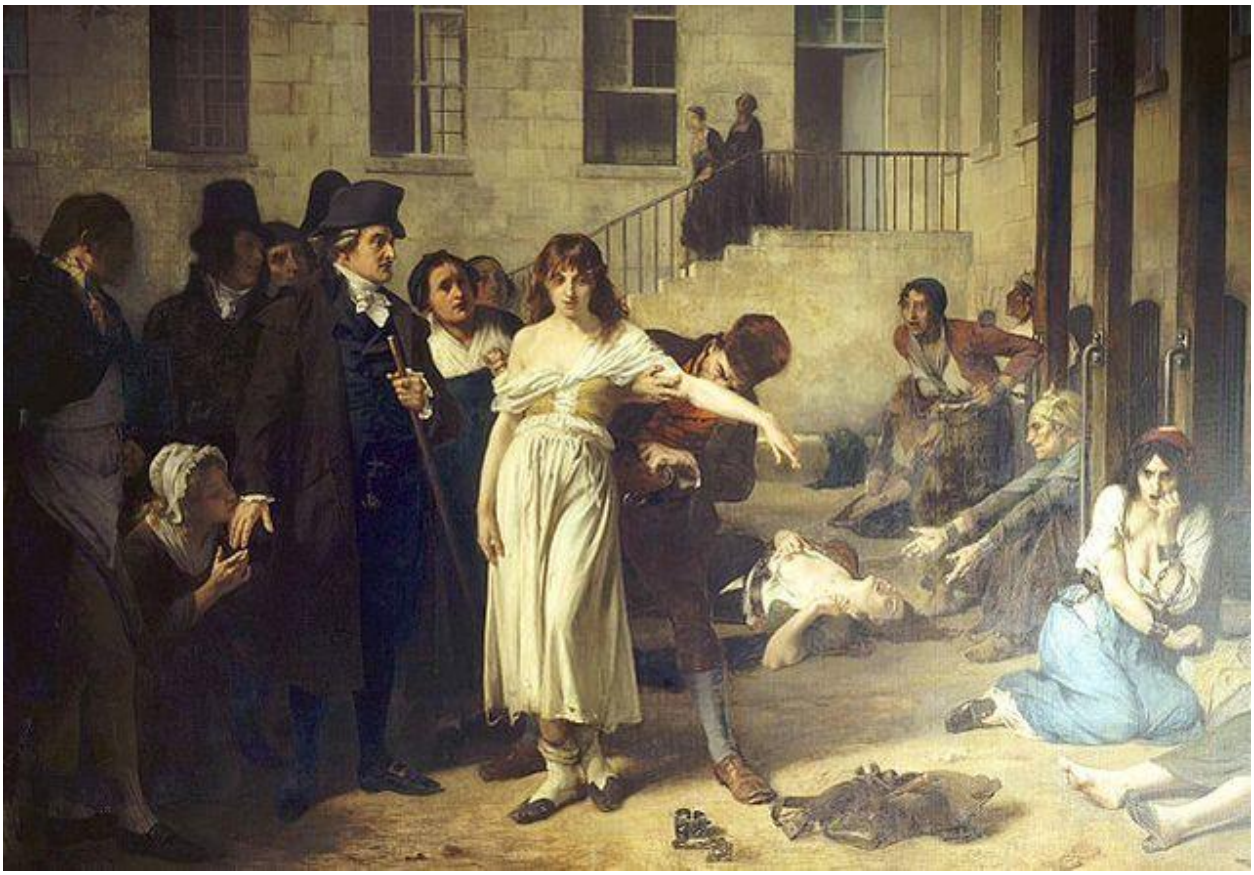
Myth #2: Since "voices" and other psychiatric symptoms possess meaning for some individuals and may be related to past experiences, mental illness is not real disease.

This assertion is based on the fallacy that psychosocial or psychological explanations of human experiences such as "hearing voices" nullify the pathological nature of these experiences. In so far as emotions, cognitions, and behaviors are mediated by brain function, there is *always* an inherent biological foundation to dysfunctional mental states. That certain human experiences (e.g., hearing voices) have a discernible "meaning," symbolism, or psychological significance for the patient (or doctor) does not mean they have no neuropathological etiology. Nor do these psychological explanations remove these experiences from the domain of medicine.

Furthermore, it is simply incorrect to assert that psychiatry sees psychiatric symptoms as random and meaningless experiences, caused solely by "chemical imbalances." The late psychiatrist and psychoanalyst Silvano Arieti published extensively on the psychoanalytic understanding of schizophrenia, and his work is an example of an integrated psychological and biopsychosocial theory of mental disorder (see Ruffalo, 2018b). Arieti wisely concluded that the psychodynamic and the biological are *complementary,* not conflicting, paradigms. This is a view shared by most contemporary psychiatrists and mental health professionals.

Myth #3: Psychiatry exists as a state-sanctioned agent of social control.

This claim insists that government and psychiatry have always been involved in an attempt to rid society of mentally ill persons—or at least, to confine and marginalize them—and that psychiatry is unique among medical specialties in this respect. Szasz termed this association between government and psychiatry "The Therapeutic State," and Michel Foucault made a similar argument about the social function of "the asylum." While it is true that psychiatry as a medical specialty has a specialized relationship with state authority (since it is the only medical specialty which routinely treats patients involuntarily), the claim that psychiatry is "an arm of the state," entirely distinct from other medical specialties, is, at best, a gross oversimplification.



In perhaps the most famous painting in the history of medicine, Philippe Pinel removes chains from a female patient in Paris.

Source: Public domain

In the first place, the involuntary confinement of persons deemed "mad," "insane," etc. arose long before there was any profession or discipline called "psychiatry." For example, in 1773, to deal with mentally disturbed people who were causing problems in the community, the Virginia legislature provided funds to build a small hospital in Williamsburg (U.S. National Library of Medicine, n.d.).

Secondly, the legal-philosophical basis for involuntary civil commitment arose not from the urging or instigation of institutional psychiatry, but from two foundational legal principles: *parens patriae* (Latin, "parent of the country") and the *police power of the state.* As Testa and West (2010) explain,

Parens patriae . . . refers to a doctrine from English common law that assigns to the government a responsibility to intervene on behalf of citizens who cannot act in their own best interest. A second legal principle, police power, requires a state to protect the interests of its citizens. . . . Because of this obligation to all citizens, the state has the right to write statutes for the benefit of society at large, even when providing this benefit may come at the cost of restricting the liberties of certain individuals.

Indeed, both the power to quarantine persons with highly infectious diseases and the power to institute involuntary civil commitment for persons deemed dangerous to themselves or others stem from the long-recognized police power of the state—a power that predates the founding of the republic (Gostin & Friedman, 2014).

Furthermore, psychiatrists are not unique in being granted legislative authority to initiate short-term, involuntary observation and treatment of severely disturbed persons, under very restricted circumstances. For example, in New York State, *any two physicians* may initiate an emergency psychiatric admission, allowing a patient who is an immediate danger to himself or others to be hospitalized involuntarily (for up to 60 days). *Long-term institutionalization* cannot be authorized by psychiatrists or any other physicians—only by a judge or magistrate. It is also important to note that the vast preponderance of psychiatric treatment in the U.S. occurs on a voluntary, outpatient basis (see New York State Office of Mental Health, n.d.).

Claims of psychiatry's enmeshment with state power may have been more valid 70 years ago, when large numbers of individuals were involuntarily committed to U.S. state hospitals. But the threat once posed by "coercive psychiatry" has long since been replaced by the gross undertreatment and neglect of the most seriously mentally ill individuals (Frances & Ruffalo, 2018). Ironically, while antipsychiatry groups complain bitterly of state-authorized involuntary hospitalization, the largest mental health "system" in the U.S. is now the prison system. In fact, there are now ten times more individuals with serious mental illnesses in prisons and jails than there are in state mental hospitals (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). Yet one rarely hears this issue raised by the voices of antipsychiatry.

Myth #4: The notion of mental illness or psychiatric disorder is a recent "invention" of institutional psychiatry.

This claim asserts that if it were not for psychiatry's "discourses" (to use a Foucauldian term), we would have no notion of schizophrenia, bipolar disorder, etc. This assertion is based on a selective and incomplete reading of history.

Writings that precede psychiatry by thousands of years clearly depict individuals suffering from mental illness, including depression, bipolar disorder, and schizophrenia. During the Middle Ages, Arabic medical and psychological literature describes schizophrenia-like symptoms, including irrational, bizarre, and disorganized behavior. Robert Burton's classic work, *The Anatomy of Melancholy* (1621), is filled with rich descriptions of various psychotic states. The Bible—and in particular the story of King Saul in the *First Book of Samuel*—is perhaps the earliest depiction in recorded history of bipolar affective disorder (Felman, 2014). Clearly, mental illness existed and caused widespread suffering long before the founding of modern psychiatry in the early 1800s.

Myth #5: Psychiatry sees all mental disorders as simple "brain diseases" or "chemical imbalances".

Pies (2017) has written previously on this myth, and we will not belabor those counterarguments in detail here. Nonetheless, the claim that psychiatry simply equates mental disorder with brain disease or a "chemical imbalance" is unfounded. Certainly, as described above, altered brain function underlies all abnormal mental states. Yet, there are a whole range of mental disorders conceptualized by psychiatry as having significant environmental and psychological etiology, e.g., post-traumatic stress disorder, personality disorders, conversion disorder, etc. Even for disorders with well-established biologic underpinnings, psychosocial factors are seen as important concomitants to illness. Despite the recent emphasis on biological factors in psychiatric illness, the dominant paradigm in academic psychiatry is the "biopsychosocial model" pioneered by George Engel (see Pies, 2016).

Myth #6: If all mental disorders were, in fact, found to be diseases of the brain, then there would be no need for a concept of "mental illness."

This idea was propagated by Szasz, who insisted throughout his career that, "The discovery that all mental diseases are brain diseases would mean the disappearance of psychiatry into neurology" (Szasz, 2001). Such a claim rests on the conceptual error that "mental illness" and "brain disease" are mutually exclusive (disjunctive) categories. In reality, many neurological diseases manifest with "mental" symptoms; and some mental disorders, such as Alzheimer's disease, have known neuropathology but remain classified (in DSM-5) as mental illnesses. The discovery that all mental disorders are actually brain diseases would not eliminate the category "psychopathology," nor would it discount the use of psychotherapy or the appropriateness of the term "mental illness." Since "mental illness" refers to a disorder of human emotion, perception, or cognition, "mental illness" and "brain disease" are *complementary,* not contradictory, terms. Regardless of future discoveries in neuropathology, we will probably always need "mentalistic" language to capture and express the lived experience of mental illness.

Conclusion

Psychiatry and the related mental health professions face attacks from a relatively small but influential movement known as "antipsychiatry." While most of what is asserted by antipsychiatry is easily refuted by the scientific evidence, philosophical claims regarding the meaning and nature of mental illness require careful consideration and response. The most harmful of these claims is that mental illness is a "myth." Such a view is not only at odds with medical reality and everyday human experience. It also leads to the gross undertreatment and harm of the most gravely ill in our society (see Frances & Ruffalo, 2018).

*It should be noted that Szasz never considered himself an anti-psychiatrist and disavowed any connection with antipsychiatry as a movement. He was especially critical of both Michel Foucault and R.D. Laing. However, Szasz's viewpoints are frequently and favorably cited by those associated with antipsychiatry.

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