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Mental Disorder as an Illness: Szasz Revisited

Abiola BAMIJOKO-OKUNGBAYE [1]

[1] Researcher, division of Mental health and Philosophy . Sofia University, Zevo Health, Dublin, Ireland, abiolaokungbaye@gmail.com

Abstract: Thomas Szasz was a psychiatrist with great intellectual sagacity, consistent and unwavering with his concept of mental illness. He famously argues that mental illness is a myth. If Szasz's arguments are prima facie propositions and mental health interventions are considered myth-making endeavors, psychopharmacological engagement during treatment might be the most unjustified coercion of this generation. For Szasz, mental disorders are in the realm of psycho-social-ethical-legal. He views the existing treatment model of mental illness as an ideological validation of coercion. This tension in his findings stems from two angles, the exclusion of bodily illness dynamics that is currently unknown and extreme activities that are not considered illnesses. Call this *the value-ladenness of the mental disorder proposition.*

I maintain that this proposition fails to show the polythetic nature of mental disorders. Specifically, I aver that the *value-ladenness proposition* on which his theory is predicated requires that we deny the emergent anatomical-physiological factual norms that plausibly can exist, namely knowledge of brain structures and functions in neuroscience. I claim that such knowledge can emerge. Howbeit, Szasz's framework is partially valid when he admits the psychosocial features of mental disorders due to the value-ladenness of mental disorders. I will consolidate this partial validity with a position accordant with realist philosophy drawing from Foucault, Fulford, and Kendell solidified by the evidence of cognitive-affective science within the domain of contemporary ampliative understanding of mental conditions to answer the questions raised by Szasz's proposition.

Keywords: *Mental Illness, Psychology, Thomas Szasz, Philosophy, Mental Health, Values.*

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Introduction

Mental disorder as an automatic process is still hotly debated today. However, the dynamics of the debate have shifted. For example, does the existence of agency make mental disorders a choice? Predominantly, researchers use various approaches to question the illness status of mental disorders in mental health care literature. Some do so using the evidence derived from psychopharmacology (Feinstein et al., 2021). However, those who opted for philosophical calculus to tackle this conceptual complexity have raised more questions that must be addressed (Fulford, 1995; 2018; Kendler, 2022; Thornton, 2006).

Besides, supporters of mental disorder as an illness allude to similarities to other bodily diseases as an evidential piece to settle the debate. In contrast, Szasz was the most vocal thinker regarding the status of mental illness as a disorder. This paper revisits the premise of his arguments. Instead of seeking these arguments to resolve this issue, I question the premise of his propositions. I will be interested in his conceptualization of mental illness when he attacks the very concept of mental illness. Even though Szasz never claimed to be a philosopher, his findings prompted philosophical discourse about the importance of patients' and practitioners' values in mental health care (Davies et al., 2020). I will use the term value-ladenness proposition as the central core argument presented by Szasz (1998).

Assessment of Szasz's Propositions

Szasz's stance provides an alternative to the dominant school of thought, viewing mental illness as a severe issue affecting part of society. His goal is to address the conceptual issues in mental health that still exist today. Others have claimed that conceptual clarification is essential to good mental health research (Bamijoko-Okungbaye & Idemudia, 2020; Kendler & Parnas, 2017; Rosenberger & Lewine, 1982). However, Szasz sees the conceptual analysis of mental disorders in the realm of psycho-social-ethical-legal. From a critical perspective, Szasz rejects the application of psychopharmacological intervention to address mental health issues that arise from human interaction with his/her environment, that is, "problems in living". Critics have countered Szasz's arguments for narrowly analysing mental disorders (Haldipur et al., 2019; Kendell, 1975; 2009). Are they right, in any case? Should Szasz's arguments be wholly discarded for considering mental illness a myth? On the contrary, the tenets of Szasz's arguments are planted on the normative elements of mental illness when analysing mental disorders.

In a discourse apropos of the theme in this paper, Szasz argues that positioning psychiatric observation as an objective truth free from ethical values is problematic (1960). As others have stated, this issue is a complex puzzle to solve. Carlo Gabbani asks similar questions about the expectation of objective psychiatry. Gabbani continues that the psychology-based concept of the I-experiential has gone through a transformation. This transformation birthed a hybrid concept of the I-experiential, the self in relationship with his bodily aspects (Gabbani, 2014).

Gabbani and Stanghellini recognize that we discern subjective facts in patients' social environment (2008).

For Szasz, the practitioner-patient relationship in mental health settings is comparative. The practitioner as a participant-observer grants the practitioner a position in the sense of being the judge of reality or what society determines the reality to be. Why is this important? At least three considerations come to mind. First, a pre-determined diagnosis of mental disorders cannot be considered a medical model. For example, an illness must somehow be capable of being understood, measured, or tested scientifically. Elaborating more about bodily diseases, he explains that a lesion in part of the central nervous system will not necessarily lead to complicated or strange behavior but paralysis or blindness. Second, Szasz views the medical model of mental illness as an ideological validation of coercion (1998). According to Szasz, it is a way of forcing violence against people with mental health conditions by representing it as a treatment. Third, psychiatry cannot be justified medically or morally applying the philosophy of John Stuart Mill to support this view, as the only way for which power can be rightfully exercised over any member of a civilized community, against his/her will, is to prevent harm to others. His physical or moral good is not a sufficient warrant.

For Szasz, brain explanations of mental disorders are unnecessary and misleading. Concretely, Szasz claims that for a mental disorder to be called an illness, it must have features of physical bodily illness, so a change of behavior will not be a disease or an illness. Therefore, if people behave or think disturbingly, that is not a mental illness or disease. Since Szasz was one of the leading figures to challenge the concept of mental illness explicitly and was considered a psychiatrist, it is essential to accurately appraise his propositions to present a more nuanced exposition of his work.

The Partial Validity of Value-ladenness of Mental Disorder Proposition in Mental Disorders and Contemporary Ampliative Understanding of Mental Conditions

To establish where I differ from Szasz, I want to spell out some common grounds between Szasz and contemporary ampliative understanding of mental conditions, which is based on medical and moral grounds. I will be introducing three assumptions. First, following Szasz, certain disorders' central norms are within the psychosocial domain. For instance, rebalancing values in the practitioner-patient relationship during clinical settings, and bringing the patient's psychosocial experiences to the fore, are central to intervention (Bamijoko-Okungbaye, 2020). Second, following Szasz, I assert that value judgments are present in specific psychiatric diagnoses, which are also within the ethical-legal domain and that applying logic and values in medicine can be preventive (Bamijoko-Okungbaye, 2019; Gungov& Tzarvulanova, 2018). In addition, Szasz reinforces this idea when he says that the deviation is calculated whenever one speaks of mental illness, but it is a psychosocial and ethical value. However, the solution is searched in terms of medical calculus, free from vast differences in ethical value (Szasz, 1960). Third, researchers have also noted the importance of human rights in mental health, a factor requiring the values of the patients to be considered during clinical reasoning (Macpherson & Warrender, 2017).

Given that this paper focuses on Szasz's seminal paper, it may be helpful to draw from other researchers who share similar assumptions with Szasz. For example, the rejection that all mental disorders are brain problems and all problems in living are attributed to physicochemical processes. The Disallowance of this proposition should not come as a surprise. Others have presented cultural dimensions of mental health and explicated how cultures shape diagnosis and recovery, a valid tenet supported by evidence-based mental health (Holmes, 2020; Idemudia & Adedeji, 2023; Mazzola, 2020). Hence, calling all mental disorders the problem of the brain is an inconclusive explanation. According to Szasz, claiming that mental disorders are just as factual and objective as bodily illness, such a call he says is confusing. The veracity of this claim rests on the research conducted in mental health literature, highlighting the psychopathology of mental disorders to be different from bodily diseases, as the cultural syndromes such as Ataque de nervios, Hwa-Byung and hikikomori showed.

For instance, the psychological model emphasises that mental illness is a learned behavior deviation. A thinker like Eysenck disagrees with the disease model, and it is flawed to use it as a model to explore an etiological

research and treatment (1973). The absorption of these approaches into mental health allows proponents of psychiatry to deem such moves problematic. This prompted Kendall to respond and propose the "biological disadvantage factor" he claims to be a key feature of mental disorders. Generally speaking, the biological disadvantage argument presented by Kendell is compatible with the psychopharmacological approach. The absorption of exogenous compounds in the body, how the pharmacological agents are processed (pharmacokinetics), and their effect on body receptors (pharmacodynamics). This approach is cardinal to Kendell's methodology to move mental illness toward illness explanation, a different spectrum than Szasz's concept. Kendell's concept of disease is to challenge the propositions propagated by Szasz. Kendell seems sympathetic to biological disadvantage; anyone struggling with a body or mental illness is in a state of biological disadvantage. The issue with this line of argument is that biological disadvantage as a feature of mental disease, as Kendell takes it, is inconclusive and problematic because the Dubin-Johnson syndrome, an abnormality of the liver enzymes without any symptoms, is not seen as a biological disadvantage. However, it is considered to be a disease.

Moreover, Foucault is another philosopher who propounds a critical view of the psychopharmacological model. Foucault's elucidatory approach stems from psychoanalytic roots developed by Sigmund Freud. The unconscious model propounds that conscious mental life is an aggregate of unconscious psychological activity, shedding light on the obscured mind from the surface of normality. In a Freudian sense, the unconscious self can be liberating to the extent that it can give voice to the voiceless group subordinated by the traditional power to voice what society deems abhorrence. Foucault is sympathetic to Freud's assertion about the properties of the I-experiential being undisclosed and adaptable. In short, the existence of humans begins as a social construct, imperfect norms, so to speak and to challenge the psychopharmacology diagnosis defined by evaluative and normative standards is justified.

Foucault is correct to a certain extent regarding the medical model of insanity as a social construct to subordinate and legitimately weed out what some deem deviant and dangerous. The manifestation of his fear is deep-rooted in history. Foucault was not hyperbolic in that science of mental disorders was propounded to be value-free even though it is implicitly value-laden and can be hijacked by regimes and power structures to perpetuate adverse actions. In this digital age, dissidents have been the victim of mental treatment, associating madness as the cause of their opposition. The demarcation across insanity, morals, medical care and policing, remains a bone

of contention when describing certain mental disorders. Foucault also called for a critical look at psychiatry to prevent new school asylums, that is, a zombie nation that upholds a quietist stance (Foucault, 2001). The case raised by Foucault is a preventive measure, as open mental health that reflects its diverse values is likely to protect patients and citizens who are susceptible to abuse. Foucault's findings are crucial when conceptualizing medicalization in postmodernity (Hancock, 2018).

The Rapprochement and Disagreement

Firstly, Szasz and Kendell agree that the concept of mental illness is the problem. In contrast, Kendell agrees that mental illness is an illness, whereas Szasz does not. Both agree that mental illness is more obscured in meaning than bodily illness. Mental illness is more value-laden in Kendell's paper, and they both support moral boundaries. For example, the absurd claims that all unhappiness and undesirable behavior are manifestations of mental illness. Kendell says psychiatrists should know their limits and consider where their responsibility ends. Szasz takes physical illness to be defined by anatomical and physiological norms. According to Szasz, mental illness does not fit the description of body illnesses. As opposed to Szasz, Kendell determines body illnesses as an agent that can produce a significant or kind of biological disadvantage associated with reduced life fatality, and mental disorders exhibit similar features. Because of this, mental disorders are illnesses, says Kendell (1975).

The Likeness Argument

Other thinkers view the proposition which considers mental disorder as an illness as a fundamental issue in the philosophy of psychopharmacology. The likeness argument adopted by Szasz and Kendell does not resolve the dispute. It states that mental illness exists or does not, depending on the extent to which mental illness, as a disease, is a universally accepted disease. For example, the features of schizophrenia decide whether it is an illness or not. If the so-called characteristics of mental illnesses have similarities with physical illnesses, then the likeness argument holds. However, Pickering, for example, doubts whether the likeness argument holds in totality when describing mental conditions. According to Pickering, there are two forms of likeness argument. Any mental illness having features of physical illness is classified as an illness, and when these features do not exist, it is wrong to categorise the experience as mental illness. He describes these two likeness arguments forms as a paradigm and generic approach (Pickering, 2005).

The likeness argument developed to resolve the propositions presented by Szasz and Kendell needs to account for a comprehensive description of mental disorders. First, Pickering describes the weak objection to the "likeness argument" to showcase that a mental condition such as schizophrenia is an illness determined by its features. These features are insufficient because human interests are implicitly and sometimes explicitly included when categorising mental disorders, so the so-called attempt to popperiaze the features needs to be revised. Next, he describes the decisive objection to the likeness argument using alcoholism and schizophrenia, stating that the illness-like disappears when we describe these two conditions based on the concept of akrasia (Bamijoko-Okungbaye, 2019). Pickering concludes that the "likeness argument" that Szasz and Kendell employed to describe their views fails because it stands as a framework to resolve the dispute and remains insufficient. Nevertheless, it does not help conditions like schizophrenia, alcoholism and ADHD, considering agency is involved when a complex classificatory concept is applied to mental disorders. For this reason, the likeness argument must fail.

Fulford's Analysis

According to Fulford, certain mental disorders possess similarities with bodily disorders, while some do not. Most people put consider schizophrenia and dementia as bodily diseases. If, for example, schizophrenia is a genuine illness, Szasz argues that the concept of mental illness falls with it. Fulford's point of view shows that the concept employed is unclear, as indicated in Szasz's and Kendell's paper. He also notes that the terminology used to describe mental illness contributes to some avoidable discussions. Furthermore, there are different mental disorders, which are more diverse than bodily illnesses. The symptoms of physical ailments, for example, are pains or dizziness, while mental disorders are the disturbance of emotion.

Mental disorder variable status as an illness, the farther it is from bodily illness, the easier it is for disagreements. The value-ladenness of mental disorders is crucial to its definition. The concept of mental illness is more complex from the above analysis. When analysing disorders, we must consider the diversity, distance from bodily disorder, variable status, and degree of value-ladenness. The value-ladenness can be observed when value orientations of a group, discipline or culture shape the way scientific questions are framed. A value is selected, interpreted, and rejected; methodologies are devised, and explanations are formulated. Observation can determine some theories; the analyst's values could also fill the epistemic gap, making most assessments value-laden to a certain degree (Fulford et al., 2013).

The questions remain about the determinant factors when we attempt to define the concept of mental illness; the various input from these philosophers, psychologists and psychiatrists are synonymous with distinctive norms in psychopharmacology. From the above findings, it is given that the dimensional outlook is panoramic. If the concept of mental illness cannot be clarified, the role occupied by psychopharmacology would be controversial. Although to further an argument, if one assents wholly to Szasz's findings, psychotropic agents like Prozac, reserpine, phenothiazine, and Ritalin would be an antithesis to a non-existent disturbance.

Szaszian's core arguments to debunk that mental illness is similar to bodily illness are criticized for his firm position when he formulated his conceptual analysis of mental disorders. It would be loathsome to deny a teenager suffering from anorexia help or a person with severe depression. I understand that Szasz wants to accentuate the moral aspect of mental diagnosis, to prevent mental healthcare abuse in treatment. Despite that, he has a case in defending the moral dimensions involved when diagnosing certain mental disorders. Because some diagnoses are behavioral, the patient's first perspective experience against the practitioner's perspective.

As shown in this paper, Szasz rejects any empirical factual evidence provided through brain-imaging techniques, brain structures and potential findings in the future. Besides, there is some bodily illness today that complete aetiological explanation is non-existent. This uncompromised line, not looking at the possibility of an emergent understanding informed by diverse findings, made his work inconclusive. It is important to note that Szasz's modus operandi is deep-rooted in intention and intension of the concept of mental illness.

Constructive Answers from Philosophy?

The models outline in this paper show that blending the diverse values in mental health diagnoses can be problematic; philosophy is apt to address the conceptual issues. We see this when philosophers call for the protection of the voiceless, and the voiceless people in mental health are the service users. The pathway to address this issue is bringing values back to psychopharmacology. Furthermore, this should be seen as a prelude to a comprehensive understanding of mental diagnoses. The attempt to impede the subjective from the objective in psychopharmacology has slowed down progress in psychopharmacological research. I have established an error with such an equation; this begs the question in psychopharmacology: how do we process the objective pathways in psychopharmacology? A detailed understanding is attained by taking a cue from the systematicity and a set of

philosophical corpus in value to form a cohesive understanding. As an illustration, a case of *x* who then, after taking psychotropic, becomes an individual y and accepts the newfound self *y*. I have made a case for the new *y*.

In this case and generally speaking, one would consider this good practice and doctoring, that is, treating and managing the dysfunction. In contrast, subjects abused in a relationship thinking to change their features would make them lovable in a distressed relationship is schmoctering, in another word putting the attention on enhancement. Besides, surgical operations to look like a Nollywood star are in the scope of schmoctering.

For example, body dysmorphic disorder BDD is when the patients always think about flaws in their physical appearance. BDD patients are in constant aesthetic sensibility and emotional drift with a disturbed body image perception associated with the vestiges of anorexia nervosa. The curve here that a critic might ask is the beauty construct propagated in the media, is this beauty construct diverse enough? Calling on the media to offer diverse beauty constructs is also pragmatic. It might be beneficial to society at large and Szaszians might attribute this BDD disorder to a "*problem in living*."

Kendell's supporters might support the case of x, who becomes y after taking psychotropic drugs, concurrently subjects who consented to take psychotropic drugs to improve their low-grade mood due to family history, a genotype compatible with response to SSRI, Selective serotonin reuptake inhibitors, and believe that medical treatment would make them feel better about themselves. Pharmacotherapy arrangements should be acceptable if the diagnosis process is grounded in science and values. However, setting the homeostatic and allostatic model parameters becomes difficult where diverse values are involved.

The question of which approach to adhere to when taking psychotropic outside of therapy is complex, one that Peter Kramer struggles to grasp in listening to Prozac. Peter Kramer struggles to differentiate between the in-therapy taking of psychotropic and outside-therapy taking. Kramer struggles to understand the reason behind the decision taken by his patients to want to continue taking their medication after they have reported that they do not have a mental illness.

According to Kramer, the request to continue taking the pill occurs whilst the patients are on Prozac, fluoxetine treatment (1994). The patients have embraced their newfound self *y*, and it is assumed that they have felt well and better. Continuing the pills outside therapy would help them retain their newfound self *y*. Another debate is whether to continue their pills after

claiming not to have the disorder. The psychopharmacological arrangement has improved their lifestyle. Instead of pushing brainless or mindless psychiatry, I-experiential illnesses are embodied in the mind-brain-society realm. I will say that certain disorders will be responsive to narrative mental health, and others will be responsive to psychopharmacological intervention.

Conclusions

Szasz's extreme take on mental illness might have caused his work to be misinterpreted. Moreover, as pointed out in this paper, his attempt to view mental illness in social-evaluative norms excluding neuroessentialist data, needs to be revisited. Also, the importance of neuroessentialist data in the discourse has been mentioned by various thinkers in the field (Bamijoko-Okungbaye, 2019; Brendel, 1999; Fulford et al., 2006; Tomasi, 2020). However, dissecting his work philosophically, one notes that his emphasis on the *value-ladenness of mental disorder proposition* led to the partial validity of his conclusions. Nonetheless, neglecting critical features of mental disorders renders his findings inconclusive in a philosophical sense.

Philosophically and in practice, his work has empowered new waves of service users, underscoring their agency during treatment. Furthermore, leading to the addition of patients' values at all stages of their care, considering service users are one of the most vulnerable, thus improving the mental healthcare ecosystem.

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