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Schizophrenia and the Theories of Thomas Szasz

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I. The Dichotomies of Dr Szasz

Anyone acquainted with Dr Thomas Szasz's previous writings about mental disorder, the nature of its relationship to the Law and to the problems of drug dependance (Szasz, 1961, 1963, 1970, 1972, 1975) has learned to look in the first instance for the dualism, the poles of which are to be demonstrated as irreconcilable. For, as Glazer (1965) has pointed out, one of Dr Szasz's main conceptual devices is 'the dichotomy game'. A phenomenon may belong to category (*x*) or another category (*y*) but not to both. As a first step it is as well to examine the definitions of the categories in question. They are liable to prove inconsistent or idiosyncratic or just to be omitted. In other cases, as Professor Stone (1973) has shown in his detailed and telling dissection of the tortuous and confused logic pursued by Dr Szasz in *The Myth of Mental Illness*, the definitions are incomplete or erroneous and the implied antithesis dubious or false. Beginning with the equation that a lie is to a mistake as malingering is to hysteria, Szasz manages, following a maze of tortuous and self-contradictory arguments, to emerge at the conclusion that it would be '. . . more accurate to regard hysteria as a lie than as a mistake'.

In the paper he has devoted to schizophrenia, the categories depicted as being mutually exclusive are on the one hand 'Disease' or 'Illness' (*x*) in which there must be demonstrable histopathology or pathophysiology and on the other 'particular forms of personal behaviour' (*y*) such as schizophrenia for which an aetiological basis does not and cannot exist. In the case of (*y*) it is not only that organic factors are precluded by definition from any possible role or causation. The quest for possible psychological causes is also misconceived and a threat to human liberty. Freud is in the dock alongside Kraepelin and Bleuler as one of the '. . . conquistadors and colonizers of the mind of man. Society, their society, wanted them to extend the boundaries of medicine over morals and law . . . and they did so; it wanted them to extend the boundaries of illness from the body to behaviour, . . . and they did so; it wanted them to conceal conflict as psychopathology . . . and they did so.'

Szasz seems to have no conception of the mental attitude an ordinary medical man takes up when he is first called to see a patient, and the mental processes that then ensue. Probably the very first thing the doctor becomes aware of is a global impression, that the patient is (or perhaps is not) obviously ill. By his history-taking and clinical examination he then confines the field of inquiry to perhaps one system. Step by step the diagnostic process works its way down to a syndrome, and eventually, perhaps, to a disease. Dr Szasz imagines it quite differently. As he supposes, the doctor first finds physical signs of macroscopic or microscopic cellular changes, proceeds from there to the naming of a disease and finally from the presence of the disease concludes that the patient must be ill. If the signs aren't there, or aren't found, he then says that there is no illness.

So it is that Kraepelin and Bleuler become the targets for Szasz's wrath and scorn. If they had only examined the patients in their asylums physically, finding nothing they would have been compelled, he says, to declare them free from illness by the medical criteria generally accepted at the time. They failed to do so, he says, through unwarranted and absurd pretensions to new discovery, intellectual cowardice and collusion with the agents of society in the coercion and control of deviant persons. It follows that when first described in the eighteenth century, Parkinsonism, according to Dr Szasz, could not have been a disease, nor did it qualify as such when James Parkinson

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wrote his famous *Essay on the Shaking Palsy* in 1817. In fact, discussing its causation, Charcot (1877) gave a prominent place to the 'violent moral emotions' commonly generated by the political disturbances which agitated France at the time. However, shortly before the First World War, European pathologists discovered lesions in the corpus striatum and neighbouring structures. Applying Dr Szasz's criteria, Parkinsonism was suddenly transmuted from category (y) into category (x) and those who suffered from it qualified overnight for treatment as patients.

Hippocrates had no right to claim in the fifth century BC that epilepsy has 'the same nature as other diseases and the cause that gives rise to individual diseases. It is also curable, no less than other illness' . . . and was not a state of sacred possession of the mind as was generally believed (Adams, 1849). For some two thousand four hundred years it was a non-disease until lesions were discovered in a minority of cases in the last century. Those who had been thus afflicted could then be correctly judged as having been ill. However, 'idiopathic' epilepsy remained a non-disease until the discovery of the EEG which showed that specific abnormalities were to be found in the electrical discharges recorded from the brain even in those cases in which cerebral lesions could not be found.

Szasz focuses his attention on syphilis as the paradigm of disease at the turn of the last century. It happens to suit his argument well. Other forms of affliction would have proved more awkward. Micro-organisms such as the streptococcus or tubercle bacillus cause fatal infections in some individuals and live harmlessly in others. As the latter do not suffer pain or incapacity we do not diagnose disease or regard them as ill. Moreover, there are good examples of diseases for which a definite physical lesion was long believed to be responsible until the advance of knowledge proved this theory false. Forty years ago, textbooks of medicine and physiology carried pictures of extremely emaciated young girls who suffered from a condition called Simmonds' Disease which was attributed to deficiency of the anterior pituitary gland. The diagnosis and treatment of such cases of indubitable illness was then presumably justified. But the inquiries of psychiatrists and endocrinologists showed the previously held explanation for the disease to have been mistaken. There is no primary lesion in the pituitary gland or anywhere else. Some subtle derangement in endocrine function is suspected, but proof is lacking. On the other hand, there are usually problems in maturation, the family environment is disturbed and the relationship of the parents ill-balanced. By Szasz's criteria these girls no longer suffer from a disease but merely show from 'particular forms of personal behaviour'. The fact that untreated, a high proportion die within a few years is irrelevant for his order of things.

The status of a whole host of conditions has to be reconsidered. Tic douloureux, narcolepsy, migraine and all forms of severe mental subnormality for which no cerebral or biochemical basis has as yet been demonstrated are non-disease. In fact, as virtually no physical causes or lesions had been established until about a century ago 'disease' was rare in the extreme. But suffering in body and mind culminating in death during childhood and early life was very common.

This is to labour the obvious. But it is necessary to spell out issues because Szasz is a brilliant writer who, working behind a smokescreen of erudition, savages facts in the manner of Procrustes and disguises absurdities so that they appear to many lay and some medical people as self-evident and axiomatic truths. Psychiatrists are once again accused of 'inventing' or 'manufacturing' mental disorder for ignoble reasons. The poets and novelists who anticipated many discoveries of modern psychiatry must have sinned in similar fashion. Szasz would say it is not insight and compassion we find in the words of Macbeth:

> '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 stuff'd bosom of that perilous stuff
> Which weighs upon the heart?'

but an early version of the medical model with its depraved pharmacological practices.

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Of course, if illness is a matter of lumps, lesions and germs most schizophrenics are perfectly healthy. But such definition of disease would be repudiated even by physicians as too arid and restrictive for general medicine. For psychiatry which is primarily concerned with mental suffering, its mitigation and prevention irrespective of cause, they are even more relevant. It is with the tribulations of people that the analysis of the scope and limitations of psychiatry has to begin. 'Disease' is a highly complicated concept, and to impose upon the word the concreteness of hard fixed objects of one's personal choice is something different from understanding. The Greeks recognized it as a form of sophistry.

It is time to turn to the definition of the other category in Dr Szasz's dichotomy. It is apparent from the outset that schizophrenia is to be proved one way or another to be a myth. One looks, therefore, for a definition of those states of mind which Szasz believes that psychiatrists designate as 'schizophrenia' and which is to be demonstrated in due course to be non-existent in the sense of 'disease'. He describes schizophrenia as '. . . a particular form of personal behaviour'. As he does not particularize, this is of little help. Nor does the statement 'many of the persons given this diagnosis by psychiatrists often behave and speak in ways that differ from others in their environment' provide a clear picture of phenomena about which he is writing.

However, a study of the International Pilot Study of Schizophrenia (WHO, 1973), provides him with an opportunity to specify more clearly the type of disorder to which his paper is devoted.

It enables him also to 'dramatize the degree and the depth to which psychiatry has been debauched by physicians who prefer to be detectives rather than doctors'.

To the accompaniment of much merriment, for which he begs to be excused, he describes the first four 'inclusion criteria' which were allegedly used in this inquiry for the diagnosis of schizophrenia. But the clinical features to which he refers were not intended to select schizophrenic patients. That 'hallucinations' and 'delusions' do not define any one form of psychiatric disorder would have been obvious to anyone familiar with an elementary textbook of psychiatry. The criteria in question were, in fact, utilized as a screen for the selection of 125 patients with any form of functional psychosis at each centre that participated in the inquiry. Manic and depressive psychoses and paranoid states were intended for inclusion as well as all the different forms of schizophrenia.

There was a cluster of features which commanded a consensus from psychiatrists of different countries as being schizophrenic. But this bore little relationship to the symptoms and behaviours with which Szasz makes such free and jocular play. The report of the International Pilot Study is quoted among the references. But Szasz cannot have read it. This will not surprise anyone who has submitted his previous polemical excursions to careful scrutiny (Stone, 1973). Of greater importance in the present context is the fact that Szasz's knowledge could hardly be more vague concerning the condition to which the majority of psychiatrists in the world would give a diagnosis of schizophrenia. This does not deter him from writing a paper with numerous references to the historical, pathological, clinical and psychoanalytic literature and relegating the disorder to non-existence.

II. Szasz and the History of Medicine

Szasz's account of the history of medicine in the nineteenth century contains heroes and villains, true creative spirits and mythologists. Medical science is depicted as having made rapid strides discovering the causes of a multitude of infectious and other diseases. The sequence of events that culminated in these discoveries is exhibited by a consistency that enables Szasz to enunciate a general principle which is exemplified in all advances in knowledge of causation of true disease. In the first instance pathological changes are discovered '. . . macroscopic pathological changes in organs, microscopic changes in tissues or cells, microbial invasions, and so forth are observed first; the precise naming of diseases comes next'. He complains that the sequence has been 'reversed and corrupted in psychiatry' by the observation, description of classification of disorders. As the main burden of Szasz's thesis is that disorders

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like schizophrenia having nothing in common with bodily illness, it is unclear why the course of events followed by medical discovery should be held up as a paradigm for psychiatry to emulate. Whatever the reasons that led him to draw this particular comparison, he stands the history of medicine on its head to argue his case.

General paralysis, to which he devotes such a large part of his paper provides a case in point. The pathological changes and the evidence of infection by micro-organisms are said to have come first, the precise naming of the disease thereafter. The true story is quite different. The principal features of the disorder were described 150 years ago. The relationship with syphilis was suspected but remained for decades the subject of embittered controversy until the discovery of the Wassermann test. Henry Maudsley (1879) attributed general paralysis to sexual excess which '. . . by degrees sapped the vitality of the nervous system'. Some physicians held such views with an unshakeable conviction that has a familiar ring. But there were some prescient workers who suspected the syphilitic origin of the disorder decades before Noguchi's discovery and whose views were rejected by eminent contemporaries. Had the opinions of those who insisted that there was nothing to investigate—a moral problem and not a biological one—gained general acceptance, knowledge of the causes and treatment of general paralysis might have been delayed for decades. The moral of the story is clear. Those who observed and recorded what happened to patients made a valuable contribution and, so did those who advanced hypotheses that had testable consequences. Those who made dogmatic assertions contributed nothing.

The scientific achievement of Virchow wins Szasz's unstinted praise. His summary goes like this: Before the publication of *Die Cellularpathologie*, abstract and theoretical concepts prevailed. The work of Virchow initiated a period of sturdy empiricism with concrete concepts, until the nebulous theories of psychopathology, psychoanalysis and psychosomatic medicine once again obscured the light of day. The basic scientific 'concept and model of disease' is summarized in Virchow's famous statement '. . . the real question which the modern scientific physician puts to himself when called to treat the case is: what cells are out of order and what can be done for them'? In contrast to the scientific physicians who observed histopathology and thereby earned the right to name diseases and the credit for making discoveries, Kraepelin and Bleuler did not discover the diseases for which they became famous. They merely invented new words such as 'dementia praecox' and 'schizophrenia'.

What Szasz does not tell the reader is that the question posed by Virchow had to go unanswered in relation to the overwhelming majority of patients seen by scientific physicians who practised in his day. And more than a century later the question has to go unanswered in most patients treated. Even when certain cells can be shown to be the seat of pathological change further questions are posed rather than the aetiological problem resolved. The coronary vessels may show marked atheroma in a man of 45 who has had a myocardial infarct. But one learns more about the reasons why he had it from the number of cigarettes he smokes a day and the sort of life he leads than from the degree of occlusion of vessels.

And if the clinical descriptions of Kraepelin, Bleuler and Freud are to be reckoned as no achievement the same verdict has to be passed on Hippocrates, Sydenham, Laennec, Heberden, Graves, Charcot, Addison, Gowers and Parkinson. For the large part they were able to provide no more than clinical descriptions. But the fact that they could see what others could not laid the foundation for the knowledge of causes that followed.

The advances in understanding and treatment of infectious disease are greeted with enthusiasm as real achievements of medical science. But they did not come out of the blue. Szasz does not appear to have heard of Sydenham who first studied the natural history of infectious diseases. In claiming that histopathology and microbiology came first and the naming of diseases afterwards, Szasz has surely turned the story upside down.

The account we are given of the history of medical science in the 18th and 19th centuries makes no reference to the emergence of medical statistics or public health, to Farr or

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Florence Nightingale or to the contributions of improved nutrition and housing to health and to the decline in rates of mortality.

III. The Dualism of Szasz's Concept of Schizophrenia

If the concept of 'disease' is confined by arbitrary definition to conditions in which physical lesions have been found, all forms of mental suffering are neatly consigned to the category of 'non-disease'. That it is impossible to reconcile such a sharp line of demarcation with the existing facts, does not impede the argument; for the observations that bear upon the validity of the concept of disease are nowhere considered.

For example, patients suffering from the commonest forms of 'non-disease' seen by psychiatrists, the neuroses and affective disorders, have been shown in a number of clinical and epidemiological inquiries (Roth and Kay, 1956, Kay *et al*, 1964 (a) and (b), Hare and Shaw, 1965; Shepherd *et al*, 1966), to exhibit a significant excess of somatic illness. Among the aged the excessive prevalence of physical disease is partly responsible for the markedly diminished life expectation of elderly depressives (Kay and Bergmann, 1966). But this is not the whole explanation. For the emotional disturbance with the typical features of a 'non-organic' psychiatric disorder may be the early harbinger of malignant disease (Kerr *et al*, 1969). In some measure the association stems from the emotional response to physical disablement. But it is a far more complicated matter than this; there is no single formulation that satisfactorily covers all cases. That the association is highly significant both clinically and statistically is beyond reasonable doubt. And it is plain that the personality setting, heredity psychodynamic factors, physical disablement and its significance for the patient are intertwined in varying combinations in the genesis of emotional disorder.

This complexity both of physical and mental disorder in their commonest forms is incompatible with Szasz's 'all or none' concepts. But he gives no indication as to how he deals with it. Is the physical lesion 'disease' and the depression 'non-disease'? The majority of modern physicians, the real doctors, towards whom Szasz adopts an attitude of such profound respect, would regard such dismemberment of the sick person into mind and body as archaic and irrational.

The situation is not essentially different in relation to schizophrenia. Painstaking investigations have shown that a closely similar syndrome, often with 'nuclear' features, occurs in significant excess among those with temporal lobe lesions of long-standing (Slater *et al*, 1963). Among elderly schizophrenics cerebral lesions have been demonstrated in a substantial minority; they appear to potentiate the effects of hereditary factors (Kay and Roth, 1961; Post, 1966). Decades of investigation have served to establish in an indubitable manner that lesions in certain areas of the cerebrum are associated with excessive prevalence of a syndrome that has by phenomenological criteria to be diagnosed as schizophrenic (Davison and Bagley, 1969). And a specific chronic intoxication, i.e. with amphetamine, will often closely simulate the clinical picture of paranoid schizophrenia.

Such identifiable organic factors are not to be found in the majority of cases of schizophrenia. But the testimony provided by the 'symptomatic' cases cannot be brushed aside in any objective evaluation of the status of the disorder that most psychiatrists describe as 'schizophrenic'.

Moreover, as the contribution of genetic factors to the causation of schizophrenia has been clearly established in recent years, the feat of denying that it has some specific biological basis can be achieved only by turning a blind eye on any evidence that fails to accord with preconceived notions. The hereditary factors do not make schizophrenia into a wholly organic disease. It is clear that a wide range of factors, biological, familial and psychological are involved. But genes are concrete biological entities. That they are necessary for the development of a substantial proportion of those identified as schizophrenic has to be conceded by those who treat evidence as scholars and scientists can be expected to treat it. Dr Szasz refers neither to the older evidence relating to heredity, nor to the recent investigations into the fate of children adopted shortly after birth to

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schizophrenic and normal mothers (Heston, 1966; Kety *et al*, 1968; Rosenthal *et al*, 1968; Wender *et al*, 1968) which have conclusively established the role of heredity in schizophrenia. Nor does he explain how the theory concerning the nature of schizophrenia, implicit in his writings is to be reconciled with the fact that it has been described in every country, culture, race and social class investigated. Szasz would say, no doubt, that all over the world, where schizophrenia is found at approximately the same incidence, in India, Africa, Asia, Europe and the Americas, 'professional degraders' are at work, with equal intensity, doing the diagnosing. We had best laugh at this, lest we weep.

IV. Szasz's Theory of Schizophrenia

Although Szasz rejects all the theories that have been advanced for the causation of schizophrenia, whether genetical, familial, psychodynamic or biochemical, and by implication all theorizing about it, he insinuates a theory of his own. This purports to explain how it comes about that certain individuals are examined by psychiatrists and given a diagnosis of 'schizophrenia'. These individuals differ from other people in society only in so far as they deviate from them in mode of speech or conventional standards of conduct. Psychiatrists are agents specially trained to silence all those who transgress against the prevailing power interests in contemporary society. They now fulfil the role assigned to them by pronouncing 'defamation disguised by diagnosis' or 'the manufacture, with state approval, of stigmatized individuals and classes by professional degraders' (Szasz, 1970). Those who enter into conflict with it can be labelled, dehumanized and then imprisoned. The 'most denigrating diagnostic label' applied is the diagnosis of schizophrenia. In such a context 'treatment' is a euphemism for 'torture' and 'rape' (Szasz, 1975). As he has repeatedly explained in a long series of publications, but particularly in *The Manufacture of Madness* (1970), there is treatment administered by physicians and there are the disguised forms of coercion and brain-washing inflicted by psychiatrists upon the oppressed on behalf of the oppressors. There is real psychotherapy administered for fees privately by Dr Szasz, and there are the therapies of institutional psychiatry which consist of the 'Dehumanization of Man'.

We are not informed about the precise identity of the power interests psychiatrists serve. In some cases institutional psychiatry appears to act on behalf of the 'dominant ethic'. Elsewhere it favours prevailing 'religious beliefs', or acts to keep the poor and ill-educated in their proper station of subordination to the rich.

Szasz's theory about schizophrenia is, therefore, conspiratorial. Here arguments and explanations begin and end with the sinister and ignoble motives imputed to those whose opinions differ from one's own. They hold such views because they and those they serve stand to gain from them. No evidence is presented. Indeed it is implicit in the argument that the psychiatrists' quest for evidence is itself part of the politically motivated endeavour in which they have been engaged since Kraepelin first advanced the concept of dementia praecox. Such an attitude of mind precludes discussion and makes it impossible to arrive at the truth. For there is no public criterion by which the veracity of such statements can be tested.

In short, Szasz advances an essentially Marxist theory which explains the existence of schizophrenia in the following terms. The true nature of the behaviour of certain individuals who come into conflict with society has to be disguised as something different. The reasons that necessitate camouflage for such dissident acts are socio-economic in character. The ruling classes in a given society are thereby protected from the danger of direct confrontation with their critics. A class of professional defamers is, therefore, created. Their task is to affix labels on all individuals whose deviance threatens the power of the ruling classes. These labels have the effect of invalidating the actions of deviants and concealing or nullifying their political significance. Whether psychiatrists fulfil the social role assigned to them consciously or unwittingly is immaterial.

The question is under what circumstances could such a theory clash with evidence? What are its consequences? What testimony would serve to falsify it or call it in question? The answer is that the theory is immune

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from any such challenge from independent observation. It remains for ever impregnable. It explains all disease in all cultures and races at all times. It follows that it can explain nothing. But the fact that he can 'explain' everything and anything is one of the reasons for Szasz's remarkable achievement. Over a period of thirty years in which he has placed no observations of his own on record but has published a large number of books and papers in many languages flashing rays of darkness upon the entire field of psychiatry, he has made a remarkable number of converts.

V. Szasz and the Treatment of Schizophrenia

The fourth step of Szasz's version of the history of modern psychiatry was the 'systematic use of somatic treatments in schizophrenia'. He complains that psychiatrists have 'set out to prove' that schizophrenia is a disease by 'subjecting schizophrenics to certain procedures . . . called treatment, despite the fact that . . . after a century of search psychiatrists could still not demonstrate the characteristic histopathology, much less the organic aetiology of schizophrenia'. There would probably be no purpose in trying to convince Szasz that controlled therapeutic trials are designed not to 'prove' but to disprove the beneficial effects attributed to them. It would have been possible for the best clinical trials of phenothiazine compounds to have disposed of the early claims made on their behalf. In the event they survived the tests, and their efficacy, both in the acute and chronic stages of schizophrenia, was substantiated; Leff and Wing, 1971; Hirsch *et al*, 1972).

Szasz's tone changes to deep respect when he refers to medical diagnosis and treatment. Yet many forms of treatment in medicine are no less empirical than those used in psychiatry. The causation of trigeminal neuralgia, migraine and idiopathic epilepsy, torticollis and many other forms of involuntary movement is unknown and the treatments employed are empirical, symptomatic or of dubious efficacy. The aetiological basis of virtually all serious illnesses in medicine, including myocardial infarction, hypertension, cerebrovascular disease and peptic ulcer is poorly understood or completely obscure, and the main therapies employed are palliative.

Physicians nowadays try to devote effort to reducing the prevalence of smoking and obesity, since these have proved to be correlated with an overall decrease in life expectation and with a number of diseases which carry a high mortality. If the underlying basis of the associated states of dependence were better understood, the results of intervention would be more impressive than they are. In the meantime physicians can only travel hopefully. If they should hit upon a new finding, whether positive or negative, they will be expected to back it with evidence when they try to place it on record.

Szasz has been more or perhaps less fortunate. Over a period of 30 years, he has made numerous pronouncements about the care and treatment of patients. But in no case has he submitted his views to formal tests that could have disposed of them or substantiated them. Yet his statements about the treatment of schizophrenic patients imply that individuals so 'labelled' fare better without treatment than under the care of those who employ modern psychiatric therapy. Here is a clear hypothesis that could be submitted to critical evaluation. Even more interesting would be an experiment in which the fate of patients treated by the majority of clinical psychiatrists could be compared with the fate of those managed under the aegis of Dr Szasz.

Indeed, as Szasz dispenses with diagnosis and accepted forms of treatment and yet continues to practise as a psychiatrist and to profess his subject, the methods he employs are of the greatest possible interest. How does he manage the problems of those who complain that their innermost secrets are broadcast to the world at large or that voices, which they feel a compelling urge to obey, tell them to mutilate themselves? What form of help does he provide for men who show him imaginary seminal stains on their wives' underclothes, and what steps does he take to protect lives so endangered? Does he tell such clients that they suffer from having been declared outsiders and deviants by a society with debased moral standards? What are the exact means used to

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encourage those who seek Dr Szasz's aid 'to adopt a critical attitude towards all rules of conduct significant to him and to maximize his free choice in adopting either socially accepted or unaccepted rules of conduct' (Szasz, 1965). And what are the results obtained? We seek in vain among Szasz's multitudinous pages for an answer. His discourse with himself takes place in a realm where the effects of making diagnoses and administering treatment or withholding them have to undergo no tests and where conjectures concerning the nature of disease, or anything else for that matter, run no risk of exposure to challenge or refutation.

VI. Negations and Affirmations

Such words as Szasz has set down for the guidance of those whose main concern is to mitigate mental suffering, have been few and uninformative. He has nothing positive to offer. Psychiatric disorders are 'problems of living'. So are wars, earthquakes, floods, famines, bad digestion and a cold climate. The plight of psychiatric patients, whom he classes among the oppressed, derives from the misdeeds of the oppressors and their agents, but he does not divulge who these oppressors are. Elsewhere (*The Manufacture of Madness*, 1970) it is stated that the function of psychiatrists is to protect 'the rich and well educated'. The remedies are, therefore, to be sought in some different form of social organization. But we are not provided even with the faintest glimpse of that just, equitable and better-ordered society in which mental distress could be expected to be less than it is. For an indefinite time ahead we have to resign ourselves to the irreconcilable opposition of oppressors and oppressed and the anguished states of mind this engenders.

Szasz is far more explicit and eloquent in negation. He says 'no' to the 'medical model' and 'no' to psychiatrists who are, he says, professional hirelings of the dominant classes. He gives an equally emphatic 'no' to psychoanalysis; the concept of mental pathology inherent in it is spurious. Psychiatric diagnosis is falsehood and the description of such a condition as schizophrenia is 'the greatest scientific scandal of our time'. Psychiatric hospitals, he maintains, are prisons, and the psychiatrists who work in them are jailers and torturers. One would suppose that it could only be by an effort of will that he shuts his eyes to the manifest facts: that these are places of asylum, of refuge; that a great number (in Britain nearly all) of those who go there go voluntarily for help; that their troubles are desperate, their sufferings extreme; that, indeed, they feel, and are, very ill; that the psychiatrists who care for them are not guilty conspirators but earnest and compassionate men and women, trying to do what they can to help the sufferer in each individual case.

There are numerous examples of simplistic philosophies with close affinities to that of Szasz, which provide simple explanations for complex and painful human predicaments in terms of the deeds of exploiters, oppressors, conquistadors, their hirelings and dupes. It requires no leap of the imagination to perceive how, by revealing 'the truth' to multitudes of people in a blinding flash, their influence spreads far and wide.

A philosophy with similar ingredients was the main weapon of the 'Spirit of Negation' who dominated the nightmare of Bertrand Russell's metaphysician (1954): 'He himself is the most complete improbability imaginable, he is pure nothing, total non-existence, and yet continually changing. . . . Before going forth he clothes himself in shining white armour, which completely conceals the nothingness within. Only his eyes remain unclothed and from his eyes piercing rays of nothingness shoot forth seeking what they may conquer. Wherever they find negation, wherever they find prohibition, wherever they find the cult of not-doing, there they enter into the inmost substance of those who are prepared to receive him. Every negation emanates from him and returns with a harvest of captured frustrations.'

Russell's metaphysician uses a simple device for disposing of the argument of the Prince of Darkness that non-existence is the only reality. Their fallacies serve to reveal to the philosopher a profound truth. He concludes that the word 'not' is superfluous. Thereupon, he proceeds to expunge all words expressing negation from his dictionary, saying: 'My speech shall be composed entirely of the words that remain. By the help of these words . . . I shall be able to

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describe everything in the universe.' When the Spirit of Negation was thus denounced as a bad linguistic habit, '. . . there was a vast explosion, the air gushed in from all sides and the horrid shape vanished. The murky air which had been due to inspissated rays of nothingness cleared as if by magic'.

Szasz has exhibited no tendency, over the decades, to follow the example of Russell's metaphysician. He appears unlikely to expunge any words from his now familiar vocabulary. For, as a philosopher, he is untroubled by the uncertainties of those compelled by evidence to abandon arrogant dogmatism and 'to travel into the region of liberating doubt' (Russell, 1959). He never concludes that perhaps there may be some substance in the views of those who dissent from his view. This endows him with powerful advantages in his polemical excursions as compared with scholars, scientists or philosophers in the broad sense of the term.

Szasz's meteoric rise, his growing influence and world renown are not, therefore, unexpected. The reasons are perhaps to be found in the verdict, 'I think that bad philosophers may have a certain influence, good philosophers never.'

VII. Conclusions

Why then, do psychiatrists continue to record Thomas Szasz's *beliefs* regarding the nature of schizophrenia? Why do they not emphasize instead his utter inability to support his belief in its non-existence as an illness with a shred of relevant—i.e. biological, epidemiological, clinical—*evidence*? Why? Perhaps one can put one's finger on the answer.

Although he has called psychiatrists 'professional degraders', we must not think of him as a professional mountebank. Under his specious argumentation he is deeply sincere. He has not only the gift of words but fire in the belly. Although he takes care not to show it, he is in fact a very angry man; and one can deduce what he is angry about from the effects he has produced. His philosophy has been widely influential. He has led psychiatrists, always unsure of themselves and aware of the extreme limitation of their knowledge, to undertake a critical reappraisal of their practices and the principles underlying them. He has made explicit the danger that in certain roles they may have double allegiance, to their patient and to the community. Among his achievements may be reckoned the right for better or worse, now enjoyed by certain citizens of the United States to commit suicide. He has been a powerful fighter for the freedoms, rights and responsibilities of psychiatric patients. The attitude of the law and the legal profession to psychiatry and mental disorder has been transformed by the writings of Thomas Szasz, in the USA. He is obsessed by the need he feels for psychiatric patients, psychotic or neurotic, to be accepted by us all as human beings of no less value than ourselves, and therefore not ill; for if they are thought of as mentally ill, they cannot but be devalued, dehumanized, degraded. This is the conclusion at which he *has* to arrive; and hence comes the necessity to stand logic on its head in order to get there.

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