

Myths, Projections, and Overextensions: the conceptual landscape of Thomas Szasz

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Thomas Szasz claimed that his writings belong to neither psychiatry nor antipsychiatry. “They belong to conceptual analysis, social-political criticism, civil liberties, and common sense.”¹ Whether or not this self-description makes him more philosopher than psychiatrist, as many have suggested, it serves as an invitation to philosophically-mined readers to take his conceptual analysis a step further, and to interrogate the normative basis for his politics.²

When, as a college student, I first read The Myth of Mental Illness, I had just heard that my cousin was schizophrenic and about to be committed to a mental institution. I read that up to 10% of Americans suffer from schizophrenia. An acquaintance who did mental health counseling told me that “schizophrenia” is defined as “unclear thinking”. These factors – being a college student, being upset about my cousin, being skeptical about the statistics, recognizing the inadequacy of the definition – primed me to be sympathetic to Szasz’s message. But I did not give much thought to what it means to claim that mental illness is a *myth*. As far as I was concerned, a myth was an influential but false story; so Szasz’s book could just as well have been titled The Influential but False Story of Mental Illness.

It was only later, as I struggled with the increasingly popular term “social construction”, and as I reconsidered the less-than-clear line that divides the imaginary from the real, that I returned to Szasz’s critique of psychiatry and his notion of a myth. Szasz offers detailed explications of his use of the term “myth”, yet many questions remain regarding his application of that term and its relevance to psychiatry. In what follows, I seek to distinguish cases in which psychiatric concepts and conventions have resulted in myths from cases in which psychiatric concepts and conventions have resulted in projections or overextensions. In light of these distinctions, it is possible to ask whether Szasz’s own reliance on the notion of an autonomous person might itself qualify as a myth, a projection, or an overextension.

¹ Szasz 1961/2010, p. xxix. Also, in Szasz 1994: “My critique of psychiatry is two-pronged, partly conceptual, partly moral and political. At the core of my conceptual critique lies the distinction between the literal and metaphorical uses of language – with mental illness as a metaphor. At the core of my moral-political critique lies the distinction between relating to grown persons as responsible adults (moral agents) and as irresponsible insane person (quasi-infants or idiots) – the former possessing free will, the latter lacking this moral attribute because of “mental illness”. Szasz goes on to complain that his critics have failed to address these issues, concentrating instead on his motives and on the benefits of psychiatry. This essay, thus, addresses the two aspects of his work that he thinks are most important and most neglected.

² It is less clear how one might advocate for common sense in the context of widespread acceptance of the psychiatric terms and practices that Szasz rejects – a complication that Szasz notes himself p. x of Szasz 1961/2010.

I. What is a myth? What are the myths of psychiatry?

Szasz's claim that contemporary psychiatry rests on a "myth" owed much to Ryle's view that contemporary philosophy of mind rests on a "myth".³ Ryle objects to the way in which concepts that are appropriate to the domain of physical substances get applied, inappropriately and with bad results, to the domain of the mental – to the way we talk about knowledge, will, emotion, sensation and imagination as well as 'the mind' in general. Unlike Ryle's critique, which largely revolves around the contrast between objects and their functions, and between descriptive and expressive uses of language, Szasz's critique focusses primarily on the contrast between literal and metaphorical uses of language. He distinguishes himself from other critics of psychiatry as someone "willing to look at the problem through the resolving lense of literal/metaphorical meaning." (1987, p. 166)⁴ So I want to begin by considering the notion of a metaphor before relating it back to the notion of a myth.

A metaphor is a descriptive use of a non-literal application of a term or phrase; so we can judge some use of a term to be metaphorical only insofar as we can recognize other uses to be literal. The clearest cases of this contrast arise when the literal use of a term meets physical criteria such as physical type (bear), physical function (cup), or physical relation (higher), while metaphorical use applies the same term to things that do not meet those physical criteria (bear market, cup half full, higher status).⁵ Certainly, this is what Szasz has in mind when he claims that "mental illness" is a metaphor. He regards the literal meaning of illness to be bodily illness ("[T]he decisive initial step I take is to *define illness as the pathologist defines it – as a structural or functional abnormality of cells, tissues, organs, or bodies.*" (1987, p. 12)) and he argues against

³ Both Ryle and Szasz were writing at a time when the methodology appropriate to the study of human beings was widely contested. Ryle's extremely influential The Concept of Mind (which opens with a chapter entitled "Descartes' Myth") was published in 1949 and Szasz's Myth of Mental Illness was published in 1961. Szasz frequently included passages from Ryle's writing in his books, including the following passage from The Concept of Mind, which is quoted at the beginning of Law, Liberty, and Psychiatry: "A myth is, of course, not a fairly story. It is the presentation of facts belonging in one category in the idioms belonging to another. To explode a myth is accordingly not to deny the facts but to reallocate them."

⁴ Likewise, in the Preface he wrote to the reissue of The Myth of Mental Illness, Szasz describes his work as "an effort to recast mental illness and psychiatry from a medical into a linguistic-rhetorical phenomenon." (p. xxiii)

⁵ Defining metaphor is, of course, a topic of ongoing dispute. Recognizing the difficulty of defining metaphor, Szasz invokes Turbayne's claim that metaphor "involves the pretense that something is the case when it is not", and he cites dictionary lists of synonyms and antonyms for literal – some more relevant than others: "The synonyms of literal are: Verbal, veritable, accurate, true, exact, precise, regular, real, actual, undeviating, veracious, undisputed. Among its antonyms we find, in addition to metaphorical, the following Wrong, erring, misleading, mistaken, false, erroneous, deceiving, untrue, delusive, beguiling, fallacious, unsound, lying, distorted, unreal, allegorical, allusive, colloquial, symbolical, figurative, and mythical." (1987, p. 138)

the view that so-called mental illness can, in fact, be equated with such bodily abnormalities.⁶

“Clearly, if disease means bodily disease, then mental diseases are metaphoric diseases, just as priests are metaphoric fathers. ... Conceptually, psychiatry (except insofar as it addresses bona fide brain diseases) thus rests on a literalized metaphor.” (1987, p. 37).

Often a metaphor is recognized as a metaphor. When its users fail to recognize its metaphorical status, however, a metaphor is said to be “literalized.” There are many cases, of course, in which we don’t *notice* the metaphorical status of some use of a term but we quickly *acknowledge* its metaphorical status once it is brought to our attention. I might not notice the metaphorical nature of the term “sharp” when I speak of sharp minds, but I will quickly agree that minds are not literally sharp. (Many instances of so-called tired metaphors are like this.) There are also cases in which the metaphorical application of a word ceases to be metaphorical, gaining a literal meaning instead. Vigorously cheerful people are literally hearty, regardless of the state of their hearts. The cases that concern Szasz, however, are cases in which people mistake metaphorical truths for literal truths – for example, cases in which participants in the rite of communion interpret the phrase “the blood of Christ” as literally applicable to the liquid they are offered.⁷

Why is this so bad? The problems arise, primarily, from supposing that the methods and implications of one domain (the domain in which a given term applies literally) apply to some other domain (the domain in which the term applies only metaphorically). As though we could investigate Jesus’s ancestry by analyzing DNA in the consecrated wine, and as though we could infer that there must be an enormous amount of Jesus’s blood in the world. In the case of “mental illness”, according to Szasz, a failure to recognize the metaphorical status of “mental illness” leads us to the inappropriate use of medical methods – drugs, surgery, electroshock, and a host of other tools (tools that are suited to physical ailments like broken bones and polio and Lyme disease) – and it leads us to suppose that sufferers are passive victims of a disease when they are not.

Szasz, of course, is acutely aware of the increasingly popular view that mental problems *are* brain problems. He is quick, however, to highlight the imperfections of suggested correlations between mental problems and physical problems⁸ and, more importantly,

⁶ One influential line of defense against Szasz’s argument points to the discovery of various neurological correlations (which are seldom straightforward or universal), and assumes (usually without argument) that the existence of such correlations indicates that mental disorders are equivalent to physical disorders. Another influential line of argument invokes the notion of a proper function, suggesting that mental disorders are like physical disorders insofar as both occur precisely when some system, mental or physical, is unable to fulfill its biologically determined function. (Wakefield 1992)

⁷ One of Szasz’s examples in 1976a, p. 36.

⁸ “To be sure, it is possible to discover hitherto unidentified brain lesions. But that can be done only on the brains of specific patients. If certain never-before-seen lesions were identified in the brains of mental patients and considered to be lesions specifically identifying schizophrenia, the, given the way

he is quite willing to switch from talk of mental ailments to talk of physical ailments when and if reliable correlations can be established.⁹ He insists that genuinely mental problems, however, are problems of a different kind – namely, ailments in one’s ability to navigate the difficulties of living; they are, in effect, moral problems rather than medical problems.¹⁰ Normative judgments that belong in the domain of ethics are recast as descriptive judgments in the domain of science.

“The pancreas may be said to have a natural function. But what is the natural function of the person? That is like asking what is the meaning of life, which is a religious-philosophical, not medical-scientific, question.” (1961/2010, p.xxiii)

“... bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program. Of course, the word "sick" is often used metaphorically. We call jokes "sick," economies "sick," sometimes even the whole world "sick"; but only when we call minds "sick" do we systematically mistake and strategically misinterpret metaphor for fact--and send for the doctor to "cure" the "illness." It is as if a television viewer were to send for a television repairman because he dislikes the program he sees on the screen. (1961 pp.x-xi)

The transition from metaphor to myth involves one more step. For literalizations of metaphors do not always result in myths. A child may misinterpret a metaphorical use of the term “branch” – in the phrase “a branch of the government”, for example – without that misinterpretation constituting myth. When the literalization of a metaphor supports a wide range of beliefs and practices that serve to sustain certain social arrangements, however, it becomes a myth. (To use Szasz’s words from the above quote, the misinterpretation must be “systematic” and “strategic”.) So mental illness is a myth insofar as the metaphorical use of the term “illness” is mistaken for a literal use of that term, insofar as that mistake supports the systematic medicalization of our mental lives, and insofar as that system of errors serves certain social purposes – especially purposes having to do with the retention of power and the relinquishing of responsibility. (Social constructivist analyses also emphasize the systematic and strategic illusion of thinking that race and gender, for example, refer to physical properties, but they do not suppose that the mistake relies on the literalization of a *metaphor*.¹¹)

schizophrenia is in fact diagnosed, it is certain that many schizophrenics would not have such lesions, and that many nonschizophrenics would.” (1987, p. 78)

⁹ “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, the opposite is what actually happens: the history of psychiatry is the history of an ever-expanding list of ‘mental disorders.’” (1961/2010_p. xiv,)

¹⁰ This is just one of many examples of what Ryle would call a “category mistake”. See examples recounted in Cresswell 2008. Szasz often describes the master mistake in psychiatry as the mistake of treating reasons as causes, and justifications as explanations (1961/2010 pp. 149-151).

¹¹ According to constructivists about race and gender, there are no literal applications of racial terms or gender terms. See Church 2004 for further clarification of what I take the constructivist thesis to involve.

It is the medical and psychiatric establishment that most clearly gains from the myth of mental illness; psychiatrists and pharmacists and insurers all gain both money and power from medicalization of mental distress. But patients can also gain by perpetrating the myth of mental illness; presenting oneself as mentally ill serves to absolve oneself of responsibility, on the one hand, and it gives one access to support services that would not otherwise be available.

“Poor people, by definition, have no money and hence cannot pay, in real currency, for what they want. They therefore pay for it in the only currency they have, namely, pain, suffering, and the willingness to submit to medical and psychiatric authorities. And what is it they want and so obtain? Personal attention disguised as medical and psychiatric care; sedatives and stimulants disguised as treatment; and, finally, room and board disguised as hospitalization.” (1976a p. 128)

The master metaphor, according to Szasz, is the metaphor of mental illness. But there are many subsidiary metaphors whose literalization has also contributed to the medicalization of the mental. Consider the notion of a “conflict” or “clash” between ideas or values. Literal clashes occur between physical objects or forces, ideas and values can only clash metaphorically; but psychiatric theory, largely under the influence of Freud, has come to view these metaphorical clashes as literal clashes, leading to the positing of unconscious impulses -- inner forces that can be investigated as physical phenomena. (1987 p. 143) Similarly, the notion of being “stuck” in a certain pattern of behavior ceases to be treated as a metaphor and researchers end up looking for an inner mechanism that gets stuck literally.

There is a great irony to this pattern within the practice of psychiatry since it is psychiatry, again largely under the influence of Freud, that has identified ways in which the literalization of metaphor underwrites two key mental disorders – hysteria and schizophrenia.¹² The classic hysteric takes a term that applies metaphorically to her situation – a term like “crooked” or “twisted” or “unspeakable” or “blind” (as descriptions of dishonesty, deception, wickedness, or ignorance), and she makes it apply literally to her own body -- twisting her limbs, ceasing to speak, or ceasing to see; her body becomes the canvas on which she can express the ills of her situation.¹³ More generally, a “sick” situation is transformed into a “sick” body. Szasz suggests “that we view hysteria as a pretense of being ill” (1987 p. 177), and details several cases in which a person’s “pain” is the literalized expression of a metaphorically painful situation. He describes a soon-to-retire Naval officer, for example, as follows:

“.. all significant [painful] issues in his life were translated, so to speak, into the language of [bodily] pain and were then expressed in such a manner that neither

¹² Hysteria was the most common diagnosis of mental illness in the late nineteenth and early twentieth centuries. Schizophrenia is a more common diagnosis now, said to afflict about 10% of the population.

¹³ Classic Freudian case: hysteric whose “eyes were not right/twisted German: “Augenverdreher”, which also means hypocrite (Freud 1915, p. 207) A common contemporary case is that of Vietnamese and Cambodian women who are either “dumb” or “blind”.

the patient nor those to whom he addressed himself really knew what he was saying. ... The persistence of the pain now becomes a “complaint” and serves as retribution. This should be taken literally to mean that the patient is now complaining to (and against) those who he feels have let him down.” (1957 pp. 100, 102)

Likewise, Szasz follows Bleuler (who introduced the category of schizophrenia) in characterizing a schizophrenic as someone who interprets metaphors literally:

“The difference between the use of such phrases [as “I am Switzerland” or “I am freedom”] in the healthy and in the schizophrenic rests on the fact that in the former it is a mere metaphor whereas for the patients the dividing line between direct and indirect representation has been obscured. The result is that they frequently think of these metaphors in a literal sense.” (Bleuler 1911 p. 438; cited in Szasz 1987 p. 149)

Insofar as psychiatrists are themselves dependent on the literalization of metaphors, then, they share the defining symptoms of their hysterical and their schizophrenic patients.

Once the mythical status of a system of metaphors is recognized, whether these are the metaphors of a psychiatrist or the metaphors of a patient, it is possible to return one’s focus to the ethical and political decisions that must be made in a given situation. Szasz does not favor the elimination of myths (“I believe that people are entitled to their mythologies ...” (Vatz 1983 p. 171) but he does insist on the freedom of each person to choose their own myths and the responsibility of each person to take responsibility for the consequences of their myths. In the case of non-medical pain, for example, Szasz advocates

“... treating the client as a person responsible for his life rather than as a patient not responsible for his lesion, by treating pain as an idiom rather than as an illness, and by substituting his own dialectic and discursive language for the client’s rhetoric and nondiscursive language. If such an enterprise is successful it is not because the therapist has succeeded in controlling the patient’s pain, but because the patient has decided to become another kind of person.” (1957 xlv-xlvi)¹⁴

¹⁴ Szasz offers this further elaboration of the linguistic focus: “The patient not only learns to speak the language of real illness, but, realizing and reflecting upon the problem of communication he faces with physicians, also undertakes an explicit study of his own problem. He learns both about his own communications and about those of physicians in particular, he learns about the history, aims, and uses and abuses of each of these languages.” (1961/2010 p. 93)

II. *What is a projection? What are the projections of psychiatry?*

The term “projection” is central to psychoanalytic theory; it refers to instances in which traits of one person or thing are attributed to some other person or thing. When a child, playing with her dolls, attributes her own anger to her doll, she is projecting it onto her doll. When a teacher flirting with a student insists that it is the student who is flirting with him, he is projecting his own intentions onto the student. In these cases, one’s own mental states are assigned to someone else – typically, as a way of disowning them, of preserving one’s own self-image and relocating responsibility; but the projecting child or teacher doesn’t need to deny their own possession of the same trait. (The opposite of projection is introjection, whereby traits of some other person or thing are attributed to oneself – typically, as a way of gaining power or boosting one’s self esteem but also, at times, as a way of punishing oneself or a way of avoiding confrontation by taking on extra responsibilities.¹⁵)

Slightly different, but related, are cases in which the features of one person who is not oneself get attributed to another person who is not oneself. A student might attribute features of her mother to her teacher, or to her therapist. A worker might attribute features of a past employer to a present employer. These are often categorized as cases of “transference”.¹⁶ And while transference can certainly be an important route to knowledge – for both patient and therapist, it rests on a mistake that, ultimately, ought to be recognized as such.

Unlike the myths discussed in the previous section, projections do not mistake metaphorical attributions for literal attributions; instead, they mistake a merely possible subject of a literal attribution for the actual subject of a literal attribution. There is nothing so subtle as a “category mistake” (Ryle’s term for the wrongful attribution of properties that belong to one kind of thing to another kind of thing entirely); in the case of a projection, the designated subject *could* have had the property in question, but it doesn’t.

Szasz describes several areas in which the institution of psychiatry, as well as individual psychiatrists, are guilty of such projections. One widespread example of psychiatric projection is the attribution of distress to a patient when the distress actually belongs to those who have to deal with the patient. People may be socially deviant or socially incompetent without experiencing any mental distress. Many types of behavior that can lead to incarceration in a mental institution (e.g. nudity in public, shouted insults, a lack of personal grooming, a refusal to obey directions) are a cause of suffering in others,

¹⁵ See his account of the conflicting goals of hysterics 1961/2010 pp. 213-215.

¹⁶ Szasz also uses the term “transference” when describing cases in which attributes of external objects get reassigned to one’s own body. (1957 p. 135-6) Some such transfers will involve the literalization of metaphors, as discussed in the previous section; others will simply shift from one literal attribution to another, as discussed in this section.

not in the person misbehaving.¹⁷ But given our discomfort with infringing on the liberty of people that are not actually a threat to anyone else, it is convenient to project some of our discomfort onto those who make us uncomfortable; we can then claim to be acting for their own sake.

“... certain personally or socially disapproved behaviors, especially when they eventuate in bodily harm to the individuals who engages in them, are now conventionally classified as diseases: for example Soviet psychiatrists find that persons who cannot – or do not – control their displeasure with the political system of their own country suffer from *creeping schizophrenia*, while American psychiatrists find that persons who do not control their greed when in a casino, suffer from *pathological gambling*.” (1987 p. 14)

A more subtle and perhaps more pervasive form of projection occurs when psychiatrists project their own values and priorities onto their patients – assuming that everyone puts a premium on happiness, for example, or assuming that happiness requires physical health, friends and family. There is a growing tendency to ground ethics in evolutionary theory, with various commentators supposing that the divide between descriptive claims and prescriptive claims (a divide that Szasz is intent on respecting) can be bridged by appealing to the sort of functioning that evolution has favored.¹⁸ One can doubt the inference from ‘X is a result of the evolution of species H’ to ‘X is the best alternative for species H’, however; certain options may not yet have been tested, others results may be accidental by-products of the traits being selected for. Also, and more importantly for Szasz, there is no reason to think than any individual’s priorities ought to conform to the priorities that have benefited the species as a whole.¹⁹ Still less should we assume that another individual’s priorities ought to conform to one’s own.

“...we must decide whether we value freedom more than health or vice versa; ... I, placing freedom above health, advocate returning health and illness, mental health and mental illness, to their rightful owners – the so-called patients and mental patients, the persons who possess (or are said to suffer from) these conditions.” (1987 p. 161)

What does this mean in practice? Szasz offers the following summary:

“Diseases may be treated. Game-playing behavior can only be changed. ... In what directions, toward what sorts of game-playing behavior, does the patient want to change? In what direction does the therapist want him to change? As against the word “change”, the word “treatment implies that the patient’s present behavior is bad – because it is “sick”; and that the direction in which the therapist wants him to change is better or good – because it is “healthier”. In this, the

¹⁷ “... the idea of mental incompetence comprises certain conceptual-cognitive characteristics (of the agent diagnosed), and certain dispositional-justificatory decisions (of the agents making the diagnosis), the latter element generally greatly outweighing the former.” (1987 p. 250)

¹⁸ Wakefield 1992.

¹⁹ The same applies even if it is a gene pool, rather than species, that is selected for.

traditional psychiatric view, the physical defines what is good or bad, sick or healthy. In the individualistic, autonomous “psychotherapy” which I prefer, the patient himself defines what is good or bad, sick or healthy. With this arrangement, the patient might set himself goals in conflict with the therapist’s values: if the therapist does not accept this, he becomes “resistant” to helping the patient – instead of the patient being “resistant” because he fails to submit to the therapist.” (1961/2010 p. 228)

This brings us to the difficult topic of agency, or the capacity to be a genuine actor, versus passivity – a topic I return to in Section IV below. In interpersonal interactions, especially when those interactions are stressful, attributions of agency can be difficult. Psychiatry, according to Szasz, systematically and strategically underestimates the agency of the so-called mentally ill. This too, I want to suggest, amounts to a projection error. There is no question that agency is something that can be attributed to people literally, and there is no question that psychiatrists recognize some degree of agency in their patients. The overriding experience of a psychiatrist confronting a hysterical or schizophrenic individual, however, is an experience of helplessness with regard to that individual. Normal words and actions fail to have their normal effects, and it is often impossible to imagine oneself in the shoes of that other. In such circumstances it is very tempting to regard the other person as less of a person and more of a thing – i.e. as subject to forces outside of their control rather than pursuing paths of their own devising. What this amounts to, however, is a projection of one’s own helplessness, one’s own lack of effective agency, onto that other person – a projection that helps to restore one’s own sense of control and helps justify one’s disregard for the agency of the other.

Here again we encounter a deep irony in the projective tendencies of psychiatry itself. Some of the most studied delusions (regarded as symptomatic of schizophrenia) are delusions regarding agency, and they are delusions that involve either projections or introjections: on the one hand, the projective delusion that one can control the movements of other people; on the other hand, the introjective delusion that other people (or gods, or computers) are controlling one’s own thoughts. Insofar as psychiatry itself (and a psychiatrically-minded populace) depends on projections of passivity, it (and we) share in the symptoms of schizophrenia. While psychoanalysts are standardly taught to recognize instances of transference (counter-transference), a part of Szasz’s project, it might be said, is to teach them further to recognize how contemporary psychiatry itself, in theory and in practice, exemplifies various sorts of transference.

III. *What is an overextension? What are the overextensions of psychiatry?*

It is possible for a term to be overextended (e.g. “friends” referring to anyone accessible via Facebook), and it is possible for a practice to be overextended (e.g. sharing personal information), and the two often go together. In contrast to the notion of a myth and the notion of a projection, the notion of overextension points to attributions that are not so much mistaken – mistakenly taken as literal in the case of myth, and mistakenly attributed to one thing rather than the other in the case of projection – as they are sloppy or stretched to the point where they cease to be meaningful or effective.

Szasz often remarks on the sheer number of cases now categorized as mental illness. (Instead of mental illness being a small subset of all possible illness, it has become a very large set containing many instances that have no medical basis at all.²⁰) As we have seen, Szasz diagnoses this expanding usage as stemming from the literalization of medical metaphors – in particular, the metaphor of “illness”. There are other ways in which a term or practice can expand, however – and it is worth noting some instances of these other expansions within the terminology and the practice of psychiatry.

The class of things deemed “irrational”, for example, has continued to expand under the influence of contemporary psychiatry. Irrationality (or, more precisely, an incapacity for rationality) has been offered as the overarching criterion of mental illness (Fingarette and Moore as cited Szasz 1987, pp. 63, 246) and DSM-V cites it as a defining component of specific mental illnesses such as schizophrenia, paranoia, and obsessive-compulsive and related disorders.²¹ But, as Szasz is quick to point out, what seems rational to one person may seem irrational to another, and mere failures of communication are often mistaken for instances of irrationality.²² Psychiatry has a stake in broadening the meaning of irrationality insofar as psychiatrists gain from certifying others as irrational. So, largely under the influence of psychiatry, a narrow definition of irrationality as the occurrence of internal inconsistencies or invalid inferences can be extended to cover all kinds of failure to fit into one’s society.

Similarly, the class of conditions labeled “depression” – one of the most common psychiatric diagnoses, has also greatly expanded under the influence of contemporary psychiatry. Once restricted to states of inexplicable despondency, the category of depression has now expanded to cover inexplicable cases of prolonged sluggishness, sleep disorders, and anxiety. This expansion is largely due to psychiatrists’ discovery that drugs that were able to relieve feelings of despondency (in some cases, for some period of time) were also able to relieve sluggishness, sleep disorders and anxiety (in

²⁰ See the contrasting illustrations Szasz 1987, page 53 (smaller box for mental illness within larger box for all illness) versus page 86 (large box of mental illness totally separate from smaller box of genuine illness).

²¹ *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. 2013.

²² See also Gerrans 2014 p. 37 on doubts about equating madness/mental sickness with irrationality.

some cases, for some period of time).²³ Furthermore, in the current DSM, wholly explicable cases of despondency – those that are due to a major loss, i.e. grief – now fall under the category of depression (and now warrant drug treatment) whenever they last longer than what is deemed normal.

Over time the boundaries of our concepts are bound to change, of course – sometimes covering more than before, sometimes less, sometimes just different. What makes the extension of a term an overextension is its tendency to obliterate important distinctions – the distinction between thinking irrationally and thinking differently, for example, or the distinction between depression and grief. This affects our practice as well as our thinking for it enables psychiatrists to assume a managerial position with respect to more and more aspects of our lives and it justifies psychiatrists' use of a very narrow range of tools to address a very diverse set of conditions.

²³ This is nicely documented in Kramer 1993.

IV. *Is autonomy a myth, a projection, or an overextension?*

“Personally, I support respect for the autonomy and integrity of one’s self and others, but shall not make any attempt to justify these values here. I believe, however, that in a work of this kind it is necessary to make one’s moral preferences explicit, to enable the reader to better judge and compensate for the author’s biases.”
(1961/2010 p. 166)

In this final section I want to take up Szasz’s invitation to “better judge and compensate for [his] bias”. Given the importance of autonomy in Szasz’s writing, it is appropriate to ask whether autonomy might itself be regarded as a myth, a projection, or an overextension. We can, in brief, raise exactly the same questions about his concept of autonomy that he raises about the governing concepts of psychiatry.

First, though, a couple of clarifications. Szasz seems to assume that being autonomous is equivalent to having free will, and having free will means that one is responsible for one’s actions.²⁴ There are lots of interesting and important distinctions to be made in this area, and I think Szasz conflates several different things: making one’s own decisions versus following one’s own reasons, being guided by one’s reasons versus being guided by one’s own impulses, being responsible versus treating as responsible. For the purposes of this paper, however, I will ignore those distinctions. Another point of clarification concerns Szasz’s view of the relation between mental health and autonomy. Since he rejects the categories of illness and health (versus distress and happiness) as applicable to the realm of the mental, he would view any attempt to equate mental health with autonomy (and mental illness with a lack of autonomy) as guilty of a category mistake.²⁵ But Szasz certainly recognizes that there are some individuals, many of whom are labeled “mentally ill”, who are not even capable of being autonomous – individuals whose mental capacities are too limited or impaired to be capable of effective, rational thought; for such people – far fewer than psychiatry would have us suppose, Szasz is quite willing to advocate coercive, protective intervention.²⁶

Is autonomy a myth? Certainly it has been called that – by friends and enemies alike. Certain neo-Kantian philosophers emphasize the ethical importance of treating others *as though* they were autonomous (free, responsible) – even though literal autonomy (freedom, responsibility) does not exist.²⁷ And stepping outside the confines of academia, certain government officials have acknowledged that autonomy may be

²⁴ Szasz also seems to equate being autonomous with being free, as in earlier-cited quote from Szasz 1987 p. 161. See Dworkin 1981 and Gracia 2012 for nice overviews of a wide range of uses of the term “autonomy” in recent political, legal, and medical discourse.

²⁵ See Edwards 1981 as example of someone who defends this equation.

²⁶ Szasz 1987, p. 251, lists the unconscious and the intoxicated, and those who are acutely delirious or demented, as belonging to this class. He is quick to insist that the latter states, like the former, “are acute and chronic disturbances of brain function” – capable being diagnosed by clinical tests or autopsy. Such conditions, then, in his terms, are physical rather than mental.

²⁷ Ameriks 2000, Larmore 2008.

dismissed by representatives from other countries as an American myth.²⁸ Does Szasz's own understanding of myth, detailed in Section I, suggest something similar? The meaning of "autonomy" is self-governing or self-ruled – an autonomous entity being one that is the author of its own actions, not deferential to the dictates of others. This definition relies on some key metaphors since the term "govern" applies literally to political relations between people, and the term "author" applies literally to relations between a writer and a text. If we fail to recognize the metaphorical nature of these terms when applied to an individual's psychological capacities, and if that failure has systematic and strategic import, then, by Szasz's own analysis, it becomes mythical.

Likewise, the notion of "free will" becomes part of the myth of an immaterial mind when a metaphorical application of the term "free" (to actions rather than people in a social situation) is treated as a literal description of certain parts of the mind, and when the term "will" is assigned a literal referent – namely, a special sort of action-guiding power that is not itself determined by other wills or external powers. Ryle (who clearly influenced Szasz) devotes a chapter of The Concept of Mind to the will, describing "the myth of volitions" as an extension of Descartes' "the myth of the ghost in the machine" – the myth of the ghost in the machine resulting from the assignment of a literal referent to the term "mind", and the myth of the "will" resulting from the assignment of a literal referent to the term "will". On Ryle's analysis, a willed action is not an action with a special sort of causal history; it is, rather, an action by someone with a certain range of capacities.

"When we say that someone could have avoided committing a lapse or error, or that it was his fault that he committed it, we mean that he knew how to do the right thing, or was competent to do so, but did not exercise his knowledge or competence." (Ryle 1949, p. 70)

If Szasz follows Ryle's lead, rejecting the view that free will is a special kind of force in favor of the view that it is indicative of a certain range of capacities -- capacities to think and act in ways that are reflectively integrated and not dictated by their social and physical surroundings, then his stated commitment to autonomy and personal integrity should translate into a commitment to enhancing people's ability to think and act in a reflectively integrated way. But why doesn't this allow interventions – coerced if necessary – that are designed to enhance people's autonomy? (This, of course, is the stated aim of much of psychiatry – and the stated aim of much of childrearing.) Szasz can, of course, dispute the success of such interventions (or the honesty of the stated intentions), pointing out the myriad ways in which psychiatric interventions, intentionally or not, work against autonomy. Many of his remarks point in a different direction, however:

²⁸ Michael Hayden, former director of the CIA, raised the following questions about his conversations with representatives from foreign countries: "What of my side of these dialogues did our partners dismiss as American mythology? When I talked about self-determination? Cultural pluralism? ... I never figured that out, but the longer I did this, the more certain I was that it had to be going on." (Savage 2016 p. 10)

“... it is not because I believe that so-called mentally ill persons are ‘always autonomous’ that I want to treat them as responsible moral agents: I clearly state that since somatic pathology per se is not a sufficient condition for depriving a bodily ill person of moral agency, it should not be a sufficient condition in the case of a mentally ill person either.” (1987 p. 160)

Here he appears to invoke “moral agency” as a value that ought to trump the value of autonomy. But what is the basis for moral agency if not autonomy, and what is autonomy if not the capacity to be a moral agent? Against the backdrop of Rylean analyses, it seems appropriate to wonder whether Szasz has here succumbed to the very mythologizing he identifies elsewhere.

It is also appropriate to wonder whether Szasz’s insistence on the autonomy of mental “patients” – i.e. his insistence that they are actually actors, not patients – involves a certain amount of projection on his part. There is perhaps a universal tendency to assume that one’s own abilities are shared by others – especially when those abilities are mental rather than physical.²⁹ This can be a way of being generous – of emphasizing one’s common humanity – or it can be a way of being intolerant or vindictive – insisting that others’ problems are problems of their own devising, that others’ failures are their own fault. Mistaken attributions of autonomy will only count as projections, however, insofar as they serve to deflect responsibility from oneself onto another. As we saw above, Szasz is adept at identifying ways in which mental patients manage to deflect responsibility onto others, but is he likewise guilty of deflecting his own responsibilities onto his patients?

When Szasz defends game-playing models of patient behavior, he portrays patients as fully rational players of rule-governed games – thus responsible for the unfortunate consequences of their choices. When the rules are stacked against certain patients – in the case of the poor, for example, Szasz has a tendency to invoke “the tragedy of living” – as though there is nothing much anyone can do about the unfairness of life.³⁰ When he considers offering material support to those in distress, he echoes his economist friend who worries about calling any transfer of wealth ‘aid’.³¹ And when Szasz distinguishes his own critique of coercive psychiatry from those (like Laing) whom he calls “anti-psychiatrists”, he complains that “As the communists seek to raise the poor above the rich, so the anti-psychiatrists seek to raise the ‘insane’ above the ‘sane’.”³² This pattern, I am suggesting, indicates something more than a refusal to assign responsibility for the inevitable unfairnesses of life; it indicates a tendency to project responsibility onto the wrong parties.

²⁹ For example: what would be a (cognitive) inference for us regarding external control of our thoughts might be a (pre-cognitive) experience for the schizophrenic. (Gerrans 2014)

³⁰ “... [p]sychiatry is the denial of the reality of free will and of the tragic nature of life; this authenticated denial lets persons who seek a neuro-mythological explanation of human wickedness and who reject the inevitability of personal responsibility” (Szasz 1961/2010 p. 273)

³¹ Szasz 1961/2010 p. xiii.

³² Vatz 1983 pp. 171-2. There is a distinctly Nietzschean strain to his writing here and elsewhere.

We come, finally, to the worry that Szasz's recommendations rest on an overextension of the term "autonomy". Even if we agree that there are many people who are autonomous with respect to many aspects of their lives (which is not something everyone would agree to³³), we seem to observe many people who are not autonomous with respect to some aspect of their lives. The model of rational game-playing, contractual decision-making, and rule-book punishments seems applicable in some domains but not others. Interestingly enough, Szasz seems to recognize that he is pushing the boundaries of these notions when he writes:

"My opposition to deterministic explanations of human behavior does not imply any wish to minimize the effects, which are indeed significant, of past personal experiences, I wish only to maximize the scope of voluntaristic explanations – in other words, to reintroduce freedom, choice, and responsibility into the conceptual framework and vocabulary of psychiatry." (1961/2010 p. 6)

Maximizing the scope of certain concepts at the expense of others is a familiar political and rhetorical practice, and Szasz is quick to see himself as engaged in a political and rhetorical dispute with contemporary psychiatry. He is less quick, perhaps, to see the dangers of overextending the scope of autonomy.

I conclude, then, that Szasz's concept of autonomy does indeed have elements of myth, projection, and overextension. Recognizing these elements leaves much of his critique of psychiatry intact, but it should lead to a more cautious assessment of Szasz's worldview and a more humble attitude when it comes to formulating psychiatric alternatives.

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³³ Feminists have taken a lead in recent critiques of the very idea/ideal of autonomy; see Pateman 1988 and contributors to Kittay 2003 and Kittay 2010. Radoilska 2012 contributions are also especially relevant. Some of my own reflections on this tangled topic can be found in Church 2013.

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