

ANTI-PSYCHIATRY AND THE BIOMEDICAL MODEL:  
FROM DELUSION TO DISORDER

by

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## **Abstract**

Psychiatry as it functions today is largely guided by the biomedical model of mental illness, which rests upon the notion that deviations in mental functioning are biological in nature. This thesis seeks to critique this understanding of psychological distress through the lens of the philosophical tradition of anti-psychiatry, drawing primarily from the works of Thomas Szasz and Michel Foucault. Szasz places emphasis on the diagnostic disparities between physiological and psychological illness, arguing that the experiences and behaviors that psychiatrists class as mental diseases are actually communicative strategies utilized by individuals who lack the tools to properly address the stressors in their lives. In contrast, Foucault approaches the issue from a historico-political context, considering the power dynamics involved in the psychiatric encounter by giving an account of its evolution since the days of the asylum. Drawing from the description of the biomedical model given by investigative journalist Robert Whitaker, I will consider how the philosophies of Szasz and Foucault relate to the modern psychiatric climate. Ultimately, I will argue that it is Foucault's perspective that best equips us to critique the biomedical model, as its origins are inevitably intertwined with economic and political power.

## **Introduction**

My goal in writing this thesis is to provide an overview of two philosophies that have been greatly influential in the antipsychiatric movement, followed by an analysis of the tools they give us to understand the more modern psychiatric climate. I will begin by discussing the work of Thomas Szasz, followed by a review of Michel Foucault's writings on the subject. It is my belief that, while both bodies of work are attributed to the general movement of antipsychiatry, they differ greatly both in their methods of analysis and conclusions. After considering the theoretical contrasts between these two veins of antipsychiatry, which focus primarily on the age of hysteria, I will aim to characterize the shift in the psychiatric climate that has occurred since their conception. At this point I will draw heavily from the work of Robert Whitaker, who concerns himself with the chain of events that led to the heavily bioessentialist

approach that we observe throughout today's psychiatry. I will put forth the argument that it is the theoretical foundation provided to us by Foucault, as opposed to Szasz, which most effectively allows us to consider the forces behind this chain of events, and to consider the harm that results from the biomedical model of mental illness. Finally, I would like to put forth my own suggestions regarding how we might incorporate antipsychiatric concerns into our immediate efforts to help those struggling with their mental health. It is my belief that careful attention must be paid to the way in which we attribute the origins of individual suffering, as it is most often preceded by both personal traumas and underlying systemic issues, neither of which can be spirited away with the right prescription.

### **Szasz and the Myth of Mental Illness**

Thomas Szasz's arguments against the legitimacy of psychiatry are the most well-known and subsequently most critiqued arguments to arise from the anti-psychiatry movement. His 1961 book<sup>1</sup>, *The Myth of Mental Illness: Foundations of A Theory of Personal Conduct*, is dedicated to exposing what has been described as mental illness to be the mystification of problems in living, rather than genuine disease. Here I will give a summarized account of his philosophy with regards to the status of psychiatry and the manner in which the phenomenon of mental illness has manifested in response.

Psychiatry is, in Szasz's writing, based on a false equivalency between physiological medicine and psychological suffering. In physiological medicine, doctors are able to definitively declare whether or not a patient has a particular disease, and they are able to do this because it is

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<sup>1</sup> The first version was published as an essay in *American Psychologist* in 1953.

contingent upon the discovery of a particular physical property within the patient. Physiological illness is diagnosed in an empirical fashion, with the confirmation of the presence of “alterations in the physicochemical integrity of the body” that is consistent across all manifestations of a specific disease (12). Autopsy, for example, can serve as an accurate test for the presence of a particular lesion, as the results of such a test cannot be simulated and remain consistent in any case. Meanwhile, the symptoms of mental illness are not traceable to any such observable abnormality, says Szasz. The diagnosis of mental disease depends entirely on the physician’s judgements regarding the appropriateness of the patient’s thoughts, feelings, and behaviors. This results in a diagnostic process that deals exclusively with the perceived *functioning* of the patient rather than any uniform indicator in *structure*, allowing psychiatrists to *declare* the presence of a disease rather than *discovering* it (12).

The acceptance of certain deviations in function as medical matters opens the door to the reclassification of any given undesirable behavior as a pathological phenomenon. Once an individual has taken up the mantle of psychiatrist, whatever discomfort that is brought to them may be explained in the terms of illness. Szasz demonstrates this transformation of circumstance into symptom using the example of malingering. The conception of malingering as a disease has pathologized even the supposed lack of disease, resulting in a clinical scenario in which it is impossible to fail to meet the criteria for illness. Either one’s symptoms are genuine, in which case their interpretation will lead to the diagnosis of a particular mental illness, or one’s symptoms are being simulated for attention, in which case they may be diagnosed with malingering. It is possible to offer a psychoanalytic explanation for any given behavior presented to the psychiatrist, resulting in the pathologization of all behaviors.

Szasz argues that psychoanalysis is ineffective as a science because its theoretical basis is unsound. While the sciences that inform physiological medicine, biology and chemistry, consist in causal laws, psychoanalysis relies on the doctrine of historical determinism on the level of the individual. The philosophy of taking personal history as equivalent with the determinism of physical laws leaves no room for autonomy, on Szasz's view:

“It is obvious...that not only psychoanalysis but also much of psychiatric theory assumes that personal conduct is determined by prior personal-historical events. All these theories down-grade and even negate explanations of human behavior in terms such as freedom, choice, and responsibility” (5).

His issue with the approach of psychoanalysis lies not necessarily in its attempts to change the behavior of those suffering, but rather the language it uses to interpret such suffering, which it uses to legitimize itself as a medical authority. To demonstrate the incongruity between the language used in psychotherapy and its actual mechanisms, Szasz picks apart descriptions of patients and their suffering as given by Sigmund Freud, objecting that he obscures the origin of their “symptoms” while simultaneously recognizing the situations that give rise to them. In an excerpt from one of his case studies, Freud is quoted inquiring about the origins of a hysteric's suffering:

“We may ask: What is it that turns into physical pain here? A cautious reply would be: Something that might have become, and should have become, mental pain.”

In response, Szasz remarks:

“Freud answers these questions by taking recourse to what Colby has aptly called a ‘hydraulic metaphor.’ It seems evident, however, that no such complicated explanation is required. All that is necessary is to frame our questions differently. We might then ask: Why does a patient complain of pain? Why does the patient complain about his or her body when it is physically intact? Why does the patient not complain about personal troubles? If we ask the

second set of questions, then the answers must be phrased in terms of the complainant's personality and situation." (76)

The questions listed by Szasz above serve well to summarize some of the main tenets of his objections to psychiatry. He wishes to ask why the patient complains of pain and not personal troubles because he wishes to frame such behaviors not behind the veil of the subconscious but in terms of personal motivations and reinforcement. The "hydraulic metaphor" of psychosomatic conversion is not supported by any empirical evidence but merely by speculation guided by the principles of "personal-historical" determinism. The question regarding the physical intactness of the patient's body emphasizes his initial distinction between those complaints that ought to be considered medical and those that ought to be considered personal: the presence of a lesion.

For Szasz, any issue that may be falsely interpreted as mental illness by the psychiatrist boils down to issues in communication. He objects to the medicalization of such conduct on the grounds that it legitimizes it, obscuring the patient's agency regarding the circumstances at the root of their suffering. This process of legitimization begins, as Szasz tells it, with neuropathologist Jean-Martin Charcot's work on the treatment of hysterics, most notably at the Salpêtrière. Charcot's role in reclassifying hysteria as genuine illness rather than simulation is much like the invention of the guillotine in this regard, Szasz tells us:

"To put it succinctly, Guillotin made it easier for the condemned to die, and Charcot made it easier for the sufferer, then commonly called a malingerer, to be sick. It may be argued that when dealing with the hopeless and the helpless, these are real accomplishments. Still, I would maintain that Guillotin's and Charcot's interventions were not acts of liberation, but were rather processes of narcotization or tranquilization" (24).

The transformation of hysteria from a condition imitating organic neurological disease to a condition consisting in neurological dysfunction was achieved by virtue of Charcot's medical

authority alone, contends Szasz, in spite of a woeful lack of empirical evidence indicating an organic basis for the hysteric's symptoms. In considering the legacies of Charcot and Freud, it is further demonstrated that the constituent symptoms of mental illness are merely asserted to be pathological in nature, by extending the status of illness to those whose complaints could not be traced back to any discoverable bodily lesion.

“The adjectives ‘mental,’ ‘emotional,’ and ‘neurotic’ are semantic strategies to codify -- and, at the same time, to conceal -- the differences between two classes of disabilities or ‘problems’ in meeting life: one consists of bodily diseases which, by impairing the functioning of the human body as a machine, create difficulties in social adaptation; the other consists of difficulties in social adaptation not attributable to a malfunction machinery but, on the contrary, *inherent in the purposes the machine was made to serve by those who ‘built’ it (parents, society) or by those who ‘use’ it (individuals)*”<sup>2</sup> (37).

Reading the passage in italics, it would seem that Szasz positions the causality of the experiences presented to the psychiatrist as illness somewhere within the impression societal values and individual desires have on behavior. Reading on, we find that Szasz draws attention to two societal influences that serve to encourage the simulation of mental symptoms as a method of communication -- the games of childhood and religion. He insists that both of these institutions reward helplessness, citing the power dynamics of the family, and passages of the Bible that condemn success as unholy (169). Ultimately, Szasz reveals a sort of fundamental belief that seems to inform much of his disdain for the reinforcement of help-seeking behaviors when he tells us that “we must continue to scrutinize all therapeutic attitudes and arrangements attributed to benevolence...such arrangements serve to debase the patient and elevate the physician” (176). It seems that he places the utmost value on personal autonomy, expressing resentment for societal influences he perceives as glorifying help-seeking behaviors.

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<sup>2</sup> Emphasis mine.

The frame of reference that is most equipped to produce an accurate analysis of the behaviors psychiatry deems disordered is, as Szasz tells it, that which examines behavior as it functions in game-playing and rule-following. Indeed, interventions based on the principle of revealing these patterns to the suffering individual are the only interventions Szasz deems appropriate. Psychoanalysis has the potential to successfully utilize this, if it could only re-orient its theoretical perception of itself. This must be achieved by

“...abolishing the categories of ill and healthy behavior, and the prerequisite of mental sickness for so-called psychotherapy. This implies candid recognition that we ‘treat’ people by psychoanalysis or psychotherapy not because they are sick but because they desire this type of assistance; second, because they have problems in living for which they seek mastery through understanding of the kinds of games which they, and those around them, have been in the habit of playing; and third, because, as psychotherapists, we want and are able to participate in their ‘education,’ this being our professional role” (248).

This is the only frame of reference that Szasz feels fully accounts for the extent of human autonomy in motivating the behaviors and experiences that the psychiatrist declares disordered.

### **Responses to Szasz’s Anti-Psychiatry**

Early responses to the critiques of anti-psychiatry, particularly those directed at Thomas Szasz, tend to focus on establishing a definition of “disease” that will rightfully include mental illness within its bounds. R. E. Kendell and Christopher Boorse are two individuals who played important roles in this effort, and I shall recount their arguments here. While their objections to Szasz raise some important questions, I believe that they are ultimately unsuccessful for reasons that will be more attentively explored in Foucault’s work.



Kendell, in his article “The Concept of Disease and its Implications for Psychiatry,” puts forth a definition of disease based on biological function. He begins by ruling out definitions based on complaint, and based on the point at which medical intervention is necessary. Both of these criteria, he argues, allow arbitrary cases of illness to be declared based on the whims of either the patient or the clinician. More essential is his rejection of disease as the presence of a lesion, which Szasz leans on quite significantly in his own work. Although this definition is not as susceptible to social and political misuse, it ultimately fails to encompass some things rightfully considered disease, and wrongfully includes others. Kendell cites trigeminal neuralgia as an example of a disease whose biological origin is unknown, and notes that the physiological basis of many diseases have only recently been discovered, despite their historical status as illnesses. Additionally, there are physical “deformities” such as fused digits and albinism that cannot rightfully be called diseases despite the presence of physiological abnormalities. In addition, there are many physicochemical deviations from the norm that occur in degrees, making it difficult to declare at which point they become “lesions,” such as hypertension.

Indeed, it is by considering the case of hypertension that Kendell comes to the biological function model of disease. Hypertension may be considered illness not necessarily because the patient complains of suffering, nor simply because it is identified as dangerous by the clinician, but because it ultimately leads to a higher mortality rate. Kendell proposes the increase of mortality and decrease in fertility as hindrances to objective biological functions of the human species, giving us two criteria by which we can indisputably judge a condition to qualify as illness. The remainder of his argument, then, consists solely in providing evidence that specific types of mental illness do indeed increase mortality and decrease fertility, meaning that they may

rightfully be classified as diseases alongside the physiological ailments traditionally considered the subject of medicine.

Christopher Boorse employs a similar line of reasoning, honing in on the concept of mental functions as inherent in the biological reality of the human species. In “What a Theory of Mental Health Should Be,” he writes:

“What the healthy mind is like is an empirical question that can be answered correctly or incorrectly. We are no more free to define mental health as the constellation of qualities we most admire than we would be for physical health. Mental health must be a constellation of qualities displayed in the standard functional organization of members of our species. Only empirical inquiry can show whether normal human beings have an even temper, engage in socially considerate behavior, and advance the species.” (70)

So in essence, these critiques are aimed at responding to Szasz’s charge that psychiatry holds no empirical weight, insisting that the study of the mind and its functioning can be based in the objective notion of species design. While Kendell strives to show that the consequences of mental illness may be gauged by the same criteria as physiological illnesses, namely, an interference with the species-wide goals of survival and reproduction, Boorse lays out the justification for declaring certain mental properties as pathological, namely, those properties that defy species-design. While both of these objections to anti-psychiatry raise necessary questions of nuance regarding the concept of disease where Szasz’s work does not, they inevitably collapse into self-contradiction, as can be observed simply in each piece of writing discussed.

After citing statistical evidence of increased mortality and decreased fertility in schizophrenics and other sufferers of psychosis, Kendell concedes that such trends may very well be explained by the *social* consequences of the diagnoses in question, such as time spent in asylums and the disdain experienced by individuals who may be considered dangerous and

unpredictable. He goes on to suggest that social consequences such as these may, in a sense, themselves be considered biological consequences, considering that man is a social animal. In fact, some traits that may lead to an objective biological disadvantage may prove advantageous in particular social contexts: Kendell suggests the example of homosexuality and its resulting decrease in fertility, frowned upon by evolutionary standards but useful in communities that require additional resources to care for existing children. Nevertheless, he urges us to “ignore the increasing importance of cultural factors in who determines who lives and who dies,” lest we end up with the purely subjective concept of mental health that Szasz seeks to condemn (313). To conclude his argument, Kendell even goes so far as to wonder whether the needless psychiatrization of mere unhappiness (as opposed to those specific disorders that create a “biological disadvantage”) is what has prompted the anti-psychiatry movement in the first place, coming full-circle into Szasz’s fundamental objections towards the field.

There have been multiple criticisms of the naturalist approach to dysfunction which have, in my opinion, rendered it outdated. KWM Fulford, in his piece ““What is (mental) disease?: an open letter to Christopher Boorse,”” discusses how values fundamentally cannot be extracted from the concept of mental illness. While physical disease may be described in objective terminology vis a vis departures from the norm, the same methodology cannot be carried over to mental disease, as it would first require a general consensus regarding which departures from the norm are positive and which are negative. Fulford also broaches the issue of the biological teleology inherent in naturalistic conceptions of illness such as Boorse’s and Kendell’s, reminding us that the concept of a “goal,” which cannot be avoided when speaking of “species design,” contains within it a positive evaluation. In a similar line of criticism, Derek Bolton

reminds us that evolutionary function cannot possibly be separated from social function, considering that cooperative behaviors account for a large portion of the traits that have allowed humans to survive and prosper over the genesis of our species. He goes on to note that the study of epigenetics has reinforced the notion that our environments are determinant of the ways in which our genetics are expressed, meaning that even on a fundamentally biological level it is impossible to separate “innate” function from that which is learned. Furthermore, any study of mental functions will inevitably have to be conducted by considering their manifestations not in abstract hypotheticals but in observable life – meaning that they will be tied up in the person’s desires, experiences, and beliefs.

Though such counterarguments against the attempt to conceive of a “values-out” psychiatry are relatively successful in beating back the concerns of Kendell and Boorse, I do not believe that they vindicate Szasz’s convictions either. He contends that psychiatry is a field of study devoted to misinterpreting the communications of those who are struggling to claim agency in their lived conflicts. The most pressing issues with Szasz’s philosophy, in my opinion, lie not in his arguments against the empirical status of psychiatric symptoms but in his explanation of what they “really are,” in which he heavily emphasizes the fickle-mindedness of the hysterics who simulate bodily symptoms as a strategy for sympathy. I think that the role of the societal values he sees as responsible for encouraging this behavior, religion and the dynamics of the family, are misinterpreted in his account. Ultimately, I feel that his libertarianesque prizing of human autonomy prevents him from understanding the larger structures at play in the clinical encounter, which is why I will be turning to Foucault for a more nuanced political analysis.

## **Foucault and Psychiatric Power**

Though French philosopher Michel Foucault's writings regarding psychiatry are typically listed adjacent to Szasz's as part of the anti-psychiatry tradition, his analysis differs a great deal from the one just examined. While Szasz places emphasis on the ways in which psychiatry fails to properly follow the methods constitutive of proper medicine, instead identifying its major feature as the misidentification of problems in living as pathological, Foucault grounds his critique of psychiatry in historical and political developments. In order to gain a meaningful understanding of this critique, I would like to first give a brief explanation of Foucault's account of the shift from sovereign power to disciplinary power.

Initially developed in his *Discipline and Punish* and later referenced in his series of lectures entitled *Psychiatric Power*, Foucault's study of the metamorphosis of political power places focus on changes in the mechanisms used to control the members of a society. Sovereign power refers to the instruments of control employed by monarchs, which served as the main form of government until the x century. This form of control was defined by public displays of might, the purpose of which was to reinforce the public's fear of the monarch's God-given power. Punishment was not designed to correspond to a particular individual's actions but to send the message that disrespect in the face of divine power would not be tolerated.

Disciplinary power first began to develop in the military, spreading to other contexts before eventually becoming the all-encompassing mode of operation of society. Its defining feature is its omnipresence -- the structure it imposes on every aspect of life. Contrasting its features with the divine right of sovereign power, Foucault writes:

“One is not then marked by an action made once and for all, or by a situation given from the start, but visible and always in the situation of being under constant observation. More precisely, we can say that there is no reference to an act, an event, or an original right in the

relationship of disciplinary power. Disciplinary power refers instead to a final or optimum state. It looks forward to the future, towards the moment when it will keep going by itself and only a virtual supervision will be required, when discipline, consequently, will have become habit.”

This last part of Foucault’s explanation -- the reference to virtual supervision and habit -- is especially important to understanding the design and impact of disciplinary power. Foucault makes use of Bentham’s invention of the Panopticon in explaining the mechanisms of disciplinary power. The Panopticon is a system of surveillance that Bentham suggested could be of use in schools, prisons, workplaces, etc, which involves a circular tower in the center of the space that allows for the observation of all surrounding activity. Individuals would be arranged around the tower in separate units so that everyone can be accounted for at all times. Though the structure gifts the individual within an exhaustive view of the institution, it will be opaque from the outside, meaning that those being surveilled have no way of telling whether or not they are being observed in the present moment. This creates the possibility that one may be watched at any given time, forcing the individual to permanently behave as is expected.

As the base principle of the Panopticon -- constant anonymous surveillance -- has been integrated into more and more dimensions of life, we have become our own keepers. The threat of grand punishment is no longer necessary to curb unwanted behavior. With this ultimate goal of discipline in mind, we can start to understand the context of the history provided in *Psychiatric Power*.

At its core, Foucault describes psychiatric intervention not as a medical procedure but as a display of power. In order to demonstrate this, he begins with a history of the mechanisms of the asylum, investigating the manner in which they are meant to have a therapeutic effect. In agreement with Szasz, Foucault contends that the psychiatric approach to madness bears nothing

in common with medicine methodologically, and merely adopts the mantle of medical authority in order to grant its actions legitimacy. In the asylum, there are no efforts made to identify differential diagnoses, and the treatment given to a particular patient is not determined by the supposed cause of their disease but by the problems their behavior presents to the doctor. It is not any medicinal practice administered by the asylum but the structure of the asylum itself which seeks to cure madness, as it is designed to stage the confrontations of will required to reform the sick individual to society's standards.

Madness during this period of time, explains Foucault, was essentially the presence of a will that refused to bow to others. He explains:

“If you look at how a delirium, an illusion, or a hallucination was analyzed in this period, you see that it doesn't much matter whether someone believes himself to be a king, that is to say, whether the content of his delirium is supposing that he exercises royal power, or, to the contrary, believes himself to be ruined, persecuted, and rejected by the whole of humanity. For the psychiatrists of this period, the fact of imposing this belief, of asserting it against every proof to the contrary, even putting it forward against medical knowledge, wanting to impose it on the doctor and, ultimately, on the whole asylum, thus asserting it against every other form of certainty or knowledge, constitutes a way of believing that one is a king” (28).

If madness consists of a belief that cannot be touched by the words of others, then the cure must consist not in words but in displays of power, events designed to demonstrate the victory of the doctor's will over the will of the mad. Such interventions again do not involve the methodology of medicine but of discipline, administered in ways designed to reflect proper adjustment to the world beyond the asylum walls. Foucault gives a great deal of attention to the specific strategies used in the asylum, drawing from various historical accounts given by pioneers of “moral treatment” like Pinel and Leuret.

The methods utilized by these figureheads of the asylum were designed specifically to structure the totality of the madman's time, filling it with tasks that mirror the functionality of the outside world. Patients must demonstrate that they have internalized the values taught by these regimens, the values of work, currency, and exchange, through the admission of their madness in response to the doctor's questioning. They will be punished repeatedly until they have internalized the doctor's conception of their madness, until there is a moment in the interview where the truth is accepted by the patient and reproduced by him. We can see through these accounts of treatment that its goal is to reconfigure the recipient into someone who is capable of existing within the systems outside the asylum; the asylum exists to catch those who generate difficulties in the administration of disciplinary power and reform them in its image.

Foucault's conception of hysteria, much in contrast to that of Szasz, is developed as a direct result of the systematic role of the asylum as described. As a point of disciplinary intervention, enrollment in the asylum is dependent not upon differential diagnosis but upon an ultimate judgment of the presence of madness.

"In organic medicine, the doctor vaguely formulates the following demand: Show me your symptoms and I will tell you what your illness is. In the psychiatric test, the psychiatrist's demand is much weightier, much more surcharged, and is: With what you are, with your life, with the grounds for people's complaints, with what you do, and what you say, provide me with some symptoms, not so that I know what your illness is, but so that I can stand before you as a doctor. That is to say, the psychiatric test is a double test for the official establishment of an individual's life as a tissue of pathological symptoms, as well as the constant official establishment of the psychiatrist as a doctor, or of the supreme disciplinary authority as a medical authority. Consequently, we can say that the psychiatric test is an endless test of admittance into the hospital. Why is it that one cannot leave the asylum? One cannot leave the asylum, not because the exit is far away, but because the entrance is too near. One never stops entering the asylum, and every encounter, every confrontation between the doctor and the patient begins again and indefinitely repeats this founding, initial act by which madness will exist as reality and the psychiatrist will exist as doctor" (268).



Hysteria is, on Foucault's view, a strategy devised by patients that allows them to escape the totality of the psychiatric interview. It allows them to demand the process of differential diagnosis, of medical legitimacy, by presenting the doctor with symptoms that must be analyzed with regard to a literal cause. The simulation of bodily symptoms is an antipsychiatric strategy in Foucault, a phenomenon that arises not from the desire to enter into the status of pathology, as Szasz explains it, but to lessen the consequences of such a status.

### **The Anatomy of an Epidemic**

The two primary anti-psychiatry philosophies that we have examined thus far, those of Thomas Szasz and Michel Foucault, both center the bulk of their analyses around the historical concepts of delusion and hysteria. I would like to make an effort to extrapolate their criticisms to address the current psychiatric climate, which has evolved rapidly in the last half of the century. The first step in undertaking such an effort will be to give an account of this evolution.

My primary source regarding the rise of the biomedical model of illness shall be *The Anatomy of an Epidemic*, a text written by investigative journalist Robert Whitaker. The central line of questioning explored in the work considers, given the trends of increasing rates in the prescription of psychotropic medications and the increasing population of those disabled by mental illness, whether it's possible that the biomedical paradigm of care is worsening the modern mental health epidemic. Whitaker's methods of investigation include the meta-analysis of clinical studies and statistics, the recounting of historical events that lead to the prominence of particular treatments, and reflection upon various anecdotes provided by patients grappling with mental illness and medication.

I would first like to place emphasis on the story of how psychotropic medications came to be heralded as the ultimate treatment for mental distress, which will help us to understand how the celebrated success of such treatments contributed to the widespread perception that mental illness is fundamentally biological in nature. Whitaker sets the stage by recounting the origin of the notion of the “magic bullet” in medicine, starting with the discovery of salvarsan, a compound capable of selectively killing the microbe responsible for syphilis. When researchers realized that they could test for substances with specific structures that allowed them to target the agents of disease without bringing harm to the rest of the body, the widespread search for magic bullets began, motivated by the possibility that any particular ailment may be susceptible to the same approach. Whitaker cites the exposition of terrible asylum conditions surrounding WWII as a catalyst that drove the search for medication that might serve as magic bullets in psychiatry, a search which became increasingly supported by federal funding as public concern for mental health continued to heighten (45).

The development of the first major psychiatric drugs, however, occurs much differently from the discovery of the lock-and-key mechanism that allows “magic bullets” in traditional medicine to be so effective. Initially administered as part of the search for a medicine effective against malaria in 1949, the compound chlorpromazine was found to induce anaesthetic-like effects in patients without the loss of consciousness. Henri Laborit, the French surgeon who discovered the drug, went on to suggest that it might be useful in psychiatric settings, as its effects were comparable to a “medicinal lobotomy,” which remained a common form of treatment at that time (49). Not much later, another compound with muscle-relaxing side-effects is discovered by chemist Frank Berger in London, who quickly recognizes its commercial

potential as a “minor tranquilizer” and aids in its development into the popular prescription medication Miltown. Finally, researchers at Hoffmann-La Roche observe that a compound found to yield effectiveness in treating tuberculosis, iproniazid, also conjured a sort of mania in patients. Though the administration of this drug appeared to result in some weighty side-effects, researchers contended that its extended use prompted a “complete remission in all symptoms” with regard to depressed patients (56). Reflecting on this trend, Whitaker reminds us that

“none of these drugs had been developed after scientists had identified any disease process or brain abnormality that might have been causing [these] symptoms. They arrived out of the post-World War II search for magic bullets against infectious diseases, with researchers, during that process, stumbling upon compounds that affected the central nervous system in novel ways” (54).

Whitaker goes on to explain how investigation into the mechanisms of iproniazid and imipramine, initially described as “psychic energizers” but gradually rebranded as “antidepressants,” came to inform the chemical imbalance theory of mental illness. As it was discovered that this family of medications had an inhibitory effect on an enzyme responsible for the reuptake of the neurotransmitters norepinephrine and serotonin, researchers hypothesized that those who suffer from affective disorders must have a deficiency of these neurotransmitters, which would account for the improvement in mood observed when the medication is administered. Though this account of mental illness remains popular amongst the general public, Whitaker cites multiple studies that, even shortly after its emergence, cast doubt upon the chemical imbalance hypothesis.<sup>3</sup> It would seem that, in general, patients tested before the administration of any drug do not display neurochemical deviances as compared to baseline

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<sup>3</sup>For those interested, Whitaker also gives a detailed explanation of the mechanisms behind SSRIs on pages 79-84, pointing out that the transformation in neurotransmitter functionality that occurs cannot be described as correcting an imbalance, as it results in a configuration much different than what is seen in the “healthy” unmedicated brain.

levels, and observations of alterations in neurological function and anatomy are mostly found in patients who have adhered to a drug regimen over an extended period of time (63-79).

As psychotropic medications continue to garner legitimacy via the newly proposed biological mechanisms behind mental illness, the prognosis for such diseases begins to shift. Depression, for example, had a relatively positive long-term outcome in the first half of the 20th century, with episodes of melancholy manifesting scarcely and the majority ending in remission (153). However, as treatment with antidepressants became increasingly common, so did relapse, particularly in cases in which a patient previously treated with antidepressants attempts to wean off their medication. The explanation provided for this phenomenon is that chronicity must be inherent to the disease; that depression is generally a life-long condition that requires consistent medication to manage. Whitaker wonders if perhaps this narrative is an inverse of the actual chain of events that follow from long-term use of antidepressants: the brain adapts to the altered baseline in neurotransmitter function, and when the agent responsible for this alteration is removed, the brain finds itself unable to re-adapt to the new state of affairs.<sup>4</sup>

Finally, we can further observe the transformation of how mental illness is perceived in the anecdotal sections of Whitaker's work, which follow the life events of various patients prescribed psychotropic medications, many of whom entered into psychiatric care at a young age. The majority of individuals Whitaker interacts with tell him that the most immediate explanation they were given was that they suffered from a chemical imbalance and would likely require medication for the rest of their lives (28). Besides entering a regimen of medication upon the first episodes of mental distress, many of the individuals Whitaker interviews share another

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<sup>4</sup> Whitaker is not the only one calling the effectiveness of antidepressants into question. Those interested should look to the work of psychologist Irving Kirsch, who has conducted research regarding antidepressants and the placebo effect.

trait: trauma experienced in childhood, or other circumstances that give rise to significant stress.

In none of these individual's stories do their psychiatrists seem concerned with the etiology of their mental distress, only with finding the medication that will stabilize their symptoms the most quickly.

### **The Bigger Picture**

Thinking back to the writings of Szasz and Foucault, I would like to argue that the former does not provide us with a coherent basis from which to criticize the recent bioessentialist direction taken by psychiatry, while the latter provides us with an underlying political analysis than can be easily brought to bear on the motivations behind the rise of medication as psychiatry's primary paradigm of care.

We may recall that one of Szasz's most pertinent frustrations with psychiatry as it functioned in the age of hysteria was its reliance on the principle of determinism via personal history. It would seem that psychiatry has taken a drastic turn away from this psychoanalytic approach, as an opposite conception of mental illness can be seen in the anecdotes given by Whitaker. The prevalence of the chemical imbalance theory of mental disorder has resulted in a downplaying of environmental factors, past and present, that may have a role in the distress experienced by psychiatric patients. The explanatory strategy of psychiatry in regards to such distress has now come to overlap with the explanatory strategy that Szasz claims is rightly attributed to physiological medicine; that is, that the root of mental suffering can be traced back to a neurological basis that remains consistent across its manifestations.

I also do not feel that Szasz's own explanatory strategy regarding the experiences classed as mental illness includes enough nuance to account for the culture of microdiagnosis that has developed in recent years. The societal indoctrination of helplessness, which he believes are instilled by the structures of family and religion, is now greatly overshadowed by late capitalism's demand for self-sufficiency and independence. Cultivating these virtues in one's self is not only encouraged but required for survival. The notion that people suffering from debilitating depression and anxiety have chosen to simulate their symptoms as a cry for help seems less likely when we consider that such symptoms oftentimes result in financial and interpersonal poverty.

It is at this juncture that I feel Foucault's work provides more valuable resources for understanding the social role that psychiatry serves. His contention that psychiatry intervenes to reform those individuals that cannot successfully fulfill their roles as given to them by the overarching disciplinary system tracks with the trends we have seen with regards to increasingly psychotropic treatment regimens. He discusses the manifestation of hysteria as the original psychiatric patient's escape from the binary of madness, an attempt to legitimize one's suffering that I feel continues into today's culture of self-diagnosis and illness as identity. This is not to say that I understand the embrace of clinical diagnosis as a method of simulation, but as a method of re-appropriating the disordered status given by psychiatric authority. Nonetheless, the internalization of the disciplinary system is a main theme in Foucault's work, and it is my suspicion that the integration of clinical labels into one's sense of self, while intended as a liberatory act, only serves to reify the systems of classification which deem particular feelings and behavior to be disordered.

The implications my analysis of these philosophies has for psychiatry going forward are largely political. I believe that mental health professionals must acknowledge the role of social and economic matrices of discipline in order to gain a meaningful understanding of why and how mental suffering presents itself. To individualize the sources of symptomatic behavior, whether it be via recourse to the principle human autonomy, or the doctrines of neurochemistry and anatomy, is to obscure the massive influence of disciplinary power has on the way people experience and respond to their lives.

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anti-inflammatory drugs  
Obsessive-compulsive disorder  
Once daily  
Occupational therapy.  
PD  
PMS  
PoM.  
PTSD.  
self, the world and the future.  
Delusions  
A delusion is a false belief, unshakeably held, which is outside the individual's normal social and cultural belief system.  
Types of delusion

The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social, and cultural as well as in anatomical, physiological, or biochemical terms (7). 3) Diabetes and schizophrenia have in common the fact that conditions of life and living constitute significant variables influencing. Overview. Delusional disorder is an illness characterized by at least 1 month of delusions but no other psychotic symptoms, according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). [1] Delusions are false beliefs based on incorrect inference about external reality that persist despite the evidence to the contrary; these beliefs are not ordinarily accepted by other members of the person's culture or subculture. The presence of homicidal or suicidal thoughts related to delusions should be actively assessed and the risk of carrying out violent plans should be ascertained. A review by researchers revealed a 21% risk of suicidal ideation and behavior in the persecutory and somatic subtypes. Delusional disorder is a generally rare mental illness in which a person presents delusions, but with no accompanying prominent hallucinations, thought disorder, mood disorder, or significant flattening of affect. Delusions are a specific symptom of psychosis. Delusions can be bizarre or non-bizarre in content; non-bizarre delusions are fixed false beliefs that involve situations that occur in real life, such as being harmed or poisoned. Apart from their delusion or delusions, people with delusional Psychodermatologic disorders fall into three categories: psychophysiologic disorders, primary psychiatric disorders and secondary psychiatric disorders. Psychophysiologic disorders (e.g., psoriasis and eczema) are associated with skin problems that are not directly connected to the mind but that react to emotional states, such as stress. The management of psychodermatologic disorders requires evaluation of the skin manifestation and the social, familial and occupational issues underlying the problem. Once the disorder has been diagnosed, management requires a dual approach, addressing both dermatologic and psychologic aspects. Psychological disorders may bring unexplained physical symptoms, irrational fears, and suicidal thoughts. A reminder of our species' fragility. 4. Psychological Disorders. To study the abnormal is the best way of understanding the normal. William James (1842-1910). There are 450 million people suffering from psychological disorders (WHO, 2004). [current population of US is 307 million]. Depression and schizophrenia exist in all cultures of the world. 5. Defining Psychological Disorders. When physicians discovered that syphilis led to mental disorders, they started using medical models to review the physical causes of these disorders. 1. Etiology: Cause and development of the disorder. 2. Diagnosis: Identifying (symptoms) and distinguishing one disease from another.